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Pensketch

Vincent Shaw spent his houseman year in Namibia in 1984, and then spent a number of years in hospital practice and later private practice. He obtained the DA (SA) in 1986, and the DCH (SA) in 1988. He then joined a 3-man practice in Queenstown. Two years later he rejoined the public sector to practice first at Hewu Hospital in the former Ciskei, and later in a clinic-based post in Queenstown. He completed his MFamMed degree in 1994. He is involved in the training of primary health care nurses working in remote rural areas and his research interests are on the use of participatory research methods to help communities develop.

In this series of articles our country cousins enlighten us as to their problems and solutions.

We invite any rural practitioners to share their experiences with us.

Summary

Each year numerous young men either die or are severely disfigured following traditional circumcisions. This two-part article describes the admission of a young man following a traditional circumcision. It goes on to discuss the traditional practices and how they contribute to the development of complications.

Based on this, a three-stage diagnosis is developed. The second part looks at the pathogenesis of lesions, and the clinical picture that develops in initiates. A multi-pronged strategy is developed for dealing with the different aspects of this tradition, and the effect that this has had on the development of complications, admissions and deaths is discussed.

The article concludes by looking at the application of the principles of family medicine in dealing with complications arising from the traditional circumcision practice.

TRADITIONAL CIRCUMCISION

Part I: Implications for family practitioners

On 16 December 1993 I was on duty in the casualty department of our hospital and was called in very early on in the day to certify a corpse. It was a young man who had been circumcised eleven days previously. During the course of the day, I admitted eight patients with septic circumcisions, and certified a second corpse.

Jezile M

Jezile M was one of the patients I admitted. He had undergone a traditional circumcision two weeks before and had been brought in by concerned relatives. He was very sick: semi-conscious, dehydrated and he appeared to be septicaemic. His penis appeared gangrenous along its entire length, the shaft firm and indurated. There was some ulceration at the base of the penis. The glans was soft and fluctuant, like necrotic tissue.

I attempted to pass a catheter but was unable to do so, as it was difficult to identify the urethral meatus because of the swelling and distorted anatomy. He was admitted, put on antibiotics (penicillin, gentamicin intravenously and metronidazole) and rehydrated. I also requested a urea and electrolytes (U+E), a full blood count (FBC) and blood culture. His sodium was 165mmol/l and the urea was slightly elevated. The full blood count was within normal limits. Based on these results and his poor general state, it was decided to transfer him to a larger referral hospital. His transfer was discussed with his uncle and the family was agreeable. Jezile was unable to consider the option fully, and he was not consulted in this regard.

Management

At Frere Hospital, East London, a sub-total penectomy was performed. After this he was sent back to Queenstown (arriving back on 23 December) for Milton dressings until a skin-graft could be performed. Eventually, a skin-graft was done locally on 20 January and he was discharged on 4 February.

How did this situation arise? Why did Jezile not seek help earlier? What was the reason for the development of gangrene? The following section is a description of the traditional practice of circumcision and is given here to provide a clearer understanding of the context in which these problems arose.

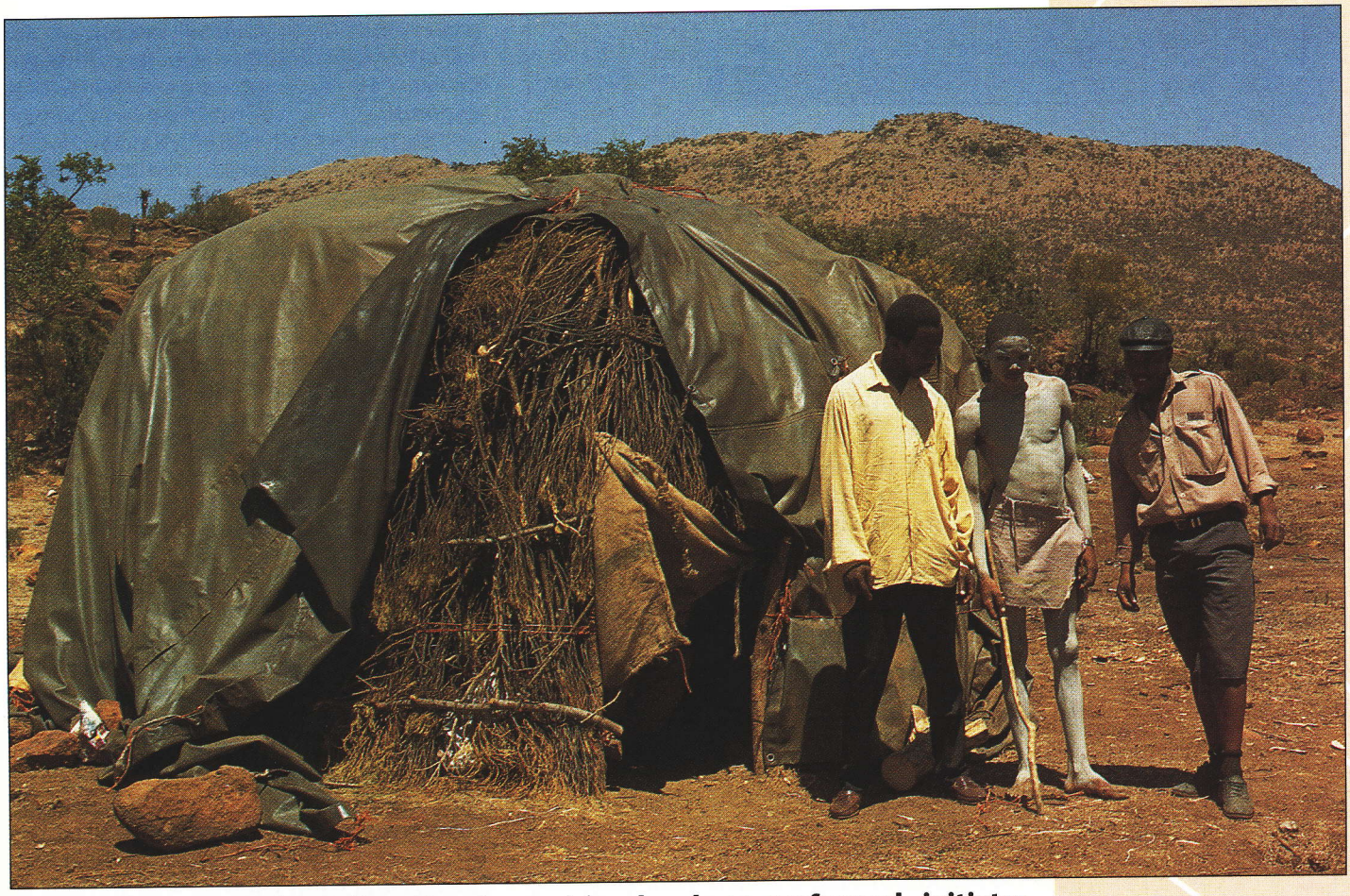
Understanding the context of the problems related to the circumcision rite

Traditional circumcision

The following description of the circumcision rite is based on readings from Aubrey Elliot[1], unpublished data by Monwabisi Mgulwa (a male nurse who has written a great deal on the subject), and personal observations. I have only identified the issues that are of relevance to the complications that we have experienced. For a fuller description of the rite, readers are referred to original texts.

Traditionally, the ceremony used to take place during March to coincide with the ripening of the maize crop. As candidates now generally attend school, the December vacation is more convenient. In the past, the whole procedure took three to six months, and could be divided into the following periods:

- the separation of the boy from his group and ceremonies preceding the circumcision
- the ceremonious removal of the foreskin by an *incibi* (traditional surgeon)
- the isolation of the boy which embraces the following periods:
  - first seven days
  - a period of isolation from day eight onwards (a three month period)
- the integration of the 'man' into the community:



For the first seven days after the circumcision has been performed, initiates apply a white paste to their bodies and remain inside a grass-and-branch hut built for them by family members. In urban ceremonies, however, a small zinc structure may be used, leading to overcrowding and extreme temperatures.

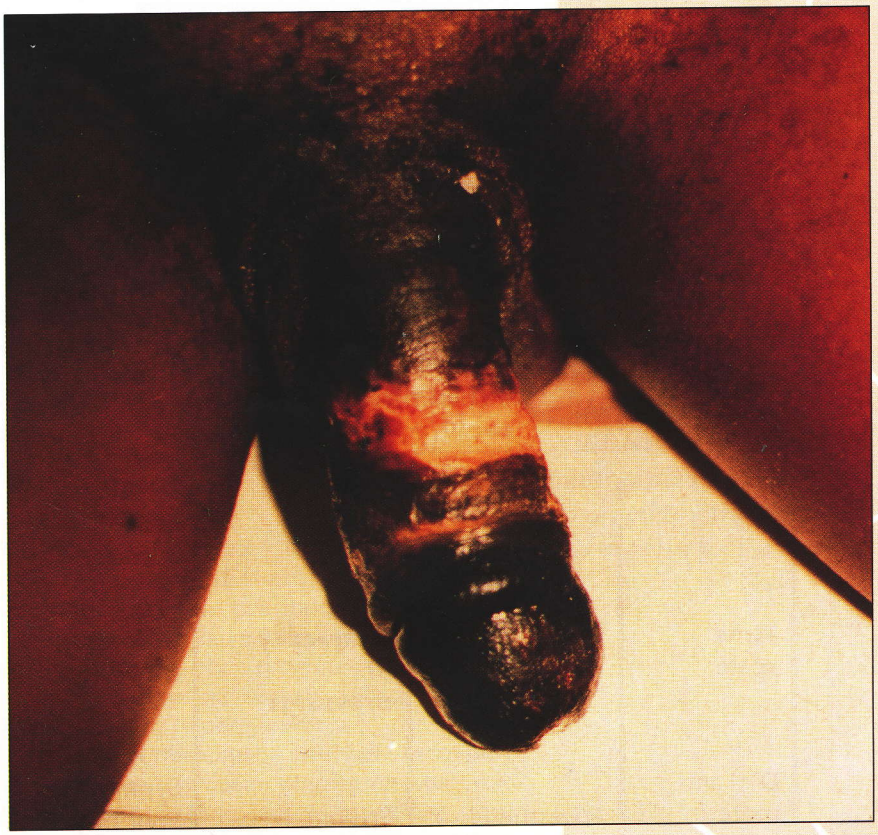
- the coming out ceremony
- a period as an *amakrwala* (a three-month period).

The traditional circumcision is an extremely important socio-cultural ceremony with deep-rooted implications for the Xhosa nation. It marks the transition from the period of boyhood (*ubukhwenkwe*) to that of manhood (*abadoda*). It used to be an educational institution where initiates were taught about courtship, negotiating marriage, dealing with elders and community gatherings (*imbizo zelali*), and settling disputes.

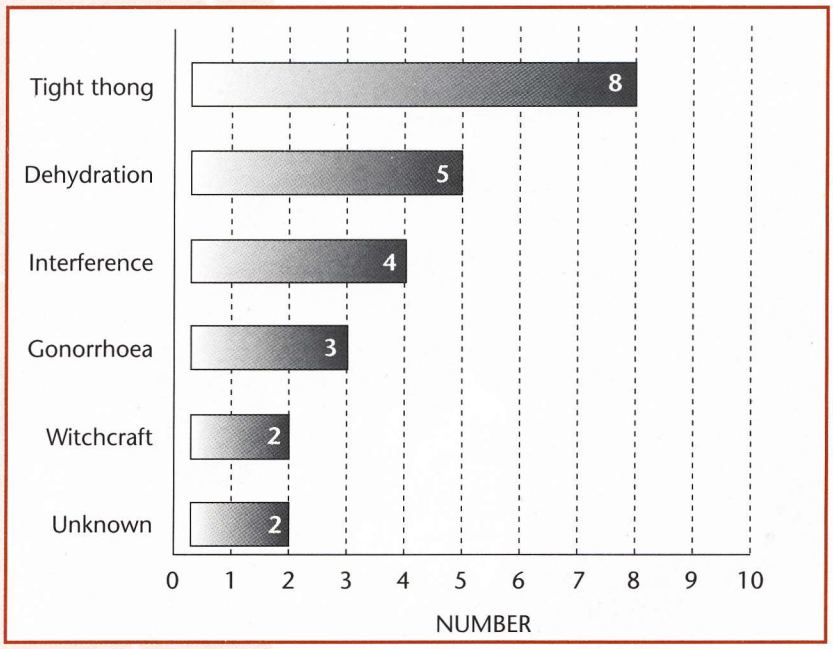
Prior to the circumcision rite, the Xhosa regard the boy as a *thing* and not a person. Having completed the rite, he is regarded as a man.

The process is characterised by humility and submission to others, so that while he is still an *umkwetha* (boy) he has no will of his own and must obey others. This has implications for the modern *umkwetha,* as it often happens that he has to follow the advice of seniors who visit his camp and advise him on how he should be doing his dressings. It also means that advice given by health workers may be negated by other advisers who are not recognised health workers.

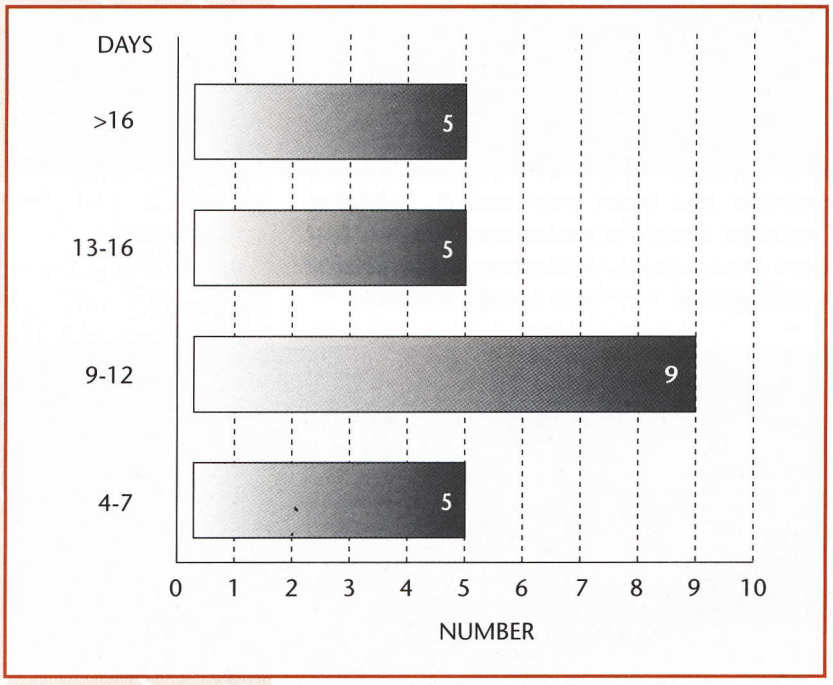
The family of the initiate must select an



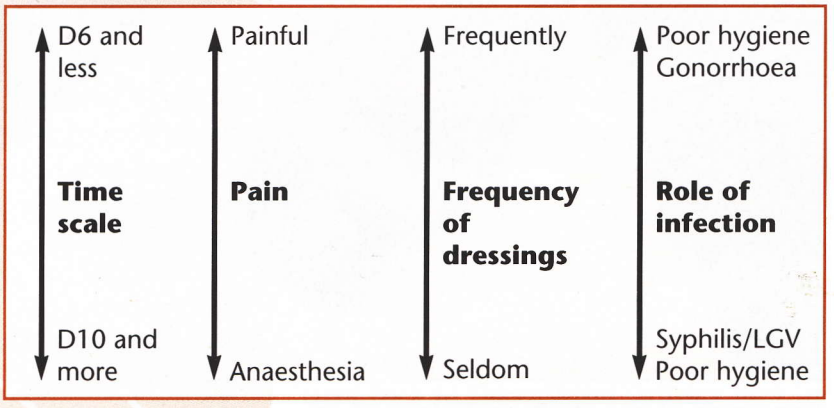
Gangrene of the shaft and glans of an initiates' penis.



Causes of Complications Perceptions of Bakwetha (n=24)



Interval between circumcision and admission (n=24)



Factors contributing to penile lesions

incibi, a traditional surgeon, to perform the circumcision, as well as a person to be in charge of the ceremony (called a *khankatha).*

The latter is the co-ordinator and is supposed to be responsible for the welfare of the initiates. He will liaise between the family (father) of the initiate and the initiate himself during the whole process.

Traditionally, he should stay and live with them, but often these men have to work and are unable to be there all of the time. In the past, young men first went to work and then returned to their homes to be circumcised. These days, the initiates are usually still at school and the age at which boys undergo the circumcision ceremony is largely younger than in the past. Generally, it is felt that boys should be 18 years or older.

Ceremonies preceding the circumcision

On the eve of the circumcision ceremony a goat is killed and the initiates eat the right foreleg of the goat. They are not allowed to eat any salt with it, nor are they allowed to eat the fat.

On this night, the *abakwetha* have a party with other boys and girls from the area. The party lasts most of the night and, apparently, unprotected sexual activity is common.

The circumcision rite

The surgeon, *incibi*, used to perform the circumcision using a spear with a large blade. Nowadays, a large knife is used. Until recently, the same knife was used for all the initiates in the group.

With the appearance of AIDS, and the possibility of the spread of other diseases like hepatitis, this practice has certain implications which concern health workers and initiates alike.

Following the circumcision, one to three initiates enter a hut which has been constructed for them by family members. This hut is traditionally made of grass and branches, is fairly large and can accommodate the initiates comfortably. These structures allow the air to circulate and are remarkably cool. However, in most urban areas, and even in some rural areas, this practice has become corrupted to small structures made of zinc which retain the heat and do not allow for free circulation of air. They are cramped and can barely accommodate a single initiate sitting upright. Often, two or three initiates are housed in these structures. It is estimated that the temperature in these huts exceeds 45°C in the heat of the summer months. In addition, a fire is lit in the hut and is kept burning or smoulder-ing day and night. This used to keep wild animals away.

The first seven days

During this period the initiates remain inside the hut. The reason for this is unclear, but it

is a custom rigidly adhered to. Initiates apply a white paste to their bodies during this period, and keep doing so until they enter the period of *amakrwala*.

Some of the initiates in our area are not allowed to drink any fluids during this time. There appears to be some confusion about this custom as some of the parents stated that they are allowed to drink home-brewed beer, but not plain water. In some instances they are allowed to drink water mixed with antheap soil or fine ash which is made into a thick mixture.

It is clear that this tradition has important implications as many of the initiates admitted to hospital are dehydrated.

Their diet during this period is rather plain, consisting of dry maize which has been lightly boiled.

The day and night are spent undoing and reapplying the thong and leaves to the wound. The interval between the applications varies from 15-30 minutes depending on the belief of the *khankatha*. In our area it seems the general trend is to do them every 15-30 minutes. The process involves the following:

- undoing a leather thong which is wound around the penis
- removing a layer of brown paper and the leaves covering the wound
- applying new leaves
- applying a new layer of brown paper on top of the new leaves
- reapplying the thong in the following way: beginning at the base, it is wound tightly around the penis until the tip is reached and then it is wound back again to the base where it is tied to another thong around the waist. At the tip of the penis, the brown paper that extends beyond the penis is shredded lengthwise and all the ends are twisted together. This end is then tied with a thin thong to the thong around the waist. In this way the penis is kept suspended at an angle of 20 degrees from the horizontal. The initiates apply either leaves (*izichwe*) of a small plant found high up on the mountain slopes, or the onion-like layers of a bulbous plant (*ishwadi*) to the raw skin following the circumcision.

The thong measures about 7-10mm in width. This ritual dressing is kept up until the wound is almost healed, after which the thong is discarded and the healing wound is covered with a small piece of cloth. If all goes well, the wound will be almost healed within seven to ten days. However, wounds that are not healing by day seven should be regarded as suspect and closely monitored.

Closely linked to this stage is the lack of status of the initiates, which adversely affects their ability to make decisions regarding their own well-being. In addition, an initiate who has succumbed to treatment using Western medical practices is seen as a failure - in some extremes he is seen as not having succeeded in the transition from boyhood to manhood.

Period of isolation from day eight onwards

On the eighth day, another goat is killed and the initiates are allowed to eat a normal diet again. They are now permitted to move around the environment in which the huts are located, but they are not to be seen by married women. This period lasts for up to four weeks nowadays, but in the past it used to last up to three months.

The period of integration

The time frame for the circumcision rite has been shortened because of the pressures of modern-day living and this has certain implications:

- initiates are usually in a hurry to get their wounds healed and
- initiates may take part in the coming out ceremony before complete healing has taken place.

Once the initiates are ready to come out, a number of ceremonies are performed. The initiates' hut is burned along with some of the items used by them during their period in the hut.

The initiates under-go a ritual washing ceremony after which a fatty red ochre is applied to their bodies. In addition, they now wear khaki clothes and a jacket, they carry a stick and they usually wear a black hat. The integration process is accompanied by feasting and drinking, and various educational processes related to behaviour as a youth and as a man.

At some stage following this, the initiates are allowed to have intercourse with girls. This is in fact a prescribed ceremony known as '*ukumetsha*' (the initiate makes love to a girl whom he does not intend marrying and whom he will 'hate' afterwards).

The three-stage diagnosis

Having described the traditional practice, we can now make a more holistic assessment of Jezile M's presentation. The three-stage diagnosis[2,3] is a useful tool for doing this, as it allows us to explore the patient's presentation on three fronts:

a. Clinically

Jezile was dehydrated. This was due to the excessive heat of the summer months, compounded by his restriction to a small zinc hut which acted like a sauna. In addition, his fluids intake had been restricted and, because sweat is a hyponatraemic solution, fluid losses result in hypernatraemia.[4]

He was septicaemic - probably secondary to the bacterial invasion of gangrenous penile tissue. Contributing factors were the poor living conditions, the methods used in dressing the wound and the absence of hand

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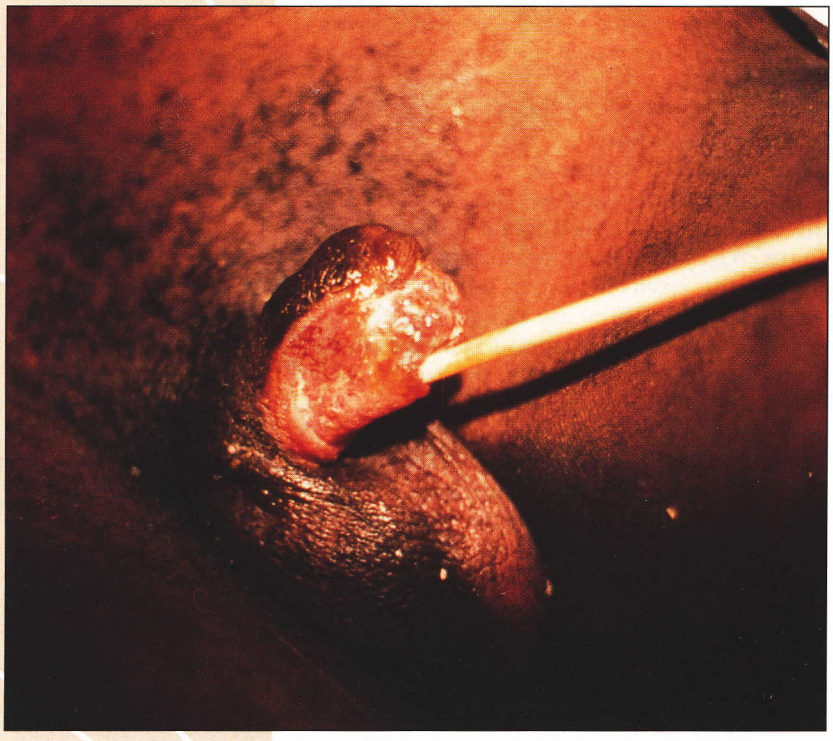
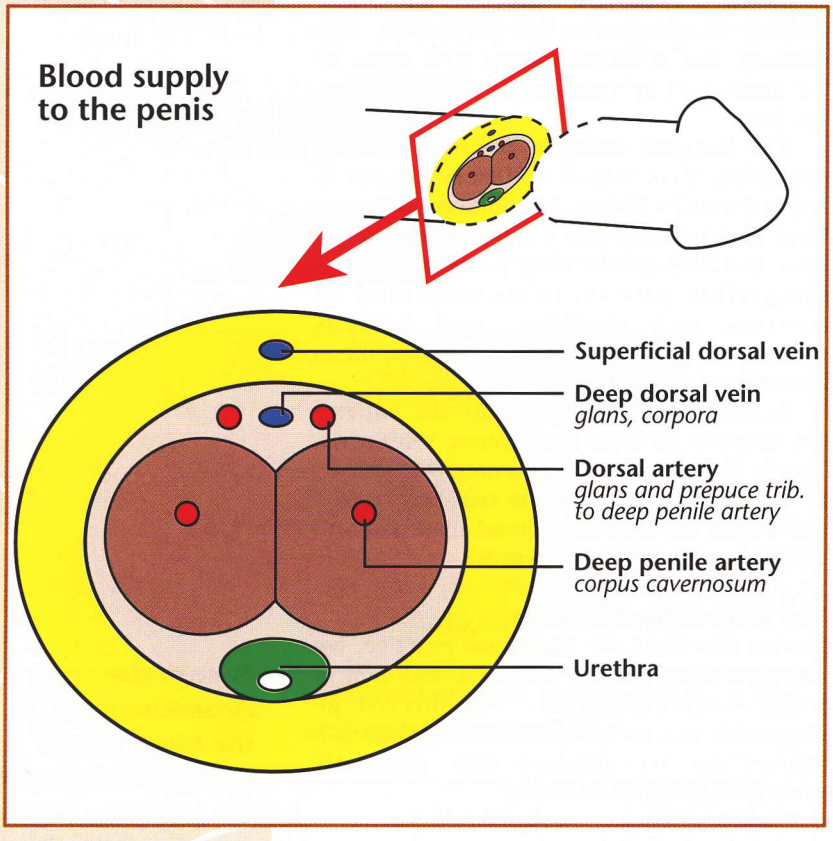


The shortened stump of an initiate's penis (left) due to gangrene of the distal portions following circumcision.



washing prior to dressing. The development of gangrene was probably related to the tension during the application of the thong, the frequency of dressings and the thickness of the thong.

b. Personally

Jezile was taking part in a traditional ceremony marking entry into manhood. To him, it was essential to proceed with the tradition. However, his reluctance to be brought to hospital for fear of being scorned and considered a weakling probably compounded his problems.

Had he wanted to seek care earlier, he would have had to persuade his advisers that this was necessary.

During the initiation the initiates are supposed to be subservient to the men in the community. 'We have no say, we must obey their commands.'

Despite this, many are fully aware that their wounds are not healing as they should, and that they are developing complications but are powerless to do anything about the situation.

c. Socially

The patient was brought by his family who were driven to the hospital in desperation. Up to that point they were hoping he would pull through on his own. The family members, especially the women, are often caught between the 'cultural norm' and what they believe is necessary for their son (ie medical care).

When they bring him in and hand him over to medical expertise, they request that he not be discharged until his lesions have healed completely. Decisions around the management of these issues are often shrouded in controversy and infighting. Women disagree with the men, health care workers disagree with *khankhata,* initiates often disagree among themselves for, as a group, they may feel let down by one individual who seeks Western medical care.

Conclusion

Understanding the traditional practices of circumcision sheds light on the circumstances surrounding the presentation of initiates. One becomes aware that the clinical problem is compounded by complex socio-cultural dynamics, and that there is no simple explanation for the way in which patients present. ●

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3. Fehrsen GS, Henbest RJ. *In search of excellence. Expanding the Patient-centred Clinical Method: A Three-stage Assessment.* J Fam Pract 1993;10:49-54.

4. Harrisons *Principles of Internal Medicine.* 9th ed. McGraw Hill, 1980:436.