



“We See It Differently”
Examining Power/Knowledge in the Contestations of
the WHO’s Interpretation of Male Circumcision

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This document represents part of the author's study programme while at the Institute of Social Studies. The views stated therein are those of the author and not necessarily those of the Institute.

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
HIV	Human Immunodeficiency Virus
MDG	Millennium Development Goal
MoHCW	Ministry of Health and Child Welfare
MP	Member of Parliament
NAC	National AIDS Council
PSI	Population Services International
SDA	Seventh Day Adventist
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USA	United States of America
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
ZNFPC	Zimbabwe National Family Planning Council

Abstract

Since 2007 a number of African countries including Zimbabwe have adopted male circumcision as another HIV prevention strategy following recommendations by the WHO and UNAIDS. The study interrogates this simplistic portrayal of male circumcision by first identifying and examining the discursive shifts regarding this practice since colonial times. Using the Foucauldian approach to power and knowledge, the research explores the representation of male circumcision by specific powerful western dominated institutions notably the WHO/UNAIDS and the church. Taking male circumcision as a case study, the study challenges the perceived neutrality of development and scientific health discourse revealing instead how these discourses are used not only to justify interventions, but to also sustain the unequal power relations between powerful institutions and indigenous people – the former having more power to name and shame. After analysing the data, the study problematizes the monolithic presentation of the West by revealing the conflicting interests of the WHO/UNAIDS and the church as well as the complexities and contradictions in their discourses regarding male circumcision. Sometimes the discourses contradict each other as the study shows; sometimes they reinforce each other, but are never monolithic. Further, the paper highlights the plurality nature of the discourses of the people, unlike Escobar and Said who homogenize both the West and the rest and ends by advocating for pluralities rather than singularities in studying these discourses as a way out of these dichotomies. Methodologically, the study highlights the importance of the need to transfigure the conventional way of doing research (i.e. attempting to fit data within a pre-determined model) and proposes elasticity where the data gathered should instead determine the choice of the theoretical and analytical framework.

Relevance to Development Studies

The study contributes to the growing voices on need to examine the power and knowledge nexus when studying development, even in instances where interventions are presented in the most neutral terms possible as is the case of male circumcision as an HIV intervention.

Keywords

“Discourse” analysis, power/knowledge, Male Circumcision, HIV/AIDS, power/knowledge, Zimbabwe, WHO/UNAIDS

Chapter 1

An Overview

1.1 Introduction and Research Focus

The World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) endorsed male circumcision as yet another HIV intervention in 13 “priority” African countries (i.e. Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe). This policy recommendation adopted in 2007 followed results of randomized trials carried out in Uganda, Kenya and South Africa and other earlier studies which concluded that male circumcision reduces sexual transmission of HIV between heterosexual partners (Williams et al. 2006). The 13 countries which have so far come up with national circumcision policies were targeted specifically for their common characteristics (at least in the eyes of the WHO/UNAIDS)¹: they have high HIV prevalence (i.e. more than 15% of the population), low levels of male circumcision and generalized heterosexual epidemics (ibid). When male circumcision is presented in this rather medical way, one is bound to question, so where is the problem?

The problem is male circumcision is not just a simple meaningless medical procedure but carries with it other social and political meanings especially for those groups who regard it as a practice rather than a procedure. Where circumcision rituals have been practiced over the years in some parts of Africa, it signifies a rite of passage to manhood which is also linked to identity and social status (Nnko et al. 2001; Caldwell et al. 1997; Maposa, 2011). This realization that male circumcision was more than ‘just a snip’ (Aggleton, 2007), thus carried multiplicity of meanings explains why studies were conducted to gauge people’s opinions regarding this prevention method (Scott et al. 2005; Asimwe 2011; Bailey et al. 2002; Ngalande et al. 2006; Mavhu et al. 2011; Mhangara 2011). Some studies went further and focused on the gender dimension of this intervention (Zoske, 1998; Peltzer et al. 2007).

Missing in most of these researches however is the chronological representation of this practice in different times and in different contexts. So the researcher’s interest in pursuing an investigation regarding male circumcision stems from the often obscured contradictions in discourse around this practice over the years. For instance, the practising and non-practising of male circumcision in Africa cannot be wholly understood outside the context of colonialism. Some scholars have argued that prior to colonialism male circumcision in Africa used to be practiced by many ethnic groups and at a wider scale than the current scenario. Peltzer et al. (2007: 658) for example write that ‘historians believe in Botswana, Southern Zimbabwe and parts of South Africa, circumcision was stopped by European missionaries and colonial administrators...after

¹ For the rest of the paper, WHO/UNAIDS will be used since both institutions were behind the recommendations that male circumcision health intervention be implemented in specific countries in Africa and also because they co-published most of the policy documents that will be analysed in this paper.

centuries of practices'. Maposa (2011) also posits that the colonial and modernity discourse generated by white writers portrayed circumcision in Africa as 'barbaric' to further justify their colonial project to 'civilize and modernize' the African (Chitando 2000: 57) by doing away with this practice.

When human rights issues gained momentum, human rights organizations campaigned for the ban of this practice, citing violations of human rights and children's rights. This argument was made with the backing of two United Nations (UN) reports² in which forced circumcision was seen as an infringement of human rights (Cruz et al. 2003:19). This also extends to female genital mutilation (FGM) which ironically is still regarded as a violation of women's rights when practiced in Africa, yet portrayed as an act of agentic beauty enhancing surgery when performed in developed countries (Harcourt, 2009:135-136)³.

The case against male circumcision in Africa was also more than just a human rights issue for it was also portrayed as both "traditional" and "unhealthy". This common practice was said to lead to 'permanent scars, erectile dysfunction, mutilation of the tip of the penis, and damage to the penis gland' (Gwandure 2011: 90). But explicit in the health campaigns against this practice in African countries was that this social and religious practice increased HIV infection risks because it was performed in "unhygienic" ways (ibid.). Now, some of the same organizations which previously advocated for the prohibition of male circumcision have come back with the message that the practice is now a "magic bullet" for preventing HIV. This time the health discourse is not targeted at traditionally circumcising communities but rather at the wider population who are generally non-circumcising, which now brings us to the focus of this thesis.

Situating the study in Zimbabwe, this thesis aims to examine the older and new discourses regarding male circumcision in Africa analyzing the differences or similarities in their constructions in the process interrogating why specific discourses become powerful in specific times. These competing discourses are analyzed using the Foucauldian framework of power and knowledge since literature indicates that very few studies have examined male circumcision this way despite arguments that 'male circumcision is almost inevitably linked to expressions of power – be this intra-group, between old and young... or inter-group' (Aggleton, 2007: 18). Among those who have attempted to use this framework include Lane and Rubinstein (1996) who focused on the Otherization of FGM. While the process of Otherization has often been used by numerous scholars to understand the relationship between the West and East/South, this thesis intends to go beyond this essentialist categorization of

² The UN Universal Declaration of Human Rights (Article 5) and The UN Convention on the Rights of the Child (Article 13) are the documents that were critical for Human Rights activists to expand their agenda. The UN committee even agreed that a child should be left to grow to the age of 21 before they can decide to get circumcised or not.

³ Wendy Harcourt argues that the Western ideals promoted by media are visibly 'racist' in that there is different framing of 'elective cosmetic surgery' (or what Braun, 2005 terms Female Genital Cosmetic Surgery-FGCS) which includes vaginal piercings and tucking done by white and Latina women, and the framing of Female Genital Mutilation-FGM done on African women and girls as dangerous thus needing western intervention to rescue and re-educate them on such practices.

the world for a number of reasons. Firstly, male circumcision is not only confined to African countries but also performed in developed countries such as the United States of America (USA) where, until recently, it was said to be the most commonly performed surgery (O'Hara and O'Hara, 1999). Secondly, historically there have also been conflicting discourses regarding this practice within and across western countries; some which have led to the promotion of this practice while other discourses have called for its prohibition. For instance, male circumcision used to be practiced in ancient Greece before it was outlawed in 168 BC, yet in other contexts, failing to get circumcised meant torture and death as was the case during the Ottoman and Moorish empires in Nazi Germany, India and in the recent genocides of Bosnia and East Timor (Aggleton, 2007). In the United Kingdom, circumcision was promoted as a status symbol for the British Royalty in the 19th century, while the same practice was banned in Bulgaria in the 1930s and 1980s 'because of its connotations with earlier Turkish occupation' (ibid: 18). Within USA, as far back as the 1870s the practice was promoted for health reasons after claims by one of the country's prominent surgeons Lewis Syre that it cured 'paralysis and hip-joint disease' (Aggleton, 2007: 18). Others wanted the practice to be promoted because of the belief that circumcision curtails one's desire to masturbate. Of late however there have been growing concerns to discourage this practice in USA. Aggleton writes that various interest groups, including human rights groups in 2007 submitted the Federal Prohibition of Genital Mutilation Bill to the USA Congress seeking to protect girls, women, boys and men against forced circumcision. Just this picture alone cautions us from approaching the "West" as a unitary category, the same way we should problematize the concept of "East" or "South". To this end, this paper strives to avoid generalizations through contextualizing and specifying the discourses and institutions under study.

By analyzing the WHO/UNAIDS policy documents relating to male circumcision the study seeks to understand how these institutions have framed this practice discursively and upon what assumptions. The paper interrogates the meaning that dominant western institutions have attached on male circumcision? The thesis also aims to problematize the often taken for granted view that development and/or health discourse is neutral. Cognizant of the fact that the targeted populations for this health initiative are not just passive recipients of this rather simplistic version of the health discourse (or any other discourse for that matter) the study also aims to explore how different people in Zimbabwe give meaning to male circumcision. The assumption here is that people do not begin to just speak about preventive circumcision without making reference to a priori knowledge on this practice. It is upon this premise that the study analyzes how ordinary people⁴ (from circumcising and non-circumcising communities) respond to the discourses on modernity and health underlying the introduction and promotion of the WHO/UNAIDS intervention.

⁴ I use the term "ordinary people" for a lack of a better term that signifies the Zimbabwean people who do not constitute an organized institution.

1.2 Situating Male Circumcision in the Zimbabwean Context

It is important at this point to first give a brief overview of the demographics of Zimbabwe as they help to further describe the context of male circumcision in this country. The exact current population of Zimbabwe is unknown but it is estimated to be approximately 12.6 million⁵ (World Factbook, 2012). Of this population in terms of ethnicity, 82% are Shona⁶, 14% Ndebele, 2% minority groups while the remaining are whites and those of Asian origin (ibid.). It is from the 2% comprising the ethnic minority (i.e. Remba; Shangaan; Venda, Yao of Malawian origin) and some Ndebeles (e.g. Xhosas) where male circumcision is practiced. During the interviews, there were indications that even some from the Nda⁷ tribe also circumcised although the practice was done within their homesteads and not in the bush as is the case with other circumcising groups. Zimbabwe is diverse not only in terms of ethnicities but also in terms of religions with an estimated 70% - 80% of the population belonging to mainstream Christian churches⁸ and Pentecostal churches (Makahamadze et al. 2012: 711). Others also subscribe to indigenous beliefs, reasons why Zimbabwe at times is seen as a nation with 'free religious freedom' (Chitando, 2002:4). There however appears to be a dearth in literature in Zimbabwe regarding various Christian institutions' response to circumcision as an HIV prevention strategy. The church discourse that exists however (not limited to Zimbabwe but Christianity in general) relates to how Christians perceive male circumcision in general. This is elaborated later on in the paper. Capturing this diversity of ethnicities and religions in Zimbabwe is critical in attempting to understand how various Zimbabweans relate to male circumcision considering that only 10% of Zimbabwean men were circumcised prior to the introduction of male circumcision for HIV prevention although there are suggestions that the practice was more widely practiced prior to colonialism (Peltzer et al. 2007).

In response to the recommendations of the World Health Organization and UNAIDS following medical conclusions that male circumcision can reduce HIV infection, Zimbabwe launched the national male circumcision policy in November 2009 as part of its 5 year National HIV and AIDS Strategic Plan, 2011-2015. It is estimated that 1.1 million of the Zimbabwean population is infected with HIV (NAC, 2011). Battling to reduce this HIV and AIDS burden the government implemented this policy in line with Goal 6A of the Millenni-

⁵ The most recent census was conducted in August 2012 and its results were yet to be announced.

⁶ The Shona which is often labeled as a traditionally non-circumcising community, is further divided into sub-ethnicities namely; *Karanga, Manyika, Nda, Zezuru, and Korekore*.

⁷ There has been a common belief that the Nda people did not practice circumcision. From the interviews I conducted, I also discovered that not all Nda people practiced circumcision.

⁸ These mainstream churches include Roman Catholic Church, Methodist Church, and Dutch Reformed Church.

um Development Goals (MDGs) aiming to 'have halted by 2015 and begun to reverse the spread of HIV/AIDS'. The Ministry of Health and Child Welfare (MoHCW) who are spearheading the programme are partnered by The Zimbabwe National Family Planning Council (ZNFPC), United Nations Population Fund (UNFPA) and the National AIDS Council (NAC). The male circumcision project targeting the 15-29 age-group of men, is financed by Population Services International (PSI) and the WHO among other funding agencies, and hopes to have circumcised 1.2 million Zimbabwean men by 2015 (Mavhu et al. 2011). A number of circumcision centers have been set up where men are accessing these circumcision services for free.

Of interest in the Zimbabwean scenario is what has been termed a "marriage of convenience" between Shangaan people (one of the widely known circumcising group in Zimbabwe), MoHCW, NAC, UNFPA and UNAIDS. A partnership was formed between these stakeholders as a way of bringing "better and healthier" circumcision to the Shangaan community who annually conduct circumcision to hundreds of Shangaan boys and men. Medical personnel are deployed to this community annually during the period when the "initiation school" begins - to medically circumcise the boys and men present. It is not clear whether the MoHCW and partners also created alliances with other circumcising groups such as the VaRemba, and if not why. However, the partnership between the Shangaan and the stated partners has its own power dynamics considering that medical doctors are not allowed within circumcision camps since they are considered outsiders to this culture (Sachiti, 2011).

So while the WHO/UNAIDS through the health ministry explicitly targets non-circumcising men, implicitly they also target circumcising communities so that eventually medical personnel perform all circumcision for both groups. In addition, male circumcision for HIV was also introduced against a background of the negative representation of this practice by the medical discourse a few years ago. I recall as a radio presenter, actually conducting radio interviews with health experts as well as children rights defenders around 2002/2003 who spoke strongly against the practice of male circumcision. This thesis also hopes to gain an understanding of how different people in Zimbabwe perceive male circumcision in light of these shifting and contradictory discourses. Will they just embrace it because it has now been "modernized" offering health benefits? Or expressed in another way, under what circumstances would they consider 'going under the knife'? These questions are just to understand people's own discourses on this intervention since their voices appear marginalized in the public sphere hence their responses only partly address the central question.

1.3 Research Objective

Given (from the literature search during the research period) that none of the previous studies have examined the discourses of the WHO/UNAIDS regarding male circumcision in Zimbabwe and other African countries by using the Foucauldian framework of power/knowledge, the thesis aims at contributing to the on-going discursive debates on this health intervention.

1.4 Research Questions

To narrow down on the many questions that I have posed in previous sections, the main question for this study is: *How can the competing power/knowledge regimes around male circumcision in Zimbabwe be understood using the Foucauldian perspective?*

In attempting to answer this broad question, the following specific questions will be addressed:

- a) In what ways has circumcision been framed historically in dominant discourses and for what purposes?
- b) How is male circumcision currently framed by the WHO/UNAIDS and the church and upon what assumptions?
- c) What strategies are used by the WHO/UNAIDS and the church in building and maintaining their discursive dominance in the public sphere?
- d) How do different groups of people perceive male circumcision and upon what meanings are their perceptions based?

1.5 Research Approach

The research methodological tool used in this paper is Discourse analysis which, in the Foucauldian sense, 'seeks to explain the relations and forces of power from the discursive evidence available' (Weedon 1999: 115). Through examining dominant discourses on male circumcision the study aims to examine the relations between powerful organizations (i.e. the WHO/UNAIDS, church) and indigenous people. This approach according to Kumar (2007: 12) is useful in 'disentangling the argument with attention to what is implicit'. This study while focusing on what is written cannot ignore that which is also hidden and the institutions behind these discourses since 'discourses and agendas are often inextricably linked together' (ibid: 13). Foucault in Escobar (1995: 6) also credits discourses analysis for creating the possibility to 'stand detached from the development discourse bracketing its familiarity in order to analyze the theoretical and practical context with which it has been associated'. The current health discourses on male circumcision are entrenched in the development discourse which is often portrayed as both neutral and progressive, thus the paper also analyzes development discourse in general within the power/knowledge framework. The thrust is on discourses produced by dominant institutions in order to establish their 'assumptions, judgments and contestations' (Kumar, 2007: 12). The research comes in the form of a case study which 'draws attention to the question of what specially can be learned about a single case' (Stake 2005:443). My assumption is that the meanings attached to male circumcision in Africa vary across countries.

1.5.1 Sources of data

The study draws on other scholarly articles to give a historical account on how male circumcision in Zimbabwe and Africa has been presented by various institutions since colonialism. Key publications produced by the WHO/UNAIDS on male circumcision will then be analyzed. Print media articles on male circumcision will be another basis for analysis. The media has been and continues to be instrumental in channeling messages to the broader population of Zimbabwe especially regarding development-related initiatives of which male circumcision forms part. Due to the limited amount of time in the field, the study focuses on articles published between June 2011 and July 2012 in the main national daily newspapers namely *The Herald* and *Newsday* and the weekly *Sunday Mail* since these are the most widely read in Zimbabwe⁹.

Drawing on the conceptual framework for this study to be elaborated in the next chapter, there has been a tendency in the policy and discursive field to marginalize the diverse voices of ordinary people hence the choice to support my analysis with people's own discourses. These discourses will be captured by way of interviews and focus group discussions (FGDs). To ensure this variety in responses, two focus groups discussions (one with 6 men and the other with 5 women) were held while 12 semi-structured interviews were conducted with different women (5) and men (7) from diverse backgrounds. Drawn from non-circumcising and circumcising communities respondents differed in terms of age, residential location, religion, ethnicity, marital status and employment status. These elements were taken into consideration in selecting respondents as other findings suggest that they were critical in influencing people's responses.

1.6 Ethical Considerations

In the whole research process, I attempted to uphold a number of research ethics. Firstly, free and informed consent was exercised where none of the respondents was forced to participate in the research or 'induced to do so using any form of undue influence or coercion' (Smythe and Murray 2000:313). For instance, one of the six women participants in the focus group discussion walked out a few minutes into the discussion. All interviews were tape-recorded except in two cases where respondents objected. Confidentiality and anonymity was also observed for interviewees hence only pseudonyms will be used in this paper. When focus group discussions were conducted, since these were conducted at workplaces and during lunch time, I provided the participants with some snacks as an incentive for them not to walk out of the discussions in search of something to eat.

⁹ This is according to the September 2012 Zimbabwe All Media Products Survey (Zamps). See http://www.herald.co.zw/index.php?option=com_content&view=article&id=53358:the-herald-most-complete-balanced-newspaper-survey&catid=37:top-stories&Itemid=130 link

1.7 Limitations of the Research

Considering the small sample from which the data for this thesis was gathered, this paper cannot claim to represent the whole range of Zimbabwean voices. However what the study attempts to do is to provide insights into some of the issues ordinary people raise regarding male circumcision, issues that can be taken up to be investigated further with a larger sample. Owing to space limitations, the study concentrated on the health discourse of the WHO/UNAIDS and the moral discourse of the church leaving out the human rights discourse in the analysis.

1.8 The Research Journey and Methodological Reflections

Here I speak about how my research evolved as I believe by highlighting my experience it can in the process also offer some methodological insights for new as well as mature researchers. As was expected, I had to come up with a complete research design that would guide my fieldwork. As a student and advocate of gender, I had been critical of the male circumcision HIV intervention which I felt would create further constraints for some women to negotiate for safer sex. Initially therefore I was more interested in exploring women and men's perceptions on the male circumcision intervention from this gender dimension. However over the course of my field work I came to realize this gulf between people's understanding and the WHO/UNAIDS discourse which led me to change my focus. This could be attributed to my methodological choice to use semi-structured interviews and FGDs which proved to be a blessing for it gave the respondents an opportunity to freely share their experiences, knowledge and perceptions as the interviews resembled conversations, in the process revealing data that I had not previously anticipated.

The people instead spoke not only about health discourse of the WHO/UNAIDS but also raised other issues including the issue of the church discourse and how it frames the circumcision intervention. So while I had just limited myself to examining how people perceive the health discourse of male circumcision, the fresh data opened my eyes and made me realize the significance of the church as another discursive institution worth exploring. This forced me to re-write the whole thesis re-directing my focus to these multiple and conflicting discourses. Consequently, in view of the gathered data I then reviewed not only my theoretical and analytical framework, but even the research questions. Reflecting on this research journey, I now realize the importance for researchers to be reflexive (i.e. allowing their prior assumptions to be challenged) by letting the data determine the construction of the theoretical framework and not vice-versa.

1.9 Organization of the Paper

This study is presented in five chapters. This chapter has provided an overview and background to the research problem. It has attempted to offer a justifica-

tion for embarking on this study, explaining how the data was gathered, highlighting the ethical considerations observed by the researcher.

The next chapter narrows on the conceptual and analytical framework guiding this study. Power/Knowledge, discourse, post-development, orientalism and hegemony are the major concepts that will be explored explaining their usefulness in analyzing discourses on male circumcision.

The third chapter will be solely dedicated to analyzing how the WHO/UNAIDS, media and the church institutions present male circumcision. In addition the chapter makes a comparative analysis of the discourses of the WHO/UNAIDS and the church to locate their differences and similarities not only in terms of the framing of circumcision but also in terms of the mechanisms they both use in building and maintaining their discourses.

The fourth chapter presents the people's own discourses from the interviews on male circumcision in general as well as on the male circumcision intervention. These findings will be analyzed using the conceptual framework.

Finally the paper concludes by drawing conclusions from the whole study by way of reflecting on the research questions and the research findings while pointing to the theoretical contributions of the paper suggestions for further research.

Chapter 2

Conceptual and Analytical Framework

2.1 Introduction

This chapter explores concepts that guide this paper. Power/Knowledge is the major framework guiding this paper, while concepts of discourse, hegemony, orientalism, and post-development will also be unpacked as they will be useful in informing my analysis which runs throughout the thesis. The chapter will conclude by presenting the analytical framework, specifically explaining how these concepts will be used to analyze the findings.

2.2 The Concepts

2.2.1 Discourse

Discourse in the Foucauldian sense is the general domain of the production and circulation of knowledge or simply ‘a system of representation’ (Hall, 2001: 72). In Foucault’s words, discourse refers to ‘a group of statements which provide a language for talking about – a way of representing the knowledge about – a particular topic at a particular historical moment...[it] is about the production of knowledge through language’ (ibid.: 72). From this definition one can deduce that discourses are deliberately produced within specific contexts. Understanding discourse as contextual is to pay attention to ‘parameters [such] as participants, their roles and purposes, as well as properties of a setting, such as time and place [because] discourse is being produced, understood and analyzed relative to such context features’ (van Dijk, 1997: 11). According to Durant and Goodwin in Fairclough and Wodak (1997:276), discourses are also ‘always connected to other discourses which were produced earlier, as well as those which are produced synchronically and subsequently’. However this argument was rejected by Foucault who insisted that ‘in each period, discourse produced forms of knowledge, objects, subjects and practices of knowledge, who differed radically from period to period, with no necessary continuity’ (Hall, 2001: 74).

He did not believe in the ‘trans-historical continuities’ of discourse, but instead claimed that ‘more significant were the radical breaks, ruptures and discontinuities between one period and another, between one discursive formation and another’ (ibid.: 75). Analyzing this claim, makes one feel rather uneasy, because if discourse is a system of representation about maybe a practice, or a group of people, and if the same system of representation persists across historical eras, it then becomes difficult to theorize. It becomes debatable whether all discourses are so compartmentalized such that there is no semblance whatsoever to previously existing discourses. In this thesis, analyzing the health discourse of the WHO/UNAIDS for instance cannot be adequately examined without considering the fact that this discourse (and intervention) is specifically targeted at specific Third World African Countries; all of which are post-colonial states. More analysis regarding this particular claim from Foucault

will be brought later in the thesis after examining the historical and contemporary discursive representation of male circumcision.

Weedon (1987) argues that while different discourses may exist at particular times, certain discourses help legitimize the existing practices and institutions while those that are a threat to the status quo are often relegated to the lower end of the hierarchical discursive ladder. This observation directs us to examine power relations which may be sustained through discourses. For this thesis we thus need to examine the existing relations between some Western institutions and the “South” and also question whether the discourses produced by these institutions are such that they address power inequalities or in fact sustain them. This link between power and knowledge is elaborated in the next section.

While Foucault’s theoretical emphasis on examining discourses has been valuable and influential to a number of scholars, he has equally received criticism for becoming too ‘absorbed into “discourse”, and this has the effect of encouraging his followers to neglect the influence of the material, economic and structural factors in the operation of power/knowledge’ (Hall, 2001: 78). Whether this critique warrants recognition within the confines of this thesis will be revisited in the final chapter.

2.2.2 Power/Knowledge

Foucault examines the claims for truth (made by science, among others) and how these are produced in our everyday reality, characterized by processes of domination and marginalization, where certain views are privileged and others are excluded. He suggests there are ‘institutional processes at work which establish something as fact or knowledge’ (Mills 2003: 67). Foucault directs our attention to the ‘mechanisms by which knowledge comes into being and is produced’ (ibid: 68). He argues that ‘knowledge is not dispassionate but rather an integral part of struggles over power’ and analyzes how in that production of knowledge ‘one is also making a claim for power’ (ibid: 69). So from Foucault’s conceptual framework, discourse is produced with the goal of gaining power and dominance. He saw knowledge production as linked to power thus came up with the conjunction of *power/knowledge* because ‘it is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power’ (Mills 2003: 69). The two elements do not only depend on each other but also reinforce each other.

Foucault adds that the discursive environment in which knowledge is produced is characterized by power inequalities and it is these inequalities that make it possible for one group to produce specific knowledge about others. Using the example of gender inequalities, Mills (2003: 69-70) for instance writes:

Because of the institutionalized imbalance in power relations between men and women in Western countries, Foucault would argue, information is produced about women; thus we find many books in libraries about women but few about men,... the object of such research is frequently people who are in less powerful positions...this production of knowledge about disadvantaged people plays a significant role in maintaining them in this position.

In Foucault's own words, 'the term power designates relationships between partners' (Foucault, 1982: 786), adding that this was 'not a zero-sum game'. This relational characteristic of power by Foucault seems useful not only for us to understand certain discursive constructions about specific groups of people, specific practices and specific regions but also for us to identify the institutions behind these constructions. In this thesis, focus is on the discursive representation of male circumcision in Africa by dominant Western institutions. The paper goes beyond construction of male circumcision discourses by also commenting on the construction of the "Third World" in general, be it in colonial discourses or even in development discourses.

Another contribution from Foucault is that he identifies scientific knowledge (a product of modernity) as having managed to eclipse all other forms of knowledge although he rejects the claims that scientific discourse is neutral and objective arguing instead that its creation is embedded in social relations of power, another idea that will be analyzed in this thesis. Within this theorization of scientific discourse as "superior" we should still ask why some scientific discourses dominate other equally scientific discourses. For instance there are some studies that have been done that challenge the WHO/UNAIDS claim that male circumcision reduces HIV transmission, arguing instead that male circumcision actually increases one's chances of getting infected with HIV. These counter-discourses remain marginalized despite their scientific orientation.

Foucault compels us to question whose and what language is designated as proper. Who is privileged to speak about whom? Foucault describes the ways in which hegemonic discourse 'is produced and maintained in circulation in societies through the work of a number of different institutions' (ibid: 79). These institutions range from the media, the state, the church, etc. However this conceptualization of power as centralized on these institutions represents, to Foucault, just one model of power as there are other 'myriad of power relations at the micro-level of society' (Sawicki, 1991: 20). This is why he argues that there is more than just one power/knowledge regime competing, conflicting, contradicting and struggling for power. 'This word [power] must be allowed the very broad meaning which it had in the 16th century' he posits (Foucault, 1982: 789). With this theoretical argument, Foucault leaves spaces for us to identify other forms of power, some which might not be theorized as yet.

Sawicki also writes that Foucault's description of 'the social field as a myriad of unstable and heterogeneous relations of power' presents 'an open system which contains possibilities of domination as well as resistance' (1991: 25). The study will demonstrate this concept by looking at other competing discourses on male circumcision. The strength in Foucault's analytical framework is its ability to analyze 'multiple and conflicting discourses' in comparison to Gramsci, whose concept of hegemony is more relevant in examining 'power relations between two institutional actors' (Sh'hada 1999: 23). Foucault's insights on power/knowledge have been quite influential to a number of scholars including Escobar and Edward Said, whose ideas are discussed in this chapter. Escobar for instance used power/knowledge to conceptualize development discourse while Said also applied the same ideas in the context of analyzing colonial and post-colonial discourses.

2.2.3 Hegemony

The concept of hegemony is often associated with Gramsci and is useful in this paper to understand how power/knowledge regimes work through analyzing two/more discourses or institutions (the WHO/UNAIDS and the Church discourse). According to Gramsci, hegemony in its cultural form exists ‘in any society not totalitarian [when] certain cultural forms predominate over others, just as certain ideas are more influential than others’ (Said, 1993:134). Foucault cited in Mills (2003: 75) on the other hand also used this concept to describe ‘a state within society whereby those who are dominated by others take on board the values and ideologies of those in power and accept them as their own this leads them to accepting their position within the hierarchy as natural or for their own good’. With hegemony, there is a creation of an illusion that there is a consensual shared identity; that various groups in society actually share the same interests with the hegemonic group (Bertsch, 1995: 4). This attainment of hegemony by a social group is according to Gramsci, an outcome of both consent and force (Arrighi, 1993).

In addition Gramsci also saw hegemony as a product of resistance and negotiations which often take place in form of discourses. In other words, apart from this illusion of collective identity, reality is characterized by contestations of other social groups which are also striving to claim this hegemony by creating specific discourses. This was illustrated by Karam (1998) when she analyzed the power relations between Islamists and the Egyptian State in which she concluded that the use of discourse by the Islamist group former was to create counter-hegemony, while the Egyptian state uses discourse to maintain its hegemony.

Cuneo (1999) has also written about hegemony and describes it as having three dimensions; political dimension characterized by domination and force, the moral dimension marked with consent, and lastly the intellectual dimension which points to the critical role played by intellectuals in creating hegemonic discourses. The political dimension was quite applicable in Karam’s analysis of Islamists-Egyptian State power relations, by virtue of the political context. However, in this thesis, the first two dimensions appear more useful in examining the discourse by the WHO/UNAIDS and the Church regarding male circumcision as a health intervention. However the political dimension might also be used to analyze colonial discourses although it might have to be conceptualized differently based on the research findings.

2.2.4 Orientalism

Orientalism – the lenses through which the West looks at the East (Orient) - is among the influential post-colonial theories and methodological framework developed by Edward Said to study what he termed discourse of orientalism. In analyzing this kind of discourse, he proposed four methodological tools; *strategic location*, *exteriority*, *strategic formation*, and *representation*. For the purpose of this paper, only the last two tools will be examined.

Said (1978: 20-22) uses *Strategic formation* as a method used to analyze the relationship between different orientalist texts (texts here are meant to refer to any ‘knowledge’ produced about the Orient) and how they gain currency and

circulation in the public sphere and thus acquire the necessary power to become *the reference* for both the public and the specialists - those whose main interests is to produce political, cultural, economic, or intellectual knowledge about the orient.

Representation is one of the important methodological tools used by Said. In its literal sense representation does not mean to speak about the *TRUTH* about the subject; representation means to re-present, to depict, to portray or to illustrate on the basis of the views held by the author of the Oriental material. In the Foucauldian sense, these representations are just claims for truth. In these literary representations, the Orient is always depicted as ‘a locale requiring Western attention, reconstruction, [and] even redemption’ (Said, 1993: 145) then, out of altruism, Orientalists are ready to do the job on behalf of the “poor” oriental people. Said’s task was to demonstrate that, firstly, what is written about the orient is an indication of the *powerful presence* of the Orientalist and the *utter absence* (exclusion, displacement) of the Orient itself. Secondly, he saw representation of the West and East as always constructed in binary opposites (i.e. superior/inferior; rational/irrational; strong/weak; civilized/uncivilized; etc.) which he argues still persists even after colonialism. Thirdly, through representation, is the creation of stereotypes of the orient namely; the orient seen as a homogenous entity and characterized by lack of progress.

Despite the influence of his contributions, a major critique for Said’s work observed by Bhabha (1990) cited in Escobar (1995: 11) is that, ‘there is always in Said, the suggestion that the colonial power is possessed entirely by the colonizer, given its intentionality and unidirectionality’. Thus Said presents the West as all powerful understating ‘the variety of forms with which Third World people resist development interventions and how they struggle to create alternative ways of being and doing’ (ibid: 11). This critique on Said is also useful for this study particularly in analyzing the varied ways ordinary people respond to the male circumcision intervention.

2.2.5 Post-development

Post-development or post-development theory, embedded in the power-knowledge framework, emerged as a critique to the notion of development and development discourse. Theorists from this standpoint such as Arturo Escobar argued for the interrogation of the term development which in their view carried a Eurocentric definition thereby ignoring other indigenous interpretations of development. In essence, post-development scholars rejected the ‘functional conception of development conceived of as the transformation of “traditional” into a “modern” society and devoid of any cultural considerations’ (Escobar, 1995: 14). This functional conception is linked to the enlightenment era in which the concept modernity was introduced, defined and popularized. Modernity is characterized by certain values which Knobl (2002: 170) identifies as, ‘progress, growth, liberation, etc.’ Scholars such as Escobar ask whether there should just be one *definer* and definition of modernity, or development (i.e. unilinear, universal, having “progressive” [read Western] values etc.)? Or should we, in an attempt to run away from these binary constructions, talk about multiple or plural modernities as advanced by Nederveen Pieterse (2004). Escobar critiqued the exaltation of scientific knowledge as superior arguing instead that,

‘plurality of meanings and practices make up human history’ (1992: 144). Escobar’s argument regarding the plurality of (local) meanings is useful in exploring the multiple meanings people attach to male circumcision in comparison to the single meaning that development agencies such as the WHO/UNAIDS continue to give to this practice.

In his critique of development discourse, Escobar (1995) conceptualizes development as ‘a regime of representation’ introduced after the end of the Second World War.

As western experts and politicians started to see certain conditions in Asia, Africa & Latin America as a problem—mostly what was perceived as poverty and backwardness, a new domain of thought and experience, namely development was introduced leading to a new strategy for dealing with the alleged problems. Initiated in the US and Western Europe, this strategy became in few years a powerful force in the Third World. [Escobar 1995: 6]

The major argument being presented by Escobar is that the notion of “development” is a Western invention and strategy which in the process also created what is now commonly termed the “Third World”. The “Third World” was seen as experiencing similar problems as such development had to be planned as a way of ‘overcoming [and] eradicating...traditions, obstacles, and irrationalities’ in these underdeveloped countries (Escobar 1992: 135). This culminated in the systematic creation of development discourse which was not only planned but was also professionalized and institutionalized by some western development agencies (Escobar, 1992). By focusing on professionalization, Escobar points to the role played by experts in producing and justifying specific discourses and interventions for different fields of development. On institutionalization, he demonstrates how discourses become embedded within powerful institutions such as development agencies. Expressed simply, Escobar argues that development discourse is not neutral but produced to justify the continued domination of western institutions in development interventions. This critique is valuable for this study as it analyzes power/knowledge as it manifests in male circumcision for HIV as just one of the many interventions introduced by some Western agencies in developing countries.

Another contribution from Escobar (1992, 1995) is that in as much as development planning attempts to produce ‘docile bodies through systematic forms of disciplines’, the development recipients in certain instances have resisted the projects. This is why some development critics have observed a wide discrepancy between what is planned and the actual outcomes.

2.3 Analytical Framework

The above concepts are useful in my analysis and here I offer a brief outline on how the different concepts will be used to analyze specific incidences and specific discourse. By way of *discourse* analysis, I will examine meanings underlying the WHO/UNAIDS policy papers, media statements, Christian ideology, and ordinary people’s own discourses pertaining to male circumcision. The analysis will focus on how male circumcision has been framed by the various institu-

tions and actors currently as well as historically. The analyses will however also go beyond examining male circumcision discourse by also analyzing development discourse at large, searching for the underlying meanings.

I will use *power/knowledge* framework by Foucault to bring out the subjectivities underlying the discourse by powerful international institutions such as the WHO/UNAIDS. Foucault proposes that in analyzing these power relations, we should identify what he termed “the system of differentiation”. This is a system:

which permits one to act upon the action of others; differentials determined by the law, by traditions of status and privilege; economic differences in the appropriation of riches and goods, shifts in the process of production, linguistic or cultural differences... [Foucault, 1982: 792]

The thesis will use this framework to argue that in as much as male circumcision is portrayed as a simple development intervention to promote the health of people in the global South; the health discourse is far from being neutral. The thesis will analyze how scientific knowledge is often used not only to justify interventions, but to sustain the unequal power relations between these powerful institutions and indigenous people. Through examining other discourses for instance the church and their negative perception on male circumcision, the study will show that there is more than one power/knowledge regime. Secondly, analyzing people’s own interpretations is also a way of understanding Foucault’s conceptualization of power as not being centralized, but also exercised even by those at the bottom as they resist in their own ways the dominant discourse- in this case the health discourse.

The concept of *hegemony* will be used to analyze the strategies used by the WHO/UNAIDS in creating and maintaining dominance. The concept is also useful in understanding relationships between two or more groups, thus the notion of counter-hegemony, as other discourses also fight for this hegemonic position. Sh’hada (1999) employed this concept in analyzing power relations between the Islamists and the Palestinian Authority. I will in this case use the concept to analyze the power relations between the WHO/UNAIDS and the Church on how they attempt to maintain hegemony in the developing countries.

As noted earlier in this chapter, understanding the context is crucial in making use of specific concepts to analyze a specific case. I will use Said’s methodological tool of representation to analyze how male circumcision and those who practice it have been represented in the dominant discourses. Said’s method of strategic formation will be used to identify and analyze how the health discourse for instance became “common knowledge” in the public sphere. In addition, Said’s insights on orientalism will be used in this thesis to analyze the general discursive relationship between the West and the South in colonial and post-colonial times but in the process questioning this polarized representation of these regions.

I will also make use of Escobar’s conceptualization of *post-development* in my analysis of male circumcision. Through development discourse analysis I seek to analyze how development agencies such as the WHO/UNAIDS perceive development, taking male circumcision as just one of the many development interventions. Often there is an assumption that development is a neutral process and it is done in the interest of those “needing” development. I will use

his ideas on the professionalization and institutionalization of discourse by examining the media as one of the institutions that have helped legitimize this health discourse on male circumcision.

2.4 Chapter Summary

In this chapter I reviewed the major concepts that will guide this study namely; discourse, power/knowledge, orientalism, hegemony, and development. These concepts, often difficult to separate, all fit into the power/knowledge framework upon which this whole thesis is premised. One cannot therefore begin to analyze discourse (e.g. development discourse) as something neutral without paying attention to how discourses (knowledge) are created as a claim to power, often with the intention of gaining dominance (hegemony). The inequalities in the production of discourses need to also be acknowledged, specifically how some western agencies create specific discourses and representations about the people in the South or East, representations implicit in the whole notion of development. The chapter also indicated how the different yet interrelated concepts will be used in analyzing the case and discourses of male circumcision as a health intervention in Zimbabwe. Analysis will extend to development (and its discourse) in general especially as it is targeted at Third World countries. The next chapter elaborates on the WHO/UNAIDS discourse as well as the church discourse with regards to male circumcision.

Chapter 3

The Competing Discourses

3.1 Introduction

This chapter first analyzes some of the policy documents produced by the WHO/UNAIDS regarding male circumcision highlighting how they framed their main messages. Secondly the chapter discusses and analyzes, using some of the concepts in Chapter 2, discourses of the WHO/UNAIDS and that of the church comparing the mechanisms used by these institutions in attempting to build and maintain hegemony. It concludes by making reference to the next chapter in which people's discourses regarding male circumcision will be presented and analyzed.

3.2 The Health Discourse

For the sake of limited space, this section will just concentrate on the major framings of male circumcision in some of the main publications of the WHO/UNAIDS and show how such framing worked in favor of these institutions in building up a hegemonic discourse. Firstly, male circumcision is re-introduced¹⁰ as good, healthy, modern therefore developmental while female genital mutilation (FGM) is still perceived as 'a violation of human rights...has no health benefits and carries considerable physical and psychosocial risks....'(UNAIDS, 2007:14). Hence FGM according to the WHO/UNAIDS discourse remains traditional, unhealthy and thus hindrance to development. In other words, the discourse from these two institutions is claiming that male circumcision (at least male circumcision for HIV) does not violate any human rights; is justifiable because it has health benefits; and does not bring with it 'physical and psychosocial risks' for boys and men, a position that is challenged in the interviewees' narratives. Secondly, in supporting male circumcision, they highlight that based on medical 'research evidence [which] is compelling' (WHO, 2007:4), male circumcision lessens risks of getting HIV infection; Sexually Transmitted Infections (STIs); penile cancer; inflammation of the foreskin; and cervical cancer for female partners of circumcised men (WHO, 2010:13; UNAIDS/WHO 2011: 22). They go on to offer biomedical explanations on the link between male circumcision and HIV by quoting various studies conducted before these conclusions were reached in consultation with 'clinical and health experts' (ibid). They also add that another benefit - again from large randomized trials - attributed to male circumcision was 'increased penile sensitivity and enhanced ease of reaching orgasm' (WHO, 2010:8) suggesting that male circumcision enhances sexual pleasure.

¹⁰ I say re-introduced here considering that the same institutions had previously portrayed this practice as one source of HIV infections.

The health discourse still attempts to distinguish between male circumcision practice for religious and cultural reasons and male circumcision for HIV prevention by presenting the later as '*Safe, Voluntary, Informed* male Circumcision' (UNAIDS, 2007) or in other instances as '*Voluntary Medical Male Circumcision-VMMC*' (UNAIDS/WHO, 2011). Such deliberate naming and framing seems to undermine male circumcision for religious and cultural reasons, which is implied to be "unsafe", "forced", and "uninformed". In addition according to the WHO/UNAIDS, male circumcision is safer if performed by 'well-trained medical professionals' (WHO, 2007:4) implying that, that which is performed by anyone other than these experts remains unsafe. Ironically, it is in these circumcising communities engaging in this supposedly "unsafe", "forced" and "uninformed" circumcision and performed by untrained "traditional" practitioners that the health "experts" discovered low rates of HIV transmission. It is again this supposedly "unprogressive" practice which all of a sudden is now also portrayed as a symbol of modernity – thus problematizing the polar presentation of modernity. Gescheire et al (2008: 5) convincingly argues that 'the term modern is shrouded in paradoxes and contradictions, where often "tradition" turns out to be modern....'

In one of their strategic documents on male circumcision, the WHO and UNAIDS recommend as part of their Leadership and Advocacy Strategies, that health ministries in 'each priority country [should] identify, cultivate and support potential VMMC champions (such as sports and entertainment celebrities, leading media figures, and international leaders) (UNAIDS/WHO, 2011: 13-14). The underlying assumption here is that men will go in their numbers to get circumcised for HIV prevention in order to identify with their role models. Within the Zimbabwean context, the communication materials have been designed to 'appeal to men [using] analogy to football and position men's sense of achievement' (WHO/UNAIDS 2010:22). By advocating the recruitment of prominent figures in promoting the uptake of male circumcision, the WHO/UNAIDS perceive this as a strategy giving legitimacy and hegemony to their discourse. These strategies are often reflected in the mass media which is used to 'raise awareness and increase acceptance' of male circumcision in the targeted countries (ibid). Due to the media's role of informing and educating the masses, I reviewed 19 articles published in the main newspapers in Zimbabwe since June 2011 to July 2012, to analyze how they have framed the issue of male circumcision. It was evident how the media was one of the influential institutions in building up the hegemonic discourse of the WHO/UNAIDS. Male circumcision had more coverage in the *Newsday* which carried 11 out of the 19 published articles. The *Sunday Mail* had five articles while the *Herald* published three stories regarding this issue.

The central theme for the majority of the articles was male circumcision's ability to prevent HIV and other STIs. Most articles stated that circumcision reduced the risk of contracting HIV by up to 60% and would add that the intervention was introduced by the WHO/UNAIDS. However so, there was little mention and coverage of male circumcision for religious and/or cultural reasons suggesting a "take-over" by medical male circumcision in the public domain. The few times cultural circumcision was mentioned, it was in reference to the Shangaan ethnic group creating an impression that this was the only circumcising group in Zimbabwe. The *Herald* for instance published an article titled "Shangaan name, for Identity, Honor" focusing on the significance of male circumcision to the Shangaan group (Sachiti, 2011).

To further promote this health discourse, the print media also used the recommended WHO/UNAIDS strategy of providing coverage to community leaders and celebrities who underwent the surgical procedure to ‘cultivate’ interest for those that may still be hesitant. NewsDay for instance published five articles related to this theme, three of which were about male members of parliament being urged to “lead by example” by going for circumcision so as to encourage other men to go through it for health reasons. The same paper carried a story about one local musician whose decision to circumcise had created such ‘overwhelming response’ from fellow youths such that some circumcising units ‘had to turn [some of these youths] away’ (Masau, 2011). Testimonials from these popular people who had undergone circumcision at these health facilities also received significant coverage. One journalist from the Herald narrated how he had chosen to get circumcised ‘not for religious or cultural’ reasons but to be ‘exemplary to my fellow scribes as many have succumbed to AIDS...’(Matambanadzo, 2012). Another testimonial was given by a Member of Parliament (MP). The key message in these testimonials was that male circumcision performed at medical centers was painless, safe and efficient. In the journalist’s story he claims the anesthetic injection ‘was the most painful part of the entire procedure’. He added that he went back to work immediately after getting circumcised prompting his colleagues to question how he could be back at work ‘straight from the theatre’. He did not report any complications and the little pain he had ‘disappeared after seven days’ (Matambanadzo, 2012). Similarly the MP said that it was a ‘painless procedure done by an experienced team’ also adding that immediately he felt as if ‘I can actually go and play football’ (Langa, 2012). Missing not only in these testimonials, but in the rest of the articles, are the risks associated with medical circumcision giving the impression that unlike cultural male circumcision, the former is risk and complication free, something also implicit in the WHO/UNAIDS documents.

While the print media substantially promoted the WHO/UNAIDS health discourse with regards to male circumcision, they also published articles (although few) that question these institutions’ discourse promoted since 2009 when the country launched this intervention. First it was in the Newsday in February 2012 that one story questions the sudden “U-turn” of the WHO regarding male circumcision which until 2007 was portrayed as unhealthy therefore increasing HIV infection risks. Quoting a study by Gregory Boyle and George Hill based on a study conducted in Uganda the story argues that instead of preventing HIV, male circumcision actually ‘increases male-to-female transmission of HIV’. The story further names a number of countries¹¹ in which higher HIV rates are among the circumcised (Gomo, 2012). Similarly Yikoniko (2012) wrote two consecutive articles in the weekly Sunday Mail in mid-July 2012. The first article quotes the survey results of the 2010/2011 Zimbabwe Health Demographic Survey indicating that HIV prevalence in Zimbabwe was now higher among the circumcised (14%) compared to non-circumcised (12%) men. In her second article titled “Were We Fooled?” she follows up on these statistics by also quoting the Boyle and Hill study which

¹¹ The articles indicates that in Cameroon, Ghana, Lesotho, Malawi, Rwanda, Swaziland and Tanzania, HIV prevalence is higher among the circumcising communities (Gomo, 2012).

dismisses findings from the randomized trials upon which the WHO/UNAIDS arguments are based.

Reflecting on this media review, it is evident how big institutions such as the WHO/UNAIDS have an influence in how media set the agenda in most developmental initiatives. The church's voice appears silenced in the media as I did not come across any coverage of the church's perception on male circumcision. Equally marginalized in the print media were the voices of ordinary people to also share their experiences. The WHO/UNAIDS discourse is institutionalized, professionalized and presented as something required and wanted by the people to get out of their misery – HIV/AIDS. This according to Escobar is how development discourse creates and maintains hegemony. This will be further elaborated in the thesis when I make a comparative analysis of the WHO/UNAIDS discourse and that of the church. Now I focus attention on the church which offers a counter-discourse.

3.3 The Counter Discourse

As indicated earlier, the church is one of the hegemonic institutions which has 'succeeded in capturing popular imagination in Zimbabwe due to the high profile it enjoyed during the colonial period' (Chitando, 2002:4). From the field data it emerged how religious discourse can have an influence in how people respond to the issue of male circumcision hence the need to analyze how the church¹² perceives male circumcision. It must be emphasized that understanding church discourse in Africa regarding male circumcision (or other indigenous practices for that matter) cannot be done outside the colonial context. In addition the church discourse also needs to be planted within the HIV and AIDS context. But first, I address the colonial project.

For most colonized African countries, Christianity was seen as an accompanying "ally" of colonialism and modernity (ibid). According to Dubois (1991: 26), the West projected their 'colonial subjects to be primitive' rendering them "unfit" to govern themselves but rather 'to be governed' and so colonialism was born and nurtured. James Coleman cited in Osabu-kle (n.d.:4) shows how Christian missionaries were sent as an advance team 'to soften the hearts of the people and while people look at the cross white men gather the riches of the land'. Thus the church preached to Africa 'the need for subservience...to the colonizing forces' (ibid: 14) to ensure that Africans would not question their subordinated position since refusing to obey colonial masters was presented as going against God's will. Yet to the world the colonizers gave the impression that, colonizing and Christianizing Africa was 'a "burden" undertaken by the white man to civilize Africans' obscuring the idea that colonialism and Christianity served their interests as colonial powers, (ibid: 4). By civilizing Africans in a religious context it meant, they [Africans] had to abandon their "backward" indigenous religions and practices by converting to Christianity. Temu (cited in Kaplan 1986: 166) for instance claims that 'almost all the Protestant missionaries...viewed all native customs and traditions with abhorrence', a sign of 'ex-

¹² By the church, I refer to western initiated churches and not African Initiated Churches that 'epitomize indigenous responses to Christianity' (see Chitando, 2002).

treme ethnocentricity and cultural arrogance'. Practices such as male and female circumcision, rain-making ceremonies among many others were portrayed as ritualistic, "barbaric", "pagan" and therefore "evil" in the sight of God forcing the African Christian converts to abandon certain traditional practices and rituals (Makahamadze and Sibanda, 2008; Caldwell et.al. 1997; Maxwell, 1998; Mate, 2002). And because the circumcision rite, in Christian terms represented 'dark ways of the sinful past' (Silverman, 2004: 427);

Christians have shied away from puberty rites and other rites of initiation into adulthood because they have misgivings as to whether a Christian's allegiance to the church (and Christ) does not conflict with age-group allegiance and membership in secret societies. [Oduyoye, 1977: 244]

In as much as circumcision was significant for certain biblical tribes, notably in the Old Testament, Shell (2008: 349) convincingly argues that 'Christianity in its attempt to transcend the purported materialism of Judaism seeks to replace "literal" circumcision with "figural" circumcision of the heart'. This stance that male circumcision is no longer of significance is one that was tacitly passed to Christian congregations (both in colonial and post-colonial eras) especially from those communities in which the practice was common. So one had to make a choice to be either *in Christ* (by foregoing circumcision) or *against Christ* (by getting circumcised) the latter which was equated to having seen the "light". While this paints a general picture of how missionaries or Christian institutions perceived indigenous cultural practices and indigenous religions, in reality not all churches remained with this rigid stance. In what Mutangi (2008: 539) calls a 'calculated compromise', certain mainstream churches in Zimbabwe such as the Catholic Church allowed 'dual worship in which one is allowed to practice both traditional and mainstream church values' something unheard of in Christian Pentecostal churches. As such certain practices including circumcision, though against "true" Christianity were allowed to continue in some churches (Makahamadze et al. 2012; Kaplan 1986). Hence in practice churches held conflicting views with regards to different African indigenous practices thus making it problematic to talk about the church voices in monolithic terms.

When Africa woke up to the crisis of HIV and AIDS, initially this disease was associated with the "promiscuous" such as prostitutes, which created stigma and discrimination towards those who were "unfortunate" to contract the HIV virus. This explained 'the initial theological reticence on the epidemic [HIV/AIDS]' because of this perceived association between HIV and unholy sexual behavior such as homosexuality and promiscuity (van Klinken 2008:320). Van Klinken elaborates on how Christians are expected to represent the "Body of Christ" which should not be tainted by immoral behavior, which in this case would lead to HIV infection. Van Klinken (2011: 1) for instance quotes a preacher at a youth church meeting who was calling on young people truly committed to the Christian values, to be 'men and women of morality...able to control [their] sexuality, to say 'no' to temptations and to wait for sex until marriage'. This emphasizes the general church's position that sex is a reserve for married couples otherwise it becomes fornication (sin) outside these marital boundaries. It should be noted that in most Christian churches, teachings about sexuality were and are to some extent 'still considered a taboo',

which explains why some churches such as the Seventh Day Adventist (SDA) 'resisted the AIDS Education programme initiated by the Government of Zimbabwe in the 1990s' (Makahamadze and Sibanda (2008: 298). However realizing that HIV/AIDS was even infecting and affecting church members, churches could no longer ignore to discuss sexuality and morality issues although some still regard these teachings as 'a desecration of the pulpit' (van Klinken 2011: 136).

Recognizing their limited coverage in the media, churches through its pastors resort to teaching and reinforcing the morality gospel in organized church meetings and conferences 'targeting the youths, singles, married couples, men and women' (ibid: 137). Emphasizing these moral teachings is the church's own HIV "prevention strategy", (Makahamadze and Sibanda 2008; van Klinken 2011). Hence the church rejects other HIV prevention strategies such as condoms and recently male circumcision because they are perceived as 'a threat to sexual purity' (van Klinken 2011: 137) since they encourage one 'to seek pleasure devoid of self-control and responsibility' (ibid: 111). In short, on one hand the church perceives male circumcision for HIV as promoting sexual immorality; on the other hand perceiving cultural male circumcision as not only traditional but incompatible with Christian values and identity.

3.4 "Science superior to God?" – Comparing the two Discourses

Having presented the two discourses of the WHO/UNAIDS and the church in previous sections, certain similarities and contradictions can be drawn which is what will be examined in this section using the Foucauldian framework. At first both institutions use specific discourses to negatively frame male (and female) circumcision in Africa with the intention of wiping away this practice; the WHO/UNAIDS using a combination of negative health discourse and human rights discourse and the church using the modernity and salvation discourse as well as its powerful discourses on God. Van Dijk (1997) argues that every discourse is intentional and created to achieve a certain goal. Similarly Foucault likens power/knowledge as a force 'which determines what will be known' (Mills, 2003:70). Here we observe dominant discourses; one claiming (in earlier times) that male and female circumcision is unhealthy because it increases risk of getting HIV; the other claiming it to be ungodly and uncivilized, thus against the progressive moral values-both discourses created with the intention of having these practices stopped in these African countries. Upon closer scrutiny, it becomes clear how these seemingly "progressive" discourses are embedded in colonial discourses which sought to facilitate easier penetration of the colonies, hence van Dijk's supposition that any kind of discourse is always linked to earlier discourses. This colonial and imperialist context enabled the uneven exchange of discourses; discourses presented in binary opposites emphasizing the 'Western superiority over Oriental backwardness' (Said, 1993:136). Similarly the church discourse was presented in a dichotomous and polar way; that is between wrong and right, moral and immoral, Christian and non-Christian. These binary representations resemble what Edward Said saw as the discursive stereo-

typical creation of the orient or the Other. Additionally, the indigenous people's own discourses regarding this practice were marginalized in the construction of these dominant discourses.

In relation to colonial discourses, the literature demonstrated how Christianity discourses on circumcision during colonialism became hegemonic through what Said terms 'moral power' (ibid) especially considering the discourses on God and salvation. Foucault however labels this kind of power as pastoral power, a 'form of power [that] is salvation oriented as opposed to political power' (Foucault, 1982: 783). Within the colonial context and other earlier times, this pastoral power was mainly to 'assure individuals salvation in the next world' however Foucault argues that this power has assumed a new objective in post-colonial times which is to ensure people's salvation in this world (ibid.: 783-784). By leading people to "salvation", it meant pastors now had an obligation to protect people from bad health (i.e. HIV infection); insecurity and 'protection against accidents' (ibid). This is why church discourses now emphasize abstinence as the only way to protect its congregations from HIV infections. For Christians and non-Christians, a rejection of this discourse is akin to sin which attracts eternal judgment from God.

In as much as these hegemonic discourses have continued with their construction of the African as pre-modern and hence needing guidance to embrace modernity and development, it is imperative to highlight the discursive shift that followed the end of colonialism 'as new relations of power came into existence, breaking old relations of domination and necessitating new ones' (Dubois, 1991: 26). In line with Escobar's argument, the introduction of development discourse by western development institutions such as the WHO/UNAIDS legitimized their hegemony through these 'positive mechanisms' (ibid.) rather than force as was the case in colonial times, creating an illusion of equality and mutuality between western development agencies and the targeted developing countries. Nevertheless the old discourse about "traditional" male circumcision continues to be present and alive even when it is promoted in the name of health. Nonetheless this desire to "save" Africa from diseases such as HIV/AIDS as a development goal has ironically created a rift between the modernity/health discourses of the WHO/UNAIDS and the Church which previously had disapproved of circumcision. But as observed by (Sawicki, 1991:26) there are no permanent and privileged discourse 'coalitions in history, but rather a series of unstable and shifting ones'. Thus the WHO/UNAIDS begins to "soften" its stance on male circumcision by producing discourses re-framing it as desirable and casting it as a healthy, preventive, modern, and civilized practice-but *only and only if* it is performed by *medical* professionals. On the other hand the church discourse on this practice remains the same with very slight modifications; earlier the church emphasized discourse on male circumcision as sinful but now they combine with discourse on morality.

In 'making a claim for power' (Mills, 2003:69), the two institutions employ various mechanisms; the WHO/UNAIDS to build a hegemonic discourse while the church seeks to maintain its hegemony. It should be emphasized here that both institutions appear to direct their discourses at the same target. Explicitly, they target, albeit with different intentions, those from non-circumcising communities largely comprising Christians. Implicitly they also still target the "traditionally" circumcising groups, the WHO/UNAIDS with the intention to "modernize" this practice through replacing "traditional"

practitioners with medical professionals, while the church seeks to bring “salvation” to the same circumcising societies. In order to build hegemony, the WHO/UNAIDS presents the health discourse regarding male circumcision backed by scientific based evidence. According to Foucault, the scientific method is said to supersede all other methods of knowing thus granting it epistemic privilege to be ‘admitted into the category of true knowledge’ (Dubois, 1991:7) although he sees this as just a claim of truth rather than believing it to be “true”. Thus in promoting male circumcision as an HIV prevention strategy, the WHO/UNAIDS discourse quotes “unquestionable” medical reports and scientific research findings (to show it prevents HIV and STIs, cervical and penile cancer) to validate their claims and justify their intervention. This strategy used by the WHO/UNAIDS of quoting other scientific and experts’ texts adds weight to their discourse through what Said conceptualized as strategic formation. In the process, the WHO/UNAIDS claim impartiality by arguing that the male circumcision intervention was a result of scientific studies which are “objective” and non-political. However, as is demonstrated in this study and elsewhere (see Escobar 1995; Dubois1991; Said 1993), this seemingly neutral health discourse is highly political marked by domination and resistance. The WHO/UNAIDS also uses discourses on development, in which reducing the HIV prevalence is seen as contributing to the overall success of MDGs in developing countries. Within the health discourse, there are also traces of modernity discourse in which male circumcision for HIV emphasizes free choice, contrasting it to the common practice. Overall, I therefore argue that the WHO/UNAIDS discourse ascends to hegemony by way of *persuasive* rather than *coercive* discourse. This creation of persuasive discourse constitutes what Escobar terms planning in development discourse.

Escobar also identifies professionalization as being part and parcel of development discourse; what Dubois (1991) calls the ‘expertization of development efforts’. The consistent reference to the male circumcision intervention as being an outcome of research by “scientists”, “health experts” and “consultants” not only gives hegemony but also legitimacy to their discourse as these experts ‘begin prescribing and proscribing through the introduction of "safer," "more efficient," "healthier," "better," "newer," and "proven" ways of doing things’ (ibid.: 21). The WHO/UNAIDS, through local implementing agencies in the targeted countries, is also recruiting powerful figures notably celebrities and political figures in selling male circumcision to gain consent of Zimbabweans as indicated in the media analysis, which brings in the intellectual and moral dimensions of hegemony as described in the conceptual chapter. This is why Gramsci concludes that gaining hegemony ‘involves both attaining consent and using force when necessary’ (Sh’hada, 1999:24) implying that gaining power through force is often likely where attaining consent has failed. In this particular case there is absence of force.

Here I would also add that another mechanisms used by the WHO/UNAIDS to maintain a hegemonic discourse is through financial power. That this intervention is heavily donor-funded explains why this discourse maintains more presence in the public sphere because of the financial resources that come with it. In one of its publications, the WHO (2007: 10) writes that ‘bilateral and multilateral donors should consider male circumcision as an important, evidence-based intervention for HIV prevention and allocate resources accordingly’. So it is not only about producing scientific and convinc-

ing discourse that propels it to hegemony, but it can also depend on the financial muscle to produce, promote and sustain that discourse. Van Howe et al. (2005: 260) for instance observe that the randomized trials which produced the scientific results which have culminated in the introduction of the male circumcision intervention in Africa were heavily funded by the US National Institutes of Health. And like in any other funded research, findings may be manipulated to fit the interests of the funder be they scientific or not.

We also observe in the WHO/UNAIDS, what Escobar termed the institutionalization of development discourse. As another strategy, they make use of powerful institutions such as the state (through the health ministries and institutions) and media as analyzed earlier to gain and maintain this discursive dominance. Foucault's description of power/knowledge as constituting domination and marginalization is important in the analysis of the mechanisms used by these two hegemonic institutions. Through the health and scientific discourse, the WHO/UNAIDS has attained hegemony using the powerful media, which has led to the marginalization of the church discourse as it is not backed by "scientific" or objective knowledge thus cannot make convincing claims for truth. The church on the other hand, in trying to maintain its hegemony, has produced a counter-discourse by reinforcing morality teachings to its members during organized church meetings targeted at different groups in church such as youths, married couples, and single people. The church refers to its powerful discourse on what is morally good and bad in the eyes of God. In this church discourse, however I argue that both consent and force are present as mechanisms to maintain hegemony.

As noted in the previous chapter, gaining hegemony can involve creating an illusion of shared identity; thus a "Christian identity" is created to gain consent from those who ascribe to this identity, at the same time using moral force by threatening Christians with God's eternal punishment should they go against these moral values and teachings. And van Klinken (2011: 134) sums this argument by claiming that, Christians, since the time of missionaries were and are still taught to believe 'in the eternal conscious bliss of all true believers in Christ and also in the eternal conscious punishment in the lake of fire of all Christ rejecters'. These Christian beliefs promoted through religious ideology are also presented by the church as representing the 'ultimate truth' (De Kadt, 2009:784) because what God says cannot be questioned, and adds that this 'God told us so [stance] places clear limits on what is regarded as acceptable development'. The church therefore portrays male circumcision intervention as "inappropriate development" for implicitly promoting sexual immorality and in resisting the WHO/UNAIDS discourse, promotes abstinence as the more "appropriate" development. Comparing these two discourses one can agree with a claim by Spronk (2012: 113) that 'while AIDS has led to the medicalization of sexuality, the moralization of AIDS and sexuality has gained momentum with it'.

These institutions have not possessed power but exercised it in its varying forms. The fluidity nature of power, when exercised allows it to 'incite...induce...seduce...in the extreme constrain or forbids absolutely' (Foucault, 1982: 789). Having examined both discourses from these dominant institutions one realizes that in as much as they are 'formulated from a Western perspective with Western interests at their core' (Mills, 2003: 72) they also co-exist as powerful competing and contradictory power/knowledge regimes attempting to impose their legitimacy on people. So instead of having one uni-

fied Western power/knowledge regime, we observe conflicting discourses of the WHO/UNAIDS and the Church which put to question Escobar and Said's conceptualization of the Western discourse as homogenous.

While these institutions through discourse fight for dominance they have in the process marginalized the voices of the "subjects" from whom they seek legitimacy. They seem to pay little attention to the many and complex discourses at the micro-level of social relations, which according to Foucault, goes beyond the classical conceptualizations of power as centralized and repressive (Sawicki, 1991). This issue is examined in the next chapter after presenting people's discourses on male circumcision.

3.5 Chapter Summary

This chapter has analyzed the two powerful competing discourses; that of the WHO/UNAIDS and that of the Church in terms of how they present male circumcision. Emphasis of the chapter was on the mechanisms used by the two institutions to build hegemony (on the part of the WHO/UNAIDS) and to maintain hegemony (on the part of the Church). For the WHO/UNAIDS, the study shows how scientific evidence based documents on the health benefits of male circumcision and media as an institution were used to build up their now dominant and rather persuasive discourse. On the other hand, the church employs threatening discourse about God which is taught in various church meetings to ensure that its members remain morally upright by avoiding sex except in the confines of marriage. The next chapter examines people's discourses as they respond to these hegemonic discourses.

Chapter 4

People's Discourses

4.1 Introduction

In this chapter the thesis shows the complex and multi-dimensional nature of people's discourses regarding male circumcision. By way of quotations from the interviews and FGD participants, I attempt to create space for them to articulate their responses on the dominant discourses which are often privileged and accessed. In the last section of this chapter I attempt to provide a synthesis of the findings in this and the previous chapters using the analytical tools presented in Chapter 2.

4.2 Perceptions on the health discourse

Virtually all respondents in my sample, including those from "traditionally" circumcising communities, expressed that male circumcision (for HIV prevention) was now more hygienic now that it was being performed by experienced medical personnel using sterilized equipment thereby reducing the likelihood of complications. One of the respondents however explained that in earlier times, while just one knife was used to circumcise a large number of boys and men, the circumcisers tried to make the process hygienic by sterilizing these knives by heating them with fire to kill germs.

You see, in the past our elders believed that by heating the knives used in circumcising, germs would be killed in the process...and by then resources were limited such that it was difficult to get an object for each person. [Shaun]

When HIV and AIDS became a cause for concern in Zimbabwe, a female respondent from the VaRemba tribe explained that their community adapted by asking each of those boys and men undergoing circumcision to bring their own razor blades as that would limit chances of transmitting HIV infections between them.

For these respondents from circumcising groups, the promotion of HIV preventive male circumcision was desirable not because they believed that the practice lowered one's risk to HIV infection, but because the health and HIV discourse had led to some acceptance of their practice previously shunned in the past. Hazvinei, a woman from the Ndau ethnic group said 'we used to be ashamed to be identified as a circumcising group because of the stigma that came with being circumcised'. However with the introduction of the national male circumcision programme in the country 'it has now made us [circumcising groups] to be more accepted because prior to that, if you dare mention anything regarding circumcision you would be perceived negatively' (Gabriel, a Shangaan man).

Regarding the message that circumcision prevents HIV and other STIs, only a few expressed optimism that circumcision could reduce the risk of HIV transmission with one 57 year old Jonasi of the Karanga tribe stating that:

...look for someone to have said people should go through that [circumcision] there must have been substance to back that so yes I do agree it reduces risk for HIV otherwise they wouldn't have said it for the fun of it.

The majority however (especially men) while confident that male circumcision reduces chances of getting STIs (from the childhood stories about the benefits of circumcision) they were not convinced that this procedure lowered one's susceptibility to HIV, and they offered their own explanations. Alison, a married man in his 30s had this to say:

although they emphasize that it [circumcision] reduces risk of HIV, I personally don't buy that because my belief is that the virus [HIV] is sucked in through the penis opening or wound so having a foreskin or not does not matter'.

On the contrary, most responses indicated that the male circumcision intervention was increasing people's risk to HIV transmission by indirectly promoting promiscuity as some were now getting circumcised with the belief that they would be totally protected from HIV and STIs. Their concern emanated from promotional messages which they felt were presenting circumcision as if it offered 100 percent protection from HIV.

I have been reading some newspaper articles and the so called benefits of circumcision seem to be outweighed by the after effects. Look at the high rate of HIV infections among the recently circumcised as was indicated in the Sunday Mail report [Kudzai]

Gilbert, a 28 year old single man had similar opinions and shared a story about how:

...one friend of mine, a church pastor fooled himself, he used to be pompous saying I am circumcised and he hired a bitch [i.e. prostitute] and he got an STI called *sicé* [read syphilis] and his [walking] step changed.

A significant number of respondents associated undergoing the HIV preventive male circumcision with a promiscuous sexual lifestyle with one male interviewee remarking that "if you observe the kind of guys that have been circumcised under this intervention you see that they are the fast¹³ ones". This point to the perception that when one goes for the circumcision procedure, it is an admission of infidelity otherwise, like 38 year old Phyllis questioned with

¹³ The term "fast" here implies a person with multiple sexual partners.

reference to her husband, ‘where will he get the disease from?’ Another male respondent in his 60s and a member of the Anglican Church concurred:

Suppose you have a wife and you are both Christians would you really prioritize circumcision? It’s difficult, isn’t it? ...when she hears that it [circumcision] prevents STDs then you tell her that you want to go for circumcision, she will ask why and from whom are you getting the disease that you want to protect yourself from?

This HIV intervention brings the issue of infidelity to the discussions between married and Christian couples whom according to religious morals have to remain faithful to each other as long as they are within the institution of marriage.

Research participants also highlighted other benefits they associated with male circumcision, 40-year old Gloria for instance shared how she had actually encouraged her husband to get circumcised mainly because ‘I can also benefit from it by lowering my risk to develop cervical cancer’. Others mentioned improved penile hygiene as another benefit accruing to circumcised men. Be that as it may, there were others who felt that the issue of penile hygiene had been overemphasized. Coming from non-circumcising communities they indicated that they had also been taught how to keep themselves clean and so for the campaigners of male circumcision to imply that non-circumcision is synonymous with lack of penile hygiene was in their opinion rather offending.

At this age hygienically surely I can take care of myself, so for me to go under the blade to be circumcised for that, No! [Makumbe, in his late 50s from Karanga tribe]

If male circumcision has to do with being hygienic, if my husband has grown to this age without having an STI surely he can keep his penis clean! [Kudzai, 33 year old, of Ndau tribe]

Some were concerned that the campaign messages had just focused on the health benefits of circumcision without also explaining if the procedure had any side effects. In their arguments they cited a number of “negative” stories (in media and personal interactions) shared by those who had undergone circumcision for HIV prevention.

[On the] internet... [there are] men who have been circumcised who are now writing and complaining [saying] you misled us...we were duped but now we can’t correct it to the original thing [laughing]

Similarly, one married woman after being asked why her husband was unwilling to go for circumcision, she responded:

There is this [radio] programme in which these issues are discussed where some listeners talk about their complaints...[some] say they regret having un-

dergone circumcision [under the HIV programme] because now they say their organ is now crooked [bent], others say they now experience pain during sexual intercourse and there is a man who claims it has been over two months since he last had sexual intercourse with his wife due to pain....)

Another explained how after getting information about the health benefits of medical circumcision encouraged her husband to get circumcision. However after the procedure ‘the wound took longer to heal and he was complaining of pain and excessive bleeding, it was however soon fixed with the doctor, now he is fine’.

The perceived association of circumcision with pain is one issue that ran through virtually all interviews. In as much as some respondents (men especially) were of the view that medical circumcision had health benefits, they were unwilling to let themselves or their sons go through it because they perceived it to be a very painful process, whether one is circumcised by “traditional” practitioners or by medical doctors. They saw no difference in the circumcision process since in both cases the “operation” is done while one is wide awake which in their view is not only painful but ‘traumatic’. Even those participants from circumcising communities also described circumcision as a very painful process.

It was something that I used to dread each time a boy child was born because I knew they had to undergo this process which at times took a long time to heal. If I was a parent back then I would probably run away with my son because I wouldn’t want him to pass through that painful process [Hazvinei]

Since most respondents doubted the efficacy of circumcision in reducing HIV transmission risk, the general feeling was that it was really not worth it to go through the painful process.

4.3 Perceptions on sexuality and manhood discourse

One issue that generated interesting debate especially in the focus groups is association (or lack of it) of circumcision with sexual pleasure. There were conflicting views and theories on whether male circumcision enhanced sexual pleasure. A married man in his early 30s claimed that ‘circumcision is basically for sexual satisfaction, and has nothing to do with [preventing] disease or anything - circumcision was and is done for men to enjoy sex’. Another added that the removal of the foreskin before a man’s sexual debut would ensure that he will not experience pain during the first sexual encounter. A significant number of men felt women would enjoy sex more with a circumcised man since ‘penetration will be smooth and easy’ (Taurai). Male circumcision was also said to benefit those men struggling with premature ejaculation, the argument being that once the foreskin is removed, the head of the penis becomes ‘less sensitive’. Bernard (40 years) was of the opinion that male circumcision ‘helps prolong sex therefore you are better able to satisfy a woman’. But if indeed circumcision reduces penis sensitivity one man asked,

‘doesn’t this actually “kill” a man’s sexual feelings?’(Nimrod). Another woman had a different theory:

Although some say circumcision reduces sexual libido, I personally like this because it reduces my husband’s temptation to have extra-marital affairs...of what use will he be to that other woman if he can’t perform?

In the end there was no prevailing opinion among participants on whether circumcision resulted in less or more penis sensitivity and/or sexual satisfaction. The majority of men however highlighted that the perceived sexual benefits were the main reason some men from commonly non-circumcising groups were getting circumcised in the first place, stating it had little to do with wanting to be protected from diseases.

It is unfortunate that those behind the promotion of male circumcision for HIV prevention underestimated how much men want sex. I am telling you, so because they think it (circumcision) enhances [sexual] pleasure; men are going specifically for that! [Obert]

While some men were said to get circumcised for sexual benefits, others expressed that the six week healing period after circumcision was ‘too long’ a time to abstain from having sex especially when one is already in a sexual relationship and more so when one is married. Interestingly, those from circumcising communities did not endorse the sexuality discourse. None of them indicated enhancement of sexual satisfaction as being one of the reasons they circumcise choosing rather to speak about it as being a practice linked to manhood. This theme of manhood was quite central in the field interviews and discussions where there was a general acknowledgement that the practice of male circumcision was linked to notions of manhood and cultural identity on the part of circumcising societies. This was affirmed by the respondents drawn from circumcising ethnic groups where Nxumalo in his 50s from the circumcising Xhosa ethnic group explained that ‘after *Ukusoka*¹⁴ you would be given a certificate indicating that you are now a man among men’. Without getting circumcised ‘you will not be properly integrated into the community, you would be like an outcast’ (Janet, from VaRemba tribe). A number of respondents from non-circumcising societies although having the conviction that male circumcision could reduce STIs in men, they still felt that the circumcision was a norm for specific ethnicities, hence should be limited to these circumcising communities where it would be of more cultural significance.

4.4 Discourse of people in conceptual framework

Foucault’s analytical framework is acclaimed for its usefulness in analyzing multiple discourses. So while the church and the WHO/UNAIDS have pre-

¹⁴ *Ukusoka* is the Xhosa name for male circumcision.

sented their discourses in simplistic and dichotomous ways, the interview data indicates that there are more than two discourses or power/knowledge regimes. The many yet complex discourses on male circumcision from the perspective of the “recipients” include those on health, sexuality, modernity and manhood. These discourses are not clearly distinguishable as they intersect at different times and in varying degrees which is why Escobar (1992:143) argues for the “West” to acknowledge ‘plurality of meanings’. It is evident from people’s discourses that there is more than one meaning attached to male circumcision, in as much as the WHO/UNAIDS would like to present it as such.

We see in Chapter 2 how ideology is a critical element of discourse due to its ability to ‘control what groups themselves usually hold to be true beliefs’ (van Dijk, 1997: 28) thus influencing attitudes of their members. Hence we deduce from field responses the influence of cultural ideology on those who identify as coming from circumcising communities; and church ideology on religious respondents. Those who identify as Christians during interviews for instance negatively perceive the male circumcision health intervention because they associate it with immorality (in the manner the church ideology also perceives it) which goes against their religious values. But again, as reflected in the same primary data, this ideological power contained in dominant discourses may still fail to manifest in its repressive form but rather in its productive form as argued by Foucault. This is because the mere existence of relations of power – in this case between the two institutions and the people – produces discourses that create ‘possibilities of resistance...[making] it possible [for power] to modify its hold’ (Sawicki, 1991: 25). In this case there are stories of Christians (including church pastors) who have actually undergone circumcision for HIV prevention, an indication of resistance to the ideological and hegemonic church discourse. It is not only the church discourse that is resisted by the people, but also that of the WHO/UNAIDS presented in scientific terms hence thought to be unquestionable. Through creation of their own micro-level power/knowledge regimes people for instance contest the WHO/UNAIDS health discourse on male circumcision especially the claim that it reduces risk of HIV transmission and that it enhances sexual pleasure. The other resistance mechanism the men use is by simply not going for the circumcision procedure which could be why in Zimbabwe, three years after introduction of the intervention only 80 000 men¹⁵ have been circumcised against a target of one million (Chipunza, 2012). So as Escobar argues in his critique of Said, the Western discourses might be hegemonic but not “all powerful” considering how these interviewees seem to contest the health discourse of the WHO/UNAIDS.

Through these interviews, some of the marginalized discourses were revealed. For example, the WHO/UNAIDS has continued to portray cultural circumcision as falling short in safety and health measures which makes this type of circumcision risky. However, contrary to this depiction the interviews have revealed that these communities had their own ways of maintaining hygiene, but unfortunately these indigenous discourses on male circumcision have according to Escobar and Said been eclipsed by western discourses.

¹⁵ This figure is as of September 2012. The government had targeted to circumcise 1, 2 million men in 5 years.

4.5 Chapter Summary

This chapter has presented and analysed the findings from the perspective of different research participants. Focus was on the major highlights in terms of the different ways that men and women perceive male circumcision. What emerges from the findings are the complex perceptions and interpretations of male circumcision and that medical male circumcision presents an opportunity in which people try to make sense of the issues surrounding male circumcision either discursively or in its actual practice. The next and final chapter presents a summary of the study findings highlighting the paper's contributions regarding the study of power/knowledge regimes.

Chapter 5

Conclusions

5.1 Introduction

In this final chapter as a way of providing a synthesis to the thesis, the main question that this study sought to answer is revisited summarizing the major findings. By summarizing the findings the paper highlights its contributions to the theoretical debates regarding the Foucauldian approach in understanding not only male circumcision but other areas as well. The paper concludes by reflecting on other issues that might be explored in future studies.

5.2 Revisiting power/knowledge: A synthesis

At the beginning this paper raised this main question: *How can the competing power/knowledge regimes around male circumcision in Zimbabwe be understood using the Foucauldian approach?* In attempting to answer it discourse analysis was adopted as the major methodological tool to analyze the dominant discourses of the WHO/UNAIDS and the church pertaining to male circumcision. The people's discourses were also included by way of interviews which were later analyzed in relation to the dominant discourses. Since the major aim was to apply a theory on power/knowledge, analyses presented throughout the paper was done using the concepts that are intrinsically linked to this framework; power/knowledge; discourse; hegemony; orientalism; and (post)development.

Firstly, the paper has shown the usefulness of the Foucauldian conception of power and knowledge in understanding the competing power/knowledge regimes regarding male circumcision. It has demonstrated that when discourses are produced they are an act of power, meaning they are neither benign nor impartial in as much as they are presented as such. The study has shown that while the WHO/UNAIDS has presented male circumcision as a neutral health and development intervention, this discourse is largely political because it was constructed within a discursive environment characterized by power inequalities where cultural circumcision continues to be depicted as inferior. Thus Mills directs us to interrogate 'every instance of production of knowledge, every instance when someone seems to be speaking on behalf of someone else, no matter how good their intentions are' (2003: 78).

Secondly, in line with Escobar the thesis concludes that the production of the health discourse was to gain discursive dominance to legitimize the institutions' intervention in the Third World. As discussed in Chapter 2, Foucault argues that scientific based discourses are often exalted at the expense of other discourses. In this regard the study has also shown how 'local knowledge and practices are held suspect until they are championed by the outside using the science or language of experts' (Dubois, 1991: 23). By highlighting the initial negative representation of the male circumcision practice by the WHO/UNAIDS and the new shift, the study reveals how this practice only

became acceptable following scientific studies linking it to a reduction in HIV transmission. And prior to this “grand” discovery, the same institutions have marginalized indigenous discourse regarding this practice. So for a Foucauldian question; who produces knowledge about whom? In this specific study the answer is clear - it is the western dominated institutions whose language has determined what is to be known about male circumcision. Edward Said through his theory of Orientalism also reached similar conclusions when he analyzed the discursive representation of the East by the West; and also Escobar in his analyses of development discourse. Implicit in these representations is the view that knowledges emanating from people in these regions are backward and inferior.

Thirdly, the case study reveals that systematic processes are followed to validate specific knowledge projected as fact or truth. By analyzing the health discourse of the WHO/UNAIDS the paper demonstrated how this discourse is professionalized and institutionalized to make it legitimate and hegemonic. The WHO/UNAIDS achieved this not only by recruiting health experts and consultants but by also making use of prominent personalities to sell the male circumcision discourse. In addition, the study has also shown how this discourse was further strengthened by translating it into development policy adopted by the state and promoted through media institutions.

Fourthly, as argued by Foucault the paper demonstrates that other than political power other dimensions of power are also exercised. Through examining the mechanisms used by the institutions of the WHO/UNAIDS and the Church in producing hegemonic and counter-hegemonic discourses the thesis has demonstrated that in relatively non-political contexts there is less use of force and subjugation but more of intellectual and moral dimensions of power. The WHO/UNAIDS for instance gain consent through persuasive power. On the other hand, the church uses its moral or pastoral power to counter this health discourse. From a Foucauldian perspective, numerous discourses are produced in social relations and also create possibilities for resistance (Sawicki, 1991: 25).

Elements of resistance are also evident in the people’s discourses as they contest the health discourse being pinned to male circumcision arguing instead that this procedure would not reduce HIV. Therefore the paper concludes that regardless of the presentation of certain knowledge as objective thus unquestionable, the so called subjects have their own way of showing resistance by creating their own micro-level discourses which I would argue has more power to weaken these hegemonic discourses. It was clear in the paper how there are more than one power/knowledge regime.

Overall, former colonial powers and development agencies continue to treat indigenous people as ignorant, traditional, and backward despite their diverse and rich contributions. While the research acknowledges the multiple and diverse meaning of male circumcision, thus the difficulty for generalization, the WHO/UNAIDS and other such powerful agencies in reality continue to dominate the discursive universe by their simplistic and superficial one-dimensional discourse.

5.3 Theoretical Contributions

What also emerges in this study is the plurality of hegemonic discourses. This means that neither the WHO/UNAIDS alone nor the church alone dominate the discursive field. Rather, in their hegemonic position, they compete with each other. In this manner, the paper, unlike Escobar and Edward Said, and based on careful examination of existing and fresh data, reveals that the hegemonic discourse even in one specific field, is not necessarily one, but rather multiple. Upon examination of the church's stance on male circumcision the study has for instance also revealed competing power/knowledge regimes within Christianity itself regarding the male circumcision rite. Additionally, the case study has shown the plural nature of western discourses and people's discourses thus going beyond Escobar and Said who have often seen the Third World, East and West as monolithic. Plurality in this case does not mean an equal distribution of power among these discourses. On the contrary, discourse represents the unequal power in society and as such, one is often able to identify the dominant discourses about a specific subject in specific time and space as the paper demonstrated.

In Chapter 2 Escobar (1995: 4) concluded that 'the Third World has been produced by the discourses and practices of development since their inception in the early post-World War II period'. This paper however argues that the creation of the Third World is rather a colonial product in which discourses on civilization and modernity were introduced with development discourses only coming to reinforce these earlier discourses. With this argument in mind, it is problematic for Foucault to reject that some discourses can actually transcend historical boundaries. The discursive representation by the WHO/UNAIDS and the church of "traditional" cultural circumcision as "traditional", together with its people in Africa as being "backward" and "too traditional" remains embedded in colonial discourses. However Foucault's idea of identifying discontinuities in discourse still remains significant considering the sudden shift in the portrayal of male circumcision in recent years. Identifying these "ruptures" and when they occurred directs us to the need to situate our analyses of discourses within and across specific historical times.

In as far as time and space allowed to review the literature on male circumcision, none of Zimbabwean studies specifically used the Foucauldian approach to understand male circumcision. However some researchers such as Mavhu et al. (2011) and Mhangara (2011) explored people's discourses investigating factors affecting willingness to get circumcised under the WHO/UNAIDS intervention. Gwandure (2011) on the other hand highlighted the contemporary shift in the representation of male circumcision for HIV; van Klinken (2011) and Mutangi (2008) explored the church discourse while Silverman (2004) and Kaplan (1986) looked at the colonial and historical perspective. Using the insights from these studies as well as examining the discourses of the WHO/UNAIDS and the church combined with the empirical evidence of diverse people's discourse, and given the limited time and space, this thesis has succeeded in bringing together a complex analysis of the broad discursive field on male circumcision.

5.4 Suggestions for further research

While the study has addressed the research questions there are still gray areas which could not be explored in this research owing to time and space limitations. It was mentioned in the first chapter that human rights institutions had also in previous years called for the abandonment of male circumcision, however this study could not examine the current human rights framing of male circumcision now that it is portrayed as a health intervention. Instead the study concentrated on the discourses of the people, church and the WHO/UNAIDS. In addition, the study also highlighted that in as much as churches appear to have similar moral discourses, their stance on cultural practices such as circumcision varies across churches. The paper therefore advocates plurality and particularity in examining multiple discourses. As such future studies require comparative studies across specific institutions, churches and countries – this approach would be more beneficial in revealing reality often obscured in dichotomous representations.

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Appendices

Appendix A Profiles of Interviewees

	Name	M/F	Description
	Chipo	F	32 years; married; from Zezuru tribe (non-circumcising) ; unemployed; Christian (Johane Masowe); lives in Epworth (high density suburb); with secondary education
	Dzidzai	F	34 years; married; from Manyika tribe (non-circumcising), has primary education; does not go to church but used to be member of Jehovah's Witness; lives in Epworth (high density suburb)
	Tracy	F	40 years, from Karanga tribe (non-circumcising), married, has secondary education, not aligned to any church; lives in Epworth (high density suburb)
	Jonasi	M	57 years; married; from Karanga tribe (non-circumcising); Johane Masowe church; lives in Hatfield (low density suburb); degreed
	Kudzai	F	33 years; married to a church pastor; from Ndaube tribe (non-circumcising); university graduate; media practitioner; lives in Avondale (medium density suburb), Christian (Apostolic Faith Mission).
	Gabriel	M	30s; from Shangaan tribe (circumcising); university degree; married; lives in Glen Norah (high density suburb)
	Nxumalo	M	53 years; from Xhosa tribe (circumcising), married and church elder in the Seventh Day Adventist; lives in Greendale (low density suburb), educated
	Bernard	M	40 years; from Karanga tribe (non-circumcising); divorced; lives in Houghton Park (medium density suburb), not aligned to any church; degreed
	Taurai	M	36 years; married, attained secondary education, Christian (Johane Masowe); lives in Epworth (high density suburb)
	Judas	M	36 years; a Muslim (circumcising), and of Yao tribe (also circumcising); married; university degree; lives in Avenues (medium density suburb)
	Gilbert	M	28 years; single; from Manyika tribe (non-circumcising), degreed; does not belong to any church
	Janet	F	31 years; single; university graduate; from vaRemba tribe (circumcising); Christian

Appendix B Focus Group Participants

	Male Focus Group
	Description
Shaun	30s; Married; from Zezuru tribe (non-circumcising); university degree; lives in Greendale (low density suburb); Christian (Baptist Church)
Richard	60 years; married; from Zezuru tribe (non-circumcising); Anglican church; lives in Glen View (high density suburb)
Obert	Mid 30s; married; from Karanga tribe (non-circumcising); lives in Chitungwiza (high density suburb); college diploma; Christian (AFM)
Alison	30s; married; from Zezuru tribe (non-circumcising); lives in Warren Park (high density suburb); university degree; Christian (AFM)
Makumbe	50s; married; lives in Mabvuku (high density suburb); from Ndaube tribe (non-circumcising)
Nimrod	Late 20s, Karanga, single, Epworth (high density suburb); Roman Catholic
	Female Focus Group
Gloria	40 years; married; from Zezuru tribe (non-circumcising); Mt Pleasant (low density suburb); university degree
Hazvinei	Early 30s; Ndaube tribe (circumcising); lives in Kuwadzana Extension (high density suburb); Methodist church; relatively educated
Phylis	38 years, married; Christian (Anglican); university degree; from Karanga tribe (non-circumcising)
Charity	24 years; single; university degree; Zezuru (non-circumcising); Christian; lives in Kuwadzana (high density suburb)
Samantha	22 years; single; college diploma; Karanga (non-circumcising); Christian (AFM)

Appendix C Interview Guide

1. What do you know about male circumcision?
2. Have any of your friends/family members gone through it?
3. What do they think of it?
4. What comes to your mind when you hear about male circumcision?
5. How do you personally view the practice of male circumcision?
6. What advantages if any do you associate with male circumcision?
7. What disadvantages if any are linked to male circumcision?
8. How is male circumcision viewed in your religion?
9. Of what significance is male circumcision in your ethnic group?
10. What stories have you heard about the link between male circumcision and HIV/AIDS?
11. In your opinion, what do you think is the link between male circumcision and HIV/AIDS?
12. Should male circumcision be promoted and why?
13. Would you recommend your son/relative/friend/partner/husband to get circumcised and why?
14. What do you think are the reasons that encourage one to get circumcised?
15. What reasons do you think may discourage one from getting circumcised?

