The experiences of nurses in caring for circumcised initiates admitted to hospital with complications

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ABSTRACT

The circumcision of males is a ritual that is performed in the veld, out of the public eye. Traditionally, it has to be attended by circumcised men only; no one is allowed to see the initiates before they are officially released or discharged. In recent times, initiates have been admitted to hospitals following complications during the circumcision process. In the hospitals, they are cared for by nurses. Hospitalisation of initiates creates problems for the elders who accompany the initiates as well as the nurses who are expected to care for them. The purpose of the study was to explore and describe the experiences of nurses who care for initiates who have been admitted into hospital with medical and physical complications. A qualitative approach was adopted for this study, and the data was collected by means of unstructured interviews.

A purposively selected sample of nurses of different categories from a rural hospital in the Nkangala district in Mpumalanga Province, South Africa, participated in the study. The data was analysed, and five major categories were developed. The major categories were: conflicting cultural practices, emotions, common complications, ethical issues and possible solutions. Based on the findings of the study, it is recommended that traditional circumcision should be regulated to avoid complications that lead to the admission of initiates into hospitals. Also, a collaborative partnership should be established between the health institutions and the traditional surgeons and healers in caring for initiates.

Keywords: experiences; circumcision; ritual; initiate; complications

Introduction

South Africa is a country with a diverse racial population with groups of different beliefs and practices. All these cultural groups have a constitutional right to practise and preserve their cultures (Constitution of South Africa, Act 108, 1996). The circumcision of boys in preparation for manhood is a common practice in many African cultural groups. The performance of and participation in this ritual gives the young men a feeling of satisfaction and belonging. Research has shown that circumcision has medical benefits as well. A study conducted in Kenya revealed that circumcision can reduce the risk of

HIV-1 infection (Agot, Ndinya-Achola, Kreiss, & Weiss, 2004, p. 158). Another study, in Botswana, found that circumcision was becoming increasingly popular in that country. It was also found, based on clinical trials, that circumcision might be an acceptable option as an HIV prevention strategy among sexually active people (Kebaabetswe et al., 2003, p. 214). Circumcision is undoubtedly beneficial in reducing the risk of HIV infection and other sexually transmitted diseases.

The ritual of circumcision is a highly valued practice, especially among black South African cultural groups. It is believed to potentially develop boys into men. In South Africa, this practice is most common among ethnic groups such as Xhosas, Northern and Southern Sothos, Southern and Northern Ndebeles, Vendas and Tsongas. However, there are variations even between local cultural groups in the way the ritual is conducted. For example, the Southern Ndebele group spends three to four months in seclusion whereas the Northern Sotho group spends only four to six weeks. The ritual is also common among other cultures, including Western cultures, varying again with regards to the processes involved and the significance attached to it.

In South Africa, traditionally, the ritual is performed in the mountains or in the veld, away from the initiates' homes. One of the reasons for this is that circumcision is not only about cutting the foreskin, but also an opportunity to educate the young men about the life skills relating to manhood. The initiates spend up to four weeks in the mountains; they could stay even longer if not yet properly healed. During that period the boys are taught about issues such as respect for one's elders, how to treat women and how to protect and take care of one's family. The lessons are given by the elders and traditional circumcision nurses (Bottom, Mavundla, & Toth, 2009, p. 29). Initiation normally takes place during the winter months in order to reduce the risk of sepsis. Despite this, many circumcision operations develop complications which could lead to lifelong health problems and even death. In July 2002, it was reported that 14 initiates had died in South Africa and that more than 100 initiates had been treated in hospitals, most with septic wounds (*The Times of India*, 2002). In 2003, 20 youths were reported to have died from botched circumcisions in the Eastern Cape and another 100 had been injured, some as a result of having been severely beaten during the initiation (Dempster, 2006). In 2005, 12 boys died and 100 were hospitalised. Some of the initiates suffered the loss of their sexual organs (Staff Writers, 2006). In 2006, an 18-year-old youth from Makhubeni village in the Eastern Cape was admitted to a hospital in the area after losing part of his penis following an unsuccessful circumcision. At the time, the death toll was reported to be 16 while more than 300 initiates had been admitted to hospital with complications (Zuzile, 2006, p. 4).

Background and problem statement

African cultures that practise circumcision dictate that the initiates are not to be touched or even seen by women before the completion of the initiation. The rationale for secluding initiates from women is to promote and facilitate the healing process. The belief is that contact with women may lead to excitement and penile erection which may delay the healing (Mbito & Malia, 2009, p. 41). This can cause complications such as bleeding, swelling and tears or pain. However, nowadays due to factors such as climate change and the type of food that children eat, initiates often experience complications and end up in hospitals where they are cared for by nursing staff who are predominantly female. This means they come into contact with females, which is against their culture. For many of the boys who get hospitalised, they experience a feeling of failure and shame, and feel they are not proper men. The nurses also experience problems, where they are harassed and insulted by the escorts of the initiates, who will demand that male nurses should attend to the initiates, which, in many cases is practically impossible because

the nursing profession consists mainly of females. The nurses are thus subjected to considerable stress and emotional trauma which affect their productivity and interest in their work.

Nurses are obliged to care for all patients without fear or favour. However, these same nurses are also social beings themselves with community affiliations. They want to respect and adhere to their community's cultural values. The situation is made worse by the lack of cooperation that the nurses receive from the patients (initiates) who could be experiencing discomfort and unease about what they perceive to be a breach of their cultural beliefs.

Several studies have been undertaken to determine the extent of the problem, its causes and related complications. Very little information is available on the care of these patients in the hospitals where they get admitted and the experiences of the caregivers in these institutions. The purpose of the study was to close this gap by exploring and describing the nurses' experiences with regards to caring for circumcised initiates who are admitted to hospital with complications. This knowledge will help better our understanding of the dynamics involved in caring for these patients in hospitals and possibly improve the relationship between these institutions and the Indigenous communities.

Research design

The study was qualitative and descriptive in nature. Leininger (1985, p. 5) defines qualitative research as a type of research that incorporates methods and techniques of observing, documenting, analysing and interpreting attributes, patterns, characteristics and meanings of specific contextual or gestalt features of the phenomenon under study. The researcher accordingly collected and then analysed the narratives of the participants (Polit & Beck, 2004, p. 15).

Population and sampling

The population in this study consisted of nurses of all categories who were working or had worked in the Casualty Department and Male Surgical Ward of a selected hospital in the Nkangala district in the Mpumalanga Province. The researcher used a purposive sampling method for selecting the hospital in the district for the study. The particular hospital was selected because of its rural location in relation to the prevalence of ritual circumcision (Polit & Beck, 2004, p. 729).

The purposive sampling method was also used in the selection of the participants in the hospital, based on specific characteristics. In order to obtain information on direct experiences and knowledge on the subject, only those nurses who had actually cared for admitted initiates were interviewed (Brink, van der Walt, & van Rensburg, 2006, p. 133). It was not easy to trace nurses who had nursed circumcision initiates among the nurses working in the departments; as such some of the participants were identified and referred to us by their colleagues, in which case the snowball sampling method was used. This method is a form of non-probability sampling whereby participants are asked to refer others who meet the study's eligibility criteria (Polit & Beck, 2004, p. 236).

Data collection

The process was carried out using interviews, audiotapes and field notes. Unstructured interviews were used to collect data from the study participants. The content of the interviews was completely controlled by the participants; the researcher did not influence them to include anything in their narratives (Burns & Grove, 1999, p. 270). An open-ended question was put to the nurses as follows:

> What are the experiences of nurses in caring for circumcised initiates admitted into hospital with complications?

The researcher used audiotapes to record the interviews and later listened and analysed the data. Observational and methodological notes were made during the interviews. Observational notes gave more meaning to the recorded data and reminded the researcher of what had taken

place in the field. The methodological notes were used to guide the researcher during the interviews.

Ethical considerations

The researcher observed all the ethical principles to ensure that the study was conducted in a safe and ethical manner. These include the principle of beneficence, the principle of respect for human dignity and the principle of justice.

To ensure compliance with ethical guidelines, the study was approved by the Ethics Committee of the Faculty of Health of the University of Pretoria, the Department of Health in Mpumalanga and also by the hospital where the data were collected. Informed consent was obtained from the participants before the interviews were conducted. The participants were given information about what the study entailed and assured of anonymity (Brink et al., 2006). The audiotapes were destroyed after use. This was done to ensure that the participants were protected against any kind of abuse in keeping with the principle of respect for the person (Brink et al., 2006, p. 64).

Data analysis

Data analysis is described as the process of transforming data into research results (Le Compte, 2000, p. 146). Data analysis for this study was done on the day of the interview or the following day, when the data were still fresh. Data analysis thus occurred concurrently with data collection (Burns & Grove, 2003, p. 378). The researcher listened to the participants' verbal descriptions on the audiotapes and transcribed the data verbatim, studied the data in-depth and identified themes (Streubert & Carpenter, 1999, p. 70). Data coding was done according to the eight steps described by Tesch (Creswell, 2003, p. 192).

The verbatim transcriptions were read and reread to get a sense of the whole. In the process, significant statements were identified and clustered. The clusters were then represented as codes. The topics were grouped together according to similarities, and each time topics were narrowed until a limited number of categories was formed. These were further grouped into subcategories. Comprehensive themes were developed to support the subcategories. At the same time, the data were cleaned (Burns & Grove, 2003, p. 476), in the course of which errors in the recording of the data were remedied and unwanted or irrelevant data discarded. Follow-up interviews were held with the participants where necessary to clarify certain information. During the process of data analysis, literature control was carried out to link the data to the available literature and to create meaning. The data were then given to an independent coder to analyse and confirm the findings. After the co-coder had analysed the data, the researcher and the co-coder discussed the findings and compiled a final analysis report.

Discussion of the results

Five major categories were identified from which subcategories were developed. The categories identified were: conflicting cultural practices, emotions, common complications, ethical issues and possible solutions to the problems.

Conflicting cultural practices

Conflicting cultural practices emerged as the first category. Four themes were identified from the Western versus Traditional subcategory: nurses' dilemmas as social beings and professional practitioners, culture of sacrecy and secrecy, male supremacy and dominance, supremacy of circumcised men over uncircumcised men and interference with medical practice.

The nursing staff in the selected hospital belong to different cultural groups and accordingly perceived and experienced the ritual of circumcision differently. Some conflicts arose during the interviews, indicative of the disharmony between Western culture as part of the nursing profession and initiation as a cultural practice. The participants identified the admission of initiates in the hospital as a nurses' dilemmas. It became evident during the interviews that the nurses sometimes found themselves torn between their culture as social beings and the prescriptions of their

profession. They found themselves acting in conflict with their culture, and this placed them in a dilemma because their communities viewed them as disrespectful and anti-traditional.

The following expression articulates this view:

> I know that culturally I am not supposed to even see the initiates, come near a circumcised man or touch them, but I felt frustrated because professionally I am compelled to care for them. 'I did not feel free at all … but I am a nurse I had no choice.'

This finding is supported by Bottom et al. (2009, p. 29), who assert that it is taboo for initiates to come into contact with women or experience the intervention of western medicine. This clearly posed a problem for the nurses as professionals and social beings. Some of the nurses (participants) believed that they were professionally obliged to act on behalf of the patients (initiates) but also felt culturally restricted in doing so. Many ended up neglecting their responsibilities as professionals for the sake of their culture.

It became evident during the interviews that the ritual of circumcision was a highly sacred and secret practice. All the participants reported that the escorts demanded the attendance of a male person for the initiates, who himself has undergone circumcision. It took a lot of time and effort to convince the escorts to allow female nurses to attend to the initiates given that there was a shortage of male nurses, especially circumcised ones. The initiates and their escorts did not like being admitted into hospital, because it is against their culture.

The participants mentioned that:

> They wish that they could be attended by a man. Initiation is sacred and only men should care for the initiates … They do not want to be touched by women; yet in the hospital they find women nurses only.

> We try to keep them isolated from others and the public by keeping doors closed because we know the tradition.

Circumcision is considered a sacred practice in many cultures and religious denominations who practise it. According to the Balante group of Guinea Bissau, it is believed to be a holy practice ordained by God and indicates people's commitment to Him (Niang & Boiro, 2007, pp. 23–24). A circumcised man is regarded as purer and more spiritual and is rightfully the one to pray during religious ceremonies. The blood that is shed is considered a sacrifice to the ancestors, as such, the practice of circumcision is treated with great respect because of its holiness.

The elders were also not happy to have the initiates admitted to hospital because of the secretive nature of the circumcision ritual. Even if they eventually agreed to admission and treatment, they would return later and remove the patient before he had fully recovered. The following response was recorded from the participants:

> The patient was reluctant to utter a word about whether he was willing to be admitted or not. I felt that he could not say anything to object in front of the elders and I also kept quiet when in fact I had to advocate for my patient. The thing is there is so much secrecy about what is happening, … how they do it. If you ask them why they are bruised they will tell you they fell from a tree or something … they are very secretive.

Another important feature was that most initiates would be brought to the hospital at night. Their consultation times in the emergency unit were late at night regardless of when the problem began. Even when they fetched the patients, they would come very late at night, once again highlighting the importance of the secrecy of the ritual to its custodians.

It was emphasised that:

> … even if the problem started in the morning they will not come same time; they will wait until night before they bring the patient.

> My worst nightmare was when they agreed that the patient be admitted and came back at night and took the patient away. I felt so helpless.

Another issue that came to the fore was the blatant display of male supremacy and dominance by the escorts of the initiates over the female nurses. Most of the participants reported that they were bullied and harassed by the elders who ordered them around, shouted at them and did not allow them to care for (look after) the initiates properly. This is evident in the following statement:

> A group of older men brought the initiate and started shouting and harassing the female nurses.
>
> The elders bully us around and want to instruct us what to do.
>
> At times they become harsh and want to act like your man or your father.

Nurses were often not given the necessary recognition as professionals simply because they were women. The escorts adopted a superior attitude because it is generally believed that circumcised men have a higher status in society (Meissner & Buso, 2007, p. 372).

Although any man was considered more suitable than a woman to look after initiates with complications, it emerged that an uncircumcised man did not have equal status to a circumcised man. The escorts of the initiates wanted them to be attended to by a circumcised man. One of the participants mentioned that after they had been denied access to help a patient, a male doctor had to be called to attend to the patient. Unfortunately, the doctor had not been to initiation school. The escorts became angry and made statements to the effect that the doctor is not a real man. They did not want to listen to him and just walked away while he was trying to talk to them. They regarded him as a boy, incomplete and lacking the necessary dignity. The participants said:

> They started arguing that the doctor was not from initiation school.

Stinson (2008) states that men who have been through initiation are distinguishable by their social behaviour and a particular vocabulary they learn during their time in the bush. They possess a special kind of experience and information, which nobody else possesses. In certain cultures an uncircumcised male cannot inherit goods or property and has to be treated as a minor. Men as well as women thus look down on an uninitiated man (Meissner & Buso, 2007, p. 372). In Ndebele, he is labelled '*itshuburu*' (Ndebele word meaning 'an uninitiated man').

There was evidence of interference in the normal provision of care to the patients. Some of the participants reported that sometimes they were told how to perform certain procedures and, on some occasions, their responsibilities were taken from them. One of the participants had to give an initiate dressing material to dress himself because he was not willing to be dressed by a woman. This caused a dilemma because the nurse had to assess and record the condition of the wound and also monitor its progress on a daily basis.

The escorts also demanded the isolation of the patient and did not understand it when they were told that no space was available in the hospital for isolation. Hospitals have criteria for the isolation of patients, and circumcision is usually not one of them. The participants recorded the following response:

> The traditional doctors give instructions to nurses about where and how the patient must be cared for … demanding isolation.
>
> We first have to deal with the escorts before we care for the initiate.
>
> When we are still treating the patient and hoping that he will get better then the family signs a refusal of hospital treatment (RHT) and take the patient away.

Emotions

There are some inner feelings which were expressed by the participants as they described their experiences in caring for the admitted initiates. These were generated during their interaction with the patients and their escorts. The feelings they expressed included fear for own safety, anger, helplessness, guilt and sympathy and empathy towards

the initiates. They also reported certain emotional tendencies that they observed from their patients, which included shame, degradation and anger.

The participants reported that they did not always feel safe in the units as they were sometimes threatened and harassed. They sometimes got caught up in the argument amongst the escorts on whether to allow the initiates to be attended by women or not. Occasionally, after the initiates/patients had been admitted, somebody would come and take them away. The worst part was that these incidences occurred at night and involved large numbers of people who accompanied the initiates.

The following statements were recoded:

> A group of older men brought the initiate and started shouting and harassing the female nurses.
>
> We were afraid of the elders … they looked like they could slap you.
>
> They come in groups … they usually come in groups.
>
> They came at night to take the initiate away by force.

The participants also feared for their own children who, too, were eventually to undergo initiation as part of their culture. They therefore feared that their own children might end up with the same complications.

> I have a son who is expected to go through the same ritual and I am afraid the same thing might happen to him.
>
> It is difficult when you are a mother … I fear for my son who is supposed to undergo the same ritual very soon.

Some of the participants expressed that they felt helpless in some situations when the elders exerted their dominance and superiority. Sometimes, patients would be removed from the hospital before they had fully recovered, and the nurses could do nothing to help. They felt powerless and helpless in the situation. Milberg, Strang, and Jakobsson (2004, p. 121) point to lack of control as a core element in Seligman's 'learned helplessness theory of depression'. The nurses experienced a similar lack of control when they were disregarded and dominated by the escorts of the initiates. This was aggravated by their fear and insecurity due to the danger they faced from the escorts. They verbalised their feelings as follows:

> They came to take the patient and … I could not say anything. I still feel like I failed somehow.

The nurses sometimes found themselves in situations that made them angry because of the interference and disrespect shown by the escorts of the initiates. This prevented them from carrying out their duties properly; the consequences of which could be serious, including loss of life. The result was confrontation and conflict. They verbalised their feelings as follows:

> I felt angry that they were preventing me from doing my job just because I am a woman and when I found out that they came and took the initiate away during the night when he was still sick. I felt like I had failed to do my job.

Sometimes people control their anger because of circumstances they find themselves in or because of the ethics that govern them in a particular situation. They do not express their anger in physical aggression because aggression is viewed as a taboo in many social situations, especially at the workplace (Duncan & Owen-Smith, 2006, p. 494). Similarly, the nurses were obliged to suppress their anger because they were on duty where they are expected to behave in accordance with their work ethics. However, their cultural obligations and moral codes would cloud their judgement; for example 'the respect of elders'.

Some of the participants expressed feelings of guilt arising from their failure to do their work optimally according to set standards and prescripts. The participant who had been compelled to give the initiate dressing material to dress his own wounds was not happy with the situation

and felt guilty about it. Because she could not assess the initiate's response to the treatment, she experienced feelings of guilt and self-blame.

Participants' feelings of guilt were expressed as:

> I feel … guilty especially if I know the initiate because I don't know what the relatives are saying about me. I know that I should not interact with them but as a nurse I must just treat them like any other patient.

> I felt guilty and disappointed for letting them take the patient that way.

Feelings of guilt also arose from the inevitable situation of nurses finding they have to act against their cultural traditions. The public then viewed them as outcasts who disrespected and ignored their culture. Nauta (2008, p. 591) suggests that guilt arises from choosing the wrong alternative from a multitude of options. He adds that a person who is guilty tries to make amends. One of the participants, who felt guilty about allowing the removal of the patient from hospital before full recovery, wanted to trace the patient so that she could find out how he was doing. She wished that the patient could be brought back so that she could correct the wrong she had done.

The participants expressed their feelings as follows:

> Even today I am still asking myself where the patient is … I feel that I have failed somehow.

The participants expressed that they felt sympathetic and empathetic to the initiates. Darwall (1998, p. 263) states that sympathy for a person and his/her plight is felt from a third-person perspective of caring whereas empathy involves sharing the other person's mental state, which goes beyond merely caring about a person.

In the process of caring for initiates, some of the nurses ended up sympathising with them because of the condition they were in. The complications were occasionally so severe that the participants (nurses) were often emotionally touched. Some initiates came in shivering due to exposure to the cold, and some would have even lost their penises due to sepsis. The participants indicated that they were worried about what would become of these young men when they grew older and became men. They expressed sentiments such as the following:

> They come to the hospital in a state. They are often half dressed shivering in cold weathers with only a blanket on. The painful part is that you realise that they feel like failures or traitors. They don't want to be admitted.

> Some of them come very late. By then the penis is already septic. They lose their manhood … this is traumatic and I sympathise with them.

Other emotions noted by participants were the confused and mixed emotions observed with the initiates. They would be angry one minute and guilty the next. The initiates appeared angry because they felt dominated by the women who ordered them around and supervised them. They were angry also because of the loss of an important body part (their penis) and that they were maimed for life.

> The first day in hospital is the most difficult … initiates did not understand that they have to be touched, washed and dressed by women. They feel angry because they feel dominated by females. On the other hand they know that the procedure done in the mountains is supposed to be a secret. They feel exposed.

Bottom et al. (2009, p. 33) report that admission to hospital during the initiation period has life-long implications. The initiates feared the negative life-time stigma they would carry of not having a 'pure' circumcision. They would be harassed by peers and rejected by the community. The initiates had expected to be at the school for the entire initiation period without interruption.

Common complications

The participants reported several common complications in the circumcised initiates. The

complications included: bleeding and anaemia, septic wounds, exposure to low temperature, injuries sustained through assault, compliance or adherence problems. Some of the initiates were brought to the hospital in a critical state, some ended up with permanent damage to their genitals and some died.

Anaemia and bleeding were the most common problems the initiates presented with, especially during the first few days of initiation. They would come in with bleeding wounds, and some would already be showing signs of shock. On occasion, the condition of the initiate would be critical, and the nurses would have to act promptly to save the patient's life. The following response was recorded:

> The initiate had bled a lot and was very pale … we just grabbed the patient from the elders, while they were still arguing about the uncircumcised doctor, in order to save the patient. The initiate was in coma due to bleeding because they were told that a man does not go to hospital.

> Many a time the patients are very dehydrated and cold and even require blood transfusion.

In his article on adult male circumcision, Porche (2007, p. 227), asserts that bleeding and infection are the most common complications of adult circumcision. Bleeding is viewed in a different light by the traditional circumcisers. The blood from the circumcised penis is regarded as a sacrifice to the ancestors, who are represented by the ground on which it falls (Niang & Boiro, 2007, p. 24). As such, it takes long for the traditional nurses to react or even consider the seriousness of the bleeding until it is too late.

Another common problem cited was septic wounds resulting from poor hygienic conditions. Peltzer and Kanta (2009, p. 85) report that male circumcision for religious, cultural or social reasons frequently takes place in non-clinical settings, which exposes the initiates to a range of infections. Some initiates would arrive with wounds covered with soil and grass and sometimes dressed with dirty bandages. The escorts were also often reported to have been drunk and dirty (on arrival at the hospital or during the surgery), which further aggravated the situation. The participants mentioned that initiates came in with varying degrees of sepsis. Their responses included the following:

> The wound was bleeding, full of soil and grass and was septic.

Dilika, Bremner, and Meyer (2000, p. 452) assert that the type of herb used by the traditional surgeons in Transkei was found to be effective only against five gram-positive bacteria and was ineffective against all gram-negative species. This puts the initiates at risk of infection and sepsis.

Exposure to cold temperature was indicated by the participants as another common need for hospital admissions. Most of the participants reported that the initiates were admitted with frostbite caused by prolonged exposure to excessively cold conditions (Duldner, 2008). Some of the initiates allegedly said that they had been exposed to the cold as a form of punishment. The following response was recorded:

> Some initiates beg the nurses to ask the doctor to keep them for long in hospital for fear of the cold. Many of them are admitted with severe frostbite.

> Some are admitted for bronchopneumonia from the exposure to cold temperatures.

Mbito and Malia (2009, p. 41) report that the traditional Kikuyu circumcision procedure involves the immersion of the initiates into cold river water as a form of anaesthetic. This exposes them to cold temperatures and puts them at risk of contracting diseases related to cold conditions. Some developed pneumonia, and those suffering from conditions like tuberculosis became even more ill.

Many initiates were reported to have been admitted to hospital with physical injuries resulting from assault. Some of them would disclose that they were assaulted, and others would give vague causes of their injuries. They would say that they had fallen off a tree or mention something that bears no relationship with

their condition, thus making diagnosis and management difficult at times. According to the Patients' Rights Charter, the patient has to provide the healthcare worker with relevant and accurate information for diagnostic, treatment, rehabilitation and counselling purposes (Muller, 2002, p. 8). Another factor that exacerbates the situation is that the initiates are usually not brought to hospital immediately following the injury. They are usually kept in the mountains until complications set in or until it is late at night because they are not meant to be seen by members of the public. Sometimes they are kept until they are unable to walk or have lost consciousness due to shock or sepsis. The following response was recorded:

> Some initiates sustain serious assault injuries … they are secretive about how they sustained the injuries due to the culture.

Meissner and Buso (2007, p. 372) also report that of the 24 deaths amongst initiates in the Eastern Cape reported between December 2005 and June 2006, two were caused by assault by traditional nurses. This often happens as a form of punishment for misbehaviour. Initiates normally play strong and pretend not to be in pain because they are encouraged to persevere as a test of manhood (Bottom et al., 2009, p. 33). This causes them to wait long periods before seeking medical attention and thus most come to hospital when they are already in a serious state. As such their management becomes a challenge.

The problem of non-compliance with treatment for chronic conditions was also mentioned. One of the participants reported that an initiate had been admitted with severe burns because he fell into a fire during an epileptic fit. He apparently went to the initiation school without his epileptic medication. Some of the participants cited cases of comatose diabetic initiates who had been brought in with elevated blood sugar levels because they had not taken their medicine for some time. The participants reported as follows:

> The patient was badly burned … he fell in the fire during an epileptic fit and he was not taking treatment whilst at the initiation school.

Ethical issues

Ethical issues emerged as the fourth major category, under which two subcategories were identified: violation by nurses and nurses avoiding harm.

Some violations were committed by nurses during their care of initiates. Some violations were committed consciously but some were unconscious. The violations were sometimes brought about by conflict between cultural beliefs and the provisions of the profession.

The participants pointed out instances where they committed violations against patients. In some cases, the elders would come to the hospital after the patient had been admitted, sign a refusal of hospital treatment form and take the patient away without even discussing the matter with the patient. The patient's rights were violated in front of the nurses, but the nurses did not intervene on behalf of the patient. In most cases the patient's right to choose was also violated because he was not afforded the opportunity to be attended by a male person as required by his culture. The following response was recorded:

> I know that the patient has rights … the elders just discussed amongst themselves and decided to take the patient away.

One of the participants reported that the group of escorts refused to leave the emergency room when they were asked to do so by the nurses and that they (the nurses) had to continue assessing the initiate in front of the whole group. The patient's right to privacy was thus violated. The following response was recorded:

> The group of men who brought him refused to leave the room … we just started assessing

him in front of them because we just wanted to help the patient.

The participants sometimes found themselves in a dilemma when they had to perform their duties as professionals and, at the same time, had to contend with the demands of the escorts and the patients. In some cases, the nurses were prevented from touching the patient although the professional code dictates that life should be preserved at all times. In most cases, the patient's right to demand not to be touched was violated. The following response was recorded:

> As a woman I am not supposed to touch the initiates but I'm obliged by my profession to care for patients.

Nurses are controlled by a code of conduct that provides a convenient short cut for them when they have to make ethical decisions (Robinson, Van der Mescht, & Lancaster, 2003, p. 118). However, they sometimes have to make a difficult choice between adhering to the professional code and saving their own lives following threats from the mob of escorts.

Nurses have a responsibility to protect a patient's rights and promote his/her dignity in their everyday care (Muller, 2002). They have to protect the patient from harm. Harm goes beyond the physical; it also includes emotional and spiritual harm. Weait (2005, p. 107) states that if something is harmed, it means that prior to the harm, it was intact and perfect. He adds that the particular thing was in a state of stasis and equilibrium and that, when it was harmed, the stasis was subject to a negative dynamic force and its equilibrium was disrupted. The nurses endeavoured to avoid harm to the initiates' image and feelings by trying not to expose them to unfavourable conditions. That is why they attempted to organise special care and accommodation for them.

It was evident during the interviews that initiates are an additional burden to nurses although the participants try to make the patients as comfortable as possible. Some of the participants reported that, where they could, they put the initiates in a separate room. They even kept their files separate in order to ensure confidentiality and to avoid harming their emotions and to maintain their dignity. The following statement was recorded:

> We keep initiates in the same room and their medical records are kept away from the cubicles.

Possible solutions to problems

The fifth major category that emerged was labelled 'possible solutions to the problems'. One subcategory was identified under this category: health/nursing service. Three themes were identified under this subcategory: health screening prior to initiation, education of chiefs and traditional doctors/surgeons and collaborative partnership.

The participants made various proposals to improve the management of initiates admitted to hospital. The proposals covered all stakeholders, including the health service and the community. It is hoped that the proposals will bring about a collaborative type of healthcare in which all stakeholders play a role.

Traditional circumcision is performed away from home, but it is almost unavoidable that some initiates will be admitted to hospital. The health service has to play a major role in their care. The majority of the participants thought that initiates should be screened for health problems and general fitness prior to the initiation period. They argued that this would enable identification of health problems that might compromise the initiates' health during initiation and also ensure prompt treatment. They further suggested that initiates with chronic conditions like epilepsy or diabetes should be given enough treatment to cover the course of the initiation period. The screening would also provide an opportunity for the treatment of diseases such as sexually transmitted infections. The participants made proposals like the following:

> They must find a way to do pre-examination of the initiates … to improve their health.

Some of the participants suggested that traditional leaders and traditional doctors should be

involved in discussions on how the initiation process could be handled to minimise complications. The opportunity could also be used to educate the community about the rights of initiates, which would prevent assaults and harsh punishment. Bottom (2006, p. 53) argues that traditional nurses should be trained to control bleeding and apply dressings to circumcised penises and to identify weakness and dehydration in initiates. The participants verbalised this as follows:

> The health system must involve the chiefs and traditional surgeons about aseptic surgical practices and educating the community about the rights of the initiates.

Some of the participants suggested some kind of collaboration between the Health Department and the initiation schools. Some proposed that the initiation schools should involve doctors who have undergone initiation to perform circumcisions for them, and others had proposed that circumcisions should be performed at clinics or hospitals and that the initiates should subsequently be taken to the mountains to learn about manhood. They argued that if such a partnership were established, traditional doctors would feel freer to come forward if they had initiates with complications before the situation worsened. The following response was recorded:

> I think they should have a medical doctor who has gone through the initiation to help them with circumcision.

Conclusions and recommendations

Many problems exist in caring for initiates admitted to hospital with complications because of cultural and professional conflicts. The research question 'What are the experiences of nurses in caring for circumcised initiates admitted to hospital with complications?', assisted the researcher to focus on the experiences of nurses as the main content. The participants expressed and described their experiences on caring for circumcised inmates. Their experiences centered around: nurses' dilemmas as social beings and professional practitioners, culture of sacrecy and secrecy, male supremacy and dominance, supremacy of circumcised men over uncircumcised men and interference in medical practice.

It is recommended that collaborative partnership is established between the health institutions and traditional surgeons and healers in caring for initiates. This will encourage information sharing and continuous interaction even when problems are experienced, including complications related to initiation. Collaborative efforts may assist the modern health care practitioners to make suggestions such as pre-initiation medical examination of prospective initiates to ensure that they are in a good state of health before the initiation commences. This will also help identify undiagnosed conditions that may put initiates at risk such as haemophilia, diabetes and HIV/AIDS. The hospitals may also plan for the circumcision season and ensure that, where possible, male nurses are allocated to their emergency departments and male wards. If possible, private wards should be provided, especially in areas where the practice is more common.

Nurses' training curriculum should incorporate more information on culturally safe nursing and transcultural nursing to ensure that nurses are more receptive to patients' cultures and cultural practices. It has also been recommended that debriefing sessions be made available for nurses who care for initiates to help them cope with traumatic experiences, many of which affect them personally as parents whose children will have to undergo the same ritual at some time or another.

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