

UNIVERSITY OF KWAZULU-NATAL

**THE DELIVERY OF CULTURAL CARE BY HEALTH
PROFESSIONALS AMONG THE HOSPITALIZED
AMAXHOSA MALE INITIATES OF TRADITIONAL
CIRCUMCISION IN THE EASTERN CAPE**

2009

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**The delivery of cultural care by health professionals among the hospitalized
AmaXhosa male initiates of traditional circumcision in the Eastern Cape**

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The Faculty of Health Sciences
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By

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DEDICATION

This work is dedicated to the many health professionals who deliver cultural care among the hospitalized *AmaXhosa* male initiates of traditional circumcision. It is also dedicated to health professionals that I have had the great pleasure of knowing and working with during the writing of this study. Nothing will be more rewarding than to see many medical doctors and nurses use this information to expand their worldviews, and provide meaningful cultural caring practices among the hospitalized *AmaXhosa* male initiates of traditional circumcision. I also dedicate this research to the late Mr Thamsanqa Spamla and Mrs Mambele Spamla for their contribution to my life and education. May God bless your souls!!

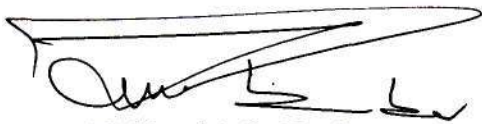
The following excerpt was mentioned by one of the hospitalized initiate.

“___ men will tell me that they did not come to hospital for admission. They say we are disappointing them yet they have failed in their intervention strategies in the bush.”

(General informant)


DECLARATION

I Mohlomi Jafta Ntsaba, do hereby declare that except for the referenced citations in the text, this thesis titled “**The delivery of cultural care by health professionals among the hospitalized *AmaXhosa* male initiates of traditional circumcision in the Eastern Cape**” is representative of my original own work.



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23/04/2009
Date



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23/04/2009
Date

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ABSTRACT

Traditional male circumcision is a rite of passage among the *AmaXhosa* in South Africa. According to the custom of male traditional circumcision, initiates should remain in the bush for the entire seclusion period. The *AmaXhosa* male initiates encounter complications due to a ritual that has gone wrong. Common complications are penile sepsis, dehydration, penile amputations and septicaemia. As a last resort, when the *AmaXhosa* male initiates do not improve from complications associated with the custom they are referred to hospital for admission (Meintjes, 1998; Warren-Brown, 1998).

The main purposes of this study were, first to explore and describe the delivery of care to the hospitalized *AmaXhosa* male initiates whilst in the hands of healthcare professionals and professional care system. Second, to describe what constitutes culturally appropriate care for hospitalized *AmaXhosa* male initiates.

This study took place in three research sites, that included one rural hospital and two urban hospitals which admitted the *AmaXhosa* male initiates of traditional circumcision. A total of 13 hospitalized *AmaXhosa* male initiates and nine health professionals took part in this study. Leininger's ethnonursing qualitative research approach was used to guide this study. Data were collected, using purposive sampling, by means of unstructured interviews using guides, tape-recorder, and field notes. The study was first piloted at Umlamli Hospital using the same data collecting strategies as for the major study.

Data from key and general informants were analysed separately using Leininger's (1991) four-phase method. This was carried out in order to answer the research questions and research purposes. Major themes and patterns emerged from this process. The major

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CHAPTER ONE

INTRODUCTION

1.1 Introduction

Male circumcision has the unique distinction of being the oldest routine surgical operation. It is practised almost throughout the world for various reasons such as medical, religious or ritual (Taylor, 1995). In South Africa the *AmaXhosa* of the Eastern Cape practise male traditional circumcision as a rite of passage. During this process, surgical circumcision of the prepuce is performed and commonly the wounds become septic (Warren-Brown, 1998). The complications of traditional circumcision include sepsis of penile wounds and septicaemia. As a last resort initiates are transferred from initiation schools to hospitals. Meintjes (1998) mentioned that there were stories of open arguments between staff and family members regarding the care of hospitalised initiates. Health professionals from cultures other than the *AmaXhosa*, who work in the hospital, often interact with the initiates in a purely clinical perspective, without considering their cultural needs. A range of attitudes on the part of health professionals towards initiates admitted with septic circumcision have been reported. Family members, doctors, nursing staff, traditional practitioners, and the initiates often end up in a situation of conflict.

1.2 Background to the study

Taylor (1995) refers to male circumcision as the surgical removal of the foreskin of the penis. There are complications associated with this practice among the *AmaXhosa* male initiates of traditional circumcision in the province of Eastern Cape, South Africa. Meintjes (1998) reported that complications such as penile mutilations, sepsis and death among the *AmaXhosa* male initiates are attributed to ischaemia,

bacterial infection and dehydration. Sepsis alone accounts for the majority of all hospital admissions post traditional circumcision in the Eastern Cape (Meintjes. 1998; Shaw, 1997; van Vuuren & de Jongh, 1999). The complications that arise from *AmaXhosa* traditional circumcision at times do not improve or heal whilst the boy is in the initiation school, and as a last resort initiates are referred to hospital as a last resort: According to *AmaXhosa* custom, traditional circumcision initiates are secluded in the bush until they complete the ritual. Hence, hospitalization of the initiates leads to mixed feelings from the communities and health care professionals.

In the early mid 1990's there were reports in the media concerning traditional circumcision operations that have been performed incorrectly among the *AmaXhosa* male initiates (van Vuuren & de Jongh, 1999). Images of young *AmaXhosa* male initiates of traditional circumcision with physical scars of abuse, stories of *AmaXhosa* initiates dying in the bush, and mutilations made headline news in regional papers such as *Daily Dispatch* of East London and *Eastern Province Herald* of Port Elizabeth (van Vuuren & de Jongh, 1999). Some of the initiates were admitted in the hospital for the treatment of sepsis and other problems related to traditional circumcision. Moreover, statistics indicate that although there has been a progressive decline in hospital admissions from 1995 to 2005, deaths from traditional circumcision, were on the increase until 2002. The statistics from the office of the Eastern Cape provincial coordinator for circumcision for the period 1995 to 2005 appear in table 1.

Table 1: Statistics of hospital admissions, mutilations and deaths in the Eastern Cape Province from 1995 to 2005 as a result of traditional circumcision

Year	Hospital Admissions	Mutilations		Deaths	
1995	1042	42	4%	41	3.9%
1996	801	22	2.8%	16	2%
1997	555	34	6.1%	17	3.1%
1998	357	8	2.2%	17	4.8%
1999	616	33	5.4%	26	4.2%
2000	384	23	6%	22	5.7%
2001	324	31	9.6%	36	11.1%
2002	447	33	7.4%	50	11.2%
2003	339	29	8.6%	41	12.1%
2004	391	6	1.5%	12	0.3%
2005	589	20	3.4%	48	8.1%
Total	5845	281	4.8%	326	5.6%

The number of *AmaXhosa* male initiates admitted to hospital in the year 2003 for the Eastern Cape District Municipalities appears in Appendix A. The Traditional Circumcision Task Team in Bisho compiles the number of hospital admissions, mutilations and deaths during every traditional circumcision season. However, the statistics do not illustrate causes of admissions other than mutilations and deaths. Meintjes (1998) and Shaw (1997) state that initiates are admitted as a result of complications such as dehydration and sepsis, however this information does not appear in the Eastern Cape Circumcision statistics. The statistics of deaths in the initiation schools is compiled by Medical Officers as defined in the Health Standards in Traditional Circumcision (Eastern Cape) Act (Act No. 6 of 2001), and the statistics of deaths of hospitalized initiates is also reported to the Circumcision Task Team by hospitals where the death has occurred. According to the statistics in table 1, some

mutilations and deaths were also counted as hospital admissions. The mutilation and death percentages that are shown in table 1 are calculated based on the number of hospital admission as opposed to the total number of initiates that had undergone traditional circumcision in the Eastern Cape. No statistics are available to indicate the total number of traditional circumcisions performed per year in the Eastern Cape due to reporting difficulties. Therefore, it is not known what proportion the above statistics represented.

Initiates that are admitted with complications are referred to as “septic circumcisions” rather than calling them by their names. Health professionals often do this whilst there are other patients and this means that they disclose medical diagnosis of initiates in the public. Some doctors perceived and referred to hospitalised male initiates as uncivilised and responsible for the problems and complications emanating from traditional circumcision (Meintjes, 1998). How the health professionals, particularly the nurses and medical doctors in the context of this study, responded to the health care needs of the hospitalised initiates was crucial to their physical and psychological recovery.

Extensive review of literature produced no studies examining health professionals’ cultural care of hospitalized *AmaXhosa* male initiates of traditional circumcision. Even more troubling, was the lack of academic and professional discourse on what was meant and/or understood by the term “cultural care” for hospitalized *AmaXhosa* male initiates of traditional circumcision. There was a need for an empirical knowledge on cultural care in the delivery of healthcare among the hospitalized *AmaXhosa* male initiates of traditional circumcision in the Eastern Cape.

(Leininger, 1991) defines Cultural care as “the broadest holistic means to know, explain, interpret, and predict nursing care phenomenon to guide nursing care

practices. It means the subjectively and objectively learned and transmitted values, beliefs, and patterned life ways that assist, support, facilitate, enable individuals, groups and communities to maintain their well being, health, or to deal with illness, handicap or death” (p. 47).

The purpose of this study is to explore what constitutes cultural care for the *AmaXhosa* male initiates of traditional circumcision.

1.3 Problem statement

The complications of circumcision lead to the admission of initiates to hospital. According to Adler’s (1984) traditional circumcision among the *AmaXhosa* is an initiation rite in which there is a transition from boyhood (*ubukhwenkwe* in *IsiXhosa*) to manhood (*ubudoda* in *IsiXhosa*) and to a high state of responsibility. The initiates are taught the mysteries of tribal practices, customs and laws, and what is demanded by the man’s estate in the forms of social responsibility and conduct. From the ceremony the boys must emerge as men, loosing all signs of immaturity (Adler, 1984).

In this study the term initiates refer to those boys who are in the bush for a considerable period of time of at least six to two months and have been surgically circumcised their foreskins (*Abakhwetha* in *IsiXhosa*). The period of the ritual has changed due to students who attend the custom. It is more likely to be at the same time as winter and summer school holidays in order to accommodate students. The traditional nurse instructs initiates, depending on the number of initiates at times two traditional nurses look after them (Meintjes, 1998; Ntsaba, 2002).

The geographic origin of the boys depend on many factors such as whether they are relatives (rural or urban), and could be from the same or not the same

village/township. Amongst them, it is common to find that there is one initiate per Lodge. After the cutting of the skin the name changes from being a boy to a man (*indoda*).

Every year some *AmaXhosa* male initiates are hospitalized or die from circumcision wounds undergone during traditional initiation rites. Whenever the *AmaXhosa* male initiates are admitted in hospital, they do so against their will because of the stigma attached to it. Meintjes (1998) discovered that hospitalization of initiates is a last resort having delayed their admission dangerously. Men from the initiation school (who have themselves undergone traditional circumcision) take the initiates to hospital for admission. At times initiates steal their way to hospital without the knowledge of the traditional attendant or traditional nurse (*ikhankatha* in *IsiXhosa*). Initiates that are transferred from the initiation schools to the hospital are usually taken at night, in order for the public not to see them (Ntsaba, 2002).

Warren-Brown (1998) mentioned that neither the belief of initiates being mentally strong, patient and uncomplaining nor the society that endorses traditional circumcision show mercy when the complications arise from the ritual. Hospitalized initiates are ostracised and are denied the dignity of being called men. They are looked down on for going to hospital. Initiates are made to believe it is their fault when they do not heal and have to be hospitalized. It is said they have done something wrong and are being punished. According to Meintjes (1998) a hospitalised initiate is teased by his peer group and called a “hospital man”. Funani (1990) states that the fact that the initiates end up in the hospital shows negligence among Africans and the solution is a social philosophy of education which includes health education.

1.4 Research Purpose

The purposes of this qualitative ethnonursing research study were to describe the delivery of culturally appropriate care by healthcare professionals, and to explore what care hospitalized male initiates' desire. A final purpose would be to develop a framework that could guide policy in the delivery of cultural congruent care for hospitalised *AmaXhosa* male initiates of traditional circumcision.

1.5 Research Questions

The following research questions were used to explore the domain of enquiry:

1. What do health professionals say is appropriate health care for *AmaXhosa* boys who are hospitalized for septic wounds following traditional circumcision:
2. What do *AmaXhosa* boys, hospitalized for septic wounds following traditional circumcision; say how they would like to be treated while in the hospital?

1.6 Definition of terms

Culture

Leininger (1991) refers to "culture as the learned, shared, and transmitted values, belief, norms and lifeways of a particular group that guides their thinking, decisions, and actions in patterned ways" (p. 31). Diller (1999) asserts that there is never in any group a complete consensus about such components of culture as values, beliefs, or norms, the way of life of any group depends on the general agreement in such matters. Some measures of agreement are essential in the society as a whole. Without shared culture, members of the society would not be able to communicate or cooperate and confusion would result. Culture represents the legacy from the past,

that is, from ancestors and it is also influenced by their beliefs. People are not prisoners of culture because it is constantly changing.

Nursing Care

To care may mean to be charged with the protection, welfare, or maintenance of something or someone. Nursing care is specifically directed toward the protection of human dignity and the preservation of human health (Stanhope and Lancaster, 2000). Caring refers to actions, attitudes and practices to help others towards healing and wellbeing. Care has a cultural and symbolic meaning such as care as protection, and care as respect (Leininger and McFarland, 2006). In this study nursing care means assisting, supporting hospitalized *AmaXhosa* male initiates with anticipated needs to improve their conditions or support them with handicaps or death. It includes cleaning of the circumcision wounds and application of topical medications and bandages in order to promote wound healing.

Cultural Care

In this study, “cultural care” or “Culturally Appropriate Care” refers to the provision of necessary health care (whether medical, nursing or community health care) within the context of the patient’s culture, to the degree possible.

Circumcision

“To circumcise is to cut off the foreskin of a boy or man for religious or medical reasons or to cut off all or part of the external sex organs of a girl or woman and the action or ceremony of circumcising is called circumcision” Oxford Advance Learner’s Dictionary (1995, p. 200).

***AmaXhosa* traditional circumcision**

AmaXhosa traditional circumcision is a rite of passage from boyhood to manhood. When the boys arrive in the bush for a seclusion period of two to three months, men take them to the river and they are instructed to talk about their sins and past misdeeds (Confession or *Ukubula in IsiXhosa*). The belief is that if the boy does not confess all the wrong things he did in the past, then there would be delay of wound healing (Ntsaba, 2002). The traditional circumcision custom involves an initiate or a group of initiates undergoing a period of seclusion in the bush and in the process the prepuce is cut off. The traditional surgeon (*Ingcibi in IsiXhosa*) uses a knife called “*umdlanga*” to circumcise all the boys in a lodge. Today it is common to use a razor blade to circumcise the boy in order to prevent cross infection. Thereafter, the traditional attendants or traditional nurses look after the initiates, and apply thongs to the initiates circumcised wounds. The initiates are not supposed to drink fluids during the first eight days; hence they are more likely to suffer from dehydration. In the initiation school initiates are taught about courtship, negotiating marriage, social responsibility and conduct. Adler (1984) states that after the circumcision operation the wound is dressed with plants (*izichwe in IsiXhosa*) and Thongs. Shaw (1997) states that wound dressings are changed every five to 10 minutes. Ntsaba (2002) also states that after the circumcision operation circumcision wounds are dressed until they heal.

The term traditional circumcision school will be used interchangeably with the term initiation school, mountain, Lodge and in the bush, meaning a secluded area where initiates are kept during the ritual.

Initiates

Initiates are boys who undergo the traditional circumcision rite.

Culturally Appropriate Care

In this study, “cultural care” or “Culturally Appropriate Care” refers to the provision of necessary health care (whether medical, nursing or community health care) within the context of the patient’s culture, to the degree possible.

Circumcision Act

The Circumcision Act refers to the Health Standards of Traditional Circumcision (Eastern Cape) Act (Act No. 6 of 22 November 2001). In this study it will be referred as the Circumcision Act. Although the Circumcision Act does not apply to hospitals, it has some recommendations that could be applied by health professionals.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The review of literature is presented in this chapter in order to discuss culture, cultural beliefs in health care, cultural competence, Leininger's Sunrise model, circumcision, traditional circumcision and The Health Standards of Traditional Circumcision (Eastern Cape) Act (Act No. 6 of 22 November 2001).

2.2 Conceptualisation of culture

McGrane (1989) states that in the nineteenth and early twentieth centuries, another enigmatic and radical reformulation of the non-European other occurs. It was not until the twentieth century did culture emerge and became part of a decisive and inescapable part of our world. In actual fact the use of the term "culture" to apply to folkways and began in the 19th century with Anthropology.

In the United States, Leslie White and Alfred Kroeber developed the term culture between the two World Wars. During the Second World War Anthropologists were used to help explain the Japanese and German cultures to the military. Leslie White referred to culture as a general human phenomenon and did not speak in a plural. Leslie further believed that culture meant the total sum of all human cultural activity on the planet, and was evolving. He differentiated between three components of culture, technological, sociological and ideological. The technological component plays a primary role or is a determining factor of cultural evolution. It can be described as material, mechanical, physical and chemical instruments as well as the way people use these techniques (http://en.wikipedia.org/wiki/Leslie_White).

Goodman and Marx (1978) mentioned that there are no uncultured societies. Every human being is cultured in the sense of participating in some culture or another.

Leininger (1991) refers to “culture as the learned, shared, and transmitted values, norms and lifeways of a particular group that guides their thinking, decisions, and actions in patterned ways” (p. 47). Although there is never in any group a complete consensus about such components of culture as values, beliefs, or norms, the way of life of any group depends on the general agreement in such matters. Some measures of agreement are essential in the society as a whole. Without shared culture, members of the society would not be able to communicate or cooperate and confusion would result. The members of the society share the norms and values, and when acted upon they produce behaviour considered acceptable within that society. Culture represents the way in which people behave, experience and evaluate their life world. Culture represents the legacy from the past, that is, from ancestors and it is also influenced by their superstitions. People are not prisoners of culture because it is constantly changing (Diller, 1999; <http://en.wikipedia.org/wiki/Culture>).

A number of authors, Diller (1999) and Goodman and Marx (1978) Stanhope and Lancaster (2000) view culture as a dynamic process that develops over time and changes with difficulty. For these authors, in response to the needs of its members and their environment, culture provides guidance to help them solve life’s recurrent problems and live meaningfully. It is also a design for living for the members of a particular society. The behaviour of human beings should be based on guidelines that are learned during socialisation. Individuals learn about their culture during the process of language learning and it is handed down to the next generation. Parents teach their children the implicit and explicit behaviour of culture (Diller, 1999; Spector, 1985).

Mead (as cited in Andrews & Boyle, 1999) refers to culture as the arts and sciences, religion and philosophies, but also the system of technology, the political practices, and small intimate habits of daily life, such as ways of preparing food or hushing a child to sleep.

Leininger (1991) and Diller (1999) and Goodman and Marx (1978) and Spector (1985) and Stanhope and Lancaster (2000) conceptualise culture almost the same way because they mention that culture is learned through socialisation of language learning. It is also shared among the members of the community so that there can be order in the society. If problems arise then culture is used for intervention strategies to solve such problems, because it is shared, this means that members agree on beliefs, norms and values. Although it is a difficult process to change it is dynamic in nature. Mead (as cited in Stanhope & Lancaster, 2000) mentioned other terms not mentioned by other authors such as culture is a science, art, religion and small habits of daily living. What is important in Mead's definition of culture is that culture is a philosophy, system of technology and political practices. From these conceptualisations of culture it can be deduced that culture provides a guide for determining people's values, beliefs and practices including those pertaining to health and illness. Haviland (1993) explains culture as consisting of the "abstract values, beliefs, and perceptions of the world that lie behind people's behaviour and which are reflected in their behaviour." The members of the society share them, and when acted upon they produce behaviour considered acceptable within that society. Culture represents the way in which people behave and experience and evaluate the life world.

2.3 Cultural Beliefs Systems, Health and Health Care

Andrews and Boyle (1999) agreed that the way individuals perceive health and ill health is determined by culture. These authors further maintain that whatever practices people do are referred to as culture. Practices differ according to different communities in what they have agreed upon as their way of living and internalise them as their culture so that they can pass it to the next generation.

Health itself is a concept determined by culture and society. Health is so important to the basic functions of survival that it is not surprising that most societies in the world have well-established ideas about health (Hubley, 1993). Every individual person brings cultural attitudes toward health, health care and illness. There are varying health and illness beliefs within different societal groups. Health and illness can be interpreted in terms of personal experience and expectations. People learn from their cultural and ethnic backgrounds how to be healthy and the way they can recognise their illnesses. The notion of illness and health attach the basic culture and values by which people define a given experience and perception (Spector, 1985).

The cultural customs and practices of an individual, family and community may influence the interactions between service providers and health care consumers. So too, do they influence health behaviour. Gilbert, Selikow and Walker (1996), Lynch and Hanson (1992) assert that the concept of culture should be explored in order to develop a more comprehensive understanding of health and disease, people's understanding of this and their responses to it. Every community has its well-established ways of maintaining health, preventing diseases and treating the sick. Since perceptions of illness, disease and their causes vary by culture, the individual preferences affect the approaches to health care. Culture also influences how people seek health care, how patients respond to medical services and preventive intervention

and the way they behave toward health care providers. The relationship between culture and health-related beliefs and behaviour is complex. Personal experiences, family attitudes, and group beliefs interact to provide an underlying structure for decision making during illness. In the clinical setting, effective communication is maximised when the patient and the health care provider share the same beliefs about the sickness (Gilbert et al., 1996; Sutton, 2000).

Nursing is a service involving interaction with patients and consumers of health care. Communication is culture based, and it is the core of most nursing practice. Once health professionals conceptualise culture as basic to health care, they move into culturally informed clinical practice that is tolerant to diversity in the health beliefs, which leads to improvement of health care (Papo, 1996). The providers of health care, including nurses, are socialised into the culture of their profession, which is usually westernised. Their medical practices and institutions are shaped by Western theories of illness and subsequent treatment. The professional socialisation teaches the student a set of beliefs and practices, habits, likes, dislikes, norms, values and rituals that are different from the individuals' background. This means that students of non-Western cultural background move further from their own culture and adopt the new Western culture. Because of this, non-Western consumers of health care do not understand health care providers (Spector, 1985).

It is acknowledged that race, although often used to differentiate among groups of people, denotes only biological rather than cultural differences (McCown, Driscoll, & Roop, 1996). Nevertheless, race and ethnicity, in South Africa at least, cannot be separated from discussions about culture. In South Africa, interracial and intra-racial differences in values, norms and beliefs exist, and as such race, ethnicity and language constitute the most fundamental sources of cultural diversity. In

reference to the United State of America, Diller (1999) asserts that ethical guidelines of all human services professions expressly forbid discriminating against clients on the basis of race and ethnicity. Yet, according to Diller (1999) the reality is that most service providers regularly, though unknowingly, discriminate against culturally different clients because they lack the skills and knowledge necessary to serve them properly. This leads to a situation whereby the culturally different clients under utilise the health facilities that are available to them. Clients may not trust the health care providers and may be unfamiliar with the services because they conceive them differently. Services will only be used if culturally sensitive care is available routinely (Diller, 1999).

Health care professionals have their own cultural tradition and therefore they are more likely to differ from those of the client. They have their own cultural experiences that give meaning to their behaviour. This means a client and a healthcare professional are more likely to view health problems differently and have different expectations. Diller (1999) refers to this difference as “dynamic difference” when a client and a provider come from different cultures, the author foresees a problem where there will be miscommunication and or misjudging the behaviour of the other.

A basic knowledge of anthropology, specifically cultural anthropology, would make nurses more sensitive to respect the client's values (Stanhope & Lancaster, 2000). Even if healthcare professionals may come from a different culture from that of the client, they have an ethical obligation to provide quality care to every patient, because ethical practice is integrated into professional practice. Healthcare professionals play a role in providing care to people who belong to various cultural groups. Not only are there cultural differences and expectations between provider and client, there are also cultural differences and expectations based upon gender. Men

and women are not socialized alike and do not see the world the same way (Diller, 1999).

Oosthuizen (1996) conducted a study involving nurses on ethical nursing practices across cultural boundaries. The aim of her study was to examine the attitudes of nurses towards the culturally different patient. Nurses who participated in her study were of the opinion that their attitudes towards culturally different patients differed from their attitudes towards patients of their own cultural groups. She further asserts that even in Bonaparte's (1979) study, clients with different health care values, beliefs and practices to that of the health care provider were more likely to show a negative attitude towards health professionals than clients whose health belief system was the same as the health care provider. Oosthuizen found that nurses did not have the knowledge or the skills needed to care for the culturally different patient, and therefore the nurses' attitudes might prevent them from establishing nurse-patient relationships which may ensure mutual respect and a therapeutic environment. The nurses experienced various problems in building a caring relationship with a culturally different client. The author recommended that the nurse-patient relationship should be that of trust which is unconditional without any prejudice. To deliver total patient care nurses need to respect patients as cultural beings with values and beliefs, which might differ from the nurses. Oosthuizen (1996) concluded that nurses lacked cultural awareness, and this situation might lead a nurse depriving a patient of therapeutic value of caring nurse-patient relationship.

Transcultural nursing basic concepts and case studies (1997-2001) (<http://www.culturediversity.org/> retrieved 3rd December 2006) stated that adapting to different cultural beliefs and practices requires flexibility and respect for others' viewpoints and also requires knowledge of the other person's culture. Therefore,

healthcare providers need to possess the ability and knowledge to communicate and to understand health behaviour influenced by culture, because if there are different cultural orientations then discrepancies in beliefs and behaviours will ensue. Having this knowledge can eliminate barriers to the delivery of health care and will lead to cultural competence.

2.4 Cultural Competence

Campinha-Bacote (2003) define cultural competence as a set of knowledge-based and interpersonal skills that nurses use to effectively care for the client. Cross, Bazron, Dennis, and Isaacs (1989) defined “cultural competence as a set of congruent behaviours in a system, agency, or among professionals to work effectively in cross-cultural situations”. Cross et al. (1989) states that cultural competence is not a one-day training or reading of books. Rather, it is a developmental process that depends on the acquisition of knowledge and new skills.

Looking into the above definitions, Campinha-Bacote (2003) defined cultural competence in narrow manner because her definition is centred only towards nurses without mentioning in “cross-cultural situations” whilst Cross, et al. (1989) define it broadly, that is, including the entire system within which a nurse is functioning. Both definitions state that the nurse is effective when she is knowledgeable about cultural competence. This means that for effective culturally competent care, both the health system and the health care providers should be aware and be knowledgeable in practising and achieving health care outcomes (retrieved 28th October 2006 from http://cecp.air.org/cultural/Q_howdifferent.htm) states that cultural competence is the integration and transformation of knowledge about the individuals, community and

the society at large so that standards, and practices can be used effectively in delivering health care with better outcomes.

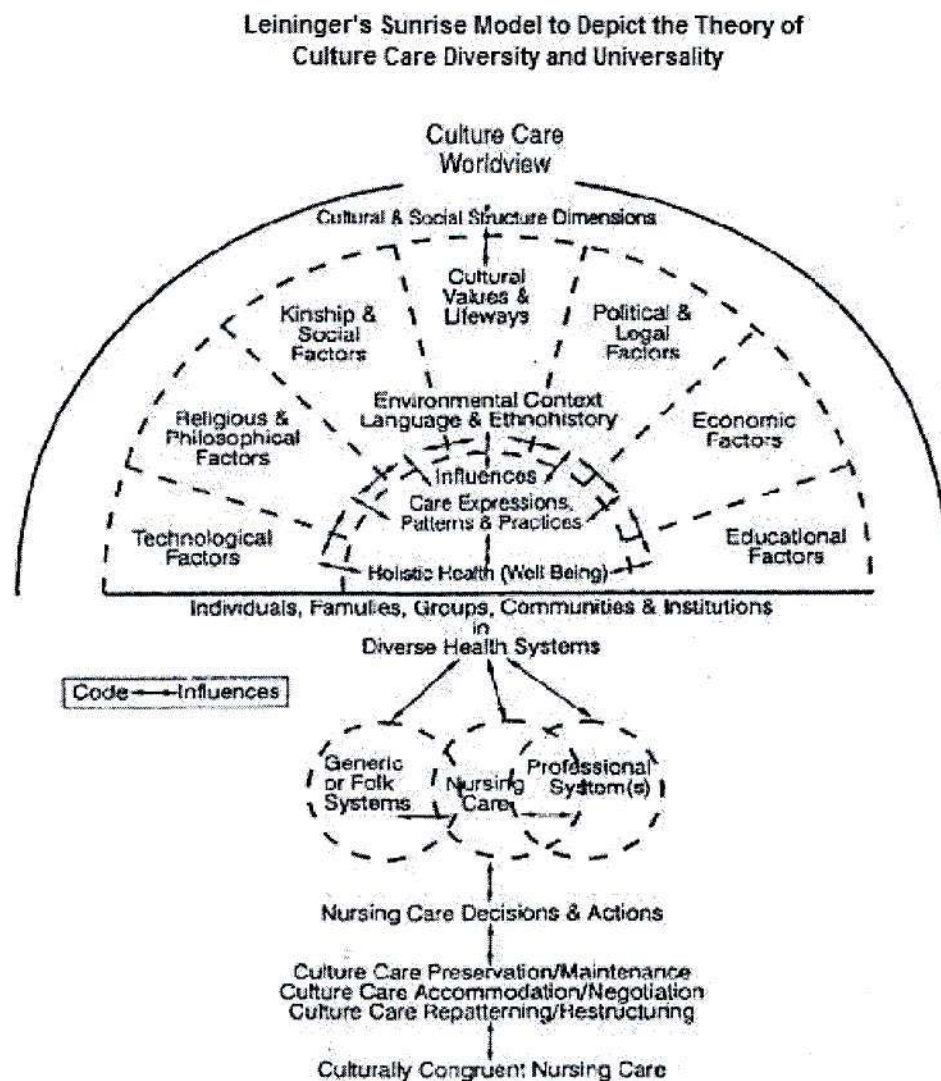
The increasing diversity of people brings challenges and opportunities that are often experienced by patients and consumers of health care. Sensitivity and empathetic listening can bridge this gap between health care providers of organisations and patients who bring cultural differences to the health encounter. Many health organisations and policy makers have recognised the importance of cultural competence in facilitating accessible and effective health care or culturally and linguistically diverse people (The NSCLASHC, 2001).

2.5 Models of Cultural Care

The models of cultural care are many, such as the Papadopoulos, Tilki and Taylor model (1998), Giger and Davidhizar (1990) model, Cross, Bazron, and Isaacs (1989), Carballeira's model (1997) and Campinha-Bacote's (2002) model.

In this dissertation only Leininger's Sunrise Model will be discussed in detail. The model is referred to as both abstract and concrete aspects of a culture care diversity and universality theory whose goal is to discover inductively. It also explains, interprets and predicts culture care knowledge and its influences in order to understand and develop ways to provide culturally congruent nursing care (Leininger, 1991).

Figure: 1 Leininger's Sunrise Enabler to discover cultural care (Leininger & MacFarland, 2006, p. 25).



2.5.1 Leininger's Sunrise Enabler

Leininger and MacFarland (2006) refer to the Sunrise model as an Enabler. Leininger's Sunrise Model to depict the Theory of Culture Care Diversity and Universality was developed and refined over a period of three decades to provide a

view of the major components of her theory. The Sunrise Enabler is not the theory rather a conceptual picture to depict the components of the theory and to study how the components influence the care and health status of individuals, families, groups and sociocultural institutions. The Enabler helps researchers to systematically study the theory's diverse components such as world view, social structure factors, cultural values and beliefs, folk and professional health systems, and how the components interface with each other in a gestaltic perspective. If the components of the enabler are viewed holistically then this will lead to a researcher viewing the whole conceptual picture of the theoretical components. The enabler has three modes proposed for making nursing decisions and taking actions for cultural congruent care. The modes are identified from and acted upon using data obtained from a comprehensive study of individuals, families and groups (Leininger, 1991).

Leininger's Enabler has wholeness and interrelatedness with the nature of the full connections to be studied in relation to human care. It helps researchers to discover human care or caring within diverse components so as to gain cultural care knowledge in its fullest ways for the discipline of nursing. Leininger further recommends inductive qualitative ethnonursing method. The ethnonursing method is used to discover the unknown, subtle or less objective facts of care within naturalistic contexts. The Enabler has three models/decisions to guide nursing judgments, decisions or actions that are beneficial and meaningful to people they serve:

2.5.1.1 Culture care preservation and-or maintenance

Leininger (1991) refers to "cultural care preservation or maintenance as those assistive, supporting, facilitative, or enabling professional actions and decisions that help people of a particular culture to retain and/or preserve relevant care values so that

they can maintain their well being, recover from illness, or face handicaps and/or death” (p. 48).

2.5.1.2 Culture care accommodation and-or negotiation

Leininger (1991) refers to “cultural care accommodation or negotiation as those assistive, supporting, facilitative, or enabling creative professional actions and decisions that help people of a designated culture to adapt to or to negotiate with, others for a beneficial or satisfying health outcome with professional caregivers” (p. 48).

2.5.1.3 Culture care re-patterning and-or restructuring

Leininger (1991) refers to “cultural care re-patterning or restructuring to those assistive, supporting, facilitative, or enabling professional actions and decisions that help a client reorder, change, or greatly modify their life ways for new, different, and beneficial health care pattern while respecting the client’s cultural values and beliefs and still providing a beneficial or healthier life ways than before the changes were co-established with the client” (p. 49). Therefore, Leininger’s Sunrise Enabler provides a method for assessing clients in order to provide a comprehensive and culturally sensitive care. Leininger (1991) believes that the western medical models fail to explore cultural patterns of illness. The Sunrise Enabler suggests that the worldview and social structure of the client are important areas to investigate and can be explored using seven dimensions of cultural values and life ways, religious, philosophical, and spiritual beliefs, economic factors, educational factors, technological factors, kinship and social ties, political and legal factors. Leininger (1991) asserts that health professionals should develop the skill as well as patience in order to explore and

validate what is being said and done by the client. Once information has been obtained from the seven dimensions then the health professional can guide the treatment and other intervention strategies. According to this Enabler health professionals should base their selection of a treatment approach or combination of approaches on information gathered from the assessment of the client. In this study the researcher will take the nursing care component as well as nursing care decisions in order to discover culturally congruent care for *AmaXhosa* male initiates of traditional circumcision.

2.6 Cultural Diversity

Every culture is unique and different from all others. Diller (1999) states that “cultural diversity refers to the array of differences that exist among groups of people with definable and unique cultural backgrounds” (p. 4). A provider and a client may come from different cultural backgrounds even if they are members of the same cultural group. Cultural diversity is an unavoidable issue, particularly in the South African context. Demographic and ethnic trends cannot be ignored in our society. Cultural diversity should not be regarded as a necessary evil instead it should be valued. Herbst (1990) stated that knowledge concerning culture and subcultures and its implications for health care has become a major issue in South Africa. Nurses need to have understanding of cultural diversity among the patients they serve.

Factors such as class, gender, age, geography, social and political leanings may lead to a situation whereby members of the same group may feel that they have little in common. Health providers must be aware of the diversity that exists both across and within ethnic groups. Differences among the same group can also be extensive. The first task of a health provider is to carefully assess the client’s demographic and cultural situations, in the following aspects: place of birth, number of generations,

family roles and structure, language spoken at home, economic status, education, amount of acculturation, traditions, religious affiliation and community and friendship patterns (Diller, 1999).

2.7 Cultural Relativism

Cultural relativism refers to each society's culture and should be understood in terms of the meanings, attitudes, and values shared by the members of that society. Most cultures travel along different roads for the sake of achieving different goals. The goals and ends in one society cannot be judged in terms of another society (Goodman & Marx, 1978).

2.8 Circumcision

The origin of the ritual is not clear but it seems that it was performed for religious or ritual reasons. Adler (1984) estimates that more than three hundred millions population of the world practise the circumcision custom and the Muslims alone number about 250 millions. The author further mentions that the figures could be underestimated. Circumcision in ancient people was practiced as a punitive measure, a puberty or premarital rite, as an absolution against the feared toxic influence of vaginal blood (that is blood of the hymen), and as a mark of slavery (Milos & Macris, 1992). The Queensland Law Reform Commission (The QLRC) (1993) states that Egyptians practised circumcision as early as 3600 BC. The arrival of Abraham was 1600 years later when he was circumcised at the age of 80 years. Another view is that Abraham was 90 years when he circumcised himself and his son Ishmael was circumcised at the age of 13 years. Although, the Egyptians seemed to have started the custom, Adler (1984) believes that the custom could have started

from the Hebrews, and they had to undergo it as a sign of covenant between them and God. Funani (1990) also states that the origin of circumcision could have been from the Hebrews and the Ethiopians, which eventually spread it to the Egyptians. The QLRC (1993) based its argument of circumcision and its origin from the bible. In Genesis 17 of the Old Testament, God is said to have directed Abraham to circumcise himself, his son and all other males in his house. He said “This is my covenant, which ye shall keep, between me and you and thy seed after thee; every child among you shall be circumcised”. This meant that all male children in Abraham’s house were circumcised presumably by the instructions of God. In (<http://www.cirp.org/library/history/> retrieved 28th October 2006) and Milos and Macris (1992) it is stated that circumcision is far older than the biblical account of Abraham as mentioned above. It seems as if it began in East Africa long before the time of Abraham. Funani (1990) states that circumcision began as a religious ritual but in Africa it is associated with male initiation into manhood. Circumcision was practiced long before Islam. It is estimated that about sixth of the population of the world can be considered circumcised on religious grounds (Richards, 1996).

For some inexplicable reason the prepuce has been shrouded with controversy that encompasses many disciplines. In addition to the medical aspects, religion, aesthetics, sexuality, cultural sensitivity, social engineering, psychology, ethics, and constitutional right are all concerned with this small part of the anatomy (van Howe, 1999). Circumcision is practised in many parts of the world among the Muslims, Jews, Arabs, Aborigines, Malaysians, Americans, West Africa and the sub-Saharan Africa (Funani, 1990). It is regarded as one of the oldest forms of surgery and is a common procedure performed for medical, ritual and religious reasons throughout the

world (Adler, 1984; Boczko & Freed, 1979; Gerhard & Haarmann, 2000; Milos & Macris, 1992; Richards, 1996; William & Kapila, 1993).

2.8.1 Circumcision as a religious ritual

Gerharz and Harmann (2000) stated that circumcision began as a religious ritual. It is assumed that the history of circumcision started from a religious point of view. In many countries, Christians were not forced into conversion, or circumcision, because only uncircumcised males could be legally taxed and Arab Caliphates needed the money, therefore people did circumcise to avoid tax (<http://www.cirp.org/library/history/> retrieved 28th October 2006).

In the Jewish communities circumcision means a religious ritual, a Mohel (Ritual circumciser) circumcises a child when he is eight days old or the child may be circumcised by a Jewish doctor who must read the appropriate religious service and name the child. It is stated that the Jews learnt circumcision from the Egyptians. By the time the Roman takeover of Egypt 30 BC the practice had ritual significance and only the circumcised could perform certain religious offices (The QLRC, 1993).

Muslims also practise circumcision on religious grounds. The procedure is widely practised among the Muslims as a tradition of the prophet. Most Muslim youths must wait to become true believers until sometime between their adolescents and marriage, depending upon the sacred traditions of the various tribes because there is a belief that signifies spiritual purification (The QLRC, 1993).

The ancient Hindus regarded the genitalia as the main part of life and as such they sacrificed the foreskin to the gods. However they no longer practise routine circumcision (Boczko & Freed, 1979).

2.8.2 Circumcision and health

New excuses based on health and hygiene issues were propagated to substantiate the circumcision operation (Iyambo, 1997). In First World countries circumcision was performed for medical reasons. In the United Kingdom it was a common operation performed on neonates for medical reasons as recommended by the British Medical Association (William & Kapila, 1993).

Milos and Macris (1992) mentioned that in the United States of America circumcision was also performed for non-religious reasons, this means circumcision was performed for the many illnesses that their origins were not known. Instead they associated the unknown illnesses with an uncut prepuce, which they believed led to masturbation. For example in 1891 Dr Remondino (as cited in Milos & Macris, 1992) advocated that circumcision treated chronic disorders such as epilepsy, alcoholism and bronchial asthma and this was a myth. Another myth was that an uncut prepuce would lead to masturbation, however nowadays the prepuce is regarded as a healthy part of sexuality, and it is safe (<http://www.cirp.org/library/history/moscucci/> retrieved 28th October 2006)

In the 1930's there was a belief that circumcision prevented penile cancer, whilst in the 1950's it was also believed that uncircumcised males cause cervical cancer to the female partners (Gerharz & Haarmann, 2000; QLRC, 1993). The reason for this argument is that the human papillovirus and herpes simplex type II are both suspected of playing a role in penile cancer and therefore they are eliminated by cutting the prepuce (Gerharz & Haarmann, 2000).

William and Kapila (1993) stated that circumcision does not prevent carcinoma of the penis. He compared the rate of carcinoma between USA (where circumcision is performed at birth) with Denmark and Japan where circumcision

rarely performed. In the USA the rate of penile carcinoma is 2.1 per 100 000 compared to Denmark's 1.1 per 100 000 and Japan 0.3 per 100 000. The tumour is more likely to develop from the glans penis or prepuce in the uncircumcised whilst it develops from the surgical scar in the circumcised. It seems as if there are other causes of penile cancer other than the lack of circumcision. Balinitis and prosthitis, phimosis, paraphimosis, condyloma accuminata and localized cancer are more common conditions that are normally seen in adults. Surgery is recommended only when there are recurring forms and the conditions do not respond to antibiotics. In phimosis and paraphimosis the intervention by circumcision is performed when the inflammation process has healed (Gerharz & Haarmann, 2000).

During the first and second world wars, circumcision was done for hygienic purposes because there were less hygienic facilities. It was also performed for prevention of sexually transmitted infections (The QLRC, 1993). Similarly, Joshua 6:1-3 (<http://www.cirp.org/library/history/moscucci/> retrieved 28th October 2006) states that even the Israelites were circumcised first and thereafter they were incorporated into Joshua's army for the conquest of Palestine. However, today, wars are not fought or won in the trenches and penile cleanliness is not the problem. Therefore this means that proper hygiene should be carried out, instead of carrying out circumcision operation in trying to keep the penis clean.

Shaka having placed the *Zulu* people on a war footing, could not afford to have armies incapacitated by circumcision and stopped it. He substituted it with his military regiments (*AmaButho*) because it served as a condition to manhood (<http://www.cirp.org/library/history/moscucci/> retrieved 28th October 2006); (Funani, 1990).

Circumcision in South Korea has a short history, it started after the Second World War, but at the moment the rate is 60%. Its history is unusual because it is associated with lack of information on phimosis and outdated notions about it. It is not practised as a rite of passage but at the same time it is not practised in neonates. The indications for such a procedure seem to be medical. The starting age is when the child is 12 years old. South Korea has a high rate of circumcision, for instance from January to December 2000, 5434 South Koreans aged 0-92 years were circumcised. The reason for such a high rate is the belief that is held by the general public and doctors that industrialised countries must have good living standards. South Korea is the only country in the world that has its first generation of circumcised men and those who still practice the ritual (Pang & Kim, 2002).

2.8.3 Circumcision as a rite of passage

Africans practised circumcision as a rite of passage to manhood, that is, before marriage and for the preparation of battles. About 60-70% Africans are circumcised as a rite of passage (<http://circlist.com/rites/african.html> retrieved 28th October 2006). In some desert tribes, circumcision is included in the wedding ceremony. The bridegroom's newly-flayed penis was used in a test of his manly strength. The Arabs practise circumcision as a rite of passage and it predates their modern religion. In tribal settings circumcision is associated with traumatic puberty rites. The operation certifies the subject's readiness for marriage and adulthood and testifies to his ability to withstand pain. Occasionally the severed part is offered as a sacrifice to spirit beings. This is common among Africans. Circumcision can also distinguish cultural groups from their uncircumcised neighbours. Therefore, this means that different

cultures have different views of circumcision

(<http://www.cirp.org/library/history/moscucci/> retrieved 28th October 2006).

The Australian Aborigines also practise circumcision as a rite of passage. With them it provides a personal identity and social integration. Boys attend the initiation ritual at the age of eight or nine years. With the introduction of western culture, operations are performed with proper surgically clean instruments. Like any other circumcision rite of passage if an Aborigine boy fails to pass through, then he cannot take part in religious, ceremonies and festivals nor can he acquire marriage (The QLRC, 1993).

Funani (1990) mentioned that the *AmaXhosa*, *AbaThembu*, *AmaMfengu*, *AmaBonvana* and *AmaHlubi* are classified under the *Nguni* group. According to Meintjes (1998) traditional circumcision in these tribes is the formal incorporation of males into *Xhosa* religious and tribal life, in *Xhosa* tradition an uncircumcised male cannot inherit his father's possessions nor establish a family. Adler (as cited in Ntsaba, 2002) describes initiates as boys who undergo an initiation rite and this is a passage from childhood to manhood and to a high state of responsibility. The boys are taught, during the ceremony the mysteries of tribal practices, customs and laws, and what is demanded by man's estate in the forms of social responsibility and conduct. This seclusion process takes place in the bush for a period of about two to three months. From the ceremony the boys must emerge as men losing all signs of immaturity.

Warren-Brown (1998) states that within their own communities, the hospitalised initiates are ostracised and denied the dignity of being called men instead they are called "hospital men". After being discharged from the hospital their peer group and parents sometimes reject them without giving them the status of being

called “men” whereas sometimes they have lost their penises due to complications associated with the ritual. The rejection experienced by initiates may lead to psychological trauma. After the discharge of hospitalized initiates, they are handed over to male parents or guardians to go back to the initiation school. Meintjes (1998) states that initiates who go back to the initiation school risk being killed by the initiate who were in the bush. At times they remain in the hospital until the day when those who were in the initiation school go home. Usually they do not move away from home but are ostracised for the rest of their lives for being admitted to hospital whilst they were undergoing traditional circumcision.

According to Funani (1990) the *AmaXhosa* culture dictates that initiates do not come into contact or be seen by women during the seclusion period (six weeks to three months); a practice which might be very difficult to maintain once the initiate is hospitalised, at least within the current health system, organizational structure and available health human resources.

A few studies (Adler, 1984; Funani, 1990; Meintjes, 1998; Ntsaba, 2002; Shaw, 1997; Taljaard, 2000; van Vuuren & de Jong, 1999; Warren-Brown, 1998) have been done on traditional circumcision in South Africa. The studies by Shaw (1997) focused on the care experiences of the initiates in the hands of health professionals, Funani (1990) and Meintjes (1998) and Warren-Brown (1997) discussed the experiences of initiates in the hands of the healthcare professionals to a lesser extent in their traditional circumcision studies. Ntsaba (2002) discussed the care experiences of initiates in the hands of healthcare professionals in the bush where the initiation rite takes place. Adler (1984) and Funani (1990) and van Vuuren (1999) discussed traditional circumcision from an anthropological point of view, while Taljaard (2000) discussed the incidence of HIV/AIDS among the circumcised males.

These previous studies fail to specifically identify or describe what would constitute cultural care for the hospitalized initiates.

Interventionist approaches aimed at integrating traditional circumcision into the western medical approach have not been very widespread so far. Efforts will need to be made to ensure that once admitted to hospitals, initiates receive cultural care. Based on the results of a study examining acceptance of westernised health care into the Ulwaluko in the Eastern Cape, Ntsaba (2002) recommended that intervention strategies should prevent physical complications such as sepsis of penile wounds, penile amputations and psychological complications associated hospitalisation of initiates which leads to stigmatization of being called “hospital men, denied being called men, problems of not being able to produce children if there is penile amputation.”

Owing to the morbidity and mortality associated with traditional circumcision, the Eastern Cape government had discussions with Non-Governmental organisations, Kings, Traditional leaders, Traditional nurses, and Traditional surgeons in 1995. After many years of negotiations, all stakeholders reached an agreement about the Legislation to regulate traditional circumcision. The Traditional Circumcision Act (Act No. 6 of 2001) of the Eastern Cape was formulated.

Mamabolo, Masemola and the Shangana people in the Limpopo Province also practise traditional circumcision as a rite of passage from boyhood to manhood (Funani, 1990). Steyn (as cited in van Vuuren & de Jongh, 1999) reported that the *AmaXhosa* respondents that were studied considered circumcision to be a necessity for various reasons, such as a requirement for marriage, promotion of tradition and access to manhood. They considered an uncircumcised man as inferior. The reasons for undergoing the ritual were that it is a good tradition where respect is taught.

Warren-Brown (1998) states that originally, the initiation had a powerful practical and spiritual motivation such as initiates practising ancient stick fighting. The elders would pass on traditions and teach them about becoming responsible men in society, about how to behave and how to gain respect both as the head of a household and a wise man in the community.

Ntsaba (2002) in his study of the acceptance of westernised health care into Ulwaluko (traditional circumcision) custom by *AmaXhosa* in a rural Eastern Cape Village found that the reasons for *AmaXhosa* to attend traditional circumcision were that;

- People believed in customs and traditions such as traditional circumcision and that is why they continued to practise it.
- Uncircumcised boys could not relate well with their brothers and fathers who have undergone the custom.
- Traditional circumcision is practised because there is a belief that people who die before undergoing the ritual demand to undergo the custom, usually this would come as a dream to close relative, and if the demand is not met the person who dreams about that will suffer physical illnesses.
- An uncircumcised man is not respected as well as his house, and communities do not live in harmony if there are people who have not undergone the custom (Ntsaba, 2002; Taylor, 1995).

The *Basotho* tribe (in Lesotho) practise traditional circumcision as a rite of passage. In olden days the Chief used to organise the ritual of traditional circumcision and all boys in the Village would join his son. The uncircumcised were banished by the tribe, and would not take part in community festivals. There was a belief that if

children did not attend the initiation school they would be crippled or become impotent (Laydevant, 1978).

In Kenya there are about 45 tribes and among them, only the *Luo*, *Turkama* and some clans of *Pokot* and *Nilotic* tribes do not practise traditional circumcision as a rite of passage. Those who do not circumcise are not regarded as people. They are regarded as being dirty and primitive (<http://circlist.com/rites/african.html> retrieved 28th October 2006). Women cannot practise sexual intercourse with uncircumcised men. Such men are regarded as being abhorrent. The *Kikuyu* (circumcising tribe) and the *Luo* represent the opposition parties and they do not agree in co-operation because the *Luo* do not circumcise and therefore the uncircumcised people cannot lead the *Kikuyu*. This means among the *Kikuyu* circumcision acts as an identity form (<http://circlist.com/rites/african.html> retrieved 28th October 2006; Marck, 1997).

In Tanzania the *Masai* also practise traditional circumcision as a rite of passage from childhood to adulthood. They regard a man as being complete after undergoing circumcision, and therefore the man must protect the family. Thereafter, he can discuss family affairs and be taken into consideration for the first time by virtue of being a “man”. Traditionally, in Tanzania like in Kenya an uncircumcised man cannot have sexual intercourse with a circumcised woman. Culturally circumcised women should have a relationship or sex with a circumcised man. This practise is common amongst communities which practise traditional circumcision as a rite of passage. If an uncircumcised man can engage in a relationship or have sexual intercourse with a circumcised woman then is fined a cow as a form of punishment. The reason for this is to encourage men to undergo traditional circumcision, because uncircumcised women can have sex with circumcised men. After the circumcision

operation an initiate is given presents as a sense of appreciation of bravery (<http://circlist.com/rites/african.html> retrieved 28th October 2006); Mark, 1997).

In Namibia the *Herero* practise traditional circumcision, whilst other indigenous groups have done away with it. They believe that the circumcision custom was given to them by their ancestors. They maintain that they will continue to practise it so that they can be respected among those circumcised, because it serves as an identity among the *Herero*. If a man is not circumcised he is not regarded as a man. The blood that makes him a man has not been shed from his penis. The *Herero* also believe that circumcision protects them against sexually transmitted infections and also help men and women not to experience pain during sexual intercourse because the foreskin (*Omukova*) is cut off. Many *Herero* women are afraid of pain during sexual intercourse because they believe that sexual intercourse with uncircumcised man is painful (<http://circlist.com/rites/african.html> retrieved 28th October 2006).

In Cameroon the *Dawayo* tribe also practise traditional circumcision. They believe that circumcision is equivalent to menstruation and therefore they regard the foreskin as to be like a female's vagina, which is wet and smelly. Meaning that they are more likely to perform circumcision to avoid being wet and smelly. After the circumcision operation has been performed a boy is regarded as being reborn with a new name. The attributes of the culture are taught to the new man (Bailey, 1986). The researcher is aware that giving of new names to initiates is also common among the *AmaHlubi* and *South Sothos* of South Africa, but the names are only used for a short period.

Most Ghanaians circumcise and those who do not, get a lot of teasing. Almost all adults have undergone circumcision. In Sudan most of the tribes are circumcised

except the *Nuba* tribe, which is a small group (<http://circlist.com/rites/african.html> retrieved 28th October 2006).

In Democratic Republic of Congo the *Pigmy* people practice circumcision (encumby is the name given to the ceremony) as a “pass through age” usually at the age of eight to 12 years. The *Pigmy* people live on hunting and picking up of fruit, and are regarded as the most ancient and cultural pure of the world. To them, traditional circumcision makes a difference between boys and men as well as between the village and the jungle (<http://circlist.com/rites/african.html> retrieved 28th October 2006).

2.8.3.1 Intervention strategies to incorporate western health into traditional circumcision in the Eastern Cape

In an effort to prevent the morbidity and mortality among the initiates of traditional circumcision in the Eastern Cape, there have been appeals for western health care to be incorporated into the practice (Ntsaba, 2002). First of all the Circumcision Act ensures that the hygienic standards are maintained in the custom.

In Queenstown various activities were carried out as part of a strategy, as well as the success of it. Meetings were held with members of the community, specifically the traditional surgeons and traditional nurses. Community members were encouraged to use alternative measures to avoid complications. A campaign to address the initiate-to-be at schools was carried out. Boys were taught how complications develop and were encouraged to attend a clinic for examination before they undergo traditional circumcision. The reason for the attendance of clinic was to screen boys for STI's, cardiac conditions, epilepsy, diabetes mellitus, mental illness and HIV/AIDS. If diseases or conditions were identified, appropriate treatment or referral ensued. Male

nurses were also allocated to visit the bush in November each year. Any health problems identified were dealt with on the spot and the male nurses carried out the wound dressings (Shaw, 1997).

Funani (1990) states that, in Alice a programme was started with traditional practitioners to address the problems associated with the traditional circumcision in that area. As a result of the programme, the traditional surgeons in Alice use surgical blades for circumcising, and a new one is used on each initiate instead of using the same instrument (*umdlanga*) for all the initiates.

In the areas such as Port Elizabeth, there have been projects to teach traditional surgeons about hygienic standards in performing circumcision operations (Ntsaba, 2002).

Traditional circumcision is secretive in nature. There are intervention projects that are taking place in the Eastern Cape, but because of the secrecy of the ritual some of them are not known. Ntsaba (2002) stated that there were intervention projects in Umtata, Maluti and Mount Fletcher to reduce the morbidity and mortality among the initiates of traditional circumcision, however the details are not known.

The project of westernised health care into the traditional circumcision was introduced into the *AmaHlubi*, *South Sotho* and *AmaXhosa* communities in the Sterkspruit area. The researcher reached an agreement with the hospital authorities at the Umlamli and Empilisweni hospitals to use the hospital equipment in the bush.

- Sterile packs, antibiotics, surgical blades, additional material such as gauze, bandages, topical ointments and use of Government vehicles when going to the initiation schools.
- There were consultations between the hospital pharmacist, nursing personnel in the clinics and Central Sterilising Department.

- The Community, Kings, Chiefs, Headman and men in general were consulted by male nurses regarding the introduction of westernised health care into traditional circumcision.
- Male community members were trained on how to circumcise.
- Members of the community were educated that all boys should be physically examined before they go for traditional circumcision.

The researcher has experience from the old school of initiation (that is where no western health care was used) and a registered nurse by profession planned and introduced projects that incorporated western health care into traditional circumcision in the Sterkspruit area. Three Registered male nurses, one Enrolled male nurse, and one environmental male health Practitioner were involved in the carrying out of circumcision operations in the bush according to western methods. Operations are carried out in the bush under clean conditions using sterile material. Today the projects run every winter and summer circumcision seasons with success. The members of the team carried out the following activities in the bush:

- Educating communities about the causes of morbidity and mortality among the initiates of traditional circumcision
- Preventing complications by performing aseptic circumcision operations, suturing wounds and applying sterile dressing of wounds with topical medicines in the bush
- Use of local anaesthetic before the operations instead of cutting the foreskin without any local anaesthetic.
- Treating diseases such as STI's,
- Ensuring that initiates are given adequate fluids from the first day in the initiation school

- Teaching traditional nurses to monitor wound healing and report any abnormalities to male nurses (Ntsaba, 2002).

Today, the projects are sustainable and the majority of boys and communities benefit from them.

2.8.4 Male circumcision and HIV/AIDS

There is a controversy about male circumcision and HIV/AIDS prevention. The researcher looked into the history of the subject in terms of the research done on evidence of the relation of reduction of HIV in circumcised men as well as studies, which contradict with this evidence.

The debate about the relationship between circumcision and HIV infection in medical literature started in 1986. Dr Fink (as cited in (<http://www.cirp.org/library/disease/HIV> retrieved 28th October 2006) who was a California urologist maintained that there was a link between lack of circumcision and the increase of HIV infection. He supported his statement by arguing that the foreskin increases infection and the circumcised male reduces the HIV penetration infection because of the absence of the prepuce (<http://www.cirp.org/library/disease/HIV> retrieved 28th October 2006).

2.8.4.1 Male circumcision reduces HIV infection

Many studies (Bailey, Muga, Poulussen & Abicht, 2002; Horison, 2000"; Hove, 1999; Huff, 2000; Mark, 1997; New England Journal of Medicine, 2000; Population Council Momentum, 2000; Richards, 1996; Susman, 2000; Taljaard et al, 2000) were carried out in Africa where male circumcision is practised as a rite of passage, associated circumcision with reduction of HIV/AIDS.

According to Horizons (2000) male circumcision in sub-Saharan Africa is associated with the reduction of HIV infection by 50%. It is suggested that the results are more pronounced if the operation is carried out before puberty or before sexual activity.

Huff (2000) came up with the theory that the reduced mucosa surface of the prepuce due to circumcision leads to less opportunity of HIV infection. Gray (as cited in Huff, 2000) studied Muslims in Uganda from 1994 to 1998 and found that 99% men were circumcised, and the incidence of HIV infection among the Muslims was 1.1 per 100 person years (py) compared to 1.8 per 100 py among the uncircumcised men. The rate of HIV infection in those who performed circumcision before puberty was 0.9 per 100 person years whilst it was 1.5 per 100 person years for those circumcised after 12 years. Among the couples no HIV infection occurred in 50 circumcised men whilst 16.7 per 100 person years occurred among the uncircumcised (Huff, 2000).

Buve (as cited in Susman, 2000) reported that in West Africa two cities Yaoundé in Cameroon and Cotonou in Benin the prevalence of HIV infection is less than 4.5% because almost all men in those cities are circumcised compared to Kisumu in Kenya and Ndola in Tanzania whereby 10-25% men are uncircumcised with the rate of 20-25% that have contracted HIV infection (Susman, 2000). In the study of *Luo* people in Kenya, about 57% of HIV infection was attributed to lack of circumcision among the males. The study assessed the knowledge, attitude and beliefs among the uncircumcised *Luo* men and women in as far as the acceptability and feasibility of *Luo* men being circumcised as a strategy to prevent HIV infection. Although they cited factors such as pain and tradition which make them an uncircumcised nation, the study found that the *Luo* men were prepared to circumcise

for hygiene and prevention of STI's including HIV infection provided they were given health education on health benefits, health risks and complications of circumcision (Bailey et al., 2002).

In spite of the fact that researchers recommend the use of circumcision to prevent HIV infection some feel that this strategy is premature. The reason is that research in some parts of Africa illustrate that the HIV infection has an equal chance between the uncircumcised and the circumcised (Population Council Momentum, 2000).

2.8.4.2 World Health Organisation and United Nations AIDS recommendations for male circumcision to prevent HIV infection

Currently 665 million or 30% men world wide are estimated to be circumcised. The World Health Organisation and the United Nations AIDS Secretariat convened an internationally expert consultation to determine whether male circumcision should be recommended for the prevention of HIV infection. The consultation was held in March 2007 in Montreux, Switzerland. The experts who attended the consultation recommended that circumcision should now be recognised as an additional important method of reducing the risk of heterosexually acquired HIV infection. The evidence of the recommendations came from randomised controlled trials undertaken in Kisumu, Kenya; Rakai District, Uganda and Orange Farm, South Africa, that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. Therefore, this means male circumcision should always be considered as part of a comprehensive HIV prevention strategy which includes:

- The provision of HIV testing and counselling services

- Treatment for sexually transmitted infections
- The promotion of safer sex practices, and
- The provision of male and female condoms and promotion of their correct and consistent use

Counselling of men and their sexual partners in partial protection of male circumcision (<http://www.news-medical.net/?id=22707> retrieved 01st April 2007).

Boseley (2007) mentioned that the United Nations has urged all countries with AIDS epidemics to embark on launching mass male circumcision. The statement came after there was evidence that male circumcision protect against HIV infection by 60%. In Sub-Saharan Africa male circumcision could prevent 3 million deaths over the next years. The World Health Organisation recommends that circumcision should first be performed on male adults rather in children because of the urgency in reducing infections in sexually active group.

2.8.4.3 Male circumcision does not reduce HIV infection

There are studies (<http://www.cirp.org/library/disease/HIV> retrieved 28th October 2006; Musoke, 2001) that do not agree with the earlier studies that circumcision reduces HIV infection. It seems as if there is bias in the selection of the population in studying the HIV infection and circumcision. Some researchers (<http://www.cirp.org/library/disease/HIV> retrieved 28th October 2006) feel that other factors should be looked into when studying the relationship of the two, such as cultural differences and sexual practices. A study that was carried out by Caldwell & Caldwell in Africa depended on the anecdotes without actually examining the subjects instead the research method associated data with religious or tribal affiliation only. It stands to reason that the results cannot be regarded as being valid based on the said

reasons because the samples were too small to generalise to other situations (<http://www.cirp.org/library/disease/HIV> retrieved 28th October 2006).

In Sub-Saharan Africa there is a tendency to practise “dry sex”. The reason for this is to make a woman’s vagina dry and tight. The practise is supposed to generate extra sensation for the men during sexual intercourse but may be painful for the woman. The practice is of concern because it increases the chances of STI’s and HIV/AIDS transmission due to lacerations, tears and abrasions during sexual intercourse. Because of the increased risk, it is apparent that there is a confounding factor, which most researchers ignored when they studied the increased risk of HIV and male circumcision. Genital ulcer disease is common in Sub-Saharan Africa and this may provide an access of HIV infection. O’Farrel cited from (<http://www.cirp.org/library/disease/HIV> retrieved 28th October 2006) discovered that the *Zulu* men are more likely to continue practising unprotected sexual intercourse in spite of the fact that they suffer from genital ulcer disease which may lead to a contraction of HIV infection.

Therefore, genital ulcer is another confounding factor in HIV infection transmission. Although researchers seem to debate about the high rate of HIV infection in Africa, in the United States of America there is also a high rate of circumcision as well as the prevalence of HIV infection (<http://www.cirp.org/library/disease/HIV> retrieved 28th October 2006)

Laumann et al., (<http://www.cirp.org/library/disease/HIV> retrieved 28th October 2006) states that according to the 1995 statistics released by World Health Organisation the United States of America has a high rate of HIV/AIDS, 3.5 times higher than the closest industrialised country, which is Australia. In 1992, 1511 people were circumcised in the United States of America. There is an increase of

HIV infection in spite of the fact that the circumcision rate is high among the Americans. It stands to reason that the U.S. failed to curb HIV infection in spite of its high rate of circumcision. The risk of sexual behaviour among circumcised men is that they are more likely to be engaged in riskier unsafe sexual practices (retrieved from <http://www.cirp.org/library/disease/HIV> 28th October 2006).

In parts of Africa Genital Ulcer Disease (GUD) is endemic, and it is a very strong risk factor in HIV infection. HIV positive males often have pre-existing GUD of an untreated STI other than HIV infection. It is believed these lesions may provide an entry point for the HIV virus (<http://www.cirp.org/library/disease/HIV> retrieved 28th October 2006).

It is apparent that the relation is between the genital ulceration disease rather than the foreskin, which is believed to facilitate the transmission of HIV infection. Because the elevated rates of HIV transmission through sexual contact is the presence of genital ulcer disease and this seem to be the general background as to why parts of Africa has a high rate of HIV (Marck, 1997).

Van Howe (1999) reported about studies that have been carried out in the relationship between male circumcision and HIV infection. When the raw data was combined in all the studies a man with a circumcised penis was at a greater risk of acquiring and transmitting HIV infection than an uncircumcised man. This means the advice to perform circumcision, as a prophylactic measure to prevent HIV/AIDS is scientifically unfounded. Van Howe (1999) further argued that other factors such as cultural and religious practices must be taken into consideration. Other factors which were considered when the analysis was done was Muslims practised polygamy, which meant that close relations among the wives were possible, post coital genital washing and prohibition against alcohol and risky sexual intercourse could be other factors

which reduced the HIV infection amongst the Muslims, and not circumcision. Therefore, there is a strong possibility that these protective factors led to a reduction of the rate of HIV infection among the circumcised Muslims and the non-Muslims. It is concluded therefore that such a study cannot be generalised to other communities because of the combination of the Muslims' practices and their religious beliefs (Huff, 2000).

2.8.5 Myths about circumcision

Circumcision has a strong irrational bias because health professionals and parents still believe in old myths as well as developing new ones. Current studies that were reviewed on circumcision have methodological flaws with conflicting evidence of results. It is argued that the ritual has nothing to do with medicine, health in practically all cases (Milos & Macris, 1992).

In the United States of America and Australia circumcision was common for non-religious purposes, because of a belief in masturbation theory. Masturbation was believed to cause ill-health (Iyambo, 1997). Brigman (as cited in Richards, 1996) stated that circumcision was grounded in the anti-masturbation theory that occurred in the late 1800's. The reason for the belief was the fear that boys with a prepuce would learn to masturbate. Masturbation was believed to lead to insanity and blindness (<http://www.cirp.org/library/history/> retrieved 28th October 2006).

There was also a belief that loss of semen due to masturbation led to general debility. In 1850 interest to treat masturbation with circumcision emerged and uncleanliness of the prepuce was later focused as a cause of masturbatory activity (<http://www.cirp.org/library/history/moscucci/> retrieved 28th October 2006).

There is a theory that postulates that circumcision was practised as a way of purifying individuals and society in decreasing sexuality and sexual pleasure. The reason for this was that, human sexuality was regarded as dirty (O'Hara & O'Hara, 1999).

This belief is associated with the removal of sexual sensation neuroreceptors of the penile foreskin (the nerve endings that are sensitive to fine touch are removed, and therefore one would be demotivated to practice sexual intercourse. O'Hara & O'Hara, (1999) stated that when women were asked whether they preferred a complete anatomic penis over that with a circumcised penis, 85.5% preferred intact non-circumcised sexual partners. This high percentage could be attributed to fine neuroreceptors to touch that are not being removed (O'Hara & O'Hara, 1999).

Richards (1996) disagrees with the fact that circumcision is justified by hygiene. There is a belief that a circumcised penis is clean. About 85% of the intact males argue that there is no problem because it is easy to clean (Milos & Macris, 1992; Richards, 1996).

Circumcision originated in ancient tribes and its basis cannot be regarded as being scientific. There has been also a belief that circumcision prevents male penile cancer. Cancer has been documented in both circumcised and uncircumcised including those circumcised in infancy. It is regarded as a rare malignancy with a rate of 0.05% in all men. It is argued that penile hygiene only, can prevent cancer and not circumcision because there are more deaths from circumcision than from cancer (Boczko & Freed, 1979; Milos & Macris, 1992). There is no medical indication for a routine neonatal circumcision.

There are many factors that are involved in cancer of the penis other than circumcision or non-circumcision. It stands to reason that both medical and legal opinion cites no benefits of circumcision (Richards, 1996).

Women with circumcised partners have a lower incidence of cervical cancer. This statement is inconclusive because Muslims women have a high cervical cancer in spite of the fact that male husbands circumcise at an early age. In India *Parsis* do not circumcise but their cervical cancer is low. The predisposing factor in cervical cancer could be a history of sexual intercourse at an early age as well as multiple partners (Gerharz & Haarmann, 2000; Milos & Macris, 1992).

Some researchers (Armed et al., 2000; Gerharz & Haarmann, 2000) state that circumcision prevents urinary tract infection. However, The American Academy of Paediatrics (as cited in Milos & Macris, 1992) reported that there could have been methodological flaws as well as selection bias in the studies that were carried out in urinary tract infections among intact boys.

2.8.6 Complications of male Circumcision

2.8.6.1 Usual Complications of circumcision

People still believe that circumcision is a minor operation. There are many risks and complications that have been identified in both neonatal circumcision and adults. In South Africa, traditional circumcision has complications such as penile mutilations, sepsis and other related problems. The complications of circumcision appear to be between 1.5% and 5.5%. The complications may be immediate or delayed (Meintjes, 1998; Milos & Macris, 1992).

Haemorrhage is regarded as the most common circumcision complication. The most common site is the frenulum. The incidence is about 0.1 to 35%. Although

it does not need extensive intervention, sometimes it can be severe due to other factors such as haemostasis, abnormal blood vessels and coagulopathy. The treatment to this problem is electrocautery or suture ligation (Gerharz & Haarmann, 2000; Williams & Kapila, 1993).

Meatitis and meatal stenosis may occur due to exposure of the urethral meatus after circumcision, the glans penis may be exposed to ammoniacal agents (Gerharz & Haarmann, 2000). Other complications such as fistula, urethral injuries, and phimosis after circumcision, skin bridges, surgical trauma and operative complications, inclusion cysts, chordee, and penile lymphoedema may occur (Gerharz & Haarmann, 2000; Williams & Kapila, 1993).

2.8.6.2 Complications of traditional circumcision among the *AmaXhosa* initiates

There are many complications of traditional circumcision among the *AmaXhosa* especially ischaemia and bacterial infections. Sepsis after circumcision is up to 10% (Meintjes, 1998). In South Africa the problem of sepsis and other related complications is associated with traditional circumcision among the *AmaXhosa* of the Eastern Cape (Armed et al., 1999). At times sepsis leads to gangrene and ultimate amputation of the penis among the *AmaXhosa* traditional initiates (Shaw, 1997).

Crowley & Kesner (cited in Meintjes, 1998) mentioned the following complications:

- Deaths in traditional circumcision:
 - 70% of deaths take place in the circumcision schools
 - Dehydration alone accounts for 20%
 - Septicaemia alone accounts for 9% and
 - 1% due to other causes

- Penile injuries such as skin loss, amputations, fistula, traumatic hypospadias and traumatic epispadias
- Infections which may be localised such as regional abscesses, septicaemia, septic embolisation, tetanus, gangrene, Hepatitis B, AIDS, Polyarthritits
- Urinary retention
- Healing problems such as phimosis, meatal stenosis, chordee
- Severe beatings by the traditional nurse when initiate's wound do not heal, there is a belief that if the initiate do not confess all his sins and past misdeeds (*Ukubulo in isiXhosa*) the healing process of the wound will not take place. For instance initiates should confess if they have had sexual intercourse with an older woman. At times the beatings take place when the initiates show signs of experiencing severe pains during wound dressings. Initiates should be strong and endure pain as sign of manhood (Ntsaba, 2002).
- Psychological disturbances (Meintjes, 1998; van Vuuren & de Jongh, 1999).

Armed et al., (1999) stated that traditional circumcision in Nigeria is performed in children in the hospital. The authors stated that haemorrhage is the commonest complication especially in neonates. The reason for bleeding complication is due to inadequate haemostasis. Although this problem can be avoided by the use of bipolar diathermy, it is seldom used. Boys who present with bleeding usually have a reduced haematocrit, prolonged bleeding and clotting times. Infection is local which normally respond to wound dressings and antibiotics. Armed et al, (1999) further state that in Nigeria circumcision is rarely performed on males, yet in South Africa traditional circumcision is performed on male adults as a rite of passage and is associated with high mortality rate due to sepsis of the penile wound or dehydration.

2.8.7 Psychological effects of circumcision

Williams & Kapila's (1993) discussion on complications of circumcision is very good. William and Kapila (1993) argued from the Freudian theory that the child at phallic stage enjoys the sexual excitement. If circumcision is performed at this stage the child usually perceives it as an act of aggression and castration. This may arouse castration fears. If circumcision is done in a neonate it is more likely to cause marked behavioural changes. Again there can be dysmorphobia, acute psychosis and schizophrenia (Gerharz & Haarmann, 2000; Williams & Kapila, 1993).

In the Eastern Cape the mortality, morbidity and hospital admissions are high. Warren-Brown (1998) reported that initiates that are admitted in the hospital are often abandoned by their family members. These young men suffer from severe depression, because they are in hospital because they were seriously ill. They are also ostracised and denied the dignity of being called men. They are looked down upon for going to hospital and they are made to believe it is their fault that they are suffering from complications, which led to their admission. The reason is that the ritual should be completed in the bush and not in the hospital. The cause of depression is usually due to severe mutilation or amputation of their penis. After being discharge their peer group and parents sometimes reject them and this leads to psychological trauma. Some parents more especially mothers become anxious when their children are in the initiation school (Warren-Brown, 1998). Despite the fact that there are complications associated with traditional circumcision, the *AmaXhosa* people will continue practicing this custom. Warren-Brown (1998) reported that initiates that are admitted in the hospital do so as a last resort, and their families often abandon them in the hospital, because they believe that the ritual should start, and end in the bush rather than in the hospital. To the families and the peers of the initiates, it

is a shame and a disgrace that an initiate is admitted in the hospital. Often the initiates are made to believe it is their fault that they are suffering from complications that resulted in their hospital admission. A study on cultural care will lead to a new body of knowledge for the health professionals, and therefore hospitalised initiates will receive culturally congruent care based on the folk system and not from a professional system point of view (Leininger, 1991).

2.8.8 Factors associated with complications of traditional circumcision among the *AmaXhosa* male initiates

The admission of initiates to the hospital is a new phenomenon in the history of traditional circumcision custom. Medical and ethnographic literature shows little documentation on problems related to the Traditional circumcision in the past. A number of factors are attributed to lack of complications, and thereby, reasons and/or need for hospitalization of initiates during the pre-industrial South African rural life. Warren-Brown (as cited in Ntsaba, 2002) states that, in the past, boys were circumcised in March when the summer heat had passed. The traditional circumcision huts were made of grass and were well ventilated, unlike nowadays where zinc sheets and plastic covers are used. The zinc sheets and plastic covers absorb the heat so that conditions become less conducive to healing of wounds. Furthermore, Meintjes (as cited in Ntsaba, 2002) reported that old men formerly performed the circumcision ceremony, but now young men have taken it up. According to him, the young men do not understand the dressing technique and neglect the cleanliness. However, there are factors that contribute to problems associated with traditional circumcision custom nowadays.

Funani (1990) explains that today some boys suffer from sexually transmitted infections (STI's) something which would not happen in the past because sex before marriage was prohibited. The use of one instrument (assegai) in circumcising boys, which is not changed in between the initiates, can further expose them to cross infection. Funani further explains that there is lack of cleanliness of the traditional surgeons and the lodges in which the initiates spend their period of seclusion. Unlike in the past, the custom has become associated with unclean operations and other related complications such as dehydration, septicaemia, sepsis, penile mutilations and death (Warren-Brown, 1998).

Meintjes (1998) states that the types of the medical complications are varied and the most common cause is ischaemia related to the thong that is used to dress circumcision wounds. The thong is made of the skin of the cow and is left for five to 10 minutes depending on the frequency of the dressings. At times wound dressings are carried out twice to three times a day, but this is subject to the healing process. New circumcision wounds are more likely to be dressed at short intervals because the belief is that there will be rapid healing. During this process of wound dressings the traditional nurses apply the thongs too tight around the shaft of penis especially around the glans penis where the foreskin has been cut. Tight thongs impede blood supply to the penis which lead to lack of oxygen and nutrients to the penis. This result to tissues deprived oxygen (ischaemia) and bacterial infection of the circumcision wound, hence wound sepsis is common.

Shaw (1997) discovered five species of micro-organisms when culture of swabs was taken from the circumcision wounds. Most of the micro-organisms were secondary invaders related to poor hygiene in the lodge. Other complications that

have occurred are multiple organ failure due to dehydration, and renal failure. Circumcision can also precipitate psychotic delusional behaviour.

There is a theoretical but real risk of transmitting blood-borne infections such as HIV/AIDS and Hepatitis B whenever the same surgical instrument (assegai/umdlanga) is used to circumcise more than one initiate without sterilisation in between initiates. It would be difficult to prove that such transmission has occurred or find definite cases, but this is a risk based on theoretical understanding. Rusty instruments may cause complications of local sepsis or tetanus (Meintjes, 1998). Warren-Brown (1998) as cited in Ntsaba (2002) states that time has changed and the prevalence of STI's makes an alteration of this practice a matter of life and death. The above-mentioned studies, illustrate health problems in traditional circumcision including the mortality and morbidity of the initiates.

2.8.9 The government's response to the problems associated with traditional circumcision

Owing to the morbidity and mortality associated with traditional circumcision, the Eastern Cape government promulgated the Health Standards of Traditional Circumcision (Eastern Cape) Act (Act No. 6 of 22 November 2001). The government had discussions with Non-Governmental Organisations, Kings, Traditional leaders, Traditional nurses and Traditional surgeons from early in 1995. The reason for the discussions was to formulate remedial strategies such as promulgating a legislative tool which would regulate traditional circumcision. The Traditional Leaders resisted the formulation of the remedial strategies, and expressed anger towards the government because they felt that the regulation of the traditional circumcision of the

morbidity and mortality among the initiates of traditional circumcision. It is difficult to enforce this Act unless community men report to Police that a particular initiation school is not following the protocols of the Act.

The Circumcision Act does not address the issue of culturally appropriate care of hospitalised initiates in the hands of healthcare professionals. Therefore, western trained healthcare professionals are less likely to take care of that aspect of cultural care because there is no legislation or literature stipulating the measures to be followed once initiates are admitted in hospital. Health professionals are more likely to deliver health care according to what they perceive is appropriate even though it is not culturally acceptable to the general informants.

According to research conducted by Funani (1990); Meintjes (1998), Ntsaba (2002), Shaw (1997), van Vuuren and de Jongh (1999), the community and the initiates interviewed in their studies indicated that they preferred male nurses to attend them.

The Circumcision Act stipulates that initiates should not attempt to treat or attend another initiate. Meintjes (1998) stated that in the initiation school, initiates are taught to dress their own wounds in case the traditional nurse is negligent. The Circumcision Act also stipulates that no person other than the traditional nurse, medical practitioner, the medical officer or any other person authorized by the medical officer may treat an initiate within a traditional context. This statement means that if a male nurse is not authorized by a medical officer, he cannot attend to the initiates in spite of the fact that research by Meintjes (1998) and Ntsaba (2002) has shown that initiates prefer to be attended by male nurses who have undergone traditional circumcision. This part of the Act is relevant to this study because health

professionals in hospitals will not allow hospitalized initiates to dress their own wounds.

The Circumcision Act also stipulates the age in which boys should attend the initiation. According to the Act the boys should attend the traditional circumcision custom when they are 18 years old. However, there is no scientific evidence that suggests that younger boys are more exposed to sepsis or dehydration than boys over the age of 18 years. The boys that are 18 years old and above are perceived by community as strong and mature to withstand the hardships of the ritual compared to boys that are younger than 18 years old.

The Circumcision Act fails to stipulate the amount of water that should be given to initiates per day. It states that the traditional nurse should offer initiates reasonable amount of water.

The Circumcision Act also stipulates that boys should be physically examined by the medical practitioners. Under the present circumstances there is a shortage of doctors in both rural and urban areas, the Circumcision Act should extend this role to nurses irrespective of gender. Ntsaba (2002) in his study discovered that the parents of the boys that undergo physical examination before traditional circumcision would like this to be performed by male nurses. This is not always possible because the majority of health professionals are female nurses.

The Circumcision Act also stipulates that the traditional surgeon must be known to the parents of the prospective initiate, theoretically this is possible when there is a male parent and practically it is not possible from a traditional circumcision point of view if the parent of a boy is a female. Men do not inform mothers of the prospective initiates who the traditional surgeon is going to be because women are not informed

about what is happening in the initiation school including the performance of the circumcision operation.

The Circumcision Act emphasizes the role of the surgeon rather than the role of the traditional nurse. According to research conducted by Meintjes (1998); Ntsaba (2002); Shaw (1997) and Warren-Brown (1998) there is evidence that the causes of complications among the initiates of traditional circumcision are related to the malpractice caused by traditional nurses and not traditional surgeons. The role of the traditional nurse is to:

- Look after the initiates whilst in the initiation school
- To teach initiates about courtship, manhood and marriage
- To dress the wounds of the initiates, and
- To ensure the well-being of initiates is good at all times

The Circumcision Act fails to stipulate preventative measures (primary prevention) with regard to sepsis. The Circumcision Act states that the medical officer is entitled to impose deviation from the use of traditional material only in cases where there are early signs of sepsis. This means that the Circumcision Act is concentrating more on curative than on preventing complications from occurring. It is still not known whether traditional nurses know the signs of early sepsis or other similar health issues such as dehydration.

It is also stated in the Circumcision Act that traditional nurses shall not expose initiates to any danger or harmful situation. The Circumcision Act was passed in November 2001 and in 2005 complications were still occurring in traditional circumcision. Meintjes (1998) mentioned that all complications that arise from the *AmaXhosa* traditional circumcision are man-induced and therefore they are preventable. It is apparent that little or no change if any has occurred in the way

traditional nurses' practise this custom. There is scientific evidence that traditional nurses continue to expose initiates to danger and harmful situation because initiates still suffer from sepsis and dehydration. This leads to deaths, hospitalization and other related complications that arise from the custom.

2.8.10 Conclusion

The literature review that has been presented in this study provides the reader with conceptualization of culture, cultural beliefs in health care, circumcision and models of cultural care. The literature review is very important because it identifies the need for areas that need research on cultural care among the hospitalized *AmaXhosa* male initiates of traditional circumcision. No literature review was obtained in as far as the delivery of cultural care among the hospitalized *AmaXhosa* male initiates of traditional circumcision.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research design, and the details of the methods used in this study to explore the phenomenon of cultural care among the hospitalized *AmaXhosa* male initiates of traditional circumcision in the selected settings of the Eastern Cape Province of South Africa. Other information in this chapter includes the description of how the data was managed and analysed, how the ethical issues related to the study were negotiated, and the challenges of collecting very sensitive data from key and general informants.

3.2 Research design

The design selected for this study was a qualitative approach using Leininger's (1991) ethnonursing method. This method was used to explore and describe the delivery of cultural care by health professionals among the hospitalized *AmaXhosa* male initiates of traditional circumcision in the Eastern Cape. The reason for using Leininger's ethnonursing approach was to "tease" out a complex elusive and largely unknown cultural care dimension of hospitalized *AmaXhosa* male initiates of traditional circumcision. Firstly, the use of the ethnonursing method was to obtain information and the viewpoints of how cultural care was delivered among the hospitalised initiates. Secondly, the method was also used to obtain data as to how key and general informants conceived cultural care of hospitalized *AmaXhosa* male initiates of traditional circumcision.

Leininger (1991) defines “ethnonursing as a qualitative research method using naturalistic, open discovery and largely inductively derived emic modes and processes with diverse strategies, techniques, enabling tools to document, describe, understand, interpret the people’s meanings on actual or potential nursing phenomenon” (p. 79). Ethnonursing is an open and people-centred research method which would permit people to share their ideas about care in a spontaneous and informative manner with researchers. Therefore, in this study this method was used to collect data by learning from hospitalized initiates and health professionals through their eyes, ears, and experiences and how they make sense out of situations in a naturalistic observation, and reflection. Holloway and Wheeler (1996) state that ethnonursing deals with studies of a culture like other ethnographic methods, but it is also about nursing care and generates knowledge about the nursing profession.

3.3 Informants

Leininger (1991) states that ethnonurse researchers do not have “samples” or “subjects”, “cases” or “populations” but work with key informants and general informants. Therefore, in this study the terms general and key informants will be used.

3.3.1 General informants

According Leininger (1991) general informants are persons who are not fully informed but do have general ideas about the domain of inquiry and are willing to share their ideas with the researcher. General informants are used to reflect on how similar or different their ideas are from those of key informants. In this study hospitalized *AmaXhosa* male initiates were regarded as general informants.

Leininger (1991) states that in ethnonursing, the researcher purposefully select informants who are deemed knowledgeable to the domain under study. In this study

purposive method of selecting general informants was used. The reason for using this method was that the researcher believed that the selected general informants would yield the most comprehensive understanding of the study (Babbie, 1995).

3.3.1.1 Selection of general informants

The researcher selected one hospitalised male initiate from each initiation school. The general informants were selected as follows:

- those who were admitted for more than one week
- those who were deemed to be knowledgeable about cultural care that was delivered by health professionals
- according to their geographic area in which the circumcision schools were located (for instance one initiate from Mdantsane, Ndevana, Alice or King Williams Town)
- all general informants were referred from the *AmaXhosa* male traditional circumcision initiation schools
- all interviewed general informants were above 18 years old, with the exception of one general informant who was 17 years old
- all general informants had septic circumcision as a result of surgical traditional circumcision
- all general informants volunteered freely to take part in the study without any monetary expectation
- all general informants agreed to be interviewed by the researcher and signed a consent form after the purpose of the study was explained to them
- A total of 13 general informants participated in main the study

- General informants who were hospitalised less than a week were excluded from interviews

3.3.2 Key informants

According to Leininger (1991) key informants are persons who have been thoughtfully and purposefully selected (often by people in the culture) to be most knowledgeable about the domain of enquiry of interest to the ethnonurse. Key informants are held to reflect the norms, values, beliefs, and general lifeways of the culture. In this study health professionals (medical doctors and nurses) were key informants because they delivered and described cultural care among the hospitalized *AmaXhosa* male initiates.

3.3.2.1 Selection of key informants

The researcher used purposive sampling to identify key informants. The Deputy Directors of Nursing, the Chief Executive Officers, the Chief Medical Officers and the Hospital Managers were first consulted as Gate keepers of the research sites. The Deputy Directors of Nursing and Hospital Managers directed and introduced the researcher to the registered nurses-in-charge of the wards in which initiates were admitted. No interviews were carried out with the “gate keepers” except for the explanation of the purpose of the study and request of entrance to the sites. The registered nurses-in-charge of the wards referred the researcher to other key informants who were deemed knowledgeable about the delivery of cultural care among the hospitalized initiates. The selected key informants were nurses and doctors of all categories irrespective of their gender, race or ethnic background (refer to Appendix N).

The registered nurses who worked in the wards which admitted the male initiates also directed the researcher to who delivered. Two doctors, one from rural area and another one from an urban area were interviewed and shared their experience with the researcher on how the delivery of cultural care among the hospitalized initiates takes place.

In South Africa there are four main recognised racial groups, Black Africans, Whites, Indians or Asians and Coloureds. Coloureds refer to an ethnic group of people who possess sub-Saharan ancestry, but not enough to be considered Black under the law of South Africa. During apartheid era, in order to keep division and maintain a race focussed society. They constitute a majority of the population in Western Cape and Northern Cape and most of them speak Afrikaans and about 10% speak English as their mother tongue (<http://en.wikipedia.org/wiki/Coloured>).

In this study only three racial groups took part amongst key informants. The characteristics of the key informants that were selected were as follows:

- They were Black Africans, Coloureds and Whites and no Indians were selected because there were none available in the research wards/units during the collection of data
- Had an experience of one or more years in the delivery of cultural care among the hospitalized *AmaXhosa* male initiates
- Were deemed to have necessary knowledge in the delivery of cultural care among the hospitalized initiates
- Volunteered to freely take part in the study without monetary expectation
- Agreed to be interviewed and signed consent forms after the purpose of the study was explained to them

- A total of 9 key informants participated in the main study (refer to appendix N)

3.4 Settings

The main study took place in two urban hospitals, Frere and Cecilia Makiwane (known as East London Complex) hospitals in Buffalo Local District Municipality area and in a rural All Saints hospital in the Engcobo Local District Municipality. A total of three research sites were selected (Appendix A). The reason for selecting these research sites in both urban and rural sites was to increase the possibility of transferability of the findings of the study to a wider geographic area in the Eastern Cape. Leininger (1991) refers to transferability as a criterion for evaluating a qualitative study in order to determine whether it can be transferred to other similar contexts or situations” (p. 114).

3.4.1 Frere Hospital

- Frere hospital is in an urban area
- It is the Eastern Cape provincial referral centre
- Some of the boys with extensive complications were transferred from rural hospitals to Frere hospital
- The statistics of hospitalized *AmaXhosa* male initiates of traditional circumcision in the Buffalo Local District Municipality area were high in 2003 compared to other areas of the Eastern Cape (Refer to Appendix A). This statistic was important because this meant that there were enough general informants for the study in this area

- The hospitalized initiates were admitted to a male surgical ward with other surgical patients in an open ward with screens were used to create privacy
- At the time of data gathering only female nurses were assigned to work in the male surgical ward
- All male patients in the surgical ward shared toilet and showering facilities
- Individual hospitalized initiates had different physicians

3.4.2 Cecilia Makiwane hospital (CMH)

- CMH is part of East London Complex in Buffalo Local District Municipality which is in an urban area
- It is also the Eastern Cape provincial referral centre
- Some of the *AmaXhosa* boys with extensive complications were transferred from rural hospitals to CMH
- The statistics of hospitalized *AmaXhosa* male initiates of traditional circumcision in the Buffalo Local District Municipality area were high in 2003 compared to other areas of the Eastern Cape (Refer to Appendix A) The hospitalized initiates were admitted in a male urology ward
- At the time of data gathering male and female *AmaXhosa* nurses were allocated to the urology ward
- At the time of data gathering there were 19 patients in the urology ward, all but one was a non-hospitalized initiate.
- All male patients shared toilet and showering facilities
- All initiates had one white male doctor (Urologist)

3.4.3 All Saints hospital

- The hospital met the criteria of being in a rural area
- The number of hospitalized *AmaXhosa* boys in the Engcobo district was also high in 2003 (refer to appendix A). This meant that Engcobo also had enough general informants for the study
- The hospitalized initiates were admitted in a male surgical ward
- A small portion of the male surgical ward was allocated to hospitalized initiates
- There was only one patient who was admitted in the same ward with hospitalized initiates, however he was unconscious and therefore he was not aware of what was taking place around him
- Some hospitalized initiates used floor mattresses, and two or three initiates shared one bed
- Hospitalized initiates used basins instead of showers or baths, because there was no warm water at the time of data collection
- All hospitalized initiates were looked after by one Xhosa male medical doctor/physician who had undergone traditional circumcision, and was responsible for the traditional circumcision project in the Engcobo hospital to collaborate with traditional men, traditional surgeons and traditional nurses
- The hospitalized initiates' ward was a thoroughfare to the main surgical ward
- Only one mobile screen was used to create privacy, during dressings of wounds
- At the time of data gathering there were female and male student nurses allocated to the surgical ward

- Unlike the urban hospitals there was no television in the hospitalized initiates' ward
- None of the hospitalized initiates wore shoes while in hospital
- The hospital pyjamas and gowns given to them to wear were not clean due to a shortage of water in the hospital

3.5 Data collection

The process of data collection from informants took place over a period of six months from August 2004 to January 2005. This period included the period of requesting permission, negotiating entry to the research sites from gatekeepers, until the end of data collection process. In early December 2004 the researcher had preliminary visits to the main study sites before the collection of data. The researcher wanted to acquaint himself with the hospitals that would admit initiates and also to negotiate entry and acceptance from gatekeepers.

The researcher arranged with Gate keepers to contact him, once initiates were admitted to hospital. Data gathering process was conducted in two rounds of interviews in research sites hospitals. During the second round, an interview was conducted for the first time with the medical doctor who was looking after hospitalized initiates at CMH, because of his unavailability in the first round due to his busy work schedule.

3.5.1 Research methods

In this study, interview guides, the Stranger-Friend enabler (Leininger, 1991), a tape recorder and field notes were used to collect data.

3.5.1.1 Interviews with general informants

The general informants as recipients of healthcare were interviewed individually to describe how they conceived cultural care delivered by health professionals. The reason for this was that the researcher ascertained the conception of cultural care by general informants before key informants could describe how they delivered cultural care.

The interview guide for general informants was developed in order to allow them to explain what they conceived as culturally appropriate care. The research sites, referral of initiates to other institutions, and age of initiates were included in the interview guide. The interviewer explained to general informants what “culture care” meant before conducting the interviews. There is a possibility that this could have influenced the answers of informants, because after the term was explained to them they were knowledgeable and answered questions in what they understood.

The researcher created a face sheet, which is a page at the beginning of notes stating the date and time, place of interview and the characteristics of the interviewee (Neuman, 1997). The interviews took place during the day and lasted between 10 and 25 minutes for each general informant. An interview guide written in *IsiXhosa* language with unstructured questions was used (refer to Appendix C). The reason for using the unstructured self-reports was that the researcher proceeded with no preconceived view of what the hospitalized general informants conceived as cultural care. The questions in the interview guide collected data on personal information and how healthcare was delivered. Burns and Grove (2001) state that in some cases unstructured interviews are used as a step in developing a more precise measurement tool in a particular area. However, unstructured question/interviews are also mandatory in any qualitative research interview.

The researcher posed broad questions and subsequent questions were more focused and guided by responses from the broad questions. During interviews questions that were not clear to the general informants were explained. When interesting information arose, the researcher probed the general informants.

3.5.1.2 Interviews with key informants

The researcher conducted in-depth semi structured interviews with key informants face-to-face. The reason for conducting semi-structured interviews was to encourage the informants to be conversational and describe how they delivered cultural care among hospitalized initiates (Burns & Grove, 2001). The researcher posed questions from an interview guide (refer to Appendix D) and health professionals responded in the form of self-reports in an open manner. Questions were phrased and asked in English because it is the medium of instruction for all health professionals in South Africa. There were seven nurses who took part in the main study. Five nurses knew the *AmaXhosa* culture because they grew up witnessing and some practised the custom of traditional circumcision. The *AmaXhosa* nurses needed an explanation in IsiXhosa language from the researcher and expressed their views in both IsiXhosa and English. Medical doctors and Coloured nurses responded to questions in English only. Two nurses were from the Coloured group and therefore the *AmaXhosa* traditional circumcision was not their culture and had little knowledge about it.

3.5.1.3 Leininger's Stranger-Friend Enabler

Leininger (2001) states that in a Stranger-Friend enabler the researcher moves from a stranger to a friend role when studying people so as to obtain accurate, sensitive, meaningful and credible data. This usually takes a lot of time and refers to living with people over a long period of time so they learn to know the researcher. However, in this study a short period was used in a Stranger-Friend Enabler due to time restraints. In this study the researcher created a rapport and relationship with all informants from being a stranger to being a friend before engaging himself in the study. The researcher introduced himself as a Registered Nurse and a researcher investigating on how cultural care was delivered among the hospitalized *AmaXhosa* male initiates of traditional circumcision. The Stranger-friend enabler was used by the researcher as becoming a trusted friend because the informants disclosed sensitive traditional circumcision information to him. The reason for this was that hospitalized *AmaXhosa* male initiates of traditional circumcision were comfortable with the researcher and accepted him with less difficulty perhaps by virtue of being a male nurse in environments which were dominated by female nurses. The researcher obtained sensitive information from key and general informants regarding the delivery of cultural care.

In one of the research sites urban the researcher had a problem in getting access because the Gatekeepers thought that he was a journalist. The general feeling was that in the past, journalists had reported incorrect information about the admission of initiates to the hospital and that led to a bad reputation. The researcher explained to the Deputy Director of Nursing, the Chief Medical Officer that he was a registered nurse and thereafter entry was given to him. Eventually the researcher gained entry, and the Deputy Director of Nursing introduced the researcher to the ward. The

researcher wore uniform and distinguishing devices (epaulettes) as prescribed by The South African Nursing Council. Therefore, there was no deception and covert data collection because all informants were aware of the role of the researcher. It took the researcher about half a day before all health professionals could accept him in the three research sites. As a trusted colleague the researcher was in a position to obtain credible data including informants' sensitive data.

3.5.1.4 Tape recorder

Maxwell (1996) states that interviews may be recorded using an audiotape. In this study the researcher used an audiotape, and transcribed verbatim to preserve the vernacular and the meaning in-context of informants. The audiotape was also used to capture all the information in order to ensure confirmability. The reason for using the audio-tape was explained to both key and general informants. Notes were also written in case there was a technical failure of the audio-tape.

3.5.1.5 Field notes

The researcher wrote notes everyday about events and interviews with informants. Polit and Hungler (2001) assert that the most common forms of record keeping are logs and field notes. The authors describe a log as a daily record of events and conversations. In this study the researcher used a log to document events and conversations with healthcare professionals and hospitalized initiates. Field notes were also written, in order for the researcher to broaden, analyse, and interpret the data. The reason for using field notes was to synthesise and understand the data. Neuman (1997) states that notes should be written as soon as possible after each period in the field and each field visit starts with a new page with date and time noted.

Wide margins were used so as to add information anytime. Events were recorded in an order in which they occurred as well as the duration they lasted. Paragraphs and quotations marks were used so as to note the exact recall of phrases. Small talks were recorded in case they became important later. Emotional feelings were also recorded. The researcher typed the information in the computer at the end of each day.

3.6 Ethical consideration

Permission to conduct the study was obtained from the research ethics committee of the Faculty of Health Sciences at the University KwaZulu Natal, Durban. After permission was granted further permission was sought from the Eastern Cape Department of Health (refer to Appendix Q and R). The permission to conduct the study in East London complex was obtained from the Chief Executive Officer at Frere and Cecilia Makiwane Hospitals and the Ethics Committee of Region C in the Eastern Cape (refer to Appendix S and T).

In All Saints Hospital, permission to conduct the study was obtained from the Chief Executive Officer. The researcher negotiated and bargained for access of informants and organizations. After an access was obtained the researcher developed rapport with health professionals and hospitalized *AmaXhosa* male initiates of traditional circumcision in order to maintain social relations (Neuman, 1997).

The right to self determination is based on the principle of respect. The informants were respected in the sense that they were treated as autonomous agents with freedom without being controlled externally. This meant that the informants (hospitalized *AmaXhosa* male initiates of traditional circumcision, health professionals) were informed about the nature of the study. An explanation of the content, procedures and the purpose of the study was done in English for health

professionals and Sponsors, and *IsiXhosa* for hospitalized *AmaXhosa* male initiates of traditional circumcision (refer to Appendix E1 and E2). The informants were informed that they were not obliged to take part and could withdraw at any point in time if they so wished. After the informants agreed to participate, a subject letter and a written informed consent form (refer to Appendix E1, K, L and M) were signed indicating their understanding, acceptance and willingness to take part in the study. No coercion took place and the informants who did not want to take part in the study were not negatively affected. No rewards such as large sums of money were given to informants. The researcher did not use deception because it would undermine trust between the researcher and the informants.

The privacy of the informants and institutions' records were not invaded because a written informed consent to participate in a study and voluntary sharing of private information with the researcher was obtained.

The researcher avoided discomfort to the informants by ensuring that there was anonymity in reporting the findings of the study to protect informants, and data was not shared with outsiders. The researcher ensured that raw data was not accessible to unauthorised persons by keeping it in a safe place at all times. Anonymity in reporting was ensured by not linking personal data together with the informants' identity (Moutin, 2001). Informants were assigned a number as "key or general informant No.1, No. 2 and so on ..." to protect and maintain the anonymity of informants. Therefore confidentiality was maintained.

According to Polit and Hungler (1997) the study should not expose participants to harm, either in the form of physical or undue distress. In this study no physical harm occurred because only interviews were used in data gathering process. Key informants were interviewed for a period of between 15 minutes and 45 minutes.

The researcher ensured that there was no impact adversely on healthcare professionals and hospitalized *AmaXhosa* male initiates of traditional circumcision, such as stigmatisation, loss of self-esteem or tension between informants.

The Assistant Directors of Nursing and Hospital Managers in three research hospitals informed nurses in the wards which admitted initiates regarding the study and introduced the researcher to the staff and hospitalized initiates. The researcher explained the purpose of the study and its significance to key and general informants. An explanation of the study to informants was on a one-to-one basis. The ethical principles of conducting a study were explained and maintained. All informants were interviewed separately in a private room to ensure privacy and confidentiality.

The researcher ensured that there was privacy during interviews and information given was not linked to any informant. The researcher ensured that a written informed consent was obtained from the informants at East London complex and All Saints hospital after the informants agreed to participate in the study. Again, the consent involved agreement of the publication of the research results. The possibility of publishing the study findings was stated upfront. The reason for the publication of the research results was explained to the informants, that the scientists have a responsibility to report their research findings to the scientific community in order to subject such findings to peer review and scientific evaluation.

3.7 Bracketing

The researcher is a registered nurse who has undergone traditional circumcision (*South Sotho*) and lives at Sterkspruit in the Senqu Municipality District. He was employed at Umlamli hospital which is in Senqu District Local Municipality of the Eastern Cape for a period of 19 years. The majority of the communities in

Senqu district practise traditional circumcision as a rite of passage. The researcher initiated projects on the introduction of westernised health care among the *amaXhosa*, *amaHlubi* and the *South Sothos* as an intervention strategy to prevent complications related to traditional circumcision. In June 1995 the projects took place in the bush, at the community level and initiates were attended by male nurses who have undergone traditional circumcision. In the Senqu area boys are circumcised the western way in every winter and summer circumcision season.

In 2002 the researcher completed the study of the introduction of westernised healthcare into traditional circumcision among the *AmaXhosa*. From June 1995 to June 2001, 3166 boys were circumcised in the bush according to the westernised way (Ntsaba, 2002). During this time the researcher worked as a nurse educator and therefore he was not directly involved in assessing whether cultural care was delivered to hospitalized initiates of traditional circumcision by healthcare professionals.

In this study, the researcher believed that he was qualified to conduct an ethnonursing study because in the past he conducted research using ethnography and the community members were informants. The researcher's experience in both the nursing profession and traditional circumcision was used as an advantage because they are both not foreign cultures to him. The experience of the researcher in western healthcare could have led to a situation whereby he would be biased when dealing with hospitalized initiates or his extensive knowledge and projects in traditional circumcision. However, Leininger (1991) suggests that the ethnonurse should be objective and impartial in dealing with issues as expected from academic studies. The researcher collected the data and reported the findings as emic data without influencing his perspective on health professionals and hospitalized initiates. The

researcher's previous study and projects on traditional circumcision as well as his knowledge of Nursing were not used during interviews to influence or impose the researcher's views on informants.

3.8 Academic rigor

Holloway and Wheeler (1996) established evaluation criteria that could be used in qualitative research and they feel that the language should not be the same as in quantitative research. The researcher ensured **credibility** by presenting the findings as accurately as possible in relation to the information provided by informants. Leininger (1991) refers to "credibility as the truth, accuracy or believability of findings that have been established between the researcher and the informants as accurate, believable and credible of their experiences and knowledge of phenomenon" (p. 112). The real data about the delivery of cultural care among the hospitalized male initiates of traditional circumcision collected from the informants (emic and etic data) were not altered.

Leininger (1991) refers to **confirmability** as the repeated, direct and documented evidence from largely observed data from informants" (p. 113). In this study confirmability was about cultural care for hospitalized male initiates of traditional circumcision. In essence confirmability means reaffirming what the researcher has collected for the study. This took place by "confirmed checks" with informants and by giving feedback to the researcher. The researcher ensured that confirmability was achieved by documenting the evidence during data collection and writing of findings. The interviews were also tape-recorded and transcribed.

Meaningful-in-context means data that has become understandable with meanings to the informants. In achieving meaningful-in-context the researcher took

into account the environment as well as the total situation during data collection with meanings known to the informants. The criterion focused on significance of the interpretations and understanding of the actions, symbols, events or communication in which something occurred (Leininger, 1991).

Another criterion was **recurrent patterning** which Leininger (1991) refers to as “repeated instances, sequence of events, experiences or lifeways that tend to reoccur over a period of time in designated ways and context” (p.113). The researcher ensured recurrent patterning of the uncovered results were valid and will reoccur and repeat themselves over time. The researcher documented the repeated experiences, expressions, events that reflected identifiable sequenced patterns. The study has also shown thick description and data was collected until no new information could be gathered (saturation).

The reason to conduct this study was to describe as to what constitutes cultural care among the hospitalized *AmaXhosa* male initiates of traditional circumcision in the Eastern Cape hospitals. This was to enable other *AmaXhosa* communities to benefit from the results of the scientific recommendations. Therefore, the researcher achieved **transferability** (Leininger, 1991). The findings from this study could be transferred to similar situations under similar conditions. This means findings are more likely to be applicable to other areas where the study did not take place as long there are general similarities of findings under similar environmental conditions and contexts (Leininger, 1991).

3.9 Data analysis

The analysis of data of informants has been divided into two sections in order to answer the research questions and research purposes. Firstly, data have been analysed in order to describe how hospitalized initiates conceived cultural care rendered by health professionals. Secondly, data have also been analysed to describe the delivery of cultural care provided to the hospitalized *AmaXhosa* males. Data were analysed manually and also by means of a computer. The researcher immersed himself in the research data and Leininger's (1991) four phases of analysis for qualitative data were followed in this research study.

3.9.1 Phase One

The first phase involved collecting, describing, and documenting raw data, and also elaborating on basic research ideas and findings. This stage consisted of transcribing field notes, tape recordings and naturalistic interviews. Phase one also included identifying contextual meanings, and making interpretations.

3.9.2 Phase Two

Descriptors and components were identified and categorised. In this phase data were coded and classified as related to the delivery of cultural care among the hospitalized male initiates and the research questions. Emic and etic descriptors were studied for similarities and differences. Recurrent components were studied for their meanings. The transcribed data and notes were entered into a computer for assistance with data management.

3.9.3 Phase Three

In the third phase of data analysis, the researcher searched for patterns and meaning in context. Data were studied and scrutinised for recurrent patterns of similar ideas and different meanings, expressions and practices to establish credibility, and to confirm findings.

3.9.4 Phase Four

The fourth and final phase consisted of identifying and synthesising major themes, research findings, theoretical formulations and recommendations. Throughout data analysis, Leininger's (1991) six criteria for qualitative data were used (credibility, confirmability, meaning in context, recurrent patterning, saturation and transferability). Patterns were shared with key and general informants during the second round of interviews.

As a result of data analysis major themes and patterns emerged and will be discussed in chapter four. Thereafter, each pattern will be described and explained as to its meaning as conceived by key informants and general informants.

3.10 Limitations of the study

This study involves traditional circumcision and therefore, there is a possibility that some informants did not disclose the information openly and honestly due to the secretiveness of the custom, especially women. Culturally, the *AmaXhosa* women are not supposed to discuss circumcision related issues. It is expected from African women not to talk about traditional circumcision, especially in communities which practise the custom as a rite of passage (Funani, 1990). The excerpt below was

mentioned by a female key informant to re-enforce that women are not expected to discuss traditional circumcision issues.

“We do not talk about traditional circumcision because our perception is that we are women and therefore we cannot discuss about traditional circumcision in detail. We were brought up that way that we need to respect the custom because we are women, we don’t discuss traditional circumcision and we are not informed about what happens there. We are not used to this practice of seeing an initiate. Whenever they are in the bush we don’t see them, we only see them when they come back and therefore there is nothing that forces us to talk to them. We grew up knowing that you cannot see an initiate.”

(Key informants)

Again, key informants may have acted appropriately when rendering cultural care among the hospitalized initiates during the presence of the researcher. This means, the delivery of cultural care was perhaps influenced by the presence of the researcher.

Female doctors were not sampled in this study and therefore their views regarding cultural care among the hospitalized *AmaXhosa* male initiates are not known. The references made about female health professionals are specifically referring to nurses. Therefore, the results do not include the views of female doctors and other male black doctors that have not undergone traditional circumcision.

This main study took place in three public hospitals whereby wards were not partitioned into single rooms for each hospitalized initiate and therefore the results also do not represent the views of hospitalized initiates who obtained cultural care from hospital single rooms or from private hospitals.

3.11 Conclusion

The design, method of sampling, and identifying informants for this study was described. Approach to sampling was mainly purposive, and the sample size was

determined by data saturation. A pilot study assisted in the initial trial run of the data collection process with no problems. Issues around ethics and participants protection were described and permissions were obtained from the University of KwaZulu Natal, the institutional sites for the study, as well as informed consents from all informants. This study started in August 2004 when letters of permission were sent to Gate Keepers and ended at the completion of data gathering process at the end of the first week of January 2005. Therefore, the data gathering section took about five months.

CHAPTER FOUR

PILOT STUDY

4.1 Introduction

The pilot study took place at Umlamli hospital in Senqu Local Municipality. The researcher trained his basic Diploma in General Nursing at Umlamli hospital from 1984 to 1987. From 1988 to 1991 he worked at Umlamli hospital as a registered nurse. From 1992 to 2003 the researcher also worked at Umlamli hospital as an Accoucheur and a Nurse Educator. Therefore, the researcher was aware that *AmaXhosa* male initiates were also admitted at Umlamli hospital suffering from complications of traditional circumcision. Two key and two general informants took part in the pilot study. The reasons for conducting this pilot study will be discussed in the following paragraphs.

4.2 The reasons for conducting the pilot study

This pilot study was conducted after the research proposal and permission were granted by the University of KwaZulu Natal ethics committee, the Eastern Cape Department of Health and Umlamli hospital Management.

Firstly, the researcher wanted to develop a research plan and to refine the research methodology and to acquaint himself with the problems to be corrected in preparation for the main study (Burns & Grove, 2001; Treece & Treece, 1986). Secondly, the researcher also wanted to acquaint himself with the setting, and examining the relevance and appropriateness of the research guides. Thirdly, the purpose of this pilot study was to make improvements in the research project as well as problems which needed to be solved before the major study.

4.3 Research design

The design selected for the pilot study was also a qualitative approach using Leininger's ethnonursing method (refer to chapter three, 3.2).

4.3.1 General informants

In the pilot study site there were three general informants admitted at Umlamli hospital. All three general informants were from the same initiation school. However, only two were interviewed because the third hospitalized initiate was too ill to be interviewed due to severe septic circumcision and confusion.

4.3.1.1 Selection of general informants

The researcher selected the two hospitalized initiate who:

- were admitted for more than one week
- were deemed to be knowledgeable about cultural care that was delivered by health professionals
- were both coming from the same initiation schools
- were coming from the same geographic area (same Village)
- were above 18 years old
- had septic circumcision as a result of surgical traditional circumcision
- volunteered freely to take part in the study without any monetary expectation
- agreed to be interviewed by the researcher and signed a consent form after the purpose of the study was explained
- One general informant was excluded because he was very ill, confused, on intravenous infusion and weak to take part in interviews

4.3.2 Key informants

4.3.2.1 Selection of key informants

The Nursing Service Manager directed the researcher to the General Male Ward where initiates were admitted. The Manager explained the purpose of the study to the nurses who worked in the ward which admitted initiates.

There were only two nurses in the ward which admitted initiates at the time of data collection. One Enrolled nurse and one Enrolled Nursing Auxillary took part in the interviews. The key informants:

- were Black African females from the *AmaXhosa* and the AmaHlubi tribe
- both were experienced in working with hospitalized *AmaXhosa* male initiates
- were deemed to have necessary knowledge in the delivery of cultural care among the hospitalized initiates
- volunteered to freely take part in the study
- agreed to be interviewed and signed consent forms after the purpose of the study was explained to them
- no medical doctors or registered nurses were interviewed in the pilot study site because they were not available at the time of data collection

4.4 Settings

- The pilot study took place at *Umlamli* hospital in *Senqu* Local District Municipality of the Eastern Cape (a rural hospital setting).
- Initiates were admitted in general male ward with other male patients who were above the age of 6 years old
- The ward was divided into cubicles, and each had four beds

- At the time of data gathering, only two female nurses were available in General Male Ward to deliver nursing care to hospitalized initiates
- All male patients in General Male Ward shared toilets and showering facilities with hospitalized initiates
- Hospitalized initiates were seen by the same medical doctor

4.5 Data collection

4.5.1 Introduction

The process of data collection from informants took place over a period of four months from August 2004 to December 2004. In early December 2004 the researcher had preliminary visits to the pilot study site before the collection of data. The four month period included the requesting of permission, negotiating entry to the research sites from gatekeepers, until the end of data collection process.

The researcher explained the purpose of the study and its significance to key and general informants. An explanation of the study to informants was on a one-to-one basis. The ethical principles of conducting a study were explained and maintained. All informants were interviewed separately in a private room to ensure confidentiality and comfort.

4.5.2 Research methods

In the pilot study, interview guides, the Stranger-Friend enabler, a tape recorder and field notes were used to collect data.

4.5.2.1 Interviews with general informants

The general informants as recipients of healthcare were interviewed individually to describe how they conceived cultural care delivered by healthcare professionals.

The interviews took place during the day and lasted between 10 and 15 minutes for each general informant (refer to 3.5.1.1). An interview guide written in *IsiXhosa* language with unstructured questions was used (refer to Appendix C).

4.5.2.2 Interviews with key informants

The researcher conducted in-depth semi-structured interviews with key informants face-to-face. The reason for conducting semi-structured interviews was to encourage the key informants to be conversational and describe how they delivered cultural care (Burns & Grove, 2001). The researcher posed questions from an interview guide (refer to Appendix E) and health professionals responded in the form of self-reports in an open manner. Questions were phrased and asked in English because it is the medium of instruction for the majority of health professionals in South Africa. However, the two nurses needed an explanation of questions in *IsiXhosa* language and expressed their views in both *IsiXhosa* and English.

4.5.2.3 Leininger's Stranger-Friend Enabler

In the pilot study site the researcher created a rapport and relationship with all general informants from being a stranger to being a friend before engaging himself in the study. The researcher introduced himself as a Registered Nurse and a Researcher investigating on how cultural care was delivered by health professionals among the hospitalized *AmaXhosa* male initiates.

The researcher did not encounter problems in facilitating a Stranger-Friend enabler with key informants in a pilot study site. The reason for this was that the Gatekeepers and the nurses in the pilot research site had known the researcher for a long time because he used to work in the pilot study site.

Prior to data collection for the study the researcher worked as a student nurse, Registered Nurse and a Nurse Educator at Umlamli Hospital for 19 years and knew the Hospital Manager and all the nurses who worked in the research setting. However, at the time of data collection the researcher had not been working at Umlamli Hospital for two years. The Hospital manager and nurses knew and trusted the researcher because of his involvement in circumcision projects as well as in the introduction westernised health care into the traditional circumcision custom in the Senqu Local Municipality District. The researcher knew that he was trusted by the hospital Manager and in her letter of permission for the study she stated that “the results of the study will be communicated to Umlamli hospital management, staff and Eastern Cape Department of health” (B.S. Ndaba, letter of permission, October 18, 2004, refer to Appendix V). However, the Stranger to Trusted Friend ethnonursing enabler was used by the researcher to gain access and to be trusted by hospitalized initiates.

The researcher wore uniform and distinguishing devices (epaulettes) as prescribed by The South African Nursing Council. Therefore, there was no deception and covert data collection because all informants were aware of the role of the researcher.

4.5.2.4 Tape recorder

The reason for using the audio-tape was also explained to both key and general informants. Notes were also written in case there was a technical failure of the audio-tape (refer to 3.5.1.4).

4.5.2.5 Field notes

The researcher also wrote notes about events, observations interviews with general informants that were not formally interviewed, such as the hospitalized initiate that was not interviewed. Field notes were also written, in order for the researcher to broaden, analyse, and interpret the data. The reason for using field notes was to synthesise and understand the data (refer to 3.5.1.5).

4.5.3 Ethical consideration

The ethical consideration that was discussed in the main study was also used in the pilot study (refer to 3.6).

4.6 Findings

4.6.1 Introduction

The format which was used in the main study in data analysis was also applied in the Pilot study, and therefore the data is the same except few areas that were not mentioned in the main study. However, there were few differences between the main study and the pilot study. This information will be discussed in the following paragraphs. The conclusion of this pilot study will describe how the pilot study was carried out.

The following patterns were not mentioned in the study and the researcher felt that this information was important in other areas of the *AmaXhosa* who practised traditional circumcision.

Care Pattern 1

4.6.2 Cultural care beliefs associated with the healing of the circumcision wound

The key informant and general informant in the pilot study site had traditional beliefs associated with lack of wound healing. These beliefs were not mentioned in any of the main research sites.

The below excerpt from a general informant illustrates how traditional circumcision beliefs affected hospitalized initiates.

“__ _ because other people criticise us, they say we are not going to heal, we have done wrong things, and we have failed to confess so we don't feel good about, our heart are affected by that”

(General informant)

This key informant had this to say about confessions.

“__ _ he said that the reason they don't heal is that these children have done a scandal they had sexual intercourse with their sisters and they did not report this, that is why healing doesn't take place. This is their belief as to why the initiates would not heal”.

(Key informant)

The confession traditional circumcision belief is that, if the wound does not heal, it is because the initiate has failed to confess his misdeeds such as having sexual intercourse with their sisters (could be relatives or older women). Men believe that if initiates confess about all their sins and misdeeds they had committed before coming to the initiation ritual they would heal.

Care Pattern 2

4.6.3 Traditional nurses

In the pilot study site, one of the general informants stated that they were visited by his traditional nurse. General informants in the main study sites did want to be visited by traditional nurses because they believed that their injuries were caused by them.

"My traditional nurses visited me"

(General informant)

In the pilot study site traditional nurses visited initiates whilst in hospital. General informants did mention the fact that they did not want to be visited by them.

Care Pattern 3

4.6.4 Lack of Medical Doctors

In the pilot study site hospitalized initiates and health professionals stated that there were no medical doctors available to look after hospitalized initiates.

"___ in all I do not like to look after them in these conditions because one cannot get a doctor so that we can discuss and decide about the condition of this child, it is not good, what can we do? I don't mind if we get the doctor who can prescribe treatment for him. What I don't like is that the child must remain and deteriorate in front of me being a nurse that is changing the condition whilst I am taking care of him".

(Key informant)

"___ from the doctor I cannot say he is taking care of us because the doctor has never seen me since I was admitted here, he only peeped whilst I was being attended by nurses and said he would come back. I haven't received any care from the doctor for the past nine days. He promised that he would come back in order to transfer me to East London or Bloemfontein but he never came back".

(General informant)

In the pilot study site key and general informants stated that they had a problem with the Medical Doctor to consult with hospitalized initiates to an extent that nurses did not have direction as to how to treat them.

4.6.5 Discussion

4.6.5.1 Recommendations for Practice

In the pilot study it was revealed that men told the hospitalized initiates that “they did wrong things” whilst they were boys, and “did not confess” (ukubula in isiXhosa) or “they were attended by women” therefore their wounds would not heal. At times men referred to hospitalized initiates as “women” because they were attended by women. They also told them that they had failed to endure the hardship of manhood in the initiation school hence they were in hospital. Ntsaba (2002) discovered that these were beliefs associated with the lack of healing of the circumcision wounds.

The health professionals should also recommend a separate ward for initiates in order to avoid admitting them with men who have undergone traditional circumcision. This means men will not be in contact with initiates.

Traditional nurses should be encouraged to visit initiates whilst in hospital. This will ensure that there is continuity of support to hospitalized initiates, an approach desirable in future.

There was lack of Medical Doctors at the time of data collection. The Hospital Manager should review this problem and address it during circumcision seasons. The solution to the problem will ensure that initiates get quality care whilst in hospital. Good management of wounds and other related complications of traditional circumcision by Doctors will ensure that the admission duration of initiates is

shortened, and they could be discharged to go back to the Lodge to complete the ritual.

4.7. Pre-Testing

4.7.1 Pre-testing the instruments for general informants

The length of the interview guide for general informants in the pilot study was between 10 and 15 minutes. Two questions were deleted because they appeared to collect the same data which lead to the repetition of answers. The wording of the interview guide was in IsiXhosa, but the researcher had to explain the questions to general informants before they could understand and answer. This was perhaps due to the cultural care terminology which was used, and the informants were not familiar with it. One general informant was very brief in answering questions even though they were open-ended. The researcher had to probe him to get answers. On observation, his face appearance was that of an unhappy person, probably due to his hospital admission. However, the researcher created a Stranger-Friend approach by discussing other issues before asking other research questions. This made the general informant to be at ease. By the time the interview was completed a good rapport was created.

Another general informant was open to the researcher about cultural care and general problems of traditional circumcision, and in his answers he used English and IsiXhosa. The informant was appealing for help from the researcher, because in his answers he kept on saying “*ukubangaba ningasinceda*” **translation** “if you could help us”. This meant that the general informant had confidence in the researcher and gave information freely. The data that was gathered was valid and relevant to the study

because it answered the research questions and the research purpose. Therefore, there was neither need to change the wording nor to expand the interview guide.

4.7.2 Pre-testing the instruments for key informants

The length of the interview guide for key informants in the pilot study was between 10 and 25 minutes. The wording of the interview guide was in English, but the researcher had to explain the questions to key informants in IsiXhosa before they could understand and answer. This was perhaps due to the cultural care terminology which was used, and the informants were not familiar with it. Both key informants responded to questions in English and IsiXhosa. One key informant was reluctant in discussing traditional circumcision because she stated that, when they were children they were socialised that way. However, she answered all questions but was emotional because she felt that initiates were traumatised in the initiation school.

There was no need to create a Stranger-Friend approach because both key informants had worked and knew the researcher very well when he used to work at Umlamli hospital. The two key informants also asked the researcher to assist them with the dressing of the circumcision wounds. The reason for this was that they knew that the researcher was involved in circumcision projects that prevented complications related to the custom. The researcher did assist them.

The data that was gathered from key informants was also valid and relevant to the study because it answered the research questions and the research purpose. Therefore, there was neither need to change the wording nor to expand the interview guide.

In the pilot site some health professionals (Registered Nurses and Medical Doctors) were not selected because they were not available on the day data was collected. This means that this is a limitation of the pilot study because the researcher

had no input from the above mentioned health professionals in preparation for the major study.

4.7.3 Testing the data recording tools

The **tape recorder** was used to collect data, and it was valuable because there was accuracy of information collected as it was reported without alteration. Data was transcribed as it was reported by informants. **Observational data** was recorded to a lesser extent during interviews. Feelings of informants were observed and recorded during **field note** taking as well as noting the environment/setting in which the pilot study took place.

4.7.4 Testing data collection approaches

The unstructured interviews were the main methods of collecting data from informants. These unstructured interviews were very important because informants revealed information that was relevant to the study.

4.7.5 Data analysis

Data was analysed as it was entered in the computer, themes and care patterns that had meaning emerged and were categorised together. During the analysis, it was discovered that both informants needed an explanation of questions and they responded in English and IsiXhosa. The researcher was ready for the major study in translating from IsiXhosa to English for Health professionals.

4.7.6 Ethical issues

There were no negative ethical issues in the pilot study. The researcher followed all the requirements as discussed in 3.6.

CHAPTER FIVE

FINDINGS

5.1 Introduction

The findings from key informants and general informants are discussed in this chapter. Combined results following analysis of data from key and general informants have been carried out. Thereafter, the conception of cultural care data by key and general informants will be regarded as what constitutes cultural care among the hospitalized *AmaXhosa* male initiates.

In this study the researcher began the exploration by focusing on health care in the professional care system of Leininger's Sunrise Model. The researcher obtained emic data from informants' cultural care context, and explored caring experiences and events that influenced care such as values and their folk care and professional health system. The major themes and meaningful patterns emerged about the meaning of care, experiences and cultural taboos in relation to hospitalized initiates. Then the ideas about what key and general informants believed were appropriate nursing-decisions and actions were identified and considered to constitute culturally congruent care for the hospitalized *AmaXhosa* male initiates.

The findings which have cultural undertones are isolated for description of cultural care provided by key informants. Some of these findings represent conflicts between what the general informants perceive as culturally sensitive care as well as who should provide them with health care or where health care should come from.

There were similarities of themes and care patterns between the pilot study and the major study. Few differences exist from the pilot study and were discussed separately (refer to 4.6). The similarities of the themes and care patterns of pilot and major studies will be discussed from 5.2 to 5.9.

5.2 Major theme one: The delivery of cultural care meant admission of initiates in an exclusive ward

The first major theme is related to key and general informants on how they conceived the delivery of cultural care in an exclusive ward meant for hospitalized initiates. There are five care patterns identified in major theme one. The following general informant stated that he preferred a separate ward that belonged to hospitalised initiates only.

Care pattern 1

5.2.1 General informants prefer a separate ward because it would look like an initiation lodge.

This general informant preferred to a separate ward as an initiation school.

“That is why we say we would prefer our own initiation school separate from other patients.”

(General informant)

Another general informant preferred a separate ward which will be known as belonging to hospitalized initiates only.

“I prefer if initiates can have their own room separate from the hospital which will be known as belonging to the initiates.”

(General informant)

It appears that these general informants wished to continue to be in an initiation lodge-like room exclusively known as belonging to hospitalized initiates. This meant that general informants wished to be admitted in an exclusive ward which would symbolise an initiation school in hospital setting.

Care pattern 3

5.2.3 There is a need for privacy towards men who have undergone traditional circumcision by admitting initiates in an exclusive ward

This key informant in the below excerpt reported that there was a need for privacy because men who have undergone traditional circumcision were not treating hospitalized initiates in the right manner.

“Keep the secrecy, I’ve got the feeling whereby you find there are 34 people in the ward and you find that the elder boys (men) that come around here are very cruel to them, give them privacy.”

(Key informant)

The above key informant stated that men who have undergone traditional circumcision were cruel to hospitalized initiates. The key informant uses the term “cruel” to describe the attitude of men towards hospitalised initiates. They were cruel in the sense that men despised initiates for being admitted in hospital. The key informant recommended privacy by not admitting initiates in the same ward with men who have undergone traditional circumcision.

“What I was thinking about is, we need our ward then we can get our care as hospitalized initiates.”

(General informant)

This hospitalized initiate also mentioned that they preferred their ward in order to be cared separately.

“ _ _ _ someone who enters that door to come and see his patient will think I failed the endurance of the custom because he was not in the same situation as mine. That is why I say initiates should be in their ward and patients on the other side. The way we sleep I would prefer initiates to be separate from other patients because you will find out that there are people who enter this side and have undergone the traditional circumcision and did not encounter problems whilst they were initiates. Yet when it is only us people with this problem (hospitalized initiates) we are able to support each other.”

(General informant)

The general informant stated that lack of a separate ward for hospitalized initiates meant that people who visited other patients would see them. Again, visitors would also think that they have failed manhood in the bush hence they were hospitalised. The general informant stated that the reason for this was that men who did not experience problems whilst under going traditional circumcision custom would not understand why initiates were admitted in hospital.

Care pattern 4

5.2.4 Hospitalized initiates disturb other patients whenever they are admitted in the same ward

Key and general informants stated that initiates were disturbing other patients by making noise or increasing the volume of the television. Key informants stated that hospitalized initiates would not disturb other patients if admitted in a separate ward. The following excerpt from a general informant suggests that there was a need for a separate ward.

“There are elderly people there; there is an old man we are sharing the ward with. It would be better if we had a side specifically meant for us in order to sleep whenever we feel like, chatting and watching television. When we are watching television we are instructed to switch it off early. It would be better to have our own television which we can watch and whenever we want to switch it off then we can do so.”

(General informant)

This key informant also reinforced that hospitalized initiates disturbed other patients when admitted in the same ward.

"You will find each and every group have that sort of mischief (isigezo in IsiXhosa), jokes or sometimes they increase the volume of the radio. I normally tell them that...there is an old man here. I mean there is nothing special but these initiates will be the same in behaviour with those who will be admitted next year. At night you need to tell them to be quiet but furthermore there is nothing special."

(Key informant)

The key informant felt that hospitalized initiates disturbed other patients when admitted in the same ward, for instance initiates tended to increase the volume of the television or they went to bed very late at night. The general informant also stated that nurses instructed them to switch off the television because they were disturbing other patients. That is why hospitalized initiates preferred a separate ward in order to watch television until late at night.

5.3 Major theme two: Informants prefer male nurses who have undergone traditional circumcision to deliver cultural care to hospitalized initiates

Key and general informants mentioned that the delivery of cultural care by male nurses who have undergone traditional circumcision was regarded as an ideal approach. Therefore, informants preferred male health professionals as opposed to female health professionals.

Care pattern 1

5.3.1 General informants prefer male nurses because in the initiation school they are cared by men

The excerpts below from general informants suggest that they prefer male nurses to deliver cultural care among hospitalized initiates.

“According to my point of view I think hospitalized initiates should be cared by men, the reason is, I was cared by men in the bush and secondly since we were handled by men _ _ _.”

(General informant)

The above general informant preferred to be attended by men. In this context, it means those men who have undergone traditional circumcision. The informant used the term “men” to refer to male nurses. He stated that initiates were attended by men in the initiation school. It appears that this hospitalized initiate preferred to continue with the initiation school practice of being cared by males only.

This general informant also supports the above comment.

“_ _ _ what I can say is, here in hospital we should be handled by men _ _ _”

(General informant)

The excerpt above suggests that the general informant preferred to be attended by male nurses.

5.4 Major theme three: Cultural care of circumcision wounds

The dressing of circumcision wounds has nine care patterns such as preference of who should attend and not to attend to them. Also there were cultural beliefs associated with the dressing of the wounds as well as their healing. Male nurses who have undergone traditional circumcision were preferred instead of female health professionals. Cultural beliefs associated with the attendance of the circumcision wounds by female health professionals were will be discussed.

Care pattern 1

5.4.1 Female health professionals' cultural care of the circumcision wound

5.4.1.1 Care of the circumcision wound not to be carried out by female health professionals

The majority of general informants were not happy with female nurses carrying out wound dressings.

This general informant stated that he did not like his wound to be attended by women.

"What I can say are the dressings that are performed by women — — I do not like to be dressed by women but we are in hospital here it doesn't help."

(General informant)

5.4.1.2 Hospitalized initiates are shy and uncomfortable with women dressing circumcision wounds

This general informant stated that he became shy when attended by a female nurse.

"I become shy and at times when you are dressed by your equal."

(General informant)

One of the general informants stated that he was shy when attended by female health professionals especially when they were of the same age with him.

The researcher observed discomfort during wounds dressings, and some hospitalized initiates stated that they preferred male nurses. But due to the shortage of male nurses it was not always possible to be attended by them.

Care pattern 2

5.4.2 Female health professionals may have violated traditional circumcision cultural taboo (prior sexual intercourse before wound dressing)

In the following excerpt the general informant mentioned beliefs associated with the care of the wound by female health professionals.

“___ it’s like we don’t know here whether the nurses have had intercourse with their husbands the previous night, then the following day she handles you. There will be no improvement, there will be delayed of wound healing.”

(General informant)

The above excerpt refers to the traditional circumcision belief that people who practise sexual intercourse cannot handle initiates because the wounds will not heal. Men who have undergone traditional circumcision respect this rule of not attending initiates if engaged in sexual intercourse. As a matter of principle, men who attend to initiates in the bush abstain from sexual intercourse, for example traditional nurses. Therefore, this means it becomes difficult to determine whether female health professionals have had sexual intercourse because they do not know this rule.

Care pattern 3

5.4.3 Wound dressings by male nurses

This general informant also preferred circumcision wounds to be dressed by male nurses.

“Yes, number one if we can improve the fact that they should be dressed by men only ___”

(General informant)

This general informant had the following comment about the care of the wound.

This general informant preferred hospitalized initiates to be dressed wounds by male nurses.

“ _ _ _ because they are men just like them, you will find out that when you want to dress the wounds he is not comfortable; he doesn't like to undress (clothing), to show you his penis in order to dress the wound. He is not free to do that.”

(Key informant)

This female general informant preferred the delivery of cultural care among the hospitalized initiates of traditional circumcision to be delivered by male nurses. The reason is that hospitalized initiates would have confidence in male nurses. Another reason was that hospitalized initiates were not free when attended by female health professionals. Therefore, hospitalized initiates were more likely to have more freedom when attended by male nurses. The key informant also observed that during wound dressings hospitalized initiates were reluctant to undress in order for her to carry out wound dressings.

“ _ _ _ but mostly they prefer one of the males and also prefer male nurses. I am thinking of their side because this is a male organ _ _ _ yes, number one if we can improve the fact that they should be dressed by men only.”

(General informant)

The two general informants reported that hospitalized initiates were not comfortable when wound care was carried out by female nurses, and preferred to be attended by male nurses. One of the general informants in the above excerpts stated that hospitalized initiates preferred male nurses than female nurses because their problems were centred in the male organ. This general informant felt that dressings of

wounds needed to be carried out by male nurses as part of the improvement of care among hospitalized initiates.

Care pattern 4

5.4.4 In the absence of male nurses, hospitalized initiates prefer self-wound care

“In most cases male nurses dress them, sometimes there is no male nurse ___ but mostly they prefer one of the males and also prefer male nurses.”

(General informant)

Some general informants preferred to dress their wounds.

“We do the dressings then ___ I believe in dressing myself ___”

(General informant)

“___ and they ask to put the screens and they dress themselves but the doctors say we must not allow them to do so (dressing) because they will not do it right ___”

(General informant)

In the above excerpts both key and general informants stated that hospitalized initiates were carrying out self-wound dressings. One of the key informants mentioned that medical doctors were against this practice of initiates carrying self-wound care.

Care pattern 5

5.4.5 Hospitalized initiates carry out wound dressings to each other

General informants had this to say regarding the attendance of other initiates' wound.

“Yes that is possible, you ask him to dress you and tell him that you are not capable of doing the dressings, that is, acceptable because nurses are present when we dress each other. The one who dress others use gloves meanwhile we don't use them when we ourselves.”

(General informant)

"Some initiates asked me to help them."

(General informant)

General informants stated that they carried out wound dressings to one another. It appeared that this practice was acceptable to nurses because they were present whenever hospitalized initiates attended each other.

Care pattern 6

5.4.6 Health professionals supervise hospitalized initiates when they carry out wound dressings

Informants reported that nurses supervised hospitalized initiates when they carried out self-wound.

"__ __ they supervise us whether we do them correctly."

(General informants)

"__ __ they dress themselves under supervision."

(Key informants)

"We supervise others and you can see them when they are cowards when he is not doing it properly you assist him. When I started working here this was the practice __ __"

(General informant)

Nurses stated that they supervised hospitalized initiates when they carried out self-care of wounds. However health professionals assisted those who were not capable of doing so.

Care pattern 7

5.4.7 Health professionals do not remove gangrenous tissue until it falls off

The general informant stated that nurses carried out the dressings of the gangrenous wounds until the dead tissue of the penis fell off.

“ _ _ _ this child’s wound was gangrenous and the doctor asked “sister don’t you do the removal of slough?” “No we no longer do it because once you remove that they blame you, I mean during dressings we dress, dress them until it falls off on its own because immediately it falls off he will put a blame on you and he will say you have removed it. So I was telling the doctor that we no longer do that we dress them until it falls off so that they can know that we are not the cause it fell off because it would do so eventually.”

(Key informant)

The reason for carrying out dressing of the wounds until the gangrenous part fell off was that hospitalized initiates were more likely to put blame on nurses. That they have amputated/cut off their penises, although the gangrenous part would eventually fall off. In the above excerpt the doctor did not know the reason for not removing the gangrenous part. However, the nurse explained that hospitalized initiates did not understand that a gangrenous part of their penises is a dead tissue and therefore it would eventually fall off.

Care pattern 8

5.4.8 Circumcision wounds require frequent reviews and dressings

General informants were not satisfied with the dressing of the wounds that were carried out once a day.

“I wish they can take care of us, I am not sure whether the way I will talk is wrong. I think we are dressed in the morning, we are supposed to be dressed again in the afternoon because when you check the dressing at about seven in the evening you will find the ointment is finished.”

(General informant)

This general informant preferred wound dressings to be carried out twice a day. He stated that dressings that were carried out once in the morning the topical medication was absorbed at about 7pm. In essence, the general informant regarded this as no care hence he said "I wish they can take care of us."

Another general informant wished his wound could be dressed three times a day.

"My complaint is that you change the dressing today and again you will change it tomorrow. I would like to change dressings in the morning, after lunch and late in the evening. I think that can help me ___ but I would be happy if we could change in the morning, at 1 pm and at 5pm."

(General informant)

The hospitalized initiates believed in the dressing of wounds the way they were conducted in the initiation schools. In the bush initiates are dressed several times a day. In the above excerpt the general informant believed that his wound would improve rapidly if it was dressed three times a day.

Another general informant preferred to be dressed every five minutes hence the following statement.

"I would prefer this thing that we are used to, that of changing dressings after five minutes not once, at least thrice."

(General informant)

In the above excerpt the general informant felt that wound dressings were supposed to be carried out every five minutes, the way it is done in the initiation school. The feeling of this general informant was that health professionals should also continue with this practice.

Care pattern 9

5.4.9 Cultural care beliefs associated with the healing of the circumcision wound

5.4.9.1 There is a belief that women delay wound healing

The general informant stated that according to the traditional circumcision custom there are beliefs associated with women such as, “women delay wound healing.”

“There are things that do not go well in the custom, (meaning the penis) healing delays _ _ _ when we mix with women there will be a delay in wound healing.”

(General informant)

This general informant also stated that when women attend initiates or when there is a physical contact with women, there is delay in wound healing.

5.5 Major theme four: Cultural food for hospitalized initiates

Care pattern 1

5.5.1 Hospitalized initiates need enough food

Some general informants from the rural hospital perceived the amount of food offered in hospital as insufficient compared to the amount of food which they obtained in the initiation school or at home.

“Sometimes life is up and down, I mean when it comes to food. At times we get enough and sometimes we sleep having a cup of tea with no bread. Food is too little. In the initiation school we had enough food”. We don't get enough food, because when you think of the initiation school and at home you will find that we were getting enough food. Here in the hospital I don't get enough food. I've got a complaint about food I am not satisfied like when I was in the bush. What is happening is you get two slice of bread or three at times. Or if there is left over food you will see them coming back to us.”

(General informant)

The concerns of the general informants were that hospitalized initiates were offered only two slice of bread. At times they were given left over food hence the following statement “life is up and down” meaning that at times hospitalized initiates obtained sufficient food and or insufficient food. The above statement suggests that hospitalized initiates were not offered satisfactory amount of food at all times.

Care pattern 2

5.5.2 Some hospitalized initiates prefer Xhosa food

One general informant preferred Xhosa food.

“___ we need to be given the right food like bread and soft porridge at any time.”

(General informant)

The right food according to this general informant meant Xhosa home made bread and soft porridge (irhewu in IsiXhosa). This is the stable diet in the *AmaXhosa* initiation schools.

Care pattern 3

5.5.3 Hospitalized initiates prefer to eat at any time they wish

Another general informant stated that they preferred to eat at any time they so wished.

“We must not eat according to schedule times. Like eating anytime I want to, in the bush there is no such a thing as eating at nine or at one. Here we eat according to scheduled times.”

(General informant)

In hospital initiates were offered food according to scheduled times, whilst in the initiation school they had meals at any time they wished. In the initiation school food was available throughout the day and they ate whenever they felt like.

5.6 Major theme five: Visiting within cultural care

Health professionals stated that they screened visitors because in the past men came to the hospital to check which initiates were admitted and later on despised them when they were discharged. Health professionals stated that they screened and allowed only relatives to visit hospitalized initiates.

Care pattern 1

5.6.1 Health professionals screen and minimize visitors

This general informant stated that they minimized people who visited hospitalized initiates.

"We minimize visitors, the child must be seen by a close relative only. Our policy is that they must be seen by their relatives only. Because there is a mischief that occurs in the township. They've got a term that they use once you land in here in hospital they call them bats. Visitors start here in our desk and at times they are less likely to see them because they sleep a lot especially when they are still new and therefore the chances of seeing them are slim. What we do, visitors must come to the desk and we ask who they are and what they want. Then they will say I have come to see ___ at times the policeman would say I am investigating this case so I am here to hear from him. Or sometimes would come and say I have come to see an initiate who ran away from the initiation school, and we don't allow them to see them."

(Key informant)

In one of the urban hospitals, nurses mentioned that they screened visitors because there was a tendency of men coming to the hospital to find out which initiates were admitted. The key informant referred to this behaviour as mischief. The key informant also refers to an initiate as a child, and mentioned that visitors consulted nurses first before they could see hospitalized initiates. Therefore, nurses did not allow visitors to see initiates unless they were close relatives.

Care pattern 2

5.6.2 Health professionals prevent hospitalized initiates from being seen by visitors

This key informant also stated that they instructed hospitalised initiates not go outside the ward.

"I just tell them that since they are scared even to go out because they cannot be on bed all the time but you tell them not to go out because people will see them, because it may happen that they will meet people they know from their communities and they are going to make a laughing stalk that they are in hospital."

(Key informant)

The above key informant further stated that she instructed hospitalized initiates to sit at the back of the ward where the members of the community would not see them.

"I usually tell them to sit at the back so that they can be comfortable, they must not sit in a place where they will be known that they were here. We maintain the fact that they are still initiates."

(Key informant)

This key informant reported that they instructed hospitalized initiates not to sit where they would be seen by community members that they were admitted in hospital.

Care pattern 3

5.6.3 Cultural care consistent visitors

5.6.3.1 Traditional surgeons

Some general informants preferred to be visited by traditional surgeons.

"The traditional surgeon can visit me because he performed his role."

(General informant)

This general informant stated that the traditional surgeon could visit him because he performed his role of cutting the prepuce.

"I would like to be visited by my traditional surgeon."

(General informant)

General informants did not associate their injuries with the traditional surgeon.

Care pattern 4

5.6.4 Hospitalized initiates prefer to be visited by male parents and relatives who have undergone traditional circumcision

The general informants had mixed feelings about who should visit them. Some general informants preferred to be visited by male parents and/or male relatives.

"I would like to be visited by my father, my brother and some of my brothers whom we worship together _ _ _"

(General informant)

Another general informant also preferred to be visited by male parents.

"_ _ _ that is why I say one needs to be visited by male parents only _ _ _ family visitors are right like male parents and brothers I mean your family only."

(General informant)

These general informants preferred to be visited by relatives. This included parents, brothers, and other extended members of the family as long they were males.

Care pattern 5

5.6.5 Cultural care non-consistent visitors

5.6.5.1 Traditional nurses

Some general informants stated that they did not want to be visited by traditional nurses.

"I don't want to see a traditional nurse because he injured me _ _ _ the traditional nurse is the one who injured me."

(General informant)

The general informant had a feeling that the traditional nurse injured him hence he was admitted in hospital and therefore he did not want to be visited by him.

5.6.5.2 Friends (Boys)

Friends were divided into two groups, **boys** (those who have not undergone the custom of traditional circumcision) and **men** (those who have undergone traditional circumcision custom).

Some general informants preferred not to be visited by **boys**.

"I don't want my friends that have not undergone the traditional circumcision to come."

(General informant)

In the above excerpts general informants did not want to be visited by boys. Some general informants felt that if their friends visited them they would talk about them that they were admitted in hospital whilst under going traditional circumcision custom.

5.6.5.3 Friends that have undergone traditional circumcision

Another general informant preferred not to be visited by men that have undergone the custom

"Perhaps some friends, let me make an example there are friends who did not come to hospital so they will have a misunderstanding because they don't know the cause of one being here, they will think you ran away from the custom or you unable to endure the hardship of the custom. Then he will think you ran away yet he did not experience your problem which brought you to the hospital. He will think you are weak than him or you are not strong yet our problems are not the same. That is why I say one needs

to be visited by parents only, friends no but friends are not the same those who will understand or who witnessed how your problem was can visit."

(General informant)

This general informant stated that he preferred friends who understood his situation as to why he was admitted in hospital, and those who witnessed his problem whilst in the initiation school. The same general informant further reported that if men visited him in hospital they would think that he failed the process of manhood whilst they (men) failed to prevent complications associated with traditional circumcision, such as sepsis of wounds.

"Men will tell me that they did not come to the hospital. They say we are disappointing them yet they failed in their intervention strategies."

(General informant)

The general informant stated that men were putting blame on them rather facing the reality that they failed to prevent complications in the initiation school hence initiates were transferred to hospital to be attended by western trained health professionals. However, this general informant stated that friends that have undergone traditional circumcision were not the same in behaviour and attitude towards hospitalized initiates. The general informant mentioned that friends who were not hospitalized whilst undergoing traditional circumcision custom would not understand them especially those who did not encounter the same problems as theirs. Men friends who witnessed their complications whilst in the initiation school were more likely to understand him. Based on the above statements this general informant preferred to be visited by his parents because friends would think he stole his way to the hospital.

5.7 Major theme six: Cultural care admission and discharge of hospitalized initiates

Major theme six is concerned with the process of the admission and discharge of hospitalized initiates. Hospitalized initiates are shy when admitted by female health professionals, initiates to be discharged in the evening and should be accompanied by parents

Care pattern 1

5.7.1 Hospitalized initiates are shy when admitted by female health professionals

This key informant reported that hospitalized initiates were shy on admission.

“On admission they are shy understand? You will find that they avoid eye contact with us at times even if one wants to ask something but is afraid to talk.”

(Key informant)

Firstly, this female key informant described shyness with lack of eye contact between female health professionals and initiates. Secondly, the key informant also noticed that some initiates were not free to ask something from female health professionals. This behaviour was observed by key informants on admission. It appears that the shyness of the initiates is associated with the fact that they are not supposed to be seen; be in contact with women or for the mere fact they find themselves in the hospital environment whilst they are supposed to be in the bush.

Another female key informant's excerpt below confirms the fact that initiates were shy on admission.

“___ but others are shy. But during their first day on admission they are afraid they don't want even to look at us I don't know why but they are getting better.”

(Key informant)

This key informant also felt that initiates were shy on admission, and became less shy when time went by.

Care pattern 2

5.7.2 Hospitalized initiates to be discharged when parents are ready

Another key informant reported that they discharged the hospitalized initiates according to the preferences of parents.

“When the time comes to go home parents ask for his discharge for that weekend only. We allow that and you will find that our doctor is white, he doesn’t know. What he knows is when the initiate is not sick he should be discharged. But because we are AmaXhosa we allow a situation whereby we keep the initiate even if he is discharged until such time the parents are ready to make a feast for him. We have to keep him here because he cannot go back to the initiation school he is in danger of being killed by initiates he left in the bush when he went to hospital. So we wait for one or two weeks after discharge whilst the initiate is waiting here. Then the parents would take him perhaps in the morning of the day initiates go home from the initiation school.”

(Key informant)

The above key informant mentioned multiple facts pertaining to the discharge of the hospitalised initiates. Firstly, the key informant stated that when it is time for the traditional circumcision to come to an end, and initiates to go home from the initiation school, parents of the hospitalised initiates would normally come to the hospital and ask for permission for a temporary discharge. This is to ensure that hospitalized initiates go home together with those who were left in the initiation school. Then the hospitalised initiate is permitted to go home only for that weekend, and the initiate would normally come back to hospital again after few days if he is not ready for permanent discharge.

Secondly, the key informant also stated that the western doctor, who worked in the ward, discharged initiates and expected them to go home. Nurses were aware that they could not just discharge them at any time they had to wait for other initiates

they left in the circumcision school in order to go home together. Therefore, this means that nurses kept the initiates in the hospital until the parents were ready to pick them up. Thirdly, nurses kept hospitalized initiates in the ward until such time initiates who were left in the bush completed the ritual and were going home.

Care pattern 3

5.7.3 Hospitalized initiates to be discharged in the evening or at night

The key informant made this comment about the discharge of hospitalized initiates.

“What I do know is when they are discharged they wouldn't like to be seen by others and other people from the community. Then we allow them to come late and pick them up.”

(Key informant)

This key informant stated that they allowed parents and relatives to come and pick up the hospitalized initiates in the evening in order not be seen by community members. The reason for doing this was to avoid the initiates from being seen by the community.

Care pattern 4

5.7.4 Hospitalized initiates to be accompanied by parents on discharge

One of the key informants stated that on discharge hospitalized initiates were accompanied parents.

“None, what I use is that the initiate should not go alone after discharge they must be accompanied by parents, this is what I normally do.”

(Key informant)

The discharge of hospitalized initiates was not the same as any category of patient, because of privacy. Health professionals stated that they allowed hospitalized initiates to be accompanied by relatives and or parents when they were discharged from hospital, because they could be killed by their peers.

5.8 Major theme seven: Development of a Policy to guide health professionals to deliver cultural care

Key informants stated that they rendered cultural care among the *AmaXhosa* hospitalized initiates without any policy to guide them.

This key informant described the absence of a policy in the following excerpt.

“ _ _ _ but in other words one does realize and feel there should be given a special treatment that needs to be supported by policy in order to be implemented effectively. I am not proud when I make that statement its a true statement as I said in my past response that there seems to be no special attention to the special needs of the initiates. They are treated like any other patient, one would think that if you are to treat this kind of category of patient you must in the first instance be willing to do so. You must not be forced because you are allocated or by the circumstances that _ _ _ you need to be willing to do that because there are certain special sensitivities that need to be taken into account when you treat these people but as I say its with the policy if it can be developed it could then be easier.”

(Key informant)

The key informant stated that hospitalized initiates were treated like any other patient in the hospital because of lack of policy to support the cultural care of this category of a patient. He felt that if there was a policy, health professionals would not be allocated to render health care among the hospitalized initiates against their will. The key informant also mentioned special sensitivities such as women rendering cultural care to hospitalized initiates as a sign of lack of policy.

Another key informant also stated that there was no specific policy in the delivery of cultural care among the hospitalized initiates.

“None, there is no standing policy specific to the hospitalized initiates, what they (Directors of Care) want is only statistics from us.”

(Key informant)

This key informant was not happy about the lack of policy because she stated that the Directors of Care were only interested in the number of hospitalized initiates instead of developing a policy to guide nurses on how to deliver health care among the hospitalized initiates.

This informant reinforced what has been stated in the above paragraphs, that care which was rendered by women was incompatible with the traditional circumcision custom.

“When he (the initiate) comes here to the hospital that is incompatible now. The custom is still there but it's not the same because women are involved you know? Women finish what was supposed to be completed there.”

(Key informant)

The key informant stated that whenever initiates were admitted in hospital and female professionals were involved in rendering cultural care then that was incompatible with the traditional circumcision custom. According to the custom, men are supposed to attend to initiates in the initiation school, and the ritual should end there without initiates being admitted in hospital. Therefore, the key informant felt that female health professionals completed the task that was meant for males in the initiation school.

Care pattern 1

5.8.1 Care is the same for hospitalized initiates and other patients

The majority of key informants stated that they delivered healthcare to hospitalized initiates the same way as with other patients.

“There is no difference between them and other patients.”

(Key informant)

“__yes he is an initiate but I treat him as any patient with a wound and I can't help the mere fact that he is an initiate.”

(Key informant)

The health professionals treated and attended hospitalized initiates the same way without considering the cultural care needs. One key informant stated that she treated hospitalized initiates the same way as a patient with a wound.

5.9 Conclusion

In the data analysis of key and general informants, major themes and care patterns emerged. Both informants stated that hospitalized initiates preferred to be admitted in a separate ward and be attended by male nurses who have undergone traditional circumcision. General informants and some key informants mentioned beliefs associated with female health professionals in the delivery of cultural care. These beliefs need to be respected by female health professionals as a norm of the traditional circumcision custom. Both key and general informants preferred wound care to be carried out by male nurses and or in their absence, hospitalized initiates prefer to do self-care under the supervision of female health professionals; informants also stated that hospitalized initiates' food intake was high and preferred the

availability of enough food. Health professionals also stated that they screened and minimize visitors. Hospitalized initiates were shy when admitted by female health professionals, the discharge of hospitalized initiates should take place in the evening or at night and initiates should be accompanied by parents or relatives.

The key informants mentioned that they were delivering cultural care without a clear direction because there was no policy. Therefore, there is a need for a formulation of a policy to regulate and guide health professionals in the delivery of cultural care among the hospitalized initiates of traditional circumcision. This will prevent the care of the initiates in the same as other patients.

CHAPTER SIX

DISCUSSION

6.1 Introduction

Leininger, (1991) states that the findings require synthesis of thinking, configuration analysis, interpreting and creative formulation from data in order for conclusions to be credible. This chapter represents the discussion of the findings of this study based on the research questions and research purposes of the study. The gaps and suggestions made for further research. Conclusions are drawn according to the research purposes of this study.

Leininger (1991) postulates in her Culture care Diversity and Universality Theory of nursing that there are three modalities, cultural care preservation and-or maintenance, cultural care accommodation and-or negotiation and cultural care restructuring and-or repatterning which should be applied in dealing with culture. They guide nursing judgements, decisions, or actions so that nurses could provide cultural care.

Findings from the previous chapter have been rearranged and grouped together according to what needs to be preserved or maintained, accommodated or negotiated and re-patterned or restructured for the delivery of cultural care among the hospitalized initiates. Each of the three modes will be discussed in relation to the findings from this study.

Also, findings from this study indicate several areas of cultural care that could help health professionals to preserve or maintain, negotiate or accommodate and re-pattern or restructure in order to deliver culturally congruent care to the hospitalized initiates of traditional circumcision. This chapter also carries the process of the

development of a culturally congruent care framework for the hospitalized *AmaXhosa* initiates.

6.2 Cultural care actions and decisions for hospitalized *AmaXhosa* male initiates of traditional circumcision

In light of the findings from this study, the health professional is challenged to make decisions and take actions that are culturally congruent with the needs, beliefs, practices and values of the lifeways of hospitalized *AmaXhosa* male initiates of traditional circumcision.

6.2.1 Cultural care preservation and-or maintenance

Leininger and McFarland (2006) state that the first requisite is to preserve and-or maintain the cultural values and practices that promote health and well being of the client. The findings from this study indicate several areas of generic cultural care of hospitalized *AmaXhosa* male initiates of traditional circumcision that could help nurses and other health professionals to preserve and maintain naturalistic folk practices. Therefore, in this study cultural care preservation and-or maintenance refers to:

- Preserving the seclusion of hospitalized male initiates by admitting them in a separate ward
- Maintenance of secrecy and privacy
- Maintenance and respect of cultural care beliefs associated with women
- Maintenance of cultural care by male nurses who have undergone traditional circumcision
- Maintenance of cultural food for hospitalized initiates, and
- Preserving culturally non-consistent visitors from seeing initiates

6.2.1.1 Preserving the seclusion of hospitalized initiates by admitting them in a separate ward

Adler (1984) states that the seclusion period of initiates from the community takes place in the bush for a period of about two to three months. From the traditional circumcision the initiates should emerge as men losing all signs of immaturity. Therefore, this study also corroborates the suggestion that whenever initiates are admitted to hospital a separate ward/unit should be allocated. This will enhance the principle of continuing with the seclusion period of traditional circumcision. From findings the following care patterns were discovered:

- General informants preferred a separate ward because it would look like an initiation school. In the separate ward, hospitalized initiates stated that it would symbolise or mimic the Lodge, because only initiates and men who have undergone traditional circumcision will visit and deliver culturally congruent care. This could also increase the morale of the hospitalized initiates to feel as if they are in the Lodge.
- Whenever initiates are admitted with other patients, they are more likely to be seen by members of the community when they visit their relatives. Therefore, admission of hospitalized initiates in a separate ward from other patients should be preserved as part of the expectations of traditional circumcision custom. The benefits of a separate ward are more related to cultural care of hospitalized initiates. Again, a separate ward would contribute to a more positive psychological attitude for hospitalized initiates, health professionals and the community that practise the *AmaXhosa* traditional circumcision. It is against these expected societal norms and values of communities who practise traditional circumcision that would that hospitalized initiates should be

separated from the community as it would happen if they continue their ritual in the bush.

Warren-Brown (1998) states that within their communities the hospitalized initiates are ostracised and are denied the dignity of being called men instead they are called “hospital men”. They are sometimes rejected by their peer group and parents. After being discharged from hospital if they are sent back to the Lodge sometimes the initiates who were left in the bush could kill them. It is against this background that key and general informants recommend a separate ward so that initiates could be secluded from the community especially women and other men who are more likely to despise them for being admitted in hospital. Papo (1996) believes that, once health professionals conceptualise culture as basic to health care they are more likely to move into clinical practice that is tolerated to diversity in the health beliefs, which leads to improvement in health care. This means the Eastern Cape Department of Health in conjunction with hospitals that admit initiates could formulate the policy that could ensure that initiates are admitted in a separate ward. This will prevent the initiates from being admitted with other patients and will ensure high quality of care and the culturally care needs of the initiates are met. However, after the discharge of the initiates from hospital they will still be regarded as hospital men and not real men. There is a potential improvement of the stigma attached to them if admitted in the seclusion ward and cared by males that have undergone traditional circumcision.

6.2.1.2 Maintenance of secrecy and privacy

A “secret is something not known or seen or not meant to be known or seen by others. Secrecy is the action of keeping something secret, or the state of being kept secret.” (The Oxford Dictionary of English, 2003, p. 1595). According to the custom

of traditional circumcision, secrecy is very important because women and other people who have not undergone the custom should not know what is taking place in the ritual (Funani, 1990; Warren-Brown, 1998). That is why the lodges were located far away from the villages. Meintjes (1998) states that this practice has changed especially in Mdantsane, at times the nearest lodge could be as close as 20 metres from the first house in the township. However, the practices that are carried out in the lodge remain secret to the society with the exception of men who have undergone the ritual.

In this study female key informants reported that initiates were shy on admission. Funani (1990) stated that men who accompanied initiates from the Lodge were also observed to be shy in the out-patient department. These men could be relatives, parents or other men who feel obliged to refer initiates to hospital. In order for secrecy to be maintained, initiates on admission should be directed to a separate hospitalized initiates' ward with the hope that there would be male nurses who have undergone traditional circumcision in that ward. Funani (1990) further asserts that the culture of the *AmaXhosa* dictates that initiates do not come into contact with women during the seclusion period; a practice which might be difficult once the initiates are hospitalized.

Diller (1999) believes that health professionals, perhaps unknowingly discriminate against culturally different clients because they lack the skills and knowledge to serve them properly. This is true with female health professionals because they are not knowledgeable about traditional circumcision. It is against this background that initiates prefer to be attended by male nurses who have undergone the custom. This means male health professionals would have the same cultural

experiences that gives meaning and would not view the health problems of hospitalized initiates differently.

Stanhope and Lancaster (2000), however, stated that even if health professionals may come from a different culture from that of the client, they have an ethical obligation to deliver quality, efficient, effective care to all patients to the degree possible.

6.2.1.3 Maintenance and respect of cultural care beliefs associated with women

As stated elsewhere in this study, it is taboo for women to attend to initiates. According to the traditional circumcision custom, only men who have undergone the ritual may attend initiates in the initiation school. Funani (1990) states that women, especially married ones, are not allowed to go to the lodge. The belief is that the wounds of the initiates will not heal if women are permitted to see initiates hence only girls are introduced to novices. In this study hospitalized initiates also stated that if attended by females they would not heal.

Another belief is that, the circumcision wounds of initiates will not heal if attended by people who practise sexual intercourse. Men who have undergone traditional circumcision are aware of this cultural practice as opposed to females. It is a traditional circumcision cultural practice because men especially traditional nurses who attend to initiates in the Lodge abstain from sexual intercourse. In this study hospitalized initiates stated that women were more likely to practise sexual intercourse with their husbands or partners and attend to them because they were not aware of this traditional circumcision norm. Funani (1990) stated that a man should be strong. The hospitalized initiates stated that female nurses were sympathetic (*baba namasikizi* in *IsiXhosa*) when carrying out dressings. Apparently this was due to the

extent of the injuries sustained as well as sepsis to the penis. Some initiates stated that they did not want any sympathy from health professionals. This could be related to the idea that men should endure the pain of manhood.

In order for health professionals to ensure that culturally congruent care is delivered to the hospitalized initiates, the health system needs to respect and maintain the beliefs associated with women. The health system could allocate more male nurses that have undergone traditional circumcision to the wards that admit initiates.

6.2.1.4 Maintenance of care by male nurses who have undergone traditional circumcision

According to the study conducted by Meintjes (1998) on Manhood at a Price: Socio-medical Perspective on Xhosa Traditional Circumcision, male nurses are the preferred health providers whenever initiates are admitted to hospital. In this study both hospitalized initiates and health professionals preferred male nurses to render cultural care among the hospitalized initiates. General informants stated that they preferred men, apparently to continue to be cared by men as in the initiation school. The reason for informants to prefer men was purely on a cultural belief system of the *AmaXhosa* people who practice the ritual. Although hospitalized initiates and health professionals preferred the delivery of cultural care by male nurses they did not mention whether they would accept female medical doctors or not.

The Circumcision Act (Act No. 6 of 22 November 2001) stipulates that under no circumstances should initiates attend to their penile wounds whilst in the initiation school. In the absence of male nurses, however, hospitalized initiates preferred to attend to their own circumcision wounds or to attend to each other's wounds. Key informants stated that hospitalized initiates were free to do self-wound care or receive

wound care from other hospitalized initiates. Key informants further stated that hospitalized initiates were not comfortable when their wound dressings were carried out by female nurses. The nurses permitted them to attend to their own wounds under the nurse's supervision. The professional system could therefore accommodate this aspect provided nurses educate hospitalized initiates regarding basic scientific principles of wound care.

Both key and general informants reported that they preferred hospitalized initiates to be attended by male nurses especially in the care of circumcision wounds. The feeling was that general informants were freer when attended by male nurses as compared to female nurses. Meintjes (1998) and Funani (1990) mentioned that the people who have been through the ritual themselves have knowledge of its practices as well as cultural dimensions. That is why key and general informants prefer men who have undergone traditional circumcision to deliver cultural care.

According to the South African Nursing Council 2005 geographic distribution of the population of South Africa versus nursing manpower, there were 23,413 nurses in the Eastern Cape Province. Of the total number of nurses in the Eastern Cape Province, 1,912 (or only 8.1%) were male nurses whereas 91.9% were female nurses (<http://www.sanc.co.za/stats/stat2005/Distribution%202005.xls.htm> retrieved 01 July 2007). According to the demographic statistics of the South African Nursing Council, female nurses remain in the majority in the Eastern Cape. In this study 63.6% of health professionals were female nurses. This indicates that there are no adequate male nurses to deliver cultural care. Hospital Managers and Nursing Directors need to try to allocate more male nurses who have undergone traditional circumcision; and to provide separate wards exclusively for hospitalized initiates. An arrangement could be made with Nursing Colleges and University to allocate more male nurses to the

wards that admit initiates during the circumcision seasons. The Department of Health should employ and train more male nurses as part of a long term solution. This could alleviate the shortage of male nurses especially registered nurses in the delivery of cultural care during winter and summer circumcision seasons.

6.2.1.5 Maintenance of culturally appropriate food for hospitalized initiates

Hospitalized initiates reported that they were not getting enough food in hospital compared with the lodge and or at home. Some health professionals also reported that initiates' food intake is very high compared to other patients and were not given enough food. This could be related to adequate availability of food in the initiation schools at all times. In the initiation school initiates eat as much as they want at any time they so wish. This could be the reason why they felt that food was not enough in hospital. One general informant compared the amount of food in the hospital as inadequate to an extent that he mentioned that he was starving compared to what they used to have in the initiation school. The health system and health professionals should maintain adequate availability of food at all times, especially if they could be admitted in a separate ward where they could have access at all times.

6.2.1.6 Preserving cultural non-consistent visitors from seeing initiates

Cultural non-consistent visitors refer to visitors that are not wanted by hospitalized initiates as opposed to those they do want. The majority of general informants preferred not to be visited by traditional nurses, women and friends. All hospitalized initiates stated that their injuries and hospitalization were a direct cause of traditional nurses. They showed signs of hatred towards traditional nurses hence they did not want to be visited by them. Traditional nurses looked after the initiates

whilst in the Lodge. They dress their wounds and teach them all that is related to manhood. However, Meintjes (1998); Ntsaba (2000); Shaw (1997) and Warren-Brown (1998) reported that traditional nurses applied tight thongs. Beatings were also reported. In this study, general informants reported that traditional nurses ignored them when they reported that their circumcision wounds were getting worse and at times they were too drunk to attend to them resulting in tight thongs being left for too long. These are some of the reasons that made hospitalized initiates were not happy about traditional nurses.

Friends who have not yet undergone traditional circumcision are not supposed to know that initiates are admitted to hospital. Friends who have undergone traditional circumcision were more likely to stigmatize hospitalized initiates of being weak, unable to endure the hardship of being a man, or referring to them as women. Funani (1990) states that a person is not ready to face the world with its demands and difficulties if he has been circumcised in hospital where he sleeps in between white sheets, enjoys heating, electricity, television, tea or hot baths while the other initiates are in the bush and do not enjoy all the advantages of being on the ward. In conclusion, friends of hospitalized initiates are not welcome to visit. Health professionals could more easily monitor and control who actually visits the initiate's isolation.

The researcher believes, however, that in order for hospitalized initiates to get recognition, the traditional nurses, ritual surgeons and the men who care for initiates whilst in the bush need to collaborate with health professionals. This could be done through visiting the boys in hospital and talking about their care with the health professionals. This would ensure that there is continuity of support from all those who are involved in the process of the ritual in the bush.

6.2.2 Cultural care accommodation and-or negotiation

Leininger (1991) refers to “cultural care accommodation and/or negotiation as those assistive, supporting, facilitative, or enabling creative professional actions and decisions that help people of a designated culture to adapt to or to negotiate with, others for a beneficial or satisfying health outcome with professional caregivers” (p. 48). Leininger and McFarland (2006) state that accommodation and/or negotiation is the second mode of culture care actions and decisions.

Based on the findings of this study, health professionals need to understand and accommodate or negotiate the care needs of hospitalized *AmaXhosa* male initiates’ to assist in providing care within a health care system that is efficient and culturally sensitive. In order to promote culturally congruent care, health professionals should earn the confidence of hospitalized initiates by negotiating or accommodating the following care patterns:

- Health professionals need to assist hospitalized initiates to carry out their own self-care of wounds in the absence of male nurses
- Health professionals need to negotiate with hospitalized initiates to remove the gangrenous tissues of the penis,
- Health professionals need to accommodate the tradition of frequent reviews of wounds in order to check whether dressings are still in situ, at of at least twice or three times a day.

6.2.2.1 Health professionals to negotiate the removal of gangrenous tissue

Gangrene is a complication of necrosis, characterised by the decay of body tissues due to infection and ischaemia (<http://en.wikipedia.org/wiki/debridement>, retrieved 24 November, 2008). Some health professionals reported that they did not

remove gangrenous tissue because in the past hospitalized initiates had blamed the nurses for cutting off their penises, when they actually carried out debridement. It is the belief of the researcher that if health professionals could educate the initiates about gangrene and negotiate debridement initiate would be more likely to agree instead of letting the penis fall off.

6.2.2.2 Health professionals to negotiate frequent reviews and dressings

Hospitalized initiates preferred their wounds to be dressed every five to ten minutes or three times a day because this was the practice in the initiation hut. Shaw (1997) discovered that tight thongs which were carried out during wound dressings were the cause of sepsis, gangrene and amputations of penises. Meintjes (1998) also reported that wounds were dressed every five to 10 minutes.

Health professionals need to negotiate with hospitalized initiates about this harmful traditional circumcision practice. Preferably dressings need to be carried out once a day or twice for the severe septic wounds. The general informants stated that if wounds were dressed in the morning then nurses need to review them in the evening to ascertain whether the bandages are still in place. Health professionals need to negotiate the frequent review and dressing of the wounds with initiates in order to educate them about the benefits of not dressing the wound every five minutes. Health professionals need to explain to hospitalized initiates that wound care in hospital is usually carried out once a day or less frequently than that. This is to allow the healing process to take place by promoting granulation of tissues. According to traditional circumcision belief frequent dressings of wounds would facilitate wound healing.

Leininger (1991) suggests that harmful practices should be discarded therefore this is one of them which is of no help in promoting wound healing.

Hospitalized initiates suffer from excruciating pain whenever circumcision wounds are attended, and therefore there is no need to expose them two to three times a day.

6.2.2.3 Negotiating with cultural consistent visitors

Culturally congruent visitors mean the preferred visitors by hospitalized initiates as opposed to those they do not want, such as friends, women and traditional nurses. The general informants were in favour of traditional surgeons, male parents and male relatives to visit them. Some hospitalized initiates reported that relatives would maintain confidentiality and privacy about their admission in hospital. Few general informants mentioned that traditional surgeons could visit them because they carried out the task of cutting the prepuce.

In South Africa, it is expected in the near future, that the professional health system will collaborate with the indigenous health system in order to achieve common goals of treating patients. A joint approach of addressing the problem of hospitalization of initiates could involve medical staff and traditional people involved in the custom (Nurses, Doctors, traditional surgeons, traditional healers and traditional nurses). The visiting of traditional nurses should be negotiated with hospitalized initiates in order for them to be involved in the prevention of problems associated with hospitalization of initiates.

6.2.3 Cultural care restructuring and-or repatterning

Leininger (1991) refers to “cultural care repatterning or restructuring to those assistive, supporting, facilitative, or enabling professional actions and decisions that help a client reorder, change, or greatly modify their life ways for new, different, and beneficial health care pattern while respecting the client’s cultural values and beliefs

and still providing a beneficial or healthier life ways than before the changes were co-established with the client” (p. 49).

Findings of this study indicate areas that health professionals would need to repattern and restructure are as follows:

- Restructuring of the admission and hospital discharge of initiates
- Developing a culturally congruent care policy

6.2.3.1 Restructuring of the admission, in ward processes and hospital discharge of initiates

6.2.3.1.1 Admission and in ward processes

As discussed elsewhere in this study, the admission of initiates could be a beneficiary if admitted in a separate ward where they will be comfortable. The health system and health professionals need to make arrangements of not admitting initiates with other patients. Preferably, from the bush initiates need to be admitted in a separate ward exclusively meant for them. Therefore, the present set up of wards which admit initiates is not offering care that is culturally congruent.

The researcher believes that if wound swabs could be taken on admission to isolate micro-organisms responsible for sepsis, then appropriate antibiotics could be prescribed in order to facilitate the healing process. Hospital Managers especially in rural areas should ensure that hospitalized initiates get the attention of medical doctors in order to obtain the care they deserve in order to reduce the period of admission by getting immediate attention.

6.2.3.1.2 Discharge

The absence or shortage of medical doctors contributes to a lack of referral of hospitalized initiates to medical specialists such as the Urologists and consequently this leads to the delay of discharge of hospitalized initiates.

Also, in another research site, there was only one operating theatre in use for hospitalized initiates. This meant that hospitalized initiates had to wait for weeks before they could go for surgical operations such as skin graft, re-circumcision or reconstruction of their penises. The education of medical doctors regarding the consequences of long periods of hospitalization of initiates needs to be addressed. The implications of long periods of hospitalization have negative consequences because hospitalized initiates are looked down by their peer group and the community at large.

There should be collaboration between nurses, medical doctors and parents regarding the discharge of hospitalized initiates. Hospitalized initiates need to be discharged when the time is right for them to go home or to go back to the initiation school. The discharge process needs to be in the evening or during the night when no one can see that the initiate has been discharged from hospital. Hospitalized initiates need to be accompanied by parents or relatives in order to protect them from being victimised or killed by their peers (Meintjes, 1998). Some general informants mentioned that if there were more medical doctors to carry out surgical procedures that would reduce their hospital stay and would ensure that initiates are discharged quickly to join other initiates in the bush.

6.2.3.2 Developing a culturally congruent care policy

From the information given by informants, it appears that there are no policies that exist within the hospitals of the Eastern Cape for the delivery of cultural care

among the hospitalized *AmaXhosa* initiates of traditional circumcision. The Department of Health in the Eastern Cape and institutions that admit hospitalized initiates could also benefit from a policy because the staff would have guidelines for delivering culturally congruent care.

There is a need to develop a policy in order to recommend a separate ward for the admission of hospitalized male initiates of traditional circumcision in order to preserve important practices, negotiating some areas of the delivery of cultural care with the hospitalized initiates and restructuring the delivery of care within the professional health system. There should be consultations between policy makers, people in-charge of health care facilities, health professionals, the community, traditional healers, traditional surgeons, traditional nurses and health professionals in order to integrate the policy. A separate ward could motivate male community members to transfer ill initiates to hospital because of accessibility of health services that would be available to initiates.

The Circumcision Act (Act No. 6 of 2001) does not extend its scope of practice on how initiates should be cared for once admitted to the hospital. The policy on traditional circumcision is on prevention rather than on how best to deal with complications of traditional circumcision once they exist. The Act only stipulates the hygienic measures to be followed and how circumcision should be performed in the community (in the bush). At present hospitalized initiates are regarded as general patients with no specific cultural care needs different from other patients.

In this study health professionals regarded hospitalized initiates as patients with wounds. Whilst this is true, the needs of hospitalized initiates are totally different from other patients with wounds. At present there is no literature to guide health professionals on how to deliver cultural care among the hospitalized initiates of

traditional circumcision. This is due partly to the secretive nature of the custom. It is against this background the researcher believes that hospitalized initiates need to be classified and admitted according to their cultural care needs.

Therefore, figure 2 below represents the framework for culturally congruent care among the initiates of traditional circumcision on the basis of the analysed data from informants. Whenever the three modalities of preserving, accommodating and restructuring the delivery of culturally care are used during the hospitalization of initiates, then culturally congruent care is more likely to be achieved. In conclusion, health professionals need to integrate the three modalities to achieve cultural care among the initiates of traditional of circumcision

Figure 2: The culturally congruent care framework for the hospitalized *AmaXhosa* male initiates of traditional circumcision

**Cultural care preservation
and-or maintenance**

- Preserving the seclusion of hospitalized initiates in a separate ward
- Maintenance of secrecy and privacy
- Maintenance of respect of cultural care beliefs associated with women
- Maintenance of cultural care by male nurses
- Maintenance of cultural food for initiates
- Preservation of cultural non-consistent visitors from seeing initiates

**Cultural care
accommodation
and-or negotiation**

- In the absence of male nurses, initiates to carry out self care of wounds
- Health professionals need to remove gangrenous tissue
- Frequent reviews of wounds
- Accommodation of cultural consistent visitors

CULTURAL CONGRUENT CARE

Cultural care restructuring and-or repatterning

- Restructuring of the admission and discharge process
- Developing a cultural care policy

6.2.3.4 Research

There is a need to carry out research on the prevalence of HIV/AIDS among the hospitalized male initiates. Some health professionals stated that lack of healing and complications could be attributed to HIV/AIDS. There is a possibility that poor healing process and sepsis are caused by HIV/AIDS among the hospitalized initiates. Therefore a scientific study could be beneficial to determine the prevalence of HIV/AIDS among the initiates.

A study on psychological trauma experienced by hospitalization process of initiates could be beneficial. There is no doubt that the hospitalization process has a negative impact on hospitalized initiates because of the stigma attached to it. Secondly, initiates sometimes loose their genitalia during the process of traditional circumcision. A study on the impact of this could contribute to counselling of initiates in order to understand if traumatised.

There is also a need to investigate how health professionals could be trained and educated to deliver culturally congruent care among the hospitalized initiates. It is apparent that health professionals do not have information on how to render cultural care among the hospitalized initiates.

The integration of western health system and indigenous health system in the delivery of cultural congruent care among the hospitalized initiates of traditional circumcision is needed. This needs to be investigated because at the time of data collection for this study there was no collaboration between western health systems and indigenous health system. There is a possibility that if there could be scientific study then health professionals and the community could improve the quality of life for the hospitalized initiates by working together, addressing the causes of hospitalization.

There is also a need to investigate micro-organisms which are responsible for sepsis. Once micro-organisms are identified then hospitalized initiates will be treated with relevant antibiotics in order to speed up the healing process. This will lead to the reduction of the admission period of initiates in hospital. Shaw (1997) discovered five micro-organisms among the initiates whilst in the bush. Therefore the practice of taking wound swabs need to be looked into in order to isolate micro-organisms responsible for infection and antibiotics that are sensitive for their treatment.

There is a need to investigate some mechanisms for health institutions to evaluate the effectiveness of culturally congruent care delivered among the hospitalized *AmaXhosa* male initiates of traditional circumcision. This could ensure that there is continuous quality improvement in health care.

6.2.3.5 Service

The planning phase, implementation and evaluation need to be an ongoing process in order to ensure that culturally congruent care is delivered to hospitalized initiates.

The Department of Health needs to reconsider offering training and education for health professionals on traditional circumcision. Admission of initiates is a fairly new phenomenon among the *AmaXhosa*, there is no history that suggests that the problem existed in the past. All health professionals need to be informed about traditional circumcision and the ways in which they can deal with initiates. Resources such as books, magazines, research and in-service education should be available to staff.

Accessibility of health care by hospitalized initiates needs to be written down in the policy. The traditional circumcision beliefs that discourage initiates from accessing health care need to be addressed by educating communities that practice the custom. The hospitalized initiates reported that some female health professionals

passed negative remarks to them. They told hospitalized initiates that they failed the traditional circumcision custom in the bush hence they were in the hospital “*boyisakele le ehlathini in Xhosa*”. Some female health professional call them “people” “*Abantu in Xhosa*” a term hospitalized initiates did not like. The term means human beings but in the context it was used by health professionals it undermined the hospitalized initiates or had a negative connotation. Some health professionals referred to hospitalized initiates as “cirkies” taken from the word circumcision and some health professionals referred to hospitalized initiates as “septic circums”. Meintjes cited in Ntsaba (2002) stated that hospitalized initiates are called “hospital men”. Health professionals reported that some community members referred to hospitalized initiates as “bats” (*Amalulwane in Xhosa*). In Xhosa if one is referred to as a bat it means he or she is neither a bird nor a rat. Meaning something that is not known whether it is classified an animals or birds. In the context of traditional circumcision it means hospitalized initiates are not boys or men as defined in this study because they did not complete the ritual in the bush to be regarded as men yet they are circumcised and they are no boys anymore. The above comments by the community and health professionals could lead to inaccessibility of health care by initiates of traditional circumcision.

Medical and nursing curricula need to include traditional circumcision in South Africa, especially in the Eastern Cape where there is a problem. The traditional circumcision custom is also common to other South African ethnic groups other than the *AmaXhosa*. The United Nation (World Health Organisation) has recommended that where the prevalence of HIV/AIDS is high such as in Southern Africa male circumcision should be encouraged in order reduce HIV infection to adult male by about 60%.

7. CONCLUSION

This study was designed to discover the conceptions about the delivery of culturally appropriate care to the hospitalized *AmaXhosa* male initiates of traditional circumcision, in the Eastern Cape hospitals of South Africa. Informants revealed a largely unknown dimension of meanings and expressions of culturally appropriate care. Findings may help health professionals provide culturally congruent care when providing care to hospitalized *AmaXhosa* male initiates of traditional circumcision.

Traditional circumcision of *AmaXhosa* males is a rite of passage to adulthood. Nowadays some initiates encounter complications such as penile amputations, sepsis and dehydration as a consequence of the ritual. Whenever initiates have complications they are transferred to the hospital as a last resort. The purposes of this study were to: explore and describe the delivery of cultural care to the hospitalized initiates of traditional circumcision and to describe what constitute cultural care.

Extensive review of literature did not produce any studies on the subject of cultural care among the traditional hospitalized initiates. Therefore, there was a need for empirical knowledge on the cultural care among the hospitalized initiates. However, the review of literature was conducted on culture, culture and health care, cultural competence, circumcision, circumcision and HIV/AIDS.

This study took place in the hospitals of the Eastern Cape in South Africa. There were 13 general informants and nine general informants who took part in the study. Leininger's qualitative ethnonursing approach was used and data was analysed using thematic analysis. Ethical considerations were respected and adhered to, especially with traditional circumcision because it is a sensitive and secretive phenomenon. The main findings of the study were that:

- The delivery of cultural care need to be in a separate ward/unit in order to maintain the seclusion and privacy and initiates
- Informants preferred male nurses to deliver cultural care among the hospitalized initiates
- Respect of traditional circumcision beliefs associated with female health care professionals
- Increase of the amount and available times of food in hospital
- To allow only visitors preferred by hospitalized initiates
- Restructure the admission and discharge process to accommodate initiates and their parents
- Formulate a policy to guide health professionals and the health system in the delivery of cultural care

Therefore, according to the above mentioned main findings the study has answered what constitutes cultural care among the hospitalized *AmaXhosa* male initiates of traditional circumcision. Leininger's three modalities have been used to guide nursing care decisions and actions in the delivery of cultural care among the hospitalized *AmaXhosa* male initiates. The health professionals need to maintain what is regarded as good and useful by the custom, to accommodate and-or negotiate some cultural beliefs of traditional circumcision and restructure what is of no benefit to hospitalized initiates. Therefore the delivery of cultural care need not be based on general knowledge rather the needs of hospitalized should based on the recommendations of this study.

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APPENDIXES**Appendix A**

**Statistics of hospitalized initiates in the Eastern Cape Municipality Local
Districts in 2003**

MUNICIPALITY AREA	NUMBER OF INITIATES HOSPITALIZED
INTSIKA YETHU	19
ELUNDINI	15
NYANDENI	9
UMZIMVUBU	46
INXUBA YETHEMBA	14
QAWUKENI	24
KING SABATA	21
MALUTI	10
MAKANA CACADU	12
NELSON MANDELA	16
ENGCOBO	30
MNQUMA	44
BAFFALO CITY	57
AMAPHLATHI	2
LUKHANJI	6
NKONKOBÉ	10
MHLONTLO	4
EMALAHLENI	0
MBASHE	0
MALETSWAI	0
KOUGA	0
CAMDEBO	0
SENQU	0
SAKHISIZWE	0
UMZIMKHULU	0
TOTAL	339

Appendix B

Interview guide for the hospitalized initiates (English)

The researcher proceeded with no preconceived view of what the hospitalized *AmaXhosa* male initiates of traditional circumcision conceived as cultural care. The interview guide for the hospitalized *AmaXhosa* male initiates of traditional circumcision was developed so as to allow them to discuss what they conceived as culturally appropriate care. The admission sites, referral by other institutions, and age were included because the researcher believed that these attributes had a significance difference in the manner informants responded to questions.

Research Site

- Umlamli hospital
- Frere Hospital
- Cecilia Makiwane Hospital
- All Saints Hospital

Introductory question

How is life in the hospital?

Core Questions

Describe the care you receive from healthcare professionals with specific reference to doctors and nurses

As a hospitalized Xhosa male initiate would you describe this care as culturally suitable for you according to the custom of traditional circumcision?

How would you like to be cared and treated while you are a hospitalised initiate of traditional circumcision?

Who would you prefer to visit you whilst admitted in the hospital?

In your view how can cultural care provided among the hospitalised *AmaXhosa* male initiates of traditional circumcision be improved?

Is there anything you would like to discuss with me which is not reflected in my questions?

Appendix C

Interview guide for the hospitalized initiates (Xhosa)

The researcher proceeded with no preconceived view of what the hospitalized *AmaXhosa* male initiates of traditional circumcision conceived as cultural care. The interview guide for the hospitalized *AmaXhosa* male initiates of traditional circumcision was developed so as to allow them to discuss what they conceived as culturally appropriate care. The admission sites, referral by other institutions, and age were included because the researcher believed that these attributes had a significance difference in the manner informants responded to questions.

Research Site

- Umlamli Hospital
- Frere Hospital
- Cecilia Makiwane Hospital
- All Saints Hospital

Introductory question:

Ngaba ubomi bunjani nje apha esibhedlele?

Core Questions

Chaza inkathalo oyifumana konompilo ngokukodwa koogqira nobongikazi

Nanjengokuba ungumkhwetha le nkathalo oyifumanayo ungathi ilungile na ngokwesiko lolwaluko?

Ubungathanda ukuba ukhathalelwe, unyangwe kanjani njengokuba ungumkhwetha olaliswe esibhedlele?

Xa ungumkhwetha olaliswe esibhedlela ubungathanda undwendwelwe ngobani?

Ngokwembono yakho ucinga ukuba inkathalo ebakhwetheni abalaliswe esibhedlele ingaphuculwa njani?

Ikhona na into obungathanda siyixoxe engekho kule mibuzo yam?

Appendix D

Interview guide for health professionals

In formulating this guide the researcher considered the demographic composition of the health professionals such as age, experience in delivering healthcare to the hospitalised initiates, race, ethnic group, sex, geography of the institution (urban or rural), educational qualifications, and traditional circumcision status. These factors determined how cultural care was delivered to the hospitalized *AmaXhosa* male initiates of traditional circumcision. Research questions and research objectives were considered in formulating the interview guide. The reason for this was to determine whether the posed questions answered the research questions and research objectives.

Institutional geographic area:

- Urban
- Rural

Profession:

- Medicine
- Nursing

Gender:

- Males
- Females

Race:

- Blacks
- Whites
- Coloureds

Introductory questions

What is your view about traditional circumcision as a custom?

What do you think is the role of culture in healthcare?

Core Questions

Briefly describe your role in caring for the hospitalized initiates

Which strategies do you use to learn the culture of traditional circumcision?

What attitudes, preconceive notions and feelings do you have towards hospitalized *AmaXhosa* male initiates of traditional circumcision?

Describe the values, beliefs and practices of hospitalized *AmaXhosa* male initiates of traditional circumcision?

Explain how the institution trained and developed you in delivering healthcare to the hospitalized *AmaXhosa* male initiates of traditional circumcision?

Describe methods that you use to communicate in face-to-face with hospitalized *AmaXhosa* male initiates of traditional circumcision

Which hospital policies guide you in the delivery of healthcare to the hospitalized *AmaXhosa* male initiates of traditional circumcision?

What types of traditional healing beliefs interrelate with western medical approaches in the delivery of healthcare to the hospitalized *AmaXhosa* male initiates of traditional circumcision?

What mechanisms are in place to ensure that there is satisfaction among the hospitalized *AmaXhosa* male initiates of traditional circumcision?

Is there anything that can be done to improve the delivery of healthcare to the hospitalized *AmaXhosa* male initiates of traditional circumcision?

Appendix E1

Subject information letter (English)

Dear Participant

I am a Registered Nurse presently studying towards a Doctor of Philosophy degree in Nursing at the University of KwaZulu Natal. The degree requires that I undertake a research project. The study that I wish to undertake is **“The delivery of cultural care by health professionals among the hospitalized *AmaXhosa* male initiates of traditional circumcision in the Eastern Cape”**. The reason for undertaking this study is that, the researcher would like to describe and explore how cultural care is rendered to hospitalized *AmaXhosa* male initiates of traditional circumcision. The results of this study could be used for recommendations to improve cultural care among the hospitalized initiates. You are requested to participate with the aim of obtaining information about your delivery of cultural care with among the initiates of traditional circumcision. Should you agree to participate in this study no names will appear on any documentation other than the consent forms, which the researcher will keep. The interviews will take place during the day and a tape recorder will be used in order to capture comments. The tape recorder is necessary as the researcher will not have a scribe to assist in recording the discussion. The cassettes will only be used by the researcher and will be kept in a safe place so that confidentiality can be maintained. After three years they will be destroyed.

The interviews will take approximately 45 minutes to one hour. As far as can be determined, there will be no risk. You are under no obligation to participate. You have a right to withdraw at any time and refuse to participate without giving any reasons for such an act, and you will not be paid for participating in the interviews. The researcher will check the findings of the study together with participants to ensure that what is in the report is valid. In the past Mr M.J. Ntsaba has conducted research on traditional circumcision and introduced westernised health care into traditional circumcision (projects). Therefore, he has a vast experience in dealing with problems associated with the custom outside the hospital as well as nursing hospitalized initiates.

Thank you

.....
M.J. Ntsaba B.A. Cur (UNISA), M.Tech: Nursing (DUT), Ph.D. candidate (UKZN),
RN, RM, RCN, RNE, RNA, Certificates: Pharmacology for Registered Nurses and
Registered Midwives in Primary Health Care, Curative skills in Primary Health Care.

Contact number. 0734857831

Professor N.O. Adejumo (Supervisor) Tel. No. (031) 269 3316

Appendix E2

Subject information letter (Xhosa)

Mthathi nxaxheba

Ndingumongi ofundela isidanga sobugqira kwezokonga kwidyunivesithi yaKwaZulu Natal. Ngoko ke kuyimfuneko ukuba ndenze uphando kwesi sidanga ndisifundayo. Uphando endingathanda ukulenza luthi "Inkathalo yonompilo kubakhwetha *bamaXhosa* abalaliswe kwizibhedlele zase Eastern Cape".

Isizathu esibangela ukuba umphandi enze oluphando kukuchaza ezempilo abazifumana konoompilo esibhedlele. Iziphumo zoluphando zingenza kubekho utshintsho kwindlela abakhwetha bafumana ngayo inkathalo. Uyacelwa ukuba uthabathe inxaxheba, ukuze kufumaneke inkcukacha zokuba ukhathalelwa njani ngoonompilo. Xa uvuma ukuthabatha inxaxheba, igama lakho ngeke livele ndawo ngaphandle kwi fomu yentsayino gama. Olu phando luzakwenziwa emini. Umphandi uzakusebenzisa itape rekhodi ukwenzela ukuba kungabikho nto ayishiyelelayo xa kuxoxwa. Iikhaseti zizakusetyenziswa ngumphandi kuphela kwaye zizakugcinwa kwindawo ekhuselekileyo. Emva kweminyaka emithathu zizakutshiswa.

Ingxoxo zizakuthatha malunga namashumi amane anesihlanu namashumi amahlanu emizuzu. Awunakuba sesichengeni ngokuthatha inxaxheba koluphando. Unelungungelo lokurhoxa nani na uthanda ngaphandle kokunika isizathu sokwenza oko. Awunakuhlululwa ngokuthatha kwakho inxaxheba. Iziphumo zophando zizakungqiniswa kubathathi nxaxheba. uMr M.J. Ntsaba uke wenza uphando kulwaluko ngaphambili kunye nokufaka amayeza asentshona kulwaluko, ngoko ke unamava kwingxaki zabakhwetha entabeni nasesibhedlele.

Enkosi

.....
M.J. Ntsaba B.A. Cur (UNISA), M.Tech: Nursing (DUT), Ph.D. candidate (UKZN), RN, RM, RCN, RNE, RNA, Certificates: Pharmacology for Registered Nurses and Registered Midwives in Primary Health Care, Curative skills in Primary Health Care.
Contact number. 0731405122

Professor N.O. Adejumo (Supervisor) Tel. No. (031) 269 3316

Appendix F

Letter of request of permission to conduct a study in East London Complex

Tapoleng Village
P.O. Box 313
STERKSPRUIT
9762
Cell. 0734857831
E-mail. jafta.ntsaba@bigpond.com

14 December 2004

The Chief Executive Officer
East London Complex
EAST LONDON
5200

Dear Sir

Request for permission to conduct a study in East London Complex

I am a Registered Nurse presently studying towards a Doctor of Philosophy degree in Nursing at the University of KwaZulu Natal. The degree requires that I undertake a research project. The study that I wish to undertake is **“The delivery of cultural care by health professionals among the hospitalized *AmaXhosa* male initiates of traditional circumcision in the Eastern Cape”**. The reason for undertaking this study is that, the researcher would like to describe and explore how cultural care is rendered to initiates of traditional circumcision whilst admitted in the hospital. The results of this study could be used for recommendations to improve health care among the hospitalized *AmaXhosa* male initiates of traditional circumcision.

You are requested to give permission, with the aim of obtaining information about cultural care with specific reference to the hospitalized *AmaXhosa* male initiates of traditional circumcision. If permission is granted for this study no names will

appear on any documentation other than the consent forms, which the researcher will keep. The interviews will take place during the day and a tape recorder will be used in order to capture comments. The tape recorder is necessary as the researcher will not have a scribe to assist in recording the discussion. The cassettes will only be used by the researcher and will be kept in a safe place so that confidentiality can be maintained. After three years they will be destroyed. The interviews will take approximately 30 to 45 minutes.

As far as can be determined, there will be no risk. Informants are under no obligation to participate. Participants have a right to withdraw at any time and refuse to participate without giving any reasons for such an act. Participants will not be paid for participating in the interviews. The researcher will check the findings of the study together with participants to ensure that what is in the report are valid.

The study findings will be presented to Umlamli hospital, East London complex, All Saints hospital and the University of KwaZulu Natal research committee. An abstract of the study will be submitted for possible presentation of the research at a national or international conference. The study will also be submitted for publication in a clinical journal as well as in academic libraries. The reason is to increase knowledge in nursing practice and better clinical practice. Another letter has been written to the Provincial Ethics committee, and detailed information as to how subjects and the East London complex will be protected. In the past, Mr M.J. Ntsaba has conducted research on traditional circumcision as well as introducing westernised health care into traditional circumcision (projects). Therefore, he has a vast experience in dealing with problems associated with the custom both out side the hospital as well as nursing hospitalized initiates.

Thank you

.....
M.J. Ntsaba B.A. Cur (UNISA), M.Tech: Nursing (DUT), Ph.D. candidate (UNKZ),
RN, RM, RCN, RNE, RNA, Certificates: Pharmacology for Registered Nurses and
Registered Midwives in Primary Health Care, Curative skills in Primary Health Care.
Contact number. 0734857831

Professor N.O. Adejumo (Supervisor) Tel. No. (031) 269 3316

Appendix G

Letter of request of permission to conduct a study at All Saints hospital

Tapoleng Village
P.O. Box 313
STERKSPRUIT
9762
Cell. 0734857831
E-mail. jafta.ntsaba@bigpond.com

23 November 2004

The Chief Executive Officer
All Saints Hospital
ENGCOBO

Dear Sir

Request for permission to conduct a study in Engcobo Local Municipality District

I am a Registered Nurse presently studying towards a Doctor of Philosophy degree in Nursing at the University of KwaZulu Natal. The degree requires that I undertake a research project. The study that I wish to undertake is **“The delivery of cultural care by health professionals among the hospitalized *AmaXhosa* male initiates of traditional circumcision in the Eastern Cape”**. The reason for undertaking this study is that, the researcher would like to describe and explore cultural care is rendered to initiates of traditional circumcision whilst admitted in the hospital. The results of this study could be used for recommendations to improve nursing care among the initiates admitted hospitals. You are requested to give permission, with the aim of obtaining information about cultural care with specific reference to the initiates of traditional circumcision. If permission is granted for this study no names will appear on any documentation other than the consent forms, which the researcher will keep. The interviews will take place during the day and a

tape recorder will be used in order to capture comments. The tape recorder is necessary as the researcher will not have a scribe to assist in recording the discussion. The cassettes will only be used by the researcher and will be kept in a safe place so that confidentiality can be maintained. After three years they will be destroyed. The interviews will take approximately one and half to two hours.

As far as can be determined, there will be no risk. Informants are under no obligation to participate. Participants have a right to withdraw at any time and refuse to participate without giving any reasons for such an act. Participants will not be paid for participating in the interviews. The researcher will check the findings of the study together with participants to ensure that what is in the report are valid. The study findings will be presented to the Umlamli hospital, East London complex, All Saints hospital and the University of KwaZulu Natal research committee. An abstract of the study will be submitted for possible presentation of the research at a national or international conference. The study will also be submitted for publication in a clinical journal as well as in academic libraries. The reason is to increase knowledge in nursing practice and better clinical practice. Another letter has been forwarded to the MEC Health, Provincial Ethics committee, and detailed information as to how subjects and the All Saints hospital will be protected. In the past, Mr M.J. Ntsaba has conducted research on traditional circumcision as well as introducing westernised health care into traditional circumcision (projects). Therefore, he has a vast experience in dealing with problems associated with the custom both out side the hospital as well as nursing in-patients (initiates).

Thank you

.....
M.J. Ntsaba B.A. Cur (UNISA), M.Tech: Nursing (DUT), Ph.D. candidate (UKZN), RN, RM, RCN, RNE, RNA, Certificates: Pharmacology for Registered Nurses and Registered Midwives in Primary Health Care, Curative skills in Primary Health Care.

Contact number. 0734857831

Professor N.O. Adejumo (Supervisor) Tel. No. (031) 269 3316

Appendix H

Letter of request of permission to conduct a pilot study at Umlamli hospital

Tapoleng Village
P.O. Box 313
STERKSPRUIT
9762
Cell. 0734857831
E-mail. jafta.ntsaba@bigpond.com.

23 November 2004

The Middle Manager Health
Umlamli Hospital
Private Bag x5016
Sterkspruit
9762

Dear Madam

Request for permission to conduct a pilot study at Umlamli hospital

I am a Registered Nurse presently studying towards a Doctor of Philosophy degree: Nursing at the University of KwaZulu Natal. The degree requires that I undertake a research project. The study that I wish to undertake is **“The delivery of cultural care by health professionals among the hospitalized *AmaXhosa* male initiates of traditional circumcision in the Eastern Cape”**. The reason for undertaking this study is that, the researcher would like to describe and explore cultural care is rendered to initiates of traditional circumcision whilst admitted in the hospital. The results of this study could be used for recommendations to improve nursing care among the initiates admitted hospitals. You are requested to give permission, with the aim of obtaining information about healthcare with specific reference to the initiates of traditional circumcision. If permission is granted for this study no names will appear on any documentation other than the consent forms,

which only the researcher will keep. The interviews will take place during the day and a tape recorder will be used in order to capture comments. The tape recorder is necessary as the researcher will not have a scribe to assist in recording the discussion. The cassettes will only be used by the researcher and will be kept in a safe place so that confidentiality can be maintained. After three years they will be destroyed. The interviews will take approximately one and half to two hours.

As far as can be determined, there will be no risk. Informants are under no obligation to participate. Participants have a right to withdraw at any time and refuse to participate without giving any reasons for such an act. Participants will not be paid for participating in the interviews. The researcher will check the findings of the study together with participants to ensure that what is in the report are valid. The study findings will be presented to the Umlamli hospital, East London complex, All Saints hospital and the University of KwaZulu Natal research committee. An abstract of the study will be submitted for possible presentation of the research at a national or international conference. The study will also be submitted for publication in a clinical journal as well as in academic libraries. The reason is to increase knowledge in nursing practice and better clinical practice. Another letter has been written to the MEC Health, Provincial Ethics committee, and detailed information as to how subjects and the complex will be protected. In the past, Mr M.J. Ntsaba has conducted research on traditional circumcision as well as introducing westernised health care into traditional circumcision (projects). Therefore, he has a vast experience in dealing with problems associated with the custom both out side the hospital as well as nursing hospitalized initiates.

Thank you

.....
M.J. Ntsaba B.A. Cur (UNISA), M.Tech: Nursing (DUT), Ph.D. candidate (UKZN),
RN, RM, RCN, RNE, RNA, Certificates: Pharmacology for Registered Nurses and
Registered Midwives in Primary Health Care, Curative skills in Primary Health Care.

Contact number. 0734857831

Professor N.O. Adejumo (Supervisor) Tel. No. (031) 269 3316

Appendix I

Letter of request of permission to conduct a research project in the selected hospitals of the Eastern Cape

Tapoleng Village

P.O. Box 313

STERKSPRUIT

9762

Cell. 0734857831

E-mail. jafta.ntsaba@bigpond.com

23 November 2004

The MEC

The Eastern Cape Province

Department of Health

BISHO

5600

Dear Doctor Goqwana

Request for permission to conduct a study in East London Complex, All Saints and Umlamli hospital

I am a Registered Nurse presently studying towards a Doctor of Philosophy Degree in Nursing at the University of KwaZulu Natal. The degree requires that I undertake a full research project. The study that I wish to undertake is **“the delivery of cultural care by health professionals among the hospitalized *AmaXhosa* male initiates of traditional circumcision in the Eastern Cape”**. The reason for undertaking this study is that, the researcher would like to describe and explore how cultural care is rendered to initiates of traditional circumcision whilst admitted in the hospital.

The results of this study could be used for recommendations to other hospitals in rendering culturally competent healthcare to the initiates. You are requested to give

permission, with the aim of obtaining information about healthcare with specific reference to the initiates of traditional circumcision. If permission is granted for this study no names will appear on any documentation other than the consent forms, which only the researcher will keep. The interviews will take place during the day and a tape recorder will be used in order to capture comments. The tape recorder is necessary as the researcher will not have a scribe to assist in recording the discussion. The cassettes will only be used by the researcher and will be kept in a safe place so that confidentiality can be maintained. After three years they will be destroyed.

The interviews will take approximately 30 to 45 minutes. As far as can be determined, there will be no risk. Informants are under no obligation to participate. Participants have a right to withdraw at any time and refuse to participate without giving any reasons for such an act. Participants will not be paid for participating in the interviews. The researcher will check the findings of the study together with participants to ensure that what is in the report are valid.

The permission to conduct the research will also be obtained from Umlamli Management Committee, Provincial Ethics Committee, East London health complex Chief Executive Officer, Engcobo District Municipality CEO and the informants that will be involved in the research. Explanation and the purpose of the research will be explained in English for Health Professionals and IsiXhosa for the initiates. The content, procedures will also be explained. The participants will be informed that they are not obliged to take part and can withdraw at any point in time if they so wish. The informants will sign the written informed consents. The informants will only be involved in the study after permission has been granted by the Provincial Ethics Committee and the Chief Executive Officers. The researcher will ensure that there will not be an impact adversely on the informants such as stigmatisation, loss of self-esteem as well as tension between informants. Participants will not be exposed to harm, either in the form of physical or undue distress due to the study. In this study no physical harm is anticipated because only interviews and observations will be conducted in the data gathering process.

Subjects will be interviewed during the day. To avoid discomfort of the subjects the researcher will ensure that there will be anonymity to protect subjects and data will not be shared with outsiders. Therefore confidentiality and privacy will be maintained. There will be no recording of personal data together with the subject's identity. The researcher will also ensure that informed consent is obtained from the

subjects, the institutions involved in the research and the Ethics committee about the publication of the research results. The reason is that the scientists have a responsibility to report their research findings to the scientific community so that they can be exposed to peer evaluation.

The study findings will be presented to the institutions involved in the study and the University of KwaZulu Natal research committee. An abstract of the study will be submitted for possible presentation of the research at a national or international conference. The study will also be submitted for publication in a clinical journal as well as in academic libraries. The reason is to increase knowledge in healthcare practice and better clinical practice. In the past Mr M.J. Ntsaba has conducted research on traditional circumcision as well as introducing westernised health care into traditional circumcision in Senqu Municipality District (projects). Therefore, he has a vast experience in dealing with problems associated with the custom out side the hospital as well as nursing in-patients (initiates).

Thank you

.....
M.J. Ntsaba B.A. Cur (UNISA), M.Tech: Nursing (DUT), Ph.D. candidate (UKZN),
RN, RM, RCN, RNE, RNA, Certificates: Pharmacology for Registered Nurses and
Registered Midwives in PHC, Curative skills in PHC.

Contact number. 0734857831

Professor N.O. Adejumo (Supervisor) Tel. No. (031) 269 3316

Appendix J

Letter of request of permission to conduct a study: Ethics Committee Region C

Tapoleng Village
P.O. Box 313
STERKSPRUIT
9762
Cell. 0731405122
E-mail. jafta.ntsaba@bigpond.com

23 November 2004

The Chairman
Eastern Cape Region E Ethics Committee
Department of Health
BISHO
5600

Dear Sir

Request for permission to conduct a study in East London Complex

I am a Registered Nurse presently studying towards a Doctor of Philosophy Degree: Nursing at the University of KwaZulu Natal. The degree requires that I undertake a full research project. The study that I wish to undertake is **“The delivery of cultural care by health professionals among the hospitalized *AmaXhosa* male initiates of traditional circumcision in the Eastern Cape”**. The reason for undertaking this study is that, the researcher would like to describe and explore how cultural care is rendered to initiates of traditional circumcision whilst admitted in the hospital.

The results of this study could be used for recommendations to other hospitals in the delivery of cultural care among the hospitalized initiates. You are requested to give permission, with the aim of obtaining information about cultural care with specific reference to the hospitalized initiates of traditional circumcision. If

Appendix K

Consent form for health professionals

Study title: The delivery of cultural care by health professionals among the hospitalized *AmaXhosa* male initiates of traditional circumcision in the Eastern Cape.

Researcher: M.J. Ntsaba

Supervisor: Professor N.O. Adejumo

Institution: University of KwaZulu Natal

I am a registered nurse studying the delivery of cultural care among the hospitalized initiates. Although the study will not benefit you directly, it will provide information that might enable healthcare professionals to deliver cultural care among the hospitalized initiates. The study and its procedures have been approved by the appropriate people and the research committees at the University of KwaZulu Natal as well as Provincial Ethics committee. As far as I can tell there will be no risks or discomforts to you in sharing your own experience in the delivery of cultural care among the hospitalized initiates.

The interview will take approximately 30 to 45 minutes to complete. You are free to ask any questions about the study or about being an informant, and the researcher may be contacted at 0734857831. The researcher will keep a record of who has participated in this study, and he will keep the tapes of interviews together with a transcription of those tapes. Your name will not be on the tape or on the transcription, so that data will not be linked with your name. Your identity will not be revealed when the study is reported or published. Your participation in this study is totally voluntary, even after the interview has begun you can refuse to answer specific questions or decide to terminate the interview at any point.

I have read and discussed the consent form and I understand benefits and obligations involved in participating in this study. I hereby freely consent to take part in this project.

.....

.....

Subject's Signature

Date

I have explained this study to the above informant and have sought his/her understanding for informed consent.

.....

Investigator

.....

Date

Appendix L
Consent form for initiates (English)

Study title: The delivery of cultural care by health professionals among the hospitalized *AmaXhosa* male initiates of traditional circumcision in the Eastern Cape.

Researcher: M.J. Ntsaba

Supervisor: Professor N.O. Adejumo

Institution: University of KwaZulu Natal

I am a registered nurse studying the delivery of cultural care among the hospitalized initiates. Although the study will not benefit you directly, it will provide information that might enable healthcare professionals to deliver cultural care among the hospitalized initiates. The study and its procedures have been approved by the appropriate people and the research committees at the University of KwaZulu Natal as well as the Provincial Ethics committee. As far as I can tell there will be no risks or discomforts to you in sharing your own experience in the delivery of healthcare by healthcare professionals to you or what you would like to be done in future to other hospitalised initiates.

The interview will take approximately 30 to 40 minutes to complete. You are free to ask any questions about the study or about being a general informant, and the researcher may be contacted at 0734857831. The researcher will keep a record of who has participated in this study, and he will keep the tapes of interviews together with a transcription of those tapes. Your name will not be on the tape or on the transcription, so that data will not be linked with your name. Your identity will not be revealed when the study is reported or published. Your participation in this study is totally voluntary, even after the interview has begun you can refuse to answer specific questions or decide to terminate the interview at any point.

I have read and discussed the consent form and I understand benefits and obligations involved in participating in this study. I hereby freely consent to take part in this project.

.....

Subject's Signature

.....

Date

I have explained this study to the above informant and have sought his/her understanding for informed consent.

.....

Investigator

.....

Date

Appendix M

Consent form for initiates (Xhosa)

Study title: The delivery of cultural care by health professionals among the hospitalized *AmaXhosa* male initiates of traditional circumcision in the Eastern Cape.

Researcher: M.J. Ntsaba

Supervisor: Professor N.O. Adejumo

Institution: University of KwaZulu Natal

Ndingumongi ophanda ngokukhathalelwa kwabakhwetha ngogqira nabongikazi esibhedlele. Akukho nzuzo uzakuyifuna koluphando kodwa inxaxheba yakho inganceda oogqira nabongikazi ukuba bakhathalele abakhwetha abalaliswe esibhedlele ngokukodwa.

Oluphando neenkukacha zalo lufumene imvume kwiDyunivesithi yaKwaZulu Natal, kubaphathi be Phondo LeMpuma Koloni, kunye nabaphathi besibhedlele. Ngokolwazi lwam awunakuba sesichengeni xa undinika ulwazi lwakho mayela nendlela ofumana ngayo inkathalo okanye umnqweno wendlela ongathanda abakhwetha bakhathaleleke ngayo.

Ingxoxo izakuthatha malunga nemizuzu engamashumi amane nesihlanu ukuya kumashumi amahlanu. Unelungelo lokubuza ngoluphando, okanye ngokuthabatha kwakho inxaxheba. Ndifumaneka kule nombolo 0734857831. Umphandi uzakugcina inkukacha ezokuba ngubani ebethatha inxaxheba koluphando kunye nekhaseti zengxoxo. Igama lakho alingeke libeseteyipini, ngoko ke awunakumanyaniswa tu. Ukuthabatha kwakho inxaxheba kuthetha ukuba uyazinikela, unelungelo lokwala okanye emveni kokuba ingxoxo ziqalisile ungala ukuphendula imibuzo okanye ungakhoxa nangawuphi na umzuzu.

Ndisifundile esi sivumelwano, ndaxoxa nomphandi, ngoko ke ndiyavisisa ukuba inzuzo yokuthatha kwam inxaxheba kolu phando ithini na. Ndinika imvume ngaphandle kokuzibophelela koluphando.

.....
Intsayino gama

.....
Umhla

Ndiluchazile olu phando kumthathi nxaxheba, wavisisa ngesi sivumelwano

.....
Umphandi

.....
Umhla

Appendix N

Appendix N: Demographic distribution of key informants in the main research sites

General informants	Area		Gender		Race			Age					Experience in care of initiates					Qualifications				Circum Status			
	Urban	Rural	Males	Females	Blacks (Xhosa)	Whites	Coloureds	21 to 30 yrs	31 to 40 yrs	41 to 50 yrs	51 to 60 yrs	61 yrs & above	1-5 yrs	6-10 yrs	11-15 yrs	16-20 yrs	21 yrs & above	Certificate (s)	Diploma (s)	Degree (s)	Other	Circumcised	Uncircumcised	Not applicable	Total
Dr	1	1	2	-	1	1	-	-	1	-	-	1		1	1	-	-	-	-	2	-	1	1	-	2
RN	4	-	1	3	3	-	1	-	2	2	-	-	2	1	1	-	-	-	3	1	-	-	1	3	4
EN	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ENA	1	1	-	2	1	-	1	-	1	1	-	-	2	-	-	-	-	2	-	-	-	-	-	2	2
PNA	1		1	-	1	-	-	1	-	-	-	-	1	-	-	-	-	-	-	1	1	-	-	-	1
Total	7	2	4	5	6	1	2	1	4	3	-	1	4	2	2	1	-	2	3	3	1	2	2	5	9

Appendix O

Appendix O: Demographic distribution of general informants in pilot and main research sites

Research site	Initiates referred		Age of hospitalized initiates in years				
	Yes	No	15-17	18-20	21-25	26 and above	Total
Umlamli hospital (Pilot site)	-	2	-	2	-	-	2
Frere hospital (Urban)	4	-	-	4	-		4
CMH (Urban)	-	4	1	3	-		4
All Saints Hospital (Rural)	-	5	-	1	4		5
Total	4	9	1	10	4		15

Appendix P


Appendix P: Demographic distribution of key informants in Pilot site

General informants	Area		Gender		Race			Age					Experience in care of initiates					Qualifications				Circum Status			
	Urban	Rural	Males	Females	Blacks (Xhosa)	Whites	Coloureds	21 to 30 yrs	31 to 40 yrs	41 to 50 yrs	51 to 60 yrs	61 yrs & above	1-5 yrs	6-10 yrs	11-15 yrs	16-20 yrs	21 yrs & above	Certificate (s)	Diploma (s)	Degree (s)	Other	Circumcised	Uncircumcised	Not applicable	Total
Dr	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
RN	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
EN	-	1	-	1	1	-	-	-	-	1	-	-	-	-	-	1	-	1	-	-	-	-	-	1	1
ENA	-	1	-	1	1	-	-	-	-	1	-	-	-	-	-	-	1	1	-	-	-	-	-	1	1
PNA	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	-	2	-	2	2	-	-	-	-	2	-	-	-	-	-	1	1	2	-	-	-	-	-	2	2

Appendix Q

Letter of permission to conduct research from the University of KwaZulu Natal Ethics Committee

Appendix Q



UNIVERSITY OF
KWAZULU-NATAL

Faculty of Community & Development Disciplines.

RESEARCH ETHICS COMMITTEE

Student: Mohlomi Jafia Ntsaba

Research Title: The delivery of cultural care by health professionals among the hospitalized AmaXhosa male initiates of traditional circumcision in the Eastern Cape.

A. The proposal meets the professional code of ethics of the Researcher:

(YES) NO

B. The proposal also meets the following ethical requirements:

	YES	NO
1. Provision has been made to obtain informed consent of the participants.	✓	
2. Potential psychological and physical risks have been considered and minimised.	✓	
3. Provision has been made to avoid undue intrusion with regard to participants and community.	✓	
4. Rights of participants will be safe-guarded in relation to:		
4.1 Measures for the protection of anonymity and the maintenance of confidentiality.	✓	
4.2 Access to research information and findings.	✓	
4.3 Termination of involvement without compromise.	✓	
4.4 Misleading promises regarding benefits of the research.	✓	

Signature of Student: Mohlomi Jafia Ntsaba Date: 22/11/2004

Signature of Supervisor: [Signature] Date: 22/11/2004

Signature of Head of School: [Signature] Date: 22/11/2004

SCHOOL BOARD SIGNATURE: [Signature] Date: 22/11/2004

Signature of Chairperson of the Committee: [Signature] Date: 09/12/2004

(Print Name: D.T. WANG)

ATTACHED FROM 200

Appendix R

Letter of permission to conduct research from the Eastern Cape Department of Health

Appendix R



Eastern Cape Department of Health

Enquiries: Dlamini Thomas
 Date: 5 January 2005
 e-mail address: dhlamini@mpilo.ecape.gov.za

Tel No: 040 606 3408
 Fax No: 040 639 1440

Dear Jetha M Ntsaba

Re: The delivery of cultural care by health professionals among the hospitalized Amakhosa male initiates of traditional circumcision in the Eastern Cape

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure that you will respect the rights of the participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants
3. The Department of Health expects you to provide a progress report on your study every 3 months (from the date you receive this letter) in writing. Your first progress report should be submitted to not later than the 7th April 2005.
4. At the end of your study, you will inform the Department of Health about your findings and your recommendations based on the study. Note that the recommendations should be clear, concise and implementable.
5. Your results on the findings of your study conducted in Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health

Your interest in conducting a study in our province is highly appreciated because it will play a vital role in improving the health of our people in the province

06/12/2004

DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT

Appendix S

Letter of permission to conduct research from East London Complex

Appendix S

PROVINCE OF THE EASTERN CAPE
 ISEBE LEZEMPILO / DEPARTMENT OF HEALTH
 EAST LONDON HOSPITAL COMPLEX

FRERE HOSPITAL

✉ X9047
 East London 5200
 Reference:
 Imibuzo: Dr N Pandey
 Email: pandeyn@nithfire-escape.gov.za
 ☎ : 043-7092015
 Fax : 043-7092484

REGION C

Date / Umhla : 12 October 2004

CECILIA MAKIWANE
HOSPITAL

✉ X13003
 Cambridge 5206
 Irefrensi:
 Enquiries:
 Email:
 ☎ 043-7082111
 Ifaxi: 043-7611158

M J Ntsaba
 Tapoleng Village
 P O Box 313
 STERKSPRUIT
 9762

Dear Ms Ntsaba

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY AT EAST
 LONON COMPLEX

Your letter dated 01 September 2004 is hereby acknowledged.

Your request has been approved. You are requested to contact Mrs Murray –
 Deputy Director: Nursing to make the necessary arrangements. Her contact
 number is (043) 7082124.

Yours faithfully

DR N M PANDEY
 CLINICAL GOVERNANCE : EAST LONDON HOSPITAL COMPLEX
 NMP/bs

Cc Mrs Murray

Appendix T

Letter of permission to conduct research from the Eastern Cape Region C ethics committee

Appendix T

Ethics Committee : Region C Eastern Cape**Postal Address :**

C/o East London Health Resource Centre
PO Box 12882
Amalinda
5252

Telephone : 043 - 7092386

Physical Address :

Cheltenham Road
East London
5201 South Africa

Fax no.: 043 - 7092346

October 18, 2004

Mr Ntsaba
P O Box 313
STERKSPRUIT
9762

Dear Mr Ntsaba

**RE: RESEARCH PROPOSAL: CULTURAL COMPETENCE OF
HEALTHCARE AFFORDED CIRCUMCISSION INITIATES**

We acknowledge receipt of the above-mentioned proposal.

The requirements for informed consent, lack of coercion, confidentiality and non-disadvantage to those interviewed are noted. The purposes of the study are reasonable.

There is therefore no ethical problem, thus the committee grants its approval for you to proceed.

Yours sincerely



Dr P Swift – Chairman Region C Ethics Committee

cc. Dr P Alexander, Dr G Steel

Appendix U**Letter of permission to conduct research from All Saints hospital**

Appendix U

**ALL SAINTS HOSPITAL**

Ingxowa eyodwa / Private Bag X 6215 Engcobo 5050

EngcoboTelephone - 047 - 5481111/5 ext 2204
Fax 047 - 5481116

Wednesday, November 17, 2004

Mr. M J Ntsaba

Sir

RE: YOUR RESEARCH PROJECT

Your letter regarding the project on circumcision herein refers.

All Saints Hospital management has received your written request for a permission to conduct a study within the hospital with optimism. In principle we have no objection to your request. Furthermore we appreciate your choice of our hospital and community, trusting that benefits that will accrue from the study will be of great contribution to the community at large.

The correspondence we have received refers to all various necessary authorizations being obtained from the department of Health. All these will have to be presented to our CEO on or before the date of the study. Our CEO will prepare consent for you to sign on behalf of the institution. Another consent form for individual patients will be explained to you by the Hospital Manager on your arrival.

A meeting between yourself and the hospital management will undoubtedly facilitate the process leading to your successful project.

Thank you,

Dr M Xamlashe (CMO)

Appendix V

Letter of permission to conduct research from Umlamli hospital Management Committee

Appendix V



Province of the Eastern Cape • Iphondo leMpuma-Koloni

ISEBE LEZEMPILO DEPARTMENT OF HEALTH

DEPARTMENT VAN GESONDHEID

UMLAMLI HOSPITAL

Private Bag/Ingxowa Eyodwa 5018 Sterkspruit 9762, SOUTH AFRICA

BATHO PELE

(PEOPLE FIRST/ABANTU KUQALA)

Ref. No.:
Imibuzo/Encquiries: Ndaba B.S
Cell: 072 4168799

Telephone: 051 6110079/90
Facsimile: 051 6110021
2004/10/18


Mr M.J. Nisaba
Tapoleng Village
STERKSPRUIT

Dear Sir

RE-REQUEST FOR PERMISSION TO CONDUCT A PILOT STUDY AT UMLAMLI
HOSPITAL: YOURSELF

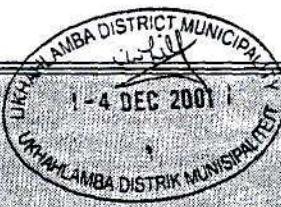
Your letter dated 21/09/2004 regarding the above matter has been received by this office, and it is my pleasure to inform you that the Umlamli hospital management has no objection against your request. Provincial approval has been granted also, for the study. Kindly inform us as when will you be doing the study and that the results of the study will be communicated to Umlamli hospital management and staff and the Eastern Cape Department of Health on completion of the study.


Good luck with your studies

Thank you
Ndaba B.S

Middle Manager Health

Appendix X

The Health Standards of Traditional Circumcision (Eastern Cape) Act (Act No. 6 of 22 November 2001)





PROVINCE OF THE EASTERN CAPE
IPHONDO LEMPUMA KOLONI
PROVINSIE OOS-KAAP

Provincial Gazette
Igazethi Yephondo
Provinsiale Koerant

Selling price: R1,50
Other countries: R1,95


Vol. 8 BISHO/
KING WILLIAM'S TOWN, 22 NOVEMBER 2001

No. 818
(Extraordinary)

We all have the power to prevent AIDS

**AIDS
HELPUNE**

AIDS
affects
us all



A
new
struggle

Prevention is the cure

0800 012 322
DEPARTMENT OF HEALTH

1281890—A

818—1

CONTENTS*No.***PROVINCIAL NOTICE**

56 Application of Health Standards in Traditional Circumcision Act (Eastern Cape) (6/2001): For general information

PROVINCIAL NOTICE

No. 56**22 November 2001****PROVINCE OF THE EASTERN CAPE****OFFICE OF THE PREMIER****PUBLICATION OF APPLICATION OF HEALTH STANDARDS IN TRADITIONAL CIRCUMCISION ACT (EASTERN CAPE) (ACT No. 6 OF 2001)**

It is hereby notified that the Premier has assented to the following Act which is hereby published for general information:

No. 6 of 2001 (EC): Application of Health Standards in Traditional Circumcision Act, 2001

ACT

To provide for the observation of health standards in traditional circumcision; to provide for issuing of permission for the performance of a circumcision operation and the holding of circumcision school; and to provide for matters incidental thereto

*(English text signed by the Premier)
(Assented to on 15 November 2001)*

BE IT ENACTED by the Legislature of the Province of the Eastern Cape, as follows—

Definitions

1. In this Act, unless the context indicates otherwise—

"circumcision" means the circumcision of a person as part of a traditional practice;

"circumcision school" means a place where one or more initiates are treated;

"Department" means the Department of Health in the Province;

"gazette" means the *Provincial Gazette* of the Province;

"initiate" means a person who is in any stage of the circumcision process as contemplated in this Act;

"MEC" means the Member of the Executive Council responsible for Health in the Province;

"medical officer" means an officer designated or a person appointed in terms of section 2;

"medical practitioner" means a person registered as such under the Health Professions Act, 1974 (Act No. 56 of 1974);

"permission" means permission in the form of a document prescribed by Annexures A and B, issued by the medical officer in terms of section 3 (a);

"Province" means the Province of the Eastern Cape established by section 103 of the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996);

"surgical instrument" means an instrument used for the performance of circumcision, and "instrument" has a corresponding meaning;

"this Act" includes regulations made hereunder;

"traditional authority" means a traditional authority established in terms of a law recognised by section 211 of the Constitution; and

"traditional practice" includes a practice according to the custom, religion or any other rules of similar nature.

Designation of medical officer

2. The MEC must designate in writing one or more officers of the Department or appoint one or more persons, on such conditions and qualifications as may be prescribed, as medical officers for the purposes of exercising and performing powers and functions conferred or imposed on them by this Act.

Powers and functions of medical officer

3. The medical officer must, in addition to any other power and functions entrusted to him or her by this Act, exercise and perform the following powers and functions:

- (a) Issuing of permissions to circumcise or treat an initiate;
- (b) Keeping of records and statistics pertaining to circumcision and reporting thereon as prescribed, to the Department; and

- (c) A right of access to any occasion or instance where circumcision is performed or an initiate is treated.

Permission to perform circumcision

4. (1) No person, except a medical practitioner, may perform any circumcision in the Province without written permission of the medical officer designated for the area in which the circumcision is to be performed.

(2) (a) A person may apply as prescribed for permission to perform circumcision and such permission may not be given unless all the conditions set out in Annexure A of the Schedule have been complied with.

(b) A medical officer may, as part of the condition provided in item 7 of Annexure A of the Schedule—

- (i) disallow the use of a surgical instrument that the traditional surgeon intends to use; and
- (ii) prescribe or supply a proper surgical instrument where the use of a particular instrument has been disallowed in terms of subparagraph (i).

(c) Where a proper surgical instrument has been prescribed or supplied in terms of paragraph (b)(i), the medical officer concerned must demonstrate to, or train, the traditional surgeon as to how the instrument should be used.

(3) A medical officer must, in the following manner, present the conditions set out in Annexure A, to the person applying for permission in terms of subsection (2)(a):

- (a) The medical officer, or any other person assisting such medical officer, and in the presence of the medical officer, must read the conditions in the official language understood by the person applying for permission;
- (b) both the medical officer and the person applying for permission to perform a circumcision, must write their full names and signatures, and the date, on the document containing the conditions.

(4) A person who has applied must within one month of the date of such application, submit proof of compliance with the conditions referred to in subsection (2), failing which the application of such person shall lapse.

(5) A person whose application has lapsed as contemplated in subsection (4), is eligible to make a new application for permission to the medical officer concerned, and the provisions of this Act Apply to such person as if application for permission is made for the first time.

Permission to hold circumcision school or treat initiates

5. (1) In the Province, no person may hold any circumcision school or treat any initiate without written permission of the medical officer designated for the area in which the circumcision school is to be held or the initiate is to be treated: Provided that this subsection does not apply to the treatment of an initiate in a hospital or by a qualified medical doctor outside the traditional context.

(2) A person may apply, as prescribed, for permission to hold a circumcision school or to treat an initiate, and such permission must be given subject to the conditions set out in Annexure B of the Schedule.

(3) A medical officer must, in the following manner, present the conditions set out in Annexure B, to the person applying for permission in terms of subsection (2):

- (a) The medical officer, or any other person assisting such medical officer and in the presence of the medical officer, must read the conditions in the official language understood by the person applying for permission;
- (b) both the medical officer and the person applying for permission to hold a circumcision school or treat initiates must write their full names and signatures, and the date, on the document containing the conditions.

(4) A person who has applied, must within one month of the date of such application, submit proof of compliance with the conditions referred to in subsection (2), failing which the application of such person shall lapse.

(5) A person whose application has lapsed in terms of subsection (4), is eligible to make a new application for permission to the medical officer concerned and the provisions of this Act apply to such person as if application is made for the first time.

Restriction of persons to treat an initiate

6. (1) No initiate may treat or attempt to treat another initiate at any stage during or after the holding of a circumcision school.

(2) No person other than the traditional nurse, medical practitioner, the medical officer or any other person authorized by the medical officer, may within a traditional context, treat an initiate.

Consent by parent or guardian

7. (1) The parent or guardian of a prospective initiate must, in respect of a prospective initiate below the age of 21 years, complete and sign a consent form in the format set out in Annexure C.

(2) The parent or guardian of an initiate must, in addition to all other responsibilities which such parent or guardian has in respect of the initiate, render such assistance and co-operation as may be requested by the medical officer in the interest of the good health of the initiate.

(3) No person, including the parent or guardian of an initiate, may interfere with or obstruct the medical officer in the performance of his or her duties under this Act.

Amendment of Schedule

8. (1) The MEC may, by notice in the *Gazette*, amend the Schedule.

(2) The MEC must, within a period of thirty days after the publication of the notice contemplated in subsection (1), submit a copy thereof to the Legislature of the Province.

Penalties

9. (1) Any person who contravenes the provisions of sections 6, 7(2) and 7(3) is guilty of an offence and liable on conviction to a fine of R1 000,00 or to imprisonment for a period not exceeding six months.

(2) Any person who contravenes the provisions of sections 4 (1) and 5 (1) or who fails to comply with any condition imposed by a medical officer in terms of sections 4(2) and 5(2), is guilty of an offence and liable on conviction to a fine not exceeding R10 000,00 or to imprisonment for a period not exceeding ten years, or to imprisonment for a period of five years without the option of a fine.

Regulations

10. (1) The MEC may make regulations in regard to any of the following matters:

- (a) The issue of permission under this Act and the form of such permission;
- (b) the form and manner of application for such permission;
- (c) the requirements to be complied with by the applicant for such permission;
- (d) the prohibition or restriction of the issue of such a permission in appropriate circumstances;
- (e) the duration of any circumcision school;
- (f) generally the conditions subject to which permission may be issued;
- (g) the conditions and qualifications which an officer or a person referred to in section 2 must satisfy or possess; and
- (h) any other matter, the regulation of which may in the opinion of the MEC, be necessary or desirable for the purpose of achieving the objects of this Act.

(2) Any regulation made under this Act may prescribe a penalty for the contravention thereof, or default in complying therewith: Provided that regulations may not prescribe a penalty in excess of the penalty imposed by section 9(2).

Short title

11. (1) This Act is called the Application of Health Standards in Traditional Circumcision Act, 2001 (Eastern Cape).

SCHEDULE**ANNEXURE A****CONDITIONS FOR OBTAINING PERMISSION TO PERFORM CIRCUMCISION**

1. There must be proof in the form of a birth certificate or an identity document that the prospective initiate in respect of whom permission is requested is at least 18 years old, or if the parents of the initiate so specifically request, at least 16 years old.
2. Parental consent must be obtained in respect of a prospective initiate who is under 21 years of age or who has not acquired adulthood, and such consent must be given either by a parent or a guardian of the prospective initiate concerned.
3. A prospective initiate must undergo a pre-circumcision medical examination by a medical doctor. The medical certificate must indicate as to whether the prospective initiate, based on the examination by the medical doctor who must have considered amongst others the medical history of the prospective initiate, is fit to undergo circumcision or not.
4. The traditional surgeon must be known to the parents of the prospective initiate, and must use instruments approved by such parents, or in the case of an orphan by his family, guardian or relatives, unless a medical officer has prescribed another surgical instrument.
5. A traditional surgeon, who is to perform a circumcision within an area falling under a traditional authority, must inform such traditional authority thereof.
6. Where a traditional surgeon does not have the necessary experience to perform a circumcision, he must perform it under the supervision of an experienced traditional surgeon.
7. An instrument used to perform a circumcision on one initiate must not be used again to perform a circumcision on another initiate, and the traditional surgeon must use the instruments supplied by the medical officer where the traditional surgeon has to perform more than one circumcision on more than one initiate but does not have sufficient instruments.
8. The traditional surgeon must keep instruments to be used by him to perform circumcision clean at all times before a circumcision, and shall use any substance prescribed by a medical officer for the sterilization of the instruments.
9. The traditional surgeon must cooperate at all times with the medical officer concerned in respect of any directive given or decision made by the medical officer under the powers vested in the medical officer by this Act.

*Traditional surgeon**Medical officer*

Name

Signature

Date

If initiate is under the age of 21 years:

Parent or guardian

Date

ANNEXURE B**CONDITIONS FOR OBTAINING PERMISSION FOR HOLDING A CIRCUMCISION SCHOOL
OR FOR TREATING INITIATES**

1. The medical officer concerned shall be entitled to impose a deviation from the use of traditional material only in cases where there are early signs of sepsis or other similar health conditions.
2. The medical officer concerned must be allowed by the traditional nurse to visit the circumcision school at any time and as regularly as the medical officer deems necessary in order to inspect the health and the condition of the initiate(s).
3. The initiate(s) must, at least within the first eight days of the circumcision, be allowed by the traditional nurse to have a reasonable amount of water to avoid the initiate suffering any dehydration.

HEALTH STANDARDS IN TRADITIONAL CIRCUMCISION ACT (EASTERN CAPE)

Act No. 6, 2001

4. The traditional nurse must not expose any initiate(s) to any danger or harmful situation and shall exercise reasonable care in the holding of the circumcision school.
5. The traditional nurse must report any sign of illness of the initiate(s) to the medical officer, as soon as possible.
6. The traditional nurse must stay with the initiate at the circumcision school 24 hours a day during the first eight days of the initiation process, and after the lapse of the first eight days of such initiation process, he must be available to the initiate(s) at least once every day until the initiation period has come to an end.
7. The medical officer concerned shall be entitled to prescribe any measure at any stage of the circumcision process that he or she on reasonable grounds deems necessary in the interest of the good health of the initiate(s), and such a measure may in appropriate circumstances include a departure from the traditional methods.
8. The traditional nurse must cooperate at all times with the medical officer in respect of any directive given or decision made by a medical officer under the powers vested in the medical officer by this Act.

*Traditional nurse**Medical officer*

Name

Signature

Date

ANNEXURE C

PARENTAL OR GUARDIAN CONSENT

I,

ID No.

Residential address

1. confirm that I am the parent/guardian of:

NAME OF THE PERSON

who will be undergoing a circumcision on

DATE OF OPERATION

in

PLACE OF OPERATION

at

TIME OF OPERATION H

and

2. consent to my child undergoing a circumcision operation and attending initiation school. I acknowledge that I understand the conditions set out in Annexures A and B hereto, which conditions bind the traditional surgeon and the traditional nurse.

SIGNATURE OF THE PARENT /or**GUARDIAN**

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Appendix Y

Abbreviations

AIDS – Acquired Immune Deficiency Syndrome

CEO – Chief Executive Officer

CMH – Cecilia Makiwane Hospital

HIV – Human Immune Virus

MEC – Member of Executive Committee

Py – Per person

The NSCLASHC – The National Standards for Cultural and Linguistic

Appropriate Services in Health Care

The QLRC – The Queensland Law Reform Commission

UN – United Nations

USA – United States of America

WHO – World Health Organisation