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AIDS AND HERITAGE MANAGEMENT
IN SOUTH AFRICA: THE CASE OF
TRADITIONAL MALE CIRCUMCISION

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Abstract

The AIDS pandemic poses a serious threat to heritage resources, tangible and intangible, and to communities who practice and value these heritage resources, especially in Southern Africa. Cultural practices, such as male circumcision and initiation rites, will also have an impact on the progress and effects of the AIDS pandemic. There has not been enough debate about how to deal with heritage issues in mitigating the impact of the pandemic and how to deal with HIV and AIDS issues in the heritage sector. This paper discusses how culture is represented as both problem and solution in AIDS discourse, and suggests how intangible heritage management can inform management of HIV risk. It then discusses the implications of a heritage management perspective for AIDS programming, using the case study of traditional male circumcision (MC) in South Africa. It concludes that by focusing on heritage safeguarding, AIDS programming can acknowledge the value that local cultural practices have for people, while negotiating acceptable change where necessary. This helps to engage communities and takes us beyond simply 'educating' people to change their behaviour.

Short Biography

Harriet Deacon has a PhD in history. After working as research coordinator at Robben Island Museum, she has been a consultant on various heritage, medical history and AIDS-related projects since 2002. Her work on AIDS has included two theoretical and methodological reviews of the stigma literature, and a study

¹ Financial support from the AIDS and Society Research Unit, UCT, gratefully acknowledged. Thanks also to Elizabeth Mills, Jo Wreford, Carol Metcalfe, and Leickness Simbayi. This paper was presented to the ICOM Special Thematic Seminar, Livingstone, 19-23 November 2007 and to the CSSR seminar, on 8 November 2007. It is not based on original research into circumcision practices, but on secondary sources in the public domain. I am aware of taboos around some traditional circumcision practices in Africa being discussed by women and in any case there are many people better equipped to 'earn these stories'. But I do believe in the value of critical research and reflection from an 'outsider' perspective.

of AIDS-related stigma in the Anglican Church of Southern Africa. She has published widely in the heritage field, has taught Conservation Management on the African Program in Heritage Management Studies at Robben Island (2002-2006), and attended various expert meetings on intangible heritage organised by UNESCO to support the implementation of the 2003 Convention.

Introduction

As heritage practitioners we are becoming more aware of the threats that war and global warming pose to heritage resources (e.g. Ammerman & McClennen, 2000). The AIDS pandemic should also be considered a serious threat to heritage resources, tangible and intangible, and to communities who practice and value these heritage resources, especially in Southern Africa where we are experiencing one of the worst HIV pandemics in the world. According to 2005 figures, Swaziland has the highest HIV prevalence and South Africa has the highest number of HIV-positive people in any country (Kates 2005).

There has not been enough debate about how to deal with heritage issues in mitigating the impact of the pandemic and how to deal with HIV and AIDS issues in the heritage sector. The AIDS pandemic places additional pressure on heritage organizations and professionals involved in heritage management and impacts negatively on staff, capacity and funding in heritage institutions. These institutional policy and human resource challenges posed by HIV and AIDS are however no different from those in other organisations. The pandemic will have broader negative effects on cultural heritage resources within society; children's ties with kin, for example, protect their connection to cultural heritage, and transmission of heritage practices can be disrupted as a result of AIDS-related illness and mortality (Young and Ansell 2003:337). Cultural practices, such as male circumcision and initiation rites, will also have an impact on the progress and effects of the AIDS pandemic itself.

Definitions of some heritage-related terms may be important to ensure clarity. Cultural practices can be defined as cultural heritage when they become so important to group or community identity that they are passed down through the generations. They can include indigenous healing and ritual practices such as male circumcision, coming of age rituals, performance, storytelling and knowledge systems. Managing heritage thus goes beyond monuments, places and objects – it includes a broad range of cultural practices, knowledge and values, which are sometimes called 'intangible cultural heritage' or 'living heritage' (Deacon et al. 2004). These heritage practices can change quite rapidly

over time, although they are often represented as part of a romanticized, static past (Lowenthal 1998:x). Defining heritage (and 'ownership' thereof) has thus always been a highly political activity, which in itself points to the effectiveness of appeals to heritage as a tool for social mobilisation.

Researchers have been quick to use an AIDS lens to measure the negative impact of some cultural practices on AIDS risk. But we have been slow to integrate this view with an understanding of the importance of culture for social mobilisation. We have also not yet attempted to use a heritage management approach in exploring culturally-appropriate responses to the AIDS pandemic. A search in ScienceDirect, MEDLINE, Academic Search Premier and Humanities International revealed little published work on how to harness heritage-related expertise to respond to problems in the heritage sphere raised by the pandemic. The academic literature on intangible cultural heritage (ICH) management in general is in fact rather small (e.g. Deacon et al. 2004, Blake 2007). There is a much larger body of work on how cultural practices affect the spread of HIV and the impact of AIDS on society (e.g. Buvé et al. 2001; De Walque, 2006; Simbayi, 2002; Hrdy, 1987).

Many biomedical researchers and epidemiologists see cultural practices (such as dry sex, multiple concurrent sexual partners, scarification) primarily as a barrier to the efficacy of HIV interventions (Taylor, 2007:973). Curiously, 'culture' is sometimes seen as a relatively easy issue to address. Edward J. Mills, an epidemiologist at McMaster University in Canada, says for example:

there is no doubt that traditional practices are spreading HIV [in Africa]. It's a growing concern ... UNAIDS has been ignoring it. I think it's because people think it's culturally insensitive to talk about [traditional practices spreading HIV]. Even if it turns out to be only a minor amount, it's a preventable amount so we really need to address it (Mills in Rosenthal, 2006).

There is a critique of this view of African culture as a preventable problem (Treichler 1991), which tends to see cultural practice as rather more persistent, and as having the potential to assist AIDS interventions. Epstein (2007:254) points out that at present, '[s]ocial mobilisation is the best weapon we have against the epidemic'. Social mobilisation is however very hard to achieve through programs that are 'packaged and paid for and then shipped around the world' (Epstein, 2007:167). In developing a sense of commitment and the will to reduce HIV risk, AIDS programming needs to speak to local meanings and values. Medical anthropologists have thus suggested ways of harnessing local cultural resources to transmit public health messages and reinforce existing practices that reduce HIV risk (Taylor, 2007:973).

Like anthropologists, heritage professionals are sympathetic to the value of cultural heritage, and therefore likely to highlight positive aspects of cultural practice in AIDS programming and development. They see cultural practice not as an expendable luxury but a central aspect of social functioning, quality of life and development (Deacon et al. 2004:9). For heritage professionals in Africa, the HIV and AIDS crisis presents an opportunity to prove the public value of heritage (Clark, 2006), in an environment where culture receives less attention than health, education and development. But in doing so, heritage professionals cannot just focus on the positive aspects of culture as a solution to some of the problems posed by the pandemic. They also need to engage with debates about HIV risk and social equity as cultural heritage is often positioned as a culprit in elevating HIV risk and threatening human rights. Heritage practices officially acknowledged as part of the national estate have to comply with human rights requirements in many countries, including South Africa. Changes to cultural practices that pose HIV risk can however be negotiated within a framework that respects the value that these practices have for communities (i.e. their heritage significance).

In this paper I shall discuss how culture is represented as both problem and solution in AIDS discourse in South Africa (after Taylor, 2007:965), suggest how intangible heritage management can inform management of HIV risk, and discuss the implications of a heritage management perspective for AIDS programming, using the case study of traditional male circumcision (MC) in South Africa. This paper is intended to suggest ways in which public health programming might consider heritage issues, and how traditional MC practitioners might engage with public health debates in the context of a medical MC scale-up that will occur alongside traditional MC practices.

AIDS and the ‘problem’ of culture

Since the 1990s we have seen an historically unprecedented, global effort to design and provide better prevention, treatment, care and support, and monitoring of HIV and AIDS programs. But this has failed to contain the African AIDS pandemic effectively. To some extent this is a problem of poor service provision, structural inequality and lack of education about HIV and AIDS, but socio-cultural cultural approaches to disease and sexuality also play a role in determining how the pandemic affects a society.

With political commitment, donor assistance and reductions in the cost of drugs, African countries are gradually managing to provide more HIV and AIDS-

related health information and services to people. But even where information and services are available and accessible, people in Africa, as elsewhere in the world, do not always know when they are at risk, they are often scared and embarrassed to disclose their HIV status in a hostile environment, and they do not always seek testing and treatment timeously. Recognition of stigma as a barrier to AIDS management worldwide in the late 1990s was part of a broader acknowledgement from public health programmers that AIDS requires social as well as biomedical interventions.

Culture is often constructed as a problem in discourse about AIDS in Southern Africa. A recent Southern African Development Community (SADC) think-tank suggested that a 'lethal cocktail' of socio-cultural and biological factors can help explain the exceedingly high HIV prevalence in Southern Africa. The main socio-cultural driver that they identified was the high level of concurrent multiple partnerships, accompanied by high gender inequality, gender-based violence, intergenerational and transactional sex, stigma and lack of openness about sex and AIDS. The main biological driver was the low rate of MC, accompanied by high levels of viral STIs such as herpes. Structural factors sustaining the pandemic include growing wealth differentials, high mobility and migrancy, and high levels of poverty and sexual violence in the SADC countries (Leclerc-Madlala, 2006:29).

Looking at this analysis, it is interesting that low rates of male circumcision are regarded as a 'biological' driver of the epidemic in the SADC report although reasons for circumcision (or not) are usually cultural – probably because new recipients of circumcision are seen to be receiving 'medical' rather than 'cultural' interventions. It is also interesting that low and inconsistent condom use, influenced by condom supply as well as socio-cultural factors, seems to be receiving less and less attention from researchers as a driver of the epidemic.

It is of course often difficult to differentiate between cultural influences on behaviour that are historically embedded practices (i.e. what might be defined as heritage) and structural socio-economic influences on people's ideas and behaviour. Sexual concurrency has some historical roots but has also undergone significant recent change, for example. Ahlberg (1994) suggests that European Christian missionaries in Africa prohibited the public rituals that had previously created protective social controls around sexual behaviour, forcing sexual practices to be conducted privately and secretly, and in an unregulated way. Trends towards earlier sexual debut, intergenerational sex, or forced sex, are generally considered to have emerged relatively recently and have structural roots in poverty, colonialism or urbanization.

Culture has also been presented as a solution. Culturally resonant, indigenous understandings of disease can be effectively deployed in AIDS programming. Green speaks of similarities between traditional Manica conceptions of *nyoka* and the biomedical definition of the immune system – *nyoka*-related illnesses could be used to explain opportunistic infections (Green, 1999 in Wreford, 2005:28). Ingstad (1990 in Wreford, 2005:29) points to similarities between biomedical understandings of AIDS and *meila*, a disease caused by sexual misconduct. There are similarities in cause (the sexual linkage), in symptoms (wasting, coughing, diarrhoea), and above all in the route of pollution (blood and semen). Thus, she proposes increasing condom use in Botswana by linking it to the prevention of *meila* (Ingstad, 1990 in Taylor, 2007:970). However, linking condoms to sexual misconduct may, as in the case of the ABC campaigns, lead to difficulties introducing them in a marriage context with HIV sero-discordant couples. This example illustrates that although traditional explanations of illness can assist in AIDS education, the context and implications of drawing such parallels should be carefully considered.

Cultural practice can be an important way of strengthening society more generally. The South African Cabinet has instructed the Department of Arts and Culture to explore ways of using heritage to foster ‘social cohesion’ by promoting *ubuntu*, the idea that we exist as individuals because of our relationship to our community (Wakashe, 2007, see also Pendlebury et al., 2004). The idea is to bring communities together at a time when the AIDS pandemic is causing massive social disruption. Similarly, Cochrane (2005:3) suggests that faith-forming entities, including traditional religious groupings, can leverage ‘religious health assets’ in the pursuit of health goals. These can be both tangible (e.g. the availability of volunteers, buildings and other resources) and intangible (information networks, relationships of trust with communities, a caring ethos, spiritual associations with health and medicine, moral formation). Cochrane et al point out that these under-researched aspects of religious health initiatives explain their ‘motivations, commitments, attitudes, actions and relational or associational strengths’ and ‘can play a very real role in fostering the health of individuals and communities’ (Cochrane, 2005: 5). Religious leaders and politicians have backed campaigns for ‘moral regeneration’ and ‘family values’, advocating a return to ‘faithfulness’. For example, ancient scriptures and religious books are scanned, in India, for messages suitable for use in national AIDS programming (Jayaraman, 1991: 102). One of the problems with this has been that returning to ‘family values’ to address AIDS can mask a return of paternalistic conservatism.

Claiming some cultural practices as heritage is a powerful tool in the discourse about culture, HIV risk and AIDS. ‘Moral regeneration’ constructs certain HIV

risk-lowering practices – such as fidelity, or partner reduction - as social heritage. Defining a practice as ‘cultural heritage’ suggests that it is more valued than other kinds of social practices. Some communities have attempted to reduce HIV risk and control the sexuality of young women by ‘reintroducing’ the long-neglected practice of virginity testing (Leclerc-Madlala, 2001:533). ‘Disclaiming’ heritage can be used to encourage change: At a workshop on intangible cultural heritage, a traditional leader told delegates that, contrary to some news reports, expensive and festive funerals were not part of African culture, so people should therefore stop getting into debt to display social status (Holomisa, 2007). Conversely, claiming heritage can also be used to resist change - having multiple sexual partners for men or not using condoms can be validated as ‘African culture’.

The battle over culture and heritage happens within the context of a broader political tension in post-colonial South Africa between ‘a desire to build on the indigenous’, which has been marginalised under apartheid and colonialism, and ‘a recognition that the indigenous may be an obstacle’ in some cases (Williams and Young, 1994: 96 in Vincent, 2006:26) – an obstacle not only to equity, but to health. The ‘universal’ tenets of liberal democracy enshrined in the South African Constitution (1996) have been in some tension with African humanism, which is based on fundamentally different understandings of the relationship between citizen and state. The liberal view suggests that individual freedom and value is intrinsic, and people should be free to act as long as it does not harm others (Vincent, 2006:20). The African humanist view, on the other hand, suggests that an individual becomes fully human and valuable because of their relationship to a community (Vincent, 2006:19).

This tension is expressed in different philosophical approaches to the need to encourage behaviour change, social cohesion and reduce HIV risk in a time of AIDS. Public health programming philosophy is based on giving people enough information so that they can protect themselves from HIV risk in a rational and individualized way. AIDS programming thus emphasizes the importance of improving access to human rights – giving people the opportunity to act freely (and rationally) (Parker and Aggleton, 2003:22). ‘Culture’ is often seen in the biomedical literature as holding people back from exercising these rights, an analysis that tends to neglect socio-economic factors (Taylor 2007, 968). From the viewpoint of many religious and cultural leaders, however, it is precisely the freedom to act ‘outside of culture’ that is the driver of the pandemic. This approach suggests that people need to be controlled and brought back into the fold, because without culture they are lost. Heritage and culture have thus been concepts that have gained considerable potency in explaining and addressing AIDS in Africa. Cultural practices operate (and are strategically deployed)

within socio-economic, political and historical contexts, and they influence behaviour within these contexts. It is a political decision to describe some social practices as 'heritage', to discredit practices as corrupted by modernity, or to discredit old-fashioned and ignorant 'tradition'.

Using a narrow AIDS lens to evaluate cultural practices encourages an instrumental and fragmented understanding of them. Culture is 'good' when it accords with current best-practice AIDS programming, 'bad' when it hampers programming, and indifferent in every other case. AIDS programming is predominantly generated through a biomedical lens, with limited recognition of social practices, which may account for this narrow approach. This does not do justice to the broader meaning and value that people invest in cultural activity, and thus cannot fully mobilize that value in developing effective interventions. At the same time, we need to acknowledge that in a time of AIDS, some specific cultural practices pose a risk to health and social survival. As heritage practitioners, we have a responsibility to explore the place that cultural practice and heritage have occupied in the discourse about AIDS, to engage with biomedical information, and to help investigate contextually-sensitive, appropriate ways of mobilising cultural resources in achieving health and social wellbeing.

Community involvement

Against the background of this discourse on culture as problem and solution, it has also been recognized that tackling AIDS effectively depends on mobilizing communities (however they might be defined) in a strategic and culturally meaningful way. Social development should attend to the cultural needs of communities, and heritage management needs to involve communities. Both heritage management and AIDS programming emphasise the importance of community engagement in theory, but in research and in practice there is inconsistent commitment and attention paid to the issue. There are historical reasons for this but there are also real power struggles between implementing agencies and communities.

The latest, cutting-edge South African National Strategic Plan (2007-2011) talks about developing 'AIDS competent communities', fostering greater engagement of communities in AIDS education and service provision (Department of Health, 2007: 55, 60, 89). Some research is now being done on this, but there has been little sustained focus on developing best practice in engaging and mobilising

AIDS competent communities (exceptions include Campbell et al. 2002; Gregson et al. 2004).

Encouraging meaningful community involvement in AIDS programming is difficult when there is a lack of trust and equity between traditional and biomedical health practitioners. Since the Alma-Ata Declaration (1978), primary health care policies have been more sensitive to the need to work with traditional healers, but there has been little real change because biomedicine is still offered as the dominant framework and when they have been involved, Traditional African healers (TAHs) have often been cast as junior partners who provide a cheap referral mechanism and who are brought in to learn from biomedical practitioners, without meaningful and respectful exchange and recognition of both healing paradigms (Wreford, 2006:2; Mills 2005:151). TAHs are often positioned as junior assistants who need biomedical 'education', not as partners with special skills. Yet TAHs can provide spiritual and psychosocial healing, referral and testing services and can effectively treat opportunistic infections. Concepts in traditional healing can be used to illuminate biomedical explanations of HIV transmission, and traditional healers may well be willing to work with public health services in a complementary way if the value and special nature of their work was better appreciated (Wreford, 2005: 37).

In South Africa, this difficult situation has been further muddied by the inconsistencies in the interventions of the state. Natrass points to a lack of public trust in scientific analysis of HIV, exacerbated by Mbeki's 'denialist' stance on AIDS (Natrass, 2007:183-184). Key officials in the government have supported research on previously marginalised traditional knowledge systems and recommended trials of traditional remedies for AIDS and related infections. But Mbeki and his ministers of Health have also undermined this emphasis on finding an effective biomedical solution with what seems to be uncritical support for remedies like Virodene and Rath's vitamins, positioned as alternatives to anti-retroviral medicines. The Department of Health has also been hoping to regulate traditional healing in ways that are unacceptable to some groups of healers by replacing internal hierarchies and insisting on minimum formal educational standards even for diviners (Wreford 2005:8). This uneven, top-down approach does not help to foster real understanding and collaboration between government, communities of healers and biomedicine.

According to current heritage management thinking the emphasis in safeguarding is supposed to be on meaningful community participation in

heritage management.² The idea of living heritage validates emic or insider definitions of value, but governments continue to define the ‘national estate’, recognising some but usually not all of these heritage resources. Local ‘communities of practice’³ have been doing heritage management very effectively for years, but heritage ‘experts’ have often not engaged sufficiently with them (Ndoro, 2001: abstract). In part this is influenced by a historically racist and ignorant view of African heritage management bluntly expressed by Hugh Tracey (1954:32):

... we have found that the African is pathetically incapable of defending his own culture and indeed is largely indifferent to its fate.

In part, the lack of community engagement can also be explained by the fact that heritage professionals and government agencies in Africa have operated for many years according to Eurocentric paradigms of heritage management focused on managing buildings and antique objects. Heritage professionals have sometimes been competing with local communities for control over heritage resources and any economic benefits. Ndoro thus emphasizes the need for integrative planning and management structures that [promote] a rapprochement between scientific and local knowledge structures. This provides the best chance of avoiding irreversible cultural degradation resulting from arbitrary decisions of management and policy makers (Ndoro, 2001: abstract).

Finally, any community is a fluid construct, as communities coalesce, and are constructed by others, around specific social, economic and political issues. Membership of communities is often contested where resources are involved, and relationships within communities are often hierarchical. This makes identification of communities, or their representatives, a subject for negotiation and review in many cases. Differential power relationships also exist within communities, which sometimes creates a tension between community-level responsibility and state involvement to ensure positive social change and the protection of human rights.

² Expressed in UNESCO’s 2003 Intangible Heritage Convention, this view is broadly accepted in South Africa where community participation is already required in the 1999 National Heritage Resources Act.

³ This term, originally coined in 1991 by Jean Lave and Etienne Wenger to describe the process of social learning that occurs when people collaborate to share ideas and construct their identities through this process, is used here to describe networks of people who gain identity from their practice of a specific heritage form. Lave, J. and Wenger E. 1991. *Situated Learning: Legitimate Peripheral Participation* Cambridge: Cambridge University Press.

Rights protection

If government and its public agencies were to allow more community-level control over either heritage management or AIDS programming they could still not abrogate their oversight responsibility to ensure that basic human rights are not infringed in terms of national legislation such as the South African constitution, or international agreements.

UNESCO has been promoting the development of cultural policy in Africa that is compatible with human rights since the 1970s. The need for a selective celebration and occasional redefinition of indigenous practices not compatible with human rights is acknowledged in the draft African Union Cultural Charter (African Union 2005:4), which promises ‘the development of all dynamic values in the African cultural heritage that promote human rights, social cohesion and human development’. In Uganda, the Cultural Policy promises to ‘promote community action on cultural practices that ... impinge on human dignity’ (Uganda Ministry of Gender, Labour and Social Development, 2008:14). This emphasis on community action is an important one, as it acknowledges the importance of community involvement and buy-in in the process of shifting cultural practices that do not comply with human rights requirements.

After 1994, South Africa became more sensitive to these issues. The Bill of Rights in the South African Constitution (1996) protects ‘[h]uman dignity, the achievement of equality and the advancement of human rights and freedoms’. The most fundamental (non-derogable) rights include the right to life and human dignity, for people ‘not to be treated or punished in a cruel, inhuman or degrading way’, ‘not to be subjected to medical or scientific experiments without their informed consent’ and for all children ‘to be protected from maltreatment, neglect, abuse or degradation’ (South Africa, 1996: Chapter 2, article 12 and 28).

The Constitution says the right to practice culture ‘may not be exercised in a manner inconsistent with any provision of the Bill of Rights’ (South Africa, 1996: Chapter 2, article 30). Clearly, heritage practices that violate human rights thus cannot be safeguarded as part of the national estate, which is sanctioned by the state. People cannot harm others by taking away their rights, but the Constitution gives people the freedom to harm themselves if they want to (Vincent, 2006:20). Because cultural practice places pressure on people to act in certain ways, however, the promotion of cultural practices that increase HIV risk may challenge the basic human right to avoid harm (as adults) and be protected from harm (as children). In a recent article, Pholokgolo Ramothwala (2007) thus

implies that cultural practices, such as unprotected ‘sexual cleansing’ of widows, that place people at risk for HIV, cannot be legally promoted by traditional leaders. But does this mean that no cultural practices associated with increased HIV risk (including, say, marriage) can be promoted?

When children are involved, the role of external agencies becomes slightly clearer: cultural practices placing them at risk for HIV infection are unconstitutional. Children need to be socialised within a specific culture, but the state also has a particular obligation to protect them from harm, even when they may consent. Vincent points out that there have however been inconsistencies in the way in which the state has applied human rights principles to virginity testing and MC. Virginity testing could harm children’s dignity but is less physically permanent and less potentially harmful than traditional MC, for example, or poor nutrition (Vincent, 2006:24-25). But while the state has banned virginity testing and ‘genital mutilation’ of children under 16, it has accommodated religious or medical reasons for circumcision of male children under 16 (South Africa 2005: art.12). Religious reasons for performing MC in infancy thus seem to override the need for informed consent or capacity to refuse circumcision. Children over 16 have to consent to virginity testing (in the case of girls) and circumcision (in the case of boys) before it is performed, but boys under 16 also seem to be given the right to refuse circumcision for religious or medical reasons, ‘taking into consideration the child’s age, maturity and stage of development’ (South Africa 2005: art 12(10)). The ‘religious purposes’ (South Africa 2005: art 12(8)) for circumcision of boys under 16 are not defined in the Act. Would indigenous African traditional circumcision under the age of 16 be permitted under the Act ‘for religious purposes’? This seems unlikely, and the main exceptions will probably be made for Muslim and Jewish practices.

Deciding what practices are problematic in a society is thus not a neutral or technical process. Is MC in childhood a violation of human rights (Brigman, 1984), a health benefit or a religious practice in which the state should not interfere? Vincent argues that notions of what is harmful to children, and thus when the state should intervene, are made within a specific socio-political context. In a diverse society it is difficult to reach agreement on what principles should govern the definition of harm, and how to define loss of dignity. She suggests that the state paid specific attention to virginity testing because of the need to ‘discipline’ or create the new South African citizen and respond to the discourse of women’s liberation (Vincent, 2006:29).

It is interesting how often researchers pronounce on the ‘desirability’ or ‘harmfulness’ of practices in African groups without asking the same questions

of other communities. Perhaps African women are stereotyped as having less agency or power to stand up for themselves in traditional contexts than, say, in the context of Christian ceremonies promoting abstinence before marriage. Perhaps the public nature of virginity testing transgresses western norms around sexuality as a private activity, and is thus defined as harmful to dignity. Perhaps, also, a lenient approach was taken on traditional MC because there is little religious, political or medical opposition to it. It is widespread in Jewish and Muslim communities, is routinely performed in America on neonates, and by 2005 it was clear that it had likely medical benefits in reducing HIV transmission (Siegfried et al. 2003).

In conclusion, communities need to be involved in tackling the AIDS pandemic and in heritage management. The state needs to use heritage professionals and public health experts to help decide both how to mobilize and engage communities, and when (and why) it is necessary to challenge cultural practices. We need to recognise that defining HIV risk, human rights and heritage itself are highly politicized activities. This is particularly true given the actions of the South African health department and the historically deeply unequal relationship that exists between biomedical practitioners and TAHs. In order to proceed, we need to engage more with emic definitions of the problems at hand, and draw on academic research on the meaning and context of cultural practices that affect the pandemic. We need to engage with these issues or they may be ‘resolved’ by decree in an environment of mutual distrust between ‘traditionalists’ and public health professionals.

Changing cultural practices to reduce HIV risk

What can we learn from heritage management about the most effective ways of changing cultural practices to reduce HIV risk? This is a special case of a more generic problem around changing heritage practices that infringe human rights. Heritage management approaches can remind us first to engage communities to understand the meaning and importance of a practice within its proper context. Risk and rights issues then need to be addressed as part of an attempt to safeguard heritage that is important to communities and not inimical to their health and wellbeing.

There are guidelines about how to manage built heritage or tangible heritage (Australia ICOMOS 1999; Pearson and Sullivan 1995), but there has been less discussion on the management of intangible heritage (Smith, 2002; Deacon et al. 2004; UNESCO-ACCU 2007). There have also been disputes about the extent to

which ideas from tangible heritage management, for example authenticity, are applicable (e.g. Nara Document on Authenticity, 1994). It is generally agreed that intangible heritage management needs to be very sensitive to emic definitions of value and authenticity. Issues of secrecy and sacredness in defining significance may require that only specific communities or groups have access to definitions of significance.

Progressive approaches to managing heritage places and objects, such as the CoBRA principle – Conservation-Based Research and Analysis - focus on finding out through research what the value or significance of a heritage resource is, and then using this to inform management (Clark, 2001). Identifying significance often involves considerable dispute, and statements of significance have to reflect these disputes, which are often linked to broader power struggles within communities. Disputes over significance are part of a heritage resource's significance (Deacon and Beazley, 2007:104). I believe that focusing on identifying and managing significance is particularly important in intangible heritage management because it is constantly being recreated – this is why it is called 'living heritage'. I have defined heritage significance in this context as those core elements (meanings, knowledge, skills, products), which express its value to a community of practice, have been passed down over time and should continue to be transmitted and enacted in the future (Deacon, 2006:5).

It is often assumed that change *per se* is a problem in heritage management, but this is no longer the case. Safeguarding can and should accommodate change because it is an essential part of living heritage. If one focuses on managing significance, then change only becomes a problem if it threatens significance. Using an approach that emphasizes safeguarding significance can help us to identify creative mechanisms for conservation and change. This includes understanding the politics of a practice, why certain groups support or reject it, and how it relates to broader beliefs and other practices. Where change is needed, it is very important to bring that change about in participatory way, or it will not be accepted or followed.

Protecting significance is not the same as protecting specific fabric, or even all practices associated with living heritage. If people doing a certain ritual have traditionally dressed in red because the colour symbolises life, for instance, then safeguarding the ritual might include ensuring continued access to dyes or knowledge of processes of dyeing rather than restoring specific clothing items. 'It is not enough to ensure that people go through the motions of such a ritual – to protect its significance the ritual has to continue to have some sustained meaning for them' (Deacon, 2006:2).

Defining significance affects how one manages a resource and what changes matter. Let us say that the ritual above had historically deployed a certain kind of grass in weaving the red clothes, but this grass became scarce. If the type of grass was not significant the community may have simply shifted to using a new kind of grass. If the kind of grass was essential to the ritual's meaning, it could be farmed, or if the wildness of the grass is a significant element, then the community may seek other sources of wild grass. If this was not possible, then a community might for the purposes of the ritual symbolically reconstitute or rename a new kind of grass as the original kind of grass. From a heritage management perspective this might usefully be coupled with a documentation process, and encouraging skills transfer and performance of the ritual.

Heritage professionals and anthropologists can help communities and governments develop participatory definitions of heritage significance, negotiate significance-based management strategies, revise national policy and legislation, and develop participatory inventorying processes. Their personal relationships to a community of practice may affect what role heritage practitioners and researchers can play in definitions of significance and negotiations around change. Ideally, communities of practice should engage with public health and heritage management perspectives to develop their own solutions.

Case study: male circumcision

As we have noted above, if we reorient AIDS programming towards safeguarding heritage practices this can address community participation as well as health and human rights issues. If there is a problem with the continuation of a specific practice, the problem needs to be clearly identified, and a common understanding of the problem needs to be reached with representatives of the community concerned. Solutions need to be participatory, and informed by research on content, context and meaning.

Anthropologists have suggested ways that cultural practices can be adapted to reduce negative health impacts in a time of AIDS (Taylor, 2007; Wreford, 2007). There is a belief in some parts of Zaire, for example, that semen is needed not only for fertilization but to help the gestating foetus grow. A nurse proposed that because this belief undermined the use of condoms, the 'requirement' of semen for babies' growth could be understood metaphorically and frequent *intercourse* with condoms could instead provide a loving environment for the growing baby (Schoepf, 1995 in Taylor, 2007:970). This proposed change was taken by Schoepf, an anthropologist, to the President of

the Traditional Healers Association who, after much deliberation, agreed that healers could advise their clients accordingly. Schoepf states that ‘the healers’ collaboration in this reinvention of cosmology, which they could not but know to be pure fabrication, suggests the possibility of other creative cultural adaptations to crisis’ (Schoepf, 1995 in Taylor, 2007:970).

In a similar vein, Wreford (2007) proposes designing new cleansing rituals that could be conducted by *igqirha* / *isangoma* for HIV-positive people. Some people believe that AIDS (or certain cases of AIDS) is a result of bewitchment (Ashforth, 2002). This concern needs to be addressed through appropriate means, alongside biomedical interventions. Unfortunately, traditional cleansing rituals involve the use of harsh cleansing agents such as enemas and emetics which have to be avoided in an immune-compromised patient. Instead of recommending a cessation of such rituals, which perform an important psychosocial function, Wreford suggests developing new rituals that will deploy a more symbolic cleansing action instead (2007: 100).

In the following discussion I am not going to offer a definitive analysis of MC but wish to raise a few issues that require consideration from a heritage management and HIV risk perspective. It is an interesting case study for this discussion because there is considerable evidence for a protective effect against HIV risk, and it is already widely used in traditional and biomedical settings. Demand for it is growing in Africa and there are calls for a scale-up of medical MC (WHO, 2007). In this debate, we can raise questions around how public health services should engage traditional MC practitioners, and likely impacts of a scale-up of medical MC on traditional MC practice.

Does male circumcision protect against HIV infection?

For a long time we have known that areas with high rates of MC within a generalized heterosexual AIDS epidemic tend to have lower HIV prevalence than areas with lower rates of MC (Siegfried et al., 2003). Western Kenya, where less than 20% of males are circumcised, has a much higher HIV prevalence than regions of the country where nearly all men are circumcised. Uncircumcised men in Kenya have a four-times higher HIV prevalence compared to circumcised men (Marum et al., 2003:229). It is suggested that this is the case because circumcised men provide a biologically less hospitable environment for HIV, but there is a big debate about the likely biological mechanism for this which will not be discussed here (see Patterson 2003).

Results from studies relying on self-report should be interpreted with caution. The social meaning associated with traditional MC can influence whether or not respondents self-report being circumcised or not. Traditional circumcision can involve varying degrees of foreskin removal which may not correspond with biomedical definitions of circumcision (Peltzer et al., 2007:658). In a Tanzanian study, ‘upon physical examination, 31% of men who reported circumcision during the interview were not circumcised, and 6% of men who had reported not being circumcised were circumcised’ (Nnko et al., 2001:217).

It has however since been established that there is a causal effect between MC and reduced HIV risk – three randomized controlled trials found that medical MC reduced HIV risk by between 51% and 60% among the circumcised men (Auvert et al., 2005; Bailey et al., 2007 and Gray et al., 2007). It was further established that providing medical MC through public health services would be cost-effective, because it lowers the overall costs of health care (Williams et al. 2006; Kahn et al. 2006). Even in areas where MC is not traditionally practiced any more, levels of acceptability are quite high and demand seems to be rising (Bailey et al., 2002). Westercamp and Bailey, (2007) concluded there is no need for further general acceptability studies.

Based on this research there has been considerable interest from a public health viewpoint in scaling up MC in a biomedical setting. The WHO recommended early in 2007 that MC be used as part of a prevention package that includes consistent and correct use of condoms, delaying sexual debut, reducing the number of partners and HIV testing (WHO, 2007a). A meeting of key public health representatives from SADC in Harare in 2007 then recommended following the WHO guidelines by scaling up MC as part of other HIV prevention services in the public health system, developing prevention messaging, and exploring task-shifting to enable nurses, midwives and medical officers to perform MC (WHO, 2007b). PEPFAR has now decided to fund medical MC programs in Africa (Kaiser Family Foundation, 2007).

Alan Whiteside is one of a number of people who advocates implementing routine opt-out medical MC at birth:

There’s no question that we need a male circumcision programme, but a mass programme is more debateable. Operationalising it is going to be complicated ...Thirty years from now we’ll be so glad we did it ... if we’d started 25 years ago we wouldn’t be in this godawful mess. ... Aren’t the arguments we hear against it – it’s too expensive, we can’t do it for everyone – just the same as those used against ARVs in South Africa in 1999 (Whiteside in AIDSmap News, 7 June 2007)?

The idea of improved ‘biological prevention’ through MC is attractive to public health programmers, as indeed to us all, because vaccine and microbicide research has produced no ‘magic bullet’ and there is increasing frustration with the ineffectiveness of current educational and structural interventions (Aggleton, 2007:20).

Even in this atmosphere of eagerness to do something effective quickly, caution is advisable. The main problems identified from a public health perspective seem to be how to scale-up medical MC in resource-poor settings, and how to mitigate against unintended effects such as behavioural disinhibition (Bailey and Egesah, 2006; Agot et al. 2006). MC scale-up will not be very effective if men who have gone to the trouble of electing circumcision for health reasons feel less inclined to practice safe sex. A cross-sectional survey in South Africa suggests that 30% and 18%, of circumcised and uncircumcised men respectively, believed that circumcision would permit them safely to have unprotected sex with multiple partners. Furthermore, circumcised men were likely to report more partners over their lifetime than were their uncircumcised peers (Lagarde et al., 2003).

Some critics have challenged the notion of MC as a magic bullet by questioning the solidity of the evidence for its efficacy and likely effectiveness (Potterat et al., 2006; Dowsett and Couch, 2007: 37). Not all the data suggests that MC is associated with reduced HIV risk (Connolly et al., forthcoming; Mishra et al. 2006 and Way et al., 2006 in Dowsett and Couch, 2007: 36). Scaling up MC could have broader social effects which need to be carefully considered. MC may not be protective for women, for example if a circumcised man is already infected with HIV. Scaling up MC could impact negatively on women in other ways, for example by validating female circumcision and reducing their already minimal bargaining power around condom use (Aggleton, 2007; Degregori, 2007; Dowsett and Couch, 2007:42). Degregori has suggested that if MC is associated with greater frequency of anal and dry sex in Africa, as she believes it is, increased levels of MC may not in fact decrease HIV risk (Degregori, 2007).

Critics have also been concerned from a programming perspective about possible dilution of other, potentially more effective, interventions. Timothy Quinlan argues that ‘A mass circumcision programme is an experiment in disguise ... It’s not focusing on the real problem’. He says we need instead to focus on concurrent partnerships as a risk factor (Quinlan in AIDSmap News, 7 June 2007). Outside of the clinical trial situation, scaling up condom use may be more efficacious than promoting MC (Garenne, 2006). Promoting condom use among all sexually active people may even be more effective than targeting specific risk behaviours like inter-generational sex (Hallett et al., 2007).

What is the extent, nature and significance of the practice of traditional MC in South Africa?

In a recent paper, Niang and Boiro (2007) complain that most research on traditional MC focuses on differentiating between medical and ritual circumcision - describing differences in practice (especially, one could add, documenting practices that increase HIV risk). They argue that more research is needed on 'the history of male circumcision in Africa, its symbolism and related cultural concepts, changes in how it is being practised, or the influence of social relations and sociopolitical environments on how it is perceived' (2007:22).

The kind of research and discussion proposed by Niang and Boiro (2007) is very similar to the process of establishing the significance of traditional MC. Understanding the relationship between actions and meaning will help in determining how one can safeguard elements of the practice of traditional MC while reducing HIV risk. Broad aspects of significance (meanings and symbolism) are played out in specific activities and aspects of ceremonies. Different groups may highlight different aspects of significance, and some significance may not be fully elaborated to outsiders.

In this section I do not wish to pre-empt this process, but for argument's sake will proceed by identifying a couple of elements that may be significant in some cases, and deal with HIV risk and rights issues in relation to them. The 2002 Nelson Mandela / HSRC study showed that about 35% of men in South Africa are circumcised (Shisana and Simbayi, 2002: 77). Circumcision rates are highest among Africans in the northern part of South Africa, who speak isiNdebele (67%), Sepedi (71%), Tshivenda (90%) and Xitsonga (53%), and those in the south east who speak isiXhosa (64%). Jewish and Muslim South Africans are also highly likely to be circumcised (79%) (Connolly et al., forthcoming). Other groups showed relatively low rates of MC. This paper will focus primarily on African traditional MC because of this group's higher HIV prevalence (Shisana and Simbayi, 2002: 46), but it is also important of course to understand Jewish, Muslim or non-religious medical MC, undertaken primarily in hospitals during infancy.

It is interesting given the importance attached to traditional MC among the amaXhosa that in the 2002 survey, circumcision was self-reported by only 64% of the sample (age 15 and up) (Connolly et al., forthcoming). It may be socially desirable but have been disrupted by migration or other factors, thus happening later than the average age of 17. Alternatively, it may be losing its significance for younger men. It should however be remembered that this research was based

on self-report alone which may be unreliable. The interviewers were western-trained female nurses, which may have made some respondents reluctant to discuss the issue (Connolly et al., forthcoming).

Linguistic evidence suggests that MC for religious or cultural reasons is a historically well-established cultural practice within Africa, although the practice has stopped in some groups. MC was stopped among the Zulu under Dingane in the nineteenth century, for example (Marck, 1997:337). In Southern Africa, compared to elsewhere in Africa, there has been evidence of greater abandonment of initiation schools (and circumcision) at times of continuing warfare and more subsequent reinstatement through borrowing from neighbours' practices (Marck, 1997:350). Considerable change in traditional MC practices has historically therefore been commonplace.

The social meaning of traditional MC is likely to be complex and linked to other social practices. Traditional African circumcision is generally associated with coming-of-age rituals at initiation schools and with age-grade systems among Bantu-speakers (Marck, 1997:337). Marck (1997:345) suggests that words for initiation schools in Southern Africa evoke the meanings 'make friends' and 'drum' because friendship bonds emerge in schools and the drum is the most common musical instrument in use in the course of a typical school and its ceremonies. Fostering relationships between boys at initiation school may thus be significant in the continuation of the practice.

Initiation rituals are coupled with education about being a man, including sexual health. In her forthcoming review of traditional MC among the amaXhosa, Vincent (forthcoming) summarises the symbolism of traditional MC rites:

Male circumcision rites are symbolically saturated: the enhancement of masculine virility, the performative enactment of the separation between men and women, preparation for marriage and adult sexuality, the hardening of boys for warfare (see for example, Crosse-Upcott 1959; Gluckman 1949; La Fontaine 1985; Spencer 1965; Tucker 1949; Turner 1962) are typical themes. Initiation rites usually involve forms of physical testing, seclusion, metaphorical death and rebirth and the demonstration of fitness for masculine approbation (Silverman 2004: 421). Symbolically, circumcision can be read as a dramatic enactment of the separation of the son from the mother and the integration of the man into the community. As such, it is a central public endorsement of a culture's accepted norms of heterosexual manhood.

Connolly et al. (forthcoming) suggest that among the amaXhosa ... a man is not accepted as a man unless or until he is circumcised. Indeed it is not uncommon for uncircumcised men to be ostracised by other men during discussions about manhood. In turn, some old or even elderly [uncircumcised Xhosa] men have to undergo circumcision later in life to finally gain acceptance of their masculinity by other Xhosa men.

Pain (and perhaps also bleeding) may be an important aspect of the circumcision ritual to prove manhood (Bailey and Egesah, 2006:2; Niang and Boiro, 2007). In Kenya one anthropologist reported that 'No medicine is applied to the wound to stop the bleeding which commonly continues for thirty or forty minutes after the operation has been performed ... If the wound bleeds excessively this is considered a sign that the candidate has committed a theft at some time in the past' (Wagner, 1949:350 in Marck 1997:348). The ritual cutting of the foreskin is conducted in different ways and with different instruments within different groups.

The age at which circumcision happens in a boy's life is significant in African traditional MC. African men tend to be circumcised at or after puberty, but ages differ between linguistic groups. Tshivenda speakers are more likely to be circumcised under 12 years, and isiXhosa speakers after 17 years (Connolly et al., forthcoming).

Circumcision is a social ritual to the extent that other community members (but often only men) are involved. The rituals associated with MC in African communities traditionally required a rural setting (the 'bush') that allowed some degree of isolation from the community for some time. This seems to have been difficult to replicate in hospital settings. In the South African study about 80% of Africans were reportedly circumcised out of the hospital setting, whereas around 90% of Whites, Indians and Coloureds were circumcised in hospital (Connolly et al., forthcoming). Social disruption caused by migration and the difficulty of setting up circumcision schools may have helped to reduce circumcision rates in urban areas. This may explain why rural men are more likely to be circumcised than urban men (Connolly et al., forthcoming). Ritual aspects of Jewish or Muslim MC seem to have adapted better to hospital-based circumcision because of the length and nature of the rituals themselves, and perhaps also because of a longer history of urbanisation. Niang and Boiro (2007) have noticed a tendency for MC to become a clinic and close family affair in urban areas of Senegal rather than a community affair.

How might we maintain the advantages of traditional male circumcision?

Traditional MC as it is already practiced in sub-Saharan Africa offers some protection against HIV infection. There do seem to be significant advantages linked to traditional MC in the observational studies. Researchers can try to separate out the protective effects of biological and cultural aspects of traditional MC through statistical analysis (Drain et al., 2006), but in the real world these factors operate together. One review concluded that circumcised men were about half as likely to be HIV positive as uncircumcised men in sub-Saharan Africa (Weiss et al, 2000; see also slightly more conservative estimates in Siegfried et al. 2003). A prospective observational study in Kenya showed that traditional MC reduced HIV risk by about a third over two years (Hazard Ratio = 0.31: Shaffer et al. 2007). How can we maintain and increase the advantages associated with traditional MC alongside a medical MC scale-up?

Weiss et al. (2000:2361) thus spoke about ‘providing safe services for male circumcision as an additional HIV prevention strategy in areas of Africa *where men are not traditionally circumcised*’ (emphasis added). In this scenario, traditional MC practices could continue alongside a medical MC scale-up. But the trials in 2006 focused attention on medical MC. In part this is because there is concern about complications associated with traditional MC (Peltzer et al., 2007:661). In fact, there is a larger literature on complications associated with MC, compared to appendectomies and hysterectomies (Dowsett and Couch, 2007:35). If risks can be established in relation to traditional MC practices in South Africa, what are they and how can we address them using heritage management principles? What are the likely effects of scaling up medical MC on the risks or social functions of traditional MC?

The first two related issues which will be discussed here are age at and place of circumcision. HIV risk reduction from traditional MC practice in West Africa may not be easily replicable in South Africa, where most MC is conducted after sexual debut and not unequivocally associated with reduced HIV risk. Pre-pubertal MC in South Africa, on the other hand, seems to be associated with greater protection against HIV (Connolly et al., forthcoming). Evidence from the randomised controlled trials suggests that recently circumcised men who engage in unprotected sex may be particularly at risk for infection (Peltzer et al. 2007:665), making it doubly advantageous to circumcise boys before they reach sexual debut. To allow for reasonably informed consent and reduced HIV risk, MC at about ten years of age may be proposed, but would it be acceptable in communities where it is linked to coming-of-age rituals?

Offering MC at around ten years of age would be consistent with practice in TshiVenda communities (Connolly et al., forthcoming), and it may not be historically inappropriate for neighbouring groups to 'borrow' this practice. Because of the place of the circumcision act itself within an initiation ritual, it may be acceptable to some communities if medical MC is conducted prior to initiation school attendance, thus maintaining the link between initiation rituals and puberty. In Senegal and Guinea-Bissau the social processes of circumcision and initiation may be separated by several years, with the former taking place in clinics and the latter in the 'bush' (Niang and Boiro, 2007:26). Among SeSotho and BaPedi, Krige reported gaps of up to five years between circumcision and initiation in the 1940s (Krige, 1946 in Marck, 1997:354).

This separation of circumcision and initiation practices may accommodate medical MC before sexual debut, although its effect on the significance of the practice may need further evaluation and perhaps even mitigation, e.g. a symbolic reference to circumcision within initiation, or clinics accommodating social rituals around circumcision. Changing the age of MC would not be easy if initiation schools did not accept already circumcised boys at puberty, or if initiation rituals required boys to experience the pain and bleeding associated with circumcision. It is interesting that in the Senegal study, Manding, Wolof, Serer, and Fulbe informants reported recent shifts in age of MC from about age 20 to between 6 and 13, changes which were not due to any specific public health intervention (Niang and Boiro, 2007:28).

The use of clinics for MC is increasing. Taljaard et al. (2000) reported that among various language groups in a mining town in Gauteng

Circumcision ... is often performed at local clinics or by general practitioners. It is still very important to certain groups and is seen as part of 'becoming a man'. People who run traditional initiation schools are not threatened by circumcision at modern medical facilities but those attending the schools must be circumcised. Many in the community gave health reasons for getting circumcised, wives often making the appointment for their husbands.

In general, an increasing acceptance of MC will impact on how traditional MC is viewed. A mass medical MC scale-up that is positioned as an alternative to traditional MC practices may exacerbate these trends. Rites of passage associated with traditional MC may be particularly important to young men at a time of social-economic disruption, loss and high levels of orphanhood caused by the AIDS pandemic. The social function and meaning of traditional MC practices could be negatively affected by medical scale-up. If the physical act of

circumcision becomes more important than initiation schools in ‘becoming a man’ there may be less incentive to go through initiation rites, which offer important social and sex educational benefits. If MC is seen only in terms of its health benefits, which seem to be widely appreciated among laypeople, HIV risk may increase because people feel completely protected against HIV and other STIs. Thus, where clinics are interfacing with or taking over from traditional MC, there needs to be more discussion with clients and traditional MC practitioners to ensure that the symbolic meaning of circumcision and the link to positive male socialisation is retained.

Traditional initiation rituals are already under pressure from rapid social change and regulatory mechanisms to improve safety. Vincent notes that increasing regulation of MC through registration of traditional circumcisers among the amaXhosa in the Eastern Cape has actually resulted in greater polarisation between ‘bush’ and clinic circumcision or even circumcision in state-approved schools. Traditional MC in the ‘bush’ has been valorised as the only authentic method, but even here ‘it has not been possible to sustain the value of the custom in cementing social ties and its inter-generational support mechanisms’ (Vincent, forthcoming). Traditional MC is now seen by amaXhosa initiates, for example, ‘as a gateway to accessing sex rather than the moment at which sexual restraint is taught’:

In this context, campaigns for circumcision aimed at curbing HIV can be very confusing because they are layered onto other messages – of abstinence, sexual restraint and sexual responsibility on the one hand, and the rights and privileges that go along with Xhosa manhood on the other (Vincent, forthcoming).

Such a shift in meaning is not surprising given massive social change and the focus on empowering women, but it is rather unfortunate both from the viewpoint of social cohesion and from the viewpoint of HIV protection based on sexual restraint. From a heritage management point of view, it would be important to investigate the reasons for change while fostering engagement between both current and older views of the ritual. It may not be possible or desirable to return to older views of male sexuality by decree, but an engagement about male violence, HIV risk and the place of men in a democratic society could happen in these forums.

The third issue is the content of circumcision rituals. Traditional MC may increase HIV risk if circumcising instruments are not sterile, if they are used for multiple circumcisions without intervening sterilization (Wagner, 1949:350 in Marck 1997:348), or if circumcised youths are encouraged to have unprotected sex before their wound has healed (Nqeketo, 2004; Simbayi, 2002). In this case,

because the use of non-sterile knives is a health risk, there should be discussion about what the symbolism is around blood mixing, or using a knife repeatedly, and developing effective and sustainable strategies for retaining this symbolism while reducing risk. This is a more meaningful and sustainable intervention than simply ‘educating’ traditional MC practitioners about the importance of using sterile instruments. For example, the common knife could be placed symbolically against the penis, while using a separate sterile instrument for each actual incision. Existing practices around infection or washing of knives could be adapted to reduce HIV risk. In a Kenyan study, Wagner noted:

Boys who suffer from a disease, though not necessarily a contagious one according to European notions, are generally circumcised with a special knife which is kept separate from the others (Wagner, 1949:350 in Marck 1997:348).

If the use of Plastibell, Mogen or Gomco clamps is recommended to allow for task-shifting and elimination of non-sterile instruments, they will have to be supplied, assembled and used safely in all settings. Resistance to using clamps is not unlikely among traditional MC practitioners, especially if some early problems occur because of faulty equipment or usage method (Federal Drug Association 2000). The significance of the traditional cutting mechanism and the acceptability of proposed changes will affect willingness to adopt new methods.

Although deaths from traditional MCs have been shockingly high in some cases, we should be careful of generalisations about risk. Traditional practice is often stereotyped as inherently more risky than interventions within public health systems. In a recent study, being circumcised in hospital was statistically associated with the same HIV prevalence as being circumcised in the ‘bush’ or at home, among sexually active African men in South Africa (Connolly et al., forthcoming).⁴ Any unsterile environments, whether in hospitals or in traditional settings, can pose a risk for HIV infection. Many hospitals in South Africa do not have functioning sterilizing equipment (Shisana et al., 2005), staff are overloaded and beds are often unavailable. Scaling up medical MC in hospitals or clinics would need to address these issues.

⁴ Admittedly, those who have died from badly performed circumcisions would not have been interviewed in this study.

Conclusion

Male circumcision scale-up is never going to be a purely biological intervention because people already associate circumcision with certain meanings, people already practice MC in Africa and in order to maximise benefit it needs to be linked to higher condom use and partner reduction. Social meaning and values are extremely powerful motivating forces for human behaviour.

Researchers have thus argued that a public health scale-up of medical MC needs to engage with the symbolic and social value of circumcision (Niang and Boiro, 2007:31). This will require greater involvement of communities and traditional MC practitioners in HIV programming. The 2007 meeting of SADC public health representatives in Harare

acknowledged the important role that traditional practitioners play in male circumcision and agreed that more consultation needed to occur at country level to better understand what the traditional practitioners are doing and define how they could be involved in safe male circumcision scale up (WHO 2007b).

It is not clear exactly how a scale-up of MC in southern Africa plans to do this, however. Public health, and specifically AIDS programming, has recognised the importance of involving communities and TAHs as referral and support agents for stretched biomedical services (Maclean, 1986; Crossman and Devisch, 2002 in Wreford, 2005), but real collaboration has been slow and unsatisfactory. This is partly because biomedical practitioners have shown too little interest in the broader spiritual context of traditional healing. Wreford points out that a major barrier to equitable collaboration between TAHs and biomedicine is the assumption that biomedicine provides the 'universal' knowledge system within which TAHs must operate (Wreford, 2005:18). Public health programmers need to engage with TAHs and communities in a more respectful and self-critical way (Wreford, 2005).

In this paper I have tried to show how AIDS programming can move beyond simply educating people to change their behaviour by focusing on safeguarding heritage practices. Heritage is a political concept, aimed at validating certain cultural practices, which is leveraged by communities of practice and by the state at times of social upheaval and change. It thus becomes a site of struggle in the context of the AIDS pandemic, but this also makes it a very powerful tool in social mobilization. Heritage practitioners and anthropologists thus have an important role to play as social commentators and mediators in the engagement between public health programmers and communities.

Focusing on the importance of cultural practices to communities, as well on innovative and appropriate mechanisms for continuity and change, could help mobilise community action to safeguard valuable social and medical dimensions of traditional MC while reducing HIV risk. Heritage management approaches to negotiate safeguarding strategies take account of politics, community participation, health and rights issues, the inevitability of change, and the need to identify and maintain significance. Just because there are mechanisms for negotiating change in cultural practice, does not mean that change is necessary or that external involvement is required. And because decisions about human rights are necessarily taken within specific political contexts, we need to ensure that rights and risk judgements are carefully considered and negotiated.

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