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**The Social Penis. Traditional Male
Circumcision and Initiation in Southern
Africa, 1800-2000: A Literature Review**

Harriet Deacon
Kirsten Thomson

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Preface

Nicoli Nattrass

AIDS and Society Research Unit (ASRU) Director

This literature review by Harriet Deacon and Kirsten Thomson was commissioned by ASRU to provide some historical background on traditional male circumcision in Southern Africa. It is reproduced here with some updating and editing by Rebecca Hodes.

The review was commissioned in order to gain insight into the different practices and meanings of circumcision in Southern Africa – and how they have changed over time. As such, the review speaks to an important part of the human dimension involved in any large-scale rollout of medical male circumcision for HIV prevention.

There is a significant body of evidence showing that medical male circumcision reduces the risk of HIV infection by more than 60% (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007; Siegfried et al., 2009; Wamai et al., 2011), but the evidence on traditional male circumcision is less well developed. Traditional circumcision does not remove as much of the foreskin as a medical circumcision (Lagarde et al., 2003, Bailey et al., 2008; Peltzer et al., 2008). This means that men who are circumcised traditionally will be less protected, as their remaining foreskin continues to provide targets for HIV infection (see Wamai et al., 2011 for a survey of the biological theory and evidence for the role of the foreskin in promoting HIV transmission). Indeed, research on the risk of HIV infection amongst young Xhosa men in Cape Town shows that those with partial circumcisions had a higher risk of HIV infection than those who were fully circumcised (Maughan-Brown et al., 2011).

The fact that traditional male circumcision varies in the extent to which the foreskin is removed, and that the important, practical differences between medical and traditional circumcisions are not always accounted for in surveys, may explain why the link between circumcision status and HIV infection is not always demonstrable in studies based on survey data. For example, no relationship was found between male circumcision and HIV status in the South African HIV survey (Connolly et al., 2008). Garenne (2008) argues that African Demographic and Health Survey (DHS) data also does not support a protective effect for circumcision – but this study is limited by its use of bivariate analysis

only (which means it does not control for other potential determinants of HIV infection). Recent bivariate and multivariate analysis of pooled DHS data finds a strong protective effect: that the odds of acquiring HIV were over four times higher for uncircumcised men and that the effect was even more pronounced once sexual behaviour and other co-variables were included in the regression (Gebremedhin, 2010).

In short, the relationship between HIV status and male circumcision as manifested in African survey data is generally supportive of a protective effect for male circumcision, although the strength – and even direction – of this relationship varies across the region. For example, Warren (2010) found that circumcision is associated with safer sexual behaviour and lower rates of HIV infection in Botswana and Swaziland, but not in Lesotho. This, in turn, suggests that the practice of traditional male circumcision may well vary in important ways across the region – and that the meanings and behaviours linked to being circumcised are probably also relevant.

The study of cultural meaning and practices is generally the domain of ethnographers. But historical analysis is helpful also. As Deacon and Thomson show in this paper, the practice of male circumcision has changed significantly over time. This suggests that the cultural space around circumcision is fluid and potentially negotiable by those seeking to promote circumcision as an HIV prevention practice. But Deacon and Thomson also warn that the meanings associated with the traditional ritual need to be understood, and that this is not easy given the secrecy surrounding what takes place in circumcision schools. Rolling out medical male circumcision – or introducing medical procedures into traditional circumcision rituals – should be sensitive to cultural concerns – even where these can be shown to have been flexible over a broader historical period.

References

- Auvert, B., Taljaard, D., Lagarde, E., Sobngwi-Tambekou, J., Sitta, R., & A. Puren. (2005). Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 Trial. *PLoS Medicine*, 2: 1112-1122.
- Bailey, R.C., Moses, S., Parker, C.B., Agot, K., Maclean, I., Krieger, J.N., Williams, C.F., Campbell, R.T., Ndinya-Achola, J.O. (2007). Male circumcision for HIV prevention in young men in Kisumu, Kenya: A randomised controlled trial. *The Lancet*. 369:643–646.
- Connolly, C., Leickness, S., Shanmugan, R., & Nqeketo, A. (2008). Male Circumcision and its Relationship to HIV Infection in South Africa: Results of a National Survey in 2002. *South African Medical Journal* , 789-794.
- Garenne, M. (2008). Long-term population effect of male circumcision in generalised HIV epidemics in sub-Saharan Africa. *African Journal of AIDS Research* , 1-8.
- Gebremedhin, S. (2010). Assessment of the protective effect of male circumcision from HIV infection and sexually transmitted diseases: evidence from 18 demographic and health surveys in sub-Saharan Africa. *African Journal of Reproductive Health*, 14 (2): 105-13.
- Gray R.H., Kigozi, G., Serwadda, D., Makumbi, F., Watya, S., Nalugoda, F., Kiwanuka, N., Moulton, L.H., Chaudhary, M.A., Chen, M.Z, Sewankambo, N.K., Wabwire-Mangen, F., Bacon, M.C., Williams, C.F., Opendi, P., Reynolds, S.J., Laeyendecker, O., Quinn, T.C., & Wawer, M.J. (2007) Male circumcision for HIV prevention in men in Rakai, Uganda: A randomised trial. *The Lancet*. 369:657–666.
- Lagarde, E., Taljaard, D., Puren, A., Rain-Taljaard, R. & Auvert, B. (2003). Acceptability of male circumcision as a tool for preventing HIV infection in a highly infected community in South Africa. *AIDS*, 17: 89-95.

Maughan-Brown, B., Venkataramani, A., Nattrass, N., Seekings, J. & A. Whiteside. (2011). A Cut Above the Rest: Traditional Male Circumcision and HIV Risk Among Xhose Men in Cape Town, South Africa. *Journal of Acquired Immune Deficiency Syndromes*: 58, 5: 499-505.

Peltzer, K., Nqeketo, A., Petros, G., & Kanta, X. (2008a). Traditional circumcision during manhood initiation rituals in the Eastern Cape, South Africa: a pre-post intervention evaluation. *Bmc Public Health* 8 64.

Siegfried, N., Muller, M., Volmink, J., Deeks, J.J., Egger, M., Low, N., Weiss, H., Walker, S., Williamson, P. (2009). Male circumcision for prevention of heterosexual acquisition of HIV in men (Review). *Cochrane Database of Systematic Reviews* 2:CD003362.

Wamai, R., Morris, B., Failis, S., Sokal, D., Klausner, D., Appleton, R., Sewankambo, N., Cooper, D., Bongaarts, J., de Bruy, G., Wodak, A. and J. Banerjee. (2011). Male Circumcision for HIV Prevention: Current Evidence and Implementation in Sub-Saharan Africa. *Journal of the International AIDS Society*, 14:49, 1-17.

Warren, K.H. (2010). HIV and male circumcision in Swaziland, Botswana and Lesotho: An Econometric Analysis. CSSR working paper no.273. Centre for Social Science Research, University of Cape Town. Available on: <http://www.cssr.uct.ac.za/sites/cssr.uct.ac.za/files/pubs/WP273.pdf>

The Social Penis. Traditional Male Circumcision and Initiation in Southern Africa, 1800-2000: A Literature Review

Harriet Deacon and Kirsten Thomson

Introduction

Since pre-colonial times, TMC has been practised in Muslim and African communities in Africa as part of initiation into manhood. In this paper we therefore refer also to the broader practice of traditional male circumcision and initiation as TMCI. In the 1990s, differences in HIV prevalence across Africa were linked to patterns of traditional male circumcision (TMC). After some randomised clinical trials conducted in the early 2000s, it was established that male circumcision (MC) was linked to significantly reduced HIV risk (Siegfried et al. 2009). However, the notion that medical MC should be ‘rolled out’ as a public health intervention to protect against the transmission of HIV and other sexually transmitted diseases has some elicited controversy in public health and human rights literature (e.g. Denniston et al. 2001), although over time the acceptability of medical MC as an intervention has grown (Wamai et al., 2011).

UNAIDS and the WHO developed operational guidelines for scaling up MC but programmatic development has been slow, largely because of sub-optimal funding (Wamai et al., 2011: 6-10). As of the end of 2010, 555,202 MCs were performed as part of the MC rollout in Sub-Saharan Africa, of which over three-quarters took place in 2010. This suggests that there is momentum behind this policy but that with less than 2.7% of the estimated 20.8 million men targeted for circumcision being reached, progress is slow indeed (Wamai et al., 2011).

Most circumcised men in Africa have not been medically circumcised (Dick and Wilcken 2009). In areas with high existing prevalence of MC, much of the circumcising has been done in traditional contexts, and in areas where MC prevalence was low, non-circumcision often had historical roots in the rejection of TMC practices common elsewhere in the sub-region. In spite of medical concerns about safety and efficacy of TMC in HIV-risk reduction, many men will continue to practice TMCI because of its social value. Clearly, cultural and religious considerations will affect the process of medical MC scale-up in

southern Africa, especially in regard to neonatal MC (Kalichman 2010:2). Historical beliefs and practices around TMC will affect the take-up of medical MC, public health messaging and broader HIV prevention strategies.

Understanding TMC and engaging with TMC practitioners are thus important aspects of HIV prevention programs. A 2007 meeting of SADC public health representatives in Harare ‘acknowledged the important role that traditional practitioners play in male circumcision and agreed that more consultation needed to occur at country level to better understand what the traditional practitioners are doing and define how they could be involved in safe male circumcision scale up’ (WHO 2007).

The process of engagement has already begun within the South African National AIDS Council (SANAC) and the Zimbabwean National Aids Council (NAC); it is acknowledged as important in Malawi (WHO/UNAIDS 2009a:9), but has been less marked in Namibia, Kenya and Tanzania (WHO/UNAIDS 2009a:13-14). A July 2009 report on a sub-regional SADC consultation on the promotion of medical MC for HIV prevention confirmed that in countries with extensive consultations engaging ‘key stakeholders including traditional providers, women and young people increased buy-in and support for scale-up’. Delegates thus wanted further ‘guidance’ from WHO about TMC and the challenge of changing community practices (WHO/UNAIDS 2009a:15).

However, in practice little research has been done on the place of African TMC in the medical scale-up of MC (Dick and Wilcken 2009, Bailey and Egesah 2006). Biomedical concerns about safety have contributed to the marginalisation of TMC research and engagement. Moreover, African TMC often takes place after sexual debut and thus has a more limited effect on HIV prevention than medical MC. In Malawi, for example, the Demographic and Health Survey (DHS) data showed that in areas with high TMC practice, HIV prevalence was also very high (WHO/UNAIDS 2009a:9).

In Botswana, the situation analysis of circumcision by traditional healers was only conducted at the end of 2009, despite Cabinet having already approved a bold plan for male medical circumcision (WHO/UNAIDS 2010:1). Since then, a traditional healers HIV training curriculum has been developed with the inclusion of safe male circumcision. In Namibia, there was an acknowledgement that traditional initiation and circumcision practices needed to be researched and that increased advocacy from traditional leaders was needed. A workshop with traditional practitioners was ‘being planned’ (WHO/UNAIDS 2010:6). Since 2009, other countries have also increased their efforts to engage traditional leaders in the scale-up of male circumcision. South Africa intends to implement

its male circumcision policy in collaboration with traditional leaders. Lesotho formed a traditional task team on MC and Tanzania completed a study on traditional MC providers in June 2010. The Zambian MC policy has also paid lip-service to the ‘sensitization and involvement’ of traditional circumcisers. (WHO/UNAIDS 2010). It remains to be seen whether these attempts to engage traditional leaders will be sustained, or progress beyond policy intentions. As yet, very little detail is given as to *how* TMC practices and practitioners will be understood or engaged in the medical MC process, despite the stated intention to do so.

It is also worth noting that the WHO/UNAIDS sub-regional consultation on the MC scale-up in mid-2009 depicted the process of engaging TMCI practitioners and communities as a kind of one-way information transfer through basic biomedical education (WHO/UNAIDS 2009:15). This depiction continues in reports of TMCI practitioner training. The approach of many public health practitioners is summed up in a presentation by Dick and Wilcken (2009):

If we really want to deal with this issue it will be a challenge to move from a "we don't want to have anything to do with them [i.e. traditional circumcision practitioners]" position: good in theory but how realistic, at least in the short term?

The paternalistic approach rejecting engagement with TMCI practitioners is not in fact sound ‘in theory’ and the focus on educating traditional circumcision practitioners in biomedical procedures been unproductive in creating common ground, collaboration and trust between biomedical practitioners and traditional healers (Wreford 2005, 2006, 2007).

How, then do we move forward productively? Clearly, we require more research, and better research on TMCI (Bailey and Egesah 2006). This research is difficult to conduct because TMC is often a highly secret, ritualized and regionally distinct process. Most current research on TMCI focuses on describing differences in practice between medical and ritual circumcision rather than on understanding the social context of TMCI itself (Niang and Boiro 2007). Socio-historical research on the motivations and meanings associated with TMCI has been widely neglected in public health discourse around the scale-up. We need a much clearer understanding of the social context of TMCI, and how social context and meaning affects its practice to inform the dialogue about ways to maximise its health benefits and minimise health risks (see Deacon 2008; Vincent 2008c).

Existing research on TMCI has also been neglected, with a paucity of literature on TMCI after the early colonial period (Berg 2007; Mayatula et al. 1997). In this review we found a large archive of missionary, anthropological and

historical writing on TMCI from the nineteenth into the twentieth century. This literature does not seem to have been widely consulted or thoroughly reviewed in light of the identified problems raised by the biomedical sector.

A review of existing information on TMCI is thus both urgent and important. This report is a literature review of social science works on traditional African male circumcision in southern Africa 1800-2000, including South Africa, Swaziland, Namibia, Mozambique, Zimbabwe, Botswana and Lesotho. It provides a regional overview of the historical practice of TMCI in southern Africa to inform the discussions around MC and HIV prevention, and future research in the area.

Benefits and risks of TMCI from a public health perspective

Assessing benefits and risks

HIV prevalence and complication rates

The biomedical literature indicates that MC helps prevent STI infection and confers some protection on heterosexual men against HIV infection, reported as 54% in a recent systematic review (Siegfried et al. 2009). Randomised controlled trials aimed at proving the efficacy of male medical circumcision (Auvert et al. 2005; Bailey et al. 2007 and Gray et al. 2007) were conducted because research demonstrated that regions where men were ritually circumcised for religious or cultural reasons showed lower rates of HIV infection (Siegfried et al. 2003). Western Kenya, for example, where less than 20% of males are circumcised, has a much higher HIV prevalence than regions of the country where nearly all men are circumcised. Uncircumcised men in Kenya have a four-times higher HIV prevalence compared to circumcised men (Marum et al. 2003:229). Traditional circumcision may thus also help to reduce HIV-infection rates if full circumcision of the foreskin is achieved, if the process does not itself transmit HIV or encourage further unprotected sexual activity, and if it is conducted on boys who are not already infected with HIV.

An assessment of health benefits associated with MC has to be considered in the light of possible complications associated with the operation. Meintjes (pers. comm. 2009) suggests that complications associated with TMCI may usefully be divided into two categories:

1. Acute/immediate, such as penile sepsis, penile gangrene, penile loss (partial or complete), dehydration, acute renal failure, septicaemia, death; and
2. Chronic / long term complications, such as HIV, Hepatitis B or C infection (although this is rare in SA), that may occur if the blade is shared.¹

Meintjes suggests that complications are both more likely and more serious in TMCI because of unsterile wound care, the tying of a tight thong around the base of the penis, dehydration due to fluid restrictions and active discouragement of seeking medical care in cases of early complications. Biomedical, ethical and public concern about TMC has been rising in recent years, and some studies suggest that complication rates associated with TMC are unacceptably high. Given the general interest in MC, together with persistent concerns about high complication rates in TMC, it is curious that there is so little evidence-based research comparing complications associated with routine medical MC with TMC. Most commentaries still rely on anecdotal evidence about TMC complications referred to public health facilities.

According to a recent systematic review of eight articles (Muula et al. 2007), the literature on complications associated with MC in sub-Saharan Africa is limited, complications are generally minor and there is no firm evidence to suggest higher levels of complications in circumcisions done by non-medically trained and medically-trained professionals. Meintjes, however, reports worrying statistics on deaths related to TMC in the Eastern Cape (see Table 1).

Shaw estimates the complication rate in the Eastern Cape in the summer seasons of 1994-6 at 10-14% of all TMCs performed (Shaw unpublished cited in Meintjes 1998:19), while a 1996 policy discussion document to develop interventions in that area estimated a mortality rate of 6% for boys referred to public health facilities in the 1990s (Meintjes 1998:127). News reports of high death tolls in Eastern Cape circumcision schools in 2009 suggest that complications associated with TMCI continue, underlining the need to explore this question further (Mail and Guardian online, July 14 2009). Complications relating to TMC may be higher in urban and peri-urban areas and may cluster in geographical locations (Meintjes 1998:19; Laubscher 1937:133). The problem seems to be reported more frequently in connection with Xhosa circumcision, but this may not reflect the true distribution of complications.

¹ Scientific evidence for this is not yet available.

Table 1: Traditional circumcision-related hospital admissions and deaths in the Eastern Cape, 1988-1995 (Meintjes 1998:18-19)

Reference	Dates	Area	Hospital admissions and deaths
Crowley and Kesner (1990)	Dec 1988-Jan 1989	Cecilia Makiwane Hospital	45 admissions, 4 deaths
Admission records, CMH	1 Jan 1991-30 June 1993	Cecilia Makiwane Hospital	222 admissions, 11 deaths
Provincial statistics	1 Oct 1994-1 Feb 1995	Regions A-D of E. Cape	743 admissions, 34 deaths
Shaw (unpublished)	1994-1995 summer season	Eastern Cape: Cala, Cofimvaba, Lady Frere, Hewu and Queenstown	281 admissions, 9 deaths
Shaw (unpublished)	1995-1996 summer season	Eastern Cape: Cala, Cofimvaba, Lady Frere, Hewu and Queenstown	132 admissions, 3 deaths

There are problems with existing research on MC complication rates. In assessing complication rates, it is important to compare circumcisions being done routinely by traditional surgeons and by biomedical practitioners in public health facilities, but the available data seldom does this (Bailey and Egesah 2006). Public health facilities and circumcision clinics in sub-Saharan Africa may not be adequately staffed or adequately supplied, and may thus have higher rates of complications than African clinical trials and in developed-country settings (Bailey and Egesah 2006). Non-sexual transmission of HIV, including transmission through medical circumcision, could be a significant avenue of infection within public health facilities in Africa (Brewer et al. 2007). In Kenya, Bailey and Egesah (2006) reported that boys who were circumcised traditionally experienced a higher rate of adverse events (35% experienced at least one) than those who were medically circumcised (17% experienced at least one). These figures were both much higher than complications associated with circumcision during the clinical trials in Kenya (1.7%, Krieger et al. 2005) and South Africa (3.8%, Auvert et al. 2005). About 6% of the adverse effects resulting from traditional circumcision reported by Bailey and Egesah were permanent, and without the study team's intervention some of the boys may have died.

More comprehensive study of complication rates associated with medical and traditional male circumcision has thus been placed high on the agenda of AIDS organisations since 2003 (Bailey and Egesah 2006:1-2). In the December 2010 WHO Bulletin, a paper by Wilcken et al. re-iterated the urgent need for more research into TMC. This paper is considered to be the first systematic review of studies on the prevalence and complications of MC. Findings suggest that more research is needed to investigate the safety of TMCI, to consider possible ways of increasing collaboration between traditional leaders and the medical sector, and to assess the efficacy of training programmes for traditional circumcisers. In addition, the authors argue that research is needed to gauge the acceptability of medical male circumcision in communities where TMCI is practised, and the extent to which this is affecting the scale-up of MC. In spite of the relative dearth of good data, medical MC is usually seen as the accepted standard of care in the public health literature.

Educational benefits

Traditional circumcision has always had an educational function. This has been interpreted as both a danger and a benefit in terms of promoting risk reduction for HIV and other sexually transmitted infections. The messages given to boys during TMCI present an important educational opportunity to reduce HIV risk. These messages could socialise boys to become responsible and caring men in a world affected by high rates of HIV-infection and rapid social change, educating men about safer sex (Munthali and Zulu 2007; Bailey and Egesah 2006), including the continued need for condom use after circumcision and delaying sexual activity until the wound has healed. Education of young men is particularly necessary because Delius and Glaser (2002) suggest that a combination of prudish missionary injunctions, atomizing urban lifestyles, and patriarchal fears have led to an ‘alarming failure of communication between parents and children on sexual issues’ and made young black South Africans disproportionately susceptible to contracting and transmitting HIV.

However TMCI has also been criticised for becoming a ‘passport to sex’ today (Vincent 2008). It has perhaps always been associated with becoming a sexually active man within a very patriarchal society, framed within the notion of ‘hegemonic masculinity’ (Jewkes 2009). Munthali and Zulu (2007) found in Malawi that having gone through traditional male initiation is associated with a higher rate of sexual activity as a teenager; sexual abstinence was emphasised more in female initiation rituals than in male ones. Bailey and Egesah (2006:32) found that, adjusting for age at circumcision, men who underwent TMCI in Kenya were over three times more likely than medically circumcised men to

have had sex before circumcision. Men undergoing TMCI were also more likely to have had sex within 60 days after their operation than those who were medically circumcised, even though after TMC their wounds healed more slowly.

Human rights

In 2001, the South African Human Rights Commission (SAHRC) acknowledged the positive role of initiation schools as cultural teaching institutions, but raised concerns about several apparent human rights violations. These included transgressions in the rights to life; human dignity; freedom and security of the person and health care, food and water (Stinson n.d.). Packer (2002:69) argues that TMC as a whole should be ‘framed as a violation of a man’s human rights to health, freedom of belief, and liberty and security’ because of the complication risks.

Under South African law according to the Children’s Act of 2005, circumcision of male children under 16 is permitted for medical or religious reasons and, with consent, over the age of 16. Forced circumcisions (excluding circumcisions of infants for religious or medical reasons) are now illegal in South Africa (Vincent 2006). Some boys are coerced into undergoing circumcision at puberty against their will. An eighteen year-old boy recently brought a case against his father in a South African court for forcing him to undergo a traditional circumcision after he had already been medically circumcised (The Sunday Times, 27 Jan 2008). He said that ‘his Christian faith did not permit him to be circumcised in a manner that involved a blood covenant with his ancestors’ (Cape Argus, 11 Aug 2009). Traditional leaders have opposed this. For instance, Eastern Cape Contralesa chairperson Chief Mwelo Nonkonyana responded that ‘those who refused traditional circumcision should be ostracised by the community’ (Cape Argus, 11 Aug 2009).

The continued practice of TMCI in spite of health risks

TMCI is still considered an essential rite of passage into manhood in many African communities. The Nelson Mandela / HSRC South African survey of 2002 (see Table 2) found that male circumcision was associated with being older, black, and resident in rural areas, and was concentrated in certain regional areas (Connolly et al. 2008:791-2). Nearly 80% of the black (African) men who were circumcised underwent the operation outside of the formal clinic setting,

while only about 10% of white, Indian and coloured men were circumcised outside the hospital setting. African men tended to be circumcised much later (at a median age of 18) than others, although there was significant regional variation in age at circumcision within this group.

Table 2: Socio-demographic characteristics of circumcised men, South Africa (2002) (Connolly et al. 2008)

Demographic factors	Circumcised					
	N	N	%	OR [†]	95% CI	p
Age group						
15 - 24	1 776	583	32.8	ref		
25 - 49	654	235	35.9	1.1	1.0 - 1.4	0.15
50+	595	249	41.8	1.5	1.2 - 1.8	<0.001
Race						
Black	1 771	747	42.2	ref		
White	307	93	30.3	0.6	0.5 - 0.8	<0.001
Indian	385	97	25.2	0.4	0.3 - 0.5	<0.001
Coloured	562	130	23.1	0.5	0.4 - 0.6	<0.001
Geotype						
Rural	799	336	42.1	ref		
Urban formal	1801	563	31.3	0.6	0.5 - 0.7	<0.001
Urban informal	425	168	39.5	0.9	0.7 - 1.1	0.40
Household situation						
Not enough for basics	1 218	455	37.4			
Enough for basics	1 135	392	34.5	0.9	0.7 - 1.0	0.20
Essentials	467	142	30.4	0.7	0.6 - 0.9	0.008
Extras	205	78	38.0	1.0	0.8 - 1.4	0.90
Religion						
Christian	1 531	503	32.9	ref		
Islam/Jew	129	102	79.1	7.7	5.0 - 12.0	<0.001
African-based	420	152	36.2	1.2	0.9 - 1.5	0.20
Other	432	104	24.1	0.6	0.5 - 0.8	0.001
None	513	206	40.2	1.4	1.1 - 1.7	0.003
Home language						
Afrikaans	702	152	21.7	ref		
TshiVenda*	21	19	90.5	34.4	7.9 - 149.2	<0.001
SePedi*	198	141	71.2	9.0	6.3 - 12.8	<0.001
IsiNdebele*	28	19	67.9	7.6	3.4 - 17.2	<0.001
IsiXhosa*	457	294	64.3	6.5	5.0 - 8.5	<0.001
XiTsonga	84	45	53.6	4.2	2.6 - 6.6	<0.001
Sosotho sa borwa*	187	70	37.4	2.2	1.5 - 3.1	<0.001
English	585	183	31.3	1.6	1.3 - 2.1	<0.001
SeTswana	231	52	22.5	1.1	0.7 - 1.5	0.30
IsiSwati	63	13	20.6	0.9	0.5 - 1.8	0.90
IsiZulu	413	60	14.5	0.6	0.4 - 0.9	0.00
Other	56	19	33.9	1.9	1.0 - 3.3	0.04
Sexually active						
Never had sex	541	121	22.4	ref		<0.001
No sex in last 12 months	378	148	39.2	2.2	1.7 - 3.0	<0.001
Mono partner	1822	685	37.6	2.1	1.7 - 2.6	<0.001
Multi partner	284	113	39.8	2.3	1.7 - 3.1	<0.001

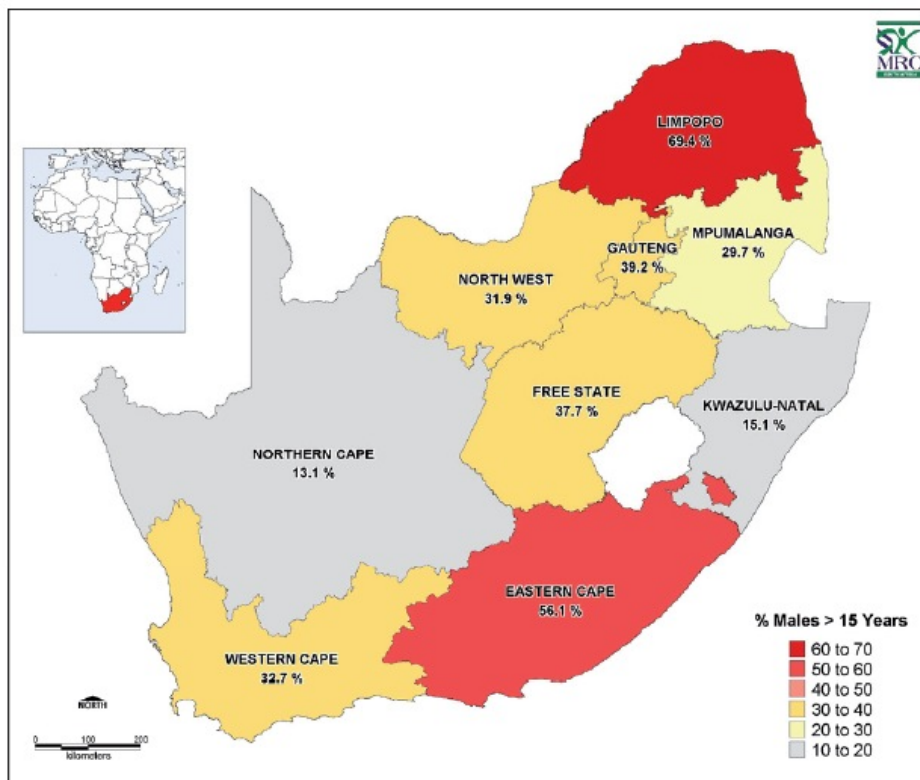
*Cultures where post-puberty circumcision is commonly practised.

[†]Unadjusted odds ratio.

The highest rates of TMCI are observed in the Limpopo and Eastern Cape Provinces (see Fig.1); it is also in these provinces that TMCI receives the worst press regarding complications. Social factors are very important in explaining

this pattern. According to Bottoman et al. (2008:28), the ‘proper execution of the ritual according to tradition’ is of paramount psychological importance to Xhosa men. Peltzer et al. (2008c) suggest that increased social desirability (and desirability to women) and sexual potency in adulthood are more important reasons for undergoing traditional male circumcision than reductions in HIV risk or other health concerns. Although 37% of their sample of 350 Xhosa boys were fearful about the experience they would have in the initiation school, 32% wanted anaesthesia for the procedure and 74% were concerned about having an inexperienced traditional surgeon, only 17% chose to be circumcised by a biomedical doctor (Peltzer et al. 2008c:1030).

Figure 1: Percentage of males circumcised in South Africa, by province (2002) (from Connolly et al. 2008)



Cultural practices like TMCI will change over time and respond to new understandings of risks and benefits (Bailey and Egesah 2006). However, even if they pose significant risks to health, they may not be altered in response to public health education and the provision of free, safe alternatives (Deacon 2008). Some African men may choose to undergo medical circumcision as a result of promotion campaigns by public health authorities (Westercamp and Bailey 2007), but traditional African leaders in southern Africa have thus far been slow to endorse medical circumcision, and take-up of medical MC has

been patchy. Kalichman (2010:2) ascribes the slow process in South Africa partly to the prevalence of TMC. On the other hand, Bailey and Egesah (2006:33) suggest that, because of the lower cost, greater safety and shorter timeframes of medical circumcision, in Kenya there was ‘a hidden pent up demand for medical circumcision services that was released only once respected community leaders signalled that the practice was acceptable’.

There have been attempts to regulate and medicalise TMC in the Eastern Cape. These initiatives have met with mixed results (Meintjes 1998; Peltzer, Nqeketo et al. 2008a). The Application of Health Standards in Traditional Circumcision Act No. 6 of 2001 requires that an initiate procures parental/guardian consent before he undergoes traditional circumcision, and is examined by a medical doctor to ensure that he is ‘fit and healthy’ enough to undergo circumcision and initiation (Province of the Eastern Cape, 2001 cited in Peltzer et al. 2008c). Interventions to reduce medical problems associated with circumcision have included registration and training for traditional circumcision practitioners, pre-TMCI check-ups and screening, and visits by male nurses to circumcision schools. Interventions like these have faced problems because contact with female nurses, for example, breaks ritual taboos and Department of Health-approved circumcision schools are scorned by many traditionalists (Meintjes 1998, Funani 1990, Vincent 2008).

Medical problems experienced by boys undergoing the ritual are often explained by those involved in terms of individual failings (not being able to cope with the pressures of manhood) or a failure to stick to the traditional ways (Meintjes 1998:73). Training TMCI practitioners in biomedical techniques may thus have limited efficacy in terms of reducing adverse health effects relating to the ritual. Peltzer et al. (2008a) found that, even after training and surgical equipment was distributed to TMC practitioners, 20% of initiates in an eastern Cape study (N=192) experienced delayed wound healing and 10% experienced mild problems relating to insufficient skin removal. However, no deaths were reported in that study so some major complications may have been avoided.²

Traditional male circumcision and the educational processes associated with initiation may confer a number of public health benefits, but a number of problems have to be addressed in order to secure these benefits. First, complication rates associated with TMC must be reduced, whether or not they are equally high in public health facilities. Circumcision should be conducted with a sterile blade to reduce the chance of transmitting Hepatitis B or HIV.

² These figures were however not compared to complication rates from circumcisions done in public health facilities.

Boys with pre-existing problems such as diabetes and HIV should be identified and given access to medication during their seclusion in keeping with the latest evidence-based treatment guidelines. Second, to maximise the chances of reducing HIV infection rates, the operation should ideally be undertaken before sexual debut. Unfortunately about 60% of South African men who undergo circumcision currently do so *after* sexual debut (Connolly et al., 2008; Peltzer et al. 2008a). Third, educational inputs associated with the ritual should help men to become sexually responsible adults. Circumcised men should be encouraged to still use condoms to protect themselves and their sexual partners from the transmission of HIV and other sexually transmitted diseases, and should be advised to abstain from sex before their wound is healed. Finally, from a human rights perspective, abductions, forced circumcisions, assaults and negligence on the part of TMC practitioners must be curtailed.

Even if the practice continues to pose significant risks to health, TMCI will continue to be practised in southern Africa for the foreseeable future. While some men will choose to be medically circumcised, ignoring and marginalising TMCI, or regulating it through measures that are regarded as oppressive or inappropriate, will neither prevent many boys from attending initiation schools nor will it necessarily improve the health outcome for boys who attend these schools.

A difficult conversation - health programmers and TMCI practitioners

Public health programs for HIV prevention must engage with TMCI practitioners and opinion-formers as well as communities practising TMCI to assess what interventions would be acceptable to them. As indicated above, the process of negotiation has begun within SANAC and in other forums around Southern Africa. Deacon (2008) explored the use of cultural heritage management principles to determine the social value of TMCI, and assess the likely acceptability of change to aspects of the ritual to improve individual health outcomes. This chapter offers evidence about historical change in TMCI to inform the debate about the future scope of acceptable change.

This discussion takes place within a highly politicised environment and carries with it the burdens of history. Building on work by Wreford (e.g. Wreford 2006) and others, Deacon (2008) discussed the preconditions for a fruitful conversation between health programmers and practitioners of African TMCI about safe MC scale-up. Both public health programmers and TMCI practitioners share a common interest in the health of men undergoing TMCI. However, the conversations between biomedical doctors or public health programmers and

traditional circumcising communities have not historically been characterised by mutual respect and trust. They also have different conceptions of ethics: for practising communities TMCI represents social health as well as individual health.

TMCI has been vilified by some and defended in its totality by others. This polarisation of the debate has created further barriers to the discussion. Members of the medical profession, the media and human rights activists have expressed strong concerns about the safety and desirability of TMC. The South African Medical Association pleaded in 2003 to ‘halt the carnage’ associated with TMC (Svoboda and Darby 2009:272). Svoboda and Darby (2009:272) suggest that because of the likelihood of complications, TMC should be considered akin to an ‘assault occasioning actual bodily harm’. Traditional circumcision practitioners and members of communities currently practising the ritual have defended it and/or refused to discuss it publicly. They have experienced these critiques and proposed biomedical interventions as a continuation of proscriptions of traditional cultural practice by colonial authorities and missionaries. In 2007, opposition from Contralesa (traditional leaders) and members of the public led to the SABC pulling from its schedule a series called Umthunzi Wentaba (Mountain Shadow) that dealt with the topic of Xhosa initiation. Ironically the series, by Mntunzima Nkwinti, was written for the specific purpose of raising the level of public debate about the number of deaths and injuries resulting from TMC (TVSA, April 24, 2007).³

In this polarisation of the debate, the practice of TMCI has often been poorly understood, de-historicised and evaluated within a narrow frame of interest. Public health programmers have judged cultural practices in terms of health outcomes, and regarded cultural practices as ‘preventable problems’ – the result of individual choices, separate from broader social patterns and easily shifted by education, access to services, or the practical realisation of rights. This broader approach in the public health field has underestimated the impact of local conceptions of illness and health, and restricted public responses to HIV prevention messages in Africa (Rödlach 2006). The defense of TMCI by its practitioners, on the other hand, is usually framed in opposition to the judgementalism of the biomedical approach and often rests on assertions of taboos associated with cultural practices. Practitioners of TMCI and their communities tend to define its ‘proper’ practice in terms of historical practice (Meintjes 1998), while underestimating the degree and speed of historical change.

³ This is not the only script circulating on the topic. See also <http://far-away-scriptwriter.blogspot.com/2007/04/initiation.html>

The colonial archive is viewed, with some reason, as a deeply discredited source of information. There are ethical problems with some of the research conducted in the past. In understanding the history of TMCI through the ‘archive’ of public material about it, it is therefore essential to set out the ethical and political context in which we use these sources today. Establishing the usefulness of the colonial literature on TMCI to the broader, current debate on the efficacy and value of TMCI from a public health perspective depends on an assessment of how the colonial context affected the content of early accounts of TMCI, and on a careful assessment of the boundaries in which this debate can take place, considering that TMCI has secret and sacred elements.

In conclusion, discussion of TMCI has not only been de-historicised, it has also been highly politicised and polarised in southern Africa today. This context affects the debate around the medical MC rollout and the safety of TMC. Although little literature exists to compare complication rates in medical MC at public health clinics with those in TMCI, it is clear that complication rates are higher in TMCI than in medical MC. Traditional circumcision has not been associated with significant HIV risk reduction in southern Africa (Connolly et al. 2008). Even so, many people will continue to choose TMCI over medical MC because of its social significance. Thus from a public health perspective it is crucial to reduce other health risks associated with TMCI even while promoting medical MC to reduce HIV infections. Traditional circumcision practice will also affect the take-up of medical MC and the public interpretation of public health messages around medical MC. Therefore, an understanding of beliefs and practices relating to TMCI are important from a public health perspective, even if medical MC is promoted (alongside the condom) as the main method of HIV risk reduction.

A review of the social science literature on TMCI in Southern Africa can contribute to a better understanding of the way in which TMCI will interface with the proposed medical MC rollout. The specific focus of this chapter is on documenting changes over time in key aspects of ritual, its regional variations, and the history and politics of TMCI in Southern Africa. In the first section of the review, we identify the sources of literature consulted and discuss ethical and methodological challenges to research in this area. The TMCI ritual is often considered highly secret and sacred by practising communities, posing specific challenges to researchers. In later sections we identify historically stable characteristics of the ritual and its regional variability, key drivers of change in the form and meaning of TMCI over the last 200 years, followed by a focus specifically on historical trends in age, timing, location, practices surrounding circumcision itself, and educational messages. The review thus provides a

context within which the social significance of the ritual may be better understood, historical drivers of change identified, and the likely impact of proposed interventions assessed.

While it is appropriate to use archival research to engage in debates around interventions that have the possibility of improving public health, the purpose of this research is not to violate social taboos or pass judgement on cultural practices. This research is intended rather to provide public health programmers, TMCI practitioners and practising communities with new ways of breaking the deadlock that has developed between them. This investigation may provide new incentives for engagement and give better access to a hitherto neglected information base, parts of which may be critically considered in discussions about the nature and effects of changing practices of TMCI.

Methodology

The literature on TMCI in Southern Africa was identified using a number of methods. An internet search of the various academic databases was conducted to identify all available literature (including biomedical), with particular attention to the social science literature and the earliest published accounts of TMCI. The platforms JSTOR, EBSCO-Host, ISI Web of Science and Google Scholar were searched using the parameters, ‘traditional+male+circumcision+africa’. The search terms were then substituted with others to get more specific results; replacing ‘circumcision’ with ‘initiation’, for example. Online theses and dissertations were found through the websites of the relevant universities. Published books on TMCI and related topics were identified using Google Books and the library catalogue of the University of Cape Town. A Reference Manager database was used to manage the citations.

The bulk of the literature examined was in English, but a number of additional sources are available in German, French (mainly from the nineteenth and early twentieth centuries) and Afrikaans. Very little literature on this topic is available in the African vernacular in general, but interestingly the number of African language texts about TMCI has actually decreased since the 1930s.

The reasons for the dominance of English sources are not only to do with the bias towards English in the databases consulted, but also with the history of Southern African colonisation by Britain and the motivations for writing about the topic for different audiences as discussed below.

Description of the literature

Regional spread of the literature

Far more publications on traditional male circumcision were identified in South Africa than in other countries, and the Eastern Cape was better represented than other areas within South Africa

Regional variations in the quantity of literature may be related to a number of issues including the relative secrecy of TMCI in different places, as well as to its frequency. For instance, aspects of the TMCI ritual were secret on pain of death in Botswana (Willoughby 1909: 238), while in the Eastern Cape, by contrast, TMCI was relatively less covert and more widespread (see discussion below). This may help to explain the much greater size of the literature on the Eastern Cape in comparison to other areas. Male initiation ceased to be practised for a time after 1902, but in the 1920s was partially revived in southern Botswana (Brown 1921: 420), which may help to explain the relative dearth of sources about that area. Variations may also be related to the uneven spread of missionary and anthropological interest across the sub-continent. The Eastern Cape was well covered by both missionaries and anthropologists in the nineteenth and twentieth centuries, compared to the Northern Cape and Botswana.

Historical origins of the literature

Table 3: TMCI Literature by date of publication

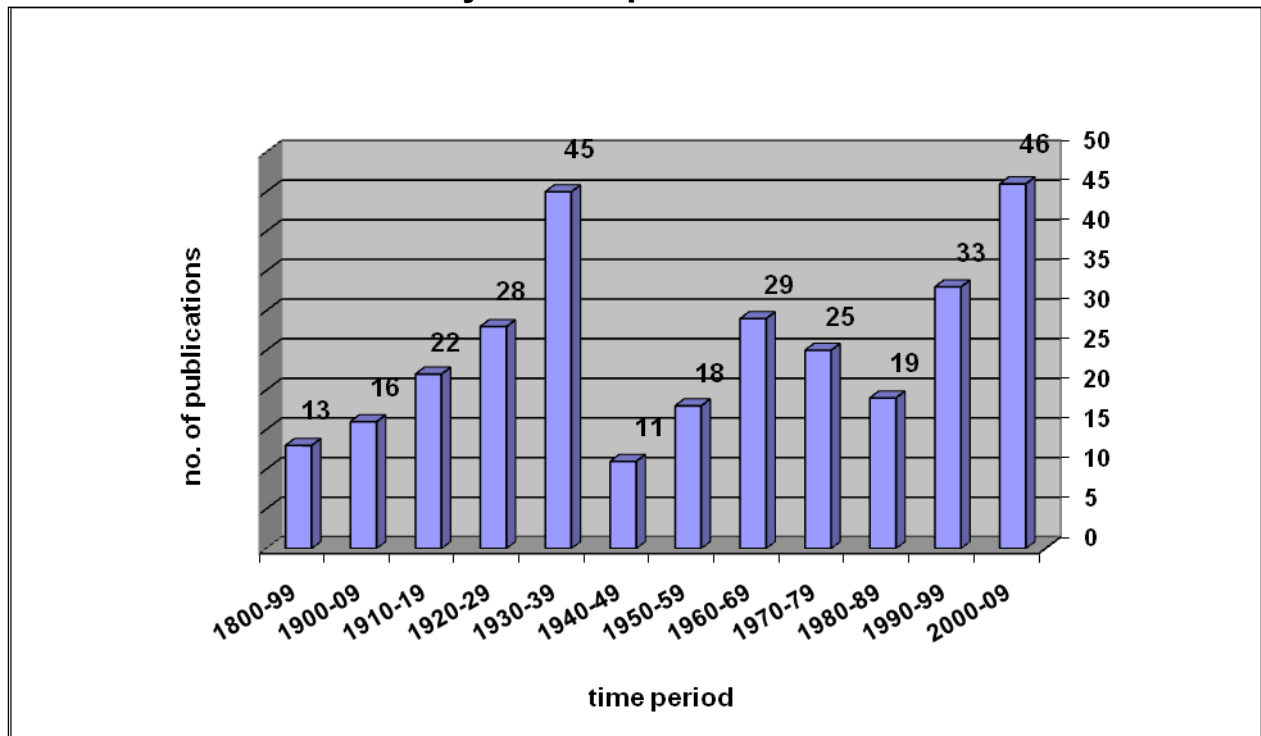


Table 3 illustrates the periodisation of the social science TMCI literature examined, showing peaks in the 1930s and 1970s with a post-colonial peak in the 2000s. Broadly speaking, the literature falls into three broad categories. Firstly there are numerous early ethnographies produced by explorers, missionaries, travellers, colonial officials and other interested outsiders, concerned mainly with describing specific groups and their various rituals without necessarily linking them symbolically or economically (Alberti 1810; Farrer 1879; Wheelwright 1905). Secondly, from the 1920s onwards, a new wave of cultural and social anthropologists began to describe rituals in African society. Later anthropologists became interested in the ways in which traditional practices were being transformed under the combined influence of western capitalism, education and racial segregation or apartheid (Hunter 1932; Schapera 1934; Hellman 1948; Mayer 1961, 1971). Some writers described changes in the socialisation of adolescents (including TMCI) as a way of illustrating this (Pitje 1950; Krige 1956; Guma 1985). From the 1980s, the interests of biomedical researchers and human rights activists in TMCI have produced a third kind of literature, focusing on social histories of sexuality and gender constructions as well as health risks.

To missionaries and officials, whose primary task was to convert or rule African communities, TMC was seen as a marker of traditionalism on the continuum between ‘primitiveness’ and ‘civilization’. Pauw (1975:205) summarises missionary attitudes towards traditional practices in the following statement:

Missionaries nurtured in the values and beliefs of Western Christianity considered the Xhosa ancestor cult to be incompatible with the gospel they preached, and assumed that Xhosa Christians should renounce their faith in the ancestors and the ritual it involved.

Earlier nineteenth-century accounts by visitors and travellers –before colonial rule was well established in the Eastern Cape - were often more sympathetic (Barrow, 1801:212-3; Alberti 1968 [1807]; Moodie 1838 II:265-80 in Ngxamngxa 1971:185). Later in the century, accounts of African societies were influenced by the broader erosion of the ‘civilizing ideal of progressively accommodating educated Africans into a single colonial society’ (Rich 1990:668). Laing (1836 cited in Ngxamngxa 1971:185) reports that boys undergoing circumcision spent their time in ‘laziness and licentiousness’. Warner (in Maclean 1858) provided what Mills (1992) calls the ‘most uncompromising missionary position’, a wholesale denunciation of any Xhosa practice (in this case) that referred to the ancestors, including TMCI. Theal (1907) described aspects of TMCI practice as ‘barbaric’. However, much of the missionary criticism, that continued into the twentieth century in practice if not always in print (Pauw 1975), focused on the rituals associated with TMCI (e.g. drinking and dancing) and not on the circumcising act itself. Mills (1992) suggests that missionaries opposed TMCI and other traditional practices in an attempt to introduce a new ‘lifestyle’ based on the precepts of Christianity and modernity.

Some colonial accounts of TMCI in the early twentieth century prefigured more formal anthropological works by being more sympathetic than missionary diatribes, which is not to say they were lacking in bias, racism and appeals to the idea of the ‘noble savage’. Some Christian missionaries were particularly interested in TMCI among the Lemba because of putative links with Judaeo-Christian and Islamic practice (Junod 1908, Wheelwright 1905, Jacques 1931, Stayt 1931). This also informed later anthropological accounts of the Venda (Van Warmelo 1974; Le Roux 2004). Many of these works were a response to nineteenth-century Christian criticism of the ritual. For example, Ngxamngxa comments (1971:186) that in Schweiger’s (1914) ‘attempt to make the rite appear innocent he omits reference to sacrifices, appeals to ancestors, magical protection, and thus does not grasp its full significance.’

Much of this writing only touched very lightly on the relationship between initiation and sex. Delius and Glaser observed that the mainly white and male travellers, officials and missionaries, who provide the richest nineteenth century writings about TMCI, described the ritual in meticulous detail while rarely recording anything to do with the sexual lives of the communities they encountered. When they did, their comments were usually refracted through the, 'profoundly distorting lenses formed by a combination of Victorian prudery, Christian morality and cultural distance' (2002:28).

Formal anthropological works on TMCI first peaked in the 1930s after the rise of anthropology as a discipline in the 1920s. This focus on ritual was sparked by the structural-functionalism of Radcliffe-Brown and Hoernlé. Malinowski's influential *Sexual Life of Savages* (1932) ensured that sexual dimensions of social life were seen as a significant and legitimate topic for anthropological study at this time. Malinowski influenced key figures in South African anthropology such as Monica Hunter and Isaac Schapera, who sought to describe and analyse total social systems; including family, marriage and the socialisation of children (as well as the rituals relating to TMCI). Some of the literature of this time framed TMCI within western theories of psychology. Laubscher, who worked in Komani Mental Hospital in Queenstown, Eastern Cape, in 1936, saw TMCI partly in Freudian terms (Laubscher 1937, Laubscher 1975), while Berg (2007) later provided a Jungian analysis of the ritual.

Anthropological works were generally sympathetic to TMCI for reasons peculiar to the development of the discipline within the political context of both English and Afrikaner anthropology in South Africa. Underlying the work of many Afrikaner anthropologists or *volkekundiges* from the 1930s into the 1970s was the notion of an authentic culture or 'ethnos' that defined the 'tribe' (Sharp 1981:20) – a framework that was central to justifying the apartheid system (Gordon 1988). Van Warmelo's (1935) work, for example, helped to classify Africans into separate 'tribes' (Galliard 2004:151). He made his argument on the basis of language rather than culture, while other conservative anthropologists, spurred on by the spectre of acculturation and black urbanisation, soon filled in the cultural gaps (Pugach 2004:827). Gordon (1988) suggests that there was a close link between *volkekunde* and the apartheid state. Werner Eiselen, from the University of Stellenbosch, and Gerard Lestrade, from the University of Pretoria, both held chairs in anthropology or 'volkekunde' and influential posts in government during this period. Eiselen, later Secretary of Native Affairs under the apartheid prime minister Hendrik Verwoerd, was influential in the promotion of the apartheid ideology of 'separate development'. Eiselen wanted to foster 'higher Bantu culture' and reverse the effects of acculturation by creating African reserves (which later became the bantustans) (Galliard

2004:151). P. J. Coertze and other anthropologists were also active in the formulation of 'Native policy' for the apartheid state and the propagation of apartheid through the language of social science (Hammond-Tooke 1997; Gordon 1988, Giliomee 2003: 467).

Early British anthropology, born out of South African roots in many ways, also influenced *volkekunde* and was not incompatible with racist ideas (Galliard 2004:151). But in response to *volkekunde*, anthropologists located at English-speaking universities in South Africa focused on charting cultural change and opposed racial segregation. At the same time, the limitations of both anthropology itself and South African liberalism prevented people like Hoernlé, Radcliffe-Brown and Shapera from imagining a common non-racial society in opposition to segregationism. Although they emphasised the importance of understanding change, they created a picture of distinct African culture that was represented as profoundly incompatible with modernity and damaged by contact with it. Max Gluckman, influenced by the historian W. Macmillan, sought to re-historicise cultural change and conceptualise the interdependence of black and white South Africans (Cocks 2001). Marxist-influenced studies of rural change and development began to influence much of the social anthropology written in this period (e.g. Carstens 1982). Deconstructions of the notion of *ethnos* and cultural difference (Boonzaaier and Sharp 1988), and Marxist analyses emphasising class over ethnic identity were popular among English-speaking anthropologists in the 1980s and 1990s, but the importance of understanding ethnic identity was revived after 1994 (Robins and Scheper-Hughes 1996).

Anthropology celebrated the 'primitive' by documenting its loss: as Landau (1998:490) says, 'it was precisely after the destruction and reintegration of pre-colonial African political entities into the white-dominated economy, that South African anthropology developed the "science of primitive cultures".' Most anthropological works from the 1930s considered TMCI as a marker of 'primitive culture' and 'ethnos'. Sympathetic accounts of TMCI were thus common within the anthropological stable. Eiselen, who wanted what he described as a 'higher culture' for Africans, was therefore somewhat unusual in following the missionary rather than the anthropological tradition in his writings about TMCI. He hoped that these would 'disillusion the natives and ... pave the way for healthy development' as TMCI was one 'those heathen customs which retard the progress of our natives' (Eiselen 1932:2). On the other hand, sympathetic accounts of TMCI may have been influenced by a widespread perception among white farmers that TMCI created better workers who were more respectful of white women. Laubscher (1937:134), for example, states that

The Abakweta ceremony has a far-reaching and good influence on the pagan native and this view is especially supported by the opinions of European farmers ... They

maintain that [a circumcised African] is more obedient and trustworthy and they can leave their farms knowing that their women and children are safe with the pagan ... Personal experience has found a dignity and sincerity among pagan natives which is sadly lacking among their fellows living in town locations. It would indeed be sad if a native in his emancipation has to lose these admirable qualities.

Some anthropologists themselves came from a farming background and thus drew on this position. Influenced by trends in English anthropology in South Africa, many of the anthropological texts in the mid to late twentieth century not only looked back to the rural idyll, but also explored changing practices of TMCI in urban and peri-urban areas, and the presumed impacts of colonialism and westernisation.

Anthropological works on TMCI peaked again in the 1970s. This revival of interest may have been influenced by landmark books by Turner's *The Ritual Process* (1969), and Bloch's *From Blessing to Violence* (1986). Bloch described the Merina TMCI ritual in Madagascar and argued for long-term historical analysis of trends in TMCI to understand its social significance. However, most South African accounts of TMCI from the 1980s and 1990s did not follow Bloch's example, perhaps because of their focus on political protest and class rather than ethnic identity. Instead, they continued to chart the impact of Christianity, urbanisation and westernisation on TMCI.

Sociologists and historians have shown increased interest in TMCI in recent years because male socialisation and sexual education have become important issues in debates about crime and domestic violence, as well as in the biomedical discussion around TMC for HIV/AIDS prevention (Delius and Glaser 2002). The current social science literature usually frames changes in TMCI as an index of broader social changes in sexualisation, gender and age relations, some of which made Africans more susceptible to HIV, rather than as an isolated cause of certain health problems. Notably, the current public health, biomedical and human rights literature, and even some of the social science literature, is much more critical of TMCI than the earlier anthropological literature.

In conclusion, political and social concerns (including academic interests) have influenced analyses of TMCI over the last two hundred years. There is a large literature on the topic, peaking in the 1930s with the birth of African Studies, again in the 1970s with the expansion of the university system and interest in TMCI among anthropologists, and finally in the post-colonial period with current interests in AIDS and sexuality.

What is striking about the literature is that it shows significant similarities in tone and content between two groups of rather unlikely bedfellows:

anthropologists and traditionalists on the one hand, who generally supported TMCI, and missionaries and public health researchers on the other hand, who generally opposed it.

On the one hand, most analyses of anthropology in South Africa have focused on identifying ways in which both liberal and conservative anthropology directly or indirectly supported the apartheid state or the colonial project in general. However the account of Southern African TMCI provided by both social anthropology and *volkekunde* (although often racist or essentialising) is generally sympathetic to TMCI, which is presented as evidence of authentic ethnic culture threatened by the pressures of modernity. This view bears some similarity to the defence of African culture by ‘traditionalists’ in the current political debate in South Africa.

On the other hand, there are strong similarities between the missionary critique of TMCI, presenting TMCI as evidence of a lack of ‘civilisation’, and more recent studies presenting TMCI as evidence of a lack of ‘reason’ or ‘education’. This includes those studies in the neo-marxist tradition that position class analysis as a possible corrective, pointing to the role of TMCI in providing compliant wage labourers for white farmers or mining companies (Carstens 1985).

The politics of knowledge production about TMCI

There is a large social science literature on TMCI in southern Africa, as illustrated by the discussion above.⁴ Anthropological descriptions of contemporary practices may provide insights into historical changes in these practices (Delius and Glaser 2002:29). A critical examination of this literature could thus make current public health interventions around MC more relevant and responsive, thus improving their efficacy. The available literature was generated within from the contexts of colonialism, apartheid, secrecy and taboo that resulted in highly judgmental and biased (although not always unsympathetic) views of the nature and value of TMCI. The politics of knowledge production has effects on the content and status of this ‘evidence’ today.

⁴ This is contrary to the views of Berg (2007) and Mayatula et al. (1997).

Historians are accustomed to reading ‘against the grain of the archive’: using sources that come from a different political position and purpose to their own to write revisionist accounts of history that celebrate the subaltern voice (normally hidden by the system that created the archive). Historians have also taken an interest in critiquing colonial anthropology’s political project for its link to colonial governance, its narrow vision and its paternalism. But because of the political sensitivities in academic scholarship about returning to studying ‘the tribe and its customs’, relatively little work has been done on assessing the archive of colonial anthropology that traces changes in the practice of TMCI. There is a tendency in current scholarship either to dismiss the whole archive as biased or to cite specific details from it without further comment on the broader political context and how it might affect the veracity of these details.

We thus have to ask a series of questions about the literature:

1. What are the likely problems with existing accounts of TMCI (by insiders and outsiders)?
2. How are these accounts viewed by insiders today?
3. How should they be used and interpreted by researchers today?

Ethics, access and secrecy

There seems to be significant regional and historical variation in the secrecy of TMCI, and various aspects of the ritual are more secret than others. Yet any commentary on the ritual at all, especially by women or outsiders, is considered by some to be a transgression of taboo, thus shutting down debate about human rights or health issues. Some commentators have historically transgressed these taboos in the name of science or truth, while more recently others have used concerns about ‘civilization’, human rights or health issues to justify breaking community taboos.

What is the role of insider and outsider researchers in an investigation of beliefs and practices around TMCI? How should researchers use material that has been obtained or published unethically, even if it is in the public domain? What are the ethics of writing about taboo subjects? How do taboos arise, how are they expressed and policed by different insiders?

Insider and outsider researchers

It is important to situate the present study and existing literature within a discussion about the rather different roles, access and constraints for insider and outsider researchers in relation to TMCI. Outsider studies have the benefit of

being able to develop a critical perspective (Meintjes 1998:15), but this privilege is not restricted to outsiders – many academic accounts draw extensively on the inputs of disaffected insiders. Critical accounts of traditional male circumcision by insiders include a recent book by Mqolozana (2009).

Outsider researchers have in the past often experienced problems getting access to secret information and interpreting it correctly. The anthropological texts frequently note the reluctance or inability of participants to explain the symbolism of the rituals to outsiders – informants merely state it is the custom (or *isiko*) to do things that way (e.g. Hunter 1979:xi). Not all outsider accounts of TMCI suffered from the same access problems, however: individual anthropologists developed relationships of trust with key informants and regional and historical variations in secrecy also allowed for greater access to information. Some researchers gained better access to information because they were men, although occasionally white women were allowed access to information officially proscribed for black women.

In the Limpopo region Junod (1927:74) was never allowed to visit a TMCI lodge but claimed that ‘Rites [were] described to me in such detail that I seemed to have lived for three months with the candidates!’ In the Eastern Cape, outsiders (especially men) were allowed to observe the ritual themselves even in the early colonial period.⁵ B.J.F. Laubscher, who was a psychiatrist at Queenstown Mental Hospital in the 1930s, wrote extensively about Tembu initiation. His assistant was a white male nurse, P. van der Merwe, who grew up in the Eastern Cape and was renowned as a boy for stick fighting. He translated culturally and linguistically for Laubscher and facilitated his entry into the Tembu community. More controversially, one of Laubscher’s key informants was a traditional healer, Solomon Daba, who seemed to have started helping Laubscher because he needed money to bail out his assistant from jail. These points of entry perhaps gave Laubscher a more complete picture than later research which depended on questionnaires (e.g. Raum 1972, Pauw 1975). Laubscher took photos of *abakweta* (circumcised boys) after circumcision and was permitted to make a cine film of the ritual by a chief *kankata* of the area, Dwali Nakompelo (1975:97).⁶ Laubscher’s work is one of many older works that raises ethical problems.

Although most anthropologists publishing in southern Africa during the twentieth century were white, a number of African anthropologists and sociologists have written on TMCI in the past (Soga 1931; Wilson and Mafeje

⁵ E.g. Von Winkelmann’s observations of 1788-1789 cited in Gitywa 1976; various other early accounts cited in Ngxamngxa 1971:185.

⁶ It is not known whether this film has survived or where it is currently located.

1963; Guma 1985). Schapera (1933:353) criticised Soga (1931) for his 'excessive tendency to defend Xhosa customs which have occasionally been misunderstood by Europeans'. Perhaps in response to this kind of criticism, precisely because black commentators on TMCI were cultural insiders, they were often careful to frame their accounts within anthropological discourse. Ngxamngxa (1971), for example, whose work is a review of largely white anthropological writing on the subject, written while still a student at Fort Hare, adds his own views on the topic mainly in the structuring of his review. He reframes the meaning of some of the anthropological material on the spiritual significance of the ritual. He takes no strong stance on the morality of TMCI (although he points out that some of the educational lessons of the TMC ritual correspond to the 'Fifth and Seventh Commandments') and focuses on its 'useful' social functions for the Xhosa as well as white society.

While questions of ethics and access are clearly important in assessing the contribution of insider and outsider accounts of TMCI, and insiders seem to have the edge on some of the spiritual meanings associated with the ritual, what is striking is the way in which disciplinary strictures on insider accounts make them so similar to outsider accounts in other ways.

Using TMCI material already in the public domain

The use of older accounts that are already in the public domain is often difficult to justify because of the conditions under which information was obtained. In considering the use of this material, questions of ethics and bias are closely linked. How much can we trust this literature?

Early accounts of TMCI often did not rely on informants but on observation, not always first-hand or in-depth. The first verbatim evidence from Africans on TMCI was that given to the 1882-3 Cape Colony Commission on Native Laws and Customs, according to Ngxamngxa (1971:186). Some of their accounts therefore have to be taken with a pinch of salt. In the early twentieth century, many anthropological accounts depended on a few willing informants. Isaac Schapera (1978) who did fieldwork among the Kgatla (a Tswana group) in Mochudi in the period 1929-34 found that although the last *bogwera* (circumcision) among the Kgatla took place much earlier in about 1902, only four initiated men were willing to tell him anything about it. His principal informant, Thomas Phiri, was an ordained Dutch Reformed Minister who had written his own recollections of the ceremony down in the vernacular. Willoughby (1909) said that the people he interviewed did not want to talk about TMCI. Eiselen did not divulge the name of his Mosuto informant to protect him

against retribution, but his sourcing of information about TMCI was clearly against the wishes of the community.⁷ Similarly, Laydevant, a Catholic missionary, received information on Sotho initiation from disaffected converts including a ‘native catechist’ who at 14 was initiated against his will (Laydevant 1951:8). It is not clear in such early accounts, often framed by unashamed attempts to damn ‘uncivilized’ practice, to what extent we are hearing the voice of the author or the subaltern voice of boys who resisted initiation.

The best way to assess the accuracy of the content of colonial-era accounts is to look at similarities and differences over time, reading along the grain of two hundred years of commentary on TMCI. Despite some broad and systematic colonial biases, accounts of TMCI were generated from very divergent political perspectives, ethical concerns and research methodologies. Yet descriptions of the format and purpose of the ritual, taking account of its changing regional and historical context, remain fairly stable. Details – such as age at circumcision, who manages the process, the handling of the circumcising instrument, wound care, educational purpose and sexual proscriptions are often represented as changing over time. Changes may also be documented by comparing accounts that are separated in time. These changes are of particular interest in a discussion of the health risks and benefits associated with TMCI. Narrative colonial anthropology, with all its biases and silences, often provides more of such detail than later accounts which focus on the meaning of TMCI within the broad political sweep of history. No colonial-era accounts should be considered outside of their political and disciplinary environment, but the charting of these differences within the broader continuities of TMCI may give some indication of the key influences on TMCI practice over the last 200 years, however general. The repetition of obvious inaccuracies in the sources may be avoided by charting broad trends.

The question remains, should we use these sources if they have been unethically obtained?

Ethics, taboo and informed consent

Ethics and the idea of informed consent have been important notions in medical research for some time. Observing formal ethics in social science research (viz. signing of informed consent forms and getting research ethics committee approval) is however a relatively new concept - in South Africa, as elsewhere. It

⁷ Eiselen’s informant himself hoped that his account of the school would be read by his fellow Mosuto. Accordingly, a Sotho translation follows the English version of the text (Eiselen 1932:2).

is clear that, in many cases, what passed as ethical anthropology in the past would not stand up to academic or public scrutiny today.

Since the early twentieth century, the general view within the academe has been that research information should not be obtained from human subjects by subterfuge or force. When this often unspoken code of ethics was transgressed, researchers in the early to mid-century generally appealed to the benefits of pursuing ‘the truth’ in the interests of the common good. The very secrecy of the ritual was thus advanced by Willoughby as a reason for documenting Tswana TMCI:

It is evident also, I think, that significance of the ritual is not known even by the tribes that preserve it. If the Anthropologist can throw upon it the light of other lands and other epochs in the history of the evolution of man, it may become eloquent, and all the more eloquent because of the jealousy with which the secrets are guarded, the care with which the ritual is performed, and the high importance attached to its due fulfilment (Willoughby 1909:229).

Anthropological works about TMCI often contained photographs of secret or sacred aspects and even transcripts of secret songs. Only a few of the later works took steps to observe community taboos: Pauw (1975: photograph 4 after p.138), for example, notes that ‘in view of possible sensitivity about publication of this photograph the faces have been artificially masked’.

Notions of what constitutes the common good and who defines it have changed over time. In the present, research results are more public, and communities outside the academe play a greater role in challenging research that breaks cultural taboos. In the Northern Territory of Australia, for example, members of the indigenous Pitjantjatjara Council brought a successful court case against Mountford, an anthropologist, in 1976 using breach of confidence rules, to prevent secret culturally-significant information obtained by him from being published. The court granted the plaintiffs an injunction to prevent sale of the book (*Foster v Mountford* (1976) in Davis 1997). Community rights have received formal recognition through the work of the World Intellectual Property Organisation (WIPO) on intellectual property associated with ‘traditional cultural expressions’.

Whereas individual consent by an injured or disaffected insider was in the past considered sufficient justification for revealing secret aspects of TMCI, in recent years this has become less tenable. In 1990 photographs taken by Steven Hilton-Barber of a Sotho circumcision school were heavily criticised in public forums. Hilton-Barber claimed in his defence to have had prior informed consent for the

publication of the photographs.⁸ This led to a number of discussions about ethics, censorship, racism and the right of outsiders (specifically white South Africans) to comment on black cultural practice. An art exhibition on the subject included a number of works by both black and white artists, some of whom did symbolic works rather than realistic portrayals out of respect for the taboos. The proposed work by Peet Pienaar resulted in further contestation over who has the right to comment on African TMCI:

Peet Pienaar and Thembinkosi Goniwe were both invited to participate in a Cape Town exhibition on male identity, curated by Jeremy Mulvey of the London-based Male Identity Group. Peet Pienaar's exhibition proposal, to undergo circumcision [on camera, for pay-per-view, conducted by a black female medical doctor] and auction his foreskin on eBay, provoked charges of exploitation and racism from Thembinkosi Goniwe, whose own proposed works were performance stills from a reenacted Xhosa circumcision ... Pienaar was expelled from the exhibition, but forged ahead anyway.⁹

Goniwe said afterwards that he had not been censoring Pienaar, but complaining about the way in which he, as an Afrikaner, was using Xhosa initiation as a negative reference point for his performance. With the emergence of public video-clips on services like Youtube, audio-visual material on traditional circumcision has become widely available.¹⁰ Viewing these clips often does not require any form of copyright or consent process, besides the viewer's verification that s/he is over eighteen. These videos have thus moved beyond the realm of research and into the public domain. Interestingly, even within the sphere of research, steps ensuring initiates' anonymity are not evident in a recent report on TMCI for the WHO (Vincent 2008c). This may be related to decreasing secrecy requirements in the Eastern Cape, where TMCI had always been less secret than in the north, and/or to less sensitivity about community taboos in the public health literature than in the anthropological literature.

The right to secrecy and owning intellectual property around taboo cultural practices is limited however by requirements of international law and various national legal systems that such practices should not transgress human rights. Breaking of taboos is thus limited to those areas where human rights issues surface. Astrid Berg (2007), prefacing her Jungian account of Xhosa male circumcision, explains this position:

⁸ To read Hilton-Barber's response to the critique, see 'In Good Photographic Faith', *Staffrider* Vol.9 No.3 1991.

⁹ Axis Gallery, *Circumcised, Circumscribed*, January 11 - March 29, 2003. See <http://www.axisgallery.com/exhibitions/circumcision/>

¹⁰ For example, <http://www.nowpublic.com/african-circumcision-dance> and <http://video.nationalgeographic.com/video/player/places/countries-places/south-africa/saf-circumcision-pp.html>

As a white South African woman I have no business in coming so close to a very old African tradition, let alone an exclusively old male tradition. I know only the minimum of the details of the ritual; I have even omitted mentioning some aspects, some words that are part of it, as these are usually not spoken about. I have chosen this topic because it is a current major public health concern in our country; I am approaching it as a medical doctor and analyst (2007:97-98).

Thus, for example, reports of secret practices, or other unethically obtained material should not be reproduced from older accounts, except in the case of human rights concerns. As Mgqolozana said at the launch of his novel on TMCI,¹¹

Imagine that this demise of your children troubles you and many others in society, as it should, but none of you is allowed to comment about this, due to cultural prescription. So the loss of your children is met with silence, your silence.

Whatever the ethical justifiability of disclosing information about TMCI in academic circles, it is not always acceptable to practising communities. Mgqolozana has been criticised for putting information about TMCI into the public domain, and so too have outsider researchers. Some critics of outsider research on TMCI suggest that no public commentary is appropriate at all, and that TMC practitioners and community leaders should be left alone to deal with any problems themselves (see WHO/UNAIDS, 2009a). As has been noted above, the defense of TMCI by its practitioners is framed in opposition to the judgementalism of the biomedical approach and often rests on assertions of taboos associated with cultural practices. It also often positions colonial anthropology as a flawed source of information.

A history in which white South Africans were given privileged access to speak about and to judge aspects of African culture has left a legacy of anger and heightened sensitivity, especially but not solely with respect to sacred or secret rituals like TMCI. The informal code of ethics that underlay much social science research during the twentieth century was not a ‘gentleman’s agreement’ between researcher and research participants in the sense that it was an agreement between equals. The focus on academic truth, the separation between academic and public worlds in South Africa, and the large differences of social and legal status between what were mainly white researchers and black research participants, led to a profoundly unequal relationship between researcher and research participants. This inequality was not fully acknowledged by researchers. Under apartheid the space for public criticism by black South Africans was very constrained. If researchers published secret information about

¹¹ Thando Mgqolozana’s Speech at the Launch of *A Man Who is Not a Man* July 14th, 2009. Accessed at <http://ukznpress.book.co.za/blog/2009/07/14/thando-mgqolozanas-speech-at-the-launch-of-a-man-who-is-not-a-man/>.

TMCI, participants (especially in rural communities with low literacy rates) would thus probably not know about it, and if they objected, their voices would not be heard.

Conclusion

Most outsider researchers today tend to locate their investigations on TMCI in terms of social benefits such as health, as we have done in this report. The present authors, doubly positioned as outsiders to the debate as white women, are not proposing to conduct any interventions in the field, but to inform the debate between public health programmers and TMCI practitioners. There is no reason why TMCI practitioners and community members cannot use all the available research, including this paper, to help reduce health problems associated with TMCI. It is true that colonial anthropology was often biased, and the information in such texts was unethically obtained in some cases. Yet in the post-colonial environment, these texts have to be opened to public scrutiny to challenge biases and correct errors. Neither blanket condemnation nor unthinking use of such material takes scholarship or ethics in this area further. Reference to specific historical material pertaining to health-related concerns about TMCI today is ethically justified because of the urgent need to reduce TMCI death rates and improve public health messaging. However, for some people, merely writing this chapter may violate taboo.

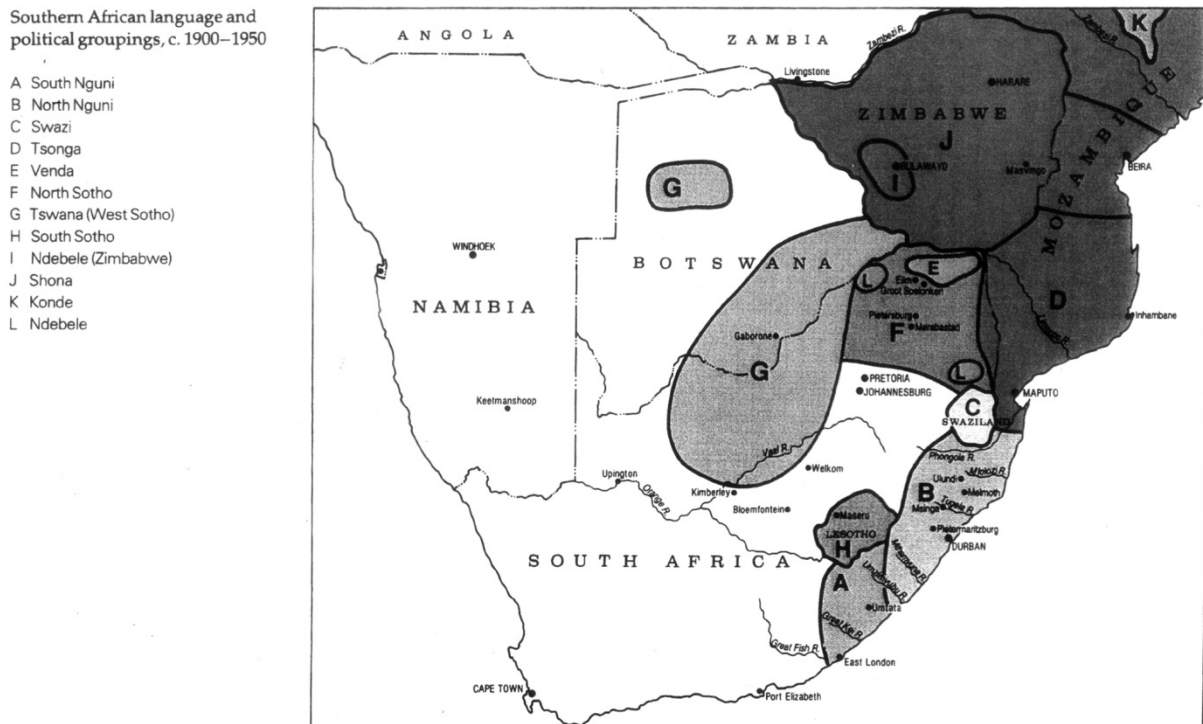
Memories about the practice of traditions in the past are malleable, as cultural practices change substantially but are represented as having happened the same way for ever. Perceptions about what aspects of the ritual are ‘traditional’, from an insider perspective, are important in discussing problems associated with TMCI because of the reluctance to acknowledge or allow change to the ritual. As one research participant said, the acknowledgement of change ‘would put our culture down’ (Meintjes 1998:81). Community members say ‘we respect the way our forefathers did things. I don’t know what would happen to us if we change these things.’ (Meintjes 1998:93). Clearly, any changes would need to be driven from within the practising community to be acceptable (Meintjes 1998:82). In encouraging this process, one outsider intervention could be to provide evidence of stability and change from historical sources. These sources are not always trusted within practising communities, but they have also often not been read and critiqued by them or by public health experts proposing new interventions for male circumcision. This data could generate debate (and possible suggestions) about acceptable change within practising communities, and inform the broader discussion about designing public health interventions to promote MC.

Understanding change and stability in TMCI

In a landmark anthropological text, *From Blessing to Violence*, Maurice Bloch (1986) described the Merina TMCI ritual in Madagascar. Bloch found significant stability in the ritual's symbolic form (ritual acts, songs, objects used) over two centuries, despite dramatically changing politico-economic contexts. These changing political and economic contexts were related to changes in TMCI, shifting from a familial ritual in the period before the growth of the Merina state to a ritual glorifying the militarist and expansionist state in the early nineteenth century, and then gradually back to a small-scale familial ritual which became associated with anti-colonial nationalism at the time of independence from France in 1960. These broader contextual shifts were associated with logistical changes to the number of people involved, expense and length of time allocated, and the age of boys undergoing circumcision. While the role of the ritual within the broader socio-economic context changed significantly, its more personal role as a marker of the transition to manhood remained stable. Bloch's work was significant for the long time frame and broad socio-economic context he drew on to assess the role and meaning of TMCI.

In southern Africa, we can trace similar continuity and change within the TMCI ritual, although there are significant regional differences. Circumcision has been retained, much changed, as part of the initiation ritual in some communities (Carstens 1982:510, Vincent 2008), stopped for various reasons in some (Krige 1956:100, Hunter 1979, Carstens 1982:507) and revived in others (Brown 1921). In the past, most societies in southern Africa marked the transition from childhood to adolescence in some way, even if TMC was not part of this process. Circumcision could therefore become incorporated into an existing initiation rite, such as when the Venda adopted an additional circumcision school, the *murundu*, to supplement their *domba* initiation school, or, as in the case of the Swazi, it could be excluded from a puberty rite that continued to be practised without it. At one time, circumcision was practised by all Nguni speakers, but ceased among North Nguni (Zulu and Swazi) while continuing in South Nguni groups (Xhosa, Thembu, Mfengu and Bomvana). It was practised by all Sotho speakers including Tswana (West Sotho), Pedi (North Sotho) and South Sotho (from Lesotho). It was practised by the Tsonga by the early 20th century according to Junod, but these schools had already been heavily influenced by Sotho practice. The Venda reportedly borrowed the practice from the Sotho and the Lemba. A small number of San groups adopted male circumcision as a result of contact with Tswana communities (Krige 1956, Schapera 1960, Van der Vliet 1974, Hammond-Tooke 1993).

Figure 2: Hammond Tooke's Southern African language and political groupings, c.1900 – 1950s (Hammond-Tooke 1993:14)



Centralised control over TMCI remained more important in the northern areas of Limpopo and Botswana than in the Eastern Cape. In kwaZulu Natal, male circumcision marked the end of chiefly control over male labour power. By abolishing circumcision as the marker of transition into manhood in the nineteenth century, the Zulu king retained control over the labour power of young men for a longer period (Hamilton, pers. comm. 2009). In the Eastern Cape, chiefs were less powerful. In the nineteenth century, under the influence of colonialism and capitalism, control over TMCI shifted from chiefly control to the control of the patriarch in the early to mid-twentieth century, and more recently to control by older peers. Its purpose in mobilising labour for chiefs shifted to mobilising wage labour for families before setting up households independent of parents and relatives. More recently, TMCI has become a means of asserting a kind of independent masculinity in relation to peers and to women. The fundamental idea of marking the transition to manhood, and the link to one's ancestors, has remained stable. However, the meaning of manhood and the purpose of invoking traditions in its support have changed. These broader socio-economic changes, and specific impacts of Christianity and western education, have had effects on the logistics of TMCI as well as the education it confers on boys.

Table 4: Common features of TMCI (regional variations)

	South Nguni (Xhosa, Thembu)	Sotho (including Tswana and Sotho-Venda)	Tsonga
Preparation	<p>Identification of candidates (<i>abakwetha</i>) (by themselves, parents and local chiefs)</p> <p>Organization on individual / small group basis.</p> <p>First sacrifice and feast (<i>umngcamo</i>)</p> <p>Ritual cleansing e.g. hair cut</p> <p>Building of lodge (<i>mkweta</i> hut)</p> <p>Some groups: all night Umguyo dance for boys (Raum 1972, Brownlee 1927); hair necklace (Ngxamngxa 1971); mock fights by circumcised men or uncircumcised boys (see Laubscher 1937:116)</p>	<p>Identification of candidates, <i>badikana</i> (formerly always on a national / chiefdom level)</p> <p>Sacrifice (right limb) and feast.</p> <p>Ritual cleansing e.g. strengthening medicines and shaving of head.</p> <p>Lashing in order of rank</p> <p>Building and doctoring of lodge (<i>mophato</i>)</p> <p>Some groups: fortnight spent in the veld prior to TMCI learning songs (Lobedu); daily meeting to tend cattle, collect firewood (Pedi) or make ropes for lodge (South Sotho); period spent working for chief (Venda) (Van der Vliet: 1974:229); preliminary ceremony <i>lexala</i> (Tau and Kone) (Pitje 1950:112)</p>	<p>Identification of candidates (<i>va ka hogo</i>)</p> <p>Night spent in the capital or headman's place.</p> <p>Building and doctoring of lodge (<i>sungi</i>)</p> <p>Some groups: jumping over firebrand (<i>thula ritsa</i>) and beatings en route to circumcision lodge. (Junod 1927:776)</p>
Circumcision / Seclusion	<p><i>Some groups:</i> Procession to the river for ritual cleansing (Ngxamngxa 1971)</p> <p>Operation by <i>ingcibi</i> (<i>incibi</i>)</p> <p>Bandaging and wound care by (<i>in)khankatha</i></p> <p>Restraint of boys</p> <p>White clay (<i>ingceke</i>)</p> <p>Restrictions on food and drink for first 8 days in lodge (Raum 1972)</p> <p><i>Hlonipa</i> language use (Laubscher 1937:123; Raum 1972; Meintjes 1998)</p> <p>Kaross of sheepskin (Alberti 1907, Laubscher 1937) / white blanket; penis sheath (Ngxamngxa 1971)</p> <p>Second sacrifice (<i>umdaga</i>) once wounds start to heal (<i>Laubscher 1937:125</i>)</p> <p><i>Some groups:</i> <i>umtshilo</i> dances (beer and ox meat) with masks and kilts (Raum 1972, Ngxamngxa 1971)</p>	<p><i>Bodika</i> circumcision school (In Lesotho, have this school only, all other groups have second school, the <i>bogwêra</i> – see follow-up) Tswana circumcision ceremony referred to as white <i>bogwêra</i>, follow up ceremony, black <i>bogwêra</i>.</p> <p>Operation conducted in order of rank on special stone (<i>sehalo</i>) by <i>thipane</i></p> <p>Bandaging and wound care by traditional doctor, assistants or boys themselves. <i>Some groups:</i> wound left unattended or immediate bathing to relieve pain (Mönig 1967:115)</p> <p>Sleeping on backs only</p> <p>White chalk and ash once wounds have healed</p> <p>Restrictions on food.</p> <p><i>Some groups:</i> drinking of water encouraged (Hammond-Tooke 1981: 42); in others, water prohibited (Laydevant 1951:14)</p> <p>Secret language (excluding Tswana) and learning of sacred songs and formulae. (<i>kôma</i>)</p>	<p>Operation (<i>murhundzu</i>) performed by <i>muxeki</i> (traveling surgeon)</p> <p>Wound care by <i>manyabe</i> (doctor)</p> <p>White clay</p> <p>Secret language and learning of sacred, secret songs and formulae</p> <p><i>Some groups:</i> daily bathing in river (if nearby) (Junod 1927: 83)</p> <p>Drinking of water prohibited (Junod 1927:84)</p>

		<p>Tests of endurance and strength.</p> <p>Sacred fire, <i>thithipe</i>, kept alight for entire seclusion period.</p> <p><i>Some groups</i>: rock monuments (cairns) erected during lodge closing ceremony (Pitje 1950:124)</p>	
Release	<p>Washing in the river</p> <p>Traditionally: race to river - chased by men (Ngxamngxa 1971)</p> <p>Smearing with butter and removal of clay</p> <p>Red ochre applied</p> <p>New karosses / (white) blankets and black doek</p> <p>Giving ceremonial sticks (<i>umnqayi</i>) (Xhosa only)</p> <p>Burning of lodge (initiates not to look back)</p> <p>Third sacrifice osisa (when wounds have healed and no further dressings required, Laubscher 1937:126); <i>ukojisa</i> / <i>ukosisa</i> rite (Raum 1972; Ngxamngxa 1971)</p> <p>Feast but initiates eat in moderation</p> <p>Admonition / instruction by elders (sometimes including women)</p> <p>Gift giving including weapons at ukusoka ceremony</p> <p>Some groups: Mock fights by circumcised men</p>	<p>Washing in the river</p> <p>Red ochre applied</p> <p>Burning of lodge (initiates not to look back)</p> <p>Procession to village carrying bundles of wood.</p> <p>New grass mats and loin-skins</p> <p>Clubs (Lesotho)</p> <p>Presentation to elders.</p> <p>Re-naming of initiates.</p> <p>Recital of praise poems (Sotho), Regimental names (Tswana and N.Sotho)</p> <p>Blanket (Lesotho)</p>	<p>Washing in the river</p> <p>Burning of lodge (initiates not to look back, except Balemba)</p> <p><i>Mayiwayiwane</i> dance (Junod 1927: 91).</p> <p>Procession of initiated into the capital of the chief (imitate gait of the chameleon)</p> <p>Giving of gifts by women</p>
Follow-up	<p>Khaki shirt and trousers (Raum 1972)</p> <p>Submissive and quiet behavior (Raum 1972)</p> <p>Service to chief / parents</p>	<p><i>Some groups</i>: Further school, <i>bogwêra</i>, held +/- 1, 2 years later. Formation of age-regiments (Tswana and Sotho – excluding Lesotho) and initiation into secrets of a mysterious being (Sotho-Venda)</p> <p>Age regiments perform first hunt (traditionally, military raid)</p>	

The adaptation of TMCI to serve new purposes in changing socio-economic contexts has helped it to survive and remain relevant in some regions where many other rituals have died out. External opposition to the ritual seems to have

made it stronger. It remained part of African Christian practice even when proscribed by the church, and was linked anti-colonial identities, and even to ethnic nationalism. Today it is considered by some to be the last bastion of traditional practice, especially in the Eastern Cape and Limpopo Provinces.¹²

Social significance: the insider perspective

TMCI is important to practising communities for a number of reasons, some of which have changed over time. Ngxamngxa (1971) provides a detailed account of the ‘functions’ of TMCI among the Xhosa, a comprehensive overview which applies in most cases to other regions where TMCI was retained. In this section we focus on the functions which relate to insider-defined social significance.

TMCI has had enduring individual, psychological relevance as a coming-of-age ritual for many southern African boys entering manhood since at least the nineteenth century. It marks their entry into manhood, educates them as men and trains them in endurance and fortitude (Marck, 1997:337; Alberti 1968 [1807]; Ngxamngxa 1971: 186; Peltzer et al. 2008c; Berg 2007:98). In the Eastern Cape TMCI is said to involve a passing of knowledge, but perhaps more importantly the transferral of spiritual and temperamental states of being, from older men to boys. Boys are cleansed of their ‘boyhood distemper’ (Mabona 2004:196) through the anointment of white clay after the circumcision and their ritual rebirth as men. The giving of gifts helps them to start a household after they have returned to their usual social environment, and boys are educated in their new status and responsibilities. These may include: the ability to inherit from their father; responsibility to care for their parents in old age; and broader political responsibilities to the group as a whole (Ngxamngxa 1971:195). TMCI also provides education about how to be a man. Thus, it is supposed to challenge the boy both mentally and physically, and survival of the ritual is regarded as a sign of manhood. In the past, crying out at the time of the circumcision was thus not permitted (Laubscher 1937:122). This notion of surviving the pain and danger of TMCI to become a man continues to influence the practice today (Meintjes 1998).

¹² For example see the comment of Siviwe in the University of Florida discussion on Human Sexuality and culture: “As a Xhosa men [sic] who went through the circumcision, i must admit we are facing health promblems which are causing permanent injuries and deaths. We are slowly losing our culture and traditions and circumcision is the only tradition which is still going strong. For me circumcision school is the only tradition which i’m sure the next generations will still perform there [sic] old traditional way.” Accessed at <http://gravlee.org/sexuality/2008/09/24/south-africa-how-safe-is-traditional-circumcision/>

TMCI also reinforces group identity, although the nature of that group has changed over time. In southern Africa, TMCI is often associated with age-grade systems among Bantu-speakers (Marck 1997:337). Words for initiation schools in Southern Africa evoke the meanings ‘make friends’ and ‘drum’ because friendship bonds emerge from participation in TMCI rituals, and the drum is the musical instrument used most commonly in the course of TMCI ceremonies (1997:345). In the nineteenth and early twentieth centuries in the Eastern Cape, TMCI played a role in establishing social and even political connections between boys from the same village who became a fighting force for the local chief and political advisers to the chief’s son (Alberti 1968 [1807]: 39; Ngxamngxa 1971:196). Even under the influence of urbanisation, rituals of childbirth, initiation and marriage remained important in reinforcing kinship ties among closer-knit groups of family, friends and neighbours (Pauw 1975:139). Carstens (1982) suggests that TMCI ‘created’ obedient wage labourers. Ngwane says that to groups like the Zizi in Cancele, who lived near the non-circumcising Bhaca, ‘initiation was the birthing of social subjects and as such it was a critical moment in social reproduction’ (Ngwane 2004:264). Ngwane (2001:270) describes how in the 1980s, as younger men took control over the ritual, it ‘became a new locus of disciplining and camaraderie during December holidays’.

There are deep spiritual meanings associated with TMCI. The associated practices and rituals do not just mark the passage of a boy to manhood, but cleanse and protect him from evil as a precursor to his establishing a relationship with the ancestors (Ngxamngxa 1971:198) that will prepare him for the spiritual world after his death (Laubscher 1975:118). Laubscher observes that a ‘mental gulf’ emerges between the initiate and the uncircumcised boy through TMCI as men’s obligations to elders and ancestors are revealed (Laubscher 1975:17, 94ff.). These aspects of the ritual are probably the most secret and sacred. The proper navigation of the boy through the dangerous ritual is proof that he has navigated through the liminal state between boyhood and manhood, and into the powerful and protected spiritual world he will inhabit for the rest of his life. There is thus much emphasis on protecting boys before and during the ritual from evil spirits. At the opening ceremony of the ritual in the Eastern Cape (called *umngcamo* / *umngcama*) boys have to be physically and spiritually cleansed (shaving of hair, burying it to protect them from evil, being reminded of boyish misdeeds) (Laubscher 1937:118). The protective charms in the seclusion place and the *ubulunga* necklace worn by many Xhosa also ward off evil. The *ubulunga* necklace (made of hairs from the sacred cow of his father) is believed to give the initiate virility and potency as a man (Laubscher 1937:119). The use of the *ubulunga* necklace was recorded in 1960 among the Xhosa and the Mfengu (Gitywa 1970:12), and its association with virility was also recently

recorded by Peltzer et al. (2008c) in the Eastern Cape. The whiteness of the clay, goats and coverings during seclusion symbolises light, is associated with diviners, and helps guarantee protection from evil during times of transition (Pauw 1975:124-6). Sacrifices are made to the ancestors to ask them to protect the initiates. A prayer is made at this time introducing the boys to the ancestors, and in the coming-out rite a further valedictory address is made which establishes a relationship between them (Soga 1931:248 in Ngxamngxa 1971:198).

Changing socio-political contexts

In spite of significant continuities in its social significance, and in the form of the ritual, TMCI in southern Africa is a thoroughly modern practice in the sense that it has been adapted to suit changing social contexts. Although male circumcision continued into the colonial period, it was affected by the introduction of Christianity, labour migration and changes in social structure (Niehaus 2000, Mager 1998, Carstens 1982, Mayer 1971, Pauw 1975, Guma 1985). Anthropological works on the effects of urbanisation in South Africa since the 1940s have documented the breakdown of the age cohort system in TMCI, an increased focus on circumcision rather than the broader initiation process, the emphasis on pain as a test of manhood and the loss of associated educational inputs enabling the socialization of men (Hellmann 1940, 1948; Longmore 1959; Mayer 1961; Wilson and Mafeje 1963 in Delius and Glaser 2002). Circumcision became an important rite of passage to political maturity for African men during the anti-apartheid struggle (Suttner 2008, McAllister 1990). In the post-colonial period circumcision practices have also been affected by socio-economic change and increased state regulation (Vincent 2008). The meaning of male initiation and circumcision has thus shifted within the broader social system, including the relationship between male and female initiation (see Carstens 1982); the set-up and economics of circumcision schools (Krige 1956:107), the meaning of male initiation and circumcision, and what is taught to the boys in socialising them as men (Brown 1921:426, Vincent 2008).

Chiefs, elders and young men

In the nineteenth-century Eastern Cape, chiefs were in charge of the TMCI ritual and initiates had to do some unpaid duties for the chief for a period after coming out of seclusion. This included fighting, since they were presented with weapons at the coming-out ceremony (Alberti 1968 [1807]:39; Maclean 1858:99-100; Smith 1870, Schweiger 1914, Cook n.d. cited in Ngxamngxa 1971:196; Van

Winkelmann and Kropf 1889:124-8 cited in Gitywa 1978: 86-89). The ritual also happened near the kraal of the chief. Those boys circumcised together with the chief's son played political roles when he came to rule (Dugmore cited in Maclean 1858 in Ngxamngxa 1971: 197). Chiefly control of the ritual becomes less and less important in twentieth century accounts in the Eastern Cape, although Laubscher mentions the circumcision of a chief's son (1937:115). Van Eeden (1991) also records that rural Xhosa men in Mandluntsha still defined their age groups according to initiation cohorts that were named after a man of royal descent, especially chiefs' sons who underwent initiation in the same period (although not necessarily, it seems, in the same group). Chiefly control over the ritual could also result in a rapid cessation of TMCI. Hunter's (1979 [1936]:165) report, based on her fieldwork in the 1930s, suggests that Chief Faku of the Mpondo (located in the coastal zone between the umThatha and umThamvuna rivers in the Eastern Cape) prohibited initiation schools during his reign (he died in 1867), while the practice continued among the Xhosa, Mfengu and Thembu. This process was sometimes resisted by his people (Hunter 1979:396). The chief's official reasoning, according to his councillors and independent observers, was that circumcised boys were often very ill. This was ascribed by some to the fact that they had limited sexual contact with women prior to circumcision (*ukumetsha*) and thus suffered ritual impurity (*impaka*) which led to their deaths at circumcision. Later evidence given before the Native Appeal Court suggested that Faku's son Mqikela, who was not circumcised, had some physical infirmity.

Hunter suggests that one reason for cessation of circumcision may have been the need at the time to mobilise young men for fighting against the Zulu. However, the practice of Mpondo initiation for girls continued unabated. One Mpondo group, the amaNqanda, retained the practice of circumcision because they were living elsewhere at the time of the change (viz. in Thembuland). A few other Mpondo and Mfengu groups living in Pondoland at the time retained it as well (Hunter 1979:165). Other groups and individuals (including some coloured and white South Africans) started practising TMCI when they moved into areas of the Eastern Cape where it was prevalent (Meintjes 1998:7). Hammond-Tooke (1962:81-82) noted that Mpondo students studying at Fort Hare and Lovedale during the 1960s frequently returned home circumcised. He reasoned that this was because they had been in contact with Xhosa and Tembu girls who refused to have anything to do with uncircumcised men.

Shaka and Mswazi were widely regarded to have 'abolished' the custom of circumcision among the Zulu and Swazi respectively because it interfered with military training and rendered boys vulnerable for extended periods (Wheelwright 1905:251; Fuze 1922:20). But Van Warmelo (1974:83) argues

that Shaka and Mswazi's power did not extend to those who fought them off or fled and states it is more probable that, 'some tribes observed the custom while others did not, so that these dictators confirmed a trend rather than made an innovation'. Bryant (1929:642) said that circumcision was already dying out in the days of Jama and Senzangakhona, and that this process was completed by the continuous warfare in Shaka's reign. Krige (1974 [1950]:117) thus questioned whether Shaka had enough power 'to do away with such a cherished custom'. It was more probable, she argues, that he was responsible for abolishing a custom that was falling into disuse, 'for other reasons which we do not know'. Zulu boys aged around nine or ten, however, continued with the practice of cutting the string on the under part of the foreskin, together with the small vein contained in it, in order to allow the glans to project (though this was not a ritual occasion) (Krige 1974:117). This was also followed by the Zulu boy's puberty ceremony (*thomba*), which included rites of passage but no operation, and his incorporation into an age-regiment (*ukubuthwa*).

In societies that continued to practice TMCI into the twentieth century, there was a broad shift from chiefly control over the ritual, to paternal control and then to younger male control of TMCI. By the mid-1960s, although fathers usually took the initiative and managed the preparations, sons were playing an increasingly important role in doing this themselves. This was true of both rural and urban locations and among Christians and non-Christians in the Eastern Cape (Raum 1972:138). Traditionally 20-30 boys in the village were circumcised together, but this practice was also becoming less common, and the trend was for each father to organise circumcision separately, although still in the traditional way (Raum 1972: 153, 155). Gitywa states that, by the 1970s, the decision to get circumcised rested largely with the boy, although the parents made all the arrangements and ensured that a male agnate represented the family at all the ceremonies connected with their son's initiation (Gitywa 1976: 147). Ngwane (2001:270) describes how among the Zizi in Cancele, job losses in the 1980s and the influence of Hlubi type Sotho-Tswana circumcision schools shifted the control over TMCI to younger men. He says that initiation thus 'became a new locus of disciplining and camaraderie during December holidays which also provide[d] food for young men, and became a source of tension with older men'.

Meintjes's informants also noted tension between younger people and their elders over control of the ritual by younger men and the failure to observe the older taboos associated with TMCI (1998:53,100). Meintjes suggested that TMCI was not simply an assertion of masculinity and virility, but also key to group identity for young Xhosa men. They had reinvented the ritual and gained greater control over it to serve their need for the construction and maintenance

of group identity and solidarity in the modern world. This form of identity was cast as an ethnic Xhosa identity (as opposed to Zulu or white identity) (1998:97), as a way of proving oneself to other peers through facing hardship; and differentiating the initiates from boys through their collective participation in the ritual.

There were regional variations in the power of the chiefs over TMCI. Accounts comparing the main features of traditional South Nguni (including Xhosa) TMCI with that of the Sotho groups insist that the former tended to be a more local affair, not related to the formation of age regiments as it was with the Sotho groups (excluding Lesotho). Schools in the Eastern Cape were smaller, the 'father' of the school usually being the father of one of the initiates, and although the chief would be informed of the intention to hold the school, there was no organization at chieftdom or national level as existed among the Sotho groups. (Krige 1956; Van der Vliet 1974; Hammond-Tooke 1993). Hammond-Tooke (1993:14-15) argues that this essential difference was the result of geographical location which had played an important role in informing initial settlement and therefore cultural practice, including the way in which TMCI was practised. Hammond-Tooke argues that the presence of varied arable soils and abundant water along the eastern coastal strip made it possible for Nguni and Tsonga communities living in this region to be fairly self-sufficient and to reside in scattered homesteads (*umzi*). The uniform soil-type, notable lack of surface water and need for defence on the central plateau, however, meant that Sotho and Venda communities there were more likely to be found living in nucleated settlements with centralized administration, with resultant effects on aspects of their initiation rituals. While the thesis may veer towards environmental determinism and oversimplification, it emphasizes the cultural changes that may be brought about by adaptation to different environments, whether natural or man-made.

In Lesotho, Ashton (1952:55) maintained that TMCI did not appear historically to have been an event of significance to the group as a whole. The chief organized the school primarily for his own family (his sons, his brothers' sons, the sons of his near relations and immediate followers), not for all his subjects. Influential headmen were allowed to have separate initiation schools for their own sons. The absence of regimental formation during TMCI in Sotho societies in the south of the country compared to the centrality of this for Sotho communities living on the highveld was apparently well documented by observers throughout the twentieth century (Hammond-Tooke 1993).

In the early colonial, and possibly even pre-colonial, period it seems that the paramount chief of the Sotho in the northern Transvaal (Pedi) was considered by

people in the surrounding areas to be the ultimate authority in charge of circumcision lodges. Every chief or headman in the district was required to present to him all of the boys who were eligible for the school for inspection and counting. After initiation the young men were brought to him for further inspection as to the state of their health and general conditional (Harries 1929; Pitje 1950). But this practice came to an end with the assassination of Sekhukhune. Pitje says that the faction fights that followed his assassination contributed to further dividing the people and estranging them from Maroteng regime so that, 'today no one thinks of asking for permission from any of the Maroteng chiefs before opening a school' (Pitje 1950:194). According to one of Schapera's Tswana informants, only the chief was entitled to authorize a *bôgwera*. If a subordinate ruler, for instance the head of a subject community, ventured to do so for his own people, he was regarded as striving for political independence. The Kgatla themselves, when they migrated from the northern into western Transvaal in the reign of Chief Masellane (c.1700), settled in territory that then belonged to the Tlhako. Masellane at first acknowledged this by paying tribute to the Tlhako chief, but he later stopped doing so. He also began to conduct *bôgwera* ceremonies without seeking permission from the Tlhako. This led to war between the two groups, from which the Kgatla emerged ultimately as victors. After 1890, when new Kgatla villages were established all the way down the Marico river, the ceremonies, including those of the Transvaal section of the Kgatla near Saulspoort) while occurring locally, still took place simultaneously and under the direction of the chief at Mochudi (Schapera 1978:3-5).

Ritchken says that the existence by the 1940s of large numbers of North Sotho villages and households with different ethnic and chiefly allegiances led to a change in organisation of initiation schools. Schools became smaller and were organised on a more local level. Although he says that some chiefly permission (as well as that of the 'native' commissioner) was required before a school could be convened, schools were no longer integrating their students into a specific chiefdom (Ritchken 1994:342). By the 1970s, though the principals of initiation schools in the former 'Bantustans' still needed the permission of the 'Tribal Authority' to hold a school, they no longer integrated the initiates as a corporate group under the chieftainship except at the most symbolic level. The link between youth leaders and the chieftainship was severed almost entirely: the initiation of a chief's son, who was automatically still placed in a leadership position, was an exception to this trend (Ritchken 1994:343).

Christianity

For the first few decades after the establishment of mission settlements in the Eastern Cape in 1799, their converts were mainly a mixture of displaced people of Khoisan and Mfengu descent, and the subjects of a few converted chiefs. Missionaries usually opposed traditional dances and spiritual practice that invoked the ancestors. Soga thus reportedly banned boys from dancing during TMCI in the 1840s, and Warner and Dugmore commented on the immorality of the TMCI ritual (Ngxamngxa 1971: 185). Schapera (1956:360) says that

in their zeal to introduce Christianity along European lines [missionaries] wished to do away with everything savouring of heathenism. They accordingly forbade converts to practice polygamy, inheritance of widows, lobola, initiation, and other heathen ceremonies, whether or not opposed to the teachings of the Gospels.

But during the earliest days of missionary and colonial penetration, it was largely the attitude of the chief towards Christianity that influenced whether TMCI continued to be carried out or not. Schapera argued that in those groups where the chief became a Christian, the ceremonies were either abolished (as among the Ngwato) or profoundly altered in character (as among the Kgatla). Where the chief did not convert and insisted that Christians should undergo the local rites as well, perhaps compelling them to do so by force, this provoked the intervention of the Colonial Administration, which did not proscribe the ceremonies but made it an offence to force participation (Schapera 1956:383).

During the twentieth century, as Christianity became more widespread, it also became more accepting of indigenous tradition in practice while maintaining an oppositional stance in principle. Raum (1972) conducted an Eastern Cape survey in 1964-65 which suggested Christian opposition to TMCI was extensive. However, this opposition focused on particular public aspects of the initiation ritual, including dancing and the celebrations associated with initiates' isolation and subsequent re-entry into society. Circumcision itself was not proscribed.¹³ Independent African-led churches in the Eastern Cape were said by informants to be less opposed to the ritual in general, but many respondents in Raum's study described independent church opposition to specific elements of the ritual, especially to the preparation/segregation rite, public dances, special dress and body painting, and release ceremonies and follow-up periods of restraint (Raum 1972:136-137). Pauw (1975) found that some independent churches gave traditional practice more leeway than others.

¹³ He surveyed 54 informants in the Ciskei, 20 of whom were urban residents of Zwelitsha and 26 residents of rural locations, Middledrift and Victoria East; 46 were Christians.

Most Christian Africans continued to practice TMCI and other traditional rituals while making some modifications (Pauw 1975:98). In the Eastern Cape these prohibitions resulted in fewer Christians and urbanised Xhosa following food and language taboos during isolation, using clay body paint, and wearing *umtshilo* dancing kilts and masks, although Christians still participated in the *umguyo* and *umtshilo* dances. Economic reasons were given for cessation of dances in some cases, as the *umtshilo* dances required beer to be brewed and several oxen slaughtered (Raum 1972:142-144). Ngxamngxa (1971:189) says that *umtshilo* dances were traditionally the main pastime for initiates during seclusion, but that masks and palm leaf kilts worn in the dances had been abandoned in the Ciskei and in towns by the 1970s. Dancing concerts between rival schools of 'traditionalist' initiates living on white-owned farms in the Eastern Cape had already died out by the 1950s as a result of legislation against it and farmers forbidding large gatherings on their farms (Hunter in Schapera 1956:402). On one of the farms that Hunter visited, the sons of traditionalists and the sons of Christians were initiated together, but on coming out they gathered with their friends in separate huts; in one there was beer and dancing, in the other hymns and prayers (Hunter in Schapera 1956:402).

In the second half of the century, Guma recorded a range of religious attitudes towards Sotho initiation in both the urban and rural areas of the Western Cape. When the first Sotho lodge was sponsored in Zwelethemba in 1956, there was strong opposition from some of the missionaries. The Roman Catholic Church in Worcester notoriously excommunicated members who sent their sons for initiation. On the other hand, the praise poems composed by initiates ridiculed Christian converts (*majakane*), referring to them as 'hybridized people' because they no longer associated themselves with *lebollo* (initiation). Church influence against initiation rites among the urban communities of Langa, Gugulethu and Nyanga was not as profound and members of the local churches sponsored initiation schools. Some groups did however discourage the brewing of beer for rituals, while some members of the New Apostolic Church reportedly disapproved of initiation in its entirety. The mainstream Christian religious leaders that Guma interviewed in Zwelethemba and Cape Town in the 1980s were reported to be strongly in favour of initiation schools of whatever form. According to Guma, these religious leaders had 'reconciled Christianity with Africanism' (Guma 1985:48-49).

Schooling and wage labour

The introduction of western schooling and wage labour also affected the TMCI ritual by restricting the time available for it and by changing career prospects for young boys. But in the Eastern Cape '[n]either school education, nor Christian

teaching, nor prolonged contact with Europeans in migrant employment ... changed the view of the Xhosa and Mfengu people that circumcision is essential to the attainment of manhood.' These external influences seem, if anything, to have encouraged male initiation among the Xhosa living in reserves (Carstens 1982: 510). Carstens cites Schapera and Mears on the revival of interest in TMCI in the 1920s among some groups where the influence of Christianity had resulted in its abolition. This revival was related to the emergence of migrant labour, and changed the ritual, not merely in terms of its symbolism, but also in terms of the education given to boys (Carstens 1982: 519). Laubscher (1937:132) for example records one orator exhorting the newly initiated men in the closing ceremony to 'go out to work on the farms for the white man. Let obedience to your masters be your first consideration'. Circumcised Xhosa men, especially in rural areas where they did not associate with uncircumcised men, were reportedly viewed by white employers as more trustworthy and honest than uncircumcised men (Pauw 1963:89-90; Wilson and Mafeje 1965:107; Laubscher 1937:134).

Thus Carstens suggests that 'we might even characterize modern male initiation ceremonies as providing an institution to legitimize migrant labour for men': 'contemporary Xhosa youth are unwittingly prepared by these ceremonies to serve the needs of white capitalist enterprise in South African towns and cities' (Carstens 1982:519-20). Pitje (1950:119) says that the preference of white employers for initiated Sotho workers on the highveld was based on the teaching of a specific principle, '*Mohlanka wa kxoši ke kxoši*' (meaning that a chief's representative is like the chief himself. Disobedience to a messenger amounts to contempt of the authority that sent him).

As western capitalism became increasingly entrenched in southern Africa, periods of migrancy could even come to replace TMCI in some societies. In 1940 Schapera writes that a Tswana boy no longer had to undergo even the much modified initiation of that time to be accepted into an age regiment. Schoolboys were exempted and those away working considered themselves, as a matter of course, members of the same regiment as their age mates' (Schapera 1940:259). This change in attitude was most probably a result of more institutionalized labour recruitment in what was then known to the British as 'Bechuanaland' than in the Union of South Africa. As Schapera points out; 'a youth recruited for work on the mines (in Bechuanaland) is immediately registered as a taxpayer, he feels that the Government and the tribal authorities no longer regard him as a boy' (Schapera 1947:116). A specific investigation into the implications that this (and other factors) had on circumcision practices could prove rewarding as a recent cross-sectional study in Botswana found that while traditional circumcision had to a large extent been abandoned (only 25%

of men interviewed were circumcised), the acceptability of medical male circumcision amongst men and women was high at over 60% (Kebaabetswe et al. 2003). Comparative studies of attitudes towards medical male circumcision in neighbouring traditionally-circumcising communities, such as those in Botswana and in the Eastern Cape for example, which take into account the historic and socio-economic factors influencing acceptability, could prove helpful in understanding what may be acceptable to currently practising communities regarding medical circumcision.

Going to work in town became a way of proving one's manhood even where TMCI was no longer practised. Among the Bhaca, a period in town by itself may have entitled the boy to claim adult status (Hammond-Tooke 1962:79). Migrancy was linked with masculinity: a saying amongst Pulana men working on the Witwatersrand in the 1920s was that 'a boy who does not visit will ultimately marry his own sister' (i.e. a man who did not migrate became so closely associated with women as to become one) (Ritchken 1994:341). Money earned from wage labour was used to purchase clothes or put in trust by fathers to pay *lobola*. After a couple of migrant contracts the young man completed his transition into male adulthood by getting married.

Access to income through labour migration could however prompt a struggle between initiated but unmarried men and their fathers over the control of the migrant remittance. Migrant income meant that young men could save sufficient resources to enter into marriages of their own choice, at a time of their choice. Ritchken (1994:341) says that although various strategies were employed by homestead heads to gain control over remittances, 'the balance of power and locus of authority within the settlement group gradually began to shift away from the non-migrant umzi/kgoro head and fathers' (Ritchken 1994:341).

Initiation was closely linked with issues of identity and in the ever-changing political and socio-economic conditions of the twentieth century some young initiates must have struggled to reconcile the often incompatible identities required of them. A place where this was revealed, observed Pitje (1950), was in the classroom; initiates attending village schools in the early twentieth century kept to themselves and did not mix with other boys. Conflict arose when teachers attempted to exert authority over them;

Although they (the initiated) are desirous of education, the fact that the teachers are uninitiated persons is most unwelcome. The position is worse where the teacher concerned is a woman. Thus they are torn between two worlds – they desire modern education and yet they hate to be taught by their social inferiors (masoboro). (Pitje 1950:124)

Schools created a new hierarchy based on a person's level of education. Ritchken (1994:398) says that some teachers treated initiation with scorn and warned pupils that it would make them 'primitive' and more likely to fail, treating the authority of initiation with disdain: 'in school we talk of a teacher-child relationship, not a teacher-man relationship'. Initiates, for their part, refused to recognize the authority of teachers who had not been initiated or circumcised, in particular, their right to beat initiated students.

As literacy increasingly became associated with enlightenment in modernist discourse, illiteracy was identified with parochialism and backwardness. Literate children claimed superior understanding of the political situation to their illiterate parents:

Youths faced a disjuncture between the ideals of chiefly, generational and gender authority, and their experience of Tribal Authorities, migrant fathers, school teachers and women. This incongruity was accepted by their parents, and as a consequence, the youth were supposed to unquestioningly accept the judgment of their elders. But, as literate men who "understood" the national situation, and as initiated men, who were prepared to protect the nation, the youth decided to act. It was in this historical juncture that the formation of youth organization (in Bushbuckridge) needs to be understood. (Ritchken 1994: 445)

However, while the youth's claim to a political voice was based on their status as both educated and initiated 'men', elderly people questioned the status of these initiates as 'men' suggesting they had not passed the same test and were therefore not 'real' men. Sotho elders argued that TMCI used to be a six month test of endurance and strength when it was controlled by the chieftainship; a boy when initiated was fit to become a warrior and fight to protect the nation. In the contemporary period, twelve year old boys were being initiated in a few weeks by businessmen resulting in the saying '*Koma ke tsjelete*' (initiation school is money) (Ritchken 1994:397).

Incorporation into a money economy added new aspects to TMCI. For Sotho and related groups, the chief had previously been personally responsible for all fees, which were paid in cattle. Individual candidates were not expected to pay; the free labour services rendered by the boys before the opening of the school was considered to be payment in kind. But as early as 1905, Wheelwright (1905:255) observed a procession of Venda initiates to the chief 'to pay their fees before being released'. Among Pedi groups, Mönning (1967:115) observed a new custom where a third man (after the doctor and the circumciser) was appointed to collect each boy's fee of 20 cents before the operation. Krige

argued that the growing popularity of Sotho initiation schools in the Transvaal during the first half of the twentieth century was not unconnected with the fact that they were a valuable source of income to the chief, who not only received fees but also continued to enjoy initiates' services before, during, and after the school (Krige 1956:107). After observing a Kgaga headman recording a profit of R6000 for holding a school in 1977, Hammond-Tooke commented that it was 'no wonder that the right to hold an initiation is highly prized' (Hammond-Tooke 1981:55). The money itself was placed next to the headman's family shrine overnight so that his ancestral spirits would be aware of the success of the rite.

In the Western Cape, Guma (1985:52) estimated that the financial expenses for sponsoring an initiate escalated by more than 100% between 1970 and 1980. The teachers and assistants who had previously been offered gifts of blankets as an expression of gratitude, now expected to be paid in cash. Other changes to the ritual included the retention of objects that would traditionally have been destroyed when the lodge was burnt. For example, Ashton (1952: 52) observed iron cooking pots and blankets used during the seclusion being taken back to the villages in Lesotho because of their value. By the 1940s, Ritchken maintained that schools in Bushbuckridge no longer initiated their students into a specific chieftom as they became increasingly commercialised. He observed how:

The principals of some schools appointed their closest relatives as leader of the 'age regiment'. At other schools, leadership was determined on a 'first-come, first-serve basis: the first students to register with the principal became the leader. The process was uneven as those chiefs who were able to preserve their hegemony over a village were able to assert greater control over the initiation process and retain a sense of corporate identity around chieftainship (Ritchken 1994:342).

Resistance to apartheid and colonialism

The practice of TMCI was linked to resistance. Circumcision became an important rite of passage to political maturity for African men during the anti-apartheid struggle (Suttner 2008, McAllister 1990). Initiation as a test of manhood was an important (although not absolutely necessary) qualification to become a soldier in the 'war' against apartheid. Ritchken cites an informant who said:

There you become a man. When you are from ngoma you won't reveal any secrets when the police capture and torture you because you have already experienced torture (Ritchken 1994:397).

Over 60% of the initiated young Sotho and Xhosa men interviewed by Guma (1985:73) maintained that the initiation rites were analogous to white youth's military training in the South African army and that hardships experienced in the army were the same as those experienced during initiation. Circumcision was considered a political coming-of-age (Suttner 2008, McAllister 1990). In Kenya, 'political leaders and aspirants without "legitimacy" within the ruling elite are often referred to by their political opponents as "uncircumcised" men who cannot lead a nation of people' (Orchardson-Masrui 1998:87). The situation in South Africa is very similar.

TMCI also became an assertion of ethnicised African masculine identity in opposition to westernisation and colonisation (specifically missionary and school influence in the Eastern Cape):

It was as a way of coping with this image of the school as a constant 'leaking' spot in society that initiation received an added value. From being merely a means of socially constituting local men out of local boys it became also an institutionalized way of resocializing educated and potentially alienable young people. A local headman put it aptly thus, 'Sibanika uphawu lwekhaya' (we are branding them with the marks of home) (Ngwane 2004:268).

One of Campbell's Xhosa informants in Grahamstown gave an indication of the meaning associated with circumcision for those who practised it in the face of opposition:

Although many of us are Christians circumcision will not die out quickly. As long as we are amaXhosa we are men, and ... if circumcision and initiation go, then we are no longer a tribe, we are no longer men and will be as nothing (Campbell 1965:52 in Ngxamngxa 1971:197).

Sotho TMCI in the late twentieth century retained a strong nationalistic character through the insistence that initiates continue to learn, by heart, secret formulae and songs. Discussing the origin of Sotho initiation schools at Worcester in the Western Cape during the 1950s, Guma (1985:36) suggests that the choice of Worcester as a site for TMCI for many surrounding communities, including those in Cape Town, was related to the existing centralization of *Mehobelo* (Sotho National Day) celebrations there. Perry also noted a revival of Sotho TMCI during the mid-twentieth century which he ascribed to new growth in Sotho nationalism (Perry in Van der Vliet 1974:228).

As with the Xhosa case mentioned above, Sotho elders and young men in Guma's two research areas in the Western Cape expressed the opinion that Sotho initiation rites were among the few ritual practices in southern Africa that had withstood domination by European cultural influence. He says that they argued that, by contrast, the TMCI ritual as practised by some South Nguni

(Xhosa) was so contaminated by European cultural ideas as to have lost its 'Africaness'. They believed the Nguni rite was performed publicly as they had 'even allowed their rituals to be presented in public media films.' They therefore referred to Xhosa TMCI as the practice of 'exposures' (*oa e leketlisa*) (Guma 1985:45).

Biomedicine

The availability of western medicine also affected the TMCI ritual, but it has not generally been accepted by insiders as a positive influence. In Lesotho, Ashton (1952) reported that medical circumcision was replacing traditional circumcision. He said TMCI had all but died out except among some of the 'oldest' groups and as a result had 'lost its old significance'. Several circumcision secrets had 'leaked out'. Initiation in Lesotho had always been associated with virility, but this association was now entirely transferred to the physical act of circumcision. Consequently, some girls still refused to have sex with an uncircumcised man; thus

Nowadays many men go to the local doctor, native or European, to be circumcised. A few fathers take their young sons to the doctor for the same purpose (Ashton 1952:57).

Whatever the validity of this observation, TMCI was in a healthy state among Sotho in the Western Cape in the 1980s. Guma (1985:23) reported that Sotho youth who had been circumcised in hospital in the Western Cape were not regarded as men unless they went again through the 'mountain school' ritual. But there were some elders and men (20% of those interviewed) who believed that initiation rites should be conducted within a historical context; and that contemporary social, economic and political conditions should be accommodated in the organisation of the schools so that the ritual did not lose its social significance. These 'reformists' maintained that the rituals would die out in the urban areas if they were not adapted to changing socio-political conditions. For example, if an initiate became ill and 'traditional means' of treatment failed, white doctors would be approached for treatment, which was never thought possible in the past. As one elder commented,

It would seem in the long run that the most important aspect of the initiation will be the incision which will reflect the influence of Xhosa initiation practices on Sotho practice. We may even end up using Xhosa as the medium of instruction as the initiates are brought up in a predominantly Xhosa speaking environment. If we deny the existence of the above our children will ultimately be circumcised in hospitals. That will signal the end of initiation rites in the Western Cape' (Guma 1985:75).

In the Eastern Cape, the influence of biomedicine has been hotly contested. In a Port Elizabeth township in the late 1960s, to 'be circumcised in hospital or by a medical practitioner [was] ridiculed almost as mercilessly as not being circumcised at all' (Mayer 1971:8). Raum reported that 44 out of 54 of his informants preferred circumcision by the *ingcibi* to the biomedical doctor because it was traditional and 'more effective' that way: it preserved the ancestral link, gave the proper education to boys and made them 'real men' in a way not achieved through medical circumcision (1972:139). Reluctance to use antiseptic creams except in an emergency, and outright refusal by most rural informants to use them at all, was very common (Raum 1972:140). In this vein, hospitalisation for TMC complications was viewed as a 'disgrace' by many communities in the Eastern Cape in the 1990s, and initiates who had undergone a pre-circumcision check-up at the clinic were in one instance forced by other fellow initiates to confess to this, undo their dressings, and have the scab scraped off as punishment.¹⁴ They were thought to have received an injection to protect them against the hardships of the bush. Antiseptic creams still have to be hidden as they are perceived to be lessening the hardship of the operation (Meintjes 1998:70-1, 76-77).

Although opposition to biomedical intervention remains strong in some contexts, some practitioners used antiseptic creams to prevent adverse health effects in initiates (see below). Some Eastern Cape fathers sent their sons to biomedical doctors for circumcision so they would be healed in time for the school term to begin (Raum 1972:138). Nevertheless, even where biomedical facilities are used for circumcision itself or for treating complications, this is often done in such a way as to cohere with the cultural requirements of the ritual. One of Raum's informants says 'Even persons who are traditional have no objection to the hospital operation as such': some villagers even have their boys circumcised in hospital and then taken for initiation (1972:155). In another South African study, the timing of requests for medical circumcision was often linked to the timing of TMC (De Bruyn et al. 2007).

Meintjes (1998:80) reports very few informants advocating MC in hospital followed by traditional seclusion and initiation, although there were anecdotal reports of this already happening in the Eastern Cape, particularly in the former Transkei (1998:92). Families of boys sent to hospital for treatment of complications often request the use of male rather than female nurses, and for the discharge to be timed for the coming out ceremony rather than for a return to the bush (Meintjes 1998:70-1). Concerns that people could identify a hospital

¹⁴ Some of the concern about injections may relate to their use by some families in the 1970s as a preparation for TMCI (Gitywa 1976:250-1).

circumcision through looking at the stitching pattern were addressed by one doctor in Alice who did the stitching in such a way as to resemble a ‘bush’ circumcision (Meintjes 1998:90).

Trends in key aspects of TMCI

In this section we document trends in key aspects of TMCI that have relevance for the current discussion about MC and HIV risk.

1. Age at circumcision and initiation;
2. Timing of circumcision;
3. Violence associated with the ritual;
4. Relationship to female initiation;
5. Taboos;
6. The circumcision process; and
7. Educational messages.

Age of participants

Eastern Cape: age of initiates

Age	08	09	10	11	12	13	14	15	16	17	18	19	20	21	..25	26
Von Winkelmann 1788-89																
Paterson 1790*																
Barrow 1797-8 (1801)																
Alberti 1807			‘when a youngster enters maturity’													
Dugmore c.1860**																
Soga 1931																
Laubscher 1930s																
Raum 1970-1			‘earlier than before’													
Gitywa 1976			before wage labour or university													
Meintjes 1998																
Mogotlane et al., 2004 – Flagstaff																
Connolly et al., 2005 (2008)			isiXhosa-speakers: 89% circumcised at 17 and older													

* Ngxamngxa 1971:185

** Maclean 1858

There are regional differences in the Eastern Cape that may be responsible for some of the variation shown in the age of initiatives. In the 1930s, Thembu initiation occurred mainly between 18 and 26 years, but few were initiated after

20 years. The timing depended on the health, physique and maturity of the boy and his ability to carry a man's responsibilities (Laubscher 1937:114). Increased age at circumcision was associated with the need to earn money to pay for the ritual in an environment where fathers were absent due to migrant labour. Reductions in the age of circumcision were associated with westernisation and urbanisation in the 1970s among the group called 'school' Xhosa (Raum 1972: 153, 155). Gitywa (1976: 145–6) explains this difference by suggesting that while 'red' Xhosa believed that a boy 'should live out his boyhood' seeking politico-judicial prowess within the peer group as a preparation for manhood, and thus tended to be circumcised later as a peer group, 'school' Xhosa preferred earlier circumcision, allowing them 'to pursue individual ideals and ambitions' by developing educational, political or economic achievements valued within the western context. The earlier age of Xhosa initiates in recent years has been advanced by participants (Meintjes 1998:56) as a reason for increased complications. For instance, it has been alleged that they could not bear the pain, did not follow instructions about dressing the wound, and were too young to follow the educational messages about being men). Vincent (2008c:31) suggests that commercial incentives were partly responsible for decreasing age at circumcision:

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

Some nineteenth-century sources claim that boys were being circumcised at 8 or 9 years. Given that these sources were not based on detailed observation, their accuracy is disputable.

Lesotho / Free State: age of initiates

Age	11	12	13	14	15	16	17	18	19	20
Mabille 1906										
Ashton 1930s										
Laydevant 1954										
Lye and Murray 1973/4										
Zietsman 1972										
Connolly (2008)	seSotho speakers: 76% circumcised at 17 and older									

In Lesotho, age at circumcision was reported as generally lower than in the Eastern Cape. Mabile put the age of initiation at 12 years at the turn of the century (1906:247). Ashton, credited as the principal ethnographer of the Sotho in Lesotho, carried out his fieldwork among the Baphuthi and Batlokoa in the mid nineteen-thirties (returning in 1949) and reported that preparations for initiation commenced when the son of a chief or important headman reached the age of about 15 or 16. If the prospects of the coming season were good, then an approximate date was fixed for the following year. The exact age of initiation in this situation could therefore vary considerably as all those boys who had not yet been initiated would have been included (Ashton 1952:46). Laydevant, a Catholic missionary living in Lesotho between 1905 and 1954, observed that when a boy reached 14 or 15, his father would sow a field of corn in preparation for the rite and approach the chief for permission to have his son initiated (Laydevant 1951:9). Lye and Murray observed boys between the ages of 13 and 17 undergoing initiation in the Leribe district of Lesotho in 1973/4 (1980:125). On a sample of 1483 people (men and women) on 26 farms in the Clocolan district of the Free State in 1972, Zietsman found that most tended to be initiated between 15 and 19 years (1972:42).

Limpopo, Mpumalanga and Mozambique: age of initiates

Age	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	...25
Junod 1920s																	
Pitje 1940s																	
Mönnig 1960-1965																	
Hammond-Tooke 1976-8																	
Connolly (2008)		tshiVenda-speakers: 11% circumcised at 17 and older xiTsonga-speakers: 23% circumcised at 17 and older sePedi speakers: 34% circumcised at 17 and older isiSwati-speakers: 39% circumcised at 17 and older															

In Limpopo, Mpumalanga and Mozambique the age of initiates fluctuated more noticeably, even within the same school. Junod reported that, by the 1920s, TMCi had largely disappeared from most of the ‘proper’ Tsonga clans. Where it was still practised, all boys between the ages of 10 to 16 were reportedly sent to by their parents to participate. Junod describes how occasionally boys of 10 and 12 and men of 25 or more could be admitted to the same school (Junod 1927:94). Konde TMCi in northern Mozambique reportedly also took place between the ages of 10 and 16 (Ndege 2007:99). Wheelwright (1905:252) reported that amongst the Venda, Tsonga and Sotho communities living in the

Zoutpansberg area, the common practice was for the chief to give due notice to his people when one of his sons was to be circumcised. His subjects would in turn bring their male relations, ‘big and small’, to undergo the operation with him. Pitje reported that there was no fixed age for admission to Pedi initiation schools in Sekhukhuniland (present day Limpopo) in the 1940s. Here, boys of 6 and 7 could attend at same time as men of 20 and 30. Occasionally some initiates were so young that it was said of them that, ‘they were carried to the lodge’ (Pitje 1950:109).¹⁵

Mönnig (1967), who carried out his fieldwork in Sekhukhuniland between 1960 and 1965, described a transition in the age of Pedi initiates. He says that the normal age of initiates was between 12 and 16 years. However, he observed that many parents, fearing that missions and schools would influence their children against initiation, had begun to send their children at a much younger age, from 6 years onwards. At the same time, older boys who were away working would attend at a later stage, and boys between the ages of 6 and 25 were therefore attending the same initiation school (Mönnig 1967:112). Hammond-Tooke reported that Kgaga boys undergoing circumcision on the lowveld ranged in age from about 6 to 15 years (Hammond-Tooke 1981:37).¹⁶ While Mönnig had questioned whether the young Pedi initiates were sufficiently equipped physically for the strenuous hardships that they had to undergo, Hammond-Tooke said that the young children in Kgaga lodges were not punished, nor did they have to undergo the severest trials. It was even said that the young ones ‘enjoyed’ the moroto (Hammond-Tooke 1981:47). In the case of the Kgaga, a difference in approach may have stemmed from Venda influence on their form of Sotho cultural practice, but this requires further investigation.

Northern Cape, North West, Botswana: age of initiates

Age	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Brown 1890-1920														
Schapera 1931														
Language 1940														
Connolly (2008)		seTswana-speakers: 62% circumcised at 17 and older												

In Bechuanaland, Brown (fieldwork 1890-1920) observed that Tswana initiates were rarely under the age of 17 or 18. The age of admission was not fixed,

¹⁵ Pitje does not indicate whether this had been the case in the past.

¹⁶ These findings were based on fieldwork conducted in 1976 and 1978.

however, and was governed by the time at which a child or near relative of the chief was judged to be ready for the ceremony. Boys of an age near to that of the chief initiate thus entered with him (Brown 1921:421). Willoughby (1909: 231) likewise observed that the age of Tswana initiates was not fixed and that it was 'quite possible for a well-developed youth to take the ceremonies four years before his less fortunate senior'. This suggests that physical development rather than chronological age was used as a prompt for TMC.

In 1931, Schapera's informant put the age of initiation among Kgatla in Mochudi as being between 17 and 21 (Schapera 1978:3). Language (fieldwork 1940) observed that there was no fixed age for initiation among the Tswana-speaking Thlaping in Taung (present North-West Province). There was a minimum age of 12, but no maximum age. Young men working as migrant labourers often delayed their initiation and so again, one could apparently find children of 12 being initiated alongside men as old as 50 (Language 1943:122). Despite the comparatively advanced age of initiates across these areas, a 2003 study undertaken in Botswana found that most respondents reported the preferred age for circumcision as being before the age of 6 (Kebaabetswe 2003:217).¹⁷ The preferred younger age for circumcision was however directly linked to the fact that virtually all respondents felt that circumcision should be performed in a hospital. Research tracking the apparent change in attitude towards the acceptable age for circumcision in Botswana and the reasons for it could also prove rewarding for comparative studies with South Africa, especially as the two countries experienced significantly different colonial histories. In the case of Botswana, it may be of further interest to investigate the cultural relationship between Tswana communities and the Hiechware (San); the only Khoisan group to be recorded as having practised circumcision (at age 12) (Dornan 1925:158 in Schapera 1960:126).

Namibia: age of initiates

Theal reported that, at the turn of the century, circumcision among the Herero in southern Namibia took place between the ages of 4 and 7. He thought this factor important enough to conclude that the early age of circumcision meant that it 'did not have the same signification' as that of neighbouring Bantu groups (Theal 1907:114), meaning it was not associated with puberty and sexual maturity. A recent study of Ovambo TMCI in Kavango, northern Namibia, put the age of initiates at between 9 and 12, while in neighbouring Caprivi, researchers found that Lozi initiation (which did not include circumcision)

¹⁷ Kebaabetswe also notes however that circumcision was no longer widely practiced among these communities.

usually commenced between the ages of not less than ten and not more than 20 years (Iipinge et al. 1999:9; Masule 1999:27). As neither study intentionally addressed the relationship between circumcising and non-circumcising groups in Namibia, further research needs to be done to identify change in the age and other aspects governing practices of TMCI in that country.

Conclusion: age of initiates

Older age at circumcision raises the chance that initiates are already HIV-positive and this fact may be responsible for the negligible effect of TMC on HIV infection risk in South Africa (Connolly et al. 2008). The tendency in all well-documented groups seems to have been towards greater age ranges and older ages at initiation, perhaps driven by the expense associated with initiation in a cash economy where costs were more likely to be borne by young men themselves, or their mothers, than by older men or chiefs. In a cash economy, difficulties in raising money for TMCI may delay circumcision, but commercial pressures from the supply side may also result in a drop in the age at initiation, as reported in the Eastern Cape (Vincent 2008c).

Timing and duration

Time of year: In the Eastern Cape, the duration and timing of the ritual was associated with food supply, and with the availability of time to gather all the required materials (Ngxamngxa 1971:191). In 1858, Maclean (1968:100) says that Xhosa circumcision generally took place ‘about the time of the new year’, which suggests January, but in the same book Dugmore says it took place over six months from the sowing season (September) to the harvest (February / March) (in Maclean 1968:161). Laubscher (1975:96) claims TMCI was originally practised among the Xhosa in spring (September) and autumn (March), but that *abakweta* ceremonies were dependent on the state of the crops, and were postponed in periods of drought. The actual circumcision was timed to be performed at the time of the new moon (Laubscher 1975:98) and also on specific days of the week, a custom which must have arisen under colonialism. Provision of formal schooling has affected the timing of TMCI rituals. Meintjes says it shifted from March, which traditionally coincided with the ripening of the maize crop (and increased wealth and food), to winter and summer school

holidays, most initiations happening in the longer summer holidays between November and February (Meintjes 1998:7).¹⁸

In Lesotho, traditional ceremonies were timed to take place during the dry winter period following the harvest to ensure adequate food supplies (Ashton 1952:47). Collectively and individually, specific fields were set aside and cultivated in advance, the produce of which was earmarked for the school and the beer used in the associated ceremonies (Laydevant 1951:9; Ashton 1952:46). The repeated performance of the rite was strongly associated with securing the success of subsequent harvests. Timing was therefore important to practising communities for both practical and religious reasons. The survival of extremely cold mountainous conditions was an important marker of the initiate's tenacity. The frequency with which TMCI was traditionally held was not affected by a need to incorporate age regiments into the chief's army as it was amongst Sotho groups outside of Lesotho (Lye and Murray 1980:125; Hammond-Tooke 1993:139). Instead, ceremonies were timed around the coming of age of the son or close relative of the paramount chief or one of his headmen and could be delayed if this person was not yet ready (Ashton 1952: 46). Chiefly control over the timing of the ritual gradually diminished. Headmen increasingly approached the chief for permission when they wanted to hold their own school, as did the private operators (or 'owners') of schools who began to determine the timing of the ritual for themselves (Lye and Murray 1980:125; Hammond-Tooke 1981:36). For those living and organising ceremonies on white owned farms, timing was often dependent on the permission of the farmer. In Clocolan (Free State), Zietsman reported that the ceremonies usually took place when the farms were less busy, in early autumn (April-May) or late winter (Aug-Sept) (Zietsman 1972:195).

Food supply and political organisation similarly influenced the timing of the ritual among Sotho, Venda and Tsonga groups in the Limpopo, Mpumalanga and surrounding areas. Ceremonies began when the harvest was ready (April / May) but were delayed during times of drought, war or any other upheaval, natural or otherwise (Wheelwright 1905:252; Junod 1927:75; Pitje 1950:109; Mönnig 1967:113). The formation of age regiments within the TMCI ritual, not common in Xhosa and Lesotho groups, was key to the social and political organization of the Sotho-speaking societies in these areas. A second ceremony, the *bôgwera*, followed the circumcision ritual and seclusion (*bodika*), between one and three years later (Junod 1929; Pitje 1950; Mönnig 1967; Eiselen 1932). Restrictions on available time and resources, as communities became

¹⁸ In Kwazulu-Natal, Krige reported that the initiation of new Zulu regiments, which did not involve circumcision, had always taken place in winter, just after the harvest, when it was cold and dry and food was plentiful (Krige 1974:108).

incorporated into the wage economy, meant that the *bôgwera* gradually ceased to take place. In Sotho-Venda (Lovedu, Kgaga) societies, where the drivers of initiation were not as obviously associated with age regiments but rather with an introduction into the religious mysteries of a mythical being, the performance of initiation rites formed part of the worship of these founding ancestors and were thought to promote abundance and rain, as well as the welfare and happiness of the people (Junod 1905; Krige and Krige 1943; Hammond-Took 1981). Environmental and religio-cultural factors could thus delay or prompt the holding of TMCI: the Lovedu (Krige and Krige 1954:67), for example, revived their *vyali-vuhwera* ceremony in 1938 after an interval of twenty years.

The average period between TMCI schools in these areas during the early to mid-twentieth century was reportedly between 4 and 7 years (Wheelwright 1905:252; Junod 1927: 75; Eiselen 1932:3; Pitje 1950:109; Mönning 1967:113; Hammond Tooke 1981:38). Mönning noted that, among the Pedi, it could not commence during the 7th year because when counting on the fingers, seven is counted on the index finger of the right hand which is used to point at witchcraft (Mönning 1967:113). The relative frequency with which TMCI occurred changed as the need to incorporate a new group of boys into regiments which fought for the chief under the command of his heirs in times of war (against other African groups as well as Europeans) gradually fell away under colonial rule and western cultural influence. Where initiation traditionally centered on the relative of a chief or headman, as it did in Lesotho, it was sometimes necessary to wait for such a boy to attain the appropriate age. Chief Sekhukhune, for example, had a gap of fifteen years from 1948 until 1963 when the last initiation was held as he was waiting for the heir apparent, Mokone, to come of age (Pitje 1950:113). By the 1970s and 80s Hammond-Tooke (1981:38) observed that the average period between Kgaga schools had lengthened to 9 years, and while they were still taking place during the winter, the need to complete them during the school holidays had drastically shortened their duration.

In some of these groups, the timing of the operation was synchronized with the appearance of the new moon or specific stars (Eiselen 1932:6; Hammond Tooke 1981:38). The Tsonga school opened in the month during which the morning star, Ngongomela (Venus), appeared. According to one of Junod's informants, this star preceded the sun and should therefore, 'lead the boys to their new life, from darkness to the light!' (Junod 1927:75).

The timing of TMCI among Tswana groups living in the Northern Cape, North West and Botswana was likewise affected by a variety of factors. According to Willoughby, the chief could set it for any date he liked during February and March, but other months were barred. Willoughby reported that TMCI in these

areas nearly always began with the new moon, Tlhakole, in February (Willoughby 1909:229). Brown says that TMCI in Southern Bechuanaland took place when the harvest was drawing near (Brown 1921:421). Language (1940) says that Thlaping ceremonies in the Northern Cape took place during the three months immediately preceding the harvest, that is, in January or February, rather than following it. Hence the timing of these ceremonies was entirely dependent on the success of the previous year's harvest. *Bôgwera* ceremonies that Schapera observed in Mochudi in the late 1920s either began in January, 'if there had been plenty of rain and the weather was fairly cool,' or in April, 'between the warm and cold seasons' (Schapera 1978:4).

The needs of the regimental age system and the availability of an heir apparent (or close relative) could likewise determine the timing of the ritual (Willoughby 1909; Brown 1921; Language 1940; Schapera 1978). Willoughby (1909) reported that the formation of regiments generally occurred every 4 years. Schapera (1978) says that in the late 1930s the period between the formation of regiments was 6 to 7 years, but by that time, only the two smallest Tswana-speaking groups in the Bechuanaland Protectorate, the Tlokwa and the Maletse, still performed the initiation rites (Lye and Murray 1980:125).

Duration: In the Eastern Cape in the early nineteenth century, Alberti (1968 [1807]:40) suggested that healing of the circumcision wound took a long time (2-3 months) because special attention is paid to stopping the formation of a seal (scab) on the wound. This would have affected the duration of the ritual as the end of the seclusion was timed to coincide with healing of the wound (Alberti 1968:40). Dugmore reported the TMCI ritual taking about six months in the Eastern Cape in the nineteenth century (Maclean 1858 cited in Ngxamngxa 1971: 190). Urbanisation and Christianity reduced the length of the ritual. Laubscher (1937:114), Soga (1931:257) and Brownlee (1927:252) reported it taking 3-12 months among the Thembu (i.e. 3 months starting in Autumn and 12 in Spring), 3-4 months among the Mfengu, and 3-6 months among the Xhosa during the mid twentieth century. Non-Christians and 'Red' Xhosa reported longer periods for the ritual into the 1970s (Raum 1972:141). The length of the ritual in the countryside was between one and six months, with one respondent reporting as long as a year. The initiation ritual lasted for 2-4 weeks in town, and the participation of school or university-going boys was restricted to three weeks (Raum 1972:141). Today, the timing can be even shorter.

Mabille (1906:248) observed boys in Lesotho spending 3 months in the seclusion hut at the turn of the twentieth century, but his informants reported that in 'earlier days' this used to last 6 months in 'earlier days'. According to Ashton (1952:52), the duration was still 3 months in the 1930s and 40s as this was the

perceived minimum time needed for the wound to heal, but it could last longer if food was available. The old lodges had, according to his sources, lasted 6 to 8 months. Laydevant (1951:17), who spent fifty years in Lesotho, observed the practice of preventing the formation of a scab which would explain the need for a seclusion of at least three months. He noted that some organizers of the schools employed western ointments specifically to speed up healing time and increase profits. Lye and Murray (1980:125) observed that the seclusion period in Lesotho in the late twentieth century was 2 months (preceded by a month of preparation). Sotho initiation schools on farms in the Clocolan district in the Free State lasted between 2 and 3 months in the 1970s, but were increasingly being confined to 2 months due to wage labour commitments. As a result 'some initiates left the schools before their wounds were healed' (Zietsman 1972:195).

The duration of Sotho (including Tswana) initiation lodges was reported by a number of observers and participants to have been between 2 and 3 months in the first half of the twentieth century, but that it had been slightly longer in the past (Wheelwright 1905; Willoughby 1909; Brown 1921; Eiselen 1932; Language 1940; Pitje 1950; Mönnig 1967; Schapera 1978). By the 1970s and 80s this had generally dropped to 4 or 5 weeks to coincide with the winter school holidays.¹⁹

Guma says that the Sotho ceremonies organised in Zwelethemba in the Western Cape in the 1950s lasted for 6 months, and it was the collective responsibility of a group of men in charge to ensure that the school remained in session for no less than 5 months. However, by 1984 a school had been run lasting 4 weeks, and those in urban Cape Town ran for 6 weeks. The need to accommodate school and work holidays and the desire of some organizers to maximize profit shortened the time spent on the ritual and meant that, in addition to initiates leaving before their wounds were properly healed, significant content and some of the educational opportunities of the original ritual were lost (Guma 1985:72).

Conclusion: duration and timing

The duration and timing of TMCI has been affected by environmental, political, religio-cultural, and economic factors, but perhaps most of all by the strictures of formal schooling and wage labour. The duration of TMCI has decreased and it has been concentrated into vacation periods for school boys and migrant labourers. This has meant that TMCI takes place in the hottest months of the year and many boys leave circumcision schools before their wounds have

¹⁹ An example of this process is described by Hammond-Tooke (1981:38) with regards to the Kgaga.

healed. The shift to summertime has also caused further problems with dehydration (Meintjes 1998). The use of plastic rather than grass-covered huts for the seclusion of boys, and more strictly enforced ritual restrictions on liquid, have contributed further to increased dehydration during the initiates' convalescence (Meintjes 1998:56). The shorter duration of the ritual has increased HIV risk if the men had sex immediately after 'coming out', as some claimed to do, as their wounds had not yet healed (Van Dijk 2002:38). Also, some of the educational opportunities of the original ritual have been lost due to the shortening of its duration (Guma 1985:72).

Enforced circumcision and violence associated with TMCI

Enforced circumcision

Forced abductions to attend circumcision school were documented in the Eastern Cape in the 1990s (Meintjes 1998:105) and also more recently (Vincent 2008c). This is not a recent development. Descriptions of TMCI in practising African societies from the early years of European contact emphasise the absolute centrality of its performance to an individual's acceptability within the group. In the nineteenth century, Dugmore reported that boys who did not wish to be circumcised were occasionally seized and circumcised by force, although this happened rarely (Dugmore in Maclean 1968 [1906]:161). The uninitiated or uncircumcised were 'despised persons' – deemed perpetual children who were unable to marry or participate in adult male decision-making processes. Circumcision was enforced by each subsequent generation through rigorous social pressure supplemented by force if necessary (Wheelwright 1905; Junod 1927; Krige 1956; Schapera 1978). Few options existed for individuals who did not wish to conform, though accounts mention some boys successfully resisting initiation for a few years before eventually being compelled to attend (Eiselen 1932; Ashton 1952).

In Lesotho, Ashton (1952:47) was of the opinion that boys' fear and reluctance to face initiation and their willingness to act on this fear had been increasing since before the 1930s as a direct result of the influence of opposition towards TMCI voiced by schools, missionaries and chiefs who had been converted. As a result, the 'traditional inducements for initiation needed bolstering'. He cites the example of his 'young helper' who as a child had longed for his turn to be initiated but found when his time came that he was enjoying the Mission school and feared being expelled if he went to the initiation lodge. He therefore ran away from home and had to be brought back and 'pushed' into the lodge.

In the Zoutpansberg, Wheelwright (1905: 254) likewise observed that during the existence of Sotho and Sotho-Venda lodges, gangs of men were sent around to all the villages to induce the uncircumcised to attend 'by force or persuasion'. If they could not be persuaded to attend, says Wheelwright, they were then generally persecuted 'in some way well known to, and effectively carried out by the community'. He describes how both young boys and men over the age of 60 who had been taken into the lodges against their wishes, when released by the authorities, refused in many cases to say what had happened to them beyond that they had been circumcised.

According to Junod's Tsonga informants, in former times, boys who tried to escape from the lodge were hanged on the last day of the school and burnt to ashes, together with all the contents of the lodge (Junod 1927:85). Eiselen's Sotho-speaking informant in the former Transvaal described how strangers encountered in the countryside while the initiates were out hunting would be approached by the lodge fathers, asked to respond correctly to the secret formulae recited, and interned in the camp if it was found that they were uninitiated. The chief would be approached and the stranger would either be circumcised, if the koma-lodge was still 'young', or killed if the koma was 'almost ripe' (Eiselen 1932:11). In the late twentieth century, Guma described how, in cases in which individuals were forcibly interned in Sotho lodges in the Western Cape, the group of men in charge of the school would contribute collectively to the costs of initiating these individuals (Guma 1985: 24).

Violence

Formal training in physical combat was an important part of TMCI schools which produced regiments (Schapera 1956: 383). The regimental organization characteristic of the Zulu, Swazi, and Sotho apparently survived in some form into the late 1950s, but Schapera argues that the disappearance of 'inter-tribal' warfare deprived the regiments of perhaps their most important function, along with the immediate need for training soldiers.

Fighting nonetheless continued to be encouraged as a means of displaying manly courage and skill by some schools, but was regulated in the traditional environment by the elder men in charge who used fighting as a practical means of teaching deference to elders. Pitje describes 'sham fights' held between Sotho initiates and the young men of the last two initiation regiments in which the juniors had to surrender to the seniors. They had to pretend to be defeated, even if not – impressing upon them the fact that in matters of some importance a junior should always give in to a senior. So successful was the teaching of this

value that Pitje claimed he often heard initiated males say, ‘I would have hit him were he not my elder’ (*moxolwane*). This included even the ‘*Amalaita boys*’ in the towns (Pitje 1950:119). The ritual thrashing (Pedi: *dikxating*; Kgatla, *tetemisa*) in order of rank among some Sotho (including Tswana) groups was intended to impress upon the initiates that, whereas previously their leader had been chosen on the grounds of strength and ability to use the *moretlwa* switches (boys’ fighting sticks), from now on rank and status would be decided by birth and social superiority. The action of lashing in order of rank was extremely important for resolving future conflict, in court and elsewhere. Once the question, ‘who was thrashed first?’ was answered, says Pitje, the argument stopped (Schapera 1978[1930s]:4; Pitje 1950:119; Mönning 1967:115).

Stick fighting among initiates was an important part of the TMCI ritual in the Eastern Cape, although not among all groups (see Table 4). According to the Mayers (1970:173), ‘when Red Xhosa talk about education or maturing there is no theme that they harp upon more constantly than “boys settle things by the stick” but “men should settle things by law” (or by words). This is supposed to be the prime lesson of initiation’. However, the ritualized inclusion of stick fighting in TMCI seems to be diminishing in the Eastern Cape.

Violent behaviour, especially stick-fighting, played a central part in the making and manifestation of initiates’ and pre-initiates’ masculine identity. But youth organisation and adult authority set definite limits on its expression. Delius and Glaser (2002) trace the erosion of these forms of control and the infusion of values from an increasingly violent urban world. In the cities, older boys and young men, especially those who did not attend school, formed themselves into social groups that encouraged internal conformity, rebellion and ritual fighting. The socializing framework for what Spencer called ‘ritualised rebellion’ (a key feature of initiation ceremonies) did not exist in the cities and these groups adopted new forms of violent behaviour.

Whereas in the countryside these groups were regulated by the older generation as part of the process of growing up, in the cities they were unsanctioned and beyond the control of parents. And they were regularly involved in anti-social criminal activity, such as mugging or raping ordinary township residents (Delius and Glaser 2002:43).

Conclusion: enforced circumcision and violence

There has always been an element of social or physical coercion associated with initiation although its importance during TMCI may have increased as younger men began to control the ritual and as drinking became more intense due to

changes in the drink of choice (Meintjes 1998). Boys often asserted their masculinity or physical prowess through fighting or endurance of beatings.

Relationship to female initiation

While the initiation of girls (particularly when it involves female genital mutilation) features in the recent biomedical and social science / human rights literature, far more anthropological literature exists on the initiation and circumcision of boys than girls. The material that pertains to TMCI tends to be more detailed than that of traditional female circumcision and initiation (TFCI).

Girls' initiation schools of the scope and size associated with the boys' circumcision lodges were found among the Lobedu, Venda, Pedi, South Sotho and Tswana. The Tswana, Lobedu, Pedi and Venda schools were closely linked with the school held for boys at the same age. The Tswana girls' initiation school formed a new girls' regiment shortly after the boys, the two sharing the same name. Lobedu *byali* for girls takes place at the same time and in conjunction with boy's *buhwera*. Sotho (Pedi) *byale* for girls starts at the close of the boys' *bôgwera*, and the Venda *domba* is a combined school for girls and boys, though more emphasis is placed on attendance of girls than boys (Van der Vliet 1974:233).

By the 1930s when Hunter was conducting her research, the practice of examining girls to test their virginity had come to an end. Girls refused to submit to these inspections and it was suggested that they had been the source of trouble, 'because a girl might be declared by the women who examined her to be no longer a virgin, and her mother would quarrel with them and say that they were lying' (Hunter 1936:184 in Delius and Glaser 2002:35). Female initiation in the Eastern Cape became less prevalent during the 1950s, ostensibly because of cost factors. Although TFCI has not been widespread in South Africa, the advent of the HIV/AIDS epidemic has spurred a re-emergence of virginity testing as a female initiation practice and prevention strategy (George, 2008: 158). Virginity testing continues in areas such as the Transkei (Vincent, 2007) and Kwazulu Natal (Wickstrom, 2010; Leclerc-Madlala, 2010; George, 2008; Taylor et al., 2007) despite the government prohibition.

Regulation of sexual activity

Understanding the reasons for taboos around certain activities during TMCI and how they relate to broader patterns of social activity is essential to understanding patterns of change and stability in their observance.

Social rules of sexual engagement were clearly enunciated in initiation schools, and they marked the passage into marriage and sexual maturity. Perhaps this is one reason why some early descriptions of traditional initiation ceremonies viewed them as ‘sexually immoral’ and ‘obscene’. Missionaries in particular condemned the ritual for ‘inciting the passions’ of the initiates, as well as of the adult community at large (Brown 1921; Wheelwright 1905; Willoughby 1909; Junod 1927). Some Christian Africans also objected to the schools as ‘hot-beds of immorality and sedition’, condemning the traditional forms of limited pre-marital intercourse (Pitje 1950:200). Other observers preferred to underplay the role of sex in TMCI. For example, Ashton, observing TMCI in Lesotho in the early twentieth century, remarks that

Sex was not an important aspect and here initiation functioned not as an immediate introduction and stimulus to erotic experience, but only as an essential but indirect prelude to marriage ... The only sexual instruction given consists of exhortations to avoid adultery. “Smut” and lewdness are not encouraged. (Ashton 1952: 51, 55)

Pre-marital intercourse had long been socially regulated in southern African societies (Krige 1956:110) with a strong emphasis on fertility:

Sex in its pro-creative aspect was conceived of as a mystical force that had to be treated with circumspection and was hedged around with prohibitions. But mere lovemaking was morally neutral, indeed good, and a young person who had no lover was ridiculed. There were special techniques of limited intercourse and pre-marital sex was conducted specifically to avoid pregnancy (Hammond-Tooke 1993:98)

Later writers such as Van der Vliet (1974) suggested that the ‘traditional’ African attitude towards sex did not draw as strongly on the concept of sin as in Western society, but nevertheless proscribed full sexual intercourse before initiation. The songs that were so fiercely objected to by missionaries for their ‘obscenity’ were intended to warn girls of the ridicule that would follow should they find themselves pregnant before marriage (Van der Vliet 1974:237). In their historical analysis of sexual socialisation in southern Africa, Delius and Glaser argued that traditional African communities

... attempted to negotiate the tricky terrain between acknowledged adolescent sexuality and the risk of pre-marital pregnancy through establishing limited forms of sexual release and effective forms of sexual monitoring and management. Adolescents received some guidance in the contexts of family, kin group and neighbourhood, but probably the most striking aspect of these strategies was the central role played by peer group organisation and peer pressure. There were considerable variations in the form that this took. And the role of peer groups was most fully formalised and

recognised in societies which practised male and female initiation (Delius and Glaser 2002:31).

Regulating sexual activity before initiation

Full sexual intercourse prior to marriage was avoided by the practice of intra-crural intercourse; referred to by Zulu groups as *hlobonga* and by the Xhosa as *ukumetsha* (Delius and Glaser 2002:33, 36). By the 1950s and 1960s, *ukumetsha* practices were considered to be unfashionable in towns like East London, where sexual debut was around 15 for girls (Mayer 1961:254-55; see also Longmore 1959:46 on East Native Township in Delius and Glaser 2002: 46). Intra-crural intercourse was also practised among the Venda, Lobedu, Shangana-Tonga, Mpondo, Fingo, Pedi and Mmamabolo (Krige 1956:110). The Swazi practised *kudlalisa*, using a thin piece of goat's skin to cover the vagina (Engelbrecht 1930:21). In all groups, primary responsibility was placed on girls to ensure that the limits were observed, and in some groups they were regularly examined by their mothers to determine whether their virginity was 'intact'. Loss of her virginity brought shame not only on the girl but, as among the Zulu and Mpondo, on her whole age-group, whose members would punish her in turn (Van der Vliet 1974:237). Krige says that the prohibition on pre-marital laxness and the strict control of the *hlobonga* custom in Zulu society was shown clearly by the fact that the worst insult to offer a girl was to call her '*isiGalagala*' or '*isiHobo*', which implied that she had excessive sexual intercourse. Any girl whose chastity was questioned in this way and who could prove otherwise was entitled to seize a head of cattle from the slanderer and destroy anything she wished in their hut. This was subsequently banned under the Natal Code of Native Law (Revised 1932), but the girl was allowed to go to the courts and received a head of cattle if found 'innocent' (Krige 1974 [1936]:106).

Pitje (1948:67–8) described how peer group supervision of the Pedi pre-initiate began at an early age. At adolescence, youths formed pretend marriages and girls would build durable miniature villages where couples then spent most of their time flirting. While these arrangements allowed considerable scope for learning about relationships and for sexual exploration, there was an absolute prohibition on full sexual intercourse between the boys and the girls, and despite the obvious temptations of the situation, boys and girls monitored each other's relationships and leaders reminded others of the limitations that had to be observed. Peers chided boys who were suspected of overstepping the limits, and Pitje says that some were given herbs which caused them to urinate blood and were told that if they had intercourse that even worse consequences would follow (Pitje 1948:67). Likewise, Brown says that Tswana boys were warned against full sexual intercourse prior to initiation. They were told that intercourse among the

uncircumcised had the same connecting effect as when dogs indulged in it. The internal organs of the woman would be drawn out of her (Brown 1921:421).

Fear of physical retribution, ridicule or isolation during initiation acted as an additional deterrent for adolescents who transgressed these boundaries. Krige says that Zulu boys undergoing traditional puberty ceremonies were sometimes threatened with death or expulsion 'to the white people' if they had made a girl pregnant (Krige 1974:93). Boys and girls who were known to have had full sexual intercourse suffered additional humiliation to other initiates, at the hands of both the adult leaders of the schools as well as their peers (Delius and Glaser 2002:32). A boy responsible for making a girl pregnant was subjected to the most severe treatment (Brown 1921; Pitje 1950; Schapera 1978; Delius and Glaser 2002). Among the Pedi, this included being circumcised on a different stone to the other boys – the infamous *tlaba* (Pitje 1950:112; Mönnig 1967:115) and Pitje describes how this boy is

... overburdened with nicknames that have reference to 'a lover of women'. It is to such a one that the cruel practice of pressing his fingers between small sticks is applied. When he misses a tune during singing they say: 'You must be thinking of so-and-so's vagina' and so forth. When they fetch wood he carries a bigger log, or one that has termites in it and is thrashed when he tries to scratch them off (Pitje 1950:122).

Initiation schools, then, rather than encouraging immorality as some early observers believed, in fact regulated the sexual (and other) behaviour of the youth. This they did by punishing previous 'bad behaviour' while simultaneously educating initiates about the appropriate sexual behaviour required of them in the future. Taboos around the sex act were directly related to notions of uncleanness or pollution (Krige 1956:108) and were said to be among the most important because the sex life and function of an individual was believed to influence nature (Krige 1956: 102).

In the early and mid-20th century in the Eastern Cape the TMCI ritual played an important role in regulating the access of younger men to older women, presumably because the ritual was managed by older men. Boys were traditionally not supposed to engage in penetrative sex (especially with women who had borne a child) prior to initiation. Prohibitions on full intercourse become increasingly difficult to monitor or enforce under the social, economic and political changes of the twentieth century. In urban areas of the Eastern Cape, as traditional controls on pre-marital sex lost power in the 1950s and 1960s, and younger men began to control the ritual, some of the sexual taboos fell away. Meintjes (1998:52,56-7) comments that the failure of the boys to observe taboos around sex before and immediately after the ceremony are blamed by insiders for a range of problems occurring today. From a biomedical

perspective, they may raise the chances of contracting an STI and sepsis. Boys who go into TMCI with an STI raise their chances of complications associated with the circumcision, and as the age of sexual debut has been dropping, it is not surprising that complication rates have been rising.

Schapera noted that full sexual relations among unmarried Kgatla youth in Botswana were, by the 1930s, the norm rather than the exception. He argued that many of the forms of organisation and the rites and taboos which had formed part of the process of initiation had atrophied, and that this had a major impact on levels of pre-marital pregnancy. He was told that in the past such instances had been very infrequent, partly as a result of peer group pressures and sanctions. However, by the 1930s the rate of pre-marital births throughout the group was exceedingly high; in the fifteen households he visited in the village of Sikwane, seven contained unmarried women with children (Schapera 1933:73 in Delius and Glaser 2002:37).

Other observers in the 1930s suggested that illegitimate children within Pedi society, for example, were still fairly rare, although Pitje found in the 1940s that incidents of both seduction and pregnancy were not uncommon (Eiselen 1949:42–43 in Delius and Glaser 2002:33). Krige (1943:157) noted that unmarried girls among traditional Lobedu rarely had illegitimate children, and that this was more frequent among the Christians. The Mayers likewise commented on what appeared to them to be a relatively high rate of teenage and pre-marital pregnancy amongst Xhosa ‘school’ communities when compared with that of ‘red’ or traditional Xhosa (Mayer 1961:38). But this contrast between ‘Christian’ and ‘pagan’ might have been most marked in societies where traditional forms of youth organisation retained a degree of vitality. In the Eastern Cape, Hunter commented that among the Mpondo, who had abandoned initiation in the early nineteenth century:

There is much pre-marital pregnancy. Constantly I saw girls with the short skirts of an unmarried women with suckling babies, but I think the proportion of girls who bear children before marriage is about equal in the two [Christian and Traditional] communities (Hunter 1936: 481).

It is clear then that adolescents in traditional societies experienced a comprehensive process of sexual socialisation to which TMCI was an important contributor. Exactly how effective it was in terms of preventing full sexual intercourse or pre-marital pregnancy among adolescents is open to question. As Delius and Glaser observe, there are no nineteenth century records which provide clear answers (Delius and Glaser 2002:33). However, in the twentieth century, while the prohibitions on full intercourse that characterized traditional societies were increasingly disregarded by Christian and non-Christian alike,

peer group pressures that had previously restrained adolescent sexuality now urged youth on to greater levels of sexual experimentation and ‘helped to entrench models of masculinity which celebrated the commodification, conquest and control of young women’ (Delius and Glaser 2002:50).

TMCI nonetheless continued to be an important means through which sexual knowledge was imparted to the youth. In the Western Cape during the 1980s, Guma (1985:25) related how it was believed that a boy was not aware of how he was born as it was taboo for elders to discuss reproduction issues with uninitiated children. Mythical stories, such as the mother being given the child as a gift from the doctor, were apparently related. Through the singing of the *koma* during Sotho-organised TMCI, the elders began to reveal the ‘truth’ about reproduction and the origins of man. Guma says that it was a surprise for the initiates that the elders now called ‘a spade, a spade’ given the fact of social taboo in the everyday use of language related to sexual matters. The initiate was henceforth an adult human being who was compelled to build a family and a nation through his virility (Guma 1985:27). An account of Sotho practice in the Free State, less than ten years before, stated the opposite, arguing that there was never any direct sex education because this would undermine respect for the parents and the *mosuwe* and it was believed that a ‘son’s blood will take him in this direction’ (Zietsman 1972:187). In the twentieth century, what was considered appropriate education around sex, including taboos, became far more open to individual interpretation and contestation between the generations.

Regulating sexual activity during initiation

Taboos on sexual activity during TMCI applied not only to the boys, but to those attending the initiates and the community at large; their ‘uncleaness’ could have a direct effect on the physical health of boys undergoing TMCI.

In the Eastern Cape during the 1930s Laubscher (1937:120) says the prohibition on sexual activity by initiates (*ukumetsha*) during the ritual was more a matter of ‘decency’ than a sin – the idea was specifically to avoid contact with older women (mothers / wives). After the third sacrifice (when the wound had healed), initiates were allowed to receive gifts from their girlfriends through an intermediary. The intermediary, a woman who had given birth to an illegitimate child or been divorced, gave the gifts to the junior *kankata* and they were presented at the *Tshila* dance (1937:127, 129). Gift relationships with girlfriends during the ritual marked the continuity with pre-marital sexual activity, but TMCI also marked a shift towards more formalized sexual relationships that could result in having children. In the 1970s Raum (1972:142) says there was an

absolute prohibition on initiates having sex before their wound was healed, but that it was allowed by some schools after the *ukojisa* rite.²⁰ The teachers (*amakhankatha*) were supposed to enforce this. There seemed to have been more restrictions on adult male sexuality during the TMCI ritual than on boys' sexual activity in the early part of the 20th century in the Eastern Cape. The *ingcibi* and *inkhankatha* were not supposed to have sex while the boys were in isolation (Laubscher 1937:120). Initiates' parents had also been subject to this taboo in the past although few observed it any more by the 1970s (Raum 1972:142). Meintjes (1998:52-3) found that in the 1990s the failure of the *iingcibi* to observe taboos around sex and drinking during the ceremony are blamed for some of the problems occurring today. This emphasis on 'proper' sexual behavior by those conducting the ritual may be an indication of the tension between elders in the society and the increasingly young men conducting the ritual today.

Wheelwright observed that while TMCI schools (Sotho and Sotho/Venda) were being held in the Zoutpansberg, intercourse between husband and wife was forbidden. Furthermore, no business was allowed; work was suspended and disputes, transactions and marriages could not take place. Wheelwright wrote that no man attending the lodge was allowed intercourse with his wife, but followed this statement with the assertion that 'the morals are allowed to become very lax; prostitution is freely indulged in, and adultery is not viewed with any sense of heinousness on account of the surroundings' (Wheelwright 1905: 254). Willoughby (1909) says that he was told over and over again that, of the officiating Tswana regiment, only those who had 'never known women' were allowed to perform the duties of the *makgaye*. He believed, however, that this demand had only been enforced seriously in the past. As far as he could make out, the practice then present among the strictest groups in the area was to demand that only those who had maintained their chastity since the date of their own initiation (approx. 4 years past) should perform the duties of the *makgaye*. It was believed that if an unworthy person performed the duties of the *makgaye*, then the mortality among the neophytes would be great, especially among those from his own *lekgotla*. Hammond-Tooke noted that the second half of the TMCI rite among the Sotho Kgaga, the *bôgwera*, was strongly associated with fertility, and says there is evidence that the rites were accompanied by a period of sexual licence between adult men and women (Hammond Tooke 1981:81).

In Botswana, members of the older regiments who visited the *bôgwera* camp were meant to 'avoid' women during the entire seclusion period (Willoughby

²⁰ In light of more recent practices, it is notable that at this time there was no impression given that this should be a new lover.

1909:232). Brown (1921:423) noted that, should a Tswana initiate require attention, none but the 'ceremonially clean' were permitted to assist him. Cleanness, in this case, consisted of abstention from sexual intercourse for at least a year, and was usually undertaken by the old men 'in whom the fires of passion are dead'. Two Kgatla men whom Schapera interviewed in Botswana in the 1930s told him that members of the age set last formed had to stay at the camp throughout the ceremony and that their great *moila* (taboo) was that none of them 'should sleep at home' (Maswe). Anyone violating the rule, especially by having sexual intercourse, was on his return thrashed or fined an ox (Phiri) (Schapera 1978:9).

Junod said that sexual intercourse was likewise strictly prohibited for all the adult men who acted as 'shepherds' and that breaking this law was believed to kill the uncircumcised. Married people in the village were permitted to have sexual relations, but there was to be no noise and no quarrels between jealous co-wives. If co-wives insulted each other and if this became known in the *sungi* (lodge), the shepherds would come one evening and plunder that village (Junod 1927:80). In Lesotho, Ashton says that certain taboos during TMCI applied to the entire society and were strictly enforced. In the *liphiri* (wolves) practice of the Tlokoa, attendants dressed in flowing grass costumes occasionally "visited" the chief by suddenly appearing in broad daylight near the village, circling round it once or twice, and then disappearing over the hill. Apart from being held up as 'bogeys' to children, they were used to threaten and punish adults who had 'misbehaved', such as the 'dissolute' widow whose hut he witnessed being destroyed (Ashton 1952:51).

One of Schapera's Tswana-speaking informants described a similar form of organized violence, '*rasephiphi*', where *bagokane* were sent into the village at sunset shouting (what was translated as) 'those who are being hurt, those who are being hurt.' Women and children doused every fire with water and rushed into the huts as the *bagokane* ran all over the village, thrashing and swearing at anyone they found in the open, including men coming home from the camp. Special victims were women of whose 'bad and rebellious' conduct husbands had complained in the camp. They entered the compounds of these women, tore down the thatch of the huts and smashed all the pots in the courtyard. They did not go inside the huts, but if any woman came out to protest they beat her severely and insulted her freely, even if she was one of the chief's wives. The affair signaled to the community the 'white' (first) *bôgwera* was approaching its end (Schapera 1978:15).

Seclusion from women

One of the key reasons boys are secluded during TMCI is to effect a separation from older women. This was noted as early as 1807 among the Xhosa (Alberti 1968 [1807]:40; Dugmore in Maclean 1968 [1906]:162). It continues to be an important aspect of TMCI in the Eastern Cape, although this kind of isolation is not as easy in modern urban contexts. Meintjes (1998:52) reported that people blamed the closeness of initiation huts to the township (and consequent visibility to women) as one of the reasons problems arose in the ritual today. Berg (2007) explains the ritual in oedipal terms, as does Laubscher (1975), which may well be significant, but does perhaps underplay the supernatural aspects of the reasoning behind isolation. Raum (1972:140) asked a number of questions in his survey about the purpose of isolation that illustrated the continuing relevance of this taboo – 24 of 54 respondents said it was to separate the boys from women, and women were described both as mother-figures who may harbour evil spirits, and as witches.

The Sotho initiate is believed to be in a dangerous and vulnerable state; this problem was recognised and addressed by practising communities in a variety of ways. Boys undergoing initiation are believed to be especially susceptible to witchcraft and the influence of evil spirits. For this reason, separation from women, who were accused of witchcraft more frequently (but not exclusively), was and continues to be an important aspect of TMCI. The care taken against witchcraft can be seen in the example of precautionary measures taken by the Pedi in relation to initiates' meals. Women of the village were responsible for the preparation of thick, unsalted mielie meal porridge, prepared in special wooden bowls which they carried to a certain place at a safe distance from the lodge. The bowls were then mixed together by the men in charge (*mediti*), so that 'bewitched' or 'cursed' food could never be sent to a particular boy. Boys were also not allowed to eat from these bowls as they had been handled by women. Likewise, during the night, the *mediti* returned the bowls to the village but the women were not allowed to see them before they had been washed lest they see something that had been 'licked by the *koma*' (Mönnig 1967:118).

It was not only the fear of sorcery that drove this taboo. In Lesotho, just a look from the opposite sex was said to be able to bring great misfortune to initiates, and those who failed to follow the taboo (on both sides) were severely punished (Laydevant 1951:15). While the initiates were outside of the lodge, if any woman or uncircumcised person was seen in the distance, the officiating regiment would set up a great yelling (Willoughby 1909:235; Pitje 1950:121). According to Willoughby (1909:234), 'lately deeds of violence were done in the Protectorate because the yelling was not heeded', and in the old days it would

have meant death for the offender and any initiate who allowed himself to be seen by a woman. He also explained the use of the white clay as being partly for making the initiates invisible to women. Mönnig (1967:116) says that any unauthorised person, including women, caught in the neighbourhood of the lodge would be treated 'extremely harshly'.

Seclusion from women continued to be an essential factor in the practice of TMCI in the twentieth century, although it became increasingly difficult to secure and enforce in urban areas, owing to the close proximity of the lodge (*khotla*) to residential areas. Guma (1985:38) uses as an example an incident in 1984, in which a group of men were discussing matters pertaining to the payment of *mesuwe* (teachers) in Langa. The wife of a sponsor overheard the heated discussion directed at her husband and intervened from the back of the council house, replying on her husband's behalf. The meeting was disbanded. For Guma, the incident was an indication of how in the urban areas, the economic status of women as wage-earners affected decision making in matters initially regarded as the prerogative of men (Guma 1985:36). That the fear of women as witches and the resulting need for isolation of the initiates was still current in the mid 1980s is indicated by the fact that those who were expelled from lodges for having had sexual relations with women (or divulging secrets) were thereafter associated with sorcery (Guma 1985: 38).

Few sources exist that could give us an idea of whether seclusion from white women was generally viewed any differently by practising communities. Barbara Tyrell, the ethnographer-artist whose travels in southern Africa lasted from the 1940s to the 1960s, says that when she came across a group of Mpondo initiates near Hole in the Wall, they talked freely with her and her young son and 'at no time has a *kwetha* attempted to conceal his face in my presence, as they must do when near their own women folk' (Tyrell 1968:169). She describes another experience in the Eastern Cape where a group of initiates ensured her of a safe place to park her car overnight and the following morning they were joined by the village headman, his councillors and a group of children who watched as they posed and performed a dance for her. She described how

'The women, who dare not approach, communicated in shrill voices from a safe distance. Obviously I did not rate as one of them, pale of skin and clad as I always was in mannish trousers, shirt and jacket. Occasionally I heard here – as I had done elsewhere – discussion as to my sex, with candid allusions to my underlying shape' (Tyrell 1968:190)

Regulating sexual activity after initiation

Only a few of the historical accounts consulted mention specific taboos on sexual activity for initiates in the period directly after TMCI. Many of these accounts assumed that prohibitions on full sexual intercourse would stand until formal marriage. The newly-initiated Tswana males that Willoughby observed in the former Bechuanaland were under the ‘obligation of chastity’ for four years, or until the next regiment has been initiated. In these ceremonies the beestings (colostrum) of cows that had calved during that time were offered as milk that could only be drunk by virgins or by the *dialogane* (overseers) who had been faithful to their obligation of chastity. If any other person drank the beestings, it was believed that the calf would swell at the knees or die, and there was a danger that the cow would lose its next calf (Willoughby 1909:245).

In societies where TMCI was composed of two consecutive ceremonies, a boy’s sexual activity post circumcision remained subject to monitoring. Pitje says that during the *bôgwera* ritual, carried out a year or two after circumcision, the *mediti* (overseers) led what was known as the *tsêlêtsê* ordeal with the aim of punishing offenders, especially those who seduced girls in the interim. Traditionally, those known to have behaved well were not thrashed as a reward; but in punishing the so-called offenders, Pitje mentions that the *mediti* were ‘inclined to go to extremes’ (Pitje 1950:195). In the 1960s, Mönning likewise observed that during the period that lapsed between the *bodika* and *bôgwera* sessions, the initiates were not allowed to have intercourse with girls. Usually they retreated to the cattle-outposts where they stayed until the *bôgwera* session was convened (Mönning 1967:122).

In the early twentieth century, Junod referred to Tsonga initiates being taught formulae which referred to ‘certain diseases of women, of which not a word is told outside the Ngoma’ (Junod 1927:88). In describing Tswana ritual in Mochudi, Schapera noted that initiates were taught various rules of sexual conduct, ‘because in the old days boys grew up at the cattle posts and knew nothing of women’ (Schapera 1978:14). He says that initiates were warned not to sleep with a woman during her menstrual period, if she was pregnant by someone else, had recently miscarried, or was much older than them. Intercourse with women in these states would allegedly make boys ill and perhaps even cause them to die. They were told not to ‘throw away their seed’ by sleeping with women of other wards or villages. If they impregnated someone outside, they would have to pay compensation to her people, whereas if they ‘made a mistake’ with a woman of their own group ‘they would be treated lightly’ (Schapera 1978:14). This kind of rule seems to protect the rights of older men over ‘their’ women against the possible intrusion of younger men.

Pitje reports that during initiation it was impressed upon Pedi initiates that once they had attained the status of manhood, they should have no dealings (sexual or otherwise) with uninitiated girls. Should an uninitiated girl become pregnant by an initiated man, he could be taken to court and heavily punished because it was said that he has ‘disgraced all men’ by having relations with an uninitiated girl (Mönning 1967:111). Initiates were also warned against the ‘danger’ and ‘impurity’ of a woman during her menstruation through the means of a song (Pitje 1950:122). Researchers in the Caprivi district of Namibia (Masule 1999:29) reported that taboos regarding women were addressed during boy’s initiation, including how to avoid contracting a disease referred to as *kahomo*, the symptoms of which are similar to those of HIV/AIDS. *Kahomo* is contracted only by men following intercourse with a woman who has recently miscarried and not undergone treatment by the elders with cleansing herbs. Herbal powders are rubbed into incisions made on the body during the initiation process to ensure protection against this sexually transmitted disease.

After the ritual, engaging in penetrative sex seems to have been the norm across southern Africa. Circumcision is a cultural ‘passport to sex’ (Vincent 2008) – and this may be underlined by the idea that MC confers immunity to HIV infection. After TMCI men were ‘often required to start immediately to build his own home and to obtain a wife’ (Raum 1972:152). Mabona says (2004:345) that before circumcision Xhosa boys could have ‘more carefree ways and easier access to girls’, although less power in persuading girls to have sex with them (penetrative or not). It is not clear to what extent forced sex played a role in this post-initiation period of freedom for men. Maclean (1968 [1906]:101), reported that, after the wound had healed, men ‘have the special privilege of seizing by force – if force be necessary – every unmarried woman they choose, for the purpose of gratifying their passions’. In the 1970s, one of Raum’s informants told him that ‘today, youths fresh from the initiation lodge tend to fall in love with *amankazana* (unmarried young women who have had a child) and marry them’ (1972:136, 149). This may indicate the specific vulnerability of women who have already been socially marginalized in some way. Meintjes reported that, on returning from ‘the bush’, men feel the need to have sex to ‘test your penis’ (1998:98). Shaw and Meintjes reported that boys specifically sought sex with a woman whom they did not love to ‘clean off’ and ‘take away bad luck’ after TMCI (Meintjes 1998:57). Van Dijk (2002:38) found that some respondents in her Port Elizabeth questionnaire in 2000-2001 said that they had had sex immediately after leaving circumcision school. This pattern has also been observed in Malawi and Kenya (see above).

Use of specific language during TMCI

TMCI is often a secret activity, which makes it difficult for outsiders to research. Instruction in, and use of, a secret language or series of terms following the circumcision of initiates in Sotho lodges in Lesotho and elsewhere was well documented by observers throughout the twentieth century [including Mabilile (1906), Eiselen (1932), Pitje (1950), Laydevant (1951), Mönnig (1967), Ashton (1952), Zietsman (1972), Lye and Murray (1980) and Hammond-Tooke (1981)]. The various ‘laws’ taught to the initiates during their seclusion are communicated in a language, which is by both insider and outsider accounts, very difficult to translate or interpret (Brown 1921:420; Junod 1927:86; Zietsman 1972:187).

Pitje says that this secret language was more or less common among all of the Sotho-speaking groups investigated and supported his theory of the common origin of the rites themselves (Pitje 1950:118). Laubscher documents the use of *hlonipha* language to describe objects and people using new words in Thembu initiation in the 1930s – immediately after circumcision (1937:123). The *hlonipha* dialect of Xhosa, where certain words are avoided, was used during initiation even in township contexts in the 1970s (Raum 1972:53). Meintjes (1998:89) also reports this in the 1990s. Junod reported that, in Tsonga lodges, special expressions were used during the school which he said were either archaic or foreign – for example, all orders were given in a tongue which he said was neither Tsonga nor Sotho, e.g. *Khedi!* (smear with white clay). Actions were not designated by ordinary words but by unusual terms, e.g., the daily smearing of the body with clay was referred to as ‘eating sheep’s fat’ (Junod 1927:80). He was told that the aim of the terminology was to increase the impression of mystery which the rites were supposed to convey to the uninitiated. A more recent interpretation saw the promotion of verbal mysticism in the Tsonga lodges as a means of increasing the power of the officiants (Johnston 1974:330). The use of special terms was not a key feature during Tswana TMCI.

As discussed earlier, many missionaries and other early observers repeatedly criticized the apparently ‘obscene’ language surrounding the TMCI rituals. A number of accounts mention a traditional practice where the initiates’ overseers would address the women who delivered food to the lodge with derogatory language or a rude song, particularly if any of the food previously prepared had not been of a good quality (Wheelwright 1905:254; Junod 1927:80; Pitje 1950:118; Krige 1956:102). In some accounts, women were permitted to respond in equally ‘obscene’ terms (Wheelwright 1905) or they had the right to sing obscene songs when they pounded the mielies for the *sungi* (Junod 1927). Junod found it strange that despite the sex taboos which operated in the

community during TMCI, such obscene (and usually tabooed) language was in the meantime permitted and even recommended. He was one of the earliest observers to identify this contrast (1927:80). On the last day of the Tsonga lodge, when women brought porridge with sauce flavourings (which had been taboo until then), the shepherds were no longer allowed to use insulting words when they received the pots (1927:93).

An account of Sotho (Masemola) TMCI in the former Transvaal by an initiate describes how *mediti* (most recently initiated men) were allowed to shout at any women they encountered while returning empty food dishes to an appointed place; this was not allowed if the woman was accompanied by young maidens, in which case the *mediti* just sang songs (Eiselen 1932:15). Formal and regulated use of taboo language was also described by Hammond-Tooke during Sotho Kgaga TMCI. At the end of the *bogwêra*, *baale* female initiates joined hands with male initiates in a circle and sang a sexually obscene song that made reference to the officers of the initiation school who had been responsible for their many hardships, a practice which appeared cathartic in function (Hammond-Tooke 1981:77).

Food and drink taboos

Initiates in traditional Tsonga and Sotho-speaking communities appear to have subsisted predominantly on a diet of unseasoned/unsalted porridge, with slight variations on what was permitted to supplement this (Junod 1927; Eiselen 1932; Pitje 1950; Mönnig 1967; Hammond-Tooke 1981). Initiates were made to consume large quantities of this porridge. While the diet may have nauseated them at first, Junod observed that initiates quickly became accustomed to it and grew fat. He commented that it was ‘wonderful how their physical appearance sometimes improves during these few months’ (Junod 1927:85). Salt does not appear to have been taboo for Tswana initiates and the evidence suggests that, in addition to porridge, they were also provided with meat (Willoughby 1909; Schapera 1978 [1930s]). Tinned food, coffee, tea or any other food from home was regarded as polluted and thus taboo in the Western Cape among Sotho initiates during the 1980s (Guma 1985:73).

In the Eastern Cape, fluids are usually limited for about 10 days after circumcision, although boys drink muddy water. Laubscher (1937:123) reports that a mixture of water and ground-up ant heaps was given to boys if they bled too much. Raum (1972:153-4) reports that initiates were given a number of cows to keep while they stayed in the veld for 7-12 months during seclusion. Since the early nineteenth century they made sour milk in calabashes (see also Alberti

1968 [1807]:39; 1883 Commission:407, Kropf 1889:125; Laubscher 1937:118; Wilson and Mafeje 1963:105 cited in Ngxamngxa 1971:192), but in some cases the boys were not allowed to drink any milk or water between the circumcision and the third sacrifice (Laubscher 1937:123). Raum says this practice had stopped because of starvation in the villages and the shorter period of seclusion. Other taboos on food, such as beans, remained (Raum 1972:153-4). According to Guma, Xhosa (and Sotho) initiates in the Western Cape in the 1980s were not supposed to utilise water from the townships as it was believed to be polluted by women, but the lodge was alongside a river instead (Guma 1985:33). Meintjes (1998:55) suggests that fluid restrictions were still a key part of TMC in the Eastern Cape during the 1990s, and had in some cases intensified. The presence of infection was ascribed to the wound being ‘watery’ (*umlambo*) and thus resulted often in further restrictions on fluid intake (1998:74).

Consumption of alcohol by those performing the circumcision has been linked to increased complications. The *iingcibi* and *amakhankhatha* had some restrictions on beer and smoking in preparation for the circumcision process (Brownlee 1927 in Ngxamngxa 1971:187). But other parts of the ritual permitted beer drinking. Laubscher describes the traditional beer brewing process conducted by women, but associated with circumcision, among the Thembu (1937:116). He points out that in the township context, sugar was added to grape juice for ‘a highly intoxicating liquor’. Meintjes (1998:52-3, 61, 84) found that drunken *iingcibi* and *amakhankhatha* were blamed for some of the problems occurring today as taboos around drinking and sex had fallen away for them. He also noted that the trend towards drinking brandy rather than *umqombothi* resulted in a higher level of drunkenness (1998:85).

Restrictions on the intake of water by initiates in areas other than the Eastern Cape were only mentioned specifically in a few of the sources, and a pattern is not easily discernable. Wheelwright (1905:253) says that for the first five days after Sotho and Sotho/Venda circumcision in the Zoutpansberg, boys were permitted to drink only as much water as was given to them by the doctors in attendance. Junod identified ‘thirst’ as one of the main trials that Tsonga initiates were supposed to endure, saying that it was:

... absolutely forbidden to drink a drop of water during the whole initiation; boys apparently sometimes succeeded, during their hunting trips, in enticing their shepherds in one direction so that some initiates managed to escape and go to the river to drink but they would be severely punished if caught (Junod 1927:84).

In the 1950s Laydevant said that initiates in Lesotho were not allowed ‘even a drop of water’ immediately prior, during or just after the operation (Laydevant 1951:14). By the 1970s however, Hammond-Tooke reported that Kgaga (Sotho-

Venda) initiates were made to drink plenty of water to counteract the effects of loss of blood at circumcision (Hammond Tooke 1981:42). Guma (1985:74) said that sorghum beer was the only approved beverage during the practice of the Sotho rite in the Western Cape in the 1980s, and that it was taboo to bring any other liquor into the lodge or to attend while intoxicated. He also reported that elders had complained of the 'irresponsibility of the youth owing to the excessive use of intoxicants'. Drunkenness was regarded as inculcating bad manners in the initiates.

Use of foreign objects

In the Eastern Cape in the 1970s, European objects (especially mirrors and caps) were not favoured in the isolation context. An exception was made for knives for eating meat, and about half the informants were prepared to allow for the use of other European objects (Raum 1972:143).

Ashton observed in the 1930s that 700 pounds of meal required weekly for a Tlokoa chief's lodge in Lesotho continued to be ground with traditional implements and transported in traditionally-made bags. European handmills and sacks were taboo, though he noted that iron-cooking pots were permitted (Ashton 1952:50). In the past every item that had been used during the lodge would have been destroyed, but iron cooking pots and blankets were then being returned to the village as they were 'too precious to be wasted; even the boys' skin cloaks are now taken back and given to the younger boys of the village' (Ashton 1952:52). By that time, much of the red ochre used in the ritual was ordinary 'Venetian red' bought from the stores, but Ashton described a practice whereby to make it 'genuine', and to provide a symbolic link with the past, ochre brought from Bopeli (believed to be one of the Tlokoa ancestral sites) was added to it (Ashton 1952:53). Pitje says that in the 1940s blankets and clothes were being used with the permission of the chief in some Pedi lodges, but that such an action was unpopular with conservatives who believed that the suffering of the cold was itself a test of 'manhood' (Pitje 1950:116). At a Lesotho trading store in the 1960s, Tyrell observed a recently returned initiate wearing a pantaloons of folded light blanket treated with what she says he called 'ochre from America' and wearing safety pins and other new items that were 'from America' (Tyrell 1968:93). She was told that initiates lived naked whilst secluded which implies that prohibitions on foreign items were probably stricter during the lodge than in the period immediately after.

Guma cites elders' disapproval of the use of writing material for note-taking by initiates in the Western Cape during the 1980s, as they believed these objects

rendered the lessons too easy. Initiates were meant to listen attentively and to memorize the lessons to develop fully their mental capacity to be creative and to be able to compose their own praise poems and songs without too much assistance from the teachers. Pens and writing material would also violate the taboo on secrecy. Lodges were being located not far from the township's view because organisers could not obtain leased land from neighbouring farmers who feared a cholera outbreak, such as the one which was known to have occurred in Zululand in 1979. Sponsors had to promise to erect latrines for the initiates, but it was taboo for them to defecate in the same place (Guma 1985:73-75).

The circumcision process and associated complications

The cutting of the foreskin

During the circumcision process, a shortened assegai (*umdlanga*) was traditionally used to cut the foreskin (Alberti 1968[1807]:40). In some cases, a knife or scalpel is now used (Meintjes 1998:9) although the use of the assegai is considered more authentic (Vincent 2008c). Meintjes (1998) reports that one informant considered the washing of the assegai as traditional, but there is no mention of sterilising or washing practices in historical accounts (see Ngxamngxa 1971: 187-88). Laubscher (1937:122) refers to cleaning the rust off the blade by doing the first circumcision. In fact, in the nineteenth century, the mixing of the blood of the chief's son with those of the boys before and after him was considered an important part of bonding them as 'blood relations' (Ngxamngxa 1971:193).

The assegai has important ritual significance. Laidler describes the manufacture of the assegai from an iron rasp from which two could be made, although it had to be handmade in the original fashion, the bellows made of hide and the smith 'a pure blooded Bantu' (Laidler 1922 in Gitywa 1976:118). This instrument has an enduring importance as part of the ritual. In Peltzer et al.'s (2008a) study practitioners were trained in using a surgical blade for the operation and provided with blades and gloves, but only 47% of the boys reported being circumcised with these blades (53% were still circumcised with the traditional assegai). There was a greater willingness to use gloves after training: 83% reported that their surgeon had used gloves. The continued use of the assegai is perhaps a sign of its importance as a symbol of the spiritual connection between boy and surgeon. The temperament of the circumcision surgeon was said to magically affect the boys' temperament (Soga 1930 in Ngxamngxa 1971:199), hence the great care taken in the selection of the surgeon.

There seems to have been less reluctance to adopt other instruments of circumcision, even in the early twentieth century, among other circumcising groups. At this time, accounts of the operation in Sotho and Tswana communities mention the use of an 'ordinary knife' for performing circumcision (Wheelwright 1905; Willoughby 1909; Junod 1927; Ashton 1952). Junod (1927:76) said that 'surgeons now use an ordinary European knife; formerly they only had native-made knives'. Brown (1921) mentions the use of either a knife or a spear with a sharpened edge during Tswana TMCI. Eiselen (1932:8) says that among the Masemola (Sotho) the surgeon, an old man, was himself called 'the little knife'. Johnston (1974:330), who carried out research among the Tsonga in the 1970s, mentions a razor-blade being used for the operation. Hammond-Tooke described the person who performed the operation in the 1930s as a 'ritual specialist' who used a 'special knife' to perform the operation (Hammond-Tooke 1981:39).

Junod reports that Tsonga and Sotho candidates in the Zoutpansberg area entered the same lodges and both Wheelwright and Junod mention the operation as being composed of two movements; first the upper prepuce was removed (quickly and apparently with little pain), followed by the lower part and the string, (a longer, more careful and painful operation) (Wheelwright 1905:253; Junod 1927:76). The operation was described as being performed deftly and swiftly (Mönnig 1967; Wheelwright 1905). Zietsman cites an early vernacular account on cutting practice in the traditional past (said to have come from the San or Barwa; although other accounts denied the San circumcised). This practice was called *leripa*, and it entailed cutting away the whole foreskin, and later cutting away the string of flesh under the foreskin (*mosele*), allowing it to be pulled back completely (*kwena* method). These apparently replaced an earlier Sotho method, in legend if not in reality, of removing the testicles and replacing them with rocks (Zietsman 1972:199).

Accounts of Sotho TMCI mention a boy (or boys) of low rank, referred to by Pitje (1950:112) as the 'sacrifice of the lodge', being circumcised first to 'try out the knife' (Eiselen 1932:8; Roberts and Winter 1915:562). Mönnig says that this individual was called *molobi* and was circumcised before the leader in case of witchcraft. During the entire initiation period, in all ceremonies performed according to rank, he preceded the *kgosana* (chief's son) to test the ceremony and cleanse the utensils or apparatus used from any witchcraft (Mönnig 1967:115). One of Schapera's Tswana informants in the 1930s, who knew only of the *bôgwera* through hearsay, said that it had been customary before the circumcision to kill one of the boys 'from a different ward each time'; the doctor apparently then removed some parts of the boy's body and mixed them with other medicines, which he rubbed into cuts that he made on the body of every

other boy immediately before the latter was circumcised (Schapera 1978:8). Another informant stated that the doctor smeared the surgeon's (*rathipana*) knife with *tshitlho* (medicine containing foreskins of previous initiates) each time before it was used. Schapera said that he was not told anything else about the knife (Schapera 1978:7).

During circumcision, boys were not supposed to move or cry out (Laubscher 1937:122; Meintjes 1998:9). Blood was either supposed to drip on the ground or on the kaross (Laubscher 1937:122). In his description of Sotho TMCI on the lowveld during the 1970s, Hammond-Tooke (1981:39) observed that, 'unlike the position among the Nguni, the boy is permitted to wince and even cry out, but not to shed tears'. Ashton likewise mentioned that occasionally a boy had the courage and self-control to tell the men restraining him to let him be and underwent the operation alone. Although such courage was greatly admired, according to Ashton, it was not expected, and that those who flinched were not dishonoured. Their cries were drowned out by the hullabaloo raised by the onlookers (Ashton 1952:49).

Laydevant provided an entirely different account of the situation in Lesotho saying that, if in spite of instructions given to him, the child cried out, the wound was then examined and enlarged 'to intensify the pain', while the rest of the company sang songs to drown out the noise (Laydevant 1951:16). Wheelwright (1905:253) reported that a boy's shrieks or cries were looked upon as cowardly and unmanly, and were disguised by the shouting of onlookers. Pitje says that courage and endurance were emphasized from the moment of circumcision, and that a boy was not supposed to show any sign of pain. For this reason, some of Pitje's informants denied statements by Harries and others that the men in charge made a noise to drown out the cries of the one undergoing the operation; they admitted a noise was made but said that this was intended to scare away women and uninitiated (Pitje 1950:121). Willoughby (1909:233) observed that a Tswana initiate made it a mark of his manhood to lie still without crying or wincing but 'should there be any obstreperousness, the switch is freely and unhesitatingly applied'. Brown (1921:423) said that the initiate usually shrieked with agony, and also mentions the noise of his cries being drowned out by the shouting of the previously initiated. Schapera's informant's confirmed that if the initiate cried, the men who beat him stood around shouting or singing loudly so that the other boys could not hear. He was also held in such a way that he could not stir (Schapera 1978:7).

Among all groups who circumcise in the Eastern Cape, the foreskin and bandages are buried. Ashton (1952: 49) says that the foreskins of initiates in Lesotho were collected, burnt and buried while Laydevant's (1951:16) informant

told him that they were thrown to the ground to be the prey of crows and dogs. Accounts of Sotho TMCIs outside of Lesotho described how the severed foreskins were collected, roasted, powdered and stored in the chief's 'medicine horn' to be used during the next initiation ritual (Eiselen 1932, Mönnig 1967, Pitje 1950). Hammond-Tooke is the only observer to mention a practice among the Kgaga whereby the *thipane* (surgeon) took the foreskin of the first boy to be circumcised (who should be the son of a relative of the chief) and put it in his mouth after rubbing it with a certain herb called *serokolo*. This was said to strengthen him, so that he would not be afraid of the blood of the boys to follow, and he retained this foreskin in his mouth until he had circumcised all the boys which Hammond Tooke (1981:39) observed may have numbered a couple of hundred. Willoughby (1909:233) reported that the amputated foreskin was simply thrown away, but Schapera described in detail the practice of collecting and preserving the foreskins for the chief, so that he was given 'control over the whole of the new age set' and gained a preventative medicine against witchcraft to be used during the next initiation (Schapera 1978:7).

Post-operative care

A variety of traditional post-operative care practices for initiates are described in the literature. In the nineteenth century Eastern Cape, Alberti (1968 [1807]:40) reported that 'certain healing herbs are attached with the help of a broad leaf', but he did not mention a thong tying on the dressing. Both Winkelmann (1790) and Wilson et al. (1952) speak of penis caps and sheaths (*izidla*) rather than dressings tied with thongs (cited in Ngxamngxa 1971:189); Laubscher (1937:116) mentions 'leather for supporting the penis after the operation' which Ngxamngxa (1971:192) interprets as a 'penis sheath', and Paterson (1790) refers to a penis sheath as well (in Ngxamngxa 1971:191). Based on observations in 1960, Gitywa (1970:11) reported the use of two strips of sheepskin with hair removed to make a girdle round the waist (*igqesha*), and the binding for the leaf bandages (*ityeba*). Meintjes notes that in certain cases the hide thong binding the wound was replaced with elastic, sometimes against the advice of fathers, which strangulated blood supply to the penis (1998:25).

Alberti (1968 [1807]:40) suggested that healing of the circumcision wound took a long time (2-3 months) because special attention was paid to stopping the formation of a seal (scab) on the wound. Later commentators reported the use of *izichwe* (*Helichrysum pedunculare*) or *izigqutsu* leaves or onion-like *swadi* (gifbol) bulbs after circumcision among the Thembu, Xhosa, Mfengu and Bomvana (Laubscher 1937:122; Cook n.d., Wilson et al. 1952 in Ngxamngxa 1971:188). Meintjes reports the continued use of *isichwe* and *ishwadi* as dressings in the 1990s (1998:25), but the decreasing skill of the circumcision

surgeon and attendant were blamed on the increasing availability of western medicines as well (1998:87).

In the 1970s, rural informants expressed some reluctance to the use of antiseptic creams except in an emergency; most of them refused outright (Raum 1972:140). Raum (1972:152) says 'Christians prefer such applications as iodine, blue butter, gentian violet, and Vaseline, because they alleviate the pain and hasten healing'. In the same period Gitywa found that some traditional circumcisers used penicillin ointment applied directly to the wound before the traditional leaf bandages were applied, while some parents had injections administered to their children before the circumcision. According to a chemist shop assistant, practitioners used ointments like Exekure healing Ointment, or AT4, which were applied to the leaf bandages and then put on the wound; or they mixed DDT insect powder into an ointment with Blue Seal Vaseline and applied it directly to the wound after circumcision. An alternative was the application of methylated spirits to the wound before dressing with a cloth bandage. This replaced the traditional daily dressing with *Helichrysum pedunculare* leaves (Gitywa 1976:250-1).

In Lesotho, Laydevant said that the wound received no attention for the first eight days, following which a circular piece of cloth was cut out of a sheepskin with a hole in the middle intended to support the penis and to prevent rubbing of the wound. Eight days later the leaders of the school examined the wound, and with a wooden knife, removed the scab and pus that had formed. To aid recovery the doctor then used an ointment made of mutton-fat, powdered lichen and the root of the *kolitsane* (a kind of rhus). When this was insufficient, they also applied a mixture made of red ochre and fat (Laydevant 1951:17). Around the same time, Ashton described how initiate's wounds were sometimes sterilized with brandy, or protected with the cool, smooth *leshoma* leaf. Pain was relieved by passing around a large bowl of medicine some hours after the operation, consisting of roasted butterfat mixed with a powerful narcotic made of *leshoma* bulb. Each initiate ate a handful and within a few minutes fell into a profound stupor, which lasted a day or more and apparently effectively deadened all pain. Every morning at sunrise the boys went to the river to wash their wounds. Those who shrank from 'cleaning themselves properly' were held by the *babineli* while the wound was 'forcibly washed and any pus and dirt scraped away by means of a stick' (Ashton 1952:50).

Wheelwright says that the wounds of Sotho (and Sotho-Venda) initiates in the Zoutpansberg during the early part of the twentieth century were wrapped up for four or five days in leaves possessing 'curative or healing power', and that the patient was not allowed to remove the dressing or apply any form of lotion

(Wheelwright 1905:253). Eiselen's informant denied that the wounds of Sotho initiates in the Transvaal were treated with healing plants, saying that their wounds were neither dressed nor treated with medicine but that they were washed with water to prevent inflammation (they did not use the ordinary term for 'wash', but a secret term) (Eiselen 1932:9). According to Pitje (1950:113) the practice among the Pedi groups he studied was to suspend the penis by means of a string tied around the waist. The string served the same purpose as the *kgolego* of the Bagananoa described by Roberts, which not only acted as a tourniquet but served as a support and kept the bleeding wound away from the scrotum (Pitje 1950:113). He also mentions the use of short kilts during the day to protect the wound while out in the veld, but among the Tau for instance, these coverings had to be left outside of the lodge (1950:116).

Mönnig (1967:116) observed that the wounds would have formerly remained unattended, to heal of their own accord, and boys would have been made to lie on their backs in the shade for the rest of the day following circumcision. After an outbreak of tropical ulcer in 1936, Mönnig reports that the application of antibiotic ointments and penicillin became customary. He also mentions the use of a specially prepared leather skirt (*motsabelo*), presented by each father to his son, to protect the wound from being hurt by grass and shrubs (Mönnig 1967:116). Sotho initiates were told to lie and sleep in a special position on their backs with their legs drawn up to keep the wound from their thighs (Eiselen 1932, Mönnig 1967, Schapera 1978). Sotho-speaking Kgaga in the 1970s still wrapped initiates in leaves, and their penises were kept away from their thighs by being encircled by a grass ring (*marabe*) attached to a grass belt around the waist (Hammond-Tooke 1981:40).

Junod (1927:76) described how circumcised Tsonga males likewise received rings of soft woven grass which they put on their wounds, tying them round the loins with a string. He said that formerly they did not anoint the sore with any medicaments: the boys used only to drink a decoction which was believed to stop hemorrhage (although apparently some had recently begun to use paraffin externally). The *manyabe* (doctor of the school) did not stay in the *sungi* but could be called at any time to administer medicine to the boys who were unwell or whose wounds did not heal properly. Boys who were ill were not made to take part in the hunting trips. However, upon the return of their fellow initiates, they were allowed to fall upon them and beat them for not having come along to help (Junod 1927:80-82). Initiates were led to a pool of water early in the morning and were made to remain there until the sun rose. Junod says that this formed part of the 'trial of cold', but according to one of his informants, this was also said to help the wound to heal (Junod 1927:83). Roberts and Winter (1915:563) say that Pedi initiates were likewise ordered to enter a pool of water

once the operation was over, where they were meant to remain submerged to the neck, while the rest of the boys were brought one by one. This statement was collaborated by Harries (1929:67) but denied by all of Pitje's informants in the 1940s. They argued that after the operation, some of the boys were so weak that they fainted and so could not be made to 'remain in the water submerged to the neck'. Pitje therefore of the opinion that this custom did not exist (1950:113) but it is quite possible that such a practice may have been dependent on local circumstances.

Brown (1921: 423) says that the Tswana took steps to check severe hemorrhage by the application of herbal astringents immediately after the operation. When inflammation was severe, the patient was not allowed to walk about and the pain of the swelling was 'partly alleviated' by a suspensory bandage in the form of a ring which was placed over the penis and attached to a broad band around the waist. One of Schapera's informants in the 1930s told him that, 'immediately after the operation the doctor smeared some medicine (*pheko*) on the boy's penis, to prevent the wound from festering'. If the wound was seen to be bad and bled excessively, the doctor washed it and applied a poultice. Another of his informants, however, said that nothing was put on the cut and there was also no 'doctoring' immediately before the operation (Schapera 1978:7). Kgatla boys remained in the camp for the first four days after the circumcision; many could hardly walk. On the fifth day they were taken to the river to wash their wounds and each *mogokane* who accompanied them had a powder called *mogoke*, supplied by the doctor. After washing, the boys sat about and the *bagokane* walked among them and gave each some of the powder to 'pat' (*phaphathela*) on his wound. It was said that 'the medicine itches, it makes the place sore, it sucks out the water that is on the wound' (Schapera 1978:11). As in the Sotho schools to the east, when sleeping the initiates had to lie on their backs and not on their sides, 'lest they *ithonkga*' (rub the scab off their wounds) (Schapera 1978:14).

Among the Mampana, the newly circumcised were taken down to the river by attendants who made pot-holes in the sand into which the wounds bled. The pot-holes were then covered with sand and the area tabooed – anyone who was found loitering around it was accused of sorcery. It was also taboo in other groups for a man to step on any spot upon which an initiate had been bleeding, and breach of this taboo was punished with a fine of one cow (Pitje 1950:113). A circumcised Tswana boy was led to 'a special spot' where he knelt while the blood dripped from the cut' (Schapera 1978:7).

Complications

Based on the analysis of historical sources, Meintjes (1998:20-21) suggests that septic circumcisions and other serious complications were rare in the past.²¹ It is not easy to track the history of complications associated with TMC in the literature because of the lack of systematic studies and the secrecy associated with problems experienced by boys undergoing the ritual. This arises out of the secrecy surrounding the ritual itself, but also because illness during seclusion was considered a very bad omen and initiates were only taken out of seclusion in cases of very serious illness (Laubscher 1937:125). This pattern was observed by Meintjes (1998:67) in the 1990s as contributing to circumcision-related deaths. Historically, problems arising out of the circumcision (e.g. sepsis) were often blamed on boys themselves rather than on the conduct of the operation. Tightening the thong seems to be a test of manhood, a struggle for control between the initiates and the *amakhankhatha* (1998:61-2). Slowness of wound healing was associated with a history of irregular sexual activity, or misdeeds that were not confessed prior to the circumcision rite (Laubscher 1937:121, 124-5; Meintjes 1998:52; Turner 1915; Nauhaus n.d. and Schweiger 1914 in Ngxamngxa 1971: 199). In the ritual context, the initiate may have been beaten until he confessed this sin, after which his cow-hair necklace was changed and, if deemed necessary, the first sacrifice repeated (Laubscher 1937:121, 124-5).

Complications associated with TMCI today are often ascribed by insiders not to the ritual itself but to urbanization and modernity (Meintjes 1998:72-3). Problems experienced in TMC in urban contexts, and in recent years, may be greater than in the past because of the loss of traditional controls over circumcisers and their work (Laubscher 1937:133; Meintjes 1998:20-21). Laubscher argues (1937:133) that TMCI rites 'performed in town locations lead frequently to septic wounds due to the unhygienic conditions and the absence of ritualistic care exercised under tribal customs'. He suggests (1975:96, 118) that there are itinerant, and by implication less well vetted, *iingcibi* who circumcise weak or mentally ill boys in rural areas and do a truncated ceremony in the urban areas. However, the introduction of western medicines into the ritual to protest against infection may also have been more common in urban areas.

²¹ He cites Barker (1962) on the Hlubi, Turner (1915) on general circumcision practice in southern Africa, and the records of the Fitzgerald manuscripts in the Kaffrarian Museum from the Eastern Cape in the nineteenth century

To some extent, traditional checks on TMCI quality have reduced in number over time. Alberti (1968 [1807]:40) refers to an official of the chief checking that the process of TMCI has followed ritual precepts on the painting of initiates' bodies, and that the wounds were kept clean. This office is not mentioned in later accounts of Xhosa circumcision in the twentieth century, as the role of fathers became more important than that of chiefs in selecting the circumcision practitioners, even in urban areas (Schweiger 1914:58; Laubscher 1937:114-6; Cook n.d.:52-6 in Ngxamngxa 1971:186). However fathers retained some control over who was selected through information networks about the reputations of practitioners. It has been suggested that in female-headed households, such controls were less possible because of the taboos around female knowledge about TMCI; that fathers were often away as migrant labourers; and that nowadays *amakhankhatha* are young and inexperienced as well as abusing drugs and alcohol (Meintjes 1998:53, 84-5). Greater control of the ritual by younger men may also have made it more dangerous by focusing on surviving hardship in an environment of fewer interventions by older men (Meintjes 1998:103).

Laubscher (1937:115) comments that because of his influence on the character of the boys, the '*incibi* must be a man of excellent character and respected by the people ... before a man is elected as *incibi*, inquiries are made as to the results of his previous circumcisions; whether the men are alive, the state of their health, and whether they have become good law-abiding citizens.' On the election of suitable *amakankata*, who dress the wounds, he comments that people need to respect them, they should not have committed a crime, and they require sound knowledge of 'native laws and customs' (1937:115-6), which may also include the customs associated with dressing the wound. Meintjes (1998:84) refers to one *ingcibi* who was beaten for performing an operation incorrectly. But he also refers to a general impression among informants including some *iingcibi* that the level of knowledge and skill in dealing with complications was now lower than in the past, particularly in urban areas. The consequences of the lack of knowledge by surgeons and families about how to manage complications were starkly evident in the deaths of seven Mpondo²² boys during a TMCI ritual in 1996 (Meintjes 1998:104). This incident also indicates significant pressures for the ritual to be reinstated or introduced among groups that interact with other circumcising groups.

Ashton commented that, in Lesotho, the operation was 'usually skillfully performed' and that 'cases of mutilation are said to be rare'. Any misfortunes, including accidents or deaths, were attributed to the use of inferior medicines

²² A group that did not traditionally circumcise.

(Ashton 1952: 49). Pitje quotes Harries as observing that ‘not infrequently does an initiate faint from exhaustion or loss of blood and this is an indication that he has not been a strictly moral young man. Some actually bleed to death, but this rarely happens’ (Harries 1929:67 in Pitje 1950:113). Mönnig observed in the early 1960s that boys ‘occasionally’ died during initiation; but said this happened particularly among young boys, ‘who have to undergo exactly the same treatment as others and frequently cannot stand up to it’, implying that deaths could be as much the result of the number of physical hardships encountered as of the operation itself (Mönnig 1967:119). Schapera noted the opposite during Tswana (Kgatla) TMCIs in the 1930s, saying that ‘the older boys especially, suffered greatly and it was not unusual for one or more of them to die’ (Schapera 1978:7). Zietsman (1972:192) says that if an initiate had to go into hospital during initiation they would be cleansed on return to the school by the ‘*toordokter*’ with *lebetsa* medicine. If there was a death during the initiation school, it usually closed a few weeks early.

Zietsman says that in the traditional areas of Lesotho under colonial British rule, the law *Melao ea Lerotholi* dictated that schools would be inspected after any deaths without reasonable explanations, and that transgressors of the law would be liable for a fine of up to 15 pounds or two months prison (Zietsman 1972:72). The paramount chief of the Pedi and later the Native Commissioner, who were considered to be in charge of all circumcision lodges in the area (Harries 1929:63; Pitje 1950:109), had to inspect the lodges and the health of the boys:

Just as today the government requires a chief to report at the office of the Native Commissioner before opening an initiation school, even so did Sekhukhune, the great. Every chief or headman in the district was required to present to him for inspection and counting, all the boys who were eligible for the school. Similarly after the initiation the young men were brought to him for further inspection as to the state of their health and general conditional. Deaths were reported to him and the chief concerned had to give a satisfactory report as to the causes otherwise he had to pay heavily for his carelessness or negligence of duty (Pitje 1950:109).

On the choice of surgeon, Ashton says that among the Phuthi and other clans in Lesotho, the boys were not accompanied by individual mentors from their own families (as amongst the Tlokoa) but had two or three men for the whole school. They were known as *mosuoe*, though only one of them performed the actual operation and Ashton says that one of them, at least, had to be an authority on local lore and custom (including, perhaps, circumcision practice) (Ashton 1952:51). Roberts and Winter (1915) claimed that the chief and men of the kraal gathered and chose one of their own number as *thipane* (cutter). Wheelwright commented likewise that unlike the Venda, the Sotho had no regular priests or doctors to perform the operation, and it was apparently done by any volunteer

from amongst those present who had been initiated previously (Wheelwright 1905:255).

However, Pitje's informants in the 1940s denied this emphatically, saying that in their country the surgeon should of necessity be an outsider who did not know the boys or their parents. They explained that, in this matter of life or death, the role could not be given to a local man who may have been prejudiced against some of the boys. The people generally looked upon this job as a menial one and it was therefore given to an Ndebele or Tsonga man. So long as the community was satisfied with the performance of a surgeon, it would engage him regularly. Semi-independent sections within the chiefdom were permitted to engage their own *thipane* (Pitje 1950:110). This practice was corroborated by Mönnig (1967:113).

Junod does not discuss the identity of the surgeon in Tsonga TMCI but Johnston says that it was performed by a visiting Pedi medicine man known as *muxeki* (from *ku xeka*, 'to cut with a knife'), who had been 'licensed' by the local chief (Johnston 1974:228). Of Tswana practice, Willoughby (1909:233) says; 'the circumcision is sometimes performed by some of the *makgaye* of the ward to which the boys belong; but more frequently the chief appoints an older man of acknowledged skill to perform the operation for the whole regiment. There is no official name for this man'. Schapera says however that each camp had only one doctor (*ngaka*) and one operator, termed *rathipana*, 'father of the little knife', or *motshola-thipa*, 'knife-bearer'. This man had to be of Kgatla stock and fairly old, and was specially chosen for his known skill and good fortune in castrating cattle. If he proved incompetent or 'unlucky' in his work of circumcising the boys, he would not be used again (Schapera 1978:7).

Junod (1927:85) says that the circumcised were supposed to be prepared to die if their wound did not heal properly and if the *manyabe*'s medicine was not successful. It was absolutely forbidden to mourn over them, even their mothers' were not supposed to cry, and the corpse had to be buried in a wet place to counter the 'heat' generated by the pollution of death. A similar taboo existed among the Sotho; any deaths occurring amongst inmates during the existence of the school were kept secret, the bodies buried quietly in the surrounding vicinity without any shape or form of mourning, and the deceased was looked upon as having simply 'disappeared' (Wheelwright 1905:253). Both Pitje (1950:124) and Mönnig (1967:119) say that deaths in the schools were announced at the end by the method of dropping small gourds containing fat and ochre at the homes of the deceased and it was said in characteristic language that 'they have been eaten by the *koma*'. People were permitted to mourn for them, but afterwards their names became taboo (Pitje 1950:124).

According to Schapera (1978:7), secrecy was similarly maintained among the Tswana when an initiate died while at the school. These shared notions of the requirement for secrecy and taboo where the death of an initiate was concerned have serious implications for determining the extent to which complications and deaths occurred in the past as well as for preventing such occurrences in current and future practice of TMCI. The belief that initiates were not supposed to know the identity of the person who circumcised them also needs to be understood in discussions concerning the responsibility of the operator for complications and deaths (Wheelwright 1905:255; Willoughby 1909:233; Schapera 1978:7).

Conclusion: circumcision and complications

Active pre and post-operative care of the wound (including pain-relief) using both ‘natural’ and ‘supernatural’ methods has always been a part of the TMCI process. Meintjes (1998) suggests that the main medical problems in TMC in the Eastern Cape arise from unsterile wound care, dehydration and the tightness of the thong around the dressing, while the repeated use of a non-sterile blade may transmit HIV and other infections (Peltzer et al. 2008b). Some of these problems have been exacerbated by recent trends (e.g. towards less skilled people tying the thong), while others have potentially always caused complications (e.g. the use of non-sterile blades).

Systematic evidence for historical rates of TMCI-related complications is not available in the sources consulted. Potential complications have however always been acknowledged and addressed in some way by the TMCI process. Although there was a widespread belief that the survival of the operation was itself a mark of one’s manhood, steps were taken to tend to those who fell ill. However, should these efforts fail, the organisers were generally absolved of responsibility as it was believed that such complications may occur if the boys were weak in some way. This would not be the case if it came to light that the person performing the operation had acted negligently or outside of the bounds of ‘tradition’.

It seems that medical assistance is sought more often today when severe complications arise and there is greater pressure on practitioners to ensure, as far as possible, that deaths do not occur. Yet such recourse is still rejected by many practitioners and deaths continue to result from complications because medical attention is sought too late. In part, this is because it is still widely believed to be the fault of the boy who suffers complications, and not the fault of the TMCI practitioner or his assistants. A recent fictionalised account by a Xhosa initiate

describes the social ostracism he suffered, even at the hands of his nurses, because he was admitted to hospital suffering from complications resulting from traditional circumcision (Mgqolozana 2009).

Some TMCI practitioners incorporated aspects of western medicine from the time that they were first introduced, while others rejected western medicine. Some western or biomedical practices may by now have become widely accepted within TMCI practice. But many TMCI practitioners and clients continue to believe that circumcision performed in a hospital, or similar biomedical environment, is not equivalent to one performed in the 'traditional' way.

Educational messages

Brown (1921), in a generally unsympathetic account of Tswana TMCI in the early twentieth century, said that one of the main aims of the school was evidently to teach:

Reverence for antiquity, aversion to change, conformity to traditional custom, and the completeness of Sechuna (Tswana) manhood and womanhood as embodied in circumcision rites ... there must be no change. As things were in the days of long ago, so they are today, so they must remain. A man must do as his forbears did, speak as they spoke. Nor must any question be asked of the elders or any thing strange and new said to them which might reveal their ignorance. To do so is tshita, that is, to ask about or speak of something too great for the younger generation (Brown 1921:426).

Pitje (1950:118) observed that, traditionally, initiates were made to repeat formulae by attendants who were, as far as possible, members of kin. It was believed that a relative would teach the candidate better than a non-relative. The notion of rote learning through repetition was an important aspect of TMCI historically.

The shift from chiefly to parental control changed the main focus to care of parents and obedience to elders in general rather than service to the chief. Educational messages promoted by initiation ceremonies (in songs, or in lectures or exhortations by elders) include the following:

1. **Service to the chief:** After initiation, men could be paid by the chief for work done (Alberti 1968 [1807]:41); and provide their services in war. This was also later linked to wage labour.
2. **Service to parents:** Initiates are told to respect older men and provide for their parents in their old age (Schweiger 1914, Maclean 1858 cited in Ngxamngxa 1971: 195).

3. **Establishing the family:** Circumcision and initiation were a pre-requisite for marriage and setting up a man's domestic establishments and animal husbandry in Xhosa, Mfengu and Thembu society (1883 Commission, Laubscher 1937:133, Pauw 1965:89 cited in Ngxamngxa 1971: 194). Initiates are told to stop doing childish things on release from circumcision school, such as causing girls to become pregnant thinking their father would pay the fine (Laubscher 132 cited in Ngxamngxa 1971: 195). Initiates are also told not to touch another man's wife (1883 Commission, Schweiger 1914, Laubscher 1937, Campbell 1965 cited in Ngxamngxa 1971: 195).

It has been suggested that educational messages in TMCI could reduce HIV risk by regulating sexual activity. What remains unclear, however, is whether this would be within a framework of empowerment for women. On the one hand, a Grahamstown study in 1976 showed that some African men preferred the 'traditional' role of the woman within marriage, which reinforced patriarchal privilege, and gave men freedom from household chores, and greater social, sexual and financial freedom than women (for example, freedom to have many girlfriends). Monogamy and gender equality were associated with 'modern' western marriages (Van der Vliet 1991: 230). On the other hand, there were 'traditional' limitations on pre-marital sex in African society (Delius and Glaser 2002), and 'traditional' sex education within the initiation ritual constrained male sexual behavior, regulated age relationships between men and reduced sexual violence (Vincent 2008a, see also Hunter (1936:476ff cited in Ngxamngxa 1971:186). These restrictions were cast, however, within the patriarchal mode rather than within the notion of gender equality. Reviving them may be of limited utility in reducing gender-based violence, which also contributes to HIV infections.

An MRC policy brief (Jewkes 2009) on the results of research undertaken to understand the prevalence of rape perpetration in a random sample of adult men (1,738 rural, urban and city households in the Eastern Cape and KwaZulu Natal Provinces, aged 18-49 years) reported that rape of a woman or girl had been perpetrated by 27.6% of the men interviewed and 42.4% of men had been physically violent to an intimate partner (current or ex-girlfriend or wife). The researchers found no overall difference between the HIV prevalence of men who had raped women and those who had never raped. In both cases, prevalence of HIV was very high, in excess of 25% among all men aged 25-45 and over 40% among those aged 30-39 years, but the research did find that circumcised males were less likely to be infected. However, men who had been physically violent to a partner on more than one occasion were significantly more likely to have HIV (OR 1.48 95% CI 1.01, 2.17, $p=0.04$). The relationship between violent

behaviour (including rape) and circumcision was not investigated. The reported pervasive belief in a masculinity predicted on marked gender hierarchy and the sexual entitlement of men suggests that educational messages which counter such a view need to be transmitted through as many means as possible; including during TMCI (and TFI) rituals wherever these are practised.

Conclusion: educational messages

The idea that one ‘becomes’ an adult man and gains the right to marry and have sex through participation in a circumcision and initiation ritual was used in the past to develop notions of hegemonic masculinity. In the past, African masculinity may have been defined principally through social controls over the behaviour of young men by older men. These are now increasingly absent, leading to the trend Jewkes (2009) identifies in recent times in which African masculinity is associated with violence against women and is thus a driver of HIV transmission. Changing educational messages during TMCI may assist in promoting education and self-awareness, and in socialising boys to become responsible and caring men in a world affected by high rates of HIV-infection. However these changes cannot be easily effected if young men who have adopted such practices continue to control the content of the education within the ritual. Traditional male circumcision and initiation has always been a ritual that mirrors and often reinforces the power dynamics between age and gender sets in the broader society, and thus in a time of crisis, both the ritual and the social relations that inform it need to be explored as avenues for change.

Conclusions and Recommendations²³

This report has provided a literature review of social science works on traditional African male circumcision in southern Africa 1800-2000, including South Africa, Swaziland, Namibia, Mozambique, Zimbabwe, Botswana and Lesotho. It reviewed the historical practice of TMCI in southern Africa to inform the discussions around MC and HIV prevention, and future research in the area.

The TMCI debate remains highly politicised and polarised today between public health programmers seeking to promote MC and those who wish to promote TMCI. There has been a dearth of meaningful dialogue between the parties

²³ These recommendations draw freely from our own work, Meintjes’ work (1998) and discussions after the seminar in the AIDS and Society Research Unit on 13 August 2009.

which has had negative consequences for the scale-up of MC in preventing HIV infection in southern Africa. This explains the lack of research on TMCI in the MC scale-up process, and the slowness with which traditional practitioners have been involved in the scale-up to date. Understanding the reasons for the impasse is critical in improving HIV prevention strategies in the sub-region.

Representatives of each group tend to respectively defend positive and negative positions based on the cultural importance and health risks associated with the ritual, drawing from differing conceptions of the ethical issues involved. Coupled with a history of poor relationships between traditional African and western biomedical practitioners, this makes it difficult to find a position from which meaningful dialogue might take place. In searching for such a position, we must recognise that practitioners on both sides of the debate have a common interest in promoting the health of the boys involved.

On the one hand, for many health programmers the primary ethical consideration is the right to health, and TMCI is considered to be intrinsically unlikely to contribute to better public health. Insufficient data has been collected to substantiate this claim, although it may well be true. In addition, the human rights discourse around TMCI tends to focus on the right to health defined in biological terms associated with the circumcision act alone. It does not take into account the social and health consequences of failing to undergo TMCI in societies in which this is the norm. There has been too little introspection about the use of human rights discourse in the TMC debate. Proposals for interventions to reduce complications thus often do not take the social context and significance of TMCI into account, and adopt a patronising attitude towards traditional practitioners who are positioned as recipients of knowledge rather than as partners.

On the other hand, for communities who practice TMCI, there is a lot of emphasis on maintaining traditional practice and secrecy, although these goals are not always realised. However, the idea of TMCI as a sacred tradition in itself reduces practitioners' willingness to change and open up to scrutiny from outside, especially as this scrutiny is often hostile. Some TMCI practices encourage complications that affect boys' health. Communities practising TMCI express concern about complications associated with the ritual, but may blame them on the boys concerned because of the symbolic association of the ritual with overcoming mental and physical hardship. This limits the impact of public health education programs to reduce associated health risks if they are designed to instruct people how to make their TMCI rituals more like medical circumcision that takes place in a hospital or clinic.

Most of the debates on TMCI today tend to flatten the story of historical change within TMCI. The colonial archive on TMCI is detailed and extensive, and may be mined for copious information about historical change and continuity through comparative analysis, as we have shown above, while taking account of the bias of past accounts and the ethics of such research. It is notable that current debates about TMCI mirror the politics of earlier discourses. In the social science literature and the broader public domain colonial, anthropology is sometimes dismissed out of hand as irrelevant and biased. However, we found that colonial anthropologists were often sympathetic to the continued practice of TMCI in the same way that older members of practising communities today promote the maintenance of rural TMCI tradition. Public health writing on TMCI today is much less sympathetic, with resonances of early twentieth century missionary complaints about the negative effects of ‘pagan’ practices.

The literature examined in this paper suggests that there has been significant change in a number of key aspects of the ritual over the last 200 years, although its significance as a rite of passage into manhood has remained strong, and has indeed been revitalised among some communities. The literature review suggests that TMCI is deeply influenced by the broader socio-economic environment, and is a thoroughly modern practice in this sense, adjusting constantly to changes in society. The simple fact that change has occurred in the practice over the last 200 years does not, however, indicate that future change prescribed by others will always be possible or acceptable to communities.

This literature review identifies historical changes in specific aspects of TMCI as well as likely drivers of change, suggesting some areas in which change may be more acceptable than others.

TMCI practices reflect developments and occurrences in other parts of social life. Therefore, simply advocating for changes in the TMCI ritual cannot fix broader problems in society. For example, changes in the content of educational messages in the TMCI ritual around issues of sexual socialization could challenge gender-based violence, but shifts in existing messages are part of a broader change in TMCI control and management by younger men. Younger men have taken over some TMCI practices due in part to urban dislocation and unemployment among older men. This broader shift in power relations between younger and older men is expressed within TMCI through more permissive sexual messaging, intensified fluid restrictions placed on initiates by inexperienced assistants, or a shift towards the consumption of brandy rather than beer. These changes are challenged by older TMCI practitioners, but this does not make them easy to change because they are to some extent a symbol of younger men’s authority over the TMCI process. It is thus advisable to link

messaging changes within TMCI to a broader movement of young men organised for the promotion of positive social and health outcomes

Some changes in practice that affect health outcomes from TMCI, such as the shift towards shorter summer-time circumcision rituals, would be difficult to change outside of a broader socio-economic intervention because of school and work-related vacation calendars. The significant changes in age at circumcision over time, although always linked to puberty, suggests that earlier circumcision might be acceptable, but only if families had access to money for circumcision at the correct time.

TMCI communities consider some practices more important to maintain than others because of their associated symbolic values. Continuity in the use of a non-sterile blade may be difficult to change through training, for example, because it is linked to deeper symbolic meanings around the bond between ancestors, circumciser and circumcised boys. Change would require a debate about symbolic value as well as possible health issues associated with changes in the circumcision instrument.

Finally, TMCI has historically been a mark of resistance to modernity, colonialism, and missionary repression. Today, it could even be said to express the independence of young men, whereas in the past it focused on their inculcation into the responsibilities of manhood – to chiefs, parents and relatives. Outsider interventions to change the practice for reasons external to the tradition itself are therefore unlikely to succeed. Any changes to the practice in the future must be driven or at least endorsed publicly by practitioners or community opinion-formers in order to find acceptance among communities.

Rethinking public health messaging

TMCI may not be as efficacious in preventing HIV infection as medical MC, especially if it is done after sexual debut and it considered, subsequent to completion, as a passport to sex. Improving health outcomes for men who choose to undergo TMCI may require some changes in TMCI practice to reduce the risk of complications. This study shows that TMCI has changed over time: in fact, it has been very sensitive to social development and transformation. But this does not mean that people in traditionally circumcising communities will wish to change the practice or its attendant rituals because of public health proscriptions. The idea that the TMCI ritual is unchanging is an important part of beliefs in the power and efficacy of the ritual, and its achievement of social

and spiritual benefits for the individuals involved, as well as the community in general.

This study has demonstrated the largely unacknowledged similarity between missionary discourse and public health messaging about TMCI on the one hand, and anthropological work and the position of traditional leaders on the other. Learning from this, direct censoring of TMCI by health authorities or external regulation may simply encourage the practice to go underground. If and when medical MC becomes broadly acceptable to communities which have in the past supported TMCI, it will probably be taken up in ways that reflect that history.

It is thus very important for public health messaging to be based on a sound understanding of the history, significance and politics of TMCI. The history and politics of health messages affects their take-up by communities. If public health messages are read in the same way as missionary messages, they will be interpreted in a negative light by many people. Opinion-formers from traditionally circumcising communities will thus play a key role in negotiating changes to TMCI practice.

More research needs to be done to explore the epidemiology of complications and social risks associated with medical MC in public health clinics, and the implications of supplanting TMCI with MC. People undergoing TMCI make a risk calculation that includes not only the risk of complications (which are often discounted because they are important in proving manhood), but also the social benefits of undergoing TMCI in certain communities. Public health recommendations against ‘bush’ circumcision do not factor in the social risks of not undergoing TMCI. Biomedical education (e.g. showing that medical circumcision is likely to result in fewer complications) may have a limited effect in face of social ostracism.

Even if large parts of the TMCI ritual are in fact within the public domain and well known to women in a community, the notion that the ritual is secret is also an important part of its social significance; taboos may also be invoked to protect commercial turf or to shut down debate.

Further Research on TMCI

Standard survey-type investigations by nurses into the circumcision status of men circumcised through TMCI will not produce good data. Existing literature on the subject should help researchers to design better methodologies. Further recommendations for research on TMCI include:

- Developing better research methodologies that take into account questions of disclosure, secrecy and differences in the extent of foreskin removal within TMC
- Exploring the ethics of research and interventions in this area
- Epidemiology - comparing complications: TMCI and routine clinic MC
- Documenting actual TMCI practice today (including control and authority and role of single mothers)
- Documenting women's experience of male circumcision
- Documenting male experiences of TMCI, and how this links to broader notions of masculinity, invulnerability, violence and so on
- Comparing TMCI practice in Southern Africa with that elsewhere in Africa, and the world
- Documenting the commercial and professional structure of TMCI practitioners, their knowledge base and their modes of knowledge transfer and how this relates to secrecy
- Exploring the efficacy of interventions to reduce TMCI-related complications and reduce HIV infection rate (e.g. Vincent 2008c)
- Documenting how messages around MC are being interpreted by the public

A note on ethnic identifiers

The existing TMCI literature uses rather outdated notions of African cultural difference that are highly regionalized. It is not easy to interpret this literature within a framework that recognizes the role of colonialism and anthropological works in constructing the 'tribe' (see Figure 2). One of the other problems in the literature is the use of the ethnographic present, which makes it difficult to track historical change except by comparing different accounts of the same group. We have tried to retain references to language groups and sub-groups as mentioned in the literature rather than regional demarcations because with migration these differences seem to be significant influences on TMCI practice (Guma 1985). However this should not be interpreted as taking a view that these groups were discrete ethnographic entities as suggested by some of the sources we have used.

Ethnic demarcations of TMCI practice remain important because specific practices of TMCI are today constructed as part of ethnic nationalism in some cases, marking people out as Sotho versus Xhosa for example (Guma 1985).

They were also probably important to participants of TMCI in the past. Junod (1927:73) said that in Spelonken, Tsonga and Sotho candidates entered the same lodges but that Nkunas (one of the Tsonga-speaking groups) maintained a separate lodge near Leydsdorp. Schapera (1978:6) observed that there were sometimes 'foreign youths' among Kgatla initiates in the 1930s and that each foreigner was looked after by the *motseta* (consul) of his area and put together with the boys of that man's ward. His parents were expected to send corn to help feed him while the ceremony lasted; failing this, they had to give the chief an ox or bags of corn after its termination. In the 1970s, Tsonga boys attended the Kgaga (Sotho-Venda) lodge but sat in a group apart from the others after the circumcision took place. When leaving the lodge at the end of the seclusion period, the Tsonga initiates were readily discernible from their Kgaga fellows by their beaded skirts and headbands (Hammond-Tooke 1981:54).

Apartheid-era ethnic classifications could also mask the relationships between groups. Guma (1985:6) encountered 'problems of classification' when discussing TMCI in the Western Cape; there were bilingual 'Sotho' as well as people officially classified by apartheid administrators as 'Sotho' but who spoke a different mother tongue. There were also Nguni individuals who had married Sotho speaking persons but who did not identify with either Sotho or Nguni culture. It was neither inappropriate then to refer to those initiated through 'Sotho' male initiation rites as exclusively 'Sotho' nor could it be assumed that all those experiencing 'Xhosa' rites were exclusively from Xhosa speaking homes. Guma (1985:22) cites the case of a man who was not permitted to visit his younger brother at a 'Sotho' lodge because he himself had been through the 'Xhosa' rite only. Feeling undermined, he joined a group of Sotho initiates. Upon his return Guma asked him whether there were any profound differences between so-called 'Xhosa' or 'Sotho' initiation practices and all he could say was, 'going through 'Sotho' rites one receives a message (the *kôma*) whereas through Xhosa rites you do not'. The boundaries between groups were therefore both real and imagined; they could be actively constructed or challenged by participants and observers. Practices also changed over time. Krige (1974 [1950]:22) speculated that groups in kwaZulu Natal who were not incorporated into the Zulu, and were scattered by Shaka, traveled far and wide, picking up many 'foreign' customs, including Sotho observances that were then gaining ground in KZN (but she doesn't mention circumcision specifically).

Annotated bibliography

Aggleton, P. (2007). Roundtable: Just a Snip?: A Social History of Male Circumcision. *Reproductive Health Matters* 15(29), 15-21. (A world-focused social history of male circumcision, looking at current biomedical interest in MC for HIV prevention in Africa and arguing against its adoption.)

Ahmed, A., Mbibi, N.H., Dawam, D., & Kalayi, G.D. (1999). Complications of traditional male circumcision. *Ann Trop Paediatr* 19 113-117. (Ahmadu Bello University Teaching Hospital, Zaria, Nigeria. The complications of traditional male circumcision were studied in 48 boys seen between January 1981 and December 1995. Their ages ranged from 3 days to 7 years. Most complications were seen between 1991 and 1995 when surgical fees had been introduced and the number of boys circumcised in the hospital decreased. The authors advocate the provision of adequate and safe facilities to cope with the increasing demand for circumcision.)

Alberti, L. (1810). *De Kaffers aann die Zuidkust van Afrika, Natuur-en Geschiedkundig beschreven*. Amsterdam: Maaskamp. (19th century account dealing mainly with South Nguni subsistence and material culture, domestic and political life, disease and relations with colonists.)

Alnaes, K. (1967). Nyamayingi's Song: An Analysis of a Konzo Circumcision Song. *Africa: Journal of the International African Institute* 37(4), 453-465. (Detailed analysis of circumcision song (and related ritual) of the Konzo in Western Uganda & adjoining parts of the Congo based on fieldwork between 1958 and 1960, and again in 1964.)

Anonymous (2002). The Making of a Man. Mail and Guardian Online. 19 July. <http://www.mg.co.za/>

Ashton, H. (1952). *The Basuto: A study of traditional and modern Lesotho*. London: Oxford University Press. (Ethnography of the Sotho in Lesotho. Fieldwork among Baphuthi and Batlokoa groups during the mid 1930s)

Auvert, B., Lissouba, P., Taljaard, D., Fiamma, A., Geffen, N., & Heywood, M. (2009). Key Facts on Male Circumcision. *South African Medical Journal* 99(1). (Summary of developments / research & trials leading to call for roll-out of medical MC for HIV prevention in Southern Africa. Answers to criticism e.g. behavioural dis-inhibition, resumption of intercourse before wound healing, benefits for women etc.)

Auvert, B., Taljaard, D., & Lagarde, E. (2005). Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. *PLoS Med* 2(11), 298.

Bailey, C., Moses, S., & Parker, C.B. (2007). Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial. *Lancet* 369 643-656.

Bailey, R.C., & Egesah, O. (2006) *Assessment of clinical and traditional male circumcision services in Bungoma District, Kenya: Complication rates and operational needs*. AIDSMark.

Bailey, R.C., Egesah, O., & Rosenberg, S. (2008). Male circumcision for HIV prevention: a prospective study of complications in clinical and traditional settings in Bungoma, Kenya. *Bulletin of the World Health Organization* 86(9), 669-677. (In their study of potential complications in both clinical and traditional settings, researchers concluded that extensive training and resources would be necessary in sub-Saharan Africa before male circumcision could be aggressively promoted for HIV prevention and that the safety of circumcision in communities where it is already widely practised must not be ignored.)

Barnard, A. (1998). Review: Imperfect Interpreters: South Africa's Anthropologists, 1920-1990 by Hammond-Tooke, W. D. *The Journal of Modern African Studies* 36(3), 535-536.

Barrett, F.J., & Whitehead, S.M. (Eds.) (2008). *The Masculinities Reader*. Cambridge: Polity Press. (Introduction to the key debates informing the study of masculinity. The book makes available some of the most important work on a range of subjects including male power; patriarchy; management and organizations; sexualities; gay friendships; sport; intimacy; identity; hegemonic masculinity; violence; schooling; language; homophobia; Black, Latino and Chicano masculinities; families; media; postmodernism; and subjectivity.)

Becker, P. (1979). *Inland Tribes of Southern Africa*. London: Granada.

Beidelman, T.O. (1965). Notes on Boys' Initiation among the Ngulu of East Africa. *Man* 65 143-147. (Very detailed anthropological description of Ngulu boy's initiation ceremonies (including translations of songs / formulae) in East Tanzania. Based on fieldwork during 1962-1963.)

Berg, A. (2007). Can we prevent colonization of the mind? Traditional culture in South Africa. In A.Casement (Ed.), *Who Owns Jung?* London: Karnac Books.

Beyer, G. (1926). Die Mannbarkeitsschule in Südafrika, speziell unter den Sotho in Nord-west-Transvaal. *Z.Ethnol.* 58 249-261. (Useful general account of initiation schools.)

Bloch, M. (1986). *From blessing to violence: history and ideology in the circumcision ritual of the Merina of Madagascar*. Cambridge: Cambridge University Press. (This book provides a detailed description and analysis of the Merina circumcision ritual today, offers an account of its history, and discusses the significance of his analysis for anthropological theories of ritual in general. Bloch explains how, at various times, the circumcision ceremony can be a familial ritual as well as glorification of a militarist and expansionist state, or associated with anti-colonial nationalism. Bloch argues that in order to understand the properties of ritual in general, it is necessary to view it over a longer time scale than anthropologists have tended to do previously.)

Bloch, M. (1992). *Prey into Hunter*. Cambridge: Cambridge University Press.

Blohm, W. (1933). Die Christeliche Familien-Gemeinschaft im Xosa-Volkstum. *Africa* 6 431-455. (Describes traditional puberty ceremonies and marriage usages, notes changes introduced by spread of Christianity, and discusses what Mission policy should be.)

Bohannan, P. (1964). Circumcision Among the Tiv. *Man* 54 2-6. (Anthropologist's account and literature review of TMCI among the Tiv in Benue Valley, Central Nigeria. Based on 26 months fieldwork between 1949 and 1953. Very detailed description of actual operation as well as photographs.)

Bonner, K. (2001). Male Circumcision as an HIV Control Strategy: Not a 'Natural Condom'. *Reproductive Health Matters* 9(18), 143-155. (This paper explores what is known about male circumcision, the risks associated with it, its relationship with sexual health, including HIV and other sexually transmitted infections (STIs), and the potential problems with implementing circumcision as an intervention internationally, particularly in traditionally non-circumcising communities and those where access to medical facilities is limited.)

Bonnner, P. (1983). *Kings, Commoners and Concessionaries: The Evolution and Dissolution of the Nineteenth Century Swazi State*. Johannesburg: Raven Press.

Bottoman, B. (2006). The Experience of Indigenous Circumcision by Newly Initiated Xhosa Men in East London in the Eastern Cape Province. UNISA. (Unpublished Masters Thesis).

Bottoman, B., Mavundla, T., & Toth, F. (2008). Peri-rite psychological issues faced by newly initiated traditionally circumcised South African Xhosa men. *Journal of Men's Health* 6(1), 28-35. (The aim of this paper was to explore the psychological aspects of traditional circumcision as experienced by newly initiated Xhosa men in East London, South Africa.)

Bowa, K., & Lukobo, M. (2006). Male circumcision and HIV in Zambia. *East and Central African Journal of Surgery* 11(2), 66-71.

Boyle, C.V. (1916). The Ordeal of Manhood. *J.African.Soc., Lond.* 15 244-255. (Initiation rituals among La La in Nigeria.)

Brain, J.L., Blake, C.F., Bluebond-Langner, M., Simeon, W.C., Coelho, V.P., Dömötör, T., Gorer, G., Fontaine, J.S.L., Levy, S.B., Loukatos, D., Natarajan, N., Raphael, D., Schlegel, A., Stein, H.F., & Wilder, W.D. (1977). Sex, Incest, and Death: Initiation Rites Reconsidered [and Comments and Reply]. *Current Anthropology* 18(2), 191-208. (Article is an attempt to show why initiation and/or puberty rites occur in so many societies and why they take the form they do, using concepts derived from social and physical anthropology and from psychoanalysis.)

Brandel, R. (1954). The Music of African Circumcision Rituals. *Journal of the American Musicological Society* 7(1), 52-62. (Analysis of circumcision songs of the Babira and Bapere of the North Ituri Forest in the Congo. Translation & recordings.)

Brewer, D.D., Potterat, J.J., Roberts, J., & Brody, S. (2007). Male and Female Circumcision Associated With Prevalent HIV Infection in Virgins and Adolescents in Kenya, Lesotho and Tanzania. *Annals of Epidemiology* 17(3), 217. (Assesses the relation between male and female circumcision (genital cutting) and prevalent HIV infection in Kenyan, Lesotho, and Tanzanian virgins and adolescents. Analyses data from recent cross-sectional national probability sample surveys of adolescents and adults in households, focusing on populations in which circumcision was common and usually occurred in puberty or later. Circumcised male and female virgins were substantially more likely to be HIV infected than uncircumcised virgins. Among adolescents, regardless of sexual experience, circumcision was just as strongly associated with prevalent HIV infection. However, uncircumcised adults were more likely to be HIV positive)

than circumcised adults. Conclusions: HIV transmission may occur through circumcision-related blood exposures in eastern and southern Africa.)

Brewer, D.D., Potterat, J.J., Roberts, J.M., Jr., & Brody, S. (2009). Unhygienic male circumcision procedures and HIV transmission. *South African Medical Journal* 99(1), 11-12.

Brown, J.E. (2002). *Integration of traditional and clinical male circumcision at Chogoria Hospital in central Kenya*. Retrieved from www.rho.org/html/files/men_brown.pdf on 20 July 2006.

Brown, J.E., Micheni, K.D., Grant, E.M.J., Mwenda, J.M., Muthiri, F.M., & Grant, A.R. (2001). Varieties of male circumcision - A study from Kenya. *Sexually Transmitted Diseases* 28(10), 608-612. (The goal of the paper was to document varied techniques of male circumcision in one area of Kenya and the visible results. Researchers interviewed men who had performed or undergone various forms of circumcision. They also did genital observations on a sub-sample of respondents and concluded that asking a man, 'are you circumcised?', is not sufficient.)

Brown, J.T. (1921). Circumcision Rites of the Becwana Tribes. *The Journal of the Royal Anthropological Institute of Great Britain and Ireland* 51 419-427. (Critical description of circumcision and male initiation amongst the Tswana.)

Browne, G.S. (1913). Circumcision Ceremonies among the Amwimbe. *Man* 13 137-140. (Kenya)

Browne, G.S. (1915). The Circumcision Ceremony in Chuka. *Man* 15 65-68. (Kenya)

Brownlee, F. (1929). The in-tonjane ceremony. *Bantu Studies* 3 401-403. (General notes on the ceremony)

Brownlee, F. (1931). The Circumcision Ceremony in Fingoland, Transkeian Territories, South Africa. *Man* 31 251-254. (Detailed description of Xhosa circumcision ritual witnessed by the author in Bawa, Butterworth on the 16th & 17th August 1927.)

Bryant, A.T. (1905). *A Zulu-English dictionary with notes on pronunciation: a revised orthography and derivations and cognate words from many languages; including also a vocabulary of Hlonipa words, tribal-names, etc., a synopsis of*

Zulu grammar and a concise history of the Zulu people from the most ancient times. The Mariannhill Mission Press. (Zulu ethnography and history.)

Bryant, A.T. (1929). *Olden Times in Zululand and Natal: containing earlier political history of the Eastern-Nguni clans.* Longmans, Green and Co. (Detailed account of early Zulu history and ethnography.)

Caldwell, J.C., Orubuloye, I.O., & Caldwell, P. (1997). Male and female circumcision in Africa from a regional to a specific Nigerian examination. *Social Science & Medicine* 44(8), 1181-1193.

Callaway, H. (1870). *The Religious System of the Amazulu.* Springvale: A.J. Blair. (Zulu texts with translations and annotations, on Unnkulunkulu, ancestor worship, diviners & witchcraft.)

Campbell, A.C. (1965). Ubukhwetha among the amaXhosa. *Nada* 9(2), 52-58.

Cape Argus (2009). South Africa: Forced Circumcision - Son Takes Parents On. 11 August.

Carstens, P. (1982). The Socio-Economic Context of Initiation Ceremonies among Two Southern African Peoples. *Canadian Journal of African Studies / Revue Canadienne des Études Africaines* 16(3), 505-522. (An attempt to understand why girls' initiation ceremonies persisted among the Nama in rural areas long after parallel ceremonies for boys had fallen into disuse; yet among the rural Xhosa, boys' initiation has continued to flourish while those for girls have tended to die out or be incorporated into the marriage ceremony. The author was guided by the clues embedded in Nama and Xhosa traditions as well as by a consideration of the roles of contemporary South African economic and political systems.)

Carton, B., Laband, J., & Sithole, J. (2008). *Zulu Identities: being Zulu, past and present.* University of Kwazulu-Natal Press.

Cassels, S., Clark, S.J., & Morris, M. (2008). Mathematical models for HIV transmission dynamics, Tools for social and behavioral science research. *Journal of Acquired Immune Deficiency Syndromes* 47 34-39.

Chabikuli, N.M., & Ogunbanjo, G.A. (2001). The feasibility of performing male circumcision at two public clinics in South Africa. *South African Family Practice*, 23(5), 16-19.

Chadwick, G.C. (1958). Initiation rites among the Basuto. *African World* 9-10 228.

Clare, A. (2000). *On Men: Masculinity in Crisis*. London: Chatto and Windus.

Clark, P.A., Eisenman, J., & Szapor, S. (2007). Mandatory neonatal male circumcision in Sub-Saharan Africa: Medical and ethical analysis. *Medical Science Monitor* 13(12), 205-213.

Coates, A. (1966). *Basutoland*. London: Her Majesty's Stationery Office.

Coates, T. (2005). The Snip that Could Save Many Lives. Johannesburg: *The Star*, 31 October.

Cocks, P. (2001). Max Gluckman and the Critique of Segregation in South African Anthropology, 1921-1940. *Journal of Southern African Studies* 27(4), 739-756.

Cohen, Y.A. (1964). *The Transition from Childhood to Adolescence: Cross-cultural studies in initiation ceremonies, legal systems and incest taboos*. Chicago: Aldine.

Comaroff, J., & Comaroff, J. (1991). *Of Revelation and Revolution: Christianity, Colonialism, and Consciousness in South Africa. Volume One*. Chicago: The University of Chicago Press.

Condor, C.R. (1886). The present condition of the Native tribes in Bechuanaland. *J.Anthrop.Inst.* 16 76-96. (Remarks on tribal divisions, religion and magic, social life and ritual, spread of European material culture.)

Connolly, C., Simbayi, L.C., Shanmugam, R., & Nqeketo, A. (2008). Male circumcision and its relationship to HIV infection in South Africa: results of a national survey in 2002. *South African Medical Journal* 98(10), 789-794. (To investigate the nature of male circumcision and its relationship to HIV infection, an analysis of a sub-sample of 3 025 men aged 15 years and older who participated in the first national population-based survey on HIV/AIDS in 2002 was undertaken. Concludes that circumcision had no protective effect in the prevention of HIV transmission. The high percentage of circumcision taking place after sexual debut is a concern and has implications for the possible adoption of the mass male circumcision strategy both as a public health policy and an HIV prevention strategy.)

Cook, P.A.W. (1931). *Social Organisation and Ceremonial Institutions of the Bomvana*. Cape Town: Juta. (Useful sketch of social and ritual life, but concise and apparently omits too much to be regarded as a standard work.)

Cook, P.A.W. (1934). *The Education of a South African Tribe*. Cape Town: Juta. (Long section on the traditional systems of education among Bomvana, followed by account of educational methods used by White authorities and suggestions for development.)

Corno, L., & de Walque, D. (2007). *The determinants of HIV infection and related sexual behaviours: Evidence from Lesotho*. Policy Research Working Paper .

Crabb, C. (2010). Male circumcision to prevent heterosexual HIV transmission gets (another) green light, but traditional circumcision in Africa has ‘shocking’ number of complications. *AIDS*, 24(1), N1–N2.

Crosse-Upcott, A.R.W. (1929). Male Circumcision Among the Ngindo. *The Journal of the Royal Anthropological Institute of Great Britain and Ireland* 89(2), 169-189. (Observations based on fieldwork among the Ngindo of Tanganyika between 1952 and 1953, including comments on how ritual has changed and photographs of operation.)

Crowley, I.P., & Kesner, K. (1990). Ritual circumcision (Umkhwetha) amongst the Xhosa of the Ciskei. *British Journal of Urology* 66(3), 318-321.

Daily News. (2002). Remaining initiates recovering in hospital. 20 June.

Davis, M. 1997. Indigenous Peoples and Intellectual Property Rights. Research Paper 20, 1996-1997. Australian Parliamentary Library. Accessed at <http://www.aph.gov.au/library/pubs/rp/1996-97/97rp20.htm#EXAMPLES>.

De Bruyn, G., Gray, G.E., McIntyre, J.A., Wesson, R., Dos Passos, G., Martinson, N.A., & Smith, M.D. (2007). Circumcision for prevention against HIV: marked seasonal variation in demand and potential public sector readiness in Soweto, South Africa. *Implementation Science* 2(2). (The public sector delivery of male circumcision in the only public sector hospital in Soweto, South Africa was examined to gauge local capacity to deliver this procedure as an intervention for prevention of HIV acquisition. From July 1998 to March 2006, approximately 360 procedures were performed per annum. Striking seasonal variations and the relatively few procedures performed may create challenges for

program planning, if male circumcision is increased to a level required to have an impact on the incidence of HIV among this population.)

De Heusch, L. (1980). Heat, Physiology and Cosmogony: Rites de Passage among the Thonga. In I. Karp, & C.S. Bird (Eds.), *Explorations in African Systems of Thought*. Bloomington: Indiana University Press.

Deacon, H.J. (2008) AIDS and Heritage Management in South Africa: The Case of Traditional Male Circumcision. ASRU Working paper 08/213.

Delius, P., & Glaser, C. (2002). Sexual Socialisation in South Africa: a Historical Perspective. *African Studies* 61(1), 27-54. (Tracks historical changes in the sexual socialization of African youth in South Africa (including system of initiation), using examples from historical and anthropological literature.)

Denniston, G.C., Milos, M.F., & Hodges, F.M. (2001). *Understanding circumcision: a multi-disciplinary approach to a multi-dimensional problem*. Springer. (Discusses the history of circumcision; documents the physical and psychological consequences of circumcision; presents the latest anatomical discoveries about the male prepuce; analyses the role of circumcision in various traditions; reveals the medical industry's investment in the practice; describes current legislative efforts to protect children from circumcision; and outlines effective, culturally sensitive methods that are being implemented today to safeguard the human rights of at-risk children.)

Dick, B., & Wilcken, A. (2009, June 1—May 2). Traditional male circumcision. Unpublished paper presented at Male circumcision and HIV prevention: operations research priorities. An international consultation, Nairobi, Kenya.

Dilika, F., Afolayan, A.J., & Meyer, J.J.M. (1997). Comparative antibacterial activity of two *Helichrysum* species used in male circumcision in South Africa. *South African Journal of Botany* 63(3), 158-159.

Dilika, F., Bremner, P.D., & Meyer, J.J.M. (2000). Antibacterial activity of linoleic and oleic acids isolated from *Helichrysum pedunculatum*: a plant used during circumcision rites. *Fitoterapia* 71(4), 450-452.

Doyle, D. (2005). Ritual male circumcision: a brief history. *The Journal of The Royal College of Physicians of Edinburgh* 35(3), 279-285. (Comparative general history of circumcision. Includes section on TMCI in Africa, refers to Zulus as a circumcising group.)

Du Toit, D.F., & Villet, W.T. (1979). Gangrene of the penis after circumcision: a report of 3 cases. *South African Medical Journal* 55(13), 521-522. (Three patients with gangrene of the penis after Xhosa ritual circumcision are reported. A review of complications which may follow circumcision is given.)

Dubb, A.A., Melamed, L., & Majodina, M. (1973). African attitudes in town: the search for precision. *African Studies* 32(2), 85-97.

Duncan, P. (1960). *Sotho laws and customs*. Cape Town: Oxford University Press.

Dutton, E.A.T. (1923). *The Basuto of Basutoland*. London: Cape. (Useful, general account, popular tone, good bibliography.)

Earthy, E.D. (1933). *VaLenge Women: The Social and Economic Life of the VaLenga Women of Portuguese East Africa*. Oxford: University Press. (Detailed monograph on this Tsonga tribe, written by a woman, dealing with social organisation, economic life, life history of the individual, religion and magic, folklore and proverbs.)

Eiselen, W.M. (1924). Die seksuele lewe van die Bantoe. *Tydskrif vir Wetenskap en Kuns* 2 165-174. (Discusses sexual morality, with special reference to role of circumcision rites.)

Eiselen, W.M. (1929). *Stamskole in Suid Afrika*. Pretoria: J.L. van Schaik. (Briefly describes puberty rites and age-groupings among various tribes, notably the Bergdama, Venda, Pedi and Thembu, followed by general theoretical explanation and bibliography.)

Eiselen, W.M. (1932). Initiation Rites of the BaMasemola. *Annals of the University of Stellenbosch* x(B 2). (Describes male initiation rite of the Bamasemola, a Sotho tribe of the (former) Transvaal, as given by informant in the vernacular. Original text and translation.)

Ellenberger, D.F. (1912). *History of the Basuto, Ancient & Modern*. London: Caxton Pub.Co. (Detailed history of early Sotho, appendix on manners and customs especially religious practices.)

Ellenberger, D.F. (1938). *A century of mission work in Basutoland*. Morija: Morija Sesuto Book Depot.

Ellenberger, D.F. (1943). *Histori ea Basotho*. Morija: Morija Sesuto Book Depot.

Engelbrecht, A., & Smith, S. (2004). Why do male patients request circumcisions? *South African Family Practice* 46(2), 25-28. (The aim of this study was to explore the motivations and perceptions of patients (mainly Sepedi & Tswana speakers) requesting circumcision at Kalafong Hospital, Atteridgeville, Pretoria. The themes that were identified were cultural acceptance, fear of mountain school, improved intercourse, prevention of disease and improved hygiene.)

Engelbrecht, J.A. (1930). Swazi Customs Relating to Marriage. *Annals of the University of Stellenbosch* viii (B 3). (Briefly mentions some sexual practices, including *kudlalisa*.)

Engelbrecht, J.A. (1930). Swazi texts with notes. *Annals of the University of Stellenbosch* VIII B,2), 21. (Taboos, hlonipha, puberty rites. Original texts with translations.)

Fairclough, T.L. (1904). Notes on the Basutos, their history, country, etc. *J.Afr.Soc* 4 194-205. (Notes on initiation schools.)

Farrer, J.A. (1879). *Zululand and the Zulus: Their History, Beliefs, Customs, Military System, Home Life, Legends, Etc., Etc., and Missions to Them*. Kerby & Endean.

Fehr, W. (1968). *Ludwig Alberti's Account of the Tribal Life and Customs of the Xhosa in 1807*. Cape Town: A.A. Balkema.

Fourie, H.C.M. (1921). *AmaNdebele van Fene Mahlangu en hul religieus-sosiaal leven*. Zwolle: La Riviere & Voorhoeve. (General account on religion, social life, organization and taboos.)

Fourie, L. (1926). Preliminary notes on certain customs of the Hei//om Bushmen. *Jl.S.W.Afr.Sci.Soc.* 1 49-63. (Contains material on puberty ceremonies, marriage.)

Franz, G.H. (1931). Some customs of the Transvaal Basotho. *Bantu Studies* 5.

Franz, H.M. (1929). Mädchenbeschneidung in Nord-West Transvaal. *Die Brücke*, 6, Wiss. Beilage No.2. (Notes on Sotho girls' initiation, apparently contained much new information on the subject.)

Funani, L. (1990). *Circumcision among the AmaXhosa. A Medical Investigation*. Skotaville: Braamfontein.

Fuze, M.M. (1922). *Abantu abamnyama, lapa bavela ngakona*. Pietermaritzburg: City Printing Works.

Fuze, M.M. (1979). *The Black People and Whence They Came: A Zulu View*. Pietermaritzburg: University of Natal Press. (Fuze was a Christian convert writing at the turn of the century who had a lifelong association with Bishop Colenso which started at his mission station at Ekukhanyeni. *Abantu Abamnyama* (The Black People) possibly one of the first books written in an African language in Natal giving an African view of history & contact with Europeans.)

Galliard, G. (2004). *The Routledge Dictionary of Anthropologists*. London: Routledge.

Garenne, M. (2006). Male Circumcision and HIV Control in Africa. *PLoS Medicine* 3(1), e-0144. (Paper argues that even though large-scale male circumcision could avert a number of HIV infections, theoretical calculations and empirical evidence show that it is unlikely to have a major public health impact, apart from the fact that achieving universal male circumcision is likely to be more difficult than universal vaccination coverage or universal contraceptive use.)

Gay, J. (1986). "Mummies and Babies" and Friends and Lovers in Lesotho. *Journal of Homosexuality* 11(3), 97-116. (This paper examines institutionalized friendship among adolescent girls and young women in southern Africa. Lesotho's economy is based on migrant male labour, which leaves the women dependent on male earnings or subsistence from the land, and also creates unstable marital relations. Young girls in the modern schools develop close relationships, called 'mummy-baby' with slightly older girls. Sexual intimacy is an important aspect of these relationships. Mummy-baby relationships not only provide emotional support prior to marriage, but also a network of support for married and unmarried women in the new towns or schools, either replacing or accompanying heterosexual bonds.)

George, E. (2008) 'Virginity Testing and South Africa's HIV/AIDS Crisis: Beyond Rights, Universalism and Cultural Relativism Toward Health Capabilities', in *California Law Review* Vol 96: 1447

Gitywa, V.Z. (1970) Initiation among the Xhosa at Ncera near Alice. *Fort Hare Papers* 4(4), 9-24.

Gitywa, V.Z. (1976) Male Initiation in the Ciskei: Formal Incorporation into Bantu Society. Fort Hare University. (PhD) Literature & Philosophy. (Initiation among the Xhosa in the Ciskei as a 'social-cultural mechanism for the formal incorporation of their male members into the broader structure of Xhosa society.' Attempt to evaluate how far male initiation is still valued and functional in the 1970s compared to the past.)

Gluckman, M. (1949). The Role of the Sexes in Wiko Circumcision Ceremonies. In M.Fortes (Ed.), *Social Structure: Studies Presented to A. R. Radcliffe-Brown* (pp. 145-167). Oxford: Clarendon.

Gluckman, M. (1962). Les rites de passage. In M.Gluckman (Ed.), *Essays on the Rituals of Social Relations* (pp. 1-52). Manchester: Manchester University Press.

Gollaher, D.L. (2000). *Circumcision: a history of the world's most controversial surgery*. New York: Basic Books.

Gordon, R. (1988). Apartheid's Anthropologists: The Genealogy of Afrikaner Anthropology. *American Anthropologist* 15(3), 535-553.

Gottschling, E. (1905). The Bawenda: a sketch of their history and customs. *F.Roy.Anthrop.Inst.* 35 365-386.

Gounden, S. (1990). The Morbidity Associated with Traditional Circumcisions. *South African Medical Journal* 78(12), 762.

Gounden, S. (1990). The morbidity associated with traditional circumcisions. *South African Medical Journal* 78(12).

Grant, E., Brown, J., Michen, K., Grant, A., Manuthu, E., & Njeru, J. (2004). Seizing the Day: Right Time, Right Place, and Right Message for Adolescent Male Reproductive Sexual Health: Lessons from the Meru of Eastern Province Kenya. *International Journal of Men's Health* 3(3), 189-196.

Grant, S. (1982). The revival of the *bôgwera* in the Kgatleng: Tswana culture or rampant tribalism? A description of the 1982 *bôgwera*. *Botswana Notes and Records* 16, 7-17. (Circumcision was largely abandoned in Botswana during the 19th and 20th centuries through the influence of western medical missionaries. The missionaries cited concerns about unhygienic conditions, but also feared the

political consequences of large male gatherings in what was at the time a British protectorate.)

Gray, H., Kigozi, G., Serwadda, D., & et al. (2007). Male circumcision for HIV prevention in young men in Rakai, Uganda: a randomized trial. *Lancet* 369 657-666.

Green, E.C. (1993). Indigenous African healers promote male circumcision for prevention of sexually transmitted diseases. *Tropical Doctor* 23(4), 182-183.

Green, E.C. (1994). *AIDS and STDs in Africa: Bridging the Gap Between Traditional Healing and Modern Medicine*. Boulder: Westview Press.

Guma, M. (1985). *'Sotho' Male Initiation Rites in an Urban Setting*. Bachelor of Social Science (Honours) in Social Anthropology, University of Cape Town. (Honours thesis on Sotho initiation in urban setting of Zwelethemba (Worcester) and Langa, Gugulethu & Nyanga in the Western Cape to show how the advent of capitalist relations of production and the apartheid policy of separate development invariably changed the notion of initiation rites as a social fact.)

Guma, M., Jama, Z., & Guma, W. (2009). A Situational Analysis of Sites for Male Initiation Schools Location in the Western Cape Province. Western Cape Department of Cultural Affairs and Sport.

Guma, S.M. (1965). Some aspects of circumcision in Basutoland. *African Studies* 24(3-4), 241-251.

Hallett, T.B., Singh, K., Smith, J.A., White, R.G., Bu-Raddad, L.J., & Garnett, G.P. (2008). Understanding the impact of male circumcision interventions on the spread of HIV in southern Africa. *Plos ONE* 3(5), e2212. (Three randomised controlled trials have shown that circumcision of adult men reduces the chance that they acquire HIV infection. However, the potential impact of circumcision programmes – either alone or in combination with other established approaches – is not known and no further field trials are planned. Used a mathematical model, parameterised using existing trial findings, to understand and predict the impact of circumcision programmes at the population level. Results indicated that circumcision will lead to reductions in incidence for women and uncircumcised men, as well as those circumcised, but that even the most effective intervention is unlikely to completely stem the spread of the virus.)

Hambly, W.D. (1935). Tribal Initiation of Boys in Angola. *American Anthropologist* 37(1), 36-40. (Anthropologist's account of initiation in Angola,

focusing particularly on changes in the ceremony and relations between neighbouring groups.)

Hammond-Tooke, D. (1993). *The Roots of Black South Africa*. Johannesburg: Jonathan Ball Publishers.

Hammond-Tooke, W.D. (1958). The attainment of adult status among the East Griqualand Bhaca. *African Studies* 17(1), 16-20.

Hammond-Tooke, W.D. (1962). *Bhaca Society*. Cape Town: Oxford University Press.

Hammond-Tooke, W.D. (1970). Tribal cohesion and the incorporative process in the Transkei, South Africa. In R. Cohen, & J. Middleton (Eds.), *From Tribe to Nation in Africa*. Scranton: Chandler.

Hammond-Tooke, W.D. (1974). *The Bantu-speaking peoples of Southern Africa*. London: Routledge & Kegan Paul.

Hammond-Tooke, W.D. (1981). *Boundaries and Belief: The Structure of a Sotho Worldview*. Johannesburg: Witwatersrand University Press. (Anthropologist's account of five and a half months spent among Sotho speaking 'Kgaga' of the Lowveld between 1976 and 1978, with emphasis on the traditional cosmological system and worldview of the Sotho in general.)

Hammond-Tooke, W.D. (1997). *Imperfect Interpreters: South Africa's Anthropologists, 1920-1990*. Johannesburg: Witwatersrand University Press.

Hargrove, J. (2008). Migration, mines and mores: the HIV epidemic in southern Africa. *South African Journal of Science* 104(1/2), 53-61. (The paper argues that the seriousness of the HIV epidemic in southern and eastern Africa has its roots in the 19th century—in the employment practices instituted on mines, farms and in cities, where millions of men have, ever since, lived apart from their families for the greater part of each year. This destruction of the family unit was a sociological disaster waiting for the arrival of HIV. Addressing this breakdown of the family and the study of the epidemiological consequences of oscillatory migration patterns is as, if not more, important as the roll-out of medical circumcision.)

Harries, C.H.L. (1906). *Handbook of Sepedi Law and Custom*. Pretoria: Government Printer. (Detailed description of marriage laws, initiation schools, ritual belief and practice.)

Harries, C.H.L. (1929). *The laws and customs of the Bapedi and cognate tribes of the Transvaal*. Johannesburg: Hortors.

Harries, P. (1981). The Anthropologist as Historian and Liberal: H.A. Junod and the Thonga. *Journal of Southern African Studies* 8(1).

Heald, S. (1986). The Ritual Use of Violence: Circumcision among the Gisu of Uganda. In D.Riches (Ed.), *The Anthropology of Violence*. London: Blackwell.

Heald, S. (1998). Isaac Schapera: A bibliography. *Pula: Botswana Journal of African Studies* 12(1&2).

Hellman, E. (1935). Native life in a Johannesburg slum yard. *Africa* 8 34-62.

Hellman, E. (1948). Rooiyard: A Sociological Survey of an Urban Native Slum Yard. *Rhodes-Livingstone Papers No.13*. Cape Town: Oxford University Press.

Hellsten, S.K. (2004). Rationalising circumcision: from tradition to fashion, from public health to individual freedom - critical notes on cultural persistence of the practice of genital mutilation. *Journal of Medical Ethics* 30(3), 248-253.

Hlangu-Ketwa, L.T.P. (2008). Rituals and Poverty: Social Change in Eastern Pondoland. *Confronting Social Change in Africa: Reflections on the Life, Work and Legacy of Monica Hunter Wilson*. Monica Hunter Wilson Centenary Conference.

Hodgson, M.L., & Ballinger, W.G. (1932). *Britain in South Africa: (No.2) Bechuanaland Protectorate*. Lovedale: Lovedale Press.

Hoernlé, A.W. (1918). Certain Rites of Transition and the Conception of !Nau among the Hottentots. *Harvard African Studies* 2 65-82.

Hoernlé, A.W. (1925). The Social Organization of the Nama Hottentots of Southwest Africa. *American Anthropologist* 27(1), 1-24.

Hoernlé, A.W. (1931). An outline of the Native conception of education in Africa. *Africa* 4 145-163.

Hoffman, C. (1914). Die Mannbarkeit-Sschule der Bassutho im Holzbuschgebirge Transvaals. *Z.KolSpr* 5 81-112. (Detailed account of circumcision schools; Sotho texts, with translations and occasional notes.)

Holdredge, C.P., & Young, K. (1927). Circumcision Rites among the Bajok. *American Anthropologist* 29(4), 661-669.

Holub, E. (1893). Die Ma-atebele (Rhodesia). *Zs.Ethnol* 25 177-206.

Hrды, D.B. (1987). Cultural Practices Contributing to the Transmission of Human Immunodeficiency Virus in Africa. *Reviews of Infectious Diseases* 9(6), 1109-1119.

Hunter, M. (1932). Results of culture contact on the Pondo and Xosa family. *South African Journal of Science* 29 681-686.

Hunter, M. (1933). The effects of contact with Europeans on the status of Pondo women. *Africa* 6 259-276.

Hunter, M. (1979). *Reaction to Conquest: Effects of Contact with Europeans on the Pondo of South Africa*. Cape Town: David Phillip.

Ipinge, E., & Shitundeni, J. (1999). *Initiation Rites in Kavango (Namibia)* Part 1. 29. Windhoek: University of Namibia, Multi-Disclipinary Research Centre (MRC), Social Sciences Division.

Jacottet, E. (1896). Mouers, coutumes et superstitions de BaSouto. *Bull.soc.géog.* 9 107-151. (Includes puberty rites, treatment of disease, ritual purifications, translated largely from Sekese's book.)

Jacottet, E. (1941). *Litsomo tsa Basotho: Buka ea bobeli*. Morija: Morija Sesuto Book Depot.

Jacques, A.A. (1931). Notes on the Lemba tribe of the Northern Transvaal. *Anthropos* 26 245-251.

Jager, E.J. (1964). Die tradisionele seksuele sedelikheid van die Suid-Afrikaanse Bantoe: 'n kruis-kulturele ondersoek. *Nederduits Gereformeerde Teologiese Tyds* 5(4), 226-241.

Jansen, G.J. (1966). Some observations about ritual mutilation in a Transkei mission hospital, with special reference to the ingqithi custom. *African Studies* 25(2), 73-81.

Jaspan, M.A. (1953). A sociological case study: communal hostility to imposed change in South Africa. In P.Duopp (Ed.), *Approaches to Community Development*. The Hague: van Hoeve.

Jewkes, R., Dunkle, K., Nduna, M., Levin, J., Jama, N., & Khuzwayo, N. (2004). *Traditional male circumcision and initiation into manhood: Legal, health and environmental perspectives*. Gonubie, Eastern Cape: Impilo ya Bantu Health and Development Projects.

Jewkes, R., Sikweyiya, Y., Morrell, R., & Dunkle, K. (2009). *Understanding men's health and use of violence: interface of rape and HIV in South Africa*. MRC Policy Brief.

Joest, W. (1884). Bei den Barolong. *Das Ausland* 57 461-465.

Johnston, T. (1974). Secret Initiation Songs of the Shangana-Tsonga Circumcision Rite: A Textual and Musical Analysis. *The Journal of American Folklore* 87(346), 328-339. (Analysis of meaning and musical structure of secret initiation songs. Importance of music in incorporating & transmitting stories of social processes within Tsonga culture.)

Jolly, P. (1996). Symbiotic Interaction between Black Farmers and South-Eastern San: Implications for Southern African Rock Art Studies, Ethnographic Analogy, and Hunter-Gatherer Cultural Identity. *Current Anthropology* 37(2), 277-305.

Jones, N. (1921). Initiation rites among the Matabele (Rhodesia). *Man* 21 147-150.

Junod, H.A. (1908). The Balemba of the Zoutpansberg (Transvaal). *Folklore* 19(3), 276-287. (Ethnography written while at the Swiss Mission, Shilouvane, Zoutpansberg. Concerned mainly with the origins of the 'Balemba' (a distinct group living amongst the Tsonga & Sotho), comprises a few notes of speculation over the origin of the rite and how it may have spread from one group to another.)

Junod, H.A. (1911). *Zidji: étude de Mœurs sud-africains (Tsonga)*. Saint-Blaise: Foyer solidariste. (A novel describing in detail the life of a young man from his passage through the initiation schools till his return home and conversion to Christianity after a period of labour on the Rand. Although a work of fiction, Schapera claimed it was 'full of useful ethnographic material'.)

Junod, H.A. (1913). The condition of the Natives of South East Africa in the sixteenth century, according to the early Portuguese documents. *Rep.S.Afr.Ass.Adv.Sci.* 10 137-161. (Discusses the sources of information, and summarises their ethnographical data.)

Junod, H.A. (1918). Native customs relating to small-pox amongst the BaRonga. *South African Journal of Science* 15 -694. (Detailed account of rites observed during a small-pox epidemic to prevent the spread of the disease)

Junod, H.A. (1920). Some features of the religion of the BaVenda. *South African Journal of Science* 17 207-220.

Junod, H.A. (1924). Le totémisme chez les Thongas, les Pèdis et les Vendas. *Le Globe* 63 1-22.

Junod, H.A. (1927). *The Life of a South African Tribe: Part I, Social Life & Part II, Mental Life*. London: Macmillan and Co.

Junod, H.A. (1929). La Seconde école de circoncision chez les Ba-Khaha du nord de Transvaal. *Journal of the Royal Anthropological Institute* 59 131-147.

Kalichman, S.C. (2010). Neonatal Circumcision for HIV Prevention: Cost, Culture, and Behavioral Considerations. *PLoS Med* 7(1): e1000219. doi:10.1371/journal.pmed.1000219.

Kanta, X.G.M. (2003) *Report on the state of circumcision in the Qaukeni local service area: experience of 10 to 14th July Inspections*. Bisho: Department of Health.

Kanta, X.G.M. (2004) *Traditional male circumcision and initiation into manhood: legal, health and environmental perspectives*. Gonubie, Eastern Cape, Impilo ya Bantu Health and Development Projects.

Kebaabetswe, P., Lockman, S., Mogwe, S., Mandevu, R., Thior, I., Essex, M., & Shapiro, R.L. (2003). Male circumcision: an acceptable strategy for HIV prevention in Botswana. *Sexually Transmitted Infections* 79(3), 214-219. (A cross sectional survey (605 people surveyed) in nine geographically representative locations in Botswana to determine the acceptability of male circumcision in the country, as well as the preferred age and setting for male circumcision.)

Kelly, R., Kiwanuka, N., Wawer, M.J., Serwadda, D., Sewankambo, N.K., Wabwire-Mangen, F., Li, C., Konde-Lule, J.K., Lutalo, T., Makumbi, F., & Gray, R.H. (1999). Age of male circumcision and risk of prevalent HIV infection in rural Uganda. *Aids* 13(3), 399-405.

Knak, S. (1931). Einflüsse der Europäischen Zivilisation auf das Familienleben der Bantu. *Africa* 4 178-201.

Köhler, M., & Van Warmelo, N.J. (1933). *Marriage Customs in Southern Natal*. Pretoria: Government Printer. (Zulu vernacular accounts and English translations in opposite columns, with a running commentary in English.)

Krieger, J.N., Bailey, R.C., Opeya, J.C., Ayieko, B.O., Opiyo, F.A., Agot, K., Parker, C., Ndinya-Achola, J.O., Magoha, G.A.O., & Moses, S. (2001). Adult male circumcision: results of a standardized procedure in Kisumu District, Kenya. *Sex Trans Dis* 28(10), 608-612.

Krieger, J.N., Bailey, R.C., Opeya, J.C., Ayieko, B.O., Opiyo, F.A., Omondi, D., Agot, K., Parker, C., Ndinya-Achola, J.O., & Moses, S. (2007). Adult male circumcision outcomes: experience in a developing country setting. *Urology International* 78(3), 235-240.

Krige, E.J. (1936). Changing conditions in marital relations and parental duties among urbanised Natives. *Africa* 9 1-23.

Krige, E.J. (1944). The magical thought-pattern of the Bantu in relation to health services. *African Studies* 3(I), 1-13.

Krige, E.J. (1956). Individual Development. In I.Schapera (Ed.), *The Bantu-speaking Tribes of South Africa* (pp. 95-111). Cape Town: Maskew Miller Limited.

Krige, E.J. (1974). *The Social System of the Zulus*. Pietermaritzburg: Shuter & Shooter.

Krige, E.J., & Krige, J.D. (1937). Traditional origins and tribal relationships of the Sotho of the Northern Transvaal. *Bantu Studies* 11 321-356.

Krige, E.J., & Krige, J.D. (1943). *The Realm of a Rain Queen*. London: International African Institute.

Krige, E.J., Preston-Whyte, E., & Argyle, W.J. (1978). *Social system and tradition in Southern Africa: essays in honour of Eileen Krige*. Oxford University Press.

Krige, J.D., & Krige, E.J. (1954). The Lovedu of the Transvaal. In C.D.Forde (Ed.), *African Worlds*. London: Oxford University Press.

Kuper, H. (1946). The Swazi reaction to missions. *Africa* 15 177-188.

Kuper, H. (1963). *The Swazi: a South African Kingdom*. New York: Holt, Rinehart and Winston.

La Fontaine, J.S. (1986). *Initiation: Ritual drama and secret knowledge across the world*. Manchester: Manchester University Press.

Lagarde, E., Dirk, T., Puren, A., Reathe, R.T., & Bertran, A. (2003). Acceptability of male circumcision as a tool for preventing HIV infection in a highly infected community in South Africa. *Aids* 17(1), 89-95.

Lagarde, E., Taljaard, D.J., Puren, A., & Auvert, B. (2009). High rate of adverse events following circumcision of young male adults with the Tara Klamp technique: A randomized trial in South Africa. *South African Medical Journal* 99(3). (Following a randomized controlled trial (MCRCT) in 3274 participants on the impact of male circumcision on HIV transmission, 69 control group members participated in this male circumcision methods trial (MCMT) and were randomized to a Forceps Guided (FG) group and a Tara KLamp (TK) group) and circumcised. All 12 adverse event sheets corresponded to the TK group.)

Lagden, G. (1909). *The Basutos: The mountaineers and their country. Vol I & II*. London: Hutchinson and Co.

Laidler, P.W. (1922). Bantu Ritual Circumcision. *Man* 22 13-14.

Laidler, P.W.(1931). Social survey of an urban Native location. (pp. 29-78). *Annual Report of the M.O.H., East London, 1930-1931*.

Landau, P. (1998). Anthropology and Apartheid. Review: Creating Order: Culture as Politics in Nineteenth - and Twentieth-Century South Africa by Schmidt, B. *The Journal of African History* 39(3), 489-491.

Language, F.J. (1943). Die bôgwera van die Tlhaping. *Tydskrif vir Wetenskap en Kuns* 4 110-134.

Laubscher, B.J.F. (1937). *Sex, Custom and Pathology : A Study of South African Pagan Natives*. (pp. 113-140). London: George Routledge and Sons.

Laubscher, B.J.F. (1975). *The Pagan Soul*. Cape Town: Howard Timmins.

Laydevant, F. (1932). Religious or sacred plants of Basutoland. *Bantu Studies* 6 65-69.

Laydevant, F. (1951). *The Rites of Initiation in Basutoland*. Roma, Lesotho: The Social Centre / St. Michael's Mission. (Missionary's account of the rites of initiation in 'Basutoland'.)

Lazarus, J. (2009). Circumcision and HIV. *South African Medical Journal* 99(1), 12.

Lazarus, J., Alexander, A., & Rode, H. (2007). Circumcision complications associated with the Plastibell device. *South African Medical Journal* 97(3), 192-193.

Le Roux, M. (2003). *The Lemba: a lost tribe of Israel in Southern Africa*. Pretoria: Unisa Press.

Legassick, M. (1969). The Sotho-Tswana peoples before 1800. In L.M.Thompson (Ed.), *African Societies in Southern Africa* (pp. 86-123). London: Heinemann.

Lemue, P. (1854). La circoncision chez les Barolong. *J.Miss.évangeliques* 29 208-213.

Lestrade, G.P. (1933). A bibliography of the Southern Sotho. *Bantu Studies* VIII.

Longmore, L. (1959). *The Dispossessed: A study of the sex-life of Bantu women in urban areas in and around Johannesburg*. London: Cape.

Lugg, H. (1907). Notes on the Puberty and other Customs of the Natives. *Man* 7.

Lukobo, M.D., & Bailey, R.C. (2007). Acceptability of male circumcision for prevention of HIV infection in Zambia. *AIDS Care* 19(4), 471-477.

Lye, W.F., & Murray, C. (1980). *Transformations on the Highveld: The Tswana and Southern Sotho*. Cape Town: David Phillip. (Interdisciplinary attempt (by a

historian and a social anthropologist) to understand both the history and contemporary situation of the Tswana & Southern Sotho people of Southern Africa. Presents a picture of change which undermined apartheid view of Southern Africa's black population as comprising separate static 'ethnic units'.)

Mabille, A. (1906). The Basuto of Basutoland. *Journal of the Royal African Society* 5(19), 233-251. (Early descriptive account of the life and customs of the Sotho in Lesotho.)

Mabona, M. (2004). *Diviners and prophets among the Xhosa (1593-1856): a study in Xhosa cultural history*. Berlin: LIT Verlag.

MacDonald, J. (1889). Manners, customs, superstitions and religions of South African tribes I. *J.R.Anthropol.Institute* 19(264), 296.

MacDonald, J. (1890). Manners, customs, superstitions and religions of South African tribes II. *J.R.Anthropol.Institute* 20(113), 140.

MacGregor, J.C. (1905). *Basuto Traditions*. Cape Town: Argus Printing and Publishing Co.

Maclean, C.B. (1906). *A Compendium of Kafir Laws and Customs*. Pretoria: State Library of South Africa.

Mager, A. (1998). Youth Organisations and the Construction of Masculine Identities in the Ciskei and Transkei, 1945-1960. *Journal of Southern African Studies* 24(4), 653-667.

Magoha, G.A.O. (1999). Circumcision in various Nigerian and Kenyan hospitals. *East African Medical Journal* 76(10), 583-586.

Magubane, P. (1998). *Vanishing Cultures of South Africa: Changing Customs in a Changing World*. London: Struik Publishers.

Mahlobo, G.W., & Krige, E.J. (1934). Transition from childhood to adulthood amongst the Zulus. *Bantu Studies* 8 157-191.

Maingard, L.F. (1932). Studies in Korana history, customs, language. *Bantu Studies* 6 103-162. (Contains information on puberty ceremonies obtained from surviving members and given in original texts with translations and comments.)

Mail & Guardian online, July 14 2009, 'Eastern Cape circumcision death toll rises to 44', Accessed at <http://www.mg.co.za/article/2009-07-14-eastern-cape-circumcision-death-toll-rises-to-44>.

Makang, J. (1997). Of the Good Use of Tradition: Keeping the critical perspective of African Philosophy. In E.Chukwudi Eze (Ed.), *Postcolonial African Philosophy. A Critical Reader*. Oxford: Blackwell.

Malan, J.S. (1985). *Swazi Culture*. Pretoria: Africa Institute of South Africa.

Marck, J. (1997). Aspects of male circumcision in sub-equatorial African culture history. *Health Transition Review: The Cultural, Social, And Behavioural Determinants Of Health* 7 Suppl 337-360.

Marwick, B.A. (1940). *The Swazi*. Cambridge: Cambridge University Press.

Marx, J.L. (1989). Circumcision May Protect against the AIDS Virus. *Science* 245(4917), 470-471.

Masule, C. (1999). *Initiation Rites in Caprivi (Namibia)* Part 2. Windhoek: University of Namibia, Multi-Disclipinary Research Centre (MRC), Social Sciences Division.

Mattson, C.L., Muga, R., Poulussen, R., Onyango, T., & Bailey, R.C. (2004). Feasibility of medical male circumcision in Nyanza province, Kenya. *East African Medical Journal* 81 320-335.

Mayatula, V., & Mavundla, T.R. (1997). A review on male circumcision procedures among South African blacks. *Curationis* 20(3), 16-20.

Mayer, P. (ed.) (1970). *Socialization: The Approach from Social Anthropology*. London: Tavistock.

Mayer, P. (1952). Gusii Initiation Ceremonies. *The Journal of the Royal Anthropological Institute of Great Britain and Ireland* 83(1), 9-36.

Mayer, P. (1961). *Townsmen or Tribesmen: Conservatism and the Process of Urbanization in a South African City*. Cape Town: Oxford University Press.

Mayer, P. (1971). Traditional Manhood Initiation in an Industrial City: The African View. In E.J.De Jager (Ed.), *Man: Anthropological Essays Presented to O.F Raum* (pp. 7-18). Cape Town: Struik. (Ethnographic account of African

views of TMCI in Port Elizabeth township of New Brighton, based on fieldwork in 1967 and 1970.)

Mayer, P. (1980). *Black Villagers in an Industrial Society: Anthropological Perspectives on Labour Migration in South Africa*. Oxford: Oxford University Press.

Mayer, P., & Mayer, I. (1967). Socialization by Peers: The Youth Organization of the Red Xhosa. In P.Mayer (Ed.), *Socialization: The Approach from Social Anthropology* (pp. 159-89). London: Tavistock.

Mbatha, M.B. (1960). *Migrant Labour and Its Effects on Tribal and Family Life among the Nyuswa of Botha's Hill*. Unpublished Masters, University of Natal.

Mbiti, J. (1989). *African Religions & Philosophy*. London: Heinemann.

McAllister, P.A. (1990). The Role of Ritual in Resisting Domination in the Transkei in the 1970's. *University of the Witwatersrand History Workshop: Structure and Experience in the Making of Apartheid 6-10 Feb 1990. 6 - 10 Feb 1990*.

McAllister, P.A. (1993). Public Oratory in Xhosa Ritual: Tradition and Change. *Ethnology* 32(3), 291-304.

McAllister, P.A. (2008). Work, Homestead and the Shades. In P. Mayer (Ed.), *Black Villagers in an Industrial Society: Anthropological Perspectives on Labour Migration in South Africa* (205-253). Oxford: Oxford University Press.

McAllister, R.G., Travis, J.W., Bollinger, D.A., Rutiser, C.L.A., & Sundar, V.E.E.R. (2008). The Cost to Circumcise Africa. *International Journal of Men's Health* 7(3), 307-316.

McDowell, L. (2001). The Trouble with Men? Young People, Gender Transformations and the Crisis of Masculinity. *International Journal of Urban and Regional Research* 24(1), 201-209.

Mcetywa, S.A.M. (1998). *Mpondo Heritage: An Expression of Ubuntu*. Durban: Institute for Black Research / Madiba Publishers.

Meel, B.L. (2005). Community perception of traditional circumcision in a sub-region of the Transkei, Eastern Cape, South Africa. *South African Family Practice* 47(6), 58-59.

Meintjes, G. (1998). *Manhood at a Price: Socio-medical Perspectives on Xhosa Traditional Circumcision*. Institute of Social and Economic Research, Rhodes University.

Meissner, O., & Buso, D.L. (2007). Traditional male circumcision in the Eastern Cape scourge or blessing? *South African Medical Journal* 97(5), 371-373.

Mgqolozana, T. (2009). *A man who is not a man*. Pietermaritzburg: UKZN Press.

Millar, A.J., & Roberts, D. (1987). Complications of circumcision using the Plastibell device. *South African Medical Journal* 72(6), 438-439.

Mills, E., Cooper, C., Anema, A., & Guyatt, G. (2008). Male circumcision for the prevention of heterosexually acquired HIV infection: a meta-analysis of randomized trials involving 11 050 men. *HIV Medicine* 9(6), 332-335.

Mills, W.G. (1992). Missionaries, Xhosa Clergy and the Suppression of Traditional Customs in *People, Power and Culture, the history of Christianity in South Africa 1792 – 1992*. UWC Institute for Historical Research Conference Proceeding.

Milos, M.F., & Macris, D. (1992). Circumcision: A medical or a human rights issue? *Journal of Nurse-Midwifery* 37(2, Suppl. 1), 87-96.

Mogotlane, S.M., Ntlangulela, J.T., & Oganbanjo, B.J. (2004). Mortality and Morbidity among Traditionally Circumcised Xhosa Boys in the Eastern Cape Province of South Africa. *Curationis* 27(2), 57-62.

Molefi, R.K. (1996). *A Medical History of Botswana 1885-1966*. Gaborone: The Botswana Society.

Momoti, N. (2002). *Law and Culture in the New Constitution with Specific Reference to the Custom of Circumcision as Practiced in the Eastern Cape*. Master of Law, Rhodes University.

Mönnig, H.O. (1967). *The Pedi*. Pretoria: J.L. Van Schaik Limited. (Anthropological account of the Pedi of Sekhukhuneland in the late 1960s with some reference to changes in social organisation taking place since traditional times.)

Moses, S., Bailey, R.C., & Ronald, A.R. (1998). Male circumcision: assessment of health benefits and risks. *Sexually Transmitted Infections* 74(5), 368-373.

Mosothwane, M.N. (2001). An ethnographic study of initiation schools among the Bakgatla ba ga Kgafela at Mochudi (1874-1988). *Pula: Botswana Journal of African Studies* 144-165.

Mpanza, M.J. (1930). *UGuqabadele: Incwadi Yamasiko esizwe sakwa Zulu*. Durban: Milne Street Church.

Mtuzi, P. (2004). *Introduction to Xhosa Culture*. Alice: Lovedale Press.

Munthali, A.C., & Zulu, E.M. (2007). The Timing and role of Initiation Rites in Preparing Young People for Adolescence and Responsible Sexual and Reproductive Behaviour in Malawi. *Afr J Reprod Health* 11(3), 150-167. (This paper examines timing of puberty and mechanisms through which society prepares adolescents to understand and deal with it in Malawi. Concludes that the significance of initiation ceremonies in some communities provides an important platform through which programs can reach many adolescents and intervene, particularly in addressing the widely held notion among initiates that attending these ceremonies symbolizes that one is not a child anymore and can have sex.)

Muula, A.S., Prozesky, H.W., Mataya, R.H., & Ikechebelu, J.I. (2007). Prevalence of complications of male circumcision in Anglophone Africa: a systematic review. *BioMed Central Urology* 7(4).

Myburgh, A.C. (1974). Law and Justice. In W.D. Hammond-Tooke (Ed.), *The Bantu-speaking Peoples of Southern Africa* (284-317). London: Routledge & Keegan Paul.

Myers, A., & Myers, J. (2007). Male circumcision - the new hope? *South African Medical Journal* 97(5), 338-341. (Looks at male circumcision in the fight against HIV/AIDS. Focuses on circumcision practices, rationalisation for circumcision and on the evidence for HIV prevention. Stresses the need for caution and more research.)

Myers, A., & Myers, J. (2008). Rolling out male circumcision as a mass HIV/AIDS intervention seems neither justified nor practicable. *South African Medical Journal* 98(10), 781-782.

Naude, J.H. (2002). Reconstructive urology in the tropical and developing world: a personal perspective. *BJU Int* 89 31-36. (Complications of traditional circumcision in South Africa.)

Nauhaus, C. (1929). Die Beschneidung bei den Xosa. *Die Brücke* 7(Wiss Beilag No.1.), i-6.

Ncayiyana, D.J. (2003). Astonishing indifference to deaths due to botched ritual circumcision: editorial. *South African Medical Journal* 93(8), 545. (Reflects on ritual circumcision in South Africa. Calls for steps to prevent circumcision deaths. Reflects on some of the malpractices associated with ritual circumcision.)

Ndaba, B. (2002) Teen dies after returning to 'hill of death'. *The Star*. 1 July.

Ndege, G.O. (2007). *Culture and Customs of Mozambique*. London: Greenwood Press. (A historian's ethnography of Mozambique, part of series on African culture.)

Ndiwane, A. (2008). Laying down the knife may decrease risk of HIV transmission: cultural practices in Cameroon with implications for public health and policy. *Journal of Cultural Diversity* 15(2), 76-80.

Ngwane, Z. (2001). Real Men Reawaken Their Fathers' Homesteads, the Educated Leave Them in Ruins: The Politics of Domestic Reproduction in Post-Apartheid Rural South Africa. *Journal of Religion in Africa* 31(4), 402-426.

Ngxamngxa, V.Z. (1971). The Function of Circumcision among the Xhosa-speaking Tribes in Historical Perspective. In E.J. de Jager (Ed.), *Man: Anthropological Essays Presented to O.F. Raum* (pp. 183-18). Cape Town: C. Struik. (Analysis of ethnographic accounts of Xhosa TMCI to identify the social functions of the ritual.)

Niang, C.I., & Boiro, H. (2007). Roundtable: You Can Also Cut My Finger! Social Construction of Male Circumcision in West Africa, A Case Study of Senegal and Guinea-Bissau. *Reproductive Health Matters* 15(29), 22-32.

Niehaus, I. (2000). Towards a Dubious Liberation: Masculinity, Sexuality and Power in South African Lowveld Schools, 1953-1999. *Journal of Southern African Studies* 26(3), 387-407. (Article investigates how masculine sexuality featured as a political issue during the liberation struggle in Impalahoek, a village on the South African lowveld.)

Niehaus, I. (2008). Biographical Lessons: Life Stories, Sex and Culture in Bushbuckridge, South Africa. *Cahiers d'Etudes Africaines XLVI*(1), 51-73. (The life story of a thirty-eight year old male resident of Bushbuckridge, South Africa, focusing specifically on his experiences of sexual socialisation, schooling, initiation, labour migration, marriage, divorce, unemployment and sexual violence.)

Nielsen, P. (1912). The manners and customs of the Matabele. *Proc.Rhod.Sci.Ass.* 12 25-40. (Birth and child life, games, puberty rites, courtship, marriage, laws of social life, sorcery etc.)

Norton, F. (1909). Puberty rites of the Basotho. *The S.A.Journal of Science VI*.

Norton, W.A. (1914). Customs of Central and South Africa: Some Notes and Comparisons. *Journal of the Royal African Society* 14(53), 81-87.

Norton, W.A. (1922). Circumcision regiments as a Native chronology. *R.Soc.S.Afr* 10 245-251.

Nqeketo, A. (2004) Male circumcision and HIV/AIDS in South Africa: The role of traditional authorities/initiation school leaders. Paper presented at *International Conference on AIDS*. Jul 11-16; 15 abstract no. E12318.

O'Hara, K., & O'Hara, J. (1999). The effect of male circumcision on the sexual enjoyment of the female partner. *BJU Int* 83(Suppl 1), 79-84.

Olpp, J. (1884). Aus dem Sagenschatz der Nama Khoi-Khoin. *Mitt.geogr.Ges.* 6 1-47.

Packer, C.A.A. (2002). *Using human rights to change tradition: traditional practices harmful to women's reproductive health in sub-Saharan Africa*. New York: Intersentia.

Pauw, B.A (1990). Widows and ritual danger in Sotho and Tswana communities. *African Studies* 4(2), 75-99.

Pauw, B.A. (1963). *The Second Generation: : A Study of the Family Among Urbanized Bantu in East London*. Cape Town: Oxford University Press.

Pauw, B.A. (1975). *Christianity and the Xhosa Tradition: Belief and Ritual among Xhosa-speaking Christians*. London: Oxford University Press.

Peltzer, K., Nqeketo, A., Petros, G., & Kanta, X. (2008a). Traditional circumcision during manhood initiation rituals in the Eastern Cape, South Africa: a pre-post intervention evaluation. *Bmc Public Health* 8 64.

Peltzer, K., Nqeketo, A., Petros, G., & Kanta, X. (2008b). Evaluation of a safer male circumcision training programme for traditional surgeons and nurses in the Eastern Cape, South Africa. *African Journal of Traditional Complementary and Alternative Medicines* 5(4), 346-354.

Peltzer, K., Nqeketo, A., Petros, G., & Kanta, X. (2008c). Attitudes of preinitiates towards traditional male circumcision in the context of HIV in the Eastern Cape, South Africa. *Social Behaviour and Personality* 36(8), 1023-1034.

Peters, P. (1983). Gender, Developmental Cycles and Historical Process: A Critique of Recent Research on Women in Botswana. *Journal of Southern African Studies* 10(1).

Pitje, G.M. (1948). Traditional and Modern Forms of Male Education Amongst the Pedi and Cognate Tribes. Unpublished Masters thesis, University of South Africa.

Pitje, G.M. (1950). Traditional Systems of Male Education Among the Pedi and Cognate Tribes. *African Studies* 9 194-200.

Plowman, C.H.F. (1919). Notes on the Gedamoch Ceremonies among the Boran. *Journal of the Royal African Society* 18(70), 114-121.

Pugach, S. (2004). Carl Meinhof and the German Influence on Nicholas van Warmelo's Ethnological and Linguistic Writing 1927-1935. *Journal of Southern African Studies* 30(4). Writing in Transition in South Africa: Fiction, History, Biography, 825-845.

Ragnarsson, A., Onya, H.E., Thorson, A., Ekström, A.M., & Aarø, L.E. (2008). Young Males' Gendered Sexuality in the Era of HIV and AIDS in Limpopo Province, South Africa. *Qualitative Health Research* 18(6), 739-746.

Rain-Taljaard, R.C., Lagarde, E., Taljaard, D.J., Campbell, C., MacPhail, C., Williams, B., & Auvert, B. (2003). Potential for an intervention based on male circumcision in a South African town with high levels of HIV infection. *AIDS Care* 15(3), 315-327.

Ramseyer, P. (1928). La Circoncision chez le Bassouto. *Rev.d' Ethnogr.et Trad.pop* 9 40-70.

Raum, O.F., & De Jager, E.J. (1972). *Transition and Change in a Rural Community: A Survey of Acculturation in the Ciskei, South Africa*. Fort Hare: Fort Hare University Press.

Rich, P. (1990). Race, Science, and the Legitimization of White Supremacy in South Africa, 1902-1940. *The International Journal of African Historical Studies* 23(4), 665-686.

Ritchken, E. (1994). Leadership and conflict in Bushbuckridge: struggles to define moral economies in the context of rapidly transforming political economies. PhD Political Studies, University of the Witwatersrand.

Roberts, N. (1915). The Baganano or Ma-laboch: notes on their early history, customs and creed. *South African Journal of Science* 12 241-256.

Roberts, N., & Winter, C.A.T. (1915). The kgoma, or initiation rites of the Bapedi of Sekukuniland. *South African Journal of Science* 12 561-578.

Robins, S., & Scheper-Hughes, N. (1996). On the Call for a Militant Anthropology: The Complexity of "Doing the Right Thing". *Current Anthropology* 37(2), 341-346.

Rohatynskyj, M. (2008). Culture, secrets, and Ömie history: a consideration of the politics of cultural identity. *American Ethnologist* 24(2), 438-456.

Sapa. (2006). Protests after Initiates Gang Rape. 31 January.

Sawires, S., Dworkin, S., Fiamma, A., Coates, T., & Szekeres, G. (2007). Male Circumcision and HIV/AIDS: Challenges and Opportunities. *Lancet* 369 708-713.

Schapera, I. (1933a). Premarital pregnancy and Native opinion: a note on social change. *Africa* 6 59-89.

Schapera, I. (1933b). South African Publications Relating to Native Life and Languages, 1931-2. *Journal of the International African Institute* 6(3), 352-361.

Schapera, I. (1934a). The present state and future development of ethnographic research in South Africa including select bibliography. *Bantu Studies VIII*(3).

Schapera, I. (1934b). *Western Civilization and the Natives of South Africa: Studies in Culture Contact*. London: Routledge.

Schapera, I. (1938). *A Handbook of Tswana Law and Custom*. London: Oxford University Press for the International African Institute.

Schapera, I. (1956). *The Bantu-speaking Tribes of South Africa: An Ethnographical Survey*. Cape Town: Maskew Miller Limited.

Schapera, I. (1960). *The Khoisan Peoples of South Africa*. London: Routledge, Kegan and Paul Ltd.

Schapera, I. (1970). *Tribal Innovators: Tswana Chiefs and Social Change 1795 - 1940*. London: School of Economics.

Schapera, I. (1978). *Bôgwera: Kgatla Initiation*. Mochudi, Botswana: Phuthadikobo Museum. (Anthropologist's description of *bôgwera* (circumcision) or gorupa (initiation) among Kgatla (a Tswana group) in Mochudi based on fieldwork 1929-34.)

Schapera, I. (1979). Kgatla Notions of Ritual Impurity. *African Studies* 38(1).

Schapera, I. (ed.) (1938). *Diterafalo tsa Merafe ya Batswana*. Alice: Lovedale Press. (Discusses male and female initiation in Botswana.)

Schmid, G.P., & Dick, B. (2008). Adolescent boys: who cares? *Bulletin of the World Health Organization* 86(9), 659-65A.

Schoemann, P.J. (1931). Volkekundige Navorsing onder die Swazis. *Annals of the University of Stellenbosch IX*(B,3), 23. (Notes on puberty rites and tribal laws.)

Schweiger, A. (1914). Der ritus der Beschneidung unter den Ama Xosa und ama Fingo in der Kaffraria, Sudafrika. *Anthropos* 9(53), 65.

Scorgie et al. (2010). 'Cutting for Love: Genital Incisions to Enhance Sexual Desirability and Commitment in KwaZulu Natal, South Africa', in *Reproductive Health Matters* 18(35).

Scott, B.E., Weiss, H.A., & Viljoen, J.I. (2005). The acceptability of male circumcision as an HIV intervention among a rural Zulu population, KwaZulu-Natal, South Africa. *AIDS Care* 17(3), 304-313.

Sechefo, J.J. (unknown). *Customs and Superstitions in Basutoland*. Maseru, Lesotho: The Catholic Centre.

Segoete, E. (1913). *Raphepheng: Bophela ba BaSotho ba Khale*. Morija: Sesuto Book Depot.

Sekese, A. (1907). *Mekhoa le Maele a BaSotho*. Morija: Sesuto Book Depot. (Valuable description of Sotho life, mostly translated by Jacottet, and a large collection of proverbs and idiomatic sayings and comments upon them.)

Shaffer, D.N., Bautista, C.T., Sateren, W.B., Sawe, F.K., Kiplangat, S.C., Miruka, A.O., Renzullo, P.O., Scott, P.T., Robb, M.L., Michael, N.L., & Bix, D.L. (2007). The protective effect of circumcision on HIV incidence in rural low-risk men circumcised predominantly by traditional circumcisers in Kenya - Two-year follow-up of the Kericho HIV Cohort Study. *Journal of Acquired Immune Deficiency Syndromes* 45(4), 371-379.

Sharp, J. & Spiegel, A. (1990). Women and Wages: Gender and the Control of Income in Farm and Bantustan Households. *Journal of Southern African Studies* 16(3).

Sharp, J.S. (1981). The Roots and Development of Volkekunde in South Africa. *Journal of Southern African Studies* 8(1), 16-36.

Shilumani, C. (2004). Research Update. National Department of Health. *Health Systems Research, Research Coordination and Epidemiology* 6(1).

Sibeko, A.V. (1931). Imilingo nemithi yokwelapha pakathi kwabantu. *Native Teacher's Journal* 11 197-253.

Sidler, D., Smith, J., & Rode, H. (2008). Neonatal circumcision does not reduce HIV/AIDS infection rates. *South African Medical Journal* 98(10), 762.

Siegfried, N., Muller, M., Deeks, J., & Volmink, J. (2009). The Cochrane Review: Male circumcision for prevention of heterosexual acquisition of HIV in men. *The Cochrane Library* (2).

Siegfried, N., Muller, M., Volmink, J., Deeks, J., Egger, M., Low, N., Weiss, H., Wlaker, S., & Williamson, P. (2003). Male circumcision for prevention of heterosexual acquisition of HIV in men (Review). *The Cochrane Database of Systematic Reviews* (3).

Silverman, E.K. (2004). Anthropology and circumcision. *Annual Review of Anthropology* 33 419-445.

Soga, J.H. (1930). *The South Eastern Bantu*. Johannesburg: University of the Witwatersrand.

Soga, J.H. (1931). *The Ama-Xosa: Life and Customs*. Lovedale.

South African Human Rights Commission. (2001). *Report into Initiation Practices at Educational Institutions and a Preliminary Report on Cultural Initiations*.

Spiegel, A., & McAllister, P.A. (1991). *Tradition and Transition in Southern Africa*. Johannesburg: Witwatersrand University Press.

Stannus, H.S. (1910). Notes on Some Tribes of British Central Africa. *The Journal of the Royal Anthropological Institute of Great Britain and Ireland* 40 285-335.

Stayt, H.A. (1931). *The Bavenda*. London: Oxford University Press.

Steyn, M.G. (1996). Marital expectations of the formally trained black late-adolescent and the implications for a marriage preparation programme. UNISA dissertation.

Stinson, K. (n.d.). Male Circumcision in South Africa: How does it relate to Public Health? Accessed at <http://www.africanvoices.co.za/culture/circumcision.htm>.

Suttner, R. (2003). Culture(s) of the African National Congress of South Africa: Imprint of Exile Experiences. *Journal of Contemporary African Studies* 21(2), 303-320.

Suttner, R. (2008). Gendering the Underground. In R.Suttner (Ed.), *The ANC Underground* (pp. 113-117). Jacana.

Svoboda, J.S., & Darby, R. (2009). A rose by any other name? Symmetry and asymmetry in male and female genital cutting. In C.Zabus (Ed.), *Fearful*

Symmetries: Essays and Testimonies Around Excision and Circumcision. Amsterdam: Rodopi.

Taylor et al. (2007). 'Perceptions and Attitudes of Secondary Schools Students in Kwazulu Natal Towards Virginity Testing', in *Health SA* 12(2)

Tenge, S. (2006). *Xhosa Teenage Boys' Experiences During the Period Prior to Circumcision Ritual in East London in the Eastern Cape.* Masters Health Studies, UNISA.

The Star. (2008). Botched circumcision deaths mount. 8 July.

The Sunday Times. (2008) Teen sues father after forced circumcision. 27 January.

Theal, G. (1907). *History and Ethnography of Africa South of the Zambesi, 1505 to 1795.* London: Swan Sonnenschein & Co.

Thilenius, G. (1915). Die Mädchenbeschneidung der Basotho. *Archiv.f.Anthrop.* 13 72-75.

Tournas, S.A. (1996). From Sacred Initiation to Bureaucratic Apostasy: Junior Secondary School-Leavers and the Secularisation of Education in Southern Africa. *Comparative Education* 32(1), 27-43.

Tucker, J.T. (1949). Initiation Ceremonies for Luimbi Boys. *Africa: Journal of the International African Institute* 19(1), 53-60.

Turner, G.A. (1911). Some of the tribal marks of the South African Native races. *Transvaal Medical Journal* 66 141-153. (Distribution of circumcision, cicatrization, amputation of finger joint and other body transformations and adornment based on examination of Africans on the mines.)

Turner, G.A. (1915). Circumcision among South African Natives I. *Medical Journal of South Africa* x(8), 133-138.

Turner, G.A. (1915). Circumcision among South African Natives II. *Medical Journal of South Africa* x(9), 150-154.

Turner, V. (1955). A revival in the study of African ritual. *Rhodes-Livingstone J.* 17 51-56.

Turner, V. (1962). Three Symbols of Passage in Ndembu Circumcision Ritual. In M.Gluckman (Ed.), *Essays on the Ritual of Social Relations* (pp. 124-173). Manchester: Manchester University Press.

Turner, V. (1982). Liminal to liminoid, in play, flow, ritual: an essay in comparative symbology. In V.Turner (Ed.), *From Ritual to Theatre: The Human Seriousness of Play* (pp. 20-60). New York: Performing Arts Journal Publications.

TVSA, April 24, 2007. 'uMthunzi we Nthaba's Writer Speaks Out', Accessed at <http://www.tvsa.co.za/default.asp?blogname=tv&ArticleID=4693>.

Tyrrell, B. (1968). *Tribal Peoples of Southern Africa*. Cape Town: Books of Africa.

UNAIDS & NERCHA. (2008) Monitoring the declaration of commitment on HIV/AIDS (UNGASS): Swaziland Country Report.

USAID/AIDSMark (2005). *Becoming a man during AmaXhosa ceremonial rites of initiation: a manual for teaching traditional surgeons and attendants about safe circumcision and social and sexual responsibility*. Washington, D.C: USAID.

Van der Linde, I. (1996). Manhood rites: Finding it may mean losing it. *South African Medical Journal* 86 (8), 902.

Van der Vliet, V. (1991). Traditional husbands, modern wives?: constructing marriages in a South African township. In P. Mayer, I. Mayer, A. Spiegel, & P.A. McAllister (Eds.), *Tradition and transition in Southern Africa: festschrift for Philip and Iona Mayer*. New Brunswick: Transaction Publishers.

Van der Vliet, V. (1974). Growing Up in Traditional Society. In W.D.Hammond-Tooke (Ed.), *The Bantu-speaking Peoples of Southern Africa* (pp. 211-234). London: Routledge & Keegan Paul.

Van Dijk, D. (2002). *"Hulle kan nie hulle hormone intoom hou nie": A study on gender, adolescents and sexual behaviour in relation to HIV in South Africa*. University of Nijmegen, CIDIN / Development Studies. Occasional Paper 109.

Van Eden, K. (1998). Rites of Passage As The Basis Of Programme Development For Young People At Risk In South Africa. MSocSci in Criminology, University of Cape Town.

Van Eeden, J. (1991). *Ageing and Seniority in a Rural Xhosa Community*. Observatory: HSRC / UCT Centre for Gerontology.

Van Gennep, A. (1960). *The Rites of Passage*. Chicago: Chicago University Press.

Van Vuuren, C.J., & de Jongh, M. (1999). Rituals of manhood in South Africa: circumcision at the cutting edge of critical intervention. *South African Journal of Ethnology* 22(4), 142.

Van Warmelo, N.J. (1930). *Contributions to Venda History, Religion and Tribal Ritual*. Pretoria: Government Printer.

Van Warmelo, N.J. (1930). *Transvaal Ndebele Texts*. Pretoria: Government Printer. (Ndebele texts, translations and annotations on the life of boys, courtship and marriage.)

Van Warmelo, N.J. (1974). The Classification of Cultural Groups. In W.D.Hammond-Tooke (Ed.), *The Bantu-speaking Peoples of Southern Africa* (pp. 56-84). London: Routledge & Keegan Paul.

Varga, C.A. (2001). The Forgotten Fifty Per Cent: A Review of Sexual and Reproductive Health Research and Programs Focused on Boys and Young Men in Sub-Saharan Africa. *African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive* 5(3), 175-195.

Vilikazi, A. (1962). *Zulu Transformations: A study of the Dynamics of Social Change*. Pietermaritzburg: University of Natal Press.

Vincent, L. (2008a). Boys will be boys: traditional Xhosa male circumcision, HIV and sexual socialisation in contemporary South Africa. *Culture Health & Sexuality* 10(5), 431-446.

Vincent, L. (2008b). Cutting tradition: The political regulation of traditional circumcision rites in South Africa's liberal democratic order. *Journal of Southern African Studies* 34 (1), 77-91.

Vincent (2008c). *Male Circumcision Policy, Practices and Services in the Eastern Cape Province of South Africa: Case Study*. World Health Organisation.

Walk, L. (1928). Initiationszeremonien und Pubertätsriten der Südafrikanischen Stämme. *Anthropos* 23 861-966.

Warren-Brown, G. (1998). Boyz 2 Men: Initiation's Cutting Edge. *Leadership* 17(4), 54-65.

Weiss, C. (1966). Motives for Male Circumcision among Preliterate and Literate Peoples. *The Journal of Sex Research* 2(2), 69-88.

Welbourn, F.B. (1968). Keyo Initiation. *Journal of Religion in Africa* 1(2), 212-232.

Westercamp, N. & Bailey, R.C. (2007). Acceptability of male circumcision for prevention of HIV/AIDS in sub-Saharan Africa: a review. *AIDS and Behavior* 11(3), 341-355.

Wheelwright, C.A. (1905). Native Circumcision Lodges in the Zoutpansberg District. *The Journal of the Anthropological Institute of Great Britain and Ireland* 35 251-255.

Whissom, M. (2000). Circumcision widely approved despite fatalities. *Daily Dispatch*, 22 July, 27.

White, C.M.N. (1953). Notes on the Circumcision Rites of the Balovale Tribes. *African Studies* 12 41-56.

Whiting, J.W., Kluckhorn, R., & Anthony, H. (1958). The function of male initiation ceremonies at puberty. In E.E.Maccoby, T.M.Newcomb, & E.L.Hartley (Eds.), *Readings in Social Psychology*. New York: Holt, Rinehart.

WHO 2007. Note to the Press, 'Eastern and Southern Africa region agree to accelerate scale up of male circumcision services in the context of HIV prevention', 17 May 2007.

WHO/UNAIDS, 2009a. Country experiences in the scale-up of male circumcision in the Eastern and Southern Africa Region: Two years and counting. 9-10 June 2009. A sub-regional consultation, Windhoek, Namibia.

WHO/ UNAIDS 2009b. Progress in male circumcision scale-up: country implementation update, December 2009, p.4. Accessed at http://malecircumcision.org/documents/MC_country_update_web.pdf, 26 Jan 2010.

Wickstrom, A (2010). 'Virginity Testing as Local Public Health Initiative: A 'Prevention Ritual' More Than a Diagnostic Measure', in *Journal of the Royal Anthropological Institute* 16(3).

Wilcken et al. (2010). 'Traditional Male Circumcision in Eastern and Southern Africa: A Systematic Review of Prevalence and Complications', in *Bulletin of World Health* December 2010.

Wilde, M. Ed. (1912). Die heidnische Volksschule in Südafrika. *Mission und Pfarramt* 5 12-29. (Descriptions by various writers of initiation ceremonies among Pedi, Venda and Xhosa with comments by the editor)

Williams, B.G., Lloyd-Smith, J.O., Gouws, E., Hankins, C., Getz, W.M., Hargrove, J., De Zoysa, I., Dye, C. & Auvert, B. (2006). The Potential Impact of Male Circumcision on HIV in Sub-Saharan Africa. *PLoS Medicine* 3(6), e262-1040.

Willoughby, W.C. (1909). *Notes on the Initiation Ceremonies of the Becwana*. London: Royal Anthropological Institute of Great Britain and Ireland. (Early descriptive account of boy's initiation amongst the Tswana by Reverend Willoughby, a local correspondent of the Royal Anthropological Institute.)

Willoughby, W.C. (1923). *Race Problems in the New Africa*. Oxford: Clarendon Press.

Wilson, M.H. (1952). *Social Structure*. Pietermaritzburg: Shuter and Shooter.

Winter, J.A. (1913). The phallus cult amongst the Bantu: particularly the Bapedi of the Eastern Transvaal. *Rep.S.Afr.Ass.Adv.Sci.* 10 131-136.

Woods, G.G.B. (1931). Extracts from customs and history: Amandebele (Rhodesia). *Nada* 9 16-23. (Birth, death, puberty, marriage, dreams, magicians, sacrifices, spirits.)

Wreford, J. (2005). Sincedis – We can help! A literature review of current practice involving traditional African healers in biomedical HIV/AIDS interventions in South Africa. CSSR Working Paper No. 108. University of Cape Town: Cape Town.

Wreford, J. (2006). Facilitating Relationships between African traditional healing and western medicine in South Africa in the time of AIDS: A case study from the Western Cape. CSSR Working Paper no 170.

Wreford, J. (2007). Rapprochement or Resistance? Utilising Traditional Healing Principles and Practice to Enhance HIV/AIDS Treatment in South Africa. In Degregori, M.C.A. (ed.) *African Women and Access to Sexual and Reproductive Health Care in the Context of the AIDS Pandemic: Contributions from the Social Sciences*. Medicus Mundi Catalunya: Barcelona: 95-104.

Wuras, C.F. (1858). An Account of the Korana. *Bantu Studies* 3(1929), 287-296. (Useful notes on puberty rites, marriage etc.)

Young, F.W. (1962). The Function of Male Initiation Ceremonies: A Crosscultural Test of an Alternative Hypothesis. *The American Journal of Sociology* 67(4), 379-396.

Young, F.W. (1965). *Initiation Ceremonies: A cross-cultural study of status dramatization*. New York: Bobbs-Merrill.

Zampieri, N., Pianezzola, E., & Zampieri, C. (2008). Male circumcision through the ages: the role of tradition. *Acta Paediatrica* 97(9), 1305-1307.

Zenani, N.M., & Scheub, H. (1992). *The World and the Word: Tales and Observations from the Xhosa Oral Tradition*. Madison: The University of Wisconsin Press.

Ziervogel, D. (1954). *The Eastern Sotho*. Pretoria: Van Schaik.

Zietsman, K. (1972). Inisiasie by die Sotho-sprekende plattelandse Bantoebevolking van Clocolan. D.Phil., University of the Orange Free State. (Anthropologist under FJ Language. Purpose of study was to describe the initiation rituals, an aspect of African tradition that has remained relatively untouched by westernisation compared to other aspects such as dress.)

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Deacon, H. and Thomson, K. 2012. *The Social Penis. Traditional Male Circumcision and Initiation in Southern Africa, 1800-2000: A Literature Review*. CSSR Working Paper No. 304

Kerr, N. 2012. *Perceptions versus Reality: Assessing Popular Evaluations of Election Quality in Africa*. CSSR Working Paper No. 305

Pieterse, D. 2012. *Exposure to violence and educational outcomes: evidence from Cape Town, South Africa*. CSSR Working Paper No. 306

Nattrass, N. and Seekings, J. 2012. *Differentiation within the South African Clothing Industry: Implications for Wage Setting and Employment*. CSSR Working Paper No. 307

Desmond, C. 2012. *Priority setting and HIV/AIDS: Formulas and processes*. CSSR Working Paper No. 308

Nattrass, N. and Seekings, J. 2012. *Institutions, Wage Differentiation and the Structure of Employment in South Africa*. CSSR Working Paper No. 309

The Centre for Social Science Research

The CSSR is an umbrella organisation comprising four research units:

The **AIDS and Society Research Unit** (ASRU) supports innovative research into the social dimensions of AIDS in South Africa. Special emphasis is placed on exploring the interface between qualitative and quantitative research. Focus areas include: AIDS policy in South Africa, AIDS-stigma, sexual relationships in the age of AIDS, the social and economic factors influencing disclosure (of HIV-status to others), the interface between traditional medicine and biomedicine, the international treatment rollout, global health citizenship, and the impact of providing antiretroviral treatment on individuals and households.

The **Democracy in Africa Research Unit** (DARU) supports students and scholars who conduct systematic research in the following four areas: public opinion and political culture in Africa and its role in democratisation and consolidation; elections and voting in Africa; the development of legislative institutions; and the impact of the HIV/AIDS pandemic on democratisation in Southern Africa. DARU has also developed close working relationships with projects such as the Afrobarometer (a cross-national survey of public opinion in fifteen African countries) and the Comparative National Elections Project, which conducts post-election surveys over 20 countries across the world.

The **Sustainable Societies Unit's** (SSU) mission is to explore the social and institutional dimensions of economic development and the interaction between human society and the natural world. Focus areas include: winners and losers in South African economic growth and the interplay between ecological and economic concerns. The SSU was previously known as the Social Surveys Unit and still works on a number of survey projects, including the Cape Area Panel Study.
