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Stigma Experienced by Traditional Male Circumcision Stakeholders in the Eastern Cape, South Africa

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ABSTRACT The study explored the stigma experienced by traditional male circumcision (TMC) stakeholders during and after male adolescents' rite of passage from boyhood to manhood. A qualitative research paradigm was used. Data were collected through individual interviews and focus group discussions with 28 participants. An interview guide served as a data collection instrument for both the focus group discussions and the interviews. The findings revealed an array of stigma-related phenomena resulting to: newly graduated men succumbing to a state of self-stigma; families and loved ones suffering pangs of abject stigma; unreliable traditional nurses subjecting initiates to molestation, brutalisation and stigmatisation; coupled with them also suffering a state of loneliness/ hopelessness. This paper recommends indigenous and informal interventions; the promotion of the tenets and philosophies of Ubuntu tenets; stigma to become part of the community meeting agenda; and community network forums to be used as platforms of awareness against the phenomenon of stigma.

INTRODUCTION

Historically, traditional male circumcision (TMC) is among the continuum of cultural rites and rituals used by Xhosa and other Southern Nguni ethical groups as a rite of passage from boyhood to manhood (Nomngcoyiya 2018; Mdedetyana 2019). It is a very significant cultural practice among the Xhosa ethnic groups due to its invaluable social capital imbedded in it (Mpateni and Kang'ethe 2020), including the benefits of reducing chances of being infected by HIV/AIDS by at least 60 percent among men that are circumcised (Nomngcoyiya and Kang'ethe 2019). Further, the existing body of scholarship in the TMC domain suggests that traditional male circumcision has been widely practiced by at least one sixth of the global population (Sedibe 2019).

However, South Africa is experiencing devastating effects emanating from traditional male circumcision (TMC) clinical hazards, with more than 1133 initiates' deaths recorded by the Eastern Cape Department of Health (ECDoH) alone between 1995 and 2019 (Mpateni and Kang'ethe 2020). However, these are not the true reflection of initiates' deaths in the Eastern Cape Province as many deaths remain unreported by the ECDoH especially those that seem to occur a month or two months before the initiation season ends (Ngcukana 2019; Nomngcoyiya and Kang'ethe 2019). Moreover, the Eastern Cape Department of Health (ECDoH) in the same period reported more than 600 penile amputations; more than 10 000 hospital admissions; and other circumcision-related accidents (Prusente et al. 2019; Abrahams 2017).

In addition, TMC mishaps have regrettably brought stigma to those who fall victims of the rite (Nomngcoyiya 2018). This has not only created social rejection and ostracism for the newly graduated men, also immense psychosocial deficits to their families and close kins (Nyoka 2017). Perhaps, it is the increase and the severity of the clinical mishaps that have created a fertile ground for stigma. This is because the South Africans that uphold the value of TMC with high-esteem equate failing to withstand the rigours of the rite as unmanly (Mpateni and Kang'ethe 2020). Possibly, this is why cultural adherents of the TMC equate such men to an *"inkwenkwe"* a derogatory term for an uncircumcised boy (Siweya et al. 2018).

Painstakingly, current pandemonium associated with TMC has left many newly initiated boys' mothers preferring their sons to be circumcised medically (Nyoka 2017). This is because of the fear of possibly having their sons fall victim of the rite. However, the idea of undergoing medical male circumcision is both disrespected and condescended upon (Nomngcoyiya and Kang'ethe 2017a). In fact, the psycho-

social deficits associated with social rejection, ostracism and stigma are so endemic that the majority of the initiates, their families and communities are ready to face the severest risks and even avoid hospitalisation (Prusente et al. 2019). Several studies on traditional male circumcision also identified the psychosocial challenges emanating from the initiates' self-stigma; embarrassment at having failed the culture; shame; despondency; and feelings of being engulfed with pangs of guilt (Nomngcoyiya 2018; Cacioppo and Hawkley 2010). It could be for this reason that young male participants of the study mentioned that they were willing to lose their lives in the initiation school rather thanattend a hospital (Prusente et al. 2019; Nyembezi 2016). Furthermore, the social stigma and ostracism experienced by the participants may have resulted in the initiates themselves and their parents rejecting biomedical related help (Nomngcoyiya 2018; Mpateni 2017).

Aim and Objectives

Although the broader study from which this paper is developed was to expose retrogressive aspects of the traditional male circumcision as an endeavor to preserve, maintain, and immensely contribute its development in South Africa, this paper objectively seeks to explore critically aspects of stigma experienced by newly initiated men and their families as a result of traditional male circumcision.

Problem Statement

An array of overwhelming challenges seems to bedevil the institution of TMC, which has shaken the threshold of the culture to the extent that many cultural adherents are forced to think of other avenues, such as medical male circumcision (MMC). One enormous cultural spinoff associated with the rite is the stigma to which the newly initiated men to are subjected. Ostensibly, stigma causes excruciating psychosomatic pain to those who are already physically wounded, leading to social, psychological, mental and emotional trauma. The phenomenon is grave and makes the victims estrange themselves from other members of their society, which diminishes their chances of seeking assistance or interacting with psychosocial support systems. The authors of this paper contend that all the ingredients of stigma need to be annihilated if traditional male circumcision is to stand the test of the time. Thus, this paper seeks to diagnose the social underpinnings associated with stigma in order to lay bare the possible factors driving stigma. In addition, the paper suggests possible ways of addressing the problem. Since the pandemonium surrounding TMC continues to paint a gloomy picture of the country's constitutional obligation to the circumcision initiates, it is imperative for this image to be corrected through an empirical study such as this one.

Theoretical Framework

Indubitably, the theory of stigma owes a great deal to a renowned sociologist, Erving Goffman who, in 1963, perceived stigma as a process based on the social construction of identity (Yang et al. 2007). Goffman believed that individuals associated with a stigmatised condition move from being viewed as normal to assuming a discreditable social status, and therefore constantly strive to adjust their social identities (Phelan et al. 2008). Shih (2004) suggests that Goffman identified three types of stigma. The first type results from physical deformities, or from displaying some infirmity. The second is associated with perceived imperfections of an individual character that includes various non-physical phenomena, such as a mental disorder, homosexuality or radical political behavior. The third type of stigma is associated with ethnicity, race, nation, and religion. Thus, Goffman's theory of stigma facilitates the analysis and making sense of the world of those individuals who are considered abnormal by their society.

Primarily, Goffman's overarching ideas on stigma have created an understanding of the psychology of the stigmatised, focusing on the processes of the internalisation of stigma that shapes individual behaviour in terms of its profound psychological impact (Yang et al. 2007). However, Link and Phelan (2006) posit that the focus of this theory on the aforementioned underpinnings of stigma has excluded other considerations of how social life and relationships are impacted negatively by stigma (Link and

Phelan 2006). However, this theory has contributed to the discipline of social science by creating a diverse understanding of stigma. The theory identifies the social processes occurring within the sociocultural milieu whose spinoffs can be observed in the newly initiated men and their families in communities affected by failed TMC.

The theory is applicable to the initiates and their families who suffer several blows of stigma during the rite of TMC. This is because newly initiated men who succumb to circumcision mishaps during the rite of passage and opt for medical intervention are subjected to various shades of stigma. Moreover, the rite has been characterised by families and kins of the TMC victims suffering pangs of abject stigma after molestation and brutalisation from unreliable and immature traditional nurses. Similarly, the newly initiated men themselves succumb to a state of self-stigma. Therefore, the authors of this paper deem it fit to use this theory, to facilitate and investigation into the social environment of people who are suffering from stigmatisation.

METHODOLOGY

This study utilised a qualitative research approach and design that was descriptive and explorative, with a case study as the specific research design. While the study appreciates and acknowledges the significance of looking at the phenomenon using both qualitative and quantitative methods, qualitative approach was more appropriate as it enabled the principal researcher to collect data concerning the opinions, feelings, attitudes, views and perceptions of the participants in their natural environment with regard to the phenomenon under study. The design qualified to be a case study because it allowed an in-depth investigation of a few newly initiated, their close kins, in tandem with other TMC stakeholders with the goal of generating voluminous data to answer the research questions ostensibly. The study also utilised the qualitative research paradigm ethos of subjectivity, induction and value ladenness, as the researcher was close to the participants. Rhetorically, the principal researcher used the first person singular and plural to record the participants' insights.

Sampling Method and Unit of Analysis

The study followed a non-probability sampling methodology in selecting the participants. This is a sampling method in which samples do not have the same chances of being selected for an investigation. Specifically, the study adopted a purposive sampling technique where the researcher is concerned with data-rich samples that would adequately help in answering the study's research questions. Therefore, participants for one-on-one in-depth interviews and for focus group discussions, as well as key informants, were selected depending on the researcher's intuitive decision-making regarding their suitability to elicit information of interest to the research study. Purposive sampling was especially useful for selecting participants with characteristics of interest to the researcher in answering the study's research questions. As the unit of analysis, the study chose 28 samples consisting of six (6) newly initiated men, five (5) family members, five (5) community members, seven (7) traditional nurses and five (5) key informants (1 x education sector representative, 1 x circumcision monitoring official, 1 x community leader and 2 x Chief's Headmen).

Sampling Criteria

The study took note of both the tenets of both inclusive and exclusive criteria of picking the samples. Specifically, the study included those who had undergone the TMC rite within the last two (2) years and resided in the Phondoland region of Lusikisiki, in the province of the Eastern Cape. The ages of the participants ranged from 17 to 25 years old. The study inclusively considered other TMC stakeholders that had experienced and witnessed TMC related mishaps between 2012 and 2019. In addition, the study excluded all the other newly graduated men, families, community members, and government departments in other areas outside Lusikisiki, who experienced or encountered psychosocial mishaps associated with TMC. All the initiated men who had experienced more than two and a half or more years of a psychosocial deficit associated with TMC were also excluded.

Methods of Data Collection and Instruments

Data collection was facilitated by the use of an interview guide with unstructured questions. The study utilised one-on-one in-depth interviews, focus group discussions, and the key informant method to gather information from 28 TMC key role players who included newly initiated men and their families, community members, traditional nurses; and societal key informants. The traditional custodians, TMC monitoring officials and an educator were especially significant as key informants because they were knowledgeable about TMC matters.

Data Collection Process and Analysis

The study participants were subjected to one-on-one in-depth interviews, focus group discussions and the key informant method, utilising the isiXhosa language, which was later translated into English. However, those samples that were comfortable with English were allowed to use it. All the data were audio recorded and transcribed. Field notes were also taken to complement the crude data that was audio taped. Coding process aided content thematic analysis whereby the raw data were rearranged, categorised and ordered into themes as depicted by the emergent views of the study participants.

Research Domain and Justification of Choice

In this study, the research domain was Lusikisiki in the Ingquza Local Municipality of the Oliver Reginald (OR) Tambo District Municipality. The researcher considered Lusikisiki to be a suitable domain for a study of this nature. This is because; it was one of the areas in the Phondoland region that had been experiencing several initiates' mishaps, resulting in hospitalisation, penile amputation, or even death. In addition, other studies had clearly pointed to the need for further research and possible interventions to surmount circumcision-related clinical hazards.

Ethical and Legislative Considerations

In this study, the ethics of confidentiality and informed consent were adhered to expeditiously. After being briefed about the study's objectives, the participants had to voluntarily consent to be involved in the study through signing of consent forms. However, the participants above the age of 18 years old had to sign their own consent forms; however, the parents/legal guardians had to sign the forms on behalf of those participants who were younger than 18 years old. In addition, the researcher ensured that all the requisite university research protocols were followed. This made the study ethically, administratively and morally correct.

For example, the principal research investigator had to sign the researcher's declaration and conflict of interest declaration forms. Moreover, he had to seek clearance from the University Research Ethics Committee (UREC) in order to be granted the permit to conduct the study. The researcher also protected the participants' integrity by ensuring anonymity. Thus, the participant's names and institutions/organisations they worked for (or were associated with) were disguised by using pseudonyms in this research study.

RESULTS AND DISCUSSION

The study results pertaining to demographic profile of the participants has been shown in Table 1 was analysed, presented, and interpreted in line with its relevance to the current study. Similarly, Table 2 also displayed an array of stigma-related phenomena resulting to newly graduated men succumbing to a state of self-stigma, in tandem with their families and close kins suffering pangs of abject stigma; unreliable traditional nurses subjecting TMC victims to molestation, brutalisation and stigmatisation; and newly graduated men experiencing a state of apathy. Such challenges are explored more in the results and discussion in succeeding paragraphs below:

Demographic Information Pertaining to the Participants in the Study

The study ignored the biographical aspects of the participants' marital and socio-economic status. This is because the contribution of these demographic aspects was considered insignifi-

Table 1: Categories of participants, in relation to gender, age and level of education

No.	*Participants categories*	*Gender*		*Age*			*Literacy levels*		
		Male	*Female*	*17-35 years old*	*36 years old and above*	*Without formal education*	*Grade 1-7*	*Grade 8-12*	*Tertiary*
1	Newly initiated man	6	0	6	0	0	3	3	0
2	Close kin of the newly initiated men	1	4	1	4	2	2	1	0
3	Community members	5	0	2	3	0	0	5	0
4	Traditional nurses	7	0	6	1	0	1	6	0
5	Key informants	5	0	3	2	0	0	3	2
	Total	24	4	18	10	2	6	18	2

cant in this study. Perhaps, this is largely because the study was more interested in the qualitative processes, opinions, thought patterns and perceptions of people in the domain pertaining to the stigma experienced by the newly initiated men and their families in the TMC practice. However, other demographics such as age, gender and education were considered significant as they influenced the procedures and operations of this cultural practice in one way or the other.

The study findings established that four (4) of the six (6) initiates took part in this study were young men that belonged to age bracket of 18-25 years old; while two (2) of the six (6) were minors under the age of 17 years old. Ironically, the minors of less than 18 years old had not satisfied the statutory age category of undergoing circumcision, unless there were circumstances beyond the statutory measures, as provided for in Children's Act No. 41 of 2007 as Amended. This poignantly points to the violation of the law pertaining to the age of traditional male circumcision. Similarly, the study findings indicated that the majority of the traditional nurses belonged to the youth bracket age of 18 to 35 years old. This points to a dire cultural discrepancy because youths have never been considered ideal to be traditional nurses due to gaps in terms of the skills and knowledge required in the TMC practice. This may also indicate a state of cultural irresponsibility or neglect; or total absence of elders to direct the operation.

The study revealed and displayed a serious gender-skewed dimension, with only four (4) of the family members being women against twenty-four (24) men. This means that men carried the lion's share of the samples under investigation. Such findings revealed the patriarchal nature of TMC that did not allow women to be part of any decision-making processes, especially with regard to issues of the circumcision operation. Women were only supposed to handle the hospitalisation issues of the rite.

With regard to literacy, eight (8) of the TMC key players had either never been to school or had dropped out of primary level education, while eighteen (18) of the TMC key players had at least achieved secondary level education and completed matric; but only two (2) had tertiary education. Deductively, such low levels of education could mirror the high rates of unemployment in the region. The phenomenon may also point to a possibility that uneducated people are likely to be hoodwinked by the fake "fly by night" traditional practitioners. The low levels of education could also perhaps explain possibilities of cultural stubbornness and difficulties pertaining to effectuating changes in the culture of the study area. The phenomenon may also pose a drawback in realising cultural dynamism, growth, development and progression.

Initiates Succumbing to States of Self-stigma

The majority of the participants from the traditional nurses' focus group discussions (FGDs) revealed that the newly initiated men faced states of self-stigma as a response to the overwhelming environment of stigma they were subjected to by their peers that went through the rite without any clinical hazard. This was exacerbated by mocking they received from the traditional nurses and other members of society. The initiates' state of self-stigma made them lose confidence

Table 2: The themes which emerged from the data

Theme No.	*Theme description*
1.	Initiates succumbing to states of self-stigma
2.	Close kins of traditional male circumcision victims suffering pangs of abject stigma
3.	Unreliable traditional nurses subjecting TMC victims to molestation, brutalisation and stigmatisation
4.	Initiates suffering a state of loneliness, helplessness and hopelessness

and self-esteem. In addition, they were engulfed with excruciating emotional pain and a desire to estrange themselves from other members of their social group. At times, they even harboured signs of suicidal ideation. During the focus group discussions, participants expressed the following remarks:

"People don't know that I lost my manhood in the initiation school and it is difficult to tell people even my grandmother, friends and my girlfriend that I am without manhood."

"It is difficult to tell people about my manhood status."(Newly initiated man 2)

"I hide my manhood status from others including my family and I feel that I'm not equal to other men that were circumcised without having to succumb to medical treatment". (Newly initiated man 1)

"I'm leading a very lonely and useless life, after I came back from the hospital. I feel it is my own fault I have landed in hospital and lost my manhood". (Newly initiated man 4)

The above findings lay bare the skin deep and deeply engrained self-stigma; and negative self-judgment, resulting in shame, worthlessness self blame. This could by no means help such an individual to live positively. In fact, it would limit meaningful self-regulation, a high quality life style and access to psychosocial support systems as well as growth and developmental opportunities.

Close Kins of Traditional Male Circumcision Victims Suffering Pangs of Abject Stigma

Participants indicated that young men who underwent the traditional male circumcision school and ended up being admitted to hospital suffered endemic stigma, labelling and name-calling, especially from their peers. The initiates themselves indicated that the stigmatisation directed towards them had brought excruciating pain to themselves to the extent of causing them sleepless nights, becoming apathetic, and sometimes leading to their harbouring of suicidal ideation. In addition, such pangs of stigma were extended to parents and close family members. The following comment reflects the abovementioned findings:

"Communities are making a mockery of us as close kins of the newly initiated men and are making us a laughing stock of the society because of what happened to our sons in the initiation school, we are being stigmatized by others".(Close kin of the newly initiated men 4)

"We are being laughed at and being ridiculed and mocked at almost everyday of our lives ever since our children had this unfortunate situation". (Close kin of the newly initiated men 1)

The findings indicate an immense state of cruelty and an inhumane attitude directed not only to the newly initiated men who suffered casualty during the circumcision, but also to their families. This state of stigma is a recipe of the cultural stereotypical thinking and attitude that all young men should withstand the rigours and ordeals to which they are subjected to during the rite. This is ironical considering that cultural custodians seem to be associated with various male initiation gaps including professional incompetence and other initiates' health related issues just to mention the few. The perceptions of normality and abnormality as far as the results of the circumcision practice were concerned either negated or were blind to the scientific process and the unprofessionalism that embraced the rite. In addition, these perceptions indicated a sense of cultural naivety in that they did not consider the inalienable rights of the individuals to health.

Unreliable Traditional Nurses Subjecting TMC Victims to Molestation, Brutalisation and Stigmatisation

The study findings indicated that the traditional nurses derided, scorned, labeled, mistreated and demeaned the initiates, thus paving the way for their stigmatisation, especially those who became casualties of the rite and ended up in hospital. A further revelation was that the tra-

ditional nurses were not mature, had not been subjected to apt selection criteria, and displayed immoral and unethical predispositions towards the initiates, making the initiation cultural process a mockery. All this culminated in a state of stigma for the initiates and their close family members. To this end, a number of participants, agreed or disagreed that stigma existed and expressed the following remarks:

"Stigmatisation is being driven by these bogus traditional nurses. The cultural custodians are to subject them to a desirable state of selection criteria. They are making culture a mockery."(Community members 3)

"Instead of these traditional nurses treating the initiates with humanity and dignity, they scorn, deride, label and call them derogatory names. In fact, they are the ones subjecting our culture into a state of stigma. They are killing the culture we know from time immemorial." (Key informant 1)

The above findings lay bare the evidence of a lack of ethical and moral disposition on the part of traditional healers who, instead of being helpful to the initiates who suffered, spread stigma to the society. Perhaps, this may point to the failure of cultural custodians who relaxed their role of screening and ensuring that the culture uses professionally grounded traditional healers.

Initiates Suffering a State of Loneliness, Helplessness/Hopelessness

The study findings indicated that TMC brought a constellation of shame, despondency, loneliness, helplessness and excruciating physical and psychosocial pain to the initiates that cascaded to their family members and close kins. An array of these factors evoked social agony to those who became casualties of the rite. The initiates complained that they faced stigma through being called various derogatory names and being labeled by both their colleagues who went through the rite successfully and the community members at large. Ironically, those who had undergone the rite, but had been admitted to the hospital, were not considered strong enough to withstand the pain associated with TMC. Thus, those who had become victims of the rite became a laughing stock of the community. The following remarks reflect sentiments that were shared by many:

"We have become a laughing stock of even young boys who have not undergone the rite. The community is really deriding the initiates who suffer casualty of the rite and end up in the hospital."(Newly initiated man 5)

"They are insulting us about the hospitals and the fact that we appeared on television talking about our terrible clinical mishaps such as losing manhood that we experienced in initiation school."(Newly initiated man 6)

The above findings indicate the state of excruciating pain, apathy and despondency to which initiates faced on account of the rite. Perhaps, the most painful irony of the whole melee is that, instead of those who suffered casualty being subjects of consolation and psychosocial support, they were ridiculed and subjected to a state of stigma for not being able to undergo the rite successfully. They were considered a disgrace to their families and the community at large.

DISCUSSION

The study participants' profile illustrated diverse variations in the demographics, with the newly graduated men being between 17 and a majority of lying between 18 and 35 years of age 17-25 years old, and the majority of traditional nurses between 18-35 years old. Such a scenario depicts that the process had failed to comply with the standard circumcision age procedure of 18 years old, as required by law for traditional male circumcision. Moreover, the standard age of 18 years old for circumcision is also stipulated by Children's Act No.41 of 2007 as Amended as well as in the Eastern Cape Province Application of Health Standards in Traditional Circumcision Act No.6 of 2001 (Nomngcoyiya and Kang'ethe 2017b; Siweya et al. 2018). Culturally, although the age profile is based on a social contract for the initiates, facets of wellness dimensions, such as the boy's physical, psychological and mental strengths, are usually emphasised (Ngcukana 2019). Perhaps, this is to ensure that the boy undergoing the rite meets the physiological and psycho-emotional demands to endure food, water and other traditional circumcision challenges.

Moreover, he needs to have the cognitive capacity to grasp the intention and the ultimate goal of the practice (Nomngcoyiya 2018). Such

findings displayed serious discrepancies with regard to the age demographics of the newly initiated men. In addition, this could have influenced these initiates' capacities to withstand the pain and other uncomfortable conditions imposed in the current TMC environment. Perhaps, due to their being under age, some of the initiates may not have succinctly understood the role of traditional circumcision per se, or why their parents had given their consent for them to undergo the rite of passage on their behalf (Douglas and Hongoro 2018).

Perhaps, a more glaring cultural lacuna is that the majority of the traditional nurses were in the age bracket of 18-35 years old, yet they were bestowed with the task of nursing the initiates. This indicates a cultural discrepancy and neglect. Legislatively, the Eastern Cape Customary Male Initiation Practice Act No.5/2016 has provisions for the practitioners (surgeons and nurses) and for the processes and procedures to be considered during the initiation (Douglas and Hongoro 2018; Gilili 2017). These include the age as well as the obligation of the parents and guardians to consent to the rite on behalf of their children (Nomngcoyiya and Kang'ethe 2019). Moreover, the young age of the traditional nurses perhaps points to glaring professional and cultural gaps among the cultural custodians whom society has bestowed with the responsibility of ensuring that only mature and elderly men are allowed into the initiation schools to care for the initiates (Froneman and Kapp 2017; Prusente et al. 2019). Perhaps the fact that the practice itself is characterised by various circumcision accidents and initiates' deaths points to possibilities of the mayhem being caused by unskilled and unprofessional traditional nurses (Douglas et al. 2017).

The study also revealed a skewed gender dimension, as the participants included more men than women. Nevertheless, although only a handful of women took part in the circumcision process, they were captured expressing their dissatisfaction about the current modus operandi of TMC. Such a scenario sent waves of shock to the men, as the process did not entertain the inputs of women, other than the women contributing in terms of handling issues of hospitalisation. This can be understood in that the circumcision process followed the dictates and ethos of patriarchy that view women as passive on matters pertaining to the rite of passage (Nomngcoyiya and Kang'ethe 2019). However, the researcher considers it pertinent that, due to life events such as the occurrence of clinical hazards to the initiates or even death that attract the attention of women, it is humanely obligatory that the role of women should be considered. Perhaps, the fact that societies are increasingly becoming matrifocal largely compels the need to consider women as crucial stakeholders in this process (Froneman and Kapp 2017; Nomngcoyiya and Kang'ethe 2017a).

The study findings indicated serious gaps concerning the TMC stakeholders' illiteracy levels, as eight (8) (28%) of the participants had either never been to school; or had dropped out of primary school. However, eighteen (18) (64%) of the TMC stakeholders who took part had achieved secondary level education, with only a few having matric; and only two (2) (7%) had attained tertiary education. Perhaps, this state of low literacy levels partly explains why communities practicing the rite are easily hoodwinked by unreliable practitioners who pretend to be traditional surgeons and nurses (Ntombana 2017; Ngcukana 2019). It is indeed a disturbing phenomenon that people pursuing TMC might be disempowered to the extent of having missed out in pursuing lifelong desirable processes such as education. It is indeed incontrovertible that education forms a cornerstone pinnacle and a benchmark to bolster people's welfare, not only South Africa, but also globally (Sedibe 2019). Perhaps, low literacy levels affect current cultural processes and procedures because many people with low literacy levels tend to rely heavily on cultural custodians for their knowledge about issues pertaining culture. Therefore, most of the cultural practices, including that of TMC, are at risk of becoming retrogressive tools of cultural growth (Mpateni and Kang'ethe 2020). In addition, this is particularly evident, considering the current spate of accidents and initiates' deaths associated with the culture of TMC.

The study findings indicated the phenomenon of the initiates who not only became victims of the rite, but also succumbed to states of self-stigma. This finding resonates with various literature sources on TMC, such as those of

Rathebe (2018) and Prusente et al. (2019) who identified in their respective studies that there were psychosocial deficits emanating from the initiates' states of self-stigma. These included the following: embarrassment; feelings of having failed the culture; shame; despondency; and a sense of being engulfed with guilt feelings (Mpateni and Kang'ethe 2020). Similarly, anecdotal information derived from several varied discussions with TMC stakeholders during the meetings across the Eastern Cape with the researcher, reflects that some of these young men who were living with partial or complete penile amputation were socially isolated. This was due to the fear of rejection and negative evaluation. This prompted a state of stigma for the victims and drove them to estrange themselves from those with whom they used to interact with before they experienced clinical accidents (Douglas and Hongoro 2018; Abrahams 2017).

Perhaps, this could be because the stigma and discrimination surrounding the initiates who had to complete their rite in medical settings remain the greatest barriers to the integration and corroboration of various care and prevention strategies with regard to the current spate of TMC (Mpateni 2017). Therefore, the initiates who had experienced TMC challenges resorted to using and adopting alternative coping strategies, such as avoidance, denial and secrecy, because of the fear associated with stigma and discrimination (Nyoka 2017). This had serious repercussions and negatively affected their relationships not only with their families, but also with their loved ones, friends and society at large. Moreover, the issue of self-stigma also had a negative impact on the psychosocial services that they were supposed to receive from social service practitioners, which were meant to help and cushion the effects of self-stigma on those who were affected. This resulted in such interventions failing as the newly initiated men preferred to keep their status secret due to self-stigma (Phelan et al. 2008).

The study findings revealed that the close kins of the newly initiated men of TMC victims suffered pangs of abject stigma. These findings on stigmatisation parallel those of Mpateni and Kang'ethe (2020) who found that newly initiated men who faced clinical accidents during the rite were subjected to various kinds of stigmatisation. They were labelled and subjected to derogatory name-calling and teased by different people in their society because they could not complete their initiation without succumbing to formal medical intervention in a hospital (Siweya et al. 2018). This was inhuman in that the people stigmatising them were expected to be sympathetic and empathetic. The treatment that the initiates and their close family members faced constitutes a human rights violation in that it was both immoral and unethical.

In addition, it created a wave of social, emotional and psychological pain. The act cannot be condoned, as it heralded a cultural blindness driven by cultural stereotypes and a mediocrity that was oblivious to issues of human rights that are embedded in the South African Constitution (Mpateni 2017). The stigma to which the initiates and their close family members were subjected through various aspects of maltreatment was especially painful in that it was often caused by the traditional nurses who were responsible for the ineffective medical treatment (Douglas and Hongoro 2018). This mistreatment is considered across the board to be malicious, atrocious and culturally erroneous and could be seen as involving acts of hooliganism that should not only be seen purely as an expression of deviance, but also as a deliberate deligitimacy of humanity and the human rights that are embedded in many countries' Bills of Rights (Nomngcoyiya and Kang'ethe 2019; Gilili 2017).

The study findings revealed that unreliable traditional nurses subjected the TMC victims to molestation, brutalisation and stigmatisation. Similarly, in a study by Nomngcoyiya (2018), participants revealed that they were willing to lose their lives in the initiation school rather than having to be admitted to hospital owing to their fear of rejection; negative labelling; harassment by their peers; and facing an environment of disrespect from the community members. In addition, a major negative implication related to social stigma and ostracism was that the initiates themselves and their parents would often refuse medical treatment or hospitalisation for fear of stigmatisation (Nomngcoyiya 2018). Perhaps, such findings could be a clear indication that societies that practice TMC are not ready for men who complete their manhood journey via health institutions (Douglas et al. 2017; Prusente et al. 2019).

The fact that the newly initiated men were subjected to molestation, brutalisation and stigmatisation signals both the deteriorated goal posts of the TMC cultural practice and the state of moral decadence. This is a serious concern especially at a time when governments strongly encourage communities to conduct safe circumcision in formal medical settings (Mpateni and Kang'ethe 2020). Perhaps governments need to educate people on the best way forward. The researcher is of the opinion that governments need to work tirelessly to see that there are interventions to make TMC safe and hygienic. Moreover, it is the state's duty to ensure that people are afforded a principle of self-determination, which is strongly promoted in the social work discipline and the RSA Constitution with regard to the type of circumcision they wish to undertake (Nomngcoyiya and Kang'ethe 2019; Gilili 2017).

The study findings indicated that the initiates suffered bouts of loneliness, helplessness and hopelessness, especially after becoming victims of the rite. This was a reaction to the environment of shame, inadequacy and stigmatisation that confronted them. Moreover, this resulted in social, psychological and cognitive deficits because they had to contend with pangs of guilt, and despondency engulfed them to the extent that they preferred social isolation (Nomngcoyiya 2018; Cacioppo and Hawkley 2010). Thus, their environment of hopelessness and helplessness was driven by life events and a reality with which they could not easily come to terms, especially since they had failed to meet cultural expectations. In fact, this was due to cultural blindness and rigidity. Mfecane (2016) argues that in a culture where gender construction, masculinity, and patriarchy are overemphasised, becoming a man comes with certain privileges and expectations from the family and society, such as the eligibility to marry, bear children and participate in family courts. In addition, manhood means being bestowed with greater social responsibility (Abrahams 2017).

Therefore, without manhood, newly graduated initiates would be unable to meet the aforementioned expectations, such as marrying and bearing children in a natural way, as most African people would desire. The phenomenon of living bereft of the reproductive organs, therefore, usually results in devastating and disastrous effects on the psychological, emotional and social functioning of the newly graduated initiates, their families and affected community members (South African Broadcasting Corporation (SABC) 2017). Nomngcoyiya and Kang'ethe (2019) observed experiences of guilt feelings and other psychological and emotional effects, such as sadness, guilt, intrusive thoughts, emotional pain, social withdrawal and fear, especially in those initiates who were not supported by their families during the rite of passage. This heralded a state of excruciating physical and psychosocial pain that the initiates had to bear in an effort to achieve the cultural goal post of being a man in societies practising the TMC rite (Mpateni and Kang'ethe 2020; Nyoka 2017).

CONCLUSION

Mainstreaming and emphasising a strong advocacy on the tenets, value and worth of human dignity in all aspects of society practising the rite are central to the success of TMC in South Africa. This will equip and enable the role players to handle an array of challenges and problems confronting the rite, including the stigma, labelling and ostracism to which newly initiated men, who are perceived as failures during the rite of passage, are subjected. The training and capacity building of traditional practitioners might contribute immensely by adding knowledge and skills in the management of the process, and therefore mitigate the states of stigma to which the initiates, who are the casualties of the process, are subjected. Moreover, time to consider women as important stakeholders in the decision-making processes concerning the rite is rife. In addition, the development of traditional practitioners might improve the TMC environment generally and could reduce the pandemonium; the frustrations; and the animosity, especially between the traditional nurses, the newly initiated men and their families. This might make TMC a less painful and stigma-related undertaking, on the one hand, and a desirable cultural endeavour, on the other.

RECOMMENDATIONS AND IMPLICATIONS FOR SOCIAL WORK

The current study has appreciable social work applications and implication. This is be-

cause the state of molestation, brutalisation and stigmatisation faced by newly initiated men attracts critical social work interventions. Indubitably, the continuous infringement of human rights of newly initiated men and their families as a result of failed year-in-year-out TMC processes poses a serious threat to the victims of stigmatisation due to cultural stereotypes and hypocrisy. Moreover, it has a negative impact on the discipline of social work itself, as it affects its capacity to fulfil its societal goals of enhancing and promoting social functioning. Therefore, the worsening marginalisation and increased vulnerability of communities practising TMC cannot continue unabated if the social work profession in the African continent, and particularly in South Africa, is to be proactive rather than reactive. This is because the current stalemate with regard to TMC calls for social workers to work around the clock to save the lives of young boys undergoing the rite in South Africa.

This paper recommends a need for societies to consider indigenous and informal interventions to curb both the self-stigma and societal stigma suffered by newly initiated men. In addition, it endorses the promotion and advancement of humanity principles, such as Ubuntu, and using *"iimbizo"* (traditional meetings) to address and promote human value, worth and dignity by condemning every possible form of degrading and demeaning aspects of other human beings. The researcher recommends the enlisting of community forums, such as churches and learning institutions, to advocate and address the need for everyone to be involved and become aware of the negative impact of stigmatisation and labelling in the processes of TMC.

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