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THE INTERFACE BETWEEN THE TRADITIONAL LEADERSHIP AND THE DISTRICT
HEALTH MANAGEMENT OFFICES IN THE DELIVERY OF HEALTH SERVICES IN
MOPANI, VHEMBE AND SEKHUKHUNE DISTRICTS IN LIMPOPO PROVINCE
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THE INTERFACE BETWEEN THE TRADITIONAL LEADERSHIP AND THE DISTRICT HEALTH MANAGEMENT OFFICES IN THE DELIVERY OF HEALTH SERVICES IN MOPANI, VHEMBE AND SEKHUKHUNE DISTRICTS IN LIMPOPO PROVINCE

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Abstract

The study investigates the introduction of male medical circumcision in Limpopo, in a context where traditional male circumcision is practiced. The study focuses on three districts, namely: Vhembe, Sekhukhune and Mopane to understand the interaction of district health officials and traditional authorities in this process. Through a qualitative approach, the study observes the impact of the interface between traditional leaders and the District Health Management Offices on the introduction of male medical circumcision.

Traditional leaders are regarded as the custodian of traditional male circumcision while the district health officials are tasked with leading the introduction of male medical circumcision. A major finding in the study is the importance of consulting and engaging with traditional leaders in the introduction of male medical circumcision since traditional leaders saw the introduction of western medical practices in male circumcision as encroaching on traditional male circumcision, which they see as their domain. Thus, the relationship between district health officials and traditional leaders was significant in the success of the programme, especially in areas where traditional male circumcision is a dominant practice.

Key words: Traditional Male Circumcision, Male Medical Circumcision, traditional leaders, District Health Management office, district managers, health services

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Chapter 1: Setting the stage

1.1 Introduction and background to the study

The circumcision is practiced worldwide for various reasons, which could be for medical, religious and/or for traditional reasons. African communities in South Africa and, indeed in many countries in the world, have been practising Traditional Male Circumcision (TMC) as a rite of passage to full and recognised male adulthood, and that is why it is also called initiation because it initiates young men into adulthood. This practice is still prevalent in several provinces in South Africa such as Eastern Cape, Mpumalanga and Limpopo provinces and others.

The research of Thaele (2012.2) found that TMC is a cultural practice that lies at the centre of African beliefs and a way of living. There is no country in Africa that does not have an ethnic group that does not practice male circumcision for religious or cultural reasons including, but not limited to, Malawi, South Africa, and Nigeria. Many ethnic groups practice TMC in South Africa. It is highly prevalent among the Xhosa, Pedi, and Venda ethnic groups, and to a lesser extent among the Tsonga, Southern Sotho, Ndebele.

The TMC practices are universally common to many cultures in South Africa because they are historical indicators used by communities to mark the transition from one stage of life to another. It is in fact a rite of passage acknowledging the induction of an individual or individuals into a group or society. The 2010 report of the Commission for the Promotion and Protection of the Rights of Cultural, Religious and Linguistic Communities, herein after referred to as CRL Rights commission for short, states that TMC is recognised as a social rebirth for the individual or individuals in various communities (CRL Rights Commission. 2010.5).

The group or society which an individual is being inducted into could be an open society or a secret society. Universally known examples of initiation, which are similar to TMC include the Christian baptism or the Jewish bar mitzvah. Another important example of initiation and the attendant rites are the puberty rites which are common to some societies. These puberty rites attest to the transition from childhood to adolescence or in some instances, adulthood. In some communities that are practising shamanism, it is found that the transition is invariably accessed through an initiation process. Such initiation processes always involve specific rituals and rites of passage, which announce and herald the advent or the new status. The male circumcision is in many cases part and parcel of the institution of initiation (CRL Rights Commission. 2010.5).

In the African setting, the TMC is usually shielded in so much secrecy that those who did not go through the process are not allowed to participate in it, irrespective of class or status. In some communities, the TMC is equated to some form of schooling. The closeness with schooling is seen by how most people call it circumcision or initiation school because notionally this is where young men are schooled on how to be mature adults. Those who have gone through it are regarded as mature men who qualify to discuss and participate in community and family matters and if they are old enough, to marry. Those who have not gone through it are scorned and ostracised, and in the words of Chief Mwelo Nonkonyana, the past secretary of Congress of Traditional leaders of South Africa (CONTRALESA) and a Traditional Leader in the Eastern Cape are referred as “paper men” (Dingindlela. 2014. p 32).

According to CRL Rights commission (2006), in South Africa, the TMC, has been infiltrated by unscrupulous people who see it as an opportunity to enrich themselves economically. The commercialisation of the TMC has led to the rise in inadequately trained traditional surgeons and illegal schools, which further led to botched circumcisions because the standard practices of an old traditional practice have declined. These common problems are also backed up by the report from

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the CRL Rights Commission, which states that it has been established that some initiation schools are opened for purely economic reasons and initiates are required to pay exorbitant fees, thus putting burden on the poor families. (CRL Rights Commission. 2006).

CRL Rights Commission (2006), went further to report that the negative implications of TMC included the prevalence of HIV and AIDS and the associated health risks that are feared because some traditional surgeons make use of unsterile instruments or even use one surgical blade or knife for all initiates. The use of unsterile instruments has caused fear of the transmission of deadly diseases such as HIV and AIDS, Hepatitis and other blood-borne diseases. There were reports of deaths of initiates because of various problems ranging from dehydration, to pre-existing health problems that were not identified before the boys were admitted to the schools. The other reports included penile amputation, septicaemia, severe malnutrition among others.

In response to the concerns mentioned above, the medical and aseptic techniques in the male circumcision programme were introduced. This is one of the reasons that have brought about the need for Medical Male Circumcision (MMC) to complement TMC. Evidence supports that Male Medical Circumcision (MMC) reduces the rate of HIV transmission from a female to a male. Other medical reasons for MMC include the prevention of paraphimosis, phimosis, and balanitis. This means that beyond the rituals and rite of passage, male circumcision has medical benefits (Abdur-Rahman, Musa, & Oshagbemi, 2012; Can, Kahrman & Topbas, 2013; Vincent, 2008a).

Given the sacred nature of the TMC and the fact that this was the domain of the Traditional leadership and their councils for a long time, it became necessary that from the onset, the introduction of MMC would require that the Department of Health, through its management structures at various levels, to work with the Traditional Leaders to get their buy-in during the alterations and introduction of alternative methods to TMC. The following section discusses the problems that influenced government's decision of introducing medical practices in TMC, the process followed, the stakeholders involved and the public's response to this in the South African context.

1.1.1 Death, HIV/AIDS and other health risks at Traditional Male Circumcision schools

The rise in the number of deaths of the initiates as a result of the TMC, the increased incidents of botched circumcisions performed by poorly trained traditional surgeons and the risk of transmission of diseases such as HIV and AIDS due to unhygienic surgical practices, influenced the need to have a modernised approach to the male circumcision. The degree of the incidents of adverse events varied from province to province depending on the extent to which the province practiced TMC and the involvement of the health professionals in the process.

According to a study conducted by Mbuyiselo and Nyembezi (2015) from Human Sciences Research Council (HSRC): Population Health, Health Systems and Innovation unit, it was reported that every year there are reported deaths of AmaXhosa male circumcision initiates, specifically in the region of Pondoland in the Eastern Cape, one of the provinces in South Africa. The common causes of deaths in these cases are dehydration, sepsis and gangrene.

Between June 2006 and June 2013, the Eastern Cape Department of Health reported a total of 5 035 circumcision initiates that were admitted to hospitals, 453 deaths and 214 penile amputations. A total of 19 initiates have lost their lives in the Eastern Cape, two in Limpopo and one in Mpumalanga. In the same period 17 illegal schools were closed in Gauteng alone (SABC Online, 08/07/2015). These are some of the factors that have increased the need for the introduction of the MMC.

In Limpopo province, the figures are low because the Traditional Leaders cooperated with the department of health. This point was further supported by the Minister of Health during the debate

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in the National Assembly in 2012 when he said that in 2011, the National Department of Health put an operation in place to support the Traditional Leaders in Limpopo province with TMC in response to their request and 1 848 initiates benefitted. According to this debate in the National Assembly, there was no death reported for the year in question. The Minister reported during the same debate that throughout Limpopo in 2012, using the same operation, the department helped 35 621 initiates and, unfortunately, two died because the department was engaged very late (National Assembly. 2013. 49).

Furthermore, the threat of possible HIV and AIDS infections because of lack of aseptic techniques during TMC also influenced policy changes regarding male circumcision in the country. This, among others, is what led to the introduction of medical procedures in the TMC.

This came at a time when MMC had been approved by the World Health Organisation (WHO) as a strategy for HIV prevention, and the Department of Health accelerated the finalisation of the National Strategic Plan (NSP) for HIV and AIDS in 2011. Through the NSP, the Department of Health included MMC as part of the HIV and AIDS prevention strategy. The department made the budget available for the MMC in the NSP as follows: R 244 million in 2012/2013 financial year up to R 488 million in 2015/2016 financial year. In the same NSP, the department set targets for MMC of between 500 000 MMC clients and 1 000 000 clients over the same period respectively (National Department of Health, 2011. 77).

The WHO and UNAIDS (2012) recommended MMC to the member countries as an additional HIV prevention strategy based on strong and consistent scientific evidence which was released in 2007. The evidence came from three randomised controlled trials undertaken in Kisumu, Kenya; Rakai District, Uganda; and Orange Farm, South Africa and they showed that MMC reduces the risk of sexually transmitted HIV from women to men by approximately 60% (WHO and UNAIDS. 2012).

The introduction of MMC through policies and legislation in traditional initiation processes represents an intersection of cultural practices and modern medicine. In addition, there is evidence showing that the introduction of MMC in areas that have long practiced TMC is perceived publicly as being in competition with the traditional practice. Perhaps that is what has led to the Traditional Leaders to reject government assistance in TMC arguing that, they are the custodians of the ritual and they should be the ones who decide what needs to be done when things go wrong.

This was also evident in the response to the passing of the legislation by the Eastern Cape provincial legislature to regulate TMC. The reactions by the Traditional Leaders such as Chief Nonkonyana, can best bear support to that view. The Traditional Leaders, in Eastern Cape in particular, hold the views that the regulation of TMC through legislation was watering down the TMC by bringing the unqualified men to be involved in the TMC, which is against traditional practice and protocol (Dingindlela. 2014. 30).

The TMC practice, the rituals and processes are held in secrecy to anyone who does not participate or believe in the practice. This includes women and men from other cultural backgrounds where it is not practiced. Thus, regulating it through legislation would allow open discussions about the intricacies of the traditional practices which was always done in secrecy, which in view of the Traditional Leaders would undermine and contaminate their custom.

Kepe (2010) as cited by Dingindlela (2014. 32) wrote that the Traditional Leaders believe that government's involvement in TMC infringes on their traditional and constitutional rights. They have argued that TMC does not need to be regulated and that MMC is not necessary because initiates who attend these school under these circumstances can be stigmatised and branded paper boys (amadoda ephapha). One Traditional Leader added that if an initiate is not circumcised according to the custom in the mountain, that boy will not be regarded as a man (Vincent, 2008b). He went further to say that the Act on Circumcision is "nonsensical" as it striped Traditional Leaders of their power

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to administer the custom and vested those powers in the provincial health minister and the doctors, some of whom may not even be circumcised (Vincent, 2008b and Dickson et al, 2008). This showed the extent to which the Traditional Leader rejected the government interventions in TCM. Hence the need to seek collaboration with all stakeholders for the programme to be implemented (Dingindlela. 2014. 31).

Just like the Eastern Cape, the Limpopo province has been working on the integration of MMC into traditional practice using general practitioners to conduct circumcisions at initiation schools (WHO. 2012.60). The fact that the introduction of this programme requires the involvement of the Traditional Leaders, led to the decision to look deeper into their role and find out whether they have the influence on how communities respond to introduction of the new programmes.

This study examines the interface between Traditional Leaders and the District Health Management Offices (DHMO) of the Department of Health in Limpopo and the different stakeholder in the implementation of MMC. The study focuses on three districts in Limpopo province, namely Vhembe, Mopani and Sekhukhune districts, where the implementation MMC programmes has taken place on a large scale. These districts have all developed multi-year plans that strive to contribute to the national target of MMC programme as set out in the NSP 2011.

1.2 Research Problem

One of the objectives of the NSP, 2012 was to address the increasing incidents of HIV and AIDS. In the process, the department of health identified the MMC as part of male sexual and reproductive health programme, to be included in the NSP. This was also introduced as one of the prevention methods for HIV and AIDS. The NDoH set national targets for the uptake of MMC, from which each provincial department was expected to set its own targets for the districts. From these targets, each district had to include in its District Health Plan (DHP), the targets that will contribute towards the provincial and national targets.

When the targets for NSP were set in Limpopo, the idea was not only for MMC as the prevention strategy for HIV and AIDS but was also to address other health problems that are highlighted by Kepe (2010), which are brought about by botched circumcision through the use of unsterile surgical instruments. The use of unsterile instruments aids the spread of blood- borne infections such as HIV/AIDS, tetanus, hepatitis B and many other sexually transmitted diseases. The other factors included, but not limited to, medical complications that occur from botched circumcisions, where the surgical instrument is blunt, or poorly trained traditional surgeon. This is what often led to severe mutilation of either the foreskin or glans of the penis, amputation of significant part or whole of the penis, and even death, which are common because of these botched circumcisions. The third set of adverse factors is dehydration, excessive bleeding, malnutrition and infections due to failure to the use aseptic procedures (Kepe. 2010. 730).

The above adverse events can be reason enough to call for the interface between the Traditional Leaders and government officials in the implementation of MMC which does not only provide insight into state-society relations but in this case also serves as a critical element in the success or failure of the implementation of the new programmes. Thus, it is crucial to understand the roles played by different stakeholders in the introduction of the MMC into the TMC because the latter is a very important aspect of life for those African communities that practice it.

The fact that the introduction of the MMC had different levels of success in different environments does not only point to the issue of contextual effects but may also signal to other contributing factors in the way the programme was implemented. Such factors include the relationship between health department officials and Traditional Leaders among others. This is the core issue being studied in this paper.

1.3 Research question and hypothesis

1.3.1 Research Question

The main question addressed in the study is: How can the interface between the District Health Management Office (DHMO) and the Traditional leadership contribute to the successful introduction of the Male Medical Circumcision (MMC) as way of addressing the current problems that are associated with the Traditional Male Circumcision (TMC)?

The purpose of this study is to explore the extent to which the interface between the DHMO and the Traditional Leaders in the implementation of the MMC, can lead to increase in the number of men that seek MMC. The study will be conducted in the three districts in Limpopo province: Vhembe, Mopani and Sekhukhune districts. The paper will examine the process that was followed in the introduction of the MMC; the factors that influenced the increased or decreased uptake of MMC in the three districts of Limpopo; the role of the different stakeholders in the implementation of the MMC; and the relationship between DHMO and Traditional Leaders during the introduction and implementation of the MMC.

The objective of the study is to analyze the events and/or situations that helped to increase or decrease the uptake of MMC in Vhembe, Mopani and Sekhukhune districts. To this end, the study will explore all actions, processes, meetings, proceedings and historical facts related to changes in cultural practices of TMC. This will start from the introduction of MMC by the health departments to the increased utilization of MMC services by the communities. An understanding of causal link between the co-operation of the Traditional Leaders and the DHMO regarding the MMC uptake will help in the implementation of similar policies in future.

A dependent variable of this study is the uptake of MMC as part of the new practice that needs to be introduced for the improvement to the health status of initiates. The independent variables are Traditional Leaders and District Health Management office as the institutions that must work together to introduce the MMC to improve TMC. These are aimed at improving the health practices for TMC, which is seen as a contributing factor to the increased morbidity and mortality among initiates. Through MMC, the practices of TMC will be modified to ensure increased interest in the communities. This understanding will hopefully lead to the improved MMC uptake in these districts. Several intermediate variables such as legislative, social and cultural domain, departmental policy development and implementation and even the activities of individuals play important part in achieving the final goal of the study. The importance of these variables is how they lead to increased or decrease uptake of MMC.

1.3.2 Hypothesis

The study hypothesis is that the success of the implementation of the MMC policy in the three districts of Limpopo is due to:

- Commitment and cooperative activities between DHMO and the Traditional Leaders
- Acceptance by all stakeholders of each other's standpoint on the MMC and TMC.
- Working towards mutually acceptable solutions of DHMO and Traditional Leaders to achieve a common goal.
- Stakeholder engagement prior the introduction of the MMC
- Social Mobilization and community education about the importance of the MMC

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Thus, a proper collaboration between the DMHO and the Traditional leadership in the uptake of MMC will improve chances of success, especially in settings where the Traditional leadership is strong and influential. This means that uptake of the MMC is dependent on the interface between the Traditional leadership and the DHMO as some of the key stakeholders. It can be assumed that if the DHMO establishes a good working relationship with the Traditional Leaders, there is a greater chance that the uptake of the MMC will improve because the MMC may alter the social, missiological, religious and cultural aspects of the TMC. It may also mean that if the Traditional leadership has influence on the communities, and that there is good co-operation between these two organisations; there are chances that the MMC uptake will improve. This could be based on the role that the Traditional Leaders play in other spheres of lives of the rural people where they have confidence in the leadership (Papu & Verster. 2006. 179).

The assumption is that this is possible where the DHMO works well with the Traditional Leaders during the introduction of MMC. This is because the introduction of MMC in the rural areas will take place in an environment where the TMC has also been part of the custom and tradition of the communities especially those falling under the Traditional leadership, especially in Vhembe, Mopani and Sekhukhune districts.

The chapters that follow will explore how the interface between DHMO and the Traditional leadership will contribute towards the introduction of the MMC and hopefully further lead to the increased uptake of MMC; how the Traditional Leaders react to the new programme; the point at which the Traditional Leaders finally accept the MMC; how the Traditional Leaders can aid the acceleration of the intake of the MMC and how the two organisations can make this succeed or fail.

1.4 Methodology

1.4.1 Study strategy

The paper follows a qualitative research approach because it is concerned with seeking to understand how various stakeholders interpret their situation and how they share their own practical experiences in relation to the topic of the research. The researcher makes use of the qualitative research strategy because it is concerned with understanding how people interpret their own experiences, and what meaning they attribute to their experiences and how these people construct their worlds (Merriam. 2009).

The rationale for using the qualitative research method is because it is usually used to gain an understanding of underlying reasons, opinions and motivations for people making certain choices such as selecting TMC despite its much-publicised adverse events and choosing the MMC in the face of possible ostracism by their communities. Qualitative research is also used to uncover trends in thought and opinions, and dive deeper into the problem. Qualitative data collection methods will vary using unstructured or semi-structured techniques.

1.4.2 Study design

The study is qualitative because it is intended to follow the process in the introduction of MMC in an environment of the TMC. It also seeks to understand the views of the local traditional people and the health managers that are working at the district level, the staff of the department of health at both province and district levels. The study is further descriptive. It looks at the views of the respondents through interviews, studies the reports from national and the province, as it looks at the plans of the health sector on the MMC and TMC.

Action research method is also used because the data was collected from the respondents. The motivation for using this approach is that it seeks clarity on the immediate problem. The other

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approach is a reflective process of progressively solving the problem of the TMC by the stakeholders working together to improve the way the problems that have been experienced from the TMC can be solved or minimised through MMC.

1.4.3 Data collection

The data was collected through the semi-structured interviews with the managers of Vhembe, Mopani and Sekhukhune districts, the provincial and national focal persons for MMC, the members of the health professional teams the people that are working with or under the traditional leaders. This approach assisted because it allowed for rigorous interviews and follow-up interviews where the answers were unclear. This was also helpful in that the interviewees were all personally involved in the process of the introduction of the MMC or were personally affected by the TMC and were aware of the negative adverse events associated with TMC. All participants have been through the TMC or lived in the communities where TMC was practiced or are fully informed about the intricacies involving the TMC or have a relative that has undergone TMC or MMC. The participants were either working on the introduction and implementation of the MMC from the government side or from the traditional leadership side.

The interviews were conducted either through written questions, or direct conversational engagement with the respondents either through the phone or face-to-face discussions. The three district managers agreed to respond to the written questions and follow up oral questions, two Deputy Directors, three Environmental Health Practitioners, three professional nurses agreed to the telephone interviews on condition of anonymity. This includes the three interviewees who are either Traditional Leaders or work with the Traditional Leaders as councillors and one of them was a member of the royal family. A total of 14 respondents were interviewed.

Data was also collected from secondary sources such as international agencies, government policies, reports and other secondary sources. This was helpful to back up the interviews and to bring authenticity of the data provided.

1.4.4 Data analysis

The data received from the interviews was analysed in conjunction with the information from the provincial reports and the District Health Information System (DHIS). The interviews were used to determine the factual issues around the processes followed and the change management issues that were prevalent in the process.

The DHIS was used to examine uptake figures during the introduction of the MMC and to gauge the progress that districts were making over 4 years. The figures from DHIS show a year-on-year progression on the uptake for MMC. Both the interviews and the data were analysed and interpreted to shape the writing of the report.

1.5 Chapter outline

Following from this chapter, the rest of this study is structured as follows:

1.5.1 Chapter 2: Literature review

The chapter addresses the specific literature around the topic of TMC and the introduction of MMC in the various settings. The literature will be given international and national perspectives.

This chapter will also deal with how the MMC was introduced in the settings where the people were practising TMC as part of their culture and tradition. The chapter will look at how various writers have expressed their views and knowledge on the introduction of MMC to address the adverse events

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resulting from TMC. It looked at the historical background of TMC, how traditional communities regard TMC as sacred and further that it has been an old practice over many years. The introduction of MMC will bring the Traditional Leaders and DHMO face to face especially that the former claims to be the ones that are solely entitled to open the schools or authorise the person who wants to open the school. They also claim to be the sole custodians of TMC, as it shall be discussed in the following chapters.

The chapter will also look at role of the Traditional Leaders in other matters, with a view to establish their influence on the communities they rule.

1.5.2 Chapter 3: Study methods and design

The chapter outlines the methodology used in the research. It will show the hypothesis, methodology, the research strategy, and research design and data collection process. The study will bring into line the arguments, the concepts, the theories that will arise out of the literature review. The chapter will be guided by the research problem, research question and the data collection methods for the research.

1.5.3 Chapter 4: Empirical drill I: data presentation

This chapter focuses on the data presentation and how the respondents have responded to the questions posed. The data collected will show the differences or similarities of how the respondents reacted to the same question in the different settings. The chapter gives the broad overview of the three districts together through presentation of the data collected by means of the questionnaires and information obtained from the District Health Information System (DHIS). The chapter will further expose the role of each stakeholder in the introduction of MMC and the approach of departmental officials in the introduction of the MMC, in their respective districts. The chapter will deal with how TMC is and was conducted previously in order to bring out an understanding of how MMC was introduced in that context. It will further bring into focus the relationship that needs to be built or strengthened between the DHMO and the Traditional Leaders as the key stakeholders in the introduction of MMC and the provision of health services in general. It will also assist in clarifying how the Traditional Leaders eventually allowed the introduction and implementation of MMC amidst the fears and threats of the process undermining the discreetness of TMC.

1.5.4 Chapter 5: Empirical drill II: data analysis of the findings

This chapter will look at the details of what happened in each district between 2011 and 2015 in more details. This will be informed by the data analysis and how each district performed over the same period. The detailed data analysis will show, comparatively, the performance of three districts for the same period. It will also look at the details of how the MMC was introduced and rolled out in each district and how this picture changed over the same period. It will also look at the performance of the three districts individually and how the numbers increased or declined in each case depending on how each district performed. The chapter will also provide the reasons for the decline or increase in each case and will show the factors that contributed towards that increase or decline in each district.

1.5.5 Chapter 6: Recommendations

A set of proposed activities that must be undertaken based on the lessons from the afore going chapters in either strengthening or improving the male circumcision programme in general. These activities may be valuable for policy or opinion makers regarding the experience of MMC implementation in the three districts. These lessons will be helpful in taking the process forward. From this chapter, the reader will understand the general nature of the recommendations because they are meant for implementation by wider stakeholder community.

1.5.6 Chapter 7: Conclusion and policy implications

This paper will end with a conclusion that will be based on what has been observed, read and what the interviewees said in response to the questions raised. The chapter will look at the policy implications of those points raised in the earlier chapters and how these can impact on policy development in both specific and general senses. The conclusion will draw from all the interviews, observations made, data collected, literature read to demonstrate the possibilities of good performance of any programme when all stakeholders are consulted during the introduction of the new programme so that there could be buy-in and to enhance broader adoption of the programme.

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Chapter 2: Literature review

2.1 Introduction

The literature review was undertaken to critically summarise the current knowledge in the area under investigation and to learn from the lessons of other settings and countries. This further provided context within which to place this study on the interface between the traditional leadership and the district health management offices in the delivery of health services, with a special focus on the introduction of MMC.

This chapter will deal with the existing body of knowledge; review the best practices, and what is currently happening regarding both TMC and MMC. This will then drive the narrative to develop, synthesise, develop arguments and provide a clearer picture and a good structure for the study. This means that the information derived from this chapter will shape the study as the initial stages of responding to the research question. It also reflects on the Traditional Leaders in the South African context and their influence in communities; Traditional Leaders as stakeholders; Traditional Male Circumcision (TMC) versus Medical Male Circumcision (MMC).

The chapter will be used as the basis on which to locate the key points of the study, which is as follows: The historical background to TMC; the chronicle of TMC; how the Traditional Leaders conducted TMC in the past until the introduction of MMC; the second part will deal with the adverse events that arose out of TMC in its general and original form or due to illegal practices; the third aspect will present how the government responded to the adverse events; and the fourth aspect will discuss the linkages between the MMC and its role in the fight against HIV and AIDS. These points will be properly addressed in the study by looking at the national and international literature, which will show how the TMC transition to MMC can be managed and how this literature reflects on the main drivers of the introduction of MMC.

The study will further look at TMC and MMC as the two complementary programmes and see if MMC is not meant to totally replace or adapt TMC to the modern clinical and aseptic ways. The study will also look at the options that the people have of combining both TMC and MMC, so that they are hygienically safe and at the same time, they are also traditionally compliant in terms of rituals and customs. The emphasis on hygiene is based on the need of clinicians to perform the surgical work, while the traditional surgeons continue with the rituals. Last, but not least, will be the way the Traditional Leaders allowed the involvement of health professionals in the circumcision schools.

2. 2 Traditional Leaders in the South African context and their influence in communities

Traditional Leaders have long been part of the leadership of South African society, especially in the black rural areas. With the advent of democracy, their roles and responsibilities remained albeit with contestations in some place. In terms of Chapter 12, sections 211 and 212 of the Constitution of South Africa (1996), it is stated that the institution, status and roles of traditional leadership, according to customary law, are recognised. According to du Plessis (1999), the Traditional Leaders have a definite role to play at national, provincial and local spheres of government. At national and provincial spheres, they should be more involved in the formulation and decision-making process regarding policy and planning and at a local level their function is to oversee the proper implementation of policy and planning, especially regarding development in their areas of jurisdiction. In the district or rural councils where more than two traditional authorities are present, forums should be established to assist with the formulation of policy, decision making and planning at those levels (du Plessis. 199).

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Mamdani (1996) and Ntsebenza (2005) observed that in the post-apartheid South Africa, debates on the resurgence and resilience of chiefly powers have grown over the past two decades. Among others, dominant arguments include questions on whether chieftaincy is a hindrance to democratic principles and progress. This is because some of its elements still resonate with the character of the erstwhile colonial indirect-rule. Comaroff and Comaroff (2009) wrote that the anthropologists have observed that the ability of chiefs to survive in the post-apartheid era can be attributed to the increasing commoditisation of the politics of ethnic identity, culture and tradition.

The role and value of the Traditional leaders can be found in the fact that among the founding members of the African National Congress there were a considerable number of chiefs. Upon the formation of the ANC in 1912, an Upper House was created to accommodate Traditional Leaders who joined the organization. Some of the leaders such as Langalibalele Dube and Chief Albert Luthuli, both went on to become the presidents of the ANC.

Murray (2004) write that, faced with the prospects of returning from exile in 1988, the ANC wrote a document that was preparing on how to deal with the situation of Traditional Leaders. This document, which was titled “the brief set of Constitutional Guidelines for a Democratic South Africa”, was circulated in 1988 and it both hinted at the problems hereditary leaders pose and proposed imagined solutions. The document said: “The institution of hereditary rulers and chiefs shall be transformed to serve the interests of the people in conformity with the democratic principles embodied in the constitution”. This shows the extent to which the ANC viewed the traditional leadership even before it came into power.

Some of the members of the ANC viewed Traditional leaders as the stooges and collaborators of the apartheid government who were unaccountable to their communities even though they are credited to the formation of the ANC as stated in the earlier sections. Despite the labels they got, there are some of them who struggled with the masses of the people to fight apartheid, some even risked being dethroned, exiled, ostracised and/or even replaced by the collaborators (Williams. 2010). This is what led to the legitimacy of some of them being questioned, and as such they faced rebellion from the communities. This could be the reason why there was no unanimous position about the position of the Traditional Leaders during the apartheid days.

In order not to be seen to be totally antagonistic towards the Traditional Leaders, ANC government passed several laws regarding the Traditional Leadership. One such laws were the Traditional Leadership and Governance Framework Act of 2003 (Act 41 of 2003). This act re-enacted traditional authority to preside over precisely the same geographic areas that were defined by the apartheid government (Claassens, 2011. 14; Mswana, 2014b. 2). Among other things, the Act enables Traditional Leaders and their traditional councils to be granted powers over the administration and control of communal land and natural resources, economic development, health, and welfare, and to administer justice. In some communities, rural communities and civil society organisations have strongly resisted these laws mainly because they give traditional authorities disproportionate and illegitimate powers. This was made worse by what is perceived as the poor consultative and top-down nature with which the state introduced them (Claassens. 2011. 14; Mswana. 2014b. 3). This may thus demonstrate the fact that the Traditional Leaders do not have absolute powers to rule over the communities, except to regulate the traditional customs and traditional practices, without authoritatively and indiscriminately pushing down against the will of the people.

Various other legislations were passed during the democratic era concerning the Traditional Leaders, which have placed them as the important role players in the governance of the people where they are in charge. The Municipal Structures Act, Section 81 (1) (117/1998) makes the Traditional Leaders key role players in the local sphere of government in one such Act. It states that, the traditional authorities that observe a system of customary law in an area of the municipality may

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participate through their leaders identified in terms of subsection (2) in the proceedings of the council of that municipality. It further states that the Traditional Leaders must be allowed to attend and participate in any meetings of the council. The same Act, under section 81 (3) further states that before a municipal council takes a decision on any matter directly affecting the area of a traditional authority, the council must give the leader of that authority the opportunity to express a view on that matter. This may include matters such as those that have bearing on tradition and culture (SA. 1998. 57).

The Intergovernmental Framework Act (IGRFA) no 13 of 2005 is another law that has implications for the role of the traditional leadership in matters of governance. It enjoins all three spheres of governments to co-operate with each other in matters of service delivery. The objectives of the IGRFA are, inter alia, to provide a framework for the national government, provincial governments and local governments within the principle of co-operative government set out in Chapter 3 of the Constitution. This includes all organs of state within those governments, to facilitate co-ordination in the implementation of policy and legislation, including coherent government; effective provision of services; monitoring implementation of policy and legislation; and realisation of national priorities (SA. 2005. 8).

The traditional leadership is at the local sphere of government and the provisions of the IGRFA affect it when it comes to the matters that are taking place at the local level. Based on the prescripts of the IGRFA, it can be assumed that the Mayor of a district municipality that includes areas that fall under the jurisdiction of the traditional leadership will be sitting in the provincial intergovernmental forum, which is chaired by the Premier. It is further assumed that the same Mayor will consult with or report to the Traditional Leaders who may be affected by provincial and national policies decisions taken in the IGRFA meetings. These matters may include the need to introduce the new service delivery program such as MMC and how this will be implemented (SA. 2005. 12).

In Limpopo province in particular, it can be assumed that the influence of the Traditional Leaders on the communities, their roles and functions are defined in the Limpopo Traditional leadership and Institutions Act 6 of 2005, section 18 subsection (1), which states among others that: a traditional leader performs any function provided for in terms of customary law, or assigned to him or her in terms of any law, subject to section (20) of the Framework Act and without derogating from the generality of the afore going. The traditional leader performs in addition, in consultation with the traditional council, the following functions: promote the interests of the traditional community concerned. This may be assumed to include the need for the community to practice their tradition and culture freely as they used to do in the past (Limpopo. 2005. 12).

On the other hand, Congress of Traditional Leaders of South Africa (CONTRALESA) envisioned a greater role that will be played by the Traditional leaders in the rural areas. This can be seen from its objectives as captured in its constitution which are, inter alia: to reinstate, protect and promote the institution of traditional leadership, its traditional status and bonding function in the community and the nation (CONTRALESA. Unpublished. 2006). These are the historical functions that the Traditional Leaders have been performing which they were having been interfered with by the government.

The matter raised in the paragraph above is supported by the points made by Bizana-Tutu when she wrote that: "as stated by Mabutla, South Africa was for many years, before the white settlers, ruled by a succession of kings such as Shaka of the Zulu, Makhado of VhaVenda and Sekhukhune of the Bapedi nations, who were regarded as the sole source of political power for the communities. They governed through a hierarchy of territorial chiefs, who held office by their favour and their gift. Each chief had to give tribute and service either directly to the king, or indirectly through the chief next above him in the hierarchy. The higher chief had to attend the king's court on invitation" (Bizana-Tutu. 2008. 6).

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Bizana-Tutu (2008) went further to state that traditionally, this state of affairs seemed to have been acceptable to everyone although it was not always the case. The system was justified by both myths and rituals, and both rulers and communities handled conflicts in terms of the values, which were shared. As the rulers of the community, Traditional Leaders had the power to allot land, which means that the land was theoretically their property that they held as the trustees on behalf of the people. This power was not always accepted by everybody, hence the challenge of the legitimacy and credibility of the Traditional Leaders from the side of the younger generation. The conduct of some of the Traditional Leaders also led to people losing respect and thus undermining the very power they claimed to have (Bizana-Tutu. 2008.p8).

What may have further impacted on the credibility and legitimacy of the traditional leadership was the fact that some of them were seen as collaborating with the apartheid system while others were just outright corrupt as stated in the earlier section. This was perhaps exacerbated by the sentiments expressed in the documents such as the one that was attributed to the ANC while in exile in 1988. These views can be backed up by what both Mamdani (1996) and Ntsebenza (2005) wrote, which asked whether the Traditional Leaders are a hindrance or an enabler. Consequently, Traditional Leaders are perceived as having a negative impact on the total democratization of the South African society, hence the call that they should be eradicated (Mamdani 1996; Ntsebenza 2005). This may have made people to view the traditional leadership with suspicion, while there are those who felt the wrath of the apartheid government as stated in the earlier section.

Despite what has been written about the Traditional Leaders, their influence can also be backed by what happened in Limpopo during the municipal boundary's demarcation disputes. When there was a standoff between the community of Vuwani in Vhembe District and the Government on the municipal demarcation, it took the Traditional Leaders to influence the community to accept the settlement that was proposed by government. Initially the people did not want to come around the table to discuss the decision of the demarcation board to incorporate Vuwani into the newly formed municipality of Malamulele. The spokesperson for the Department of Cooperative Governance and Traditional Affairs issued a media statement on the 9 May 2016 that read "it was not easy to get people around the table to talk, until the previous day when we met with the majority of Traditional Leaders in the area" (SAFM. 9.05.2016). This media statement followed the meeting between the Provincial government officials, the Traditional Leaders and other community representatives the previous weekend in a bid to end violent demonstrations and to reopen schools in Vuwani, Vhembe district. These followed the period when the schooling had been brought to a standstill, during which more than 20 schools were torched and vandalised and 50 schools shut down in the region. From the picture painted here above, it can be assumed that the community respected the decisions that were taken in the presence of the Traditional Leaders because following this meeting the situation became normal.

It was again reported on Jacaranda FM (28 July 2016, at 12:54PM) that the agreement was signed in Polokwane by the political leadership and the traditional leadership in Vuwani. This agreement was aimed at ending the violence and ushering the opportunity for the people of Vuwani to cast their vote in the forthcoming local government elections. A Traditional Leader from Vuwani, was reported to have said that traditional authorities will engage with the community to bring the situation back to normal. It was reported during the same new bulletin that the same traditional leader went further to say that: "These communities that we represent, at times are not too confident about the processes that we are involved in and it becomes our duty as Traditional Leaders to persuade them to see what they may not be seeing." This statement confirms the important role of traditional leadership in influencing the communities in a specific course to support the implementation of government programmes.

2.3 Traditional leaders as stakeholders

The Traditional Leaders are important stakeholders when it comes to the introduction of programmes such as MMC. This is because MMC comes as a response to the adverse events of the TMC, which is practiced in many parts of South Africa by different communities under the custodianship of the Traditional Leaders. In Limpopo, the Provincial House of Traditional Leaders (LPHTL) is entitled to advise and make proposals to the Provincial Legislature or Provincial Government in respect of matters relating to traditional councils, indigenous law, or the traditions and customs of traditional communities within the Province.

According to the Traditional Leadership and Governance Framework Act 41 of 2003, a traditional community must transform and adapt customary laws and customs relevant to the application of this Act to comply with the relevant principles contained in the Bill of Rights in the Constitution. Further, the Act prescribes that the Traditional Council, should administer the affairs of the traditional community in accordance with customs and tradition; and perform the functions conferred by customary law, customs and statutory law consistent with the Constitution (SA. 2003. 13).

This Act makes the Traditional Leaders the key stakeholder in the introduction of MMC as a complementary or improvement programme to TMC, which is one of the customary activities. This is critical in that even in the urban settings where people have set up TMC schools, those are with the influence of the traditional leadership or such people they take a cue from the Traditional Leaders in the way they conduct the TMC School. This based on the way these schools are set and conducted (Dingindlela. 2014.10).

This may mean that due to this position, for the successful implementation of a programme such as MMC there must be consultation and co-operation with the Traditional Leaders. The lessons learned from the study on the Interaction of the Malnutrition and Enteric Infections: Consequences for Child Health and Development (MAL-ED) may provide such good example. This study confirmed the centrality of the Traditional leadership in the consultation of the communities in the rural area during the introduction of a programme in their areas of jurisdiction. The study confirmed that the rural areas predominantly fall under tribal/traditional authorities. This means that traditional leaders are important stakeholders in the rural areas, who have some influence on the sections or whole of the communities residing within the jurisdiction of such areas (Bessong et al. 2014. 1).

According to Bessong et al (2014. 2), the introduction of the new programmes will succeed when the local leadership, especially the traditional leadership, has been consulted properly. This was evident when conducting a study on the 'Etiology, Risk Factors, and Interactions of Enteric Infections and Malnutrition and the Consequences for Child Health and Development' (MAL-ED) South Africa project, which was initiated in 2009 and undertaken in the Dzimauli community of the Vhembe District in the Limpopo Province of South Africa.

In the above study, after identifying the village of study, the critical step undertaken was to engage the traditional and civil authority within that community before attempting to interact with the community members and embarking on the study. The traditional leadership continued to hold their meetings separate from the civic organisation meetings as sign of control and influence over their communities. It can be assumed that the idea was to ensure that the traditional leadership remains distinct and does not get subsumed in the meetings called by the civic organisation (Bessong et al.2014.1).

In another setting, the Traditional Leaders rejected the legislation that was passed by the provincial legislature to regulate the TMC because they felt that they were not consulted and as such felt undermined as the leaders of the communities and as the custodians of the TMC. They also felt that the department had watered down the old traditional practice of TMC. This provoked angry response

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from some of the prominent Traditional Leaders in the province who declared that they did not support the legislation. They claimed that they are the real and sole custodians of the ritual and complained about the involvement of females and uncircumcised male health officials in monitoring initiation practice (Kepe. 2010. 2).

Even before the implementation of the same provincial legislation, Traditional Leaders claimed that as custodians of African culture they should be given the resources and authority to oversee the regulation and management of TMC (Indabazethu, 2004; Meintjes, 1998). Chief Mwelo Nonkonyana has argued that the provincial government needs to strengthen traditional structures and support them as they are the real custodians of the ritual (Cape Times. 2003; Kepe. 2010. 2).

In this debate, the Traditional leaders often referred to how “in the past” all initiates merely accompanied the sons of chiefs to initiation schools. This shows, they argue, that the ritual revolves around Traditional Leaders, and furthermore that the Act violates their constitutional right to preside over traditional matters (Citizen. 2003). On the other hand, the provincial government has emphasised on several occasions that the Department of Health does not view themselves as the custodian of the custom and have no ambitions to do so in the future. Government has continually stated that their role is to prevent an escalation of the public health crisis arising from the TMC, but not to act as custodians of the ritual (Kepe. 2010. 1).

A response from one chief was that if an initiate is not circumcised according to the custom in the mountain, that boy will not be regarded as a man (Vincent, 2008b). He went further to say that the Act is “nonsensical” as it stripped Traditional Leaders of their power to administer the custom and vested those powers in the provincial health minister and the doctors some of whom may not have gone through the TMC (Vincent. 2008b and Dickson et al. 2008).

This reaction shows that the department needs to work together with the Traditional Leaders in the implementation of the MMC in the areas where the latter has influence and control. Failure to work together may spoil what was the best intention of the government and may even lead to inability to address a genuine concern. This may further lead to more complications of the TMC while the stakeholders are jostling for power and control over the practice.

The situation of the Traditional Leaders in South Africa can be compared to the situation in Zimbabwe in the olden days. Prior to the colonisation of Zimbabwe, the institution of traditional leadership was the sole governance structure whose legitimacy to govern was derived from tradition and culture. This means that the local headmen, who are the extension of the traditional leadership, or part thereof, are better placed to be change agents on any policy matters that come from government. This is possible if they are properly consulted because of their proximity to the people (Chigwata. 2016.70). This arrangement is similar to the South African context where the Traditional Leaders are closest to the people. This means that it is possible for the DHMO to work with them when introducing the new programmes such as MMC. In this way, the new programme will have legitimacy and the people will easily accept it.

Just like many of the legislations in South Africa including the constitution as cited in the previous sections, the constitution of Zimbabwe requires the traditional leaders to inter alia: promote and uphold cultural values of their communities in particular; to promote sound family values; to take measures to preserve the culture, traditions, history and heritage of their communities, including sacred shrines and facilitate development in their areas of jurisdiction (Chigwata. 2016. 77). This puts them in pole position to be advocates of the new programmes such as MMC if properly consulted.

Siegler, (2012) wrote that, if the Traditional Leader supports the introduction of the MMC, this will most likely lead to willingness of the communities under such Traditional Leader to opt for the MMC.

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This may further indicate that individuals that prefer to go for the TMC will start to recognise the benefits of MMC when it is supported by the Traditional Leaders and this could substantially influence individual willingness to opt for MMC. The results from this study by Siegler et al indicate that the support from Traditional Leaders can be more important in the introduction and implementation of the MMC than adherence to tradition itself. Thus, persuading them of the value of MMC, and involving them in programme design and implementation, seems likely to increase the effectiveness of interventions intended to promote MMC procedures in societies that practice traditional circumcision. (Siegler AJ et al. 2012. 6)

In the current set up where people know their rights, cultural and religious considerations may affect the process of MMC scale up in Southern Africa (Peltzer et al. 2010. 2). This is because traditional historical beliefs and practices around TMC will adversely affect the uptake up of the MMC despite its greatness of messaging and broader intentions on the HIV prevention programme if not properly managed. This means that the consultations with the relevant stakeholders will be the best way to manage the dynamics within the relationships (Deacon & Thomson.2012.5).

2.4 Traditional Male Circumcision (TMC) and Medical Male Circumcision (MMC)

TMC and MMC are the focal point of the study. This means that understanding these practices forms a good basis for examining the role of Traditional Leaders, DHMO, the health professionals and other stakeholders at the intersection of modern medicine and traditional practices. MMC is seen as an improvement of the methods and procedures used in the TMC, while the rural traditional communities see TMC as part of the indigenous practice of African tradition. As stated in the previous sections, MMC was also introduced to address various problems that arose from TMC, and as a strategy by the department of health to address HIV and AIDS epidemic.

2.4.1 Traditional Male Circumcision

As stated earlier, TMC is a rite of passage for boys and young men to full adulthood for some African communities. The key elements of TMC in South Africa are customs and rituals of initiation. Many initiation rites are regarded as incomplete without the traditionally performed ritual of initiation. Indeed, this makes TMC a crucial ritual affirming the male's passage to manhood. In the South African context, male circumcision is not complete without the ritual element. This leads to a male who has been circumcised at the health facility not to be viewed as a complete man unless he goes through the rituals of initiation. This ritual is the important aspect of the initiation rite that today poses a serious challenge of botched circumcisions (CRL Rights Commission. 2010. 12).

The practice of TMC not only relates to the procedure but it also encompasses learning that is attached to the traditional practice to prepare the young man to be the 'real man'. This is critical in that most of the initiates are at adolescent stage, which is the stage that needs to be properly monitored, otherwise it could be destructive for the individual, the family and the community. This is a delicate stage because at this point, the boy is neither a child nor is he a man, but he is developmentally excluded from the community.

Mead argued that adolescent stage is the time when teenagers begin to look beyond themselves. They are faced with two choices at this stage: to join the ranks of responsible adults or follow the band of his peers in an alternative society (Mead. 1973. 3). The role of TMC therefore becomes critical in steering this young man towards becoming a fully responsible man of dignity in his community. Therefore, the man who has not undergone male circumcision faces the scorn of the community and in extreme cases even ostracism (Dingindlela. 2014. 30).

In Ghana, for example, being uncircumcised carries such a scorn that even older men prefer to undergo male circumcision. Satyi shares a story of how he came to be circumcised at an older age.

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He stated that “being uncircumcised gave me a lot of psychological worries, as I had to live with the stigma, amidst jests and taunts from my male peers, who openly in public, made fun of me before our girls and ladies. We had open bathrooms at the college, so there was no privacy for anyone. The taunts went so far that sometimes I cursed my parents for not having acted on the issue earlier on. My academic performance was even adversely affected because of having inferiority complex among my colleagues at school. Many a time, during our Saturday evening entertainment, which usually was a record dance, my male classmates would be taunting me in front of our ladies, by telling me to go and get circumcised first before I could touch girls”. This just shows how people value the need for circumcision. Clearly, this can be improved with the addition of the aseptic techniques which will reduce the risk of infections (Satyi. 2013. 5).

However, in pursuit of this noble transition from boyhood to manhood like Satyi, many initiates have lost their reproductive organs owing to the botched circumcision because of poor performance of the traditional surgeons. Some of the surgeons are unqualified to perform traditional circumcisions which lead to botched circumcisions resulting in penile amputation and in worse cases even death of initiates. Some of the surgeons are alleged to be operating under the influence of alcohol, while others perform TMC for economic reasons. (CRL The Commission. 2006 & 2010. 10).

2.4.2 Medical Male Circumcision

Male circumcision is the surgical removal of the foreskin - the retractable fold of tissue that covers the head of the penis. The inner aspect of the foreskin is highly susceptible to HIV infections. Trained health professionals can safely remove the foreskin of infants, adolescents and adults as a medical procedure hence the name medical male circumcision (MMC). In 2007, WHO and UNAIDS issued recommendations on the MMC as an additional HIV prevention strategy based on strong and consistent scientific evidence.

The most recent data from Uganda shows that in the five years since the Uganda trial was completed; high effectiveness has been maintained among the men who were circumcised, with a 73% protective effect against HIV infection. For the programme to be introduced in the rural settings where there has been the practice of the TMC, health professionals and managers are expected to consult with stakeholders including the Traditional Leaders who have been the custodians of the TMC over many years (Wilcken, Keil & Dick. 2010).

As debated in the National Assembly in 2012, it was made clear that in situations where there was adequate consultation between the Traditional Leaders and the department of health, there has been few deaths or incidents of botched circumcision. The consultation involves allowing health professionals to introduce the MMC while the Traditional Leaders and their councils continue to subject those who are willing, to the ritual part of the TMC. In many cases, this may include having doctors performing the surgical operation, while the traditional surgeons continue with the ritual part. There are those people who would have opted to be circumcised in the health facilities, so that when the time for traditional initiation school comes, he only goes for the rituals. This is so because many African societies, male circumcision is carried out for cultural reasons, particularly as an initiation ritual. Thaele (2012. 2) cited Wilcken, Keil & Dick (2010) as having reported that the self-reported prevalence of TMC varies greatly between Eastern and Southern Africa, from 20% in Uganda and Southern African countries to more than 80% in Kenya.

2.4.3 Advocacy for MMC and international experience

For reasons mentioned above and elsewhere in this paper, there has been increased advocacy for the introduction of MMC and associated practices alongside the TMC. This advocacy was based on

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the international best practices including the decisions at both national and international levels of the need to introduce MMC to address all or some of the problems mentioned in the earlier sections.

Understanding TMC and engaging both TMC surgeons and the traditional leadership and other stakeholders is important when introducing MMC especially in the rural areas where the TMC has been practiced for many years. There are countries that had wider consultation on the introduction and scale-up of the MMC but the extent to which this convinced the Traditional leadership has not been established.

The process of stakeholder engagement in South Africa on the MMC-TMC interface began within the South African National AIDS Council (SANAC). In Zimbabwe, the Zimbabwean National AIDS Council (ZNAC) was involved while in Malawi this was acknowledged as important (WHO/UNAIDS 2009a:9). The WHO report on a sub-regional (Southern African Development Community (SADC) (July 2009) consultation on the promotion of MMC for HIV prevention confirmed that in countries with extensive consultations, the engagement of stakeholders such as traditional leaders, women and young people increased buy-in and support for scale-up of MMC. This shows that the more consultation the better the chances of acceptance and success of the programme by the communities and their leaders (Deacon & Thomson.2012.6).

In Namibia, there was an acknowledgement that traditional initiation and circumcision practices needed to be researched, which when completed, it increased buy-in and further advocacy by Traditional Leaders. (WHO/UNAIDS 2010:6). Since 2009, other countries have also increased their efforts to engage Traditional Leaders in the introduction and scale-up of MMC. When all these were happening in other African countries, South Africa was still planning to implement its MMC policy in collaboration with stakeholders including Traditional Leaders (Deacon & Thomson.2012.7). This means that South Africa came very late in the introduction and implementation of the MMC programme. This should have provided the basis to learn from mistakes or success of other countries in the continent.

In Zimbabwe, the traditional and religious practitioners have a responsibility to ensure that traditional and religious customs do not endanger life through complications of circumcisions or spread of HIV and other infections through unsafe circumcision operations. Traditional and religious practitioners use their influence to promote HIV prevention through appropriate messages during the rituals of TMC. The traditional and religious practitioners, Ministry of Health and Child Care (MOHCC) and National AIDS Council (NAC) and other technical partners jointly prepare the messages on the new approach to MMC (MOHCC. 2014. Unnumbered).

Chigwata wrote that the Traditional Leaders have provided “spiritual” and cultural leadership to their respective communities over a multi-generational period. They are the custodians of culture, customs and traditions because of their fair appreciation of the culture and tradition of their respective communities. Therefore, introducing the MMC through the traditional leadership as one of the key stakeholders before implementation is the right thing to do. South Africa can learn from Zimbabwean example in that the Traditional Leaders also act as communication mediums of government policies, notices and directives in their respective jurisdictions. Over the years, Traditional Leaders have been active in mobilising people in their respective areas to support development projects, such as, the provision of health services, water, sanitation and roads (Chigwata. 2016. 78 & 82). This makes the Traditional Leaders one of the important stakeholders in the matters of community development.

In Rwanda, men who were not traditionally circumcised are now undergoing MMC. In this case circumcision is performed to prevent HIV (Kim, Koo, & Pang, 2012). Some people cautioned that MMC would not easily replace TMC in Africa because traditional healers and surgeons will continue to play an important role especially for cultural and ritual reasons. This is compounded by the fact

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that the health system does not have the necessary capacity to take over this massive job (Dick, Keil, & Wilcken, 2010. 905).

Based on the afore going discussion, it can be assumed that the successful introduction and sustainability of the MMC will depend on some of the following principles: country leadership and ownership; involvement of stakeholders such as Traditional Leaders; consideration and preservation of human rights; gender dimensions; comprehensive package of services for HIV prevention; combination of dedicated and integrated approaches to maximize public health benefits as well as strategic coordinated actions (WHO/UNAIDS. 2012.11).

2.5 Conclusion

From the previous sections and subsections, it can be assumed that the introduction of MMC requires the stakeholder engagement in the settings where these stakeholders have influence. In the three districts in Limpopo province where the institution of Traditional Leadership is well established and has influence on the community, the consultation of the stakeholders including the Traditional Leaders during the introduction and implementation of the MMC is almost inevitable. This is so, because as it was the case in the Eastern Cape, as written by Dingindlela (2014), where the Traditional Leaders argued that TMC does not need to be regulated as initiates who attend these schools could be stigmatised and branded paper boys (*amadoda ephapha*). This implies that the consultation of the Traditional Leaders on the MMC will ensure its legitimacy at least in the area where they have influence.

From the health perspective as provided by various studies at both national and international level, MMC provides a combination of safety, hygiene, and certain HIV prevention efficacy as compared to the TMC. However, because circumcision is important in many cultures, changing current practices will require balancing traditional practices and the benefits of MMC. For this to work well, it would require the support of the Traditional Leaders on the introduction of the MMC in which case they will protect their areas of interest while the aseptic methods are applied to save lives. Thus, persuading Traditional Leaders on the value of MMC, and involving them in programme design and implementation, seems likely to increase the effectiveness of interventions intended to promote MMC procedures in societies that practice TMC.

It can further be stated that the struggle of balancing TMC and MMC is not unique to South African communities, but it is the struggle that many countries in Africa are facing. While other countries such as Tanzania have completely replaced the TMC with MMC, in some, the practice of the TMC is still a noble programme that is used alongside the MMC. Tanzania has what it is called AIDSFree regions where male circumcision prevalence is approaching 80 percent. This may be the motivation for people to under MMC in numbers to a point where it would eventually replace TMC. As was learned from Ghana that those who have not gone to the traditional school become the scorn of society, the same happens in South Africa and this was demonstrated by Dingindlela (2014) on the views of traditionally circumcised Xhosa men towards MMC.

Despite how this programme was introduced in various settings, there is literature support that shows that the successful introduction of the MMC in the rural areas requires the collaboration and co-operation between the government officials and the traditional leaders as two key stakeholders.

The fact that the Traditional Leaders could even call the legislation that is introduced to regulate the TMC “nonsensical” shows the seriousness of their stance in rejecting the government intervention if they feel that it undermines their positions. In a country such as South Africa where the democracy has entrenched the culture of consultation and persuasion of opposing parties, consultation of stakeholders is the best way to go in the introduction of the MMC.

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Chapter 3: Empirical drill down I

3.1 Traditional Male Circumcision in Limpopo province

From the separate interviews with the three district managers, namely Sirwali, Maepa & Bogale (2016), they all explained the process that is followed at the start of the TMC season. They confirmed that when the season for the TMC starts, the Traditional Leader employs the traditional surgeon whose role is to perform surgical work and traditional rituals on the initiates and the school environment in general. This is aimed to protecting the initiation school and the initiates against witchcraft from the rival traditional leaders, jealousy neighbours and relatives. The surgeon works under the directions of the traditional council by providing medicinal herbs that help with the healing of the wounds. The families that send their children to the initiation school pay for these services, which at times puts a strain on those that cannot afford. These three district managers all agree that this is the practice that is followed by the traditional leaders in their districts when it comes to initiation schools or TMC (Sirwali, Maepa and Bogale. 2016).

The interviews with the district managers and other participants revealed the commonalities of TMC in all the districts under investigation. It is from these interviews that it was discovered that the three dominant communities in these districts use the similar names for initiation school called either “koma or nkoma” which signifies uniformity of this practice among tribal communities.

The TMC is conducted discretely away from the women and men that have not undergone the same ritual. This means that mothers of initiates are not involved in the transition of their children from boyhood to manhood, something that may have lifelong implications on the relationship between the boy child and the mother. The mothers learn about the wellbeing of their sons through their husbands and the case of the single mothers and widows, they receive reports through the guardians (mostly a family member/relative) that the families appoint to oversee the boy for the duration of the TMC school.

Maepa (2016), a female district manager reported that the information provided to the mothers about the wellbeing of the boy is only limited to their general health because it is a taboo for women to know more about what is happening at the schools. This this is the practice that women have accepted as the way of life because women will do the same to men when their own turn of initiation schools comes. AIDS Foundation, (2010) found this very ironic because women and girls usually bear the consequences of what boys are taught during initiation and what happens thereafter. Women and girls as mothers, sisters and partners suffer when boys die at initiation school or when they come back with a bad attitude or come back with penile amputation.

From the interview with Hlakudi (2016), one of the members of the Traditional Council of the Acting Paramount Chief Sekhukhune, he reported that “koma” or initiation is like a baptism where the preparations and methods are also similar for all communities except for a few variations. This explains why the practice is similar in all the three districts (Hlakudi. 2016). This was corroborated by the descendent of Chief Mphaphuli from Venda community that the practice of initiation school is common, but the differences come in the finer details or minor variations. He confirmed that as far as he knows the approach is the same for the three main communities that live in the three districts (Mphaphuli. 2017).

Given the discreetness that surrounds the TMC described above, there are no open and public debates about the TMC and the plan to address the problems present a circumstantially problematic reality. Some of the problems relate to the violation of the rights of initiates, botched circumcision, adverse health conditions and in extreme cases even death of initiates. These are the challenges that sparked a debate in the context of a country that is endeavouring to heal the divisions of the

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past, to promote, to respect and to tolerate its diverse cultures and, to protect those cultural practices that were previously marginalised and are still threatened in the new dispensation (CRL Rights Commission. 2010. 8).

The challenges are further exacerbated by the fact that TMC schools are regarded as cultural educational institutions where initiates are taught the values inherent in courtship, social responsibility, discipline and acceptable conduct, as well as about their culture and tradition. These values filter down to younger boys as they grow into manhood and are viewed as critical to their social and psychological development in the middle stage of childhood, teenage, adolescent and eventually adulthood (CRL Rights Commission. 2010. 8).

The standard practice for the TMC in the three districts follow the trends of the community that is in majority in each district. In Vhembe, 67% of the total population is Venda speaking people, 24.8% Tsonga (Shangaan) and 1.6% Northern Sotho (Sepedi) speaking groups. In Mopani the two communities are almost equal with 45.9% Northern Sotho and 44.3% Tsonga (Shangaan) speaking. In Sekhukhune district, 82% are Northern Sotho and 2% Tsonga speaking tribal groups (StatsSA. 2011). This means that there is no dominant community in Mopani district and as such, there is no uniformity on TMC throughout the district because of the equal tribal split. This is the district with defined variations and it is also not practicing the traditional male circumcision on a larger scale compared to Vhembe and Sekhukhune districts.

The three districts under review were all previously predominantly under the homeland rule. Majority of the people living in Vhembe district were previously under Venda homeland administration, hence the dominance of the Venda speaking people and the practice of tradition. Majority of the people living in Sekhukhune were under Lebowa homeland administration, which explains the uniformity of the language and traditional practices such as TMC.

The situation in Mopani is complicated by the fact that half of the traditional land used to fall under Gazankulu while the other half was under Lebowa Homeland Administrations. These dynamics are because of the black administration under apartheid, which defined the place of stay for the black people because of language. This is in line with section 3 (a) to (d) of the Bantu Citizenship Act no 26 of 1970, which states that the citizenship of the people must be defined by the language they speak, or they normally use or any dialect of any such language. This is how the people of Mopani found themselves split between the two homelands even though they lived as neighbours for decades if not for centuries (SA. 1970. 5)

The influence of the traditional leadership on the communities varies between the older and the younger generations. Despite this situation, what remains though is that when it comes to traditional practices and customs in the rural areas, these are given over to the Traditional Leaders, which is what may make them think that they have control and influence over the communities. This may be based on the history of political resistance in South Africa which was led by the Traditional Leaders, which can be backed up by the fact that some founders of the ANC are Traditional Leaders (Ineke & Oomen. 1997. 562).

During the communication with Diketane (2016), it came out that the province came up with a legislation in order to manage the situation better. Through the provincial legislation, the province involved the Traditional Leaders, given the history of TMC in the rural and tribal areas and the sacredness attached to it. This was to ensure that there is consultation with the Traditional leadership to avert the situation similar to the ones in Eastern Cape where the legislation was rejected. It must be born in mind that some of the people in the rural areas, especially the older generation still respect the Traditional Leaders as the custodians of TMC, as stated here above. There is even a saying, especially among the Northern Sotho speaking people that when the word comes from the chief

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everyone must follow. It is unclear in this age of human rights, whether this old saying about the traditional practices is applies especially to the younger generation.

There is a common statement that is echoed whenever there are problems with the illegal initiation schools that “Koma ke ya Kgosi”, meaning that initiation school belongs to the Traditional Leader. The Traditional Leader decides on the times for the schools, the duration of the school etc. The Traditional Leader through the advice of the traditional council appoints the traditional surgeon and entrust him with the responsibilities of conducting the TMC. He/she also ensures that all the necessary and preliminary requirements such as parental consent, availability of resources and health fitness of initiates are satisfied before the TMC schools can open (CRL Rights Commission. 2010. 21).

3.2 The Context of Male Medical Circumcision in the three districts

Following the announcement about introduction of MMC alongside TMC by the national leadership, it became clear that this was going to be difficult because the Traditional Leaders have been running the TMC schools without any involvement of the medical professionals. The introduction of the MMC without considering the points stated above would have been futile. Rolling out MMC or introducing medical procedures into traditional circumcision rituals must be sensitive to cultural concerns. This was the case even where communities could have accommodated the involvement of medical professionals who were supporting the districts with health inspection and health promotion (Deacon and Thomson. 2012). The health professionals that were appointed to support the TMC did not have to be of the same tribal or ethnic group as the Traditional leadership, because of the similarities of the TMC practice in the three districts under investigation and the commonality of clinical practice involved. Whenever the health professional came from the same tribal community, this was an added advantage in terms of language and general understanding of the traditional practice and it enhanced trust relationship.

The fact that the National Assembly of the Republic of South Africa (2013) devoted a session to debate the MMC in the context of the negative reports about the TMC, shows how serious the matters of botched circumcisions had become to the country. The Minister of Health and other members of parliament raised points that paved the way for introduction of the MMC as a preventative programme against HIV and AIDS and to halt the adverse events associated with the TMC. He mentioned the following as the reasons in support of the involvement of the clinical people in the male circumcision programme during the debate in the National Assembly that: “the initiates suffer haemorrhage, massive bleeding that can lead to death through hypovolemic shock, septicaemia and infections resulting from poor aseptic techniques. The other adverse event is dehydration, which comes because of initiates usually being denied water to avoid massive bleeding and to facilitate healing. Denying somebody water under such gruelling conditions can lead to acute renal failure, because when the kidneys do not get enough blood and water flowing to them, they shut down, leading to acute renal failure, which can lead to multiple organ failure and ultimately death. This may also lead to venous thrombosis, which may lead to pulmonary embolism and sudden death” (National Assembly. 2013. 30).

In confirming the successful working relationship between the departments of health and Traditional Leaders the Minister of Health stated during the National Assembly debate that “The leader of CONTRALESA, Kgosi Setlamorago Thobejane, who is also a member of this House, has worked with us in health to address the clinical challenges of male circumcision in his own village. This led to many traditional leaders in Limpopo following this example, whereby we send doctors and health workers to work with them. In 2011 and 2012, we put this operation in place and helped initiates and no one died. Throughout the whole of Limpopo province, the department of health helped many initiates but unfortunately two died because the department was consulted very late. We in Health will play a supportive role in all provinces, as we did in Limpopo to save lives and limbs” (National

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Assembly. 2013. 31). During the same debate, Mr Cebekhulu of Inkatha Freedom Party (IFP) also stated that there must be a decision that all would-be initiates undergo HIV/AIDS screening before attending initiation schools as “we live in a world where HIV/AIDS is rife” (National Assembly. 2013. 19).

During the communication with Motlhabane (2017), who is a public health professional and who is also a Traditional Leader in his village, he confirmed that even in his village the involvement of the Traditional Leaders in service delivery did not start with MMC. The Traditional Leaders have been involved in crime prevention, provision of land for building of clinics and schools, community development projects, etc. When the MMC was introduced, the consultations by the DHMO were building on the foundation that was laid during the introduction of various developmental programmes in the communities. These were also introduced in line with the principles of the District Health System (DHS) which are inter alia intersectional collaboration, local accountability and community participation. This formed the basis of involving them during the introduction of the MMC for which they made great contribution especially that this is part of the customs and culture.

Following the decision of the national leadership with regards the introduction of the MMC, the Limpopo provincial Department of Health appointed a focal person to implement the programme. The focal person developed a comprehensive provincial plan, which was approved by the executive leadership of the provincial department of health. The focal person worked with the DHMOs to implement the MMC, including of the three districts.

The three districts developed their District Health Plans (DHP) which included the implementation of the MMC. The implementation process in the districts started with the establishment of teams of health professionals to work with the stakeholders. As a norm, the teams had to be led by the male colleague who has undergone TMC. The team worked with the Traditional Leaders who are the main stakeholders in the implementation and roll out of the MMC, because of their claimed custodianship of the TMC and their historical leadership in the matters of TMC. The focal person reported that the teams of health professionals from the three DHMOs started the discussions with the Local Houses of the Traditional Leaders which were established in terms of Limpopo House of Traditional Leaders Act, (Act 5 of 2005). The plan was to start with the Traditional Leaders as the custodians of tradition and customs. This was supported by the fact that some of the Traditional Leaders within the CONTRALESA had already endorsed the call for introduction of the MMC alongside the TMC. (Diketane. 2016).

From an interview with Diketane (2016), he further stated that in 2010 and earlier years, there was no proper coordination of MMC and TMC because the Traditional Leaders would announce the opening of the TMC school without the involvement of the department, except when they requested for health screening prior to taking the boys to the mountain. The Traditional Leader would consult the traditional council first before opening the school and once the consensus is reached then the traditional school would start. This was not an issue as they were able to manage the situation on their own using Traditional surgeons.

Sirwali (2016) confirmed that as things changed over time especially with threats of illnesses such as HIV and AIDS and increased adverse events including deaths of initiates, the Traditional Leaders started to advise their communities to send the young boys to the clinic or hospital for medical screening before they could go to the mountain. The young men would be screened for STIs, blood sugar, TB and other health-related problems and thereafter, the boys would bring a letter from a clinic or a doctor to the traditional leader, after which they would be admitted if they are found to be healthy. Whenever a young man was found to be having some health condition that would lead to complications later, especially given the harsh weathers during these TMC schools, the family would be advised not to send him to the mountain until his condition has improved.

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Bogale (2016) confirmed that during the same period, prior to the introduction of the MMC in its current form, the health establishments (both public and private) have been performing the MMC as an elective surgery. This was done to coincide with the season of the TMC at the request of the families who had wished not to send their children to the mountain or those who objected to the TMC based on religion or sheer preference. The family of the young men would book for a minor operation with a local doctor or at the general practice or a local hospital and have the circumcision done. This practice involved solely the removal of the foreskin and was not related to HIV prevention and also had nothing to do with the rituals that are associated with TMC school. The benefits of this option were that the healing was faster and that the boy would not have to endure the cold winter conditions, which may even expose him to further health problems.

3.3 The DHMO and Traditional Leaders in the introduction of MMC

The National Health Act, 63 of 2003 makes it a requirement for the DHMO to work together with all stakeholders as part of community participation and inter sectoral collaboration. The Traditional leadership is one such stakeholder especially in the rural tribal areas. Such cooperation is evident in the areas such as provision of land for the construction of clinics, provision of security for the clinics (where there is none), cleaning of the clinic's surroundings, representation in the clinic committees and hospital boards. The cooperation between the two offices worked well during the introduction of new programme such as MMC. Given the fact that TMC has been the domain of the Traditional Leaders in the rural tribal areas, it became necessary to consult them when introducing any changes to the TMC through MMC (AIDS Foundation. 2010. 5).

At the start of the introduction of the MMC, there are factors that may have caused anxiety on the part of the Traditional Leaders concerning MMC was because of the uncertainty about how bio-medically trained health care workers could work closely with traditional surgeons on TMC given that they have different viewpoints about the programme that must be reformed. Since the Department of Health proposed the implementation of the MMC there was a need for both TMC and MMC to be reconciled. Care was taken to consider the issues of unsafe health practices, unhealthy environments, untrained staff, inexperienced traditional surgeons and health professionals that have not undergone TMC (AIDS Foundation. 2010. 5).

The involvement of the unqualified men in the TMC was a source of tension at the time of the introduction of the MMC because of the fear that people may come to the TMC schools under the guise of being health professionals, while in actual fact they did not qualify. The position of the Traditional Leaders is strictly that it is only those health professionals who met the criteria who are allowed to work on or with the initiates during the TMC season. The Traditional Leaders wanted to guard the TMC because at first, they saw MMC as intrusion into their age-old traditional ritual. It was further reported that in the event that someone who does not qualify is found anywhere closer to the TMC schools, such a person will be circumcised on the spot. This is how serious the traditional leaders and society took the secrecy of the TMC (Bonecwe. 2016).

According to Bonecwe (2016), this led to the traditional leaders setting the strict conditions of allowing the health professionals in the initiation schools, which is the norm in all communities that are practising TMC. The traditional leaders are the only ones who approved health professionals to participate in TMC, without any compromise. Once the approval is granted, the health professionals will even be allowed to camp next to the schools a night before the start of the school to screen all prospective initiates. Such qualifying clinicians will be the ones performing the surgical work on the grounds of the school. The health professionals would continue to support the initiates throughout the duration of the school to check for sepsis, dehydration and other health needs. Through this process, there has been reduction in sepsis, dehydration and illnesses and this reduced death rates of initiates and botched circumcisions (Bonecwe (2016).

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With regard to the deaths of initiates, some of the Traditional Leaders argued that certain deaths of initiate were not necessarily because of the conditions at the schools but were due to the pre-existing health problems which were not identified earlier. They argue that these conditions become apparent when the initiates are at the TMC School. This is what led to the practice of prospective initiates to undergo thorough physical and medical examination in advance, after which a medical practitioner would provide the certificate of fitness for the initiate. (Dionisio & Viviani. 2013).

The impact of these strict rules was the slow start of the introduction of the MMC even where there were no contestations, as the Traditional Leaders had to be certain about who to involve and how they could safeguard the secrecy of the old age traditional practice. The other factor was that this was a new programme that required careful and sensitive negotiations between stakeholders because most role players were not familiar with it. Ultimately, the long and tedious process bestowed some legitimacy on the MMC and control against its abuse for nefarious purposes.

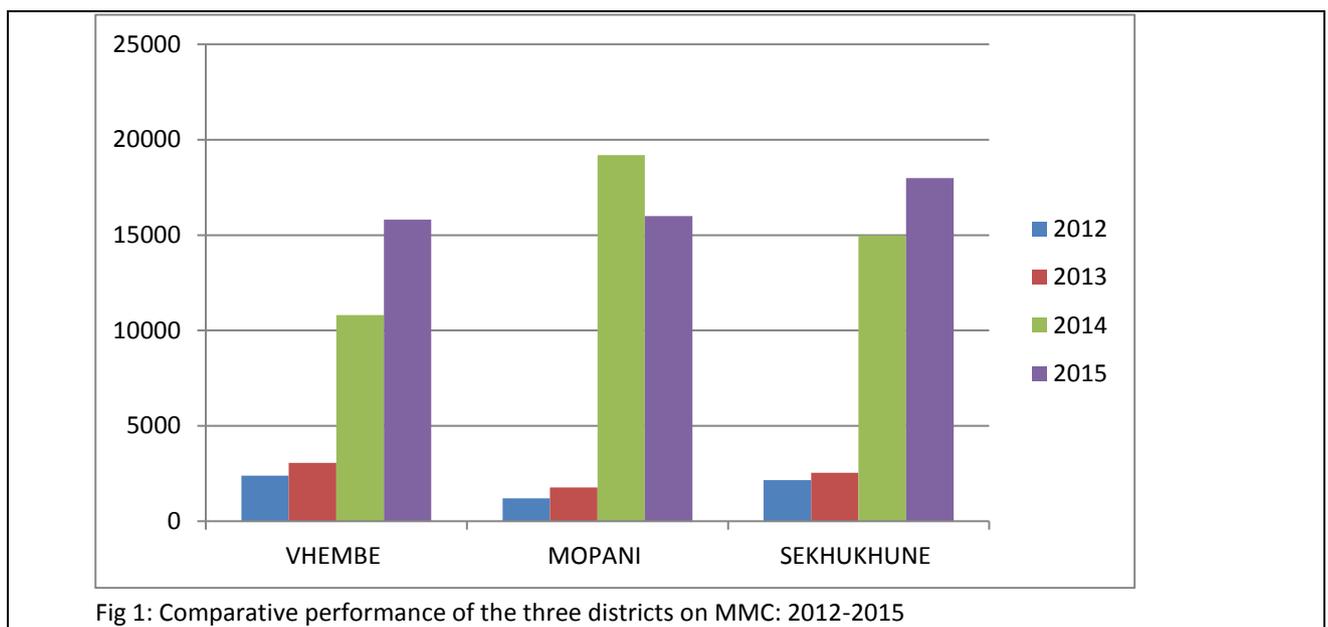
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Chapter 4: Empirical drill down II: Rolling out of the Male Medical Circumcision in the three districts

This chapter details the progress made in each district in the implementation of MMC. The varying levels of success in different environments point to the issue of contextual effects and signals other contributing factors in the way the programme was implemented. These factors include, among others, the relationship between departmental officials and Traditional Leaders as mentioned in the previous chapter. This chapter will provide a brief overview of the performance of the three districts over a period of four years.

4.1 Performance in the three districts

The figure below reflects how the three districts performed over four years. The chart shows that the performance of three districts increased steadily from 2012 to 2013 and that there was sudden increase in the following years. Both Vhembe and Sekhukhune districts maintained the good performance while Mopani declined slightly from 2014 to 2015. Despite the decline, Mopani district's performance was good because it was above the target of 15 000 cases for MMC as set in the DHP; Vhembe district performed better in the beginning, slowed down but stayed consistent in its improvement and Sekhukhune districts comes out the best in the end.



4.2 Male Medical Circumcision in Vhembe district

4.2.1 MMC in Vhembe 2011

As a sign of commitment to the national call for the men to undergo MMC, Vhembe district appointed a team of health professionals which included a communications manager for stakeholder consultations. This team was answerable to the district manager as the head of the DHMO. The stakeholders to be consulted included the local house of the traditional leaders, civil society and other interested groups. The district focal person worked with the provincial focal person to implement MMC on the ground, reported Sirwali, (2016).

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It was further reported by Sirwali, (2016) that at the beginning, it was not easy to convince the most stakeholders including the Traditional leadership to opt for MMC because they were not sure about the motives of bringing clinical people in the male circumcision arena. The Traditional Leaders did not trust some of the health professionals because they thought some of them could be those who have not gone to the TMC schools, and yet they were looking for easy ways to legitimise their access to the TMC. In Venda culture as in other African cultures, a person who has not undergone TMC is not allowed to participate in the TMC school activities irrespective of the status or how they relate to the initiates.

4.2.2 The early days of MMC in Vhembe district in 2012

The discussions between the DHMO and the Local House of Traditional Leaders continued in the early 2012 to integrate both TMC and MMC. The intention was to plan the start of the TMC season which is usually in June of that year during school break. This is in line with the provincial legislation that was aimed to avoid disruption of school activities. The other discussion focused on an agreement on the combination of the statistics of both MMC and TMC into one district statistics. Sirwali (2016) reported that at this point, there was still confusion regarding the combination of TMC and the MMC statistics before harmonisation of the two practices. While these discussions were going on, Vhembe district included the targets for the MMC in the DHP for year 2012. The figures that were reported for 2012 are only for those clients that have gone through MMC in line with clinical guidelines and protocols of the WHO (DHP. 2012. 53).

The district used the quarterly performance reviews in 2012 to monitor the MMC performance of the district in line with the DHP targets. The district reported an achievement of 2 388 against the target 3 714 for MMC, which is 64.3% of the target set in 2012 (DHP. 2012. 53 & 56).

Given the slow progress of accepting the MMC by the community and the Traditional Leaders the achievement of 2 388 was regarded as a good performance, more so that there was no baseline for the reporting period as this was the first recording for MMC. At this stage the district team was working with all stakeholders including the Traditional Leaders to persuade them to accept MMC. This was to give the assurance to the Traditional leadership about the sincerity of the DHMO regarding MMC, said Sirwali (2016).

It was reported that the quarterly performance reviews assisted to identify the areas that needed attention. According to Sirwali (2016), the intensity of the MMC was around June 2012 because that is the first quarter of the financial year and it is also the normal season for the TMC. The observation is that people also undergo MMC during the same time of the TMC season but the DHMO only counted those who had undergone MMC in line with clinical protocols and guidelines as stated in the earlier sections.

4.2.3 Steady growth of MMC in Vhembe in 2013

According to Sirwali (2016), the district built on the enthusiasm and the reports of the past year to continue with the stakeholder engagement and social mobilisation to popularise the MMC. They had also lined up the clinicians that would be performing the MMC in various settings. They had reached an agreement with the local hospitals on the need to submit the statistics of all MMC that they perform to the DHMO. This led to the district increasing its performance from 2 388 to 3 066 against the target of 10 000 cases in the same year. At this point there was an agreement with the role players on the combination of the statistics of MMC and TMC (those who were circumcised by the clinicians in the mountain) in the DHIS. The district continued with its monitoring and evaluation programme through the quarterly performance reviews.

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At this point, the district was under the impression that the community had bought into the programme, but only realised that there was double counting and that the Traditional Leaders had not fully endorsed the programme. The other down side could have been the fact that the figures of those who went to the TMC are only for winter season and that there is no activity after winter season. This forced the district to step up its campaign and social mobilisation so that MMC should be for the whole year rather than to coincide with the TMC season. The district attributed the lower figures and reluctance of some members of the community to accept MMC on the controversy that was made about around the Tara Klamp MMC device, which was used in KZN reported Sirwali (2016).

Tara Klamp (TK) is a plastic device that is clamped over the foreskin of a man's penis for seven to 10 days until the foreskin falls off. According to the Treatment Action Campaign (TAC) the device sometimes had to be surgically removed from the penis and this to them was a reason for inappropriateness of the device. It was reported in the same paper that contrary to the TAC position on the TK, the MEC for health in Kwazulu-Natal, Dr Dhlomo said in a statement that "we can proudly report that using the TK we have observed that there were no deaths, no penile amputations, no permanent erectile dysfunctions and no permanent penile disfigurement,". On the other side TAC provincial chairperson Patrick Mdletshe, (2012) said that TK was a dangerous device. "It has specifically not been approved by the World Health Organisation because it failed in the only clinical trial conducted to test its safety" (Mail and Guardian 22.08.2012).

Although this statement was meant for the experience in KwaZulu-Natal, there are possibilities that some people outside the province may have interpreted it wrongly particularly because it came through the media. Statements such as this one almost made the Traditional Leaders to doubt the effectiveness of the MMC. Despite these challenges, the district was able to record an improved performance stated Sirwali, (2016).

4.2.4 MMC growth in Vhembe in 2014

According to DHIS (2016), Vhembe district saw a sudden increase from 3 066 to 10 814 of the MMC performance which was above the annual target of 10 000 as set out in the DHP (DHP. 2014. 70). The district attributed the increased performance to the following key areas of intervention: a team of health professionals from the district office was focused on its work with clear responsibilities for each member; the co-operation of the Traditional Leaders; the increased number of the general practitioners who signed up for sessions to perform MMC in the local hospitals; inclusion of the statistics from both sides and the fact that the concerns that were raised by the traditional leadership had been addressed (Sirwali. 2016).

For the same year, the district had also identified and accredited some of the clinics and Community Health Centres where the general practitioners did sessional work for MMC. This was convenient for them, because they did not have to travel long distances to the hospitals to do this work, Sirwali, (2016).

From the communication with the provincial focal person, Diketane, (2016), the other factor that influenced the improved performance is that the provincial Department of Cooperative Governance and Traditional Affairs (COGTA) had worked with the Traditional Leaders to develop a protocol for regulating the male circumcision programme. Under this protocol, every traditional leader who wanted to open a TMC school was required to apply for a permit at the provincial COGTA department. Under this protocol, every male circumcision school had to be registered with COGTA, which would also share the information with the provincial department of health. Any Traditional Leader who opens the school without a valid permit is regarded as having set up the school illegally and as such the school will be closed/disbanded and the initiates would be transferred to a registered school under another traditional leader who is compliant.

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According to Diketane (2016), no traditional leader would want to have his school disbanded because that would be regarded as disgrace. This created a situation where the Traditional Leaders co-operated with the authorities, but it also brought normality in the way the schools are managed. This may be the other reason that led to the sudden increase in MMC intake.

4.2.5 MMC improvement in Vhembe district in 2015

The DHMO mobilised the implementing partners and Non-governmental Organisations (NGOs) to support the district with social mobilisation and for recruitment of some of the doctors, specifically to work in the rural areas. They also provided technical support in the areas of health promotion with regard to MMC. The doctors that were recruited and mobilised by the partners worked with the district teams to ensure that the statistics are combined for monitoring, evaluation and reporting and purposes, Sirwali (2016). This may be the reason that led to the district increasing the figures from 10 814 to 15 820. Diketane, (2016) corroborated this by saying that this was much higher than the set target of 10 000 for 2015, because the district and the Traditional Leaders followed the standard protocols as stipulated in the policy on MMC and the WHO guidelines.

When asked for the reasons for their improved performance, Sirwali (2016), indicated that it was because all the stakeholders were on-board. The DHMO allowed them to work independently but collaboratively while the district was doing monitoring and evaluation. The quarterly performance reviews remained the monitoring and evaluation system for the programme.

4.3 Male medical circumcision in Mopani district

Mopani district is made of two main ethnic groups which are equal in strength: Northern Sotho (Bapedi), makes 45.9% and Tsonga (Shangaan) makes 44.3%, and the rest being other tribal and racial groups (DHP. 2012. 8). According to the records, Mopani district has not been practising male circumcision at a uniform and large scale because of the different tribal traditions having different approaches to TMC. Bogale (2016), reported that prior to the MMC, which was performed by general practitioners through sessional work in the hospitals, there was no consistent practice of male circumcision across the district. Just as it was the case with Vhembe, there was no record keeping of the statistics for MMC and TMC, hence there was no baseline record at the beginning of the programme.

A few cases of MMC that were recorded are those that were performed by the general practitioners that are doing sessions in the hospitals. This means that there was no pressure for young men and even older men to undergo circumcision. Most people in this district were relaxed about the circumcision until the announcement was made by the national leadership about the need for the men to undergo MMC. Following this decision, the district identified a focal person, appointed a health professionals team, set the targets as was decided by the NDoH. The team started with stakeholder consultations before programme implementation. This can explain why there were no figures for MMC for the period before 2010, reported Bogale, (2016).

4.3.1 MMC in Mopani in 2011

According to Bogale, (2016), Mopani district assembled a team of health professionals in 2011, led by the environmental health practitioners to work with the Traditional leadership to establish the sub district teams to introduce the MMC. This team was made up of people who met the criteria, but most of them were junior in ranks because there were very few people in the management team that qualified. This team was answerable to the district manager. The team started with stakeholder consultations. The team also worked with the implementing partners to strengthen social mobilisation and health education.

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Bogale, (2016) reported that it became very difficult to start talks with the Traditional Leaders especially when there were no enough men among his managers who had undergone the TMC. This meant that there was no senior staff member who was qualified to talk about the matter with the Traditional leadership. What made this worse was the fact that this is the matter that was not a priority for some of the Traditional Leaders. Even though the TMC was not practiced at a larger scale, the Traditional Leaders in Mopani also knew that the issue of TMC is best discussed by the people that are qualified and that no woman was allowed to participate in that debate. This was a clear sign that there was going to be an uphill battle for the DHMO to introduce and implement the programme, and also that the TMC practice is uniform across the three districts.

Bogale, (2016) further indicated that for this period there were no records kept for the MMC in the district as the parties were still consulting and the district team was busy with social mobilisation. The district spent most of the time in 2011 doing stakeholder engagement and health education to ensure buy-in. The team also worked with the general practitioners, encouraging them to sign up for sessions to do MMC in the local hospitals. This also included bringing the hospital managers on board because of possible increase in theatre utilisation during the seasons once the MMC takes off the ground. It is for this reason that the district manager, a qualified doctor, approached his peers to sign up for sessions in the clinics that have been accredited to perform MMC. The district does not have data for the few cases that were performed in 2011.

4.3.2 MMC in Mopani in 2012

The district set the targets for MMC for 2012 in the DHP at 3 838 after consultations with the all key stakeholders. The targets were broken down into quarterly targets of 957 for the year. (DHP. 2012. 80). At the end of the same year, Mopani district had achieved 1 198 cases of MMC which is 31% less than the set target and this was even poor performance compared to the other two districts (DHIS. 2012/2013).

Despite the poor performance, the district considered it as a good start because there was no baseline due to lack of records of the performance for the previous years. Early in 2012, the district office used the first quarterly performance reviews of April-June to look at the performance report. This is where the district identified the weaknesses, which included the shortage of qualifying men to work with the Traditional Leaders.

Bogale, (2016) believed that the above picture led to the DHMO to negotiate with the general practitioners to sign up for the sessions in the local hospitals. This was with the view to circumvent all the challenges that the districts faced. At first, the general practitioners were unhappy with the reimbursement rate because they saw this as an extraordinary situation. The general practitioners were also not happy with the fact that they had to register with the department of health to do the work to qualify for payment. This was discussed in several meetings until an agreement was reached.

The doctors who met the qualifying criteria were also asked to sign up to do the MMC at the initiation schools. While they were happy at first, they became uneasy when they learnt that their payments would be dependent on whether the Traditional Leader under whom the school falls has registered the school with the Departments of Health and COGTA. They felt that if the Traditional Leader fails to comply then they would not be paid, while it is not their fault. After further negotiations, and assurance that the district will supply them with a list of the registered schools, they finally agreed to perform MMC at the TMC schools. The district also took it upon itself to encourage the Traditional Leaders to have their schools registered with COGTA to remain legal and to have doctors supporting them, said Bogale (2016).

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The other complication for Mopani district was that the rituals of the TMC School differ from community to community. The fact that Mopani is made of two dominant ethnic groups did not make the work easy for the focal person. The focal person who came from the one of the two main groups and had to interact with Traditional Leaders from both ethnic groups in the same way. This caused some rejections by the community from which the focal person did not come. It was also difficult for the district to appoint two focal persons as it just did not have enough resources. This was a barrier for the district and it had an impact on the performance of the district, Bogale (2016).

4.3.3 MMC in Mopani district in 2013

In 2013 the performance of the Mopani district improved from 1198 in MMC cases in 2012 to 1766, which is 67.8% growth rate. This was still a lower performance as compared to set target of 4000 for the same period (DHP. 2013-2014. 91). This led to the district to focus more attention on health education, health promotion and social mobilisation activities by working together with the stakeholders such as NGOs, implementing partners and the general practitioners.

At this point, the NGOs and the implementing partners supported the district with social mobilisation and assisted with accreditation of the identified clinics to be able to perform the MMC. The NGOs and the implementing partners motivated for the appointment of the doctors through the DHMO, to perform MMC in the health facilities especially the clinics. The down side of the implementing partners approach was that they were competing for the same scarce human resources with the district. This however made a slight improvement in the performance of the district in 2013, Bogale, (2016).

The report from Bogale, (2016) indicated that the NGOs and implementing partners participated in the quarterly performance reviews for the MMC where they jointly identified and addressed the weaknesses and barriers. The performance reviews showed that the district was performing below the target as set in the DHP. With this observation, the DHMO decided to involve the District Clinical Specialist Teams (DCST) to mobilise more doctors to assist. This was adding to the efforts already put in place by the district manager.

4.3.4 MMC in Mopani district in 2014

The district used the poor performance of 2013 to work towards improving performance. This included strengthening of partnership with CBOs, NPOs, NGOs, Traditional Leaders, Traditional and General practitioners. This led to the increased performance during the winter month of 2014 because that is the normal season for the TMC, reported Bogale (2016).

Bogale (2016) further stressed that when the DHMO realised that this approach of straightforward facility based MMC worked, they recruited more doctors to work in the accredited clinics to perform the MMC. The local hospitals were also activated to do MMC, although this was putting the strain on the theatre utilisation. When the Traditional Leaders realised that people prefer MMC, they developed interest to work with the doctors who met the criteria to support the TMC, because they feared that this may undermine the TMC as more people would go for MMC at the expense of the TMC. This means that there were two categories of doctors: one group is for those who were doing the sessions in the health facilities and the other group is for those who are working with the Traditional Leaders to support TMC. This division of work between various stakeholders led to the improved performance for Mopani District from 1766 to 19189 cases for the year under review.

From the communication with Bogale, (2016), it emerged that when the Traditional Leaders saw this response, they encouraged their communities who did not wish to undergo TMC to enrol for MMC. The candidates that were ready for MMC and were operated in the health facilities had an option of being passed on to the TMC School for rituals or to be discharged home. According to the district

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manager, this did not make any difference for most of these young men and young adults because for them they just needed to be circumcised under the environment that was advocated for during the social mobilisation. The parents, especially those who were educated were also happy that their children did not have to be exposed to more risk of botched circumcision.

4.3.5 MMC in Mopani district in 2015

The funding for most of the NGOs for 2015 onwards was reduced drastically. This forced them to scale down their activities, which adversely affected other programmes including the MMC. The DHMO was not ready for the situation and it had no contingency plans to cover up for the funding gap from the voted funds of the district. The doctors and the Traditional Leaders were on board and the district was hoping to keep on improving the performance on the MMC, but this budget cut for the NGOs led to the figures for 2015 to decline from 19189 to 16001 because they had to close some of the sites where they were operating, reported Bogale (2016).

While the withdrawal of funding for the NGOs led to slight decline in performance, the district continued to work with the Traditional Leaders by providing health professional support and involving them in the performance reviews programme. They continued to submit the statistics to the DHMO during the reviews, reported Bogale (2018).

Several doctors who signed up for the sessional work specifically for the MMC increased in the year under review. This was because that the doctors preferred to sign for the MMC as opposed to normal clinical work. They found MMC attractive because it has fewer clinical adverse events/medico-legal risks as compared to routine clinical work, reported by Bogale, (2016).

Bogale, (2016) went further to report that the sessional doctors also worked with the departmental doctors to deal with any cases that needed further clinical assessment and to monitor the adherence to the clinical protocols and guidelines. The district made use of the WHO guidelines on MMC to strengthen clinical governance and to support the MMC. This means that the DHMO had thrown everything at the programme to make sure that it succeeds. These are the people that sustained the programme when the NGO funding was cut.

4.4 Male medical circumcision in Sekhukhune district

4.4.1 MMC in Sekhukhune district in 2011

According to Maepa, (2016), Sekhukhune district set targets in the DHP following the national directives on MMC. Just like the other two districts, it immediately appointed the focal person and a health professional team. This team was made up of all men who met the traditional qualifying criteria for TMC. The team started with the stakeholder consultations, social mobilisation, and discussions with the Traditional Leaders. The other group from the district office that was included was the programme managers for HIV and AIDS, health promotion, environmental health services and sub-district coordinators so that they could familiarize themselves with details of the MMC. By the way, this was happening in the environment where the Traditional Leaders were running their own TMC as usual, reported Maepa, (2016).

The district made use of the existing working relationship through their governance structures such as hospital boards, district health councils, clinic committees to start the discussion regarding MMC. The discussions centred around the MMC; how the Traditional Leaders should apply for a permit to open the initiation school; the involvement of the health professionals and registration of the doctors to be used for the MMC; the protection of the ritual part of the TMC while allowing doctors to be involved etc. The process detailed the co-operation regime under which all must work.

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From the interview with Diketane (2016), the little complication for this districts was the fact that the district manager is a woman and the position of the Traditional Leaders was clear on this one because according to the Bapedi culture (who are dominant in Sekhukhune District), a woman cannot participate in the discussion on male circumcision irrespective of the social status. The districts manager accepted this position because she comes from the same district. The discussions were also about assuring the traditional leadership about the sincerity of the department in the introduction of the MMC. This assurance was necessary for the purposes of building a trust relationship between parties, said Diketane (2016).

4.4.2 MMC in Sekhukhune district in 2012

The DHMO deployed a team of health professionals under the leadership of the focal person to work with the Traditional Leaders. The fact that the gender of the district manager was managed smoothly because all parties understood the traditional restrictions imposed on women as stated in the section here above. Despite this position, the district was able to offer necessary assistance that was required by the Traditional leadership, reported Diketane, (2016).

From communication with Maepa (2016), for the year under review, the district recorded 2 154 against the target of 7 100 which is 30.33% of the target set in the DHP (DHP. 2012. 102). These figures did not include those of routine circumcisions that were performed by the general practitioners either in the hospitals or in their private clinics. One factor that may have led to the underperformance was the resistance from the community and the Traditional leadership, and that most time was taken by consultations with the stakeholders. The district realised that this required patience because, with best approach and good attitude, the district can perform better, reported Maepa (2016).

The fact that Sekhukhune is a rural district was another complication. This means that it had very few doctors who could easily be deployed in the clinical teams to support MMC both in the health facilities (for routine work) and on the mountains to support MMC. The district does not even have enough doctors to run the clinics and hospitals for the routine clinical services, and yet they are expected to provide for the MMC and TMC. Caught between the scarcity of doctors and the commitment made to support the TMC with doctors, the district opted to recruit a few general practitioners to allocate them to the clinics and Community Health Centres (CHC) that needed doctor coverage for service access instead of MMC. This was a tough decision to make and it certainly did not assist much, reported Maepa, (2016).

Maepa, (2016) further reported that between April and June of 2012, which is the period for the writing of the DHP, the district shared the plans with the Traditional leadership and the Municipalities so that they could see the targets that were set for MMCr. This plan showed the scarcity of the doctors for general use in the health facilities, which further demonstrated that while the targets for MMC have been set they may not be achieved because of the scarcity of doctors.

During the interview with Hlakudi (2016), a member of the Traditional Council, under the Acting Paramount Chief Sekhukhune, he reported that people who live in the cities but are committed to TMC would take their children to the rural areas during the TMC season so that they can go through the ritual. This shows how these people valued the TMC. He further reported that there are people who would go to the hospitals for MMC first, thereafter take the child to the mountain for TMC. This allows them to go through the ritual part of TMC, after having undergone the MMC, in order to be accepted as real men. This shows how strong the belief in the ritual part of the TMC is among some people in the rural tribal areas.

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The provincial focal person and the DHMO worked together to assure the Traditional Leaders about possibility and acceptability of dual process of MMC and TMC. This assurance allayed fears of the Traditional Leaders and assured their cooperation. On her part, the district manager allowed her staff to work closely with the traditional leadership and to be patient with them, despite the problems experienced, reported Maepa, (2016).

Maepa, (2016), reported that the few doctors that they had, could only assist with the MMC that are performed in the hospitals only. This exercise, while disappointing motivated the stakeholders to support the programme and it is here that the Traditional Leaders took it upon themselves to mobilise and encourage their communities to make choices about MMC and TMC. They had accepted the fact that the people could go for MMC and at the right time come for TMC, which is a nice way of combining both TMC and MMC.

4.4.3 MMC in Sekhukhune in 2013

According to the DHIS, in 2013 the district recorded a marginal increase from 2 154 to 2 534 (DHIS. 2013-2014). This performance could be attributed to the following: the DHMO focused on the hospital work as opposed to supporting the MMC due to scarcity of doctors; the Traditional Leaders did not mobilise their communities aggressively to go for MMC; the statistics for TMC was not submitted to the DHMO, reported Maepa, (2016).

Maepa (2016) reported that when the Traditional Leaders were why they did not submit the statistics to the DHMO, they responded that there was nobody in the district office that could discuss the statistics with them. By this they meant that they could not discuss with the stats with the district manager who is a woman. They also indicated that they did not see the need to combine their figures because they did not recognise the circumcisions that are performed in the hospitals. This led to the district devising means to work harder to improve performance especially in the facilities where it was performing MMC.

Diketane (2016) reported that there were allegations that some of the Traditional Leaders did not cooperate with the DHMO because they feared the loss of earning, if all the circumcisions were performed in the health facilities. This was suspected to be the reason for the passive participation of the Traditional Leaders in the MMC debates. This was however disputed by Hlakudi, (2016) one of the members of the Traditional Council of the Acting Paramount Chief Sekhukhune, who stated that the main problem was the suspicion that there is an involvement of women and unqualified men in the matters of TMC and MMC. This is what made the Traditional Leaders very uncomfortable and reluctant because for them TMC can only be discussed with people that are qualified to do so and that no woman must ever get involved in the discussions. The claims of the fear of loss of earning do not hold.

Hlakudi (2016) further reported that the other factor that dispelled the notion of the fear of loss of earning was that the Traditional Leaders or their Traditional Surgeons do not necessarily charge per client but charge for overall protection of the initiation schooling environmental and the initiates against any evil attacks by the witches. This was never an issue for the Traditional Leaders and as such, they cannot be blamed for the low figures. The low figures of MMC were as a result of the slow progress of consultation about this new programme. Traditional leaders indicated that they could not be rushed into agreeing to something that was not clear and that they have the right to first understand and agree with the programme before they could encourage their communities to participate in it. This was necessary so that when there are problems they can be able to explain to their communities (Hlakudi. 2016).

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Maepa (2016) reported that when the district realised that the figures were still low, they approached the provincial focal person, who in turn approached the Provincial House of Traditional Leaders for intervention. This led to the meeting which was held with all Traditional Leaders from Sekhukhune in September 2013 where the provincial focal person addressed them. The September month is normally the time when the season for TMC is over and as such, everybody was able to relate to what had just happened during the recent TMC schools. The provincial focal person was respected by all stakeholders because he was qualified to address them on MMC and that he came from the same district.

Diketane (2016) reported that from the meeting with the Traditional Leaders they agreed to cooperate with the department in the next season of intake. They also promised that they will allow the doctors (only those who meet the criteria) to be part of the TMC and to allow their communities to freely choose between TMC and MMC. They were further advised to ask some of their communities who work for the department of health to volunteer to support them during the TMC. This was accepted and was endorsed.

The other weakness is that the district did not have a concrete plan for MMC for the year under review. This is despite the district having a programme manager for HIV and AIDS and MMC who could have easily worked together with the focal person to deliver on the MMC targets because MMC falls under HIV and AIDS. The challenge is that the programme manager is the woman as well. This was blamed on the lack of capacity to take on an additional programme such as MMC. This is because all six posts of her subordinates were vacant and as such, the district did not want to set targets that they knew they did not have capacity to meet. This led to the MMC to be seen as an additional work in the face of under resourced district. The district has been operating with people in acting positions, said Maepa (2016).

4.4.4 MMC in Sekhukhune district in 2014

The district saw a sudden increase in the numbers of MMC from 2534 to 14983 (DHIS. 2013-2014). This could be attributed to the intervention by the Provincial House of Traditional Leaders and the provincial focal person. This could also be attributed to the fact that the Traditional Leaders took a decision, after several meetings with various structures to ensure that they implement dual system of circumcision. They also made use of their community members who are health professionals to support the programme. The other reason was that the Traditional Leaders agreed to get permits from the provincial department of COGTA and to register their schools. These can explain the sudden increase in the numbers of MMC, Maepa (2016) said.

Maepa, (2016) reported that some of the traditional leaders contracted the general practitioners directly. These general practitioners were expected to sign up with the DHMO before they could sign up with the Traditional Leaders in support of the MMC. The general practitioners agreed to sign with the Traditional Leaders and the DHMO. By signing with the DHMO, it meant that the doctors were going to support the registered TMC School and that the statistics generated will be submitted to the district office for consolidation.

4.4.5 MMC in Sekhukhune in 2015

Motivated by the co-operation and enthusiasms of their communities on the MMC, and the assurance that the department does not plan to interfere with TMC, the Local House of Traditional Leaders encouraged their members to have intakes for the initiation schools in 2015, reported Maepa (2017).

For Maepa (2016), this is most probably what led to the district improving its performance from 15 000 to 17 500. This led to the Traditional Leaders opening the TMC schools and making use of the clinical personnel as they did the previous year. This could be because their communities were now

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free to choose between TMC and MMC. Those who went to the hospitals would be allowed to proceed to the TMC for rituals later when the season opened as was the case in Mopani. The arrangement was also that the parents had an option of taking their children to the hospital at least six weeks before the start of the TMC season, so that at the right time they are ready to go with other boys to the TMC.

Maepa (2016) reported that at this point a few of the general practitioners had agreed to sign up for the programme and were registered with the provincial Departments of Health and COGTA. The DHMO was still able to send the health professionals to the initiation schools for support. The district also continued to support the programme through the pre-medical assessment of all potential initiates. The Traditional Leaders on the other hand had all registered their schools, in line with the provincial protocol. The Traditional Leaders were free to select the doctors to participate in the programme. They did not see the exclusion of women in this programme as a hindrance because they knew that all women managers in the district understood the traditional practice, said Hlakudi, (2017).

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Chapter 5: Comparative assessment of evidence

From the evidence presented for all the districts over the same period, it can be assumed that the partnership and collaboration between the Traditional leadership and the DHMO has the potential to successful implementation of the MMC. This is possible in the districts and communities where the Traditional leadership has influence and control over the community and where all stakeholders are cooperating with each other. This is also possible in situations where the Traditional Leaders take the lead in the implementation of the MMC and accept that the MMC does not replace the TMC but enhances it. A comparative assessment of the role of these stakeholders is given below:

5.1 Role of the DHMO

The role of the DHMO was to develop plans for the implementation of the MMC in line with national directives and targets set by the province. Once the plan had been developed, the DHMO were expected to identify the key stakeholders for the implementation of the plan so that they can be consulted on the way forward. This is important due to the sensitivity attached to the MMC in rural tribal communities where this practice is seen as a sacred matter.

The DHMO identified within its management structures, the people that qualify to discuss this matters in the context of traditional limitations. All three district managers understood the confidential and discreet nature of the TMC and the seriousness with which the Traditional Leaders take it. They were able to ensure that the relevant people formed part of the teams of the district offices. These are the people who met the criteria for this role and they could participate and negotiate with the Traditional Leaders on matters related to TMC and MMC. The DHMO worked on social mobilisation, communication and stakeholder engagement. The DHMO, as an agency of the department of health was responsible for setting up teams, negotiating with the stakeholders, informing the public and mobilising resources.

The DHMOs nominated teams of health professionals to work with Traditional Leaders and other stakeholders to introduce the MMC in their respective districts. There are times where the DHMO had limitations because of the lack of senior officials that met the criteria, which meant that the district had challenges of initiating the conversation with the Traditional leadership, who claimed the custodianship of the TMC. Despite this limitation, the DHMOs put together the teams of the health professionals who met the criteria. These teams started with stakeholders' consultation including social mobilisation.

It was the role of the DHMO, specifically in those areas where they do not practice male circumcision, to widen the stakeholder engagement. In Mopani, where the district manager is a medical doctor by training, approached the general practitioners so that they could take up sessions in the local hospitals and the accredited clinics with a focus on the MMC. The district went ahead with the MMC, which was led by the health professionals, with a few Traditional Leaders that came on board. The DHMO also mobilised the implementing partners to do social mobilisation and advocacy, and to support the clinic staff by employing the counsellors and contracting doctors to perform MMC.

In Sekhukhune district where the head of the district is a woman, she allocated men who met the criteria to work with the Traditional Leaders. The district manager accepted the situation with humility because she understood the culture and that she has also gone through the traditional women initiation processes, which restricts the involvement of men. She knew that the men in the teams would keep her informed about the situations where management interventions were necessary. The DHMO was able to work with the Traditional Leaders who were, at first reluctant to engage them. In the end the DHMO agreed that the Traditional Leaders were free to select the doctors that

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they would like to work with. The role of the DHMO has been the one of setting the scene and facilitating the dialogue between various stakeholders as well as resource mobilisation.

5.2 The Role of the Traditional Leaders

Sirwali, (2016) reported that the programme called “Munna ndi nnyii”, which was mentioned in the previous section, underscores commitment of the Traditional leaders in ensuring that men go for circumcision according to the Venda culture. When the concept of the MMC was introduced, the Traditional Leaders played a role of ensuring that this does not undermine the sacredness of the TMC, but was used to build on their local initiative of “Munna ndi nnyii”. The district team made use of the established traditional channels and protocols to reach out to the communities to introduce and implement the MMC.

After meeting the team of health professionals from the DHMO for the introduction of the MMC, the Traditional Leaders called the community mass meetings (Imbizo) for their communities at respective times and venues. The Traditional Leaders were also responsible to convene these Imbizos so that the health team could explain the introduction of the MMC to the communities in their presence. The Traditional Leaders did not force the communities who were opposed to the TMC, but merely expressed the support for the programme and allowed people’s free choice, reported Sirwali (2016).

Sirwali (2016) went further to say that after further discussions between the DHMO and the Traditional Leaders, the latter accepted the combination of the MMC and TMC so that the ritual part is not lost. This was done by allowing the qualified medical doctors to perform surgical circumcisions in the mountains while the traditional surgeons proceeded with their part of the rituals. In this way, they knew they could still have men who have complied with the traditional standards of being a real man, while also having avoided health complications which are associated with TMC. Various houses of Traditional Leaders played some role in breaking the impasses that were experienced at various stages of the negotiations, which if left unresolved could have delayed the implementation even further.

The Traditional Leaders continued with their programme of making use of their own traditional surgeons in the TMC. In the areas where the Traditional Leaders took the lead, they were duly supported by the DHMO through registration of the schools, provision of health and hygiene education and provision of training for the traditional surgeons among others. On the other hand, the Traditional Leaders went ahead to register their schools with the relevant authorities and adhered to the protocols, with the support of the DHMOs, reported Diketane (2016).

Diketane (2016), reported that the Traditional Leaders were so convinced that they even encouraged the parents to take their children for premedical screening before they could be admitted to the TMC school. They recruited the local qualifying doctors to train their traditional surgeons and, in most cases, even allowed them to perform surgical procedures on the initiates at the TMC schools. The Traditional Leaders further accepted that families had the right to choose between TMC and MMC or to go dual route. This made the job easy for the DHMO, hence the eventual improved performance.

5.3 The role of the general private practitioners

Diketane, (2016) reported that the districts had to make sure that all doctors who wished to work with the Traditional Leaders to perform MMC were registered with the departments of COGTA and of Health and that they met the criteria. The registration with the latter was to ensure that the doctors are duly registered with the health professions council. This was further because the department of Health was going to pay them for doing this work under the Traditional Leaders. They were in fact contracted by the Department of Health and allocated to one or more schools per season, although

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in the case of Sekhukhune district, there are those who were appointed directly by the Traditional Leaders, said Diketane (2016).

Diketane (2016) went further to say that some of these doctors have been doing MMC in the local hospitals during the times that coincided with the TMC season. There are some who did MMC in the private medical centres and private hospitals, where some of the parents would take their children. Working with them was just to reactivate and redirect them to the work they have been doing. These doctors were also keen to train the traditional surgeons with aseptic techniques of the MMC. They would also visit the TMC schools to check on health issues of initiates such as wound care, compliance with health standards among others. The difference was that as the MMC gained momentum, it was not only performed in winter but was the programme for the whole year. This is perhaps what led to the increase in the MMC uptake.

There are general practitioners who were recruited by the traditional leaders directly such as in Sekhukhune as stated here above and those who were recruited by the DHMO directly. These doctors came from their private rooms to offer their services in various settings where their work improved MMC intake. The doctors worked in the hospitals, accredited clinics and to the initiation schools to perform the MMC, reported Maepa (2016).

Bogale (2016), reported that in the case of Mopani, DHMO recruited the private doctors to join the department and perform MMC as part of their sessional work. The district manager of Sekhukhune made her contribution despite being the woman. She was not bothered by the fact that she was excluded based on gender, but she supported the MMC despite it being done by her subordinates. This is the situation that many managers may have found it difficult to deal with, but her understanding of the traditional norms and cultures has made her to be focused on addressing the problem from the back the office, while her subordinates did the work with the Traditional Leaders. In Vhembe the manager was able to take the lead with the Traditional Leaders because he also was born and bred in this area. He was able to easily build on the initiatives that were put in place by the Traditional Leaders to encourage men to accept the MMC.

This shows how each role player was able to contribute individually, and their contributions it helped immensely to the introduction and rollout of the MMC in the three districts.

5.4 The role of the Non-Governmental Organisations

The Non-Governmental Organisations (NGO) have been part of the HIV and AIDS prevention strategy for some time, especially after the WHO and UNAIDS recommend that MMC should be part of a comprehensive HIV prevention package which includes: HIV testing and counselling; correct and consistent use of female or male condoms; treatment for sexually transmitted infections and promotion of safer sexual practices such as avoidance of penetrative sex. This included the provision of Antiretroviral Treatment (ART) for people living with HIV. Although MMC is among the most cost-effective of all HIV prevention interventions, sufficient and predictable financing is nevertheless required to accelerate MMC scale-up (WHO. 2012.22). This is what led to the mobilisation of the international implementing agencies under PEPFAR and others to support the work of MMC as part of HIV prevention strategy.

The NGOs that were supported by PEPFAR were at the centre of the programme especially with regards social and resources mobilisation for MMC. At the time that they were called upon to assist, they had already been involved with the Department of Health in various programmes of HIV and AIDS prevention screening including Health Screening and Testing (HCT) and treatment initiation. The Department of health had always made use of the NGOs through the civil society organisations within South African National Aids Council (SANAC). This was after realisation that coordination of civil society is critical to national HIV and TB communication efforts. Therefore, a decision was taken

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that a specific unit within SANAC should be established to coordinate communication within and between different government departments, sectors and NGOs (NSP. 2011).

By the end of 2011, more than 1.3 million voluntary MMCs had been performed for HIV prevention, with nearly a doubling of the number from 2010 to 2011. Despite this increased pace, focused efforts are needed to achieve the number of MMC for maximum public health impact on HIV and AIDS. Key challenges include strengthening advocacy at all levels, exploring innovative approaches to service delivery including the use of medical devices for MMC, improving supply chain logistics and use of limited human resources, and creating demand for services (NSP. 2011). The PEPFAR continues to be the primary source of external financing for MMC programmes in priority countries such as South Africa. The NGOs that were funded mainly by PEPFAR, such as ANOVA and Right to Care were the main role players that supported the Districts in the roll out of the MMC.

5.5 Summary of the overview

The picture that emerges from the discussion here above is that the success of the MMC is not necessarily dependent on the role of the Traditional Leaders alone but on other stakeholders as well. The Traditional leadership only enhanced the success of the MMC in the communities where they have influence and control, and further where the community still subscribe to their rule. The other factor is that the success is more evident where the communities had a choice between MMC and TMC. This means that the increase in the MMC intake was not because of the enforcement or push by the Traditional leadership but by the willingness of the communities after seeing or learning about the benefits of the programme. The other area that contributed to the successful implementation of the programme was the extensive stakeholder engagement, health education and social mobilisation of some of the key drivers for the improvement of MMC intake. There are times where the interface between DHMO and Traditional leadership assisted by easing up potential tensions and that recognition of the latter by the former assisted to ensure that the tradition of TMC is not eroded by the introduction of the MMC.

The improvement of the MMC intake is further dependent on the responses of the people themselves, the leadership at both government and traditional leadership, the active and willing stakeholders etc. The stakeholders that were involved included but not limited to: DHMOs, Traditional Leaders, general practitioners, implementation partners, NGOs, health professionals etc. The roles played by these stakeholders however, must not exclude the interest of the parents whose children must undergo MMC and further that not all these activities must undermine the constitutional rights of the children themselves.

The picture painted by the study shows that performance in Vhembe was because the Traditional Leaders had a programme of social mobilisation, called "Munna Ndinnyi". In Sekhukhune district, where there was no full complement of the DHMO and where the district manager was inadmissible due to gender issues, the success was due to the Traditional leaders who mobilised the doctors to support the TMC. In Mopani, the involvement of the health professional is strong because the DHMO was able to mobilise general practitioners and NGOs both of whom are independent of the Traditional Leaders. This means that there is a need for the stronger partnership with many stakeholders for the improvement of the MMC intake.

From the statements here above, it can be assumed that the stronger the relationship with stakeholder, the better the performance of the district on MMC. Where there is cooperation between sectors and the information is shared, the performance has improved. In this case, the counting of the numbers for MMC included both those that were performed at the traditional school and those that were performed in the hospitals. The vigilance of the Department of Health, COGTA, and the focal persons at both provincial and local levels is a necessary for the successful implementation of

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the MMC. This means that no single stakeholder can claim credit for the successful introduction and roll out of the MMC.

Chapter 6: Conclusions, policy implications and recommendations

6.1 Conclusions and policy implications

The TMC is an old practice that was carried out under the control and influence of the Traditional Leaders, as the custodian of the practice especially in the rural areas. If there is a need to introduce changes, which may easily be dismissed as the western invasion of the old African culture, it is necessary to have adequate consultation with custodians of tradition and culture. This is even more important when there is suspicion that people that know nothing about it may adulterate the old practice. This practice must be treated with utmost sensitivity and circumspection because it involves the lives of the people in the context of the tradition and culture. Any failure to recognise this sensitivity may result in the deaths of innocent young men or even penile amputation, which is the last thing that society and the country can afford.

Having observed and understood the space within which both the Traditional Leaders and the DHMO work, it can be assumed that they both need to work together in a relationship with each other as well as with other stakeholders to improve the delivery of health services within their areas of influence and control. There is adequate legislative framework which can be confirmed by various legislations that have been cited in this study, to guide this relationship. Wherever there are weaknesses in the same legislations and policies, they can be strengthened so that they are explicit about the role of various stakeholders in the planning, delivery, monitoring, and evaluation of the health services.

It is important for both the DHMO and the Traditional Leaders to accept that the times have changed to a point where rural people have the same rights as enshrined in the Bill of Rights just like their urban counterparts. These rights are guaranteed in the constitution of the country. The two must also be aware that they need each other and many other stakeholders if they hope to have successful implementation of the new policies such as MMC.

The DHMO needs to be aware of the influence that the Traditional Leaders have over some communities. This makes them one of the key stakeholders whenever there is a need for the introduction of the new programme or adjustment of the old programme within the same communities. This awareness may result in the improvements of health service delivery because there may be less tensions and resistance to the proposed changes, especially if these have cultural implications. On the other hand, the Traditional Leaders need to be aware that DHMO operates within certain frameworks that must be observed.

During the debate in the National Assembly in 2013 and despite members of parliament being mindful of all the associated risks, it was said that the African youths choose to undergo traditional circumcision as it is regarded as a sacred rite of passage and that this speaks to one's family honour and standing in our society. It was further said that given our countries fractured past, the intolerance and subordinate status given to African culture and its practices in apartheid South Africa, all must be mindful to educate and sensitise those who wish to demean this traditional practice completely (National Assembly. 2013). This means that the government must increase its efforts to project the MMC as a programme to enhance the TMC and not to substitute or even undermine it.

During the same debate in the National Assembly (2013), it was said that, while the deaths of initiates during these rituals coupled with the scarring and substandard medical procedures that the initiates are exposed to at the TMC can't be condoned and must be vehemently denounced, the parliament must also pay heed to the cultural and spiritual significance of the TMC. Whichever way the society proceeds to engage on this issue, there must be an assurance that this is done within the letter and spirit of our progressive Constitution, which calls for respect and tolerance of the diverse cultures

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and the right of individuals, communities or groups to practise and enjoy these rights, while observing and respecting the rights of others. More significantly, it must be acknowledged that there is still significant support for the practice of the ritual within African communities (National Assembly. 2013).

From the statement above, it can be assumed that there is a need for the law and policy that will be championed by the relevant bodies such as the house of Traditional Leaders and other stakeholders, which will gently but urgently accelerate the rollout of MMC. This may require that the Traditional Leaders cooperate with all the stakeholders as the partners to avoid undermining this old age traditional practice. The situation could have perhaps been improved if the national leadership had consulted the Traditional Leaders before making an announcement on the introduction of the MMC so that they could be part of the process of the introduction of the MMC. This is so because some of the leaders within CONTRALESA had already embraced the MMC while in other provinces such as the Eastern Cape, similar legislative interventions were rejected by the Traditional Leaders.

In this debate, the one other key role player in the TMC is the traditional surgeon who works on the instruction of the Traditional Leaders. The role of the traditional surgeon has been explained in the earlier chapters. It is believed that these people must be appeased because anything to the contrary may endanger the lives of the initiates. Whether this is true or not is not an issue for this paper, but what is vital is that such stakeholders, irrespective of how one looks at them must be consulted. The other stakeholders in the process are the parents and the families of the young men who must undergo circumcision. They too need to be consulted, through whatever forum. As is the case in Vhembe, an Imbizo may be the best forum for consultation of the parents, although this may not be enough. In that instance, the Traditional Leaders and the DHMO may have to work with the local municipalities to ensure that they have access to the ward committees, which may be another forum for talking to the communities.

The health professionals that must get involved in the MMC must be properly registered with the respective professional bodies. It must be clear that the health professionals that support the MMC which takes place under the Traditional leadership, must themselves have undergone the TMC, otherwise they will remain inadmissible. The Traditional leadership and the community have a way of checking if the person has undergone the TMC. This is done through a specific language and signals that are only understood by those who have gone through TMC School. This will give assurance on the preservation of privacy and dignity with which the traditional people regard the practice.

The health professionals must attend the community mass meetings that are called by the Traditional leadership so that they can be given a slot during such meetings to provide health messages about the TMC and MMC. If this is done in the presence of the Traditional Leader, there are greater chances for buy-in and support from the community. The meetings could be the best platform to advocate for health reforms, report adverse events, discuss health outcomes and the reasons behind the slow or good progress of the implementation of MMC. In this way, the problems of poor health outcomes will become the problem of the community and the community will contribute in addressing such problems.

6.2 Recommendations

Having reviewed the literature, interviewed various people and read the stories of others who shared their views on the interface between the Traditional Leaders and the District Health Management Offices in the improvement of health outcomes with a focus on the MMC, the following are a set of recommendations:

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- The government must consult all relevant stakeholders before making major policy decisions, especially those that may have serious implications on the lives of the stakeholders and the people they represent. This will make it easy for the stakeholders to support such policy decisions and it will make the work of government easier. In this way the stakeholders will be able to share their views, fears and anxieties before such policies are implemented and the government will have time to address such fears and anxieties. In this way a good relationship will be built between the government and the stakeholders most of whom are the representatives of the people on the ground or some constituencies.
- The government departments that are responsible for the MMC must work together to design the protocols that must be followed when a Traditional Leader plans to open an initiation school. Such protocols must be discussed in the Provincial Houses of Traditional Leaders before they can be implemented to avoid confusion and ensure buy-in. The stakeholders must agree on the monitoring mechanisms for the implementation of such protocols. This will ensure that the interface between the DHMO and the Traditional leaders is promoted and protected.
- The DHMO must collaborate with the Traditional Leaders where they exist and where they have stronger influence and interest in the introduction of the new programme such as MMC. This may give the DHMO some mileage and credibility in the eyes of those who believe in the participation of the Traditional Leaders in the health service delivery. Traditional Leaders are one of the major stakeholders during the introduction of the MMC.
- The DHMO may invite the Traditional Leaders, especially in the areas where they are strong and willing to send a representative to serve in the governance structures of the health system. The Traditional Leaders can serve or nominate people, on their behalf, to serve in the District Health Councils, clinic committees, and boards of the district hospitals that are within their areas of jurisdiction. This will be one way of lobbying them for the times when the new programmes are introduced. When they feel that they are part of the health system, they will feel recognised and they will cooperate and support new programmes whenever they are introduced.
- In the situations where the DHMO has no capacity to provide support to the Traditional leadership on matters of health service delivery, the latter must be encouraged to make own initiatives to implement the programmes such as MMC. The DHMO must be ready to provide guidance where necessary such as clinical protocols and guidelines. This will be based on whether the DHMO has done enough work to lobby the Traditional Leaders and that the latter sees the programme as important.
- In the situations where the traditional leadership is not strong enough to implement the programme, the DHMO can make plans to implement the programme in line with the protocols and guidelines. This can be done by mobilising other stakeholders such as general practitioners, NGOs, implementing partners etc. At no stage should such work undermine the cultural arrangements in those areas where such cultural practices are still recognised.
- In the situations where the Traditional Leaders are not co-operative, the DHMO can approach the House of Traditional Leaders for intervention. The house of the traditional leaders may be in a better position to persuade their members concerned to work with the DHMO to implement the programme of government. In this way, they may feel that they have the support of the house of traditional leaders and as such, the programme will be viewed as legitimate.

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- The DHMO must discuss all the services such as MMC that may encroach on the cultural and traditional status quo, with the Traditional Leaders, where they are available and interested before implementation of such programmes. This must be the case whenever a new programme that has implications for one or many stakeholders is introduced. The DHMO must implement the DHS policy which enjoins them to implement principles such as intersectoral collaboration, local accountability and community participation.
- The Traditional Leaders must be free to recruit the general practitioners and other health professionals directly to support them during the TMC season. This will make these stakeholders more accountable to the Traditional Leaders. This may encourage more intakes because the MMC is seen as a programme run by the Traditional Leaders. In that way, it will assure those who may be conservative about the TMC about the possibility of maintaining the status quo by doing the right things.

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