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POLICY DEVELOPMENT: ZIMBABWE TEACHERS' PERCEPTIONS REGARDING THE MALE CIRCUMCISION POLICY

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ABSTRACT

This paper focuses on Zimbabwean teachers' perceptions of the development and implementation of the male circumcision policy of 2009. Male teachers constitute a significant part of the teaching force in Zimbabwe, and their perceptions in relation to the circumcision policy is important as they are a key component of any policy initiative in schools. Teachers are also among many mediators of culture. Given the fact that circumcision in Africa is deeply imbedded in culture, they should be allocated a role in the whole process of policy development. Drawing extensively on the qualitative methodology through purposive sampling, 10 teachers were recruited to participate in the study. Data was collected through face-to-face interviews and qualitatively analysed through the content analysis method, which resulted in the development of themes. A key finding is that the context within which policy is implemented is critically important. From the data gathered, this was not factored in the male circumcision policy.

Key words: **Policy, culture, teachers, male-circumcision policy, implementation**

1 INTRODUCTION

This paper focuses on the Zimbabwe male circumcision policy of 2009, which was introduced as one of the strategies to curb the increasing HIV-AIDS infection rate at the time (Ashengo, Hatzold, Mahler, Rock, Kanagat, Magalona & Dhlamini, 2014). The paper argues that while some key factors that facilitate successful policy implementation were considered in relation to the male circumcision policy, not much attention was given to the role of culture and teachers in the whole policy process. Based on the data collected and review of the literature, the policy could have achieved more if considerable attention was given to culture and teachers.

Culture plays a dominant role in the life of a society (Mackie, 2018; Motti-Stefanidi, 2018). In Zimbabwe, the majority population groups [the Shona, Ndebele and Manyika tribes who make about 95% of the population] do not practise circumcision as part of their cultural practices (Shumba & Lubombo, 2017; Mangombe & Kalule-Sabiti; 2018; Matumbu, & Chimininge, 2019). Despite this reality, the circumcision

policy aimed at having 3.4 million males going for medical circumcision by the year 2017. But despite this ambition, numbers were not increasing as was initially anticipated. For example, by September 2016, they showed that approximately 732 000 males went for medical circumcision – a figure far below the target of 3.4 million males (Mateveke, 2017; Feldacker, Bochner, Murenje, Makunike-Chikwinya, Holec, Xaba & Tshimanga, 2018; McGillen, Stover, Klein, Xaba, Ncube, Mhangara & Odawo, 2018). When this reality emerged, studies (Chikutsa and Maharaj, 2015; Kasprzyk, Tshimanga, Hamilton, Gorn & Montaño, 2018; Patel, Kaufman, Dam, Van Lith, Hatzold, Marcell, & Seifert Ahanda, 2018) began to emerge questioning the effectiveness of the policy. But these studies did not look at the role of teachers in its formulation and implementation. Hence, the need for this study.

It is important to note that policy making is made up of three key stages: initiation/development, implementation and evaluation – all very critical in their own right (Juma & Clark, 1995; Sutton, 1999; Cloete, & de Coning, 2000; Exworthy, 2008; Khan & Rahman, 2017). For a policy to achieve its targets, these three key pillars should be carefully thought out and well-articulated. In addition, at the heart of a successful policy development, it is important to consider the context within which it is to be implemented. Failure in this regard will result in targets largely not being achieved (Khan & Rahman, 2017). It is the central argument of this article that in the case of the Zimbabwe Male Circumcision Policy of 2009, the context within which the policy was to be implemented was not fully factored in. In fact, teachers' perceptions were ignored. Teachers are important as they can provide insight into how the process could have unfolded, and to an extent, improve the numbers of those going for circumcision.

Understanding the role of culture and teachers in policy implementation has been studied across the world (Howlett, McConnell & Perl, 2017; Manson, 2019; Luo & Xia, 2020). Major findings point out that contextual factors such as culture play a vital role in its success or failure (Greenspan, Walk, & Handy, 2018). However, much attention is not given in literature to its role in the implementation of male circumcision (Thomas, Skovdal, Galizzi, Schaefer, Moorhouse, Nyamukapa, & Gregson, 2020). This information is critical in Zimbabwe, as many teachers do not embrace circumcision. We therefore argue that in order to understand the implementation of this policy, teachers' views are critical (Coburn, 2016; Ham & Dekkers, 2019). For example, Nguyen and Bui (2016) have elegantly acknowledged the agentive role of teachers as a critical factor in implementing policy. Other scholars have also argued that teachers have the potential to exercise their transformative roles in implementing and responding to policy changes (Menken & Garcia, 2010). Therefore, it appears that this consideration is critically important in policy formulation.

We are fully aware that there is a growing body of literature (Khan, 2016; Howes, Wortley, Potts, Dedekorkut-Howes, Serrao-Neumann, Davidson & Nunn, 2017) that points to the difficulty of specifying exactly what policy failure is as many variables are involved in this exercise. As Hill and Hupe (2009) point out, policy could be affected by the design, or implementation difficulties, monitoring or even resource allocation (Pülzl & Treib, 2017). Notwithstanding the challenges around what precisely constitute policy failure, we argue that in the case of the Zimbabwe male circumcision policy, context in the form of culture seem to have had a bearing on the disappointing figures of males going for

circumcision. For example, Chikutsa and Maharaj (2015) in their study that investigated people's representations of male circumcision that may influence its uptake, found that the uptake of circumcision among men has been below expectations. They also argue that circumcision is not a common practice in Zimbabwe, except among the Vamwenye and the Chewa who are considered immigrants from Malawi.

Awad, Sgaier, Ncube, Xaba and Mugurungi (2015) note that Voluntary Medical Male Circumcision (VMMC) policy needs to be reevaluated because there is a shortfall of approximately 2.52 million from the target that was set in 2009. They suggest scaling-up male circumcision and reprioritizing the 15-34 year olds as the main target of circumcision which will have a greater impact on HIV-AIDS infection rates.

The key issue, remains that the policy is not achieving its stated goals and it is the central argument of this paper that the context in which the policy is to be implemented was not given much attention when the VMMC was developed. In the same vein, the immense role that teachers play as cultural mediators was not given much attention. It could be argued that the designers of the policy were highly ambitious on their set targets. Perhaps these targets were unrealistic. From the data we sourced, we think that culture played an important part in males not turning up in large numbers for circumcision as it is not part of their everyday life.

2 SOCIOLOGICAL FRAMEWORK

As Raymond Williams (1989:93) argues "every human society has its own shape, its own purposes and its own meanings". He sees culture as everyday life or a whole way of life; the common meanings and practices that are fundamental to one's existence. The concept culture has undergone a number of developmental stages over the years. For example, culture as a process, as a product and as practical (Williams, 1989). These stages have survived into our own period. The scope of this article will not allow for a detailed discussion about defining which one is correct. However, we think Raymond Williams (1989) provides a useful analogy of the concept. He divides culture into four categories namely, the commercial culture, the proletariat culture, family, neighborhood, society culture and majority-values and minority ideals. Of these three, we found the latter category more appealing to us. The majority- values and minority ideals notion of culture argues that norms and values of the majority often overwhelm those of the minority. Thus, our rationale for choosing culture as the conceptual framework for this study is that it helped us to undergird the position of teachers (the majority of whom does not subscribe to male circumcision) as agents of change in the implementation of any new initiative.

We found this conceptual framework helpful to understand how Shona teachers reacted or mediated in the implementation of this policy (**Williams**, 1989). This is particularly relevant in this study as the extant literature (Kasprzyk, Tshimanga, Hamilton, Gorn & Montaño, 2018) shows that the dominant ethnic group in Zimbabwe, Shona, does not practise circumcision as part of their cultural activities. But now that they are faced with the possibility of death due to HIV-AIDS infection, will the Shona males adopt the practice?

Under certain conditions, individuals can make or remake culture because of their right to think independently, hence the notion that culture is not static. Ratner (2019) argues that people are not passive recipients of a reified entity called culture, rather they play

an active role in making and remaking culture. In this context, teachers as meaning and culture mediators influence individual young Zimbabweans to change their attitudes and accept circumcision against their cultural norm of shunning circumcision.

Thus, teachers play an important role within the whole cultural enterprise in that they serve as notable cultural mediators and transmitters in the eyes of the community. Given their pronounced presence in communities/villages, and silent and expressed roles in embracing or resisting changes, we argue that they should have been broadly consulted on the male circumcision policy both in its initiation and implementation.

3 TEACHER AGENCY

Teacher agency can be defined as the capacity initiatives to bring about change (Anderson, 2010; Toom, Pyhalto & Rust, 2015). Pantic (2015) argues that teachers are considered to have agency when they act strategically in cultural and social contexts, and are regarded as agents of change when they purposefully and skillfully draw on their agency to shape curricula, take control of their work, and strategically transform and refine their teaching worlds (Wang, Mu & Zhang, 2017).

Therefore, it is important to point out that teachers' views/perceptions are not taken as valid and meritorious in and of themselves. Their views are analysed by considering suggestions by the dominant literature to be main issues involved in the whole practice of male circumcision. But it is argued here that their views are important because they are individually and collectively affected by the policy. Therefore, we need to hear and value their voices because they act as critical cultural mediators (Williams, 1989) and their social capital plays an important role in curriculum development and messaging in schools (Modipane &Themane, 2014).

Given this backdrop and the slowness in the number of males going for circumcision, our study wanted to understand teachers' perceptions on the policy. We think this information may be useful to provide answers to questions about why are the numbers not increasing as expected.

4 RESEARCH METHODOLOGY

Since we wanted to understand the nature of the problem from an insider perspective, i.e. teachers' perceptions with regard to the implementation of male circumcision, we followed a qualitative approach research methodology, which allowed us to unearth their perceptions of the implementation of male circumcision policy in Zimbabwe. We are advised by Cohen, Manion and Morrison (2011) that qualitative research is a product of descriptive cultural knowledge of a group, and offers provision as far as possible of inside accounts. Within this qualitative research approach, we adopted a case study research design.

We adopted the purposive sampling strategy. Denscombe's (2000: 35) useful description of a purposive sampling strategy is as follows: "purposive sampling operates on the principle that we can get the best information through focusing on a relatively small number of instances deliberately selected on the basis of their known attributes. Resultantly, we selected specific teachers as described hereunder.

A total of ten teachers (designated teacher 1 to 10) were chosen from five schools (designated school A to E). The teachers met three criteria: having some understanding of policy issues because of teaching HIV and AIDS education in a rural

school in their schools; being 35 years old and above, and being eligible for circumcision. These criteria were crucial as they were at the centre of implementation of the policy.

Issues of access to the field and ethics in research were adhered to in the sense that we applied for ethical clearance for the study from the University of Limpopo Ethics Committee, which we obtained graciously. We then approached the Ministry of Health and Child Care in Zimbabwe for permission because it has the legal authority of male circumcision for HIV prevention policy. We also approached the Director of the National AIDS Council of Zimbabwe for permission to conduct our research. The Council referred us to the Medical Research Council of Zimbabwe, which is a legal board that authorises researchers in matters concerning all health ethical issues that protect people in communities, and we were granted permission. Permission was also sought and granted by the Zimbabwe's Ministry of Primary and Secondary Education to gain access to the targeted sample of schools and teachers in Masvingo District.

Data collection techniques in the main involved individual face-to-face interviews with teachers and documentary analysis. The first set of data were collected through individual interviews, and the second was collected through document analysis, which included HIV/AIDS policy documents and life science school syllabuses. To adhere to confidentiality of research participants, each teacher was given a number [from 1 to 10] and when they are quoted in the data analysis, we have inserted the number and date and year when the interview took place as in Interview, participant 1 (03 May 2016). Ten teachers were approached individually at their schools. The purpose of the study was explained to them after which consent forms were signed. Data was analysed using constant and comparative themes. Four major themes emerged: culture**,** healing process, prevention (wrong messaging) and role of education.

5 RESEARCH FINDINGS

Before looking at the data on the major theme of culture within the male circumcision policy, there are certain key elements of policy that need to be taken care of if a policy is to be regarded as sound. Data was analysed through themes that in the main emanate from the literature review. The section that follows is structured according to these themes. The discussion of findings below focuses more on culture and teachers within the overall policy development and implementation. The discussion of other aspects that play an important role in policy will be brief as the purpose here is to spend more time on culture and teachers.

One of the most important and critical variables for successful policy development and implementation is that a policy should be well grounded in concrete issues that affect society and therefore require action (McConnell, 2014). One of the findings of this study is that the Zimbabwe Male Circumcision Policy of 2009 came into being as a result of prevailing social and medical conditions at the time. Reports showed increased HIV-AIDS infection rate, which called for urgent steps to be taken to arrest the situation (McConnell, 2014). On this point, the policy was not symbolic. Instead, it was based on concrete social problems that need remedying. While the male circumcision policy was clearly informed by prevailing social conditions and required actions from those in government, the problem seems to have been an unrealistic target of 3.4 million in about six (6) years. Target setting is critical in policy development. The male circumcision policy seems to fall short on this

aspect. But for now, it is important that it be acknowledged that the policy was well grounded. Thus, research findings and analysis point to the fact the male circumcision was, in many ways and to varying degrees, based on solid foundation and material conditions of high HIV-AIDS infection rate in Zimbabwe.

Besides policy being grounded on concrete issues affecting society, it is also the case that policies should be characterised by broad consultation both in the initial stages of development and later during implementation. Briefly, there should be stakeholder consultation on a broad space so that there is general buy-in on the matter. It is often suggested that policies sometimes fail to achieve their key objectives mainly because some of the key stakeholders who are critical in successful implementation were not brought on board. On this score again, the Zimbabwe Male Circumcision Policy included broad consultations with medical practitioners, traditional leaders and ordinary community members often through multi-media platforms. The only apparent shortcoming was the neglect of teachers and women in the entire consultation process. Both material and human resources were taken care of although not to a large extent.

For policies to achieve their intended objectives/goals, they should be accompanied by well thought out and carefully designed implementation strategies (McConnell, 2014). In the case of Zimbabwe male circumcision policy, for example, the ordering of goals was not, to a large extent, taken care of. Health facilities were prepared and staffed with professional stuff to carry out the circumcision, and the necessary resources were provided to realise the objectives of the policies (resources in terms of funds and relevant and qualified people).

From the data gathered, the issue of culture in influencing males to go for circumcision was identified by all the interviewees. A closer look at a sense of culture from the data shows that it is dual in nature. Firstly, they pointed to the majority ethnic group who does not practise circumcision as part and parcel of their cultural practice. The second aspect had to do with the entrenched practice where older men were put off by being circumcised by female medical practitioners. Male circumcision is something done by males as a cultural practice. Perhaps in the early years of development, it will be accepted as it is done to those below ten (10) years.

In various ways and to varying degrees, all the interviewees indicated that the dominant population group in Zimbabwe, (Shona), does not practise circumcision as part of their cultural practice. This explains why many males are not opting for the circumcision as planned by the Ministry of Health and Child Care. For all the interviewees, there was agreement that much cannot be achieved with the policy since the dominant ethnic group does not go for circumcision. One of the teachers put it:

> The Shona culture prohibits circumcision and they think it's ridiculous. The Shona don't believe in circumcision. Culture of the Shona does not support it. The Shangaan did it not for HIV protection but for other reasons. The general populace, three quarters were not going for circumcision I think culture should adapt to change for circumcision (*Interview, research participant 8 (09, May 2016*).

These views were shared by all interviewees. Given the limitation of space in this article, we cannot go into detail quoting each teacher. Suffice to say that the central

message conveyed was that culture plays an important role in the lives of the society, and that the dominant population group does not practise circumcision as part and parcel of their everyday cultural practices.

Another point was that males, especially adults, find it difficult to be circumcised by female doctors. What this point out is that traditional beliefs are still held high by a significant number of men in the country. This has a negative impact on the policy on male circumcision achieving its targets:

> Look, some nurses were given training on circumcision to have proper skills but I have observed that eehhh males are shy to be circumcised by female nurses. This is a problem as many men would have come for circumcision turn away if they realise that a female nurse will do the procedure (*Interview, research participant 1 (03, May 2016*).

The research participant concluded that this aspect reduces the number of those who want to be circumcised. The point being made here is that culturally, circumcision should be performed by men rather than women. But in some cases, medical circumcision is performed by female medical practitioners.

Another participant stated that the rejection of circumcision is dominated by Christian beliefs in which members of the community draw much from the Holy Bible:

> Huuuum on culture is dominated by the Bible, which opposes circumcision. It dominates their minds. So, for circumcision as at early ages the law in Deuteronomy urged but with Christ, he opposed it. People are dominated in mind by Churches and they oppose it (*Interview, research participant 6 (05, May 2016*).

Further analysis of the data also brought to light the human right issue in the sense that circumcising children cannot be construed as voluntary as they are not yet adults. The policy insists that circumcision should be voluntary.

The argument advanced by the research respondent has merits in the sense that anyone who is underage cannot be regarded as having made a voluntary decision to go for male circumcision as this responsibility lies with the parents. Since the male circumcision policy is voluntary, issues of human rights come into play here.

6 HEALING TAKING LONG

From the interview data with teachers, it also emerged that there were genuine concerns of surgery not going well as a result of heavy bleeding and wounds taking long to heal. While it is not mentioned by all teachers in compared to the issue of culture discussed in the preceding paragraphs, four teachers identified heavy bleeding and the prolonged period of healing as another issue that discourages large numbers of males to opt for circumcision. When we factor in the fact that the policy was targeted at those who were already sexually active in order to reduce infection, the issue of being ‘sick’ for days due to bleeding may indeed negatively affect the number of those who want to go for surgery. We are also talking about men who are 30 years old and above here.

> Some say it’s good while others say it’s bad [because of] the incidences of those who bleed after circumcision. People have negative view from such experiences and may not want to go for it. I saw some people being given

> certificates after circumcision and some were shy. But only a few manage to be circumcised (*Interview, research participant 1 (03, May 2016).*

The participant went on to say the following: "According to people, I think if one is circumcised and comes back complaining of pain it becomes a challenge". Another research participant (02) suggested that there is a perception "of fear and pain by many students as some think they can die from the procedure and there is no adequate medication for protection. Some people bleed or swell after circumcision. There must be adequate medication to avoid the pain" (*Interview, research participant 3 (03 May 2016).*

In a nutshell, there are concerns about surgery, the accompanying pain and bleeding, which may put off some of those interested in the intervention. In South Africa, there have been reported death cases in a number of circumcision schools during winter months, especially from the Eastern Cape. But in this case, surgery is not performed by medical practitioners. This has led the Department of Health to introduce medical practitioners in the "Winter School" (Kaseke, 1991).

7 EMPHASIS ON PREVENTION

Analysis of teachers' views further showed concerns with public messages that are detrimental to the objective of the intervention itself in the sense that those who are circumcised may not think about other strategies of prevention. They may assume that they are sort of immune from getting infected or infecting others. As one of the participant suggested:

> Sometimes I think those that are circumcised think they have been given authority to indulge in sex and practice it more often. Like, circumcision should not promote promiscuity. Mmmm I get a sense that those circumcised think they won't be infected because the fear of getting STI now reduced because they are circumcised. I am very concerned here and we should guard against sending wrong messages (*Interview, research participant 10 (10, May 2016).*

The point here is that there should be emphasis on prevention, and circumcision should not be misconstrued as providing protection from getting infected. It is not a bullet proof to HIV-AIDS infection.

Essentially, there are concerns that being circumcised should not be regarded as an end in and of itself, rather as one of the means towards the reduction of HIV-AIDS infection. It does not necessarily mean that once circumcised, one will not get infected or infect others with the disease. Thus authorities charged with the implementation of the policy should take steps to ensure that this message gets across to the population – that circumcision is only one strategy among many, and should be taken together with others such as condom use.

8 ROLE OF EDUCATION

All the interviewees in this study emphasised the important role of education in changing societal practices, or what is often called the transformative power of education. In many ways and to varying degrees, teachers argued that education plays an important role in breaking cultural barriers and in doing away with taboos. The interviewees were of the view that teachers were not given a pronounced role in the

whole policy process. As participant 4 pointed out:

> For me I think there should have been a consultation with schools and teachers as education is important in carrying out lessons for the youth. It is not only by seeing what teachers are doing but also being taught through life skills what students must do and not do. Do you get my point; schools are very important in driving messages? (*Interview, research participant 4 (05 May 2016).*

Another research participant put it as follows: "Education can change attitudes and no one can argue against this. It is proven that education is very important" (*Interview, research participant 10, (10 May 2016).*

Still another teacher had this to say: "Life skills in schools is important and should be supported by all, but at the same time we should watch against the age of the learners so that the children are given wrong content" (I*nterview, research participant 10, (10 May 2016).*

Most teachers argued that education can transform society, and therefore, should have been given more attention in the policy on male circumcision. Unfortunately, this was not the case. This is a limitation on the part of the policy. Broadly speaking, schools and teachers in particular play an important role as agents of transformation and the preservation of everyday practices (culture) in society.

9 DISCUSSION

Our study sought to investigate teachers' perceptions of the development and implementation of the male circumcision policy of 2009 in Zimbabwe. The study followed the qualitative research where case study design was used. Generally, we found that teachers in our sample were not disposed to the male circumcision policy.

Our results are consistent with other studies (World Health Organization, 2009; Seloana, 2011; Kuppens, Ibrahim & Langer, 2018) elsewhere in the world, which found that teachers were variance with male circumcision. However, contrary to our findings, Halperin, Fritz, McFarland and Woelk (2005) found that adult males in sample were propitious to male circumcision. Additionally, the study by Hatzold, Mavhu, Jasi, Chatora, Cowan, Taruberekera and Njeuhmeli (2014) also found that among male respondents, 11.3% reported being circumcised and 49% reported willingness to undergo VMMC. However, factors that were motivators and barriers varied. They included including fear of HIV testing, partner refusal, reluctance to abstain from sex and myths and misconceptions (Mavhu, Langhaug, Hatzold, Benedikt, Sherman & Cowan, 2011). What is novel in our study is that culture was not elevated in these studies.

It is thus suggested that when the male circumcision policy was initiated, serious interrogation should have gone into how the majority population group (Shona), with its non-circumcision cultural practices, would embrace and encourage its members to undergo medical intervention in order to reduce infection rates among the population. It is not enough that as people see the HIV-AIDS infection rate increasing, they will automatically embrace and support any intervention measure, especially given the entrenched and century-old cultural practices that are difficult to change (Kripke, Chen, Vazzano, Thambinayagam, Pillay, Loykissoonlal & Njeuhmeli, 2016).

The discussion also pointed to the fact that teachers were of the view that the

voluntary male circumcision policy was undermining human rights in instances where boys below the age of 12 were circumcised. It is correct that those below the age of 12 are still under the care of their parents and cannot independently take decisions. There are debates and literature on culture and human rights issues in Africa and India. There is a need to strike a balance between the two without necessarily judging cultural practices as oppressive and patriarchal, and worse, backward.

It is also the case that several interviewees of the study raised valid concerns about surgery going well but still with a lot of bleeding, and worse, with the wound taking extended time to heal. The second theme of prolonged healing, and in other cases even death, cannot be ignored or wished away. As such, effective communication and ensuring that skilled personnel to undertake the intervention is critical. Adequate medication is also essential to reduce bleeding and pain.

The central role of education within the whole way of life (culture) should not, and cannot, be overlooked or trivialised. Giroux (2019:18) and many others before him argue that "pedagogy is capable of awakening consciousness, challenging common sense and creating modes of analysis in which people discover a moment of recognition that enables them to rethink the conditions that shape their lives". Through education, and particularly the work of teachers, people are able to reflect on their practices, and more importantly "rethink the conditions that shape their lives" (Giroux 2019; Hooks, 2011). Along this line of reasoning, cultural practices of being averse to circumcision are transformed.

Interviews with teachers foregrounded the role of education in changing cultural patterns. Teachers play a critical role in this respect. Unfortunately, the role of education in general and teachers as agents was silent from the enactment of the policy on male circumcision.

10 IMPLICATIONS OF THE STUDY

These findings have at least three implications for policy development and implementation. Firstly, that for any policy initiative in schools to take roots, it must take teachers on board. Equally, teachers should be both willing and ready to be part of such efforts. In the case of this policy, it appears that the readiness and willingness of teachers was not adequately solicited. For example, teachers as foot soldiers of this policy were not part of the culture of the practice of male circumcision. Secondly, for any policy initiative to flourish, there should be adequate resources such as finances. Our findings did not find this to be the case. Whereas both material and human resources were taken care of, they were not enough to upscale the policy given the economic meltdown of Zimbabwe at the time of the implementation. A lack of adequate resources is at the heart of the non-achievement of every policy implementation. Thirdly, our findings have highlighted the need to consider the context under which a policy is to be implemented. We have argued that the fact that the Shona, Ndebele and Manyika tribes who make up about 95% of the population do not practise circumcision as part of their cultural practice was a strong threat to its success. We can conclusively say that teachers from these tribes were ignored at the peril of this policy and so was the transformative nature of education - critical pedagogy. Policy makers and legislators should take teachers seriously if they are to use schools as centres of any social change, including the male circumcision policy in Zimbabwe. These are important lessons to draw from these findings.

11 CONCLUSION

This paper looked at the Zimbabwe male circumcision policy of 2009 and noted that the policy came into being given concrete social and medical conditions of increased HIV-AIDS infection rate. This had to be curbed. There was broad consultation and piloting of policy intervention so that potential challenges during implementation could be anticipated and factored in before full implementation of the policy. Substantial resources were also channeled towards policy intervention to make it a success. From the perceptions of interviewees of this study, the cultural context of non-circumcising majority population was highlighted as having an impact on the number of males opting for circumcision. Teachers also argued that, given its traditional overtones in many African countries, male circumcision should be conducted by males. The data also indicated genuine concerns about pains after surgery and a prolonged healing process. But, issues of pain and bleeding after surgery pale in comparison to the benefits of being circumcised because preventative measures to reduce infection rates are important factors to consider if this policy is to succeed. It was further noted that the messaging in some cases was problematic as it tends to essentialise male circumcision to the exclusion of other equally important preventative matters in HIV-AIDS infection.

The transformative nature of education, specifically critical pedagogy which inculcates modes of thinking that enable actors to rethink the conditions that shape their lives, was emphasised in the whole policy intervention project, changing attitudes and behaviour. Teachers should be given a pronounced role in some of these interventions as they play an immense role as cultural mediators. Failure on this aspect results in policies that affect teachers falling far short on meeting their stated goals and targets.

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13 INTRODUCTION

This paper focuses on the Zimbabwe male circumcision policy of 2009, which was introduced as one of the strategies to curb the increasing HIV-AIDS infection rate at the time (Ashengo, Hatzold, Mahler, Rock, Kanagat, Magalona & Dhlamini, 2014). The paper argues that while some key factors that facilitate successful policy implementation were considered in relation to the male circumcision policy, not much attention was given to the role of culture and teachers in the whole policy process. Based on the data collected and review of the literature, the policy could have achieved more if considerable attention was given to culture and teachers.

Culture plays a dominant role in the life of a society (Mackie, 2018; Motti-Stefanidi, 2018). In Zimbabwe, the majority population groups [the Shona, Ndebele and Manyika tribes who make about 95% of the population] do not practise circumcision as part of their cultural practices (Shumba & Lubombo, 2017; Mangombe & Kalule-Sabiti; 2018; Matumbu, & Chimininge, 2019). Despite this reality, the circumcision policy aimed at having 3.4 million males going for medical circumcision by the year 2017. But despite this ambition, numbers were not increasing as was initially anticipated. For example, by September 2016, they showed that approximately 732 000 males went for medical circumcision – a figure far below the target of 3.4 million males (Mateveke, 2017; Feldacker, Bochner, Murenje, Makunike-Chikwinya, Holec, Xaba & Tshimanga, 2018; McGillen, Stover, Klein, Xaba, Ncube, Mhangara & Odawo, 2018). When this reality emerged, studies (Chikutsa and Maharaj, 2015; Kasprzyk, Tshimanga, Hamilton, Gorn & Montaño, 2018; Patel, Kaufman, Dam, Van Lith, Hatzold, Marcell, & Seifert Ahanda, 2018) began to emerge questioning the effectiveness of the policy. But these studies did not look at the role of teachers in its formulation and implementation. Hence, the need for this study.

It is important to note that policy making is made up of three key stages: initiation/development, implementation and evaluation – all very critical in their own right (Juma & Clark, 1995; Sutton, 1999; Cloete, & de Coning, 2000; Exworthy, 2008; Khan & Rahman, 2017). For a policy to achieve its targets, these three key pillars should be carefully thought out and well-articulated. In addition, at the heart of a successful policy development, it is important to consider the context within which it is to be implemented. Failure in this regard will result in targets largely not being achieved (Khan & Rahman, 2017). It is the central argument of this article that in the case of the Zimbabwe Male Circumcision Policy of 2009, the context within which the policy was to be implemented was not fully factored in. In fact, teachers' perceptions were ignored. Teachers are important as they can provide insight into how the process could have unfolded, and to an extent, improve the numbers of those going for circumcision.

Understanding the role of culture and teachers in policy implementation has been studied across the world (Howlett, McConnell & Perl, 2017; Manson, 2019; Luo & Xia, 2020). Major findings point out that contextual factors such as culture play a vital role in its success or failure (Greenspan, Walk, & Handy, 2018). However, much attention is not given in literature to its role in the implementation of male circumcision (Thomas, Skovdal, Galizzi, Schaefer, Moorhouse, Nyamukapa, & Gregson, 2020). This information is critical in Zimbabwe, as many teachers do not embrace circumcision. We therefore argue that in order to understand the implementation of this policy,

teachers' views are critical (Coburn, 2016; Ham & Dekkers, 2019). For example, Nguyen and Bui (2016) have elegantly acknowledged the agentive role of teachers as a critical factor in implementing policy. Other scholars have also argued that teachers have the potential to exercise their transformative roles in implementing and responding to policy changes (Menken & Garcia, 2010). Therefore, it appears that this consideration is critically important in policy formulation.

We are fully aware that there is a growing body of literature (Khan, 2016; Howes, Wortley, Potts, Dedekorkut-Howes, Serrao-Neumann, Davidson & Nunn, 2017) that points to the difficulty of specifying exactly what policy failure is as many variables are involved in this exercise. As Hill and Hupe (2009) point out, policy could be affected by the design, or implementation difficulties, monitoring or even resource allocation (Pülzl & Treib, 2017). Notwithstanding the challenges around what precisely constitute policy failure, we argue that in the case of the Zimbabwe male circumcision policy, context in the form of culture seem to have had a bearing on the disappointing figures of males going for circumcision. For example, Chikutsa and Maharaj (2015) in their study that investigated people's representations of male circumcision that may influence its uptake, found that the uptake of circumcision among men has been below expectations. They also argue that circumcision is not a common practice in Zimbabwe, except among the Vamwenye and the Chewa who are considered immigrants from Malawi.

Awad, Sgaier, Ncube, Xaba and Mugurungi (2015) note that Voluntary Medical Male Circumcision (VMMC) policy needs to be reevaluated because there is a shortfall of approximately 2.52 million from the target that was set in 2009. They suggest scaling-up male circumcision and reprioritizing the 15-34 year olds as the main target of circumcision which will have a greater impact on HIV-AIDS infection rates.

The key issue, remains that the policy is not achieving its stated goals and it is the central argument of this paper that the context in which the policy is to be implemented was not given much attention when the VMMC was developed. In the same vein, the immense role that teachers play as cultural mediators was not given much attention. It could be argued that the designers of the policy were highly ambitious on their set targets. Perhaps these targets were unrealistic. From the data we sourced, we think that culture played an important part in males not turning up in large numbers for circumcision as it is not part of their everyday life.

14 SOCIOLOGICAL FRAMEWORK

As Raymond Williams (1989:93) argues "every human society has its own shape, its own purposes and its own meanings". He sees culture as everyday life or a whole way of life; the common meanings and practices that are fundamental to one's existence. The concept culture has undergone a number of developmental stages over the years. For example, culture as a process, as a product and as practical (Williams, 1989). These stages have survived into our own period. The scope of this article will not allow for a detailed discussion about defining which one is correct. However, we think Raymond Williams (1989) provides a useful analogy of the concept. He divides culture into four categories namely, the commercial culture, the proletariat culture, family, neighborhood, society culture and majority-values and minority ideals. Of these three, we found the latter category more appealing to us. The majority- values and minority

ideals notion of culture argues that norms and values of the majority often overwhelm those of the minority. Thus, our rationale for choosing culture as the conceptual framework for this study is that it helped us to undergird the position of teachers (the majority of whom does not subscribe to male circumcision) as agents of change in the implementation of any new initiative.

We found this conceptual framework helpful to understand how Shona teachers reacted or mediated in the implementation of this policy (**Williams**, 1989). This is particularly relevant in this study as the extant literature (Kasprzyk, Tshimanga, Hamilton, Gorn & Montaño, 2018) shows that the dominant ethnic group in Zimbabwe, Shona, does not practise circumcision as part of their cultural activities. But now that they are faced with the possibility of death due to HIV-AIDS infection, will the Shona males adopt the practice?

Under certain conditions, individuals can make or remake culture because of their right to think independently, hence the notion that culture is not static. Ratner (2019) argues that people are not passive recipients of a reified entity called culture, rather they play an active role in making and remaking culture. In this context, teachers as meaning and culture mediators influence individual young Zimbabweans to change their attitudes and accept circumcision against their cultural norm of shunning circumcision.

Thus, teachers play an important role within the whole cultural enterprise in that they serve as notable cultural mediators and transmitters in the eyes of the community. Given their pronounced presence in communities/villages, and silent and expressed roles in embracing or resisting changes, we argue that they should have been broadly consulted on the male circumcision policy both in its initiation and implementation.

15 TEACHER AGENCY

Teacher agency can be defined as the capacity initiatives to bring about change (Anderson, 2010; Toom, Pyhalto & Rust, 2015). Pantic (2015) argues that teachers are considered to have agency when they act strategically in cultural and social contexts, and are regarded as agents of change when they purposefully and skillfully draw on their agency to shape curricula, take control of their work, and strategically transform and refine their teaching worlds (Wang, Mu & Zhang, 2017).

Therefore, it is important to point out that teachers' views/perceptions are not taken as valid and meritorious in and of themselves. Their views are analysed by considering suggestions by the dominant literature to be main issues involved in the whole practice of male circumcision. But it is argued here that their views are important because they are individually and collectively affected by the policy. Therefore, we need to hear and value their voices because they act as critical cultural mediators (Williams, 1989) and their social capital plays an important role in curriculum development and messaging in schools (Modipane &Themane, 2014).

Given this backdrop and the slowness in the number of males going for circumcision, our study wanted to understand teachers' perceptions on the policy. We think this information may be useful to provide answers to questions about why are the numbers not increasing as expected.

16 RESEARCH METHODOLOGY

Since we wanted to understand the nature of the problem from an insider

perspective, i.e. teachers' perceptions with regard to the implementation of male circumcision, we followed a qualitative approach research methodology, which allowed us to unearth their perceptions of the implementation of male circumcision policy in Zimbabwe. We are advised by Cohen, Manion and Morrison (2011) that qualitative research is a product of descriptive cultural knowledge of a group, and offers provision as far as possible of inside accounts. Within this qualitative research approach, we adopted a case study research design.

We adopted the purposive sampling strategy. Denscombe's (2000: 35) useful description of a purposive sampling strategy is as follows: "purposive sampling operates on the principle that we can get the best information through focusing on a relatively small number of instances deliberately selected on the basis of their known attributes. Resultantly, we selected specific teachers as described hereunder.

A total of ten teachers (designated teacher 1 to 10) were chosen from five schools (designated school A to E). The teachers met three criteria: having some understanding of policy issues because of teaching HIV and AIDS education in a rural school in their schools; being 35 years old and above, and being eligible for circumcision. These criteria were crucial as they were at the centre of implementation of the policy.

Issues of access to the field and ethics in research were adhered to in the sense that we applied for ethical clearance for the study from the University of Limpopo Ethics Committee, which we obtained graciously. We then approached the Ministry of Health and Child Care in Zimbabwe for permission because it has the legal authority of male circumcision for HIV prevention policy. We also approached the Director of the National AIDS Council of Zimbabwe for permission to conduct our research. The Council referred us to the Medical Research Council of Zimbabwe, which is a legal board that authorises researchers in matters concerning all health ethical issues that protect people in communities, and we were granted permission. Permission was also sought and granted by the Zimbabwe's Ministry of Primary and Secondary Education to gain access to the targeted sample of schools and teachers in Masvingo District.

Data collection techniques in the main involved individual face-to-face interviews with teachers and documentary analysis. The first set of data were collected through individual interviews, and the second was collected through document analysis, which included HIV/AIDS policy documents and life science school syllabuses. To adhere to confidentiality of research participants, each teacher was given a number [from 1 to 10] and when they are quoted in the data analysis, we have inserted the number and date and year when the interview took place as in Interview, participant 1 (03 May 2016). Ten teachers were approached individually at their schools. The purpose of the study was explained to them after which consent forms were signed. Data was analysed using constant and comparative themes. Four major themes emerged: culture**,** healing process, prevention (wrong messaging) and role of education.

17 RESEARCH FINDINGS

Before looking at the data on the major theme of culture within the male circumcision policy, there are certain key elements of policy that need to be taken care of if a policy is to be regarded as sound. Data was analysed through themes that in the main emanate from the literature review. The section that follows is structured according to

these themes. The discussion of findings below focuses more on culture and teachers within the overall policy development and implementation. The discussion of other aspects that play an important role in policy will be brief as the purpose here is to spend more time on culture and teachers.

One of the most important and critical variables for successful policy development and implementation is that a policy should be well grounded in concrete issues that affect society and therefore require action (McConnell, 2014). One of the findings of this study is that the Zimbabwe Male Circumcision Policy of 2009 came into being as a result of prevailing social and medical conditions at the time. Reports showed increased HIV-AIDS infection rate, which called for urgent steps to be taken to arrest the situation (McConnell, 2014). On this point, the policy was not symbolic. Instead, it was based on concrete social problems that need remedying. While the male circumcision policy was clearly informed by prevailing social conditions and required actions from those in government, the problem seems to have been an unrealistic target of 3.4 million in about six (6) years. Target setting is critical in policy development. The male circumcision policy seems to fall short on this aspect. But for now, it is important that it be acknowledged that the policy was well grounded. Thus, research findings and analysis point to the fact the male circumcision was, in many ways and to varying degrees, based on solid foundation and material conditions of high HIV-AIDS infection rate in Zimbabwe.

Besides policy being grounded on concrete issues affecting society, it is also the case that policies should be characterised by broad consultation both in the initial stages of development and later during implementation. Briefly, there should be stakeholder consultation on a broad space so that there is general buy-in on the matter. It is often suggested that policies sometimes fail to achieve their key objectives mainly because some of the key stakeholders who are critical in successful implementation were not brought on board. On this score again, the Zimbabwe Male Circumcision Policy included broad consultations with medical practitioners, traditional leaders and ordinary community members often through multi-media platforms. The only apparent shortcoming was the neglect of teachers and women in the entire consultation process. Both material and human resources were taken care of although not to a large extent.

For policies to achieve their intended objectives/goals, they should be accompanied by well thought out and carefully designed implementation strategies (McConnell, 2014). In the case of Zimbabwe male circumcision policy, for example, the ordering of goals was not, to a large extent, taken care of. Health facilities were prepared and staffed with professional stuff to carry out the circumcision, and the necessary resources were provided to realise the objectives of the policies (resources in terms of funds and relevant and qualified people).

From the data gathered, the issue of culture in influencing males to go for circumcision was identified by all the interviewees. A closer look at a sense of culture from the data shows that it is dual in nature. Firstly, they pointed to the majority ethnic group who does not practise circumcision as part and parcel of their cultural practice. The second aspect had to do with the entrenched practice where older men were put off by being circumcised by female medical practitioners. Male circumcision is something done by males as a cultural practice. Perhaps in the early years of

development, it will be accepted as it is done to those below ten (10) years.

In various ways and to varying degrees, all the interviewees indicated that the dominant population group in Zimbabwe, (Shona), does not practise circumcision as part of their cultural practice. This explains why many males are not opting for the circumcision as planned by the Ministry of Health and Child Care. For all the interviewees, there was agreement that much cannot be achieved with the policy since the dominant ethnic group does not go for circumcision. One of the teachers put it:

> The Shona culture prohibits circumcision and they think it's ridiculous. The Shona don't believe in circumcision. Culture of the Shona does not support it. The Shangaan did it not for HIV protection but for other reasons. The general populace, three quarters were not going for circumcision I think culture should adapt to change for circumcision (*Interview, research participant 8 (09, May 2016*).

These views were shared by all interviewees. Given the limitation of space in this article, we cannot go into detail quoting each teacher. Suffice to say that the central message conveyed was that culture plays an important role in the lives of the society, and that the dominant population group does not practise circumcision as part and parcel of their everyday cultural practices.

Another point was that males, especially adults, find it difficult to be circumcised by female doctors. What this point out is that traditional beliefs are still held high by a significant number of men in the country. This has a negative impact on the policy on male circumcision achieving its targets:

> Look, some nurses were given training on circumcision to have proper skills but I have observed that eehhh males are shy to be circumcised by female nurses. This is a problem as many men would have come for circumcision turn away if they realise that a female nurse will do the procedure (*Interview, research participant 1 (03, May 2016*).

The research participant concluded that this aspect reduces the number of those who want to be circumcised. The point being made here is that culturally, circumcision should be performed by men rather than women. But in some cases, medical circumcision is performed by female medical practitioners.

Another participant stated that the rejection of circumcision is dominated by Christian beliefs in which members of the community draw much from the Holy Bible:

> Huuuum on culture is dominated by the Bible, which opposes circumcision. It dominates their minds. So, for circumcision as at early ages the law in Deuteronomy urged but with Christ, he opposed it. People are dominated in mind by Churches and they oppose it (*Interview, research participant 6 (05, May 2016*).

Further analysis of the data also brought to light the human right issue in the sense that circumcising children cannot be construed as voluntary as they are not yet adults. The policy insists that circumcision should be voluntary.

The argument advanced by the research respondent has merits in the sense that anyone who is underage cannot be regarded as having made a voluntary decision to go for male circumcision as this

responsibility lies with the parents. Since the male circumcision policy is voluntary, issues of human rights come into play here.

18 HEALING TAKING LONG

From the interview data with teachers, it also emerged that there were genuine concerns of surgery not going well as a result of heavy bleeding and wounds taking long to heal. While it is not mentioned by all teachers in compared to the issue of culture discussed in the preceding paragraphs, four teachers identified heavy bleeding and the prolonged period of healing as another issue that discourages large numbers of males to opt for circumcision. When we factor in the fact that the policy was targeted at those who were already sexually active in order to reduce infection, the issue of being 'sick' for days due to bleeding may indeed negatively affect the number of those who want to go for surgery. We are also talking about men who are 30 years old and above here.

> Some say it's good while others say it's bad [because of] the incidences of those who bleed after circumcision. People have negative view from such experiences and may not want to go for it. I saw some people being given certificates after circumcision and some were shy. But only a few manage to be circumcised (*Interview, research participant 1 (03, May 2016).*

The participant went on to say the following: "According to people, I think if one is circumcised and comes back complaining of pain it becomes a challenge". Another research participant (02) suggested that there is a perception "of fear and pain by many students as some think they can die from the procedure and there is no adequate medication for protection. Some people bleed or swell after circumcision. There must be adequate medication to avoid the pain" (*Interview, research participant 3 (03 May 2016).*

In a nutshell, there are concerns about surgery, the accompanying pain and bleeding, which may put off some of those interested in the intervention. In South Africa, there have been reported death cases in a number of circumcision schools during winter months, especially from the Eastern Cape. But in this case, surgery is not performed by medical practitioners. This has led the Department of Health to introduce medical practitioners in the "Winter School" (Kaseke, 1991).

19 EMPHASIS ON PREVENTION

Analysis of teachers' views further showed concerns with public messages that are detrimental to the objective of the intervention itself in the sense that those who are circumcised may not think about other strategies of prevention. They may assume that they are sort of immune from getting infected or infecting others. As one of the participant suggested:

> Sometimes I think those that are circumcised think they have been given authority to indulge in sex and practice it more often. Like, circumcision should not promote promiscuity. Mmmm I get a sense that those circumcised think they won't be infected because the fear of getting STI now reduced because they are circumcised. I am very concerned here and we should guard against sending wrong messages (*Interview, research participant 10 (10, May 2016).*

The point here is that there should be emphasis on prevention, and circumcision should not be misconstrued as providing protection from getting infected. It is not a bullet proof to HIV-AIDS infection.

Essentially, there are concerns that being circumcised should not be regarded as an end in and of itself, rather as one of the means towards the reduction of HIV-AIDS infection. It does not necessarily mean that once circumcised, one will not get infected or infect others with the disease. Thus authorities charged with the implementation of the policy should take steps to ensure that this message gets across to the population – that circumcision is only one strategy among many, and should be taken together with others such as condom use.

20 ROLE OF EDUCATION

All the interviewees in this study emphasised the important role of education in changing societal practices, or what is often called the transformative power of education. In many ways and to varying degrees, teachers argued that education plays an important role in breaking cultural barriers and in doing away with taboos. The interviewees were of the view that teachers were not given a pronounced role in the whole policy process. As participant 4 pointed out:

> For me I think there should have been a consultation with schools and teachers as education is important in carrying out lessons for the youth. It is not only by seeing what teachers are doing but also being taught through life skills what students must do and not do. Do you get my point; schools are very important in driving messages? (*Interview, research participant 4 (05 May 2016).*

Another research participant put it as follows: "Education can change attitudes and no one can argue against this. It is proven that education is very important" (*Interview, research participant 10, (10 May 2016).*

Still another teacher had this to say: "Life skills in schools is important and should be supported by all, but at the same time we should watch against the age of the learners so that the children are given wrong content" (I*nterview, research participant 10, (10 May 2016).*

Most teachers argued that education can transform society, and therefore, should have been given more attention in the policy on male circumcision. Unfortunately, this was not the case. This is a limitation on the part of the policy. Broadly speaking, schools and teachers in particular play an important role as agents of transformation and the preservation of everyday practices (culture) in society.

21 DISCUSSION

Our study sought to investigate teachers' perceptions of the development and implementation of the male circumcision policy of 2009 in Zimbabwe. The study followed the qualitative research where case study design was used. Generally, we found that teachers in our sample were not disposed to the male circumcision policy.

Our results are consistent with other studies (World Health Organization, 2009; Seloana, 2011; Kuppens, Ibrahim & Langer, 2018) elsewhere in the world, which found that teachers were variance with male circumcision. However, contrary to our findings, Halperin, Fritz, McFarland and Woelk (2005) found that adult males in sample were propitious to male circumcision. Additionally, the study by Hatzold, Mavhu,

Jasi, Chatora, Cowan, Taruberekera and Njeuhmeli (2014) also found that among male respondents, 11.3% reported being circumcised and 49% reported willingness to undergo VMMC. However, factors that were motivators and barriers varied. They included including fear of HIV testing, partner refusal, reluctance to abstain from sex and myths and misconceptions (Mavhu, Langhaug, Hatzold, Benedikt, Sherman & Cowan, 2011). What is novel in our study is that culture was not elevated in these studies.

It is thus suggested that when the male circumcision policy was initiated, serious interrogation should have gone into how the majority population group (Shona), with its non-circumcision cultural practices, would embrace and encourage its members to undergo medical intervention in order to reduce infection rates among the population. It is not enough that as people see the HIV-AIDS infection rate increasing, they will automatically embrace and support any intervention measure, especially given the entrenched and century-old cultural practices that are difficult to change (Kripke, Chen, Vazzano, Thambinayagam, Pillay, Loykissoonlal & Njeuhmeli, 2016).

The discussion also pointed to the fact that teachers were of the view that the voluntary male circumcision policy was undermining human rights in instances where boys below the age of 12 were circumcised. It is correct that those below the age of 12 are still under the care of their parents and cannot independently take decisions. There are debates and literature on culture and human rights issues in Africa and India. There is a need to strike a balance between the two without necessarily judging cultural practices as oppressive and patriarchal, and worse, backward.

It is also the case that several interviewees of the study raised valid concerns about surgery going well but still with a lot of bleeding, and worse, with the wound taking extended time to heal. The second theme of prolonged healing, and in other cases even death, cannot be ignored or wished away. As such, effective communication and ensuring that skilled personnel to undertake the intervention is critical. Adequate medication is also essential to reduce bleeding and pain.

The central role of education within the whole way of life (culture) should not, and cannot, be overlooked or trivialised. Giroux (2019:18) and many others before him argue that "pedagogy is capable of awakening consciousness, challenging common sense and creating modes of analysis in which people discover a moment of recognition that enables them to rethink the conditions that shape their lives". Through education, and particularly the work of teachers, people are able to reflect on their practices, and more importantly "rethink the conditions that shape their lives" (Giroux 2019; Hooks, 2011). Along this line of reasoning, cultural practices of being averse to circumcision are transformed.

Interviews with teachers foregrounded the role of education in changing cultural patterns. Teachers play a critical role in this respect. Unfortunately, the role of education in general and teachers as agents was silent from the enactment of the policy on male circumcision.

22 IMPLICATIONS OF THE STUDY

These findings have at least three implications for policy development and implementation. Firstly, that for any policy initiative in schools to take roots, it must take teachers on board. Equally, teachers should be both willing and ready to be part of such efforts. In the case of this policy, it appears that the readiness and

willingness of teachers was not adequately solicited. For example, teachers as foot soldiers of this policy were not part of the culture of the practice of male circumcision. Secondly, for any policy initiative to flourish, there should be adequate resources such as finances. Our findings did not find this to be the case. Whereas both material and human resources were taken care of, they were not enough to upscale the policy given the economic meltdown of Zimbabwe at the time of the implementation. A lack of adequate resources is at the heart of the non-achievement of every policy implementation. Thirdly, our findings have highlighted the need to consider the context under which a policy is to be implemented. We have argued that the fact that the Shona, Ndebele and Manyika tribes who make up about 95% of the population do not practise circumcision as part of their cultural practice was a strong threat to its success. We can conclusively say that teachers from these tribes were ignored at the peril of this policy and so was the transformative nature of education - critical pedagogy. Policy makers and legislators should take teachers seriously if they are to use schools as centres of any social change, including the male circumcision policy in Zimbabwe. These are important lessons to draw from these findings.

23 CONCLUSION

This paper looked at the Zimbabwe male circumcision policy of 2009 and noted that the policy came into being given concrete social and medical conditions of increased HIV-AIDS infection rate. This had to be curbed. There was broad consultation and piloting of policy intervention so that potential challenges during implementation could be anticipated and factored in before full implementation of the policy. Substantial resources were also channeled towards policy intervention to make it a success. From the perceptions of interviewees of this study, the cultural context of non-circumcising majority population was highlighted as having an impact on the number of males opting for circumcision. Teachers also argued that, given its traditional overtones in many African countries, male circumcision should be conducted by males. The data also indicated genuine concerns about pains after surgery and a prolonged healing process. But, issues of pain and bleeding after surgery pale in comparison to the benefits of being circumcised because preventative measures to reduce infection rates are important factors to consider if this policy is to succeed. It was further noted that the messaging in some cases was problematic as it tends to essentialise male circumcision to the exclusion of other equally important preventative matters in HIV-AIDS infection.

The transformative nature of education, specifically critical pedagogy which inculcates modes of thinking that enable actors to rethink the conditions that shape their lives, was emphasised in the whole policy intervention project, changing attitudes and behaviour. Teachers should be given a pronounced role in some of these interventions as they play an immense role as cultural mediators. Failure on this aspect results in policies that affect teachers falling far short on meeting their stated goals and targets.

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