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## SOCIOLOGY | RESEARCH ARTICLE

# The Bamasaaba people's response to the implementation of the Safe Male Circumcision Policy in the Bugisu sub-region in Uganda

Bernard Omukunyi<sup>1\*</sup>

**Abstract:** Male circumcision is culturally motivated with a symbolic meaning of the rite-of-passage from boyhood to manhood in some African countries such as Uganda, particularly by the Bamasaaba local people from the Bugisu sub-region. This study aimed at investigating the local Bamasaaba people's response to the implementation of the reformed health policies on male circumcision in the Bugisu sub-region in Uganda. The qualitative research approach adopted masculinity and Bourdieu's theory of practice, presented through the lens of *Habitus*, which involved in-depth interviews with selected individuals and numerous Focus Group Discussion with the participants. Data analysis involved transcribing, interpretation, coding, categorising and generating the themes using the qualitative computer application known as Atlas. The results suggest that the Bamasaaba people have not accepted implementing the reformed health policies on male circumcision. However, these people are conditioned to rethink their traditional Imbalu (traditional male circumcision) practices due to the prevailing and persisting HIV/AIDS infections in their society.



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### ABOUT THE AUTHOR

Bernard Omukunyi (Postdoc, PhD, M.A Sociology, BED. Hon. (UWC), Dip in Ed., Cert in Ed. (Kyambogo University)).

Bernard Omukunyi is a holder of PhD and master's degree in Sociology, University of the Western Cape. In addition, he holds a Bachelor of Education (Hons) also from the University of the Western Cape. He is also a qualified a teacher with a National Diploma in Education and a National Certificate in Education, from the Institute of Teacher Education Kyambogo, (ITEK). His area of interest in research is on the family values and cultural values to promote Africanism among African people. In this he attempts to understand the significance of traditional practices and how these practices help African people instill family values into young people in their communities. Currently, he is working on a project that is attempting to understand the implications of the contemporary and western social, political, and cultural influence including the health policies on African traditions such as traditional male circumcision.

### PUBLIC INTEREST STATEMENT

This article investigates how the Bamasaaba people are responding to the implementation of the reformed health policies on male circumcision in the Bugisu sub-region in Uganda. The study focused on Connell's explanation of subordinate masculinity, which is defined as the masculinity of certain groups of men who do not seem to be living up to the dominant ideas of being a man. The hegemony of masculinity symbolically eliminates these groups of men from the definition of manhood. For example, going to the hospital for circumcision is a sign of cowardice to men in the Bugisu sub-region. Among the Bamasaaba people, bravery is the cultural driving force behind the designation *umusaani burwa* and is expressed through the act of pain endurance in the initiation process. Men's character such as courage, strength, independence, leadership, and assertiveness are believed to be acquired through the complete process of initiation by fulfilling the cultural practices of traditional male circumcision (*Imbalu*).

**Subjects: Anthropology - Soc Sci; Sociology & Social Policy; Cultural Studies**

**Keywords: response; Bamasaaba people; implementation; reformed health policies; Bugisu sub-region; traditional male circumcision; clinical male circumcision; Uganda**

## 1. Introduction

The local Bamasaaba people hail from the popular Mt. Masaaba (Elgon) area and the surrounding areas of Wanale, Wagagai, and Namisindwa, located on the Eastern frontier of Uganda (Nalinya, 2014). The local Bamasaaba people are strongly united in their tradition, culture, and custom of Traditional Male Circumcision (TMC), referred to as *Imbalu*. Wanyenya (2013) argued that the Bamasaaba people strongly hold to the cultural practice of *Imbalu* (TMC), which plays a significant role in their cultural identity and symbolic meaning of rite-of-passage from boyhood to manhood.

Currently, the Bugisu sub-region consists of six districts in Uganda and five cultural districts in the Western part of Kenya. The districts forming part of the Bugisu sub-region in Uganda include Bududa, Bulambuli, Manafwa, Mbale, Namisindwa and Sironko districts. In addition, the districts that culturally form part of the Bugisu cultural institution in the western part of Kenya include Bungoma, Kakamega, Lugari, Trans Nzoia and Uasin Gishu districts (Nalinya, 2014).

This paper is part of the major study and is presenting the general conclusion of the study. The conclusion of this study nuances a sense of socially constructed inner self-conflict of the local Bamasaaba people. These people genuinely feel a need to maintain their long-shared tradition and cultural practices of *Imbalu*. At the same time, the same people want to adopt contemporary health practices to combat HIV/AIDS in their society (Sarvestani et al., 2018). In addition, global aid on health issues in developing countries is sometimes received on conditions that suggest and enforce the health practices aimed at degrading the cultural practices in Africa. This study aimed at investigating the local Bamasaaba people's response to the implementation of the reformed health policies on male circumcision in the Bugisu sub-region in Uganda.

The following objectives were investigated to determine the holistic understanding of the problem under investigation. Firstly, the study explored the implications of implementing the reformed health policies on male circumcision, such as the Safe Male Circumcision Policy and the Voluntary Medical Male Circumcision Policy (SMCP & VMMP) on the traditional practices of the local Bamasaaba people. Lastly, investigate the extent to which the local Bamasaaba people have adapted their traditional practices to adopt the reformed health policies on male circumcision in the Bugisu sub-region in Uganda.

According to the aims and objectives, the significant findings obtained from the data analysis are summarised in the paper. This paper also evaluates the methodological framework or approach used to assess the strength and limitations of the study. Using the qualitative research approach, the detailed presentation of the implications and recommendations for subsequent research on implementing the reformed health policies on male circumcision will be suggested. Other significant issues raised in the study was presented.

Furthermore, the study provided or conceptualised the HIV/AIDS pandemic and highlighted a brief overview of the innovations implemented by the Ministry of Health in Uganda. This paper also provided innovations highlighted regarding the development, implementation, and response to the reformed health policies on male circumcisions, such as the SMCP and the VMMP. In addition, both local and international literature related to the study was reviewed. The argument of this study was aligned with the central research question and specific objectives to holistically understand the strategies used to develop systematic methodologies. The investigator did this by analysing the Bamasaaba people's response to implementing the reformed health policies on male circumcision within an appropriate theoretical framework.

Two social theories were considered appropriate to explain the social aspects of male circumcision and HIV/AIDS prevention in the Bugisu sub-region. The first theory is Bourdieu's theory of practice, presented through the lens of *Habitus*, *Field* and *Social Capital* which focused on the structuring features of societal life. In this study, I used the concept of *Habitus* to explain how the Bamasaaba men use traditional male circumcision to shape their social world.

According to Bourdieu, *Habitus* means the mental structure used by the people to deal with the social world. *Habitus* results from the internalisation of the structures of the social world, which he believes do not determine the action of the actors (Bourdieu, 2018). Räsänen and Kauppinen (2020) also explained that *Habitus* is a scientific concept based on fundamental perceptions of how social life is organised and how people act. The *Habitus* guarantees the collective confidence in the tenets of the social diversion, which the actors demonstrate through their position on the *Field* (Walther, 2014, p. 15).

This was defined by how the local people are significantly influenced by socioeconomic status, family, religion, education, and ethnicity. For example, the attitudes, mannerisms, ideologies, actions, and habits of the local Bamasaaba people are significant life traits manifested in who the local Bamasaaba people are today. Secondly, masculinity theory is discussed, referencing Connell (2003) and Petersen (2003). These scholars believed in a particular normative form of masculinity that defines the most honourable way of being a man in society. This requires all other men to position themselves according to the referred hegemonic masculinity.

## 2. Methodology

The qualitative research methodological approach was applied in this study. The study adopted the qualitative research methodological approach. Christensen et al. (2011) defined this approach as exploring issues that aim to understand specific explanations, thoughts, and motives for generated research themes. I found the approach essential to consider using this approach because qualitative investigating methods are more appropriate for exploratory studies than the current one (Creswell & Creswell, 2017). In some sensitive studies that do not commonly use contemporary theories for explanations, the qualitative research methodology could provide a deeper understanding of the problem. For example, cultural or traditional practices of male circumcision and HIV/AIDS prevention are very complex and seem to lack proper theoretical explanations.

The study population was drawn from the local Bamasaaba people, who are ordinarily known as “the Bagisu people”, comprised of four clans set up by the four children of Mwambu as claimed by Wanyenya (2013). These clans are located in Bududa, Bulambuli, Manafwa, Mbale, Namisindwa and Sironko in Uganda. In contrast, other Bamasaaba from these clans migrated to Western Kenya and resided in Bungoma, Kakamega, Lugari, Trans Nzoia and Uasin Gishu districts (Nalinya, 2014). Due to the study population's scope and familiarity, the researcher selected only three districts in Uganda (i.e., Bududa, Manafwa and Mbale districts). Mbogga (2012) estimated the population distribution of these three districts as 960,000 people.

The study population sample was obtained from the cultural leaders, clan leaders, clinical officers, 2016 initiates, traditional surgeons, and critical informants from Bududa, Manafwa, and Mbale district. A total of 41 participants were purposively recruited for individual in-depth interviews, and 29 (twenty-nine) participants who formed 7 (Seven) Focus Group Discussions were also selected using the snowball sampling technique. Out of the 41 participants, 1(one) participant was selected as the Key Informant. The Key Informant and the seven FGDs were recruited to obtain additional data in a subsequent visit to the research field. The detailed population sample is presented in the [Table 1](#) below.

Qualitative data were obtained from 41 participants and 7 (Seven) FGD, as indicated in the table above.

**Table 1. The total sample size for individual interview and FGs**

	Cultural Leaders	Traditional Surgeons	Religious Surgeons	Clinical Officers	Clan Leaders	2016 Initiates	Key Informants
District				Hospital			
	6			2			1
Bududa	-	3	1	-	5	1	-
Manafwa	-	3	1	-	5	1	-
Mbale	-	4	1	-	6	1	-
<b>Total</b>	<b>6</b>	<b>10</b>	<b>3</b>	<b>2</b>	<b>16</b>	<b>3</b>	<b>1</b>
<b>Grand Total</b>					<b>41 Participants for Individual Interview</b>		
Focus Group Discussions							
FGD No.	Category	Description	District	No. of participants in a group			
1	Religious surgeons	F GD	Bududa	3 participants			
2	Clan leaders	F G D	Bududa	4 participants			
3	Clan leaders	F G D	Bududa	3 participants			
4	Traditional surgeons	F GD	Manafwa	4 participants			
5	Clan leaders	F G D	Mbale	6 participants			
6	2016 initiates	F G D	Mbale	6 participants			
7	Traditional surgeons	F G D	Mbale	3 participants			

Lastly, the findings were discussed by contextualising the conditions that may locate the performance of masculinity (masculinity as performance or social process) as a fundamental social problem with regards to HIV/AIDS prevention in the Bugisu sub-region in Uganda. The qualitative findings demonstrate that this basic social process was identified as a tool for negotiating the conflict between traditional and medical practices.

The next section presents and analyses the data obtained from selected participants from the Bududa, Manafwa and Mbale Districts with regard to their views on safe medical male circumcision (SMMC). Traditional surgeons, cultural and clan leaders, medical officers and 2016 initiates formed the cohort of participants who answered unstructured questions in individual interviews and focus group discussions. I present and analyse data simultaneously in this paper. The qualitative interview transcripts were analysed using a computer application known as Atlas Ti. This was used to classify and organise data according to emergent categories for presentation.

### 2.1. Results

The conflict between medical and traditional practices seems to be instigated by the crisis resulting from modern medical practices. The presentation of results and later discussions followed the research objectives, located within social theories such as Bourdieu's theory of practice and the gender theory of masculinity. The researcher asked the cultural and clan leaders about the changes that TMC had undergone in recent years, especially because of the SMMCP. Responses indicate uncertainties. Some were of the view that TMC is currently losing its value, as expressed in this comment:

*If you do enough research, you will see that our TMC is losing value because of the implementation of the so-called modern health practices. You find that no matter what we do, our traditional circumcision is waning. We are not following our umukuuka who has been responding to bukhuuka-ship for a long time. For us, the Bamasaaba, we never had a specific umukuuka who was politically motivated, but every clan had its clan leader. Moreover, these clans were headed by umuyinga, who respected each other.(Cultural Leader No. 3.)*

The participants revealed that educated people no longer perform all the rituals involved in *imbalu*, claiming it is a waste of time and resources. In many cases, the traditional counselling of initiates—one of the most significant aspects of the cultural practices of the Bamasaaba—is now excluded. The participants informed the researcher that the counselling of initiates is no longer critical to some of the Bamasaaba. Yet traditionally this forms an essential and integral part of the rituals practised during *imbalu*. A cultural leader commented that the importance of the counselling sessions given to the boys during the initiation process is what builds their character. He said:

*The counselling sessions during the TMC process is to build the character of boys. This time is when useful and valuable information is given to the boys since they are about the values of life. We use these processes to instil important family values before marriage and friendship into boys who are going to be circumcised. This helps them in their lives. Some values instilled in the boys include do not steal and work hard. They also bring a hoe, give it to the boy and encourage him to dig and make money. The traditional surgeon provides a panga with to him for harvesting food for his family, and then the boys receive an axe for cutting firewood used for cooking. The surgeon then gives water for cleansing and shows the new man that he needs to bathe and be clean, and for his animals. They also provide a new straw to qualify the new man to partake in the local brew with the elders. The new man will receive the knife, inyembe, as a symbol, meaning that he has become a man through the knife and his male children should also be circumcised to be men. Nowadays a pen and book are then brought to encourage the new man to be educated, which is the key to making money in today's world, among others, which profits them in their future.*

(Cultural Leader No. 2.)

Considering both the limitations of implementing SMMCP in areas traditionally practicing circumcision and the promise of TMC for reducing infection transmission, the objective of this study is to

characterize TMC practices in Uganda. This includes the cultural implications by using a comprehensive information obtained from individual interviews and focus group discussion (FGD)-based qualitative analysis. The implementation of this health policy has had a significant effect on the cultural practices of *imbalu*. One of the cultural leaders stated:

*It must continue. We pray for the educated Bamasaaba like you to write our history for the future generation. The foundation we are trying to create should be able to help a child of the next generation in about 50 or more years. The implementation of these new health policies can remove or replace our culture and traditional norms. We want our cultural practices to be there forever. I have observed that the Western culture brought about by the health policy has diluted our culture of imbalu. Oh yes, the imbalu of today is not the imbalu of the past, because of this so-called modernity. We are adding the health policies which will affect our practice if we do not record it down for the future generation.*

(Cultural Leader No. 6.)

Other cultural leaders said that history should not repeat itself in the leadership of the Bamasaaba. The participant here means that there have been numerous attempts to abolish TMC in Uganda, particularly by the Catholic and Anglican missionaries (Omukunyi, 2021). The participants felt that because of what is happening today politically, the culture and uprightness of the people were deteriorating. One said:

*Long ago we had the omuyiga (traditional leader of the Bamasaaba), and the government removed that kind of leadership and replaced them with cultural leadership, now our Umukuuka. We want our cultural leadership to remain, and that is why our Bamasaaba anthem says forever and ever so that the next generation will know that grandfathers and great-grandfathers also got circumcised traditionally. It is the only icon that we cherish as the Bamasaaba, and we cannot afford to lose our tradition. The government health policies should not cause the removal of imbalu, in my opinion. The health policies are good, but they have the potential of replacing imbalu with hospital male circumcision.*

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(Cultural Leader No. 3.)

The participants also stated that in the past, everyone who belonged to the Islamic religion used to practise TMC. The claim by the participants confirmed Topal (2020) assertion that historically TMC is linked to religious practices in Africa including other societies such as the Ottoman Empire. A participant said:

*In the Old Testament, the Bible says you are not permitted in paradise if not physically circumcised, but this changed in the New Testament. Men need to have male circumcision for religious reasons and will never have a motivation to change.(P8, Focus Group No. 7)*

The participants believed that *imbalu* (TMC) involves spiritual entities which guide the initiates to be brave during the process of removing the foreskin. One of the cultural leaders stated:

*Yes, yes, that spiritual power is there and if you are a mumasaba, eeeeh ... when they produce you, they tell you over and over that we, the Bamasaaba, circumcise. So, any child who is a gishu grows up knowing you have to be circumcised. Aah, for example, why I say it is spiritually motivated, you might see children moving, too. The boy will cry for circumcision after seeing friends; he cries tears because he also wants, so that spirit of motivation is there, and it is always there for us as the Bamasaaba.*

(Cultural Leader No. 2.)

Among the Bamasaaba, “manhood” means that parents agree to circumcise their male children traditionally so that they can experience pain, as tradition demands. The cultural leaders acknowledged that facing one’s inherent dread of pain is a significant aspect of the cultural process of *imbalu* and is what makes boys men. This cultural leader said:

*Men will maintain a strategic distance from medical male circumcision because it reduces pain, which is the vital aspect of being a man. In light of the pain ... I am terrified of the pain, though I had traditional male circumcision. Until today, I do not know how it happened, and maybe that is why it is believed that male circumcision is spiritually motivated.*

(Cultural Leader No. 6.)

According to Makwa (2021), p. 90% of Bamasaaba men had been traditionally circumcised in the Bugisu sub-region. In the majority of Bamasaaba families, all-male members have received TMC. The participants stated that they are proud of their culture of initiating boys from childhood to manhood. One said:

*Except for a few cowardly men, a significant number of the Bamasaaba men receive TMC, and that is how tradition should be. We are proud to see every boy in Bugisu being culturally circumcised, initiating him from childhood to manhood. That is why we do not even accept uncircumcised people in our society. If you are circumcised, it means that you have taken responsibility, and if one agrees to circumcise, it makes him a grown-up man. Therefore, you have to do things with consideration to show that you are a mature person. That is one of the advantages of circumcising; you are recognised for doing something, but not as a boy.*

(Cultural Leader No. 1.)

Nonetheless, one of the surgeons indicated a fairly reconciliatory attitude to MMC, stating that if it were adequately promoted, with acknowledgement and respect for TMC, it might have a place among the Bamasaaba. He clearly indicated that TMC is not practised in order to reduce sexually transmitted diseases, as SMMC is instead, it is practised for cultural and spiritual reasons:

*We can accept these health policies if the government can tell us another reason for it because they may help us. I don’t want to break our cultural norms. If you fail it, then you face disciplinary action; we know that the importance of imbalu is to help a boy go from boyhood to manhood, not to reduce the risk of getting HIV and syphilis. (Traditional Surgeon No. 12.)*

Some participants believed that the Bamasaaba made decisions about which type of male circumcision to opt for based on the views of the traditional practitioners such as themselves. Traditional surgeons help shape people’s cultural and personal identity, which makes the SMMCP a challenge to their authority, in their view.

In addition, the fact that the government trains female doctors to perform male circumcision in the medical setting makes the procedure doubly unacceptable. Almost all participants objected to females getting involved in male circumcision. A traditional surgeon asserted:

*When it comes to matters of imbalu, there are some rituals that a woman is not culturally allowed to participate in. For example, Bukhebi, umkhasi sakhushaba umsinde ta'awe – it is taboo in our culture for a woman to circumcise a man.*

(Traditional Surgeon No. 4.)

The traditional surgeons believed that to overcome these concerns; the government needed to understand the significant value placed on traditional practices by the Bamasaaba. They said that when the government developed and implemented health policies, they ought to engage in an in-depth consultation with local people so that their programmes could be aligned with people's understanding. The participants claimed that current health policies create an uncomfortable social environment with regard to traditional male circumcision in the Bugisu sub-region.

### 3. Discussion of findings

In Uganda, the World Health Organization and the Joint United Nations Programme on HIV/AIDS revealed that more than 75% of the population were uncircumcised (World Health Organization, 2011). This study found that the local Bamasaaba people believe that they have no problem implementing the reformed health policies such as the SMCP and VMMP as long as the tradition and cultural values are maintained in their region. Noting the conflict between the medical and traditional practices, most local Bamasaaba people suggest that the reformed health policies on male circumcision be implemented in other communities in Uganda. For example, most participants stated that utilising clinical male circumcision for other communities should be a component of cleanliness, but not as an HIV/AIDS prevention strategy in Uganda.

Many scholars have portrayed clinical male circumcision with high health benefits (Feldacker et al., 2020). This has resulted in developing countries sugar-coating clinical male circumcision as the effective, safe strategy for HIV/AIDS prevention in society. For instance, the participants believed that through sugar-coating the clinical male circumcision as the only safe HIV/AIDS prevention strategies, the government of Uganda is medicalising *Imbalu* (TMC) through the implementation of the SMCP and VMMP.

These health policies conflict with the meaning and values attached to traditional male circumcision as a cultural practice for initiating boys to manhood (Mavundla et al., 2020). The participants believed that the Bamasaaba construct some form of masculinities through the practice of *Imbalu* (traditional male circumcision). According to Connell and Messerschmidt (2005) "hegemonic masculinity" which, is the most "honoured" view of masculinity, that young boys aspire to. Men gain this honour through persuasion or force, and once society accepts them accordingly, such men become role models of what constitutes "being a man" in society. Mfecane (2018) explains that notions of masculinity are central to traditional circumcision rituals, as may be heard in the cry, "I am a man!" following the fulfilment of the rituals associated with *Imbalu*.

As a result, implementing the reformed health policies on male circumcision is a strategy for HIV/AIDS prevention, but not a cultural practice in Uganda. In that case, health personnel need to consider changing their approach to conveying this message to the general population. As a result, the participants of this study indicated that Bamasaaba would go for clinical male circumcision only if they were guaranteed 100% complete HIV/AIDS prevention strategy. This is because the procedures promoted by these health policies are not practised and supported by the local Bamasaaba people.

In addition, Baczko and Dorronsoro (2021) argued that habitus is a structuring feature of life and is determined by a series of influences on the people, such as socio-economic status, family, religion, education, and ethnicity. The study found that beliefs, especially that of the local Bamasaaba people, need to be considered if the government remains committed to implementing the Safe Male Circumcision Policy for HIV/AIDS prevention strategy in the Bugisu sub-region. This is because these policies came at a time when the Bamasaaba have constructed a certain Habitus that influence their social life. For example, the attitudes, mannerisms, ideologies, actions and habits of the Bamasaaba men have been subjected to their cultural practice which, manifests through *Imbalu* rituals to determine who Bamasaaba people are.

In other words, habitus is one's physical and sociological characteristics displayed as a result of habits developed over a period of time (Wacquant, 2004). The practice of *Imbalu* rituals develop a people's attitudes towards society and influences how local people react to the world. The health policies on male circumcision are regarded as a challenge to the local Bamasaaba people's belief system, which significantly influences the implementation and response to the health policies. The SMCP and VMMCP appear to challenge the community's respect for the cultural practice of male circumcision and condition Bamasaaba to change how they socialise with their world.

Furthermore, despite the critical social issue regarding HIV/AIDS prevention, policy developers and implementers have unreasonably undermined the previous health strategies such as the A-B-C (Abstinence, Be faithful and Condom use) methods for HIV/AIDS prevention the Bugisu sub-region in Uganda. During the Safe Male Circumcision Policy implementation, the government mainly focuses on clinical male circumcision for HIV/AIDS prevention, paying less attention to other HIV preventive strategies. It is quite unreasonable to promise 60% HIV/AIDS prevention using clinical male circumcision, encouraging men to have unprotected sex.

The participants believed that the implementation of the SMCP and VMMCP in the Bugisu sub-region seems to be an organised strategy of modernising the traditional practices of *Imbalu*. In line with the findings of the study by Bonner (2001), the current study results indicated that the local Bamasaaba people believe that male circumcision does not potentially prevent health-related social problems such as HIV/AIDS infections.

The response was validated by most of the participants who reflected on the relevance of the existing HIV/AIDS prevention strategies such as the A-B-C (Abstinence, Be faithful and Condom use) method. This reflection influenced the local Bamasaaba people to dismiss all forms of male circumcision as HIV/AIDS prevention strategies. Other highly educated experts such as the clinical officers acknowledged that all forms of male circumcision should not be used to substitute existing health interventions (e.g., the A-B-C method) for HIV/AIDS prevention in Uganda. Kigozi (2008) indicated that Uganda fell among the African countries with the lowest acceptance of clinical male circumcision for HIV/AIDS prevention with less than 1% of their target coverage, especially in the Bugisu sub-region.

On a serious note, Chodorow (2002) notes that the word "man" has both positive and negative cultural implications, with "masculine" behaviour, social practices and values openly critiqued in feminist theory. Waldeck (2003) also claimed that traditional male circumcision becomes a significant resource that determines gender roles ascribed to men, defining certain habits of social life. The issues such as proposing the abandonment of traditional practices for clinical male circumcision and the training of female doctors to do the surgical procedure of male circumcision as suggested by the health policies on male circumcision also emerged as a serious issue.

In this case, the study reveals that it is a taboo in the Bugisu cultural practice for a woman to perform circumcision on a man. For this reason, the participants asserted that both Bamasaaba men and women are proud of their culture of *imbalu* and would subscribe to rigid standards to preserve it. Many participants believed that clinical male circumcision is not a requirement for men

in the Bugisu sub-region. It appears like the participants viewed this new HIV/AIDS prevention strategy as not an essential concern to them.

However, due to factors such as the political, religious, and economic pressure exerted on the local Bamasaba people by the government and other policy implementers, the local Bamasaba people have not fully maintained the cultural values regarding *Imbalu*. The local people are gradually and unconsciously adopting the implementation of the reformed health policies on male circumcision in the Bugisu sub-region under the pretext of modernising traditional practices of *Imbalu*. Politically, most of the participants indicated their disappointment that the foreign surgeons, some political leaders, and the local people from non-traditionally circumcising communities have portrayed the traditional and cultural practices of *Imbalu* as primitive and barbaric.

Some participants frequently predicted a medicalised shift in traditional practices, especially among the local Bamasaba people, where cultural institutions are politically manipulated. However, the results indicated that some participants were apprehensive that the medicalisation of *Imbalu* might result in the Bamasaba men's bodies being utilised as an influence for social and political control in the Bugisu sub-region in Uganda.

In addition, other participants believed that implementing these reformed health policies as a strategy for HIV/AIDS prevention in this region seems to be camouflaging efforts to control the local Bamasaba people politically. This has caused the local Bamasaba people to mistrust the government's efforts to implement the reformed health policies on male circumcision in the Bugisu sub-region. For example, on the 15. May 2017, Uganda's Daily Monitor News Paper reported that the Minister of Culture and Social Development suggested that *Imbalu* of the local Bamasaba people be Banned. She stated:

*"The people of Mbale must stop or reduce dehumanising the habits of the circumcision which are invoking sexuality. The 'Imbalu' culture is a backward one. Men need to circumcise, but we would wish to encourage people to do it in a manner that gives dignity to those young men"* (Angurini, 2017, N/P).

The minister's statement evoked a public debate and division among the Bamasaba people, leading to emerging group of Bamasaba called *Babukusu*. The participants believed that this is an act of political stratagem to divide and rule. As such, participants stated that there is a perception in the Bugisu sub-region that the political leaders who come from non-traditionally circumcising communities are misrepresenting the traditional practices of the local Bamasaba people. Therefore, according to the Bamasaba people, reformed health policies such as the SMCP and the VMMCP are being implemented as a government's political agenda to control them.

Religiously, the study also found that some participants, especially the born-again Christians who felt that the practice of some *Imbalu* rituals is not in line with their Christian beliefs, showed reluctance to attach themselves to the traditional values and traditions of *Imbalu*. These participants stated that every born-again Christian believes that *Imbalu* rituals involve evoking ancestors and evil spirits since it is spiritually motivated. These Christians justify that anything that involved the evocation of spirits becomes evil in the charismatic Christian belief. Yet, these Christians who participated in this study fully understood the practical values and meaning attached to the traditional rituals of *Imbalu* in the Bugisu sub-region. For example, these participants were able to identify the majority of rituals performed during *Imbalu*, such as slaughtering cows, goats and chicken, preparing millet and making local alcohol, and its values to the Bugisu communities.

In the light of the above, these born-again Christians have adapted *Imbalu* practices in line with their beliefs. These Christians are most likely to follow most of these rituals except the traditional and cultural rituals attached to *Imbalu*. In other words, even though these born-again Christians in the Bugisu sub-region practice *Imbalu*, they leave out rituals such as slaughtering cows, goats, and

chicken. Other traditions omitted are preparing millet, making local alcohol, and dancing *Kadodi*, which are believed to be associated with evil practices. The results show that the local Bamasaba people, including born-again Christians and clinical officers, feel that traditional male circumcision is still relevant since specific cultural values and cultural identity are attached to the process.

The study also indicated that most participants expressed that traditional male circumcision has become very expensive. The local Bamasaba people can no longer afford to perform all the rituals about *Imbalu* in the Bugisu sub-region. Items such as the hiring of drummers for *Kadodi*, feeding the crowds, slaughtering the cows, goats and chicken have made the traditional practice increasingly costly. Hence, the findings indicate that some local Bamasaba people are simultaneously abandoning the rituals associated with *Imbalu*, done before a young man is circumcised. The practice of giving gifts to the initiates, preparing, and keeping millet for some years, roasting chicken, making the local brew called “*kamalwa* or *Busela*” are now being excluded because of added expenses. Moreover, this local brew is specifically drunk by the traditional surgeons, grandfathers, and fathers of the young men, which was a significant aspect of building family relationships. The cultural practices of *Imbalu* are now regarded as evil and primitive and is no longer done.

Given the dilemma in dealing with the crisis of medicalised male circumcision, the current study found that effective implementation of the reformed health policies on male circumcision in Uganda should begin by focusing on youngsters. The youth might be ready to accept medicalised male circumcision over traditional male circumcision. Some participants were adamant that this could be done by beginning with the children, disclosing to them, and instilling the faith of medicalised male circumcision into them. For example, one participant states that we should help the government utilise all the medicalised options to combat HIV/AIDS, starting with the youth in the Bugisu sub-region. Those circumcising their children traditionally ought to embrace and reinforce clinical male circumcision since clinical methods are more safe and secure.

On the other hand, the approach used while implementing the reformed health policies on male circumcision for HIV/AIDS prevention strategies has conditioned some local Bamasaba people to consider medical practices of male circumcision rather than their traditions and cultural practices. These participants believed that through the pretexts of medicalised practices, the government of Uganda is gradually medicalising *Imbalu* (TMC) in the Bugisu sub-region. This was witnessed through developing and imposing the SMCP & VMMCP that directly ignore the cultural and traditional practice of *Imbalu*. The study found that even the materials (e.g., posters used to promote or campaign for the reformed health policies) directly discredit the traditional practices in the region.

As a result, the study reveals that there is increased political force being used by the government of Uganda during the implementation of the reformed health policies on male circumcision, particularly on *Imbalu* of the local Bamasaba people. This is demonstrated in the government officials’ campaign and enforces clinical male circumcision among the local Bamasaba people. The political officials instead appear in the public domain in the campaign to stop the traditional practices of male circumcision. For example, this was clear when the participants quoted President Yoweri Kaguta Museveni’s speech in 2014, stating:

“... the Bamasaba people and Kusu tribes living in Uganda and Western Kenya must shun the primitive and barbaric practice of undergoing traditional male circumcision...” (Nalinya, 2014).

In addition, the participants also quoted the minister’s statement of May 2017, which encouraged the local Bamasaba people to stop the traditional practice of *Imbalu* and seek clinical male circumcision in the hospital. The minister stated

“... There are hospitals, clinics and dispensaries that carry out safe male circumcision hence preventing the spread of HIV/AIDS instead of ‘Imbalu’ where one knife is used to cut many boys during the ceremony ...” (Angurini, 2017, N/P).

The statements such as “shun the primitive and barbaric practice” and “must stop or reduce the dehumanising and backward habit” clearly show that the government officials are using the public domain to degrade *Imbalu* in favour of clinical male circumcision.

Furthermore, a significant number of participants maintained that conducting cultural or traditional rituals within a clinical setting will most likely intrude on the cultural value of the rite of passage. This causes conflict between the medical and traditional practices, particularly in the Bugisu sub-region. To avoid tensions, this study found that the local Bamasaba people are responding by adopting some health aspects suggested by the Safe Medical Male Circumcision Policy but with reservations. The health components incorporated into the tradition are cleanliness and one knife per initiate to avoid transmission of HIV/AIDS. In line with the claim made by Wanyenya (2013), this study found that the traditional surgeons in the Bugisu sub-region were now using multiple “*Tsinyembes*” (knives) with the slogan: “one knife one boy”.

However, the highly educated and religious local Bamasaba people are calling for modernity in the cultural practices of *Imbalu* in the Bugisu sub-region. The study found that due to the increasing HIV/AIDS pandemic, the local Bamasaba people have been forced to rethink every aspect of their cultural or traditional practices associated with *Imbalu* in their society. Behavioural change has been considered significant for humanity to avoid the increasing HIV/AIDS infections in this region. Therefore, those deemed necessary for cultural, traditional and religious practices are now used in health, avoidance of infection, education, and survival of the local people to bring about substantive behavioural change.

The local Bamasaba people believe that traditional male circumcision (*Imbalu*) is spiritually motivated with cultural values relevant to society. These people further believe that issues surrounding traditional male circumcision can cause civil unrest if not handled delicately by the policy implementers in the Bugisu sub-region in Uganda. Some participants believe that attaching medicalised practices to traditional male circumcision would mean that the traditional and cultural methods losing value. This finding implies that traditional male circumcision will be practised for HIV/AIDS prevention and not as a rite of passage from boyhood to manhood.

In the stages of urbanisation, traditional practices appear to weaken and clear a path for medicalised modernity. For instance, some of the participants believed that through the practice of medicalised modernity, the government of Uganda is medicalising *Imbalu* (TMC) through the implementation of the Safe Male Circumcision & Voluntary Medical Male Circumcision Policy. As such, these policies are in direct conflict with the meaning and values attached to traditional male circumcision as a cultural practice for initiating young men into manhood. The implementation of the health policy would also have severe implications for the survival and adaptation of other aspects of standard procedures in the Bugisu society.

On another note, Coughtry (2011) viewed the patriarchal society as the societal framework whereby men hold unequal power over women. The dominant part of the social system in Uganda is male-centric, with no known matriarchal social orders in place. In such societies, women are treated in a manner that enslaves and creates segregation in light of their gender. The study found that in a more male-centric cultural, social system such as the Bugisu, control is put in the hands of males in the family or clan, with more young men coming next in the chain of importance than women and children. This factor has severe implications for implementing the reformed health policies on male circumcisions, such as the SMC and VMMC policies, especially in the Bugisu sub-region in Uganda.

For example, the study found that the response to the implementation of the reformed health policies on male circumcision in the Bugisu sub-region may be problematic. Especially when it involves a female occupying the position of a doctor and performing male circumcision on adult males in the hospital setting. The study found that it is taboo for women to complete any male circumcision in the Bugisu sub-region. In this case, “task-shifting” may be required if the implementation of the Safe Male Circumcision (SMC) for HIV/AIDS prevention successfully in the Bugisu sub-region in Uganda.

Task-shifting means that certain medical tasks are assigned to specific specialists. In this case, the female doctors and clinical officers may be transferred to other surgical procedures. In contrast, clinical male circumcision is left specifically for male doctors and clinical officers. The study found no room for female clinical officers and female doctors to implement the reformed health policies on male circumcision in the Bugisu sub-region. This means that the extension of patriarchy into contemporary public health may influence the local Bamasaba people’s response to the Ugandan public health interventions to combat HIV/AIDS.

In response to the conflict between clinical and traditional practices, some participants suggested integrating traditional and clinical male circumcision. For example, some participants believed that integration seems to be a practical method for solving some of the tensions or conflicts between tradition and medicine. Having supported the clinical procedure of male circumcision, it was not surprising that the clinical officers suggested another form of male circumcision, the “Clinical-traditional male circumcision”, which becomes a new concept of male circumcision for the Bagisu people. However, this new concept could be problematic to combine the gendered nature of clinical male circumcision enforced by the public health service with the cultural practice of *Imbalu* in the Bugisu sub-region. This was a significant challenge in implementing the reformed health policies such as the Safe Male Circumcision and the Voluntary Medical Male Circumcision Policies (SMCP & VMMCP) among the local Bamasaba people.

Tumwebaze (2012) and Green (2012) reported that Uganda’s national campaign to reduce HIV/AIDS transmission through the Safe Male Circumcision Policy took an unexpected turn in the Bugisu sub-region in Uganda. The Bamasaba men misunderstood the policy and forcibly circumcised more than 20 men in a traditional way in Mbale town. This is a clear indication that the local Bamasaba people find it difficult to embrace both modern and traditional practices and fail to integrate both medical and traditional male circumcision. This has resulted in the crisis of health concerning the cultural traditions of *Imbalu*. For instance, some participants stated that failure to go through *Imbalu* rites would result in mockery by the “*Bamakoki*” (mates) traditionally circumcised and women. This means that a man may carry this stigma for the rest of his life.

Therefore, undergoing clinical male circumcision in the Bugisu sub-region remains a secret act by men who fear discrimination and alienation. Consequently, in finding a solution to the existing problem, male circumcision as HIV/AIDS prevention strategy in communities such as the Bugisu sub-region may create other social issues for the local Bamasaba people. This has resulted in the local Bamasaba people’s perception that males who undergo clinical male circumcision in the Bugisu sub-region remain boys.

The study also found another concern of medicalising male circumcision, especially *Imbalu* of the local Bamasaba people, which may somehow be a real danger regarding cultural practices in the Bugisu sub-region in Uganda. For this reason, some participants suggested that the various attempts to address HIV/AIDS prevention need to integrate the traditional and clinical practices of male circumcision as some mixed intervention for HIV/AIDS prevention approach. This is due to self-governance and traditional adherence. The local Bamasaba people’s beliefs regarding traditional male circumcision do not allow them to collaborate with the health organisations or structures in the Bugisu sub-region. For instance, the key informant stated that this might lead to resistance against government health policies among families and communities.

The local Bamasaba people have acknowledged the increased risk of sexual behaviour. Furthermore, these people have consistently rejected preventive methods such as medical male circumcision for HIV/AIDS prevention in the Bugisu sub-region. The results indicated that the local Bamasaba people preferred the existing safer sexual practices for HIV/AIDS prevention for their society. For example, the participants were worried that the people might disregard the existing A-B-C (Abstinence, be faithful and Condom use) as an effective strategy favouring clinical male circumcision that may influence men to have unprotected sex. Similar to Fish et al. (2021), the current study found general refusal or resistance to implementing the SMCP and the VMMCP by the local Bamasaba people. For this reason, the local Bamasaba people believe that this may finally counterbalance the possible longstanding advantages of the A-B-C method to combat HIV/AIDS infection in the Bugisu sub-region.

Some participants believed that the reformed health policies on male circumcision had not been developed in good faith as an additional HIV/AIDS prevention strategy for the local Bamasaba people. Others felt that should the future president be elected from a community that practices traditional male circumcision as a cultural or religious practice, he or she may probably endorse traditional male circumcision for HIV/AIDS prevention. Even though the current study focused on the response of the Bamasaba people to the reformed health policies on male circumcision in the Bugisu sub-region in Uganda, patriarchy emerged as one of the critical social issues in this study.

The study revealed that adhering to the traditional practice of penile alteration illuminates' manhood and patriarchy, which are still major social issues in many communities in Uganda. This was particularly when most participants did not consider it significant that the consulting surgeons could be female clinical officers or female doctors. The ritual of *Imbalu* remains a longstanding tradition related to the patriarchal practices of the local Bamasaba people in the Bugisu sub-region. The local Bamasaba men critically question the position occupied by women in the medical field regarding the implementation of the Safe Male Circumcision Policy for HIV/AIDS prevention in the Bugisu sub-region. It was not surprising that the local Bamasaba people choose not to respond positively to the implementation of the reformed health policies on male circumcision due to the involvement of female doctors and clinical officers.

Lastly, the study also found that male circumcision as a biomedical intervention may only be accepted by the younger generation, who may manage the crisis caused by medicalised modernity in the Bugisu sub-region in Uganda. Some participants further stated that most health education programmes target young men and women, especially in developing countries. The older generation may be reluctant to adapt their traditional and cultural practices of *Imbalu* to have both (Clinical-traditional male circumcision) occurring simultaneously.

This implies that in the Bugisu sub-region, the older male population is simultaneously removed from potential participants to implement the reformed health policies on male circumcision. The key informant stated that the explanation behind the support for *Imbalu* (traditional male circumcision) over clinical male circumcision in the Bugisu sub-region is the preservation of the cultural and time-honoured practices of the local Bamasaba people. He explained that men would eagerly embrace cultural or traditional practices instead of accepting clinical methods of circumcision concerning the man's body and HIV/AIDS prevention.

#### **4. The implications of the study**

In the period leading up to the proposal of the current study, there was a lack of literature on the local Bamasaba people's response to the implementation of the reformed health policies on male circumcision. This study could play an essential role in opening up the debate on implementing the Safe Male Circumcision Policy (SMCP) and the Voluntary Medical Male Circumcision Policy (VMMCP). These two policies could comprise the complete HIV/AIDS prevention strategy by the Ministry of Health in Uganda. Numerous studies on the acceptability of clinical male circumcision as an

intervention for HIV/AIDS prevention in Uganda have been confined to the areas of economy, livelihood, and public health.

Other anthropological studies emphasised the cultural and biomedical implications of the Ugandan public health programmes. The sociology of health in Uganda has not made any effort in contributing to the philosophical discipline of understanding the sociological implications of the reformed health policies such as the SMCP and VMMCP in Uganda. These sociological implications are significant concerning Ugandan stakeholders' involvement in implementing clinical male circumcision as a biomedical intervention for HIV/AIDS from the Bugisu perspective. The current study demonstrates the importance of intensifying the local Bamasaba and other people's understanding of the complications associated with implementing the reformed health policies on male circumcision.

These complications are concerning male circumcision for HIV/AIDS prevention in Uganda, particularly in the Bugisu sub-region, where male circumcision is a cultural or traditional practice rather than a medical procedure. It is possible to rethink implementing the reformed health policy such as the SMCP for HIV/AIDS prevention strategy for the local Bamasaba people in Uganda. These health policies are deeply embedded in the language of contemporary public health programmes. The government do not consider the ideological framework of the cultural and traditional practices of the local people. For instance, the government of Uganda and other health organisations in Uganda are the sole developers and implementers of the reformed health policies on male circumcision.

However, the government's perceptions of traditional male circumcision and the health organisations in Uganda have critically influenced the Bugisu people's response to implementing the reformed health policies on male circumcision for HIV/AIDS prevention in the Bugisu sub-region in Uganda. Trust in the government and other public health implementers is not a usual variable for studies on standard public health feasibility studies. In the future, developing and implementing health policies, especially on male circumcision such as the HIV/AIDS prevention strategy, may need the government of Uganda and other health stakeholders to consult with the local people. In addition, the government should think of how other government ministries could play an active role in sensitising or educating the local people, such as the local Bamasaba, on the significance of using male circumcision as an intervention for HIV/AIDS prevention.

The sensitisation should be on implementing the SMCP as a quality HIV/AIDS prevention strategy in Uganda. The role of female doctors and clinical officers in implementing the reformed health policies in the Bugisu sub-region requires serious consideration as one of the significant concerns outlined by the study. This study found that the effective implementation of the reformed health policies should not involve female doctors and clinical officers who perform male circumcision in the medical setting, particularly in the Bugisu sub-region. However, this is open to further debate and criticism since Uganda is committed to human rights and gender equality to avoid gender discrimination in their society.

The theoretical value of the current study can be understood by looking at the factors influencing the local Bamasaba people to respond to the implementation of the reformed health policies on male circumcision in the Bugisu sub-region. This study sought to understand the local Bamasaba people using the clinical procedure as a biomedical intervention or strategy for HIV/AIDS prevention in their region. The idea of using the male body as an HIV/AIDS prevention strategy conflicts with the traditional and cultural connotations attached to male circumcision by the local Bamasaba people. The study demonstrates that, though traditional male circumcision remains significantly valued by the local Bamasaba people, the current sociological health theories appear to lack the ability to explain how male circumcision an intervention for HIV/AIDS prevention.

Furthermore, the current study discovered that people's decisions concerning social behaviour might be explained by social meanings that are not grounded in the research. The study becomes complex when such social behaviours are short-lived, and people who do not circumcise end up with an everlasting body modification that may have a broader sociological implication. The findings indicated that the local Bamasaba people might only respond to the reformed health policies on male circumcision when viewing it as a valued practice. This may partially help the local Bamasaba people overcome the conflict between the medical and traditional practices of male circumcision. This includes the position of the local Bamasaba people, and the specific objectives set for the reformed health policies that suggest the clinical removal of the foreskin for HIV/AIDS prevention. As a result, a significant number of research institutions have started publishing literature about the importance of male circumcision as an intervention for HIV/AIDS prevention rather than as a cultural practice.

In addition, the study also considered the individual Bamasaba people's response to social and health problems associated with HIV/AIDS infections in communities such as the Bugisu in Uganda. The current study seems to be the most recent, if not the only one, to use the contemporary rationale that explains the implementation of the reformed health policies on male circumcision, especially in the Bugisu context in Uganda. Therefore, this study contributes to existing social knowledge by identifying social behaviour's primary significant sociological scope. These behaviours are summarised as the response by the Ugandan government to combat the HIV/AIDS pandemic through the implementation of the reformed health policies on male circumcision, especially in the Bugisu sub-region. The study also contributes to the existing literature by indicating and acknowledging the responsibility for implementing the reformed health policies on male circumcision in Uganda. The response, especially from the local Bamasaba people, is critical in developing an effective health policy on male circumcision for HIV/AIDS prevention.

### **5. Recommendations**

The fundamental recommendation of the current study is that health programmes, especially for HIV/AIDS prevention, should seriously consider how the practitioners, beneficiaries, targets and policy developers understand or perceive the anticipated prevention strategies. As a result, programmes of this kind will consider the sociological complications essential during the development and implementation of health policies that target only the body as a plausible site for HIV/AIDS prevention in society. For this study, the consideration of the local Bamasaba people's response to implementing the reformed health policies on male circumcision indicated tension between traditional and clinical male circumcision. This tension was reinforced by several performances of masculinity in the Bugisu sub-region by the local Bamasaba men. Therefore, to consider this conflict, the Ministry of Health in Uganda should increase the value and significance of gendered bodies when implementing clinical male circumcision as a biomedical intervention for HIV/AIDS prevention for the local Bamasaba people Bugisu sub-region in Uganda.

### **6. Limitations of the study**

Considering the dilemma faced by implementing the reformed health policies in the Bugisu sub-region in Uganda, it is evident that this is an increasing area of scientific exploration in social science disciplines such as sociology and cultural anthropology. For that reason, there is a shortage of robust sociological studies explaining the relationship between traditional and clinical male circumcision in relation to the prevention of social illness such as the HIV/AIDS pandemic. The limitation mentioned above is related to other existing unclear explanations given by disciplines like the public health or medical sector that seem to conflict with the social understanding of how the local people, such as the Bamasaba, arbitrate social actions in their communities.

Secondly, neither medically circumcised nor uncircumcised men in the community were interviewed; therefore, the study reflects only the traditionally circumcised Bamasaba men's perceptions of the Bududa, Manafwa and Mbale Districts. The inclusion of men who had been medically circumcised may have provided a more comprehensive picture regarding the Bamasaba men's responses

to SMMC. However, the study was able to describe the philosophy of a large proportion of the men in the Bugisu community—those who had undergone *Imbalu*. The views of the Bamasaba men who have experienced the SMMCP circumcisions remains a topic for future researchers.

## 7. Conclusion

In the 1980s and early 1990s, Uganda was the first country in Africa to open an HIV/AIDS testing centre, called the AIDS Information Centre (AIC; Uganda. Ministry of Health, ORC Macro. MEASURE/DHS+ (Programme), Centers for Disease Control & Prevention (US), 2006). The centre suggested counteractive action that preoccupied the public health sector in the country. Uganda has tried to control the spread of HIV/AIDS by employing substantial coordinated interventions. The lower HIV/AIDS infection rates verify this intervention is working. Therefore, interventions have included implementing the health policies on male circumcisions, such as the SMCP and VMMCP for HIV/AIDS prevention, influenced by the recommendations of the WHO and UNAIDS. The concluding investigation by these institutions demonstrated that this body-oriented intervention to HIV/AIDS prevention is bound to the social and mental health systems that connect implications to the bodies.

The current investigation clarified how such implications are associated with the various responses from the local Bamasaba people in the Bugisu sub-region in Uganda. This includes their perceptions regarding traditional or cultural and other religious and social connotations attached to clinical male circumcision for HIV/AIDS prevention strategies. As a result, the study offered an understanding of HIV/AIDS prevention as it conflicts with the local Bamasaba people's response regarding overseeing human sexual and gender well-being in their region. For the local Bamasaba people, who resist the implementation of the reformed health policies on male circumcision, the medicalisation of traditional rites means the eradication of the traditional practices of *Imbalu* in the Bugisu sub-region in Uganda.

This may be the principal objective of the government of Uganda in developing and implementing health policies such as the Safe Male Circumcision policy, particularly in the Bugisu sub-region. It is apparent from the data analysed that even the cultural leaders and clan leaders selected to play the role of protecting the traditions and customs of the local Bamasaba people are becoming increasingly politically motivated. The Ugandan statehouse pays them to use their traditional influence to reinforce the implementation of the government policies. Yet the beliefs, especially that of the local Bamasaba people, need to be considered if the government remains committed to implementing the Safe Male Circumcision Policy for HIV/AIDS prevention strategy in the Bugisu sub-region (Joint United Nations Programme on HIV/AIDS (UNAIDS), 2013).

Currently, the Bamasaba people who were once united are now divided into two groups due to implementing the reformed health policies on male circumcision in the Bugisu sub-region in Uganda. For example, one group of Bamasaba who call themselves "*Babukusu*" under the leadership of "*Umukhongo of Babukusu*" supports the implementation of the reformed health policies on male circumcision. While the remaining majority group consisting of the indigenous Bamasaba people under the leadership of "*Umukhuka Inzu Ya Masaaba*", do not support the implementation of the clinical male circumcision for HIV/AIDS prevention. These local people have demonstrated their unhappiness through the resistance to the implementation of clinical male circumcision in the Bugisu sub-region.

Yet, some participants responded to the question regarding the reformed health policies, such as the SMCP and the VMMCP, believed that this is a radical effort to reduce HIV/AIDS in Uganda. In this case, the researcher was particularly interested in knowing the rights of the local Bamasaba people related to their traditional practices and the reformed health policies. Almost all participants were clear that the policy implementers have been legitimated to impose clinical male circumcision on them. The response of the majority of the participants seems to indicate that the

government could not assess the reformed health policies on the local people, particularly the local Bamasaba people of the Bugisu sub-region in Uganda.

Finally, it was instructive to investigate to what extent the Bamasaba people have adopted the reformed health policies while simultaneously maintaining their traditional practices of *Imbalu*. However, the participants dismissed all forms of male circumcision for the HIV/AIDS prevention strategy. The Bamasaba would prefer maintaining their traditional practices of *Imbalu* rather than male circumcision as a biomedical intervention for HIV/AIDS prevention. The participants believed that the existing HIV/AIDS prevention methods, such as the A-B-C (Abstinence, be faithful & Condom use) method is still more effective and did not require male circumcision as an additional new preventive method. In addition, the Bamasaba believed that implementing the reformed health policies such as the Safe Male Circumcision Policy in the Bugisu sub-region will encourage the local Bamasaba men to engage in risky sexual behaviours such as having unprotected sex. For this reason, the local Bamasaba people will be more vulnerable to HIV/AIDS infections in the Bugisu sub-region in Uganda.

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