

ETHICAL ASPECTS OF TRADITIONAL  
MALE CIRCUMCISION AMONG  
CERTAIN ETHNIC GROUPS IN SOUTH  
AFRICA: The grounds for change and  
societal intervention

By

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Thesis presented in partial fulfillment of the requirements for the award of the degree Master of Philosophy (Applied Biomedical Ethics) at the University of Stellenbosch, Republic of South Africa

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April 2014

## Declaration

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously, in part or in its entirety, submitted it at any university or educational institution for a degree.

SYDNEY LANGELIHLE SIBIYA

Signature:

Date: 20 February 2014

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## Acknowledgements

I would like to recognize the contributions of several people who assisted me in various ways in the preparation and writing of this thesis.

The staff of the Unit for Bioethics at the Centre for Applied Ethics in the Department of Philosophy at Stellenbosch University under the leadership of Professor Anton van Niekerk. I am grateful to them for introducing me to the study of philosophy and ethics, and for teaching me the art of logical and rational argumentation.

I am indebted to Professor A. A. van Niekerk for providing guidance during the writing of this work, and for his tolerance and belief in my capability even when he had sufficient reason not to do so.

Mrs Liesl van Kerwel, secretary of the Department of Philosophy at Stellenbosch, for always being helpful when needed.

The staff of the Language Centre Writing Lab at Stellenbosch University, for their excellent Scientific Writing Skills Workshop from which I gained valuable insights into the requirements for and format of scientific writing.

Author Mr Thando Mqgolozana, whose novel, 'A Man Who Is Not A Man' and electronic discussion with whom helped me gain initial insights into the ritual of traditional male circumcision as practised by the Xhosa ethnic group.

My wife Mbali, and my children Zandile, Siphesihle, and Ngiphiwe for their encouragement, understanding, and support.

## Abstract

Traditional male circumcision (TMC) is non-therapeutic ritual removal of the penile foreskin of a male person undertaken as part of a rite of passage from childhood into adulthood and manhood. The practice of TMC has received increased attention in recent years as a result primarily of complications that have led to hospitalization, penile amputations, and death of initiates.

This study is a literature review and philosophical-ethical reflection with the following objectives:

- To explain the current problems that beset TMC in South Africa
- To explore the socio-cultural context in which TMC takes place in South Africa
- To engage in ethical deliberation on the harms and benefits of TMC and determine whether, in its current form, the practice constitutes a net harm or benefit
- To establish the ethical basis on which society ought to intervene in TMC, and to explore the modes of intervention proposed.

Kepe (2010:729-730) identifies three concurrent crises that beset TMC in South Africa- the crisis of disease, injuries, and death suffered by some initiates, the crisis of the tension between the government and traditional leaders with regards to government intervention in TMC, and the crisis of the uncontrolled and negative way in which societal changes have impacted on the practice of traditional male circumcision. Male circumcision is the most widely accepted cultural practice among the Xhosa-speaking people of South Africa, and it is considered to be the only manner in which a boy can attain manhood and adulthood (Vincent, 2008).

In view of the ongoing, unambiguous and preventable harm associated with TMC as it is currently practised, I think that it ought not to be allowed to

continue in its current format. But I also think that the defect in TMC is remediable. I therefore feel sufficiently warranted to advocate for intervention to make the practice safer for all concerned. Intervention in TMC may be justified on public health, socio-cultural, autonomy, and beneficence grounds.

## Opsomming

Tradisionele manlike besnyding (TMB) is die nie-terapeutiese, rituele verwydering van die peniele voorhuid van 'n manspersoon. Dit word gedoen as deel van 'n seremonie van oorgang vanaf kinderjare na volwassenheid en manlikheid. Die praktyk van TMB het die afgelope jare toenemende aandag geniet, hoofsaaklik as gevolg van komplikasies van die prosedure wat gelei het tot hospitalisasie, peniele amputasies en dood van die persone wat geïnisieer is.

Hierdie studie is 'n literatuuroorsig en filosofies-etiese refleksie met die volgende doelwitte:

- Om die huidige probleme met TMB in Suid-Afrika te verduidelik
- Om die sosio-kulturele konteks waarin TMB in Suid-Afrika plaasvind, te ondersoek
- Om vanuit etiese oorweging te verduidelik wat die nadele en voordele van TMB is en te bepaal of die praktyk, in die huidige vorm, suiwer nadelig of voordelig is
- Om die etiese basis waarop die gemeenskap in TMB behoort in te tree, asook die voorgestelde metode van intervensie, te ondersoek.

Kepe (2010:729-730) identifiseer drie samevallende krisisse wat TMB in Suid-Afrika insluit – die probleem van siekte, beserings en dood ondervind deur sommige inisiandi, spanning tussen die regering en tradisionele leiers met betrekking tot regerings-intervensie in TMB, en die ongekontroleerde en negatiewe wyse waarin samelewingsveranderinge 'n impak het op die praktyk van tradisionele manlike besnyding. Manlike besnyding is die mees algemene aanvaarde kulturele praktyk in die Xhosa-sprekende mense van Suid-Afrika. Dit word beskou as die enigste manier waarop 'n seun manlikheid en volwassenheid kan bereik (Vincent, 2008).

In die lig van die voortdurende, ondubbelsinnige en voorkomende nadele wat geassosieer word met TMB soos dit tans beoefen word, dink ek dit behoort

nie toegelaat te word in die huidige formaat nie. Maar ek dink ook dat die gebrek in TMB herstelbaar is. Daarom voel ek genoegsaam verseker om intervensie te verdedig om die praktyk veiliger te maak vir almal betrokke. Intervensie in TMB mag geregverdig word op grond van publieke , sosiaal-kulturele en outonومiese voordele.

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## CHAPTER 1: INTRODUCTION AND BACKGROUND

Traditional male circumcision is non-therapeutic ritual removal of the penile foreskin of a male person undertaken as part of a rite of passage from childhood into adulthood and manhood. The practice of male circumcision is thought to have originated in ancient Egypt many thousands of years ago. Many varied reasons, sometimes contradictory, have been put forward for male circumcision by the cultures that practise it. The Jewish and Muslim faiths account for the majority of male circumcisions done for religious reasons. Other people perform circumcision for perceived hygienic and health reasons. In South Africa, traditional male circumcision is done mainly for socio-cultural reasons as part of the socialization and integration of boys into their communities, and as part of ethnic identification.

Among the indigenous African people of South Africa, traditional male circumcision is practised predominantly among the amaXhosa ethnic group in the Eastern Cape Province, the amaVendha ethnic group in the Limpopo Province, and the amaNdebele in the Mpumalanga Province. In this context, circumcision has historically had nothing to do with any perceived health benefits. The purpose which traditional male circumcision (TMC) is meant to serve may be divided into personal non-instrumental reasons, personal instrumental reasons, and community benefits:

(a). Personal non-instrumental reasons:

- It provides a sense of achievement
- It enhances self-esteem
- It provides a sense of belonging/identity

(b). Personal instrumental reasons:

- It provides access to community-sanctioned privileges such as sex, the right to marry, the right to ownership of property, the right of involvement and active participation in community affairs and ceremonies (Van Vuuren & De Jongh, 1999:144).

(c). Community benefits:

- It contributes to the survival of tribal customs
- It provides an available pool of people ready to go to war on behalf of the tribe
- It provides training ground on acceptable, socially-appropriate behavior for young members of the community
- It contributes to the enhancement of social cohesion
- It provides community validation of achievement of the requirements of a certain stage of growth.

TMC in South Africa is a practice that has endured over many centuries. The practice has received increased attention in recent years in both the popular media and academic literature primarily as a result of complications that have led to hospitalization, penile amputations, and deaths of initiates. (See table 1). Special attention has been focused in the Eastern Cape, as it is the area in which most of the complications have been reported. The quoted figures in the table are used for illustrative purposes only as the accurate denominator is often not known given the secretive nature of traditional circumcision, especially in the Eastern Cape. In addition to the broad therapeutic versus non-therapeutic classificatory scheme for male circumcision, the other category for its classification below the broad level is that of medical male circumcision (MMC) and traditional male circumcision (TMC). Medically-trained personnel perform MMC, typically in a clinic or hospital setting under local or general anaesthetic, with the use of conventional sterilized or disposable surgical instruments. It may also be done in a doctor's surgery. TMC is typically performed in the community by traditionally trained functionaries using traditionally available instruments and techniques, and typically without the use of any anaesthetic or analgesic. A comparison of the complication severity and rates between medical and traditional male circumcision shows a wide difference with those resulting from medical circumcision being predominantly minor complications and the rate of clinically significant complications not exceeding 1.5%. (Benatar and Benatar, 2003: 38; Short, 2004: 244)

There is paucity of literature that deals with the ethical considerations of tribal African traditional male circumcision in South Africa. The vast majority of the available literature concentrates on either cataloguing the medical complications of the ritual, or on the anthropological descriptions of the ritual and its purported symbolic meaning and significance. There are very few evaluative accounts of the practice itself. This study is a modest contribution to the discourse on specifically the ethical ramifications of the ritual and its complications. The practical motivation for undertaking this study is that, as a medical practitioner, I am acutely aware of the avoidable adverse consequences of suboptimal TMC, and am intimately conversant with the ease of performance and the relative safety of medical male circumcision. It is also hoped that some of the recommendations to be put forward in this study might assist in preventing avoidable deaths and suffering of initiates from ritual male circumcision. There are significant complications associated with traditional male circumcision. The more severe and significant complications are deemed avoidable, and therefore ethically troubling or difficult to justify.

The general consensus gleaned from the perused literature is that there is conflicting medical evidence regarding the risks and benefits of circumcision in general. (Short, 2004:243; Hutson, 2004:239; Mussel, 2004:254; BMA, 2004:259, 262; Mullen, 2003:249; Benatar & Benatar, 2003:43). Few authors have called for an outright ban of circumcision. There are several accounts that explore the vexed issue of intervention in the traditional practice by government authorities in order to modernize it and reduce the negative impact of its undesirable consequences. (van Vuuren & de Jongh, 1999; Vincent, 2008; Kepe, 2010). This study seeks to add to the voices that call for a reappraisal of aspects of traditional male circumcision. There are several difficulties associated with an enquiry into a subject as controversial as male circumcision in general, and traditional male circumcision in particular. The first difficulty is which criteria are to be used to assess the harms and benefits, and subsequently the permissibility or impermissibility of the practice? Broadly speaking, there are medical and non-medical (or cultural) criteria for the assessment of risks and benefits of TMC. The two sets of criteria are frequently conflated in the literature. Sometimes commentators do not

explicitly state which criteria they base their critiques on, or they may use exclusively medical criteria for the assessment of TMC sanctioned on non-medical grounds. Secondly, and related to the first difficulty, is the difficulty of weighing scientific medical, and sometimes western legal and moral criteria against particularist cultural criteria and deciding which should carry decisive moral significance. This may be termed the problem of multiculturalism or moral relativism. Thirdly, with regard to calls for interventions in cultural practices by non-cultural entities such as government and medical science, there is a difficulty of who carries the moral authority with regard to the practices and an associated difficulty of applying alien standards such as the notion of autonomy as understood in a liberal individualist perspective to an environment for which such notions were not naturally conceived.

This study is a literature review and philosophical -ethical reflection whose primary objectives may be summarized as the following:

- To briefly explain the current problems that beset traditional male circumcision in South Africa.
- To explore the socio-cultural context in which traditional male circumcision takes place in South Africa, with special reference to the Eastern Cape Province of the country.
- To engage in ethical deliberation on the harms and benefits of TMC and to determine whether, in its current form, the practice constitutes a net harm or benefit
- To establish the ethical basis on which society, in its various guises, ought to intervene in traditional male circumcision, and to explore the modes of intervention, with the specific aim of making the ritual safer for the initiates and society.
- To make recommendations informed by the outcome of the mentioned processes above, and to suggest directions for future enquiry in this field.

The study does not seek to promote circumcision as a preventive measure against HIV transmission. Although this paper may have implications for

circumcision done for religious reasons in the Jewish, Muslim, and other faiths, circumcision done under such conditions is not its focus. This paper will focus on traditional male circumcision as it is practised by the Black African members of the South African population.

Chapter 2 will provide a review of a sample of the relevant literature on male circumcision under the following themes: Interventions in Traditional Male Circumcision (TMC), Tradition and Modernity, The Ethics of Male Circumcision, Complications of TMC, Symbolic, Cultural, and Social Meanings of TMC, Male Circumcision and HIV Transmission, and On Liberty. Thereafter, building on some of the themes explicated in the literature review, an extended argument will be offered to establish the grounds for and modes of intervention in TMC. The last chapter will contain specific recommendations, suggestions for further enquiry, and the conclusion.

## CHAPTER 2: LITERATURE REVIEW

Things are defined mainly by what they are, but also partly by what they are not. In reviewing the scholarship on the subject of traditional male circumcision, attention will be paid to the literature that deals directly with the subject, as well as that which has an indirect bearing on it, in order adequately and comprehensively to illuminate the subject matter.

Traditional male circumcision is an instance of male circumcision, and, as such, it shares certain characteristics with other types of circumcision done under conditions and for reasons different from those that apply to traditional male circumcision. The two broad categories of male circumcision are therapeutic and non-therapeutic circumcision. Therapeutic circumcision is performed for a specific medical indication, e.g. phimosis, paraphimosis, penile warts, etc. It is employed to correct a specific defect or to improve or heal a specific ailment. Traditional male circumcision falls in the category of non-therapeutic circumcision wherein the operative procedure is undertaken in the absence of a medical indication. The interrogation of the literature shall be pursued under the following themes:

- Interventions in Traditional Male Circumcision
- Tradition and Modernity
- The Ethics of Male Circumcision
- Complications of Traditional Male Circumcision
- Symbolic, Cultural, and Social Meanings of Traditional Male Circumcision
- Male Circumcision and HIV Transmission
- On Liberty

## 2.1 Interventions in Traditional Male Circumcision

The authors under this theme look at what has precipitated government intervention in traditional male circumcision, the nature of such intervention, as well as the response of traditional leadership to the interventions. The work of three writers has been selected to represent scholarship in this theme – **Kepe (2010)**, **Vincent (2008)**, and **van Vuuren and de Jongh (1999)**.

I noted the following common observations in the three papers:

- All the three writers place the practice of traditional male circumcision (TMC) within a broader socio-political context, and view the practice as a contested terrain between the institutions of the democratic government and those of traditional leadership. (Kepe, 2010:730; Vincent, 2008:78; van Vuuren & de Jongh, 1999:144). Since the advent of the democratic political dispensation in 1994 in South Africa, there has been a further weakening of the power of traditional leadership that started in colonial times. Kings and chiefs now owe their legitimacy to the democratic government which determines who may legitimately claim a right to the throne in his tribe. The budgets of traditional leadership institutions come directly from provincial government coffers. There is also overlap of authority between the institutions of traditional leadership and those of the democratic government in the form of provincial and local government. Traditional and democratic institutions are required to function synergistically, and all their exercise of power is governed by the same democratic constitution. Urbanisation and the influence of Western and other cultures on the population have also had the effect of weakening the loyalty of the citizenry to institutions of traditional leadership. Access to education has also given former loyal subjects of traditional leaders increased economic freedom, mobility and self-sufficiency that have weakened their dependence on the institutions of traditional leadership. Under the conditions sketched above, the animosity of traditional leaders to further government encroachment on what they believe is their exclusive area of control- matters cultural, is not difficult to understand.

- They highlight the crisis of complications of TMC (hospitalization, penile amputations, and the death of initiates) as the trigger for societal concern and government intervention in the ritual on the basis of government's public health obligations.
- They highlight the generally negative view of government intervention in the ritual by traditionalists for whom hospital circumcision is largely unacceptable. (Kepe, 2010:732; Vincent, 2008:83; van Vuuren & de Jongh, 1999:144)
- The writers concentrate on government as the main protagonist in intervention and do not explore the possible contribution that could be made by other organs of civil society such as faith-based organizations, concerned citizens and parents of initiates, educational institutions, etc.
- All three writers attest to the fact that TMC is a deeply entrenched and overwhelmingly accepted cultural practice among the Xhosa-speaking section of the South African population. (Kepe, 2010:730; Vincent, 2008:79; van Vuuren & de Jongh, 1999:144). Citing Mayatula and Mavundla, Vincent has this to say about the significance of TMC:

*Male circumcision is the most widely accepted cultural practice among the Xhosa speaking people whether educated or illiterate, Christian or non-Christian. It is considered the only manner in which a boy ... can attain manhood and adulthood.*

- In all three papers, attention is focused primarily on TMC in the Eastern Cape Province. Additionally, van Vuuren and de Jongh give an account of TMC as practised by the amaNdebele in the Mpumalanga Province. They provide a useful contrast to the practice of the amaXhosa in the Eastern Cape.
- In spite of the generally unfavourable reception of government intervention by traditional leaders, there are clear signs and instances of their being receptive to some scientific medical influence in the surgical performance of and post operative care for traditional male circumcision. A specific case that supports this conclusion is that of the son of Chief Mwelo Nonkonyane whose surgical part of the circumcision ritual was performed by a medical

doctor before being whisked away to a circumcision school for the rest of the ritual to be conducted under the supervision of traditional functionaries. (Vincent, 2008:88). Chief Nonkonyane is a traditionalist and was one of the most vociferous critics of the Eastern Cape provincial government's statute (The Application of Health Standards in Traditional Circumcision Act, No. 6 of 2001) for the regulation and control of TMC when it was enacted in 2001. Van Vuuren and de Jongh (1999:150) also report that there was support in the community for compulsory pre-circumcision medical examination of all initiates, and that some men suggested that traditional surgeons should receive instruction on sterilization and use of surgical instruments. It is upon such seeds of common understanding that greater consensus could be built in order to make the ritual even safer for all concerned.

Kepe (2010:734) draws several conclusions from his paper. Firstly, he blames the media for fuelling the conflict between government and traditional leadership by what he calls sensationalist reporting. I do not agree with this view. The media reports on events that have occurred in reality and does not invent them. If the media puts a particular slant on the interpretation of certain events, that does not negate the fact that the events did take place. The media is also not obliged to report on the good news of government intervention only or at all. Secondly, Kepe asserts that the health crisis in traditional male circumcision is a government responsibility as government has a constitutional obligation to protect the health and life of people. I agree with this assertion, and further assert that the legitimacy of government involvement as well as that of the involvement of the broader public may also be justified on various other grounds such as public health considerations, parental authority considerations, cultural and beneficence considerations. These will be elaborated on in the discussion section of this study in the following chapters. Thirdly, he concludes that traditional leaders ignore the changes that have occurred in the ritual and that they may therefore have a limited insight into the associated problems, especially in urban settings. Some of the traditionalists' objections to government interventions may therefore be based on ignorance on their part. I agree with this observation.

Fourthly, he points out the contradiction in the attitude of traditionalists who resent the involvement of women in the ritual when some women among them are traditional leaders. He also points out that human rights apply to women equally as they apply to men. This view is uncontested. Kepe's paper is generally sympathetic to government intervention in TMC.

The tone and attitude of Vincent (2008:77) can be surmised early in her paper when she appears to place traditional male circumcision and virginity testing in the same moral category. She is sympathetic to the position of the traditional custodians of TMC, and she casts aspersions on the sincerity and neutrality of the government in this matter. She takes issue with the portrayal of all that is western/medical as inherently good and safe in contrast to the opposite view of all that is traditional and non-medical. She thinks that government intervention is aimed at legitimization of medical male circumcision and delegitimization of traditional male circumcision. Vincent (2008:81) further takes issue with the lack of understanding of the symbolic significance of certain aspects of TMC by the westernized government officials and medical practitioners, e.g. she says that the employment of anaesthetic during medical circumcision ignores the importance of pain in the eyes of the traditional custodians of the ritual. She suggests (2008:82) that the circumcision of initiates could be performed by a circumcised male nurse in a hospital setting, and then followed by their immediate return to circumcision school in the bush for traditional attendants/functionaries to preside over the non-medical aspects of the ritual. By stipulating that the male nurse must be circumcised, Vincent defers to the sensitivity of traditionalists. In the traditional setting where TMC is practised, an uncircumcised male is not considered to be a man, but is thought at best to be a boy, and at worst a dog. Such a person is not allowed to have anything to do with TMC or any other important community ceremonies. I suppose that Vincent thinks that the traditionalists would take strong exception to anyone, irrespective of his age, being involved in the circumcision of initiates when he himself is uncircumcised. The envisaged circumcised nurse must also, of necessity, be a male person because it is taboo to involve women in TMC, or even to discuss the ritual with them. I agree with the suggestion of involving trained

personnel in the surgical performance of the circumcision expressed here. I would, however, like to take this point a step further and suggest that skilled medically trained personnel in the natural traditional setting could perform the actual surgical excision. This would entail that initiates remain in the traditional environment where the ritual takes place and that skilled personnel is transported to the bush to preside over the strictly surgical component of the TMC ritual. Vincent cites an example in which the medical assistance of initiates was offered in the bush when necessary. (2008:82). To support her contention that the manipulation and administration of death in society is a function of power relations, Vincent (2008:84) quotes instances of the implication of unsafe practices by medical staff in hospitals in the deaths of babies and says these deaths do not draw similar public and government outrage as those resulting from TMC gone awry. Although the writer has a point in pointing out the inconsistencies and possible double standards, two wrongs do not make a right. She further asserts that the threat of HIV has been discursively employed to legitimize regulation of traditional male circumcision. I agree partly with this view, and will expand on it later when I assess the literature under the heading of "Male Circumcision and HIV Transmission". In the last section of her paper, Vincent deals with the traditionalists' appeal to cultural authenticity and exposes this appeal as false and disingenuous. She attempts to provide balance in this section with the harshness with which she assesses government intervention in TMC in the earlier section of the paper.

Van Vuuren and de Jongh (1999:143-144) describe the four stages of the circumcision ritual (pre-ritual preparation, circumcision stage, period of seclusion, and reintegration into society) in its more traditional rural setting. They then highlight adjustments in these stages and the whole process of initiation occasioned by urban constraints. The authors point out that there are three perceived levels of the rationale for circumcision. These are firstly, that male circumcision provides fundamental everyday integration into and recognition within Xhosa society. Secondly, they assert that circumcision is also based on strategic and instrumental reasons such as access to resources and privileges. Once a man has been circumcised, he is eligible to

marry, to own property, and to sit and discuss important community affairs with other men. He acquires a recognizable and acknowledgeable voice in the community. The community bestows an elevated status to a man who has achieved manhood through the ritual of traditional male circumcision. Thirdly, they assert that TMC provides a distinctive ethnic identity. Their paper adds an important dimension to the debate on TMC when they make comparisons between TMC done in the Eastern Cape among the amaXhosa and the practice in Mpumalanga among the amaNdebele ethnic group. They point out that, in Mpumalanga, the royal household controls the Ndebele ritual with supervision by headmen and that there is extensive involvement of medical practitioners in the performance of the surgery. They further point out that TMC in Mpumalanga is largely free of complications, and that mortality seemed to be the exception. (1999:151). The experience of TMC in Mpumalanga serves as a living example that co-operation between medical practitioners and traditional leadership and functionaries can be made a practicable reality. The authors call for a design of interventions in TMC that are contextually appropriate and acceptable to the relevant communities and for anthropologists to assist in this regard.

## **2.2 Tradition and Modernity**

The text that will provide the background for scholarship review under this subheading is a book by **Kwame Gyekye** (1997), "Tradition and Modernity: Philosophical Reflections on the African Experience". I shall also review **Jeffrey Bishop's** paper titled 'Modern Liberalism, Female circumcision, and the Rationality of Traditions' (2004), and then supplement Bishop's analysis with a brief overview of **D.A. Crocker's** essay titled 'Insiders and Outsiders in International Development' (1991). Lastly, in order to provide balance to and contrast with Bishop's paper, I shall review **Loretta M Kopelman's** (1994) article titled "Female Circumcision/Genital Mutilation and Ethical Relativism".

As it may be guessed from its title, Gyekye's book is not about male circumcision. Neither is it about traditional male circumcision. My motivation for interrogating the relevant chapters of the book is that, firstly, I hope to

show the socio-cultural milieu in which traditional male circumcision takes place within an African setting. Secondly I aim to show, with the aid of Gyekye's analysis, that there are socio-cultural grounds on which intervention in traditional male circumcision may be justified.

The notion of culture and tradition is often deployed in defence of traditional male circumcision. The same notion, together with the need to modernize, is also often cited in criticism of traditional male circumcision. The proponents of TMC claim the right to practise their culture, cultural authenticity, and the view that tradition has inherent authority over other considerations, to support their rejection of any interference with or intervention in cultural practices. Tradition and modernity are often presented as mutually exclusive and inherently antagonistic notions. I wish to dispel some of these mythical viewpoints and put tradition, culture and modernity in their appropriate perspectives.

Gyekye (1997:26) asserts that no human culture has remained pure since its creation, free from external influences. He defines culture as the entire way of life of a people as expressed by the complex of values, practices, and institutions. (1997:44). He further characterises culture as the enduring patterns of thought and ways of acting and behaving that have been created, fostered, and nurtured by a people over time and by which their lives are guided and conditioned. (1997:107). He advises that the grounds for the acceptance or rejection of a cultural tradition ought to be normative or practical in view of his assessment that however primitive a cultural tradition may be, it would have positive as well as negative features. (1997:xi). In order to be able to pronounce on the desirability or otherwise of TMC, one would need to weigh its positive against its negative features based on normative and practical considerations.

He further asserts (1997:36) that the moral status of a person raises questions about the status of the rights of the individual, how the individual sees his socio-ethical duties/roles in relation to the interests and welfare of the community, and the existence and appreciation among individual members of society of a sense of shared life or common collective good. The above

considerations are essential to the assessment of the autonomy of the individual in relation to the performance of TMC on his person, the relative strengths and the extent of the correlativity of individual rights and communal duties, and the meaning of the common good in relation to communal cultural practices as exemplified by TMC.

Gyekye (1997:36) holds that the communal or communitarian orientation of African moral and political thought characterises social relations among individuals in African societies. He quotes the view of John Mbiti as an example of the communitarian nature of the African culture, "Whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual". (1997:36-37). Although he believes that the community is prior to the individual, Gyekye holds that moderate communitarianism best describes the form of communitarianism that African societies ascribe to. After exploring the basic assumptions of radical and moderate communitarianism, he concludes, " I think that the most satisfactory way to recognize the claims of both communality and individuality is to ascribe to them the status of an equal moral standing". (1997:41) I contend that, admirable and fair though this moral stance is in theory, it cannot, in practical reality, be brought into fruition. One may be predominantly individualistic or predominantly communitarian in one's orientation, but it is impossible to be equally faithful and to do equal justice to the demands of both orientations at the same time. One could devise deadlock-breaking and consensus-enhancing mechanisms, but by their nature, these tools lead to compromise wherein there cannot be equal satisfaction or dissatisfaction after a particular course of action is decided upon. On certain occasions, the demands of individuality will trump those of communality, and on other occasions, the reverse will hold true. Gyekye (39-40) himself says that the community must be held as prior to the individual. This cannot be said to be a neutral stance. The foregoing is relevant in the assessment of the merits of presumed communal consent versus express or tacit individual consent or refusal of traditional male circumcision.

In his analysis of ethnicity, identity, and nationhood, Gyekye (1997:79-114) distinguishes four different varieties of a nation from one another- N1, N2, N3, and N4. N1 is considered to be a homogenous ethno-cultural group that shares common cultural values, practices and institutions. N2 is a variety of a nation that is formed by the grouping together of distinct communo-cultural groups as described in N1. N3 is similar in composition to N2, with the important difference being that, in N3, there is a greater degree of social cohesion and a concomitant reduction of specific ethno-cultural particularism among individual members of the various ethno-cultural groups. N4 represents a meta-national state in which individuals are the building blocks of a nation and owe their allegiance to the state and not to their original ethno-cultural group identities. I contend that the South African nation has characteristics that are largely consistent with N2, but also has features of N3. If my characterization of the current level of development of the South African nation is correct, the strong cultural acceptance of traditional male circumcision by some ethno-cultural groups and its rejection by others is an understandable phenomenon.

Gyekye (1997:219) quotes HB Acton as defining tradition as a belief or practice transmitted from one generation to another (and one that has lasted over at least three generations) and accepted as authoritative or deferred to without argument. In this sense, a cultural practice or belief could ossify into a tradition with the passage of time. Gyekye's own comprehensive definition of tradition is the following, "A tradition is any cultural product that was created or pursued by past generations that, having been accepted and preserved, in whole or in part, by successive generations, has been maintained to the present". (1997:221) His further elucidation of this definition is best left to his own words for its full import and implication to be adequately understood:

*This means that the continuity and survival of a pristine cultural product depends on the normative considerations that will be brought to bear on it by a subsequent generation. The forebears- the previous generations- do not "transmit" their cultural creations as such; what they do, rather, is to place them at the disposal of subsequent generations of people. But the subsequent generations may, on*

*normative and other rational grounds, either accept, refine, and preserve them or spurn, depreciate and, then, abandon them. The desire or intention of a subsequent generation to preserve or abandon inherited cultural products often result from some kind of evaluation of those cultural products and the tradition they lead to. Such critical evaluations are essential for the growth and revitalization of cultural traditions. (1997:221)*

Part of the purpose of this study is the evaluation of the tradition of male circumcision as it is practised by Black African South Africans. Gyekye implies that it is natural, expected, and necessary for cultural products bequeathed on a people by their ancestors to be continually subjected to normative and practical evaluation informed by what is normative and practical at the time. The survival of a cultural tradition depends on such evaluation.

Bishop's paper (2004) is specifically a critique of the Western liberal tradition's moral stance towards traditional female circumcision. It is an emotive argument in favour of moral relativism. The relevance of Bishop's paper for the present study is twofold. Firstly, the lessons learnt from the practice of female circumcision may be relevant for the ethical analysis of male circumcision. Secondly, although I maintain that male and female circumcisions are surgically and morally different procedures, I concede that some similarities may be drawn between the two practices. One such similarity is that some proponents of the two practices may put forward similar metaphysical justification for both practices. The mistake that most critics of male circumcision commit is that they often pretend that these practices are identical, instead of giving a balanced view by pointing out pertinent similarities and differences.

The upshot of Bishop's analysis is that he endorses moral relativism in as far as the practice of female circumcision (FC) is concerned. He states that practices such as FC cohere within a web of beliefs applicable in a particular cultural tradition. As such, he asserts that the standards of justification and rationality with regard to such practices must be those defined and accepted within the specific tradition (Bishop, 2004:474). He holds that if the standards

are accepted as satisfactory within the tradition, there is no need to further justify the practices by criteria established by liberal individualism which are located outside the moral framework of practicing peoples and communities. Bishop gives detailed clinical and cultural descriptions and meanings of FC (2004, 475-480). He asserts that the ability to provide counter-factual points against the perceived cultural meaning/reasons for FC is of little consequence to the role played by the practice and its meanings to the culture (2004:479). He sees the beliefs about the practice as embedded in a web of beliefs about the world and one's place in it, and not as mere reasons given independent of the web (2004:479). He asserts that the FC ceremony marks the communal acknowledgement of adulthood.

Bishop asserts that when Westerners see a list of socio-cultural reasons proffered for the conduct of FC, they see a factually refutable list only because they do not have access to the web of beliefs and the cultural context within which the practice is coherent. As a result of their perceived ignorance, Westerners are said to superimpose on the bodies of African women, the merely material consciousness of Western scientific thinking, and they therefore pass judgment on practices on which they lack insight and context (Bishop, 2004:480). I understand Bishop here to be saying that critics of female circumcision whose moral frame of reference is located outside the cultural milieu of the practicing communities, are not in a position to judge the moral permissibility or impermissibility of FC using their western liberal individualist moral framework because their framework is not applicable, and it is insufficient to judge culturally-sanctioned FC which has moral and rational coherence within a framework different from that of liberal individualism. It will be shown when Kopelman's work is reviewed below that such cross-cultural moral judgments that Bishop refers to may actually be made and that they may have moral authority and validity.

Bishop takes issue with the naming of practices such as female circumcision. He asserts that giving such practices Western and scientific clinical names has the tendency to denude the practices of their deeper socio-cultural meanings and significance (2004: 480-482). He states (2004:482),

*By naming these practices using the internationalized languages of modernity..., the traditional value of the practices - cohesion of culture, what it means to be woman in that cultural tradition, and her status in that society – no longer have to be entertained as central to the understanding and justification of the practices. Thus, that which the practice embodies beyond its action is lost in the translation into the language of modernity.*

I think that something can be learnt for our study here. In criticizing traditional male circumcision, for example, critics often conflate the medical reasons and the cultural reasons for TMC. These should be separated and dealt with individually in turn. If TMC is criticized from a cultural perspective, we need to show that it is incoherent based on cultural criteria. We need to show that it does not achieve the goals that it is purported to achieve. Alternatively, we need to show that, in achieving its intended objectives, it causes such collateral damage as to significantly negate or nullify the intended positive goals, or that its performance is not in line with the underlying assumptions of its proponents.

Quoting Alasdair McIntyre in *Whose Justice, Which Rationality* (1988), Bishop holds that a practice makes sense because it coheres within the fabric of its adherents' beliefs about the world, and does not need any further external justification (Bishop, 2004:483). He states specifically that, "a justification outside historical and cultural circumstances is itself a product of modern philosophy" (2004:484). Bishop asserts that there is no standard that transcends all cultural phenomena, and that therefore, practices are justified within the framework of those traditions that practice them, because rational justification has its own standards generated within the tradition itself (2004:484). I find this assertion of Bishop's

highly contentious and without foundation. If this line of thought were taken to its logical conclusion, we could allow that people or cultures who believe that the earth is flat are right to believe so if they have a justification that their culture accepts to be rational within its framework of rationality. And those that believe that the earth is round would also be equally justified to believe so from the authority of their standards of rationality. This would obviously render the notion of rationality a meaningless one.

In the second half of his paper, Bishop aims to discuss the possibility of dialogue between traditions of moral and rational enquiry with the assistance of the work of Alasdair McIntyre. He states that, according to McIntyre, a tradition begins with a certain set of premises, such as what defines human nature and the human good or human telos. He holds that these definitions are only possible from within a cultural, historical, and linguistic context. That means that what counts as rational is bounded by the starting points, the perceived goals, and the milieu within which it occurs (Bishop, 2004:487-488). Bishop concedes that the logical consequence of his analysis is that there are disagreements between different moral and rational frameworks or traditions (2004:488). He asserts that the only way that the identified disagreements can be resolved is through linguistic kinship between traditions in order to facilitate the delineation of which conflicting sets of premises are in question (2004:488). Quoting McIntyre (1988), Bishop asserts that there is no set of independent standards of rational justification by appeal to which the issues between contending traditions can be decided (2004:488). He states specifically, "There is no place outside of a tradition from which one can objectively assess the tradition" (Bishop, 2004:489).

In order to bridge the gap of understanding between conflicting traditions, Bishop holds that McIntyre offers a way out outside the possible options of either asserting the Western form of moral-rational justification as the one that all cultures must adhere to, or accepting moral and rational relativism. He accurately diagnoses that change in a specific tradition occurs as a result of both internal questioning/dissent from within the tradition as well as from challenges posed to the tradition from outside itself (2004:490). But I think that he fails in his explanation of how the external challenge from contending traditions interact with the index tradition to facilitate transformation or a modification of its assumptions or goals. He gives the impression that cultures influence each other only by mere passive osmosis. He even uses the following description, “one tradition bumps up against and challenges another tradition” (2004:490). Bishop does not seem to be aware of or acknowledge that there are often fierce, active contestations between cultures and traditions to gain currency and influence in a contending culture or tradition. Another weakness of Bishop’s analysis in the second half of his paper is that he contradicts himself. Whilst he accepts that conflicting or alien traditions have a role to play in influencing an index tradition, he however shuts out the space for such possible influence. For an example, Bishop asserts that internal dissent does not mean that South Africans are in a position to critique those in East Africa who participate in practices such as female circumcision, but that those who speak the same cultural language must call the practices into question (2004:490). Bishop does not admit to such critique from external traditions beyond the ‘bumping’ of traditions against each other.

I found the second half of Bishop’s analysis less lucid than his first half. Although he expressly states that his analysis, based

on McIntyre's understanding of the development of traditions, is a third way that avoids either accepting relativism or liberalism, the reading of his further analysis reveals that it is rooted in moral and rational relativism. He asserts that truth claims are constantly challenged, and that at some point they can become institutionalized and made authoritative within a tradition, but they will only last as long as they withstand internal and external dialectical challenges (2004:491-492). But then Bishop prioritizes and privileges the influence of challenges internal to the tradition. He asserts that assessing a judgment against a fact does not form truth or falsity. He states that McIntyre prefers to establish true and false judgments in terms of traditions of enquiry. Bishop subscribes to McIntyre's preference. What has just been described is the essence of moral relativism that Bishop aimed to transcend.

Perhaps the most pertinent relevance of Bishop's work for the present study is that it attempts to justify female genital mutilation from the standpoint of ethical relativism. This is the same standpoint from which some practitioners and supporters of traditional male circumcision justify that cultural practice. The merits and demerits of Bishop's argument in relation to female genital mutilation would therefore be applicable to the analysis of traditional male circumcision in as far as ethical relativism is advanced as a justificatory basis for the latter cultural practice is concerned. All in all, in my opinion, Bishop's argument fails to make a morally persuasive and rational case for the acceptance of the practice of female genital mutilation. He also fails to provide rational support for his argument that it is not possible to make cross-cultural judgments that have moral and rational authority as will be discussed below when Loretta Kopelman's paper on female genital mutilation and ethical relativism is discussed. Bishop's argument fails on empiric grounds that female genital

mutilation is associated with distinct, significant, and overwhelming harms and no obvious benefits. It also fails because his whole argument is justified on the basis of absolute ethical relativism, a framework for moral decision-making that has empiric and logical inconsistencies and incoherence. The other possible positive contribution of Bishop's paper is that it heightens our sensitivity to the complexity and possible limitations of transcultural, transhistorical, and trans contextual judgments. I would, however, suggest that David Crocker's (1991) understanding of cross-cultural communication and influence provides a more useful and persuasive analysis for the study of traditional male circumcision. I will only give a brief overview of Crocker's authoritative essay.

Crocker's essay is a reflection on who should engage in international development ethics and how such engagement should be executed. He defines international development ethics as moral reflection on the ends and means of societal and global change (Crocker, 1991:149). Crocker expressly states that, although his remarks are addressed to development ethicists, he believes that they are relevant to those involved in other forms of cross-cultural and global ethics as well (1991:170). I share Crocker's belief. In relation to his subject matter, Crocker was attempting to answer primarily the following question, "Should only a society's members morally evaluate that society's present development models, policies, and practices, or do foreigners have a contribution to make as well?" (1991:149).

Crocker extensively describes ethnocentrism, possible responses to ethnocentrism, and social insiders and outsiders in relation to social, cultural, national, and international groups. The scope of this study does not allow for a detailed

dissection of these concepts, but we may learn something from an abridged version of what they entail. He defines ethnocentrism as 'a habitual disposition to judge foreign peoples or groups by the standards and practices of one's own culture or ethnic group, and the employment of one's own standards to make invidious comparisons, judging foreign standards and practices as being inferior to those of the evaluator' (Crocker, 1991:150-151). An insider is defined by him as one who is counted, recognized, and accepted by himself and the other group members, as belonging to the group on the basis of shared beliefs, desires, memories, and hopes (1991:155). A social outsider is the opposite of an insider. Crocker describes the advantages of insiderness as the following:

- An insider knows what things mean to the community
- As part of the 'we', the insider ethicist has the capacity to make himself understood as a conversation partner in the group's dialogue about its identity (1991:161)
- The insider's moral judgments about the community's past, present, and future will be in terms accessible to the community in question
- Insider standing gives the ethicist a prima facie right to criticize the group's development path (1991:161).

Crocker thinks that the advantages of being a social outsider are the following:

- An outsider may see and reveal things that an insider misses
- An outsider can be free from an insider's prior commitments and loyalties. This freedom can enhance

the outsider's ability and willingness to say what needs to be said (1991:168).

Crocker advises that development ethicists should combine insiderness and outsidersness in such a way as to accentuate the positives and reduce or eliminate the negatives of both postures (1991:170). Outsiders should be sufficiently inside so as to immerse themselves in the different form of life of the insiders, to grasp some of what is going on, and to be accepted as dialogue partners (1991:170). He however cautions social outsiders not to mislead themselves or others by pretending to ascend to what is an impossible standpoint - a view of the inside from an ahistorical, transcendent, objective outside. He categorically rejects the existence of such a 'view from nowhere' (1991:170). Crocker further quotes Nussbaum and Sen to drive home the same point of rejecting non-contingent judgments as saying, "Ethical enquiry, Aristotle insists, must be what we might call 'value-relative'. That is, they are not 'pure' enquiries conducted in a void; they are questions about living asked by communities of human beings who are actually engaged in valuing" (1991:160-161). Crocker suggests that cross-cultural communication and judgments may be engaged in. He suggests that such cross-cultural communication and challenge is necessary for the mutual growth and development of contending cultures. The only proviso is that those doing the influencing, challenging, and evaluating must immerse themselves sufficiently in the rival culture so that they may gain some understanding of the language, meanings, and connections made by insiders of a particular culture and establish their bona fides as dialogue partners. Crocker's language appears to me to be predominantly grounded in descriptive relativism. Unlike Bishop, he accepts that cross-cultural judgments are necessary and possible. Although he advises familiarization

with the language of the foreign culture as a prelude to cross-cultural communication and judgment, he appears to be giving this advice as an aid to broaden the ethicist's understanding of what he wishes to influence and judge, but not in order to preclude rigorous rational assessment of the practices and institutions of a foreign culture.

Kopelman's paper (1994) is an excoriating criticism of female circumcision/ genital mutilation and a rebuttal of ethical relativism as a viable tool for moral judgment in cross-cultural contexts. Her argument will be viewed against Bishop's wholehearted embrace of ethical relativism in moral deliberation.

Kopelman confirms the scale of the practice when she quotes estimates of 80 million women who have undergone the procedure of female circumcision worldwide (1994:55). She further lists the groups of reasons proffered by those who promote this practice as the promotion of chastity, religion, group identity, cleanliness, health, family values, and marriage goals (1994:55). She rejects the notion that morally right and wrong actions are defined on the basis of whether they are approved or disapproved by a person's society or culture. She prefers that moral judgments should be made on the basis that they are defensible with reasons that are consistent and empirically defensible. "Moral judgments do not describe what is approved but prescribe what ought to be approved" (1994:56).

Kopelman's classification of female genital mutilation is essentially in agreement with that followed by the American Association of Paediatrics and Toubia and which is described below. She then deals briefly with the complications of the procedure, which are the following:

- Pain, bleeding, infection, and shock

- Urinary retention and incontinence
- Chronic pelvic infection
- Scarring and associated difficult and painful intercourse
- Menstrual difficulties
- Bowel and urinary tract fistulas
- Obstructed labour with feto-maternal complications
- Psychological Complications, and
- Death (1994:58).

Kopelman reports that researchers on female genital mutilation argue that the reasons advanced to support the performance of the procedure float on a sea of false beliefs (1994:61). She counters each of the reasons given above as the justification for the practice by providing counter arguments and empiric evidence that those reasons are false (1994:61-63).

The second part of Kopelman's paper deals specifically with ethical relativism and she uses female genital mutilation to illustrate her point that there are distinct circumstances in which it is eminently possible and justifiable to make intercultural judgments that have moral authority and validity. She acknowledges the validity of descriptive relativism – the view that people from different cultures do act differently and have distinct norms. She also accepts that culture has an influence on moral development, reasoning, norms, and decisions. She however rejects the notion that descriptive relativism should be viewed as synonymous with and as a basis for the acceptance of ethical relativism (1994:59-60). Kopelman's primary argument is that people from different cultures share sufficient evaluative tools/standards and some values to enable meaningful cross-cultural discussion and to make it possible, in some instances, that people can make sound cross-cultural judgments that have moral force and

authority. She does not adopt an absolutist view that this is possible in all instances. Kopelman gives four premises for the conclusion reached above:

- The methods of discovery, evaluation, and explanation that people from different cultures share may be used as a basis for making cross-cultural moral judgments. Kopelman gives the examples of science, engineering and medicine as areas that people from different cultures understand in common terms (1994:60).
- We share some moral values such as the duty to help children, the duty not to cause unnecessary suffering, and the need for food and shelter (1994:61). These shared values may be used as a basis for making authoritative and valid cross-cultural moral judgments. Even in instances in which values are not ranked similarly between cultures, it is still possible to have coherent discussion and criticism about their consistency, consequences, and factual presuppositions (1994:60-61). This view counters Bishop's assertion that the critics of female circumcision who are not from circumcising cultures are not in a position to judge the moral permissibility or impermissibility of the practice because their moral framework is not applicable and is insufficient to judge culturally sanctioned practices.
- "The fact that a culture's moral and religious views are often intertwined with beliefs that are open to rational and empirical evaluation can be a basis of cross-cultural examination and intercultural moral criticism" (1994:63).
- To determine the wrongness or rightness of an act based on whether or not it is approved by a culture is problematic because there is no clear distinction between one culture and the next, and because ethical relativism breaks down in cases where there is

significant disagreement on a particular issue within a culture (1994:64).

Kopelman succeeds in exposing the weaknesses in Bishop's argument on ethical relativism. This is made even easier by Bishop's adherence to the strand of relativism that is absolutist. It only requires a single instance of a counter example to break down his thesis. Bishop holds the view that one can never make a sound cross-cultural judgment that has moral force and acceptability. Kopelman provides evidence that it is possible to do so, at least in some instances.

The **American Academy of Paediatrics'** (AAP) Committee on Bioethics describes female circumcision/female genital mutilation (FGM) (1998) as the traditional custom of ritual cutting and alteration of the genitalia of female infants, girls, and adolescents. The committee warns that this ritual genital procedure has serious and life-threatening health risks for children and women (1998:153). The authors of the statement on FGM distinguish among four types of FGM as follows:

TYPE 1 FGM/CLITORECTOMY: involves excision of the skin surrounding the clitoris with or without excision of part or the entire clitoris.

TYPE 2 FGM/EXCISION: Entails the removal of the entire clitoris and part or all of the labia minora. Crude stitches of catgut or thorns may be used to control bleeding.

TYPE 3 FGM/INFIBULATION: The entire clitoris and some or all of the labia minora are excised, and incisions are made in the labia majora to create raw surfaces that are stitched together to cover the urethra and vaginal

introitus, leaving a small posterior opening for urinary and menstrual flow.

TYPE 4 FGM: Includes different practices of variable severity including pricking, piercing or incisions of the clitoris and or labia, cauterization of the clitoris or the introduction of corrosive substances into the vagina (1998: 153-154)

The committee asserts that the physical burdens and potential physical harms associated with FGM violate the principle of non-maleficence as well as the infants' and children's right to good health and well-being (1998:154). Quoting Kopelman, they enumerate four reasons put forward to explain the custom of FGM:

- To preserve group identity
- To help maintain cleanliness and health
- To preserve virginity and family honour and prevent immorality
- To further marriage goals, including enhancement of sexual pleasure for men (1998:154).

Toubia's classification of FGM is similar to that adopted by the AAP. She asserts that female circumcision is a major contributor to childhood and maternal mortality and morbidity in communities with poor health services. She further states that, from the perspective of public health, female circumcision is much more damaging than male circumcision. Among other complications, she enumerates the following psychological and sexual effects:

- Chronic anxiety
- Depression
- Intractable dysmenorrhea (painful menstruation), and

- Fear of infertility (1994:714)

### 2.3 The Ethics of Male Circumcision

I shall review the work of several scholars on this theme. Some of the work deals specifically with traditional or ritual male circumcision, and other work deals with neonatal medical male circumcision, and male circumcision in general. Where significant practical and moral differences exist, these will be pointed out.

Most of the reviewed scholarship holds that parents are the most appropriate people to decide, within societally-defined limits, on the permissibility or otherwise of the circumcision of their sons. They also assert that the medical evidence for and against male circumcision is either neutral or points to a marginal benefit of the procedure.

Those who oppose male circumcision generally focus on the medical or health risks of the procedure and disregard any potential non-medical benefit. They also seem to disregard the parental prerogative and authority to consent to or refuse circumcision on behalf of their minor sons. They tend to think that if a parent consents to circumcision on behalf of his or her minor son, then the son's right to bodily integrity and his right to future choice have been violated.

**Brusa and Barilam** (2009) explore the ethical aspects of introducing cultural circumcision of children from circumcising communities into European Union public hospitals. The paper deals specifically with medical male circumcision performed for cultural reasons in jurisdictions that do not ordinarily perform circumcision for this purpose.

The authors assert that, in terms of evidence-based medicine, circumcision probably prevents some mainly infectious diseases, but that the number-needed-to-treat is much too high to justify universal practice (2009:471). On the distinction between religious and cultural reasons for circumcision, and the concomitant privileging of religious circumcision over cultural circumcision, the authors find that such a distinction is unacceptable on the basis that there are

intricate links between culture and religion, and that there is no specific reason to regard one as morally weightier than the other (2009:471). I fully agree with this view. Brusa and Barilam point out that, in contemporary Islam, 'anatomical' circumcision- the adequate physical removal of the foreskin is valuable to the community whereas the act itself and its mode of performance are spiritually negligible (2009:476). In the context of TMC within the Xhosa tribe, I contend that the manner of the performance of the procedure, where it is performed, and by whom it is performed, carry more spiritual significance than the mere anatomical removal of the foreskin. This point has relevance for the possible reactions of traditionalists to medicalization of ritual male circumcision.

The authors find the question of autonomy with regard to circumcision done as part of the socialization of children to be a double-edged sword. They point out that, on the one hand, men may protest against the violation of their bodies when young and unable to protest; on the other hand, they might also complain against the omission of circumcision at an age when it is significantly less painful, risky, and complicated (2009:477). I empathize with the dilemma pointed out by Brusa and Barilam, but I do not agree that circumcision performed in childhood is significantly less painful than that performed in adulthood. Brusa and Barilam assert that circumcision has a constitutive role in many cultures-it assists in the finalization of the consolidation of personal identity (2009:477-479). They assert that, viewed from this role, the omission of circumcision amounts to child neglect (Brusa & Barilam, 2009:478).

Brusa and Barilam conclude that, on the basis of the utilitarian argument, they are in favour of tolerating medical circumcision for cultural reasons in EU hospitals (2009:479). The utilitarian argument, according to the authors, is based on the avoidance of complications of cultural circumcision and the mitigation of stigma. They believe that the performance of circumcision in EU public hospitals is justified in cases where failure to do so might result in painful and risky circumcision by non-expert hands (2009:479). They assert that further support for circumcision is derived from the recognition that,

growing up circumcised is better for the socialization of children in their native circumcising communities. They assert that, in such circumstances, the omission of circumcision could amount to active stigmatization of children (2009:480-481). They hold that such stigmatization could be more painful and debilitating than many medical complications of circumcision.

Brusa and Barilam's paper is relevant for the present study on three counts. Their contention that the dichotomy between religious and cultural reasons for circumcision is false is in concert with our own assessment of this issue. Their delineation of the anatomical and spiritual significance of circumcision has a bearing on how interventions in traditional male circumcision may be introduced and received. Finally, the utilitarian argument establishes a justification for the performance of male circumcision sanctioned on cultural grounds in a medical facility and by medical personnel. The coherence of the utilitarian argument has our support.

In 2004, the **British Medical Association** (BMA) published an article that sought to provide guidance for doctors on the issue of non-therapeutic circumcision. The BMA believed that parents should be entitled to make choices about how best to promote their children's interests, and that it is for society to decide what limits should be imposed on parental choices (2004:260). The authors of the paper stated that, at least in the United Kingdom, circumcision is considered lawful if it satisfies three basic requirements:

- It is performed competently
- It is believed to be in the child's best interests
- There is valid consent.

The BMA upheld the authority of parents to make choices for their children who cannot make their own choices, but advised that the wishes of children who are capable of expressing a view should be sought and taken into account when a determination is being made whether or not they should be circumcised. Based on the South African experience with traditional male circumcision, it is clear that there are problems with all the three basic

requirements for lawfulness advanced by the BMA. It is generally accepted that complications from TMC arise mainly from operations done inexpertly. There is debate about what are the child's best interests and who ought to pronounce on those. Consent in TMC is also a problem. Many minors go to circumcision school without the consent of their parents, and it is debatable whether the wishes of those children who have the capacity to deliberate on the desirability of circumcision are routinely sought and engaged with. Although the BMA (2004:261) holds that parents are entitled to determine whether non-therapeutic circumcision is in their child's best interests, it asserts that parental preference alone is not sufficient justification for performing a surgical procedure on the child. It cites many other factors that must be taken into consideration in decision-making, including the risk of harm or suffering for the patient, the patient's religious or cultural background, and the patient's physical and emotional needs. The BMA (2004:262) concludes that the evidence concerning the health benefits from non-therapeutic circumcision is insufficient for it alone to provide justification for the procedure.

**Mussel's** article (2004:254) is a commentary on the BMA's guidance on non-therapeutic circumcision. Mussel supports the BMA view that there is conflicting evidence for the clinical benefit of male circumcision. Given the assessed equivocal nature of the medical evidence, Mussel states that the balance of harms and benefits turned on the more indefinable and disputable concepts of harms and benefits, i.e. cultural, social, and psychological factors. He states that the arguments for net harm in the BMA document focused on the breach of children's rights to be free from physical intrusion and the right to choose in the future (Mussel, 2004:250). I contend that this latter right- the right to choose in the future is a dubious right. The authority of parental consent for medical procedures on behalf of their minor children is a well-established practice in medical ethics. If society were to wait until children developed sufficient capacity for autonomous choice on significant matters in their lives, society would be obliged not to educate children until they decided themselves when older whether they desired any education at all, and what type of education they desired. We would also be obliged not to expose them

to contact with other people lest our choice of associates conflict with our children's future choices. This would obviously lead to untenable, ridiculous, and tragic consequences.

**Viens** (2004:242) opines that the proper assessment of the moral permissibility of circumcision needs to be made by parents on the basis of an informed deliberation concerning all potential medical and non-medical risks and benefits of the procedure. This is a sane and prudent stance. He emphatically states that allowing a parent to choose whether or not to have their son circumcised does not violate the son's human rights (2004:245). Viens cautions bioethicists that, when formulating norms governing biomedical policy, they should take into consideration and as their starting point that a plurality of reasonable conceptions of the good in society will arrive at different conclusions about what is valuable or what is thought to promote wellbeing. What I read Viens to be saying here is that, in formulating policy meant for general application, we should try to be as generous and as broad-minded as we can coherently be. He advises that the starting point for our deliberations on biomedical ethical policy ought to be the realization that, in any given society, people are unlikely to agree uniformly on what will serve the common good and wellbeing. Having been initially informed by this latter observation, Viens hopes that, as we deliberate further, we are likely to be as inclusive in our policy recommendations as we can possibly be if we have taken on board the observation that there is a plurality of reasonable conceptions of the good in society. In concert with both the BMA and Mussel, Viens holds that parents have a duty to make decisions on behalf of their children concerning their wellbeing, and that such freedom to choose is based on the parents' view of the best interests of their children. He states, "The law generally provides parents with the freedom and discretionary authority, in the course of raising their children, to decide what is in the interest of their children (within reason, of course" (2004:242). He asserts that while most medical associations recognize that existing medical evidence does not support that male circumcision can be universally recommended, they nonetheless do not believe that the medical evidence shows that the procedure is so detrimental that it should be outlawed. It should be pointed

out that this assessment is in relation to medical male circumcision, and not traditional male circumcision as it is practiced in South Africa or elsewhere. Viens states that the concept of harm is a complex and difficult issue as the assessment of harm partly depends on one's conception of the good, the overall value attached to the action or event being assessed, and on how one conducts a cost-benefit analysis (2004:244). Viens (2004:246) cites precedents of accommodation of certain religious and cultural practices by medical professionals, for example, making a clitoral prepuce incision instead of a culturally required clitoral removal. This is a controversial point on which debate is likely to be polarized.

Following on his conclusion that male circumcision at least halves the relative risk of acquiring HIV infection in sub-Saharan Africa, **Short** (2004:231) advises that people in the developing world should develop better circumcision procedures that are neither physically cruel nor potentially dangerous.

In an editorial, **Holm** (2004:237) states that whether irreversible interventions such as circumcision in children are permissible or not, must depend on the risk and magnitude of permanent harm that they entail. He suspects that, because of the absence of valid comparative data regarding the effects of early circumcision on adult sexual function and satisfaction, the strident opposition to circumcision is partly driven by cultural prejudice dressed up as ethical argument. I think that the criteria of adult sexual function and satisfaction are too narrow and limiting to use as the only consideration to gauge the permissibility or otherwise of male circumcision. Holm wonders why other irreversible bodily interventions in children such as ear piercing, scarification, and tattooing do not elicit as much ethical consideration and debate as circumcision does. Holm needs to consider the possibility that maybe the mentioned practices are not the practical and moral equivalents of male circumcision.

**Hutson** (2004:238-239) mentions the various reasons that have been put forward for circumcision – religious reasons, prevention of phimosis and

paraphimosis, reduction of the risk of urinary tract infections and sexually transmissible infections, possible removal of entry sites to HIV, and a threefold reduction in the risk of penile cancer over the lifetime of a man. He concludes that circumcision offers some health benefits to baby boys and men, but only in a small percentage of the population. He holds that the cost-benefit analysis approach exposes routine circumcision as an unnecessary social operation, and that it would be hard to recommend or justify mass circumcision in the light of such a small potential gain. I agree with Hutson's assessment of the unjustifiability of mass circumcision. I however take issue with the fact that he does not consider or allow for the possibility that a cost-benefit analysis approach done in a region or locality in which the prevalence of the mentioned health benefits are much higher than those he quotes, could lead to a different conclusion about the necessity of male circumcision. One interesting statistic quoted by Hutson is that it has been estimated that one would require to perform 300 000 circumcisions to secure the prevention of one penile cancer (2004:239). This point is relevant for public policy considerations regarding male circumcision. If we advised mass circumcision as a public health policy intervention, we would have to show that it is prudent on a cost-benefit analysis.

The thrust of **Hellsten's** argument (2004:249) is that the various reasons (be they individual freedom, cultural rights, and autonomy rights) proffered by different communities in favour of male circumcision, all amount to mere rationalizations. His article focuses attention on the protection of children's rights in questioning the ethical acceptability of non-therapeutic male circumcision. Hellsten views male and female circumcision as comparable and equivalent procedures- he lumps them together and calls them genital mutilation. He specifically asserts that male circumcision (he prefers the term male genital mutilation) is an intrusive and violent procedure and that it should not be considered in isolation from female genital mutilation (2004:248). Hellsten (2004:249) argues that male genital mutilation (and female genital mutilation) violate the physical integrity of children, cause avoidable pain, and can lead to irreversible physical and psychological harm. I have previously alluded to the complexity of the moral assessment of the value of pain in

relation to male circumcision as well as to the surgical and moral non-equivalence of male and female circumcision. Hellsten asserts that the claim that circumcision helps prevent HIV/AIDS may lead on to a slippery slope that ultimately leads to it being required that female genital mutilation is practiced for the same purpose. This is a very bad argument. Firstly, the writer does not engage with the science regarding circumcision and possible HIV prevention directly and the merits and demerits thereof. Secondly, he shows inconsistency because he has previously already concluded that male and female circumcision are on the same moral platform, but now he gives the impression that he thinks that they are not. Lastly, Hellsten makes extrapolations and reaches conclusions that are not supported by relevant evidence.

Writing on the ethics of neonatal medical male circumcision, **Benatar & Benatar** (2003:36-37) attest that parental authority to consent to procedures on behalf of their minor children extends beyond only medical necessity. They cite consent for vaccination and schooling as examples of areas of appropriate parental consent. The only limitation they impose is that parents may not consent to those things that are unequivocally harmful to their children. One of the unavoidable tasks of the present study is to consider whether traditional male circumcision is or is not unequivocally harmful to initiates. The Benatars quote a risk of death from neonatal medical male circumcision as less than one in 500 000. They assert that neonatal circumcision is protective against the more severe forms of penile cancer, and is associated with a lower incidence of urinary tract infection and a highly significant reduction in the risk of HIV infection.

The Benatars (2003:43) conclude that neonatal circumcision cannot unequivocally be said to yield a net medical gain or loss. Following from this assessment, they opine that the decision whether or not to circumcise a child should be left in the hands of parents who, within certain limits, are entitled to employ their own value judgments in furtherance of their child's interests. On the question of culture, the Benatars assert that simply because a practice is culturally valued does not mean that it is inherently morally acceptable

(2003:43)-cultural views can be subject to scrutiny and evaluation. They further assert that the permissibility or impermissibility of surgical intervention must be based on a consideration of both medical and non-medical harms and benefits of male circumcision (2003:45). This latter point is a particularly valid one because, in order to arrive at a sound assessment of the merits and demerits of anything, one needs to have at one's disposal the totality of available credible information. The weakness that is often found in the writings of some writers on traditional male circumcision, whether they are for or against the procedure, is the reliance on selective information that advances their thesis and disregard of other available information that may not agree with their assumptions.

In his response to the Benatars' paper, **Sheldon** (2003:61-62) addresses himself to the religious dimension of male circumcision in relation to parental authority to consent to the procedure as well as to the question of the deployment of medical expertise to achieve non-medical goals. A third issue that he illuminates but does not address directly or consciously, is the problem of weighing the relative strengths of empirical (scientific/medical) evidence and non-empirical (religious, cultural, social) evidence for and against male circumcision.

In commenting on the religious dimension of parental authority, Sheldon (2003:61) begins by asserting that the refusal of a Jehovah's Witness parent of a blood transfusion on behalf of his/her child is the gold standard for unacceptable parental choice. He states that the reason we think parental discretion wrong in this case is that there is no perceived ambiguity regarding harm to the child. Although there may be cases in which the decision to transfuse blood may be questionable on empirical grounds, and therefore the perceived harm dubious, I agree with the main thrust of Sheldon's assertion. The technical details of how a blood transfusion could be erroneously ordered, or how expert opinion could differ on the necessity or otherwise of a blood transfusion, should not detain us. In contrast with the quoted empirical evidence for harm above, Sheldon argues that there is a problem as soon as one brings religion into the mix because what constitutes harm becomes complicated and a matter of perspective (2003:61). The upshot of his

argument on this point is that, if society were to intervene in parental discretion on male circumcision for children in which the indication for the procedure is religious, we would have the difficulty that we would not have common objective standards to base our decisions on (Sheldon, 2003:61). The relevance of this argument to the study of traditional male circumcision is that a determination must be made whether there is any perceived ambiguity regarding the harm posed by TMC. The second point is how the harm of TMC ought to be assessed.

On the point of medical interventions for non-medical indications, Sheldon worries that such intervention could lead to unacceptable consequences such as permitting surgical intervention in female circumcision. I take issue with the writer on this second point on the basis that his perception of a dichotomy between the religious and socio-cultural basis for a practice is not sustainable. He specifically states (2003:62) that harm appears to be possible to address if the issue is social in nature (female circumcision), and not capable of being addressed if the issue is religious in nature (male circumcision). There is, in my opinion, no fundamental conflict or difference between religion and social culture. The difficulties of interpretation and standards/criteria for evaluation of behavior and practices associated with a religious perspective are not significantly different from those associated with a socio-cultural perspective. In some instances, these may even be identical.

The third point about Sheldon's short paper is that it illuminates the difficulty of different standards for evaluation of behavior or practices, and of weighing the relative weights of empirical and non-empirical standards of harm and benefit of male circumcision specifically. The difficulty is not helped by the absence of randomized controlled prospective clinical trials that investigate specifically the non-medical risks and benefits of traditional male circumcision such as psychological harm, integration of initiates into their societies, impact on post circumcision conduct, etc. It is perhaps as a result of these difficulties that many authors just address themselves to the health-related or medical pros and cons of male circumcision and then make a determination whether it is permissible or impermissible.

Commenting on Benatar and Benatar's paper reviewed above, **Mullen** (2003) takes issue with why parents should be allowed to agree to circumcision on their sons for non-medical reasons since it appears from the Benatars' paper that the medical benefits of the procedure are equivocal. She concedes that religious and cultural acceptance and continuity may count as benefits attached to neonatal circumcision (2003:49). She however immediately plays down these potential benefits as being remote from the medical risks and benefits. She subsequently engages in an emotive argument that conveys her negativity towards circumcision. She describes the procedure as involving "sticking needles into small neonatal penises", says that post operative circumcision wounds are exposed to regular coatings of urine and faeces, and also asserts that if parents of prospective circumcision infants were given graphic information of the procedure in print form, they would run the other way (2003:49). The points that she seeks to make could have been made without resort to emotive language. She concedes that our response to parents who seek neonatal circumcision for deeply held religious and cultural beliefs is problematic (2003:49-50). She however makes welcome comments towards the end of the article when she gives lessons learnt from the experience of Western intervention in communities where female genital mutilation is practiced. One lesson cited is that draconian prohibitions by outsiders are neither welcome nor appreciated. The other is that there are typically multiple layers of players with vested interests and varying roles where such practices are concerned (Mullen, 2003:50). The lesson we can learn from Mullen's comments is that, when interventions in entrenched practices such as circumcision are contemplated, it would be prudent to consider and give attention and recognition to all the relevant role players if we want to improve the prospects of acceptance of such interventions. Her article also supports the observation that, where circumcision is concerned, many authors do not pay particular attention to the potential religious, social and cultural risks and benefits of the procedure.

**Pacey** (1999) explores the influence of cultural, social, political, and economic factors on the ethics of circumcision, among other practices. Although the thrust of her argument with regard to male circumcision is that it ought not to

be permitted in the absence of valid medical indication, she nonetheless gives a balanced assessment of the ethics of the procedure. For an example, she concedes that there may be instances wherein the ethics of pragmatism may trump the ethics of aspiration, when a decision would be considered moral because it complies with the patient's own definition of his or her well-being (1999:262). She further concedes that male circumcision may be carried out for strong cultural reasons (Pacey, 1999:264). She asserts that, when evaluating what is best for the patient, our own humanitarian and social values are not all that is at stake (1999:261).

Pacey cautions that while generalizations about the cultural values of patients may serve as useful background information in clinical work, they should not unthinkingly and uniformly be employed as the basis for decision making about individual patient treatment as that could deny the complexity of individual experience (1999:262). She advises that it is essential to elicit from the patient her own individual treatment wishes. This point should be taken into consideration as being consistent with individual autonomy when dealing with refusal of consent for circumcision in predominantly circumcising communities. Pacey acknowledges that what is done to females surgically during female circumcision is radically different from and much more drastic than what is done during male circumcision (1999:257).

Pacey asserts that none of the postulated prophylactic health benefits of male circumcision have been proven. She cites a report by DMT Gairdner published in 1949 that refuted all alleged benefits of circumcision (Pacey, 1999:260). She further cites Boyd (1998) who stated that circumcision is "an operation in search of a disease". She asserts that the baby's pain during circumcision induces cortisol levels consistent with torture. Pacey is one of the few scholars among those whose work is reviewed in this study who recognizes the possible psychological effects of male circumcision. She asserts that such effects are serious, and include possible castration complex, a lack of sexual confidence, and the likelihood of making the circumcised boy more prone to violence later in life (1999:263).

Pacey recognizes the ethical dilemma that may be posed by attempts to balance individual with community interests. She makes an example of the prevalence of circumcision in the USA in an earlier year when the prevalence was 90% and in later years when the prevalence had dropped to 34%. She argues that it may be pragmatically ethical and acceptable to permit circumcision on a male child from a community where the higher circumcision prevalence prevails, if the operation would help prevent the child from being troubled by his difference from his peers to an extent that his quality of life is adversely affected (1999:263). She asserts that a child has a right to be protected from emotional distress as much as from physical harm (1999:263). Quoting Dunsmuir and Gordon (1999), Pacey asserts that a child's rights extend to belonging to a group, and that in some cases, the rights of a group may be culturally more important than the individual's rights (Pacey, 1999:263). Pacey's biggest contribution to the literature on male circumcision is probably the balanced and broad-minded manner in which she treats the pertinent issues.

#### **2.4 Complications of Traditional Male Circumcision**

A tabulated summary of hospital admissions, penile amputations, and deaths resulting from traditional male circumcision in the Eastern Cape province of South Africa was given in the introduction as table 1 (Kepe, 2010:731). The named complications are emphasized in this study for their practical and symbolic significance. Practical because they are important in themselves and lend themselves to objective quantification and verification. Their symbolic significance is that they are also utilized as proxies for other less visible and less quantifiable adverse consequences of TMC. Their elevation to prominence is not meant to trivialize the significance of the less visible complications such as psychological sequelae.

As previously indicated above, the evaluation of the complications of TMC is bedeviled by the problem of the denominator. The other difficulty is that there is often no uniformity in the classification of complications among different researchers. Perusal of the literature indicates that the complications arising

from TMC, are in general, more severe and more numerous than those that follow on medical male circumcision. This statement is particularly germane with regard to TMC in the Eastern Cape. Additionally, the more severe forms of complications of TMC such as penile amputation and death are often deemed avoidable when viewed through the prism of medical science.

In a review of twenty five deaths from TMC in the Eastern Cape from 2005 to 2006, **Meel** (2010:190), listed the following causes of death:

- Septicaemia – 36%
- Pneumonia – 20%
- Dehydration – 12%
- Assault by fellow initiates – 12%
- Thromboembolism – 8%
- Gangrene – 8%
- Congestive heart failure – 4%

The significance of these figures is firstly, that the death of initiates from assault is morally and legally unacceptable. Secondly, all the listed causes of death with the exception of congestive heart failure are potentially preventable, or at most remediable in medical hands.

**Wilken and Dick** (2009:24) quote a complication rate of 2.7% reported from a review of medical records in the Eastern Cape in 2005. The authors divide complications of TMC into those related to the age of the initiate, those related to the circumciser, those related to the method of circumcision, and pain. They note the biological increase of vascularization of the penile foreskin with age which entails an increase potential for bleeding complications with the increasing age of the initiate (2009:24). They assert that the lack of formal training of the circumciser correlates with an increased risk of complications in most studies (2009:25). They state that the frequency of complications are influenced by the variability of preparation methods, surgical techniques, and wound care (2009:26). With regard to pain, the authors note that anaesthesia is not utilized for TMC since the ability to deal with pain and the preparedness to endure suffering are regarded as important components of the coming -of -

age ceremony (2009:26). They lament the problem of lack of standardization in the reporting of complications of TMC. The weakness of Wilken and Dick's account of the complications of TMC is that they do not pay attention to the potential psychological complications of the procedure.

Vincent reports that it has been found that circumcision may result in loss of penile sensitivity, which may be implicated in a decline in the rate of condom use among circumcised males (Vincent, 2008:433).

The common weakness of most accounts of complications of TMC in the literature is the neglect of potential and actual short and long-term psychological complications of the ritual.

## **2.5 Symbolic, Cultural, and Social Meanings of Traditional Male Circumcision**

The ritual of traditional male circumcision is saturated with symbolic, cultural, and social meanings that circumcising communities attach to it. The purported medical or health benefits of male circumcision do not feature in the historical rationalizations for the ritual.

In a wide-ranging paper that addresses various aspects of traditional male circumcision, Wilkin & Dick (2009) describe the meanings given to the ritual of TMC by circumcising communities. They assert that cultural identity and the desire to continue ethnic traditions are the strongest determinants for continuing TMC (2009:4). They observe that, because it is a strong cultural practice among traditionally circumcising groups, TMC is usually not an optional procedure to be decided upon on an individual basis (2009:12)

Wilkin and Dick (2009:13-14) state that the meanings given to the ritual of TMC are applicable at the individual and the socio-cultural level:

Individual level:

- Cleanliness
- Prevention of sexually transmissible infections

**Socio-cultural level:**

- Social status attained through circumcision
- The only possible way of attaining manhood in traditionally circumcising communities
- In the Xhosa culture, it is only once circumcised that men are entitled to business, property ownership, marriage, and participation in community life, e.g. feasts and beer-drinking ceremonies.

The authors note that, among the Xhosa in South Africa, boys face major social pressure to undergo the ritual (2009:21). They note that the stigma of not being circumcised or of being circumcised in hospital limits the freedom of choice regarding circumcision among Xhosa boys with regard both to whether to be circumcised and by whom and where. Although there may be local variations, the basic stages that constitute the ritual of TMC are relatively stable. The authors describe four stages of TMC:

**a). Preparation:**

- Physical – preparation of the penis
- Social – preparation for pain and feasts
- Spiritual – ritual baths and renewal of family ties

**b). Circumcision:**

- Stoical toleration of pain without flinching
- Set phrases, e.g. “I am a man”

**c). Seclusion:**

- Sexual reserve
- Sexual education and guidance on marriage and relationships
- Peer education – early involvement in coitus

**d). Reintegration into society:**

- Ritual bath and new name
- Festivities.

It must be borne in mind that in their paper, Wilken and Dick sought to describe the ritual of traditional male circumcision in a wide geographic area, and not just in South Africa. Their description of the stages of the ritual are nonetheless broadly representative of the ritual in circumcising communities in South Africa. The authors highlight the plight of boys who do not go to circumcision school, and those who get the procedure done in hospital. The social pressure and stigma is not only borne by the unfortunate boys, but extends to their families as well. Many researchers in this area often neglect this aspect of traditional male circumcision – social pressure and stigma. The phenomenon where some young boys present themselves at circumcision schools without, and sometimes against, parental knowledge and consent (Vincent, 2008:439) must be understood within this context of social pressure and stigma. This obviously complicates the notion of informed consent as we know it in medical ethics, given the fact that some of the initiates may be as young as twelve years of age.

Vincent's paper sets out to explore how the cultural and social meanings of TMC have shifted over time, especially with regard to attitudes towards sex and the role of circumcision schools in the sexual socialization of Xhosa youth (2008:431). Vincent's study is based on documentary sources, news reports, and interviews. Vincent asserts that male circumcision has a symbolic significance in the enhancement of masculine virility, the performative enactment of the separation between men and women, preparation for marriage and adult sexuality, as well as the hardening of boys for warfare (2008:434). She states that the ritual can be read as a dramatic enactment of the separation of the son from the mother and the integration of the man into the community. She describes the stages of the ritual in a manner that roughly approximates the description offered by Wilken and Dick above (Vincent, 2008:435).

Vincent describes the process of instruction/education that accompanies the circumcision procedure as consisting of three distinct features. The first aspect involves training in the secret code of the bush. The second feature involves building character traits such as forbearance, courage, fortitude and

strength through mainly exposure to deprivation and a harsh regime of punishments and criticisms. The third feature involves the teaching of what it means to be a man, including sexual instruction and guidance concerning married life, and instruction in the history, traditions, and beliefs of the initiate's ethnic tribe (Vincent, 2008:436). The author views the educational component of the TMC ritual as an opportunity for teaching young boys an alternative conception of masculinity to the prevailing negative conception. She however laments that much of the positive educational aspects previously associated with TMC have largely fallen away, and that at some of the circumcision schools the educational component itself involves a regime of violence and brutality which reinforces the problematic features of the dominant conceptions of masculinity in South Africa (2008 436-438). Vincent states that circumcised men are expected to take on greater social responsibility in their communities, acting as negotiators in family disputes, and weighing decisions more carefully (2008:438). The thrust of Vincent's argument is that while social structures and institutions supported the positive contribution of the ritual of male circumcision in the socialization of young boys in the past, those structures have largely decayed with the passage of time with concomitant negative consequences for the institution of traditional male circumcision. This I regard to be a valid observation, save to say that the extent of the decay is difficult to quantify with accuracy, and that it would be expected that the decay would affect the various circumcising communities in South Africa in varying degrees.

## **2.6 Male Circumcision and HIV Transmission**

Since the publication of the results of randomized controlled clinical trials (RCCTs) on the efficacy of male circumcision in reducing heterosexual transmission of HIV infection between 2005 and 2007, there have been increasing calls from researchers and government officials for the roll-out of male circumcision as a public health endeavor to combat HIV transmission. The RCCTs were conducted in South Africa, Kenya, and Uganda, and their results showed HIV prevention efficacy of 60%, 53%, and 48% respectively (Rennie, Muula & Westreich, 2007:357).

Any enlightened assessment of the potential utility of male circumcision in preventing the transmission of HIV infection has to take the following points into consideration:

- The advent of male circumcision predates that of HIV infection and AIDS by some six thousand years. Pacey (1999:259) states that male circumcision is widely thought to have begun in pre-Islamic Arabia about six thousand years ago. HIV and AIDS, as clinical entities, were first described in the United States of America in 1981.
- It cannot be assumed that results obtained in a controlled environment of an RCCT can be automatically extrapolated to apply in an uncontrolled setting in the general population. Such variables as prolonged contact and building of non-judgmental relationships with research staff, exposure to repeated risk reduction messages and counselling, repeated sexually transmissible infection (STI) and HIV testing for the duration of the research, and prompt STI treatment when they appear in study participants, are not necessarily available or replicatable in the general population.
- The potential beneficial effects of male circumcision in reducing HIV transmission should be weighed against its potential harmful effects in promoting HIV transmission that could result from either the surgical manner in which circumcision is performed and or the associated teachings about male sexuality conveyed to initiates during traditional male circumcision. There is evidence that some of the teachings imparted during circumcision schools may promote behavior by initiates that could potentially place them at increased risk for HIV acquisition (Vincent, 2008:433). In some circumcising communities, newly circumcised initiates are encouraged to test their newly acquired manhood by engaging in sexual intercourse as soon as possible following circumcision. Engaging in acts of coitus before adequate wound healing has taken place could potentially

increase the risk of HIV transmission from an HIV positive woman to the initiate or vice versa. Inadequate removal of the required amount of foreskin to remove potential target cells for the HIV virus could also dilute the potential beneficial effect of circumcision. Use of standardized surgical procedures of proven efficacy in reducing HIV transmission should therefore be adhered to.

- The background incidence and prevalence of HIV infection in a particular population or community will have a bearing on the potential efficacy and public health utility of male circumcision.
- The timing of the operation (neonatal, childhood, adulthood) may also have a bearing on the potential efficacy of male circumcision.
- If male circumcision is employed on the pretext that it prevents HIV transmission, will preoperative HIV tests be conducted, and what will become of those found to be infected? If the infected are also circumcised, what evidential basis exists that the operation would be beneficial to them or their sexual partners as well?
- In light of the severe shortage of medical and nursing personnel to man public health facilities in South Africa, does adequate moral, financial, and scientific justification exist to further burden the public health system with millions of circumcisions as contemplated in proposed mass circumcision programmes?

In a World Health Organization (WHO) publication, **Wilken and Dick** (2009:3) observe that the majority of males in East and Southern Africa are circumcised between the ages of twelve and twenty two years. The authors cite a recent study that reported a complication rate of 35% following traditional male circumcision in Kenya (2009:4). Wound infection and delayed wound healing were found to be the most common adverse events. The authors acknowledge the problem of the uncertainty of the accurate denominator in reporting the complications of traditional male circumcision

(TMC) in view of the secretive nature of TMC (2009:5). I have quoted a reported complication rate not exceeding 1.5% following medical male circumcision in the introduction above. The authors also quote a review of hospital records of admissions for complications following TMC in the Eastern Cape province of South Africa in which the complication rate was found to be 2.7% among 10609 initiates in 2005 (Wilken & Dick, 2009:24). The obvious limitation of this statistic is that initiates who may have suffered complications but were not hospitalized were not included in the calculation. It is also not clear whether the hospital records also include private hospital admissions or are only limited to public hospitals. The authors make an important observation when they assert that traditional male circumcision, as a rite of passage into manhood has not been designed for the purpose of HIV prevention. They further assert that there are certain aspects of the practice that could undermine the potential benefits of male circumcision for HIV prevention, or even put people at increased risk for contracting HIV (2009:31).

Vincent (2008:432) quotes the results of randomized controlled clinical trials in Uganda, Kenya, and South Africa which found that men who were circumcised were 48%, 53%, and 60% respectively, less likely to contract HIV infection than those who had not been circumcised. She cautions that the promotion of male circumcision as a public health measure to curtail the spread of HIV should be assessed within specific local cultural contexts (2008:433). Vincent asserts that historical mechanisms for the sexual socialization of youth have largely broken down. As a result, she holds that the role that traditional circumcision schools once played has been eroded and replaced by the emergence of a norm in which circumcision is regarded as a gateway to sex rather than as marking the point at which responsible sexual behavior begins (2008:433). It is within an understanding of such socio-cultural dynamics and their limitations that the author advises a sober assessment of the potential impact of male circumcision in preventing the spread of HIV. Vincent observes that the surgical procedure itself must be understood as a small component of a much larger ritual process (2008:435). She quotes the work of Wood and Jewkes (1998) in which it was found that men see sex as their right and forced sex as legitimate (2008:437). It is

against such prevailing contexts that the author cautions we should evaluate the true value of male circumcision as a public health intervention.

Rennie, Muula, and Westreich (2007:357) hail the results of RCCTs quoted above as having a potential to offer important clinical and public health benefits for individuals and populations in heterosexually-driven HIV epidemics in high prevalence settings. The authors acknowledge that there are still disagreements about whether the high efficacy of circumcision in preventing HIV transmission achieved in RCCTs could be replicated outside the confines of an RCCT. They also acknowledge that male circumcision could result in risk compensation. Risk compensation is the phenomenon of an increase in risky behavior due to a decrease in perceived risk (2007:258). The potential beneficial impact of male circumcision in combating HIV transmission could be diminished if men started to sleep with more partners and not using condoms because of their perceived invincibility following circumcision. The authors point out that the act of medicalizing circumcision by promoting it for its purported public health benefits and involving medical personnel in its performance, could change its meaning to an extent that some local communities may resist the interventions (2007:259). Finally, the authors point out the following further potential practical and ethical problems that could result from the campaigns of mass circumcision for public health purposes:

- Some aspects of TMC practices may require modification to align them with the goals of HIV prevention, e.g. the age at circumcision and some teachings about sexually testing the initiates' sexual prowess soon after circumcision.
- Connecting circumcision with HIV testing may raise ethical problems. The positive results with regard to relative protection from HIV acquisition obtained in RCCTs were obtained in studies on HIV negative males. Since the calls for mass circumcision arise from those results, I would assume that, in order to try and obtain maximum benefit from mass circumcision in the broader population, only HIV negative males would be

offered circumcision. If such a policy were followed, those who are declined circumcision would soon get associated with HIV positivity in the community, and might be stigmatized. If both HIV negative and positive males were offered circumcision in these mass campaigns to reduce the possibility of stigmatization, how would the extra burden of circumcising the positive people be justified since there is no RCCT that has been conducted to show beneficial effect for them or their potential partners? Anecdotal evidence actually shows that the policy of circumcising both HIV negative and positive males is followed in the mass circumcision campaigns.

- The already fragile health systems could be further burdened and overwhelmed by the personnel and financial demands of mass circumcisions.

Circumcision promotion as an HIV prevention tool could have a negative impact on the ability of women to negotiate condom use with circumcised men (2007:259-261).

**Sidler, Smith, and Rode** (2008:762) suspect that the desperate hope and need for action of people ravaged by HIV and AIDS rather than solid scientific evidence may be driving the demand for preventive circumcision. To their insight I might add that the desperate desire by government authorities to be seen to be responding to the desperate cry for action, any action, by the afflicted, also fuels the increased mobilization for mass medical male circumcision. The authors assert that non-therapeutic infant circumcision is merely the medicalization of an old ritual that should not be advocated as a preventive strategy for HIV/AIDS, and that research has shown the procedure to have neither short nor long-term medical benefit (2008:762). They further opine that the use of mass circumcision to curb HIV in Africa is ill advised, and that non-therapeutic infant circumcision is neither medically nor ethically justified as an HIV prevention tool. They recommend the deployment of scarce resources towards more effective and cheaper prevention tools that offer better HIV reduction outcomes than circumcision (2008:763-764).

**Connolly, Simbayi, et al** (2008), analysed a sub-sample of 3025 males aged 15 years and above from a 2002 South African cross-sectional national survey on HIV and Aids. Their key finding was that male circumcision did not appear to be protective against HIV infection among men irrespective of whether they were sexually active or not (2008:793). They found that HIV prevalence was 11.1% and 11.0% among circumcised and uncircumcised men respectively (2008:792).

They also found that circumcision took place after sexual debut among 40.5% of all the men (2008:792).

In South Africa, there are ongoing calls and campaigns from national and provincial health departments to scale up circumcision provision on a mass scale as a public health measure to curtail the spread of HIV infection. The current scientific evidence from the literature does not indicate that male circumcision (whether in the form of medical circumcision, traditional circumcision, or a collaborative effort between the two forms of circumcision) should be recommended for adoption on a mass scale as a public health measure to combat the spread of HIV infection. The majority of the evidence from epidemiological observational studies in circumcising communities points towards a positive association between high circumcision prevalence and a lower HIV prevalence. The evidence from the more scientifically robust landmark randomized controlled clinical trials quoted above point decisively towards a beneficial effect of medical male circumcision in reducing the chance of transmission of HIV from an infected female to the circumcised male during heterosexual penile-vaginal intercourse. The ordinary method for validating and advancing the claims of medical science is that once sufficient RCCTs have established a medical benefit for a specific intervention, careful planning is undertaken to introduce the discovered intervention into the real world of the general population in a contextually and culturally sensitive manner to assess its efficacy in this setting. Only after the intervention has shown significant benefit in the latter setting is a real scientific breakthrough normally celebrated. The essence of my argument in this theme of the study is that researchers, government, and society in general, must tread carefully, systematically, and modestly, in extrapolating from the medical benefit of medical male circumcision obtained in a controlled environment of

randomized controlled clinical trials to the largely uncontrolled setting of the general population. The acquisition of HIV infection is a complex phenomenon that is influenced by, among other things, social determinants such as poverty, and the level of education of the population, gender relations, and prevailing cultural and sexual practices. One of the recognized practices that influences the Southern African HIV epidemic is concurrent multiple sexual partners between men and women over an extended period of time (**Halperin & Epstein**, 2007:19). The increased risk of HIV transmission associated with concurrent multiple sexual partners is related to the high HIV viral load during acute HIV infection and the exposure of partners in the sexual network to the virus during this vulnerable period. A high viral load is directly proportional to HIV infectivity (Halperin & Epstein, 2007:20). In many African countries, cultural practices and traditional policies allow and sometimes even encourage multiple partnerships for men (Halperin & Epstein, 2007:22). We as yet do not have evidence as to how this specific vulnerability would influence the efficacy of mass circumcision for public health purposes. It is however fair and logical, based on epidemiological extrapolation, to suspect that it would most probably blunt the potential efficacy of male circumcision to reduce HIV transmission. It is important to emphasize that the randomized controlled clinical trials dealt specifically with the efficacy of male circumcision in preventing HIV acquisition by males and did not have any direct bearing on HIV acquisition by females. In the South African context of HIV transmission, women are placed at an increased risk of HIV infection by skewed gender relations in which males play a dominating role and by cultural norms that are generally tolerant of male promiscuity. This is over and above the increased vulnerability of women to HIV acquisition that is occasioned by the anatomical differences of the sexes. Add to these suboptimal messages associated with the promotion of male circumcision as a preventive tool for HIV transmission that lead some males into thinking that once circumcised, they are totally protected from the disease and therefore no longer need to use condoms, then you have a disaster in the making. The eventual potential protective effect (if any) of medical male circumcision must be understood and assessed with this background in mind. From what I have observed of the stampede for mass circumcision, I do not think that careful planning has been sufficiently

considered. Neither do I think that contextual and cultural sensitivity has been prioritized. It may be useful at this stage to remind the reader of the unrestrained government jubilation at the apparent discovery of a product called Virodene in South Africa several years ago. The product was purported to be effective for the treatment of HIV infection. Government officials offered moral and financial support to the researchers for the speedy manufacture, licensure, and rollout of the product to the general population. Fortunately for the population, Virodene was soon exposed as an industrial solvent that could cause the demise of HIV sufferers from liver disease long before they could succumb from the HIV virus.

In a recent publication of the South African Medical Journal, **Ncayiyana** (2011:775-776) cautions against what he calls the illusive promise of mass circumcision to prevent female-to-male HIV infection. He makes the following observations:

- The correctional services authorities in the province of KwaZulu-Natal in South Africa are scurrying to set up circumcision stations in response to a near-stampede for circumcision by the inmates in spite of the absence of any evidence that circumcision prevents male-male HIV transmission (2011:775).
- The extended claim that circumcision confers lifelong protection cannot be inferred from the RCCTs given that all the trials were terminated after 24 months or less of study (2011:775).
- He finds it curious and worrisome that the campaign to circumcise African men seems to be driven by donor funding and researchers from the North (2011:776).
- Circumcision rollout in South Africa will divert scarce resources in money, human resources, and infrastructure away from essential health services in a system that is already under-provided.
- Several authors have pointed out that, without field -testing, it is impossible to predict the applicability and repeatability of RCCT findings in real-world situations (2011:776).

- There is a real risk that the roll-out of circumcision will dilute the standard prevention messages and undermine the gains already made in respect of condom use and behavior modification. He attests that there is already evidence of risk compensation among traditionally non-circumcising populations whose enthusiasm for circumcision suggests that they perceive circumcision as special and sufficient protection against HIV infection (2011:776).
- Lastly, Ncayiyana observes that, although circumcision reduces the risk of female-to-male transmission in high prevalence areas, HIV acquisition rates were nevertheless high in both the circumcised and the uncircumcised groups involved in the clinical trials (2011:776).

It is debatable whether the public health initiatives with regard to mass medical male circumcision that are ongoing in South Africa at present have adequately taken into consideration all the pertinent remarks about the association of circumcision and HIV transmission I made in point form at the beginning of this section, or those that are raised by the authors quoted. My preliminary observation is that they have not.

## 2.7 On Liberty

For this last section of the literature review, I will rely on the works of **John Stuart Mill** (2010) and **Isaiah Berlin** (1995). The aim of the exercise is to determine whether there are sufficient moral grounds for society to interfere with the liberty or freedom of the individual or a group of individuals to subject himself or themselves to traditional male circumcision.

In “On Liberty”, Mill (2010) was specifically concerned about the nature and limits of the power of society – both formal in the form of government and its institutions and informal in the form of public opinion, to interfere with the independence of the individual to hold and express opinions as well as to

follow his or her self-chosen actions and conduct. He advocated for the maximum possible protection of the individual against such interference (2010:5-10). He asserted the principle that society was warranted to curtail the liberty of anyone of its members if any part of his conduct affected prejudicially or caused any harm to the interests of other members of society (2010:17, 19,110, 137). He stated that the person's own physical or moral good was insufficient warrant for society to interfere with his choice of acts or conduct (2010:17).

Mill believed that different experiments of living, different characters and modes of life should be allowed free expression and that their worth should be proved practically as long as they did not lead to injurious consequences for others (2010:82). Mill believed, perhaps too generously, that we could delineate between portions of a person's conduct and character that specifically concerned his own interests and those that concerned the interests of society. He further believed that, having made such a neat distinction, we could then protect from legal or moral censure, portions of a person's character and conduct that belonged to the former category, and justifiably restrict or punish character or conduct belonging to the latter category (2010:109, 110, 114, 119).

Mill opined that one community did not have the right to force another to be civilized if the two communities had no connection between them (2010:135). He however allowed for one person or community to influence and persuade another towards what they considered to be wise or beneficial conduct (2010:111 & 135).

In "Liberty" (1995), Isaiah Berlin distinguishes between two concepts of liberty/freedom – negative liberty and positive liberty. He states that negative liberty answers to the question 'What is the area within which the subject – a person or group of persons – is or should be left to do or be what he is able to do or be, without interference by other persons' (1995:169). This is the same concept of liberty that JS Mill argued for. It consists in the freedom of the individual or group of individuals to voluntarily choose which alternatives of action or conduct they will pursue unmolested by authority or society. Berlin

differed from Mill in his understanding of the application of negative liberty in several ways. Berlin believed that the area of a person's private life that concerned only him and did not impinge on the interests of others was much narrower than that conceived by Mill (Berlin, 1995:236). He states, 'Men are largely interdependent, and no man's activity is so completely private as never to obstruct the lives of others in any way' (1995:171). Berlin was more keenly aware of the limitations of the negative form of liberty – he realized that it could exist within an autocratic/undemocratic political environment, that it was a poor guarantee for civil liberties, and that it was distinct from positive liberty or self-government (1995:176-177). Berlin, just as Mill did, conceded that the freedom of some must at times be curtailed to secure the freedom of others (1995:173).

Berlin states that the positive concept of liberty derives from the wish on the part of the individual to be his own master, to conceive goals and policies of his own, and to bear responsibility for his choices and being able to explain such choices by reference to his own ideas and purposes (1995:178). He stresses that the desire for self-government or to participate in the process by which one's life is to be controlled (positive liberty) differs from the wish for a free area for action (negative liberty). Berlin accepts that it is sometimes justifiable to coerce people and thereby deprive them of their freedom in pursuit of some noble goal such as justice or public health. He however cautions that such coercion should be seen for what it is – justifiable coercion, and not be presented as fulfilling the latent rational wills of those being coerced (1995:179-181).

I think that it is fair to conclude that, based on their conception of liberty in both the negative and the positive sense, Mill and Berlin would accept that the individual or group of individuals have the liberty to choose voluntarily to participate in traditional male circumcision if they so desired. It is also equally fair to conclude that the two authors would grant society the right to interfere with the liberty mentioned above if they assessed that the exercise of such liberty encroached sufficiently on the interests of others or that a greater or more valuable purpose would be served by such interference. The only debatable point that the two authors might differ on would be the extent and

form of societal interference with TMC, from a mere tinkering at the edges of the practice to a total ban.

## CHAPTER 3: DISCUSSION

The discussion on the ethical aspects of traditional male circumcision will be conducted in the following format. First, I will briefly explain the current problems that beset TMC in South Africa. Next I will discuss the grounds on which I believe that intervention in the ritual practice of circumcision is justified. Thirdly, I will discuss the mode and form that the suggested intervention must take. Finally, I will comment on the controversial issue of providing pain relief during traditional male circumcision.

### 3.1 The Problems that beset TMC in South Africa

I believe that it is fair to describe the state that traditional male circumcision is currently in as a crisis; at least in as far as the practice in the Eastern Cape is concerned. Kepe identified at least three concurrent crises that beset TMC in the country- the crisis of disease, injuries, and death suffered by some initiates; the crisis of the tension between the government and traditional leaders in the Eastern Cape Province; and the uncontrolled way in which societal changes have impacted on the practice of TMC (Kepe, 2010:729-730). I will highlight a few of these problems:

- **The Problem of Consent and Autonomy**

Boys who present for TMC in South Africa are frequently below the legal age of maturity. Some boys present themselves to circumcision schools without the knowledge or consent of their parents (Vincent, 2008:439). There may also be a problem of prospective initiates who have no identifiable legal guardians.

The problem of autonomy with regard to TMC arises as a consequence of how the notion of autonomy is viewed within two sets of conceptual frameworks of society. The idea of respect for the autonomy of competent moral agents to consent (or withhold consent) to procedures on their persons is approached differently in a communitarian community

arrangement compared to how it is approached in a liberal individualistic community arrangement. There are also differences about the notion of autonomy between a conventional medical ethics perspective and a traditional medicine perspective. In a communitarian setting, the community takes priority over the individual in the majority of considerations. Culturally-sanctioned practices such as traditional male circumcision may be viewed as having been consented to communally, and the individual has little power to resist them in a communitarian context because the cost of dissent may be considerable to the individual (Wilken & Dick, 2009:12). In a liberal individualist context, the individual takes precedence over the community in most instances and may individually decide which practices he wishes to engage in or desist from without significant censure or ostracism. In conventional medical ethics practice, a person presents to the medical professional with a healthcare problem. The healthcare professional makes a diagnosis, indicates available forms of treatment options with associated harms, benefits, costs and efficacy, and then recommends an option he considers most appropriate for the patient's consideration. Following information sharing, further explanations, and weighing of the various options, the competent patient makes his preference known to the medical professional, informed consent documents are signed, and a specific treatment option is carried out. With regard to TMC, the 'patient' approaches either a healthcare professional or a traditional surgeon with a diagnosis having already been made and a treatment option decided upon - the person desires to become a man and the removal of the foreskin is part of the treatment to achieve manhood. He requests the surgeon to carry out the procedure. The medical or traditional surgeon either consents or declines to perform the procedure. There is no inherent requirement for documenting the informed consent process. With the South African nation being

multicultural and at a stage of nationhood development that I assess as a combination of N2 and N3 (according to Gyekye's nomenclature, 1997-discussed above under the theme of Tradition and Modernity), such different perspectives on the notion of autonomy and informed consent are to be expected.

- **The Health Problems of TMC**

The health problems associated with TMC have been well documented by several commentators, e.g. Kepe (2010), Meel (2010), and Wilken & Dick (2009). Wilken and Dick assert that the lack of formal training of the circumciser correlates with an increased risk of complications in most studies (2009:25).

The relative safety of traditional male circumcision in the province of Mpumalanga documented in Vincent's work (2008) contrasts sharply with the recurring problems reported in the Eastern Cape province. It is worth noting that, in the case of the practice of TMC in Mpumalanga, there is extensive involvement of medically trained personnel in the surgical component of the ritual, as well as strong traditional leadership involvement in the overall control and directing of the ritual. There are, however, encouraging signs of traditional leadership being receptive to some medical interventions in TMC aimed at improving the safety of the practice in the Eastern Cape (Vincent, 2008:88).

Deaths, penile amputations, and hospitalization are the primary indices used to quantify the health problems arising from complications of TMC in the literature. The vast majority of the health complications of TMC are eminently preventable, and society has a duty to prevent them. Interventions aimed at improving the surgical procedure and post-operative care of TMC initiatives would eliminate most of these problems. The psychological complications of TMC are underreported in the literature.

- **The Non-Health Problems of TMC**

Under this sub-heading I include a variety of issues such as the shortage of culturally appropriate venues for the conduct of TMC, physical assault of initiates at circumcision schools which sometimes leads to death (Meel, 2010:189), the demands of modern living such as education, urbanization, and employment which have necessitated an abbreviated program of the total ritual of TMC with the resultant weakening of the positive aspects of the ritual such as the educational component of TMC (Vincent, 2008:436-438). These and other similar problems need a collaborative effort for analysis and solution.

- **The Problem of Custodianship of TMC**

As a cultural practice, I believe that traditional male circumcision rightfully falls in the sphere of control of the institutions of traditional leadership. Kepe (2010), Vincent (2008), and Van Vuuren & de Jongh (1999) describe eloquently the contested custodianship of TMC between the institutions of traditional leadership and those of the democratic government of South Africa.

Financial incentives for the conduct of traditional male circumcision have a bearing on the disputed custodianship of the practice. There is anecdotal evidence that a traditional surgeon may charge as much as R1500 per initiate to conduct the procedure. In the current bleak economic climate characterized by high unemployment rates, especially in the rural areas, it is understandable why there are many untrained and unscrupulous traditional surgeons and why those that are already established would not want to relinquish their control over the ritual. Other organs of society have a right to intervene in the ritual of TMC, especially when the ritual presents problems that affect the community. Such interventions are best

done in co-operation with the institutions of traditional leadership.

### **3.2 The Grounds for Intervention in TMC**

Although I have not conducted an exhaustive consequentialist calculation of the good and bad consequences of traditional male circumcision, I do not think that there is compelling evidence to advocate for the abolition of the practice in its entirety. From my reading of the literature and, on reflection, I think that a case can justifiably be made that traditional male circumcision, in its current form, especially as it is conducted in the Eastern Cape, is unambiguously and unmitigatingly a net harm. But a glimmer of hope may be drawn from the experience of medical male circumcision and from instances of collaboration between traditional and conventional medical practitioners in the conduct of TMC. The evidence from the perused literature indicated that, before the conduct of randomized controlled clinical trials (pre 2005-2007), the medical or health benefits of medical male circumcision were either equivocal or pointed towards a marginal benefit (Short, 2004:243; Hutson, 2004:239; Mussel, 2004:254; BMA, 2004:259,262; Mullen, 2003:249; Benatar & Benatar, 2003:43). The RCCTs showed a potential for medical male circumcision to reduce heterosexual transmission of HIV from infected females to uninfected males during penile-vaginal sexual intercourse by 48 to 60% (Rennie, Muula, and Westreich, 2007:357). I am as yet unaware of randomized controlled clinical trials conducted to assess the potential socio-cultural and psychological harms and benefits of either medical or traditional male circumcision. The conduct of trials of the latter nature would understandably be methodologically and pragmatically difficult to carry out. The absence of such clinical trials does not in itself negate the possibility that male circumcision could confer socio-cultural and psychological benefits as described by some commentators (Wilken & Dick, 2009:13-14). Having concluded that the current form of traditional male circumcision constitutes a net harm, the next logical step is to decide what ought to be done about it. Some might venture that the practice ought to be outlawed outright. I however feel sufficiently warranted, on rational and pragmatic grounds, to call for

intervention in the conduct of TMC in order to make it safer than it currently is for the initiates and society. I think that there are several grounds on which a call for intervention in TMC may be justified. I will briefly discuss some of these grounds:

- **Public Health Grounds for Intervention**

Society, in its political and legal guise as the government, has the competency and duty to administer public health on behalf of the population. It is common cause that the health needs of populations outstrip the capacity of societal institutions to satisfy them. In view of the latter fact, public health is arranged such that there is prioritization and rationing of limited resources to satisfy the unlimited health needs of populations.

The costs of traditional male circumcision are considerable. Besides the finite and ultimate cost of loss of life, they include loss of future income from the deaths of initiates, cost of hospitalization for complications of TMC such as septic complications, dehydration, surgical mishaps, and psychological complications. It would not be morally permissible to turn away victims of adverse effects of TMC from public healthcare institutions. In South Africa, the right of access to health care and compulsory emergency medical treatment is enshrined in the Bill of Rights (The Constitution of RSA, 1996: section 27). Public spending on TMC complications takes away resources that could be employed elsewhere in the health care system. Since most of the complications of TMC are potentially preventable, it is difficult to justify perpetual spending of public funds on curative efforts in relation to the complications of TMC when the prevention of such events would cost the public much less in financial and human resources. It would be morally unpalatable to have to turn away a newborn baby who requires temporary ventilation for complications of childbirth such as prematurity because the available ventilator is occupied by someone who has septic complications of circumcision performed by a traditional surgeon known to be untrained in the operative procedure. Health care funding

operates on the basis of cross-subsidization. Savings made elsewhere in the system are utilized in areas of greatest need. If government were to allow preventable costs to spiral out of control, that would amount to dereliction of duty. Other tax payers who have health needs different from those occasioned by the complications of TMC would be well within their right to complain if their needs were neglected because resources were diverted to health needs that could have been prevented in the first place.

JS Mill asserts that society has sufficient warrant to curtail the liberty of anyone of its members if their conduct affects prejudicially the interests of others (2010:17,19,110,137). Berlin (1995:179) concurs that it is sometimes justifiable to coerce people in pursuit of some noble goal such as justice or public health.

- **Cultural Grounds for Intervention**

I think that it is in the interests of every cultural tradition to promote and perpetuate those customs and practices that are deemed beneficial to the cultural tradition for as long as it is possible. The survival of a culture's adherents guarantees the continuity of the specific culture. It would therefore be considered cultural hara kiri for any culture intentionally, either directly or indirectly, to require or facilitate, regular, programmed decimation and maiming of significant numbers of its adherents.

Gyekye suggests that it is a necessary and natural requirement for the survival and revitalization of a tradition that it be continually subjected to re-evaluation by subsequent generations of its adherents (1997:221). He states that the reason for refining, amending, or abandoning ideas, practices and institutions received from previous generations is twofold. One reason is that certain features of the traditional conception of things may be disharmonious with the situations of later generations, and the other reason is that institutions

and practices may be considered dysfunctional by later generations (1997:262). The current problems that beset TMC enumerated at 3.1 above attest to disharmony and dysfunction in traditional male circumcision in South Africa. One example of disharmony is the traditional conception that it is desirable for the newly initiated to test their manhood by engaging in sexual intercourse soon after the circumcision is done which is disharmonious with the present reality of rampant HIV prevalence in the community. HIV infection and AIDS did not exist at the time of inception of the practice of TMC, but their current existence demands that the tradition of TMC be conceptualized and practised in a manner that takes into account their reality and impact in mind. An example of dysfunction in the ritual of TMC is the loosening of control over the ritual by traditional leaders. Nowadays, communities are spread over vast geographic areas, institutions of traditional leadership are either weak or non-existent in urban areas, the institutions of the democratic government overlap with and are sometimes antagonistic to those of traditional leadership, and the required period of apprenticeship of traditional functionaries of TMC under the guidance of experienced elders has weakened. It is essential that, if the tradition of TMC is to continue to be normatively and practically relevant to its users, it needs to adapt to these and other changed circumstances in which the current generation finds itself. It does not matter whether the trigger and ideas for adaptation arise endogenously, exogenously, or from both sources. The important thing is that the tradition of TMC needs to remain relevant for the current purposes of its users if it is to survive and thrive. Therefore, intervention in TMC is an act of self-preservation for the cultural practice and its users, and it is not an unwanted interference. Intervention ought ideally to be initiated and carried out by the custodians of TMC and those that the practice affects directly following a careful assessment of its relevance and consequences. Government should ideally not be involved in the evaluative/intervention process except perhaps to provide technical expertise and facilitation if requested to do so.

- **Autonomy Grounds for Intervention**

Beauchamp and Childress (2001:64) state that, when viewed in its positive obligation format, the principle of respect for autonomy requires respectful treatment in disclosing information and fostering autonomous decision-making. They assert that, in some cases, we are obligated to increase the options available to persons. In the light of the health problems of traditional male circumcision, I hold that those with the information and the capacity for positive influence are obligated to disclose information and advocate healthier options for the users of TMC. As an example, the information that the circumcision procedure can be performed safer and with less associated pain, needs to be placed at the disposal of TMC users so that those who may wish to choose this particular option, may have the opportunity to do so. This would accord with treating people with dignity by enhancing their capacity for autonomous choice.

- **Beneficence and Non-Maleficence Grounds for Intervention**

Intervention in traditional male circumcision in order to make it safer may be justified on beneficence grounds. According to Beauchamp and Childress, the principle of beneficence refers to a moral obligation to act for the benefit of others. It establishes an obligation to help others further their important and legitimate interests (2001:166). Communities that repeatedly suffer the adverse consequences of TMC which result from identifiable and remediable causes deserve the assistance of government and other societal institutions that have the capacity to offer assistance. Beauchamp and Childress' (2001:167) rule of beneficence 2 (prevent harm from occurring to others) and rule 3 (remove conditions that will cause harm to others) are applicable in this case. Michael Slote is quoted in Beauchamp and Childress asserting that, "One has an obligation to prevent serious evil or harm when one can do so without seriously interfering with one's life plans or style..." (2001:170). I contend that actively advocating beneficial intervention in TMC does not constitute an unduly onerous burden to

the advocates. Positive intervention in TMC may be equally justified on the grounds of non-maleficence.

### **3.3 The Form and Mode of Intervention**

In spite of government's legislative interventions in traditional male circumcision, the problems associated with the practice continue unabated. This points to the possible inadequacy of the interventions that have been applied so far, ineffective implementation of the interventions, or both. My assessment is that the overall response to the problems posed by TMC is inadequate both in its conception and its scope. I do not think that the response should have primarily been legislative, and I think that it should encompass a wider scope of society rather than be limited to government. The consolidation of interventions in the form of guidelines or regulations would probably be less threatening than a direct statutory approach. At the outset, it should be acknowledged that traditional male circumcision is a matter whose management and control falls rightfully and primarily within the sphere of influence of institutions of traditional and community leadership. However, the problems that beset TMC in South Africa at present call for a collaborative effort by all sectors of society.

By most accounts, government engaged in protracted consultation, at least in the Eastern Cape, with stakeholders before it came up with legislative prescriptions that defined its intervention in TMC (Kepe, 2010:731-732). What may be in dispute are the scope of such consultation and the depth of consensus reached on the most appropriate remedy for the identified problems. I could not get the sense from the literature that the organized medical fraternity in the form of the Health Professions Council of South Africa, the South African Medical Association (or its forerunner) and other organized doctors' and nurses' groupings had any significant input in the deliberations of government officials and traditional leaders on the crisis in TMC. Even though the literature states that other organs of civil society such as faith-based organizations and civic organizations were involved in the consultations, I could not detect their voices in the response/outcome of

consultations, which were mainly legislative. Neither could I discern the involvement of institutions of higher learning/research think tanks or that of primary and high schools where some initiates attend. The problems associated with TMC affect the whole of society either directly or indirectly. The responses to the problems should therefore be as broad-based as possible. Government, institutions of traditional leadership, medical and nursing organizations, faith-based, community-based and civic organizations, interested individual members of communities, as well as educational institutions, should be involved in working out solutions to the identified problems. The identified societal entities should work individually to deliberate on all the issues concerning TMC as they affect the specific entities, as well as, and more importantly, collaboratively with other societal formations in order to share experiences and insights, enhance and broaden each entity's understanding of the practice, and deliberate on interventions that are likely to receive broad societal appeal and acceptance. A committee formed by representatives from all the identified entities could be constituted and tasked with overseeing and monitoring the implementation of interventions and act as a resource centre for individuals and communities who need guidance and advice on TMC matters. Such committees could result from a collaboration of social partners in the various provinces and from those a national TMC coordinating committee could be formed. Representative committees as envisaged above would stand a better chance to succeed than those with an enforcement/punitive bias formed by government officials only. Individual social entities would still be at liberty to continue conversations on TMC in their own constituencies and bring consolidated suggestions for broader deliberation within local/provincial representative committees.

The conceptual manner in which I propose that intervention in TMC should be approached is based on the conceptual understanding of a tradition in the work of Bishop (2004). Further modification of the model and analysis is based on my own reflection. Drawing on McIntyre, Bishop states that a tradition begins with a certain set of premises, such as what defines human nature and the human good. He holds that these definitions are only possible within a cultural, historical, and linguistic context. That means that what

counts as rational is bounded by the starting points, perceived goals, and the milieu within which it occurs (Bishop, 2004:487-488). Although I find some of his concepts useful as analytical tools, I wish to differ from Bishop by asserting that it is possible, on common rational grounds (if they are worth being called rational), for outsiders to a culture to make valid moral and practical assessments of the starting points, milieu, and desired goals of a practice that belongs to that foreign culture. The framework/model that I will rely on for my analysis may be presented graphically as follows:



A practice such as traditional male circumcision has its starting points or basic assumptions, occurs in a particular environment or milieu, and has its goals or outcomes desired by those who practise it. From the literature, it may be summarized that TMC is a sacred ritual that is an absolute requirement that a Xhosa boy must undertake (starting point), in a traditional or culturally approved setting presided over by a traditional surgeon and other traditional functionaries (milieu), in order to produce a man who possesses good judgment, is an upright leader in the community, and generally upholds the highest values of society as displayed in his actions and conduct (desired goals). Now, as the first step in an attempt to positively influence the practice of TMC, I suggest that any person or organization who so wishes needs to first gain an adequate understanding of the basic assumptions or starting points of the practice, the environment in which it occurs and the factors that

impact on the environment, and the desired goals that the practice aims to achieve. I regard this as a requirement of common sense and simple logic that, in order to make a sound decision, one needs to have at one's disposal, the totality of credible, relevant, and sufficient information about the subject of one's decision-making. The next step towards intervention and influence should be to decide the point at which one will start. In this case (TMC), I suggest that the best place to start is at the end- the point of the desired goals. I consider this to be a least threatening approach and one that is most likely to produce the best and enduring results. One could, for instance, point out to the custodians and practitioners of TMC that the results that they desire are not actually realized, or that they are not realized optimally. For an example, one could show that some initiates produced by the ritual do not in fact show good judgment because they have multiple sexual partners, or that their conduct is generally not consistent with upholding the highest values of society. I expect that the response of the custodians and users of the practice to the evidence that the desired goals are not achieved would be to interrogate the above model systematically backwards. I hope that they would start by looking at whether the set goals are properly conceived, properly formulated, realistic, and achievable.

After exhausting the evaluation of the goals, I expect that they would move towards the milieu in which TMC occurs and relook at that. In the milieu, they could look at aspects such as:

- The manner in which initiates are selected for TMC
- The age at which TMC is deemed desirable
- The adequacy of the educational component of the ritual in terms of content, quality, method of delivery, intensity, and length of education
- The manner in which the surgery is performed
- Post surgery care
- Economic factors that impinge on how the ritual is conducted
- Supervision and control of the whole process
- The influence of alien cultures on the practice

The re-examination would then move to the starting points and questions such as the following could be asked:

- Is TMC the best or the only way through which the desired goals could be achieved?
- Why is TMC considered sacred?
- Do the assumptions that are historically associated with TMC still all apply in the present circumstances?
- Which other rituals could be employed to achieve the same goals instead of or in addition to TMC?
- Is TMC still justifiable in light of the harms associated with it?

Other troublesome issues concerning TMC could be similarly investigated. For instance, when dead initiates are produced instead of living men, or when the ritual produces penile amputees, these could be systematically reviewed until a satisfactory resolution is settled on. This format of investigation is suitable for use by both social insiders and social outsiders to the practice of TMC. It is considered suitable as a tool for cross-cultural communication in order to gain understanding of an alien culture without necessarily having a view to suggest any modification, as well as to gain understanding in order to inform suggestions for modification or abandonment of practices that are considered unambiguously harmful.

I foresee that the above examination of the practice would not necessarily be linear, but would involve movement in both directions and could stop anywhere when a satisfactory answer is found, and to be restarted as soon as a new problem or dissonance is encountered. I also suggest that all stakeholders in the community should do the re-examination, both individually and collaboratively, and even confrontationally. Intervention in TMC should not be the preserve of government alone. The only proviso is that all participants should initially familiarize themselves sufficiently with the language, assumptions, desires, hopes, and goals of the culture in which TMC takes place so that they would gain a valuable basic understanding of the culture and the practice in order to facilitate effective and fruitful dialogue

(Crocker, 1991:163). Following the suggested approach is considered most appropriate for the following reasons:

- If the re-examination of the practice is started by questioning the starting points, it is likely to be viewed by the proponents of the practice as antagonistic as this approach would be questioning the very identity and metaphysical foundations of the specific community or culture.
- By giving the adherents of the practice the opportunity to relook at it themselves accords with the tenet of respect for autonomy, engenders goodwill, and opens the opportunity for outsiders to be accepted as negotiating partners, and the suggestions for improvement that result from such a process are more likely to be acceptable for implementation and to be more sustainable in their application.
- Gaining an understanding of the culture they wish to positively influence gives outsiders to the culture important insights that they may not otherwise acquire. This facilitates common understanding and is likely to improve dialogue and the quality and acceptability of suggestions for improvement.

### **3.4 The Surgical Pain of TMC: Harm or Benefit?**

In the ordinary course of the performance of surgery during traditional male circumcision, there is no specific pre or post surgical pain relief or anaesthetic used. The endurance of pain is considered to be an important part of the ritual. Vincent (2008:81) takes issue with the medical commitment to pain relief when interventions in TMC are implemented by government officials and medical practitioners. She cites this as evidence of lack of understanding of the symbolic significance of certain aspects of TMC by government officials and medical practitioners. The matter of pain relief during TMC is a difficult one. On the one hand, the medical commitment to pain relief is understandable from the perspective of wanting to confer benefit and do minimal harm to the initiate. Pain is frequently listed as one of the

complications of male circumcision. On the other hand, the stoical endurance of pain during the cutting of the foreskin in TMC is considered by its proponents to be an essential component of the ritual. From a medical and moral point of view, the deliberate causing of avoidable pain is not acceptable.

I submit that, for the majority of initiates who present themselves for TMC, there is a form of consent for the ritual. The consent is provided either by themselves personally expressly or tacitly if they are sufficiently mature, or by their parents who allow them to attend circumcision school. The actual quality of the informed consent process may be debatable. If pain were inflicted in the absence of consent, it would be unambiguously harmful, and morally unacceptable. Even when pain is administered with valid consent, it is still a difficult and potentially controversial notion. The first aspect of pain's controversial status is that its perception has a dual nature- objective and subjective. Pain perception can be assessed objectively by measures that are not under voluntary control such as heart rate. Subjective pain perception is impossible to standardize and compare because it is person- dependent. One person may voluntarily endure the pain of circumcision because of his conviction about the beneficial effect of undergoing the procedure, whereas someone else may give up on an attempt to run a distance of five kilometers due to the pain on his muscles and his conviction that running the distance is not essential to him. The second aspect of the difficulty of dealing with pain during TMC is that its infliction and endurance is frequently made a specific requirement for successful circumcision. Lastly, I am not convinced that society may legislate a specific threshold for pain that competent individuals are allowed to endure, beyond which its abolition becomes mandatory. I suggest that the issue of pain during TMC could be handled in the manner that I suggested for intercultural and intra-cultural communication and influence at 3.3 above. For an example, the full array of available analgesic modalities could be explained to interested parties. These could include psychological techniques such as hypnosis, topical anaesthetic agents such as gels and patches, oral analgesic agents, local injections, nerve blocks, and general anaesthesia. The different possibilities and combinations could then be discussed and evaluated from the position of a broader understanding of

the socio-cultural and scientific meaning and significance of pain during TMC. I would expect that pain relief modalities that do not completely abolish the pain, such as a combination of psychological techniques, topical and oral agents that do not involve injections, would be more likely to be readily accepted by the proponents of TMC compared to nerve blocks and general anaesthetic. The proposed model for understanding alien cultural practices and influencing modifications of the practices is laborious and time-consuming, but I believe that it has a better chance for success and sustainability than top-down approaches that do not involve the affected communities in finding solutions to their problems.

## CHAPTER 4: RECOMMENDATIONS and CONCLUSION

### 4.1 Recommendations

From what has been discussed in this study thus far, it is clear that the ritual of traditional male circumcision faces significant problems that have a negative impact in communities. It is also equally clear that something needs to be done about the ritual to alleviate suffering and prevent unnecessary deaths. Most of the recommendations have been either hinted at or discussed in some detail earlier in the text. I will now consolidate them into a list and only give their brief outline below:

- **Revisit Consultations:** Consultations at community and regional levels should be revisited. The scope of interested participants should be widened to ensure that the widest possible bases of community interests are represented. Government and traditional leadership representatives should take the lead in convening stakeholders' consultation forums. The deliberations and the results of these stakeholder engagements should be conducted in a democratic and consensus-building manner. The model for intercultural and intracultural communication presented at 3.3 above could be put to the test at these consultation and negotiation forums.
  
- **Build on existing areas of consensus:** As indicated in the theme on intervention in the literature review, there are already some areas on which common ground has been reached regarding the conduct of TMC between medical science and the traditional way of doing things, e.g. the pre-circumcision medical evaluation of initiates. Consensus and bridges built during the earlier rounds of negotiation and consultation should not be jettisoned, but built upon to achieve even greater common understanding.

- **Concentrate on Problem Areas-the Surgical Procedure and Educational Component:** Information from the literature shows that complications of TMC arise primarily from inexpertly performed surgery for circumcision and suboptimal post-operative care and monitoring. Communities in the Eastern Cape can learn from the experiences of those in Mpumalanga where traditional male circumcision is associated with minimal complications. I suggest that medical and nursing personnel who are skilled in the surgical aspects of male circumcision should be enlisted to provide practical training to traditional surgeons during circumcision schools where TMC takes place (with necessary modifications to ensure infection control). Traditional surgeons could act as surgical assistants until their competence is satisfactory, and they could then be observed doing the procedure and certified. Professional nurses could train traditional nurses similarly until their competence is secured. Once the surgery has been performed, and the post-operative evaluation of initiates has been done on the day following the operation, the medical and nursing personnel could then leave the initiates in the hands of traditional functionaries to continue with follow-up monitoring and care and the educational and other specific traditionally-sanctioned processes of the ritual. It is recommended that a medical review be conducted one week post-operatively to assess whether or not any new complications would have arisen. The specific surgical technique would have been the product of consensus reached during negotiation. As part of such negotiations, the possibility of using adhesive strips after the surgery instead of stitches would have been explored. The educational component of the ritual could also benefit from re-evaluation and strengthening of identified weak areas. For instance, a comprehensive and strengthened educational component could incorporate detailed information on the following topics: HIV and AIDS education, sex and sexuality education, sexually transmissible diseases, communication and conflict resolution skills training, and gender education and sensitivity. The strengthened educational component

of the ritual could begin in the communities once the initiates have been identified and medically evaluated well before the circumcision is done, continued during the period of isolation, and concluded post circumcision after the initiates have been reintegrated into their communities. It is envisaged that medical, nursing, psychological and related professionals could assist in delivering the upgraded educational programme in concert with traditional functionaries. The intervention in the surgery would be aimed at improving the skill of traditional surgeons so that they could subsequently be able to take full charge of the surgical component of the TMC ritual. Medical schools and hospitals could be enlisted to provide the training and certification of traditional surgeons. Government and medical personnel could thereafter play an advisory and monitoring role within the previously suggested inclusive local and regional committees. The control and standardization of procedures and financial compensation for the performance of circumcision would assist in eliminating unscrupulous practitioners who are only driven by the profit motive in their involvement in the ritual.

- **Strengthen Informed Consent Procedures:** Informed consent should be adapted to take into consideration the differences in how consent is viewed in conventional medicine and in traditional medicine. The positive aspects from each perspective could be integrated. Improved information sharing about the nature of the procedure and available options, e.g. regarding pain relief during the procedure, should be strengthened. Standard procedures should be adopted on how informed consent for orphaned children and those with absent legal guardians will be handled. The assistance of local school teachers/principals, nursing and medical personnel, pastors, and chiefs could be enlisted in the latter cases. Increased involvement of the initiates themselves to understand what the procedure entails, and to get their views in as far as their level of understanding and maturity allows, should be promoted. Greater care should be exercised to ascertain the validity of

consent by those who present for circumcision and to allow for those who voluntarily refuse the operation to be let free unmolested.

- **Suggestions for Further Enquiry:** Anthropologists and sociologists could assist us to gain further knowledge on the socio-cultural utility of traditional male circumcision by conducting longitudinal and comparative studies in circumcising and non-circumcising communities. I also believe that the issue of risk compensation following male circumcision has not been studied in sufficient depth. Further studies are also necessary to assess the full, practical, and contextualized impact of the results of randomized controlled clinical trials on male circumcision and its efficacy in preventing HIV transmission.

## **4.2 Conclusion**

At the beginning of this study, I hypothesized that traditional male circumcision as it is practised by sections of the African component of the South African population, was a subject worthy of close enquiry. I aimed at critically assessing a representative sample of the relevant literature on the subject and to engage in a philosophical reflection on specifically the ethical aspects of traditional male circumcision.

During the review of scholarship on TMC, it was considered convenient and appropriate to divide it into seven themes. The theme on interventions in TMC showed that there were sufficient grounds for government to intervene in the conduct of the ritual, but that there was considerable resistance to the intervention by government from traditional leaders. Notwithstanding the resistance just quoted, there were small but significant areas of co-operation and meeting of the minds between the institutions of the democratic government and those of traditional leadership upon which greater consensus could be built. It was thought that the process of consultation and intervention should be broadened to include all stakeholders in affected communities.

The theme on tradition and modernity pointed to the South African nation being at the stage of nationhood development that is a hybrid between what Gyekye (1997) called N2 (a constellation of distinct communo-cultural groups that remain fairly distinct within a nation state) and N3 (a coming together of communo-cultural groups as in N2 but with the difference that there is a fair amount of social cohesion between the different groups that come together in a nation state). The people who practise TMC in South Africa were assessed as being largely communitarian in their orientation. Bishop (2004) suggested that cultural relativism was a plausible stance from which practices such as female genital mutilation and traditional male circumcision could be morally assessed. Crocker (1991) suggested that the cultivation of a healthy balance of insiderness and outsidership with respect to an alien culture that we wished to understand and influence was an essential prerequisite to the critical appraisal of practices within the culture, but he did not go as far as endorsing cultural relativism.

Kopelman (1994) provided a strong rebuttal of ethical relativism as a viable tool for moral judgment in cross-cultural contexts.

The general consensus of scholars on the ethical aspects of male circumcision was that the health benefits of male circumcision were either equivocal or marginal. The scholars on this theme also showed that medical male circumcision was a very safe surgical procedure with few and predominantly minor associated complications. The utilitarian argument based on the provision of a safer circumcision and preventing the potentially harmful effects of stigma was the basis for the consideration that medical male circumcision could permissibly be deployed in the service of male circumcision requested for socio-cultural reasons.

On the complications of traditional male circumcision, the literature revealed that most of them were related to the lack of training and expertise on the part of the circumciser. The problem of lack of a standardized reporting format and the problem of the denominator in reporting complications of TMC were highlighted. The numbers of deaths, penile amputations, and rates of hospitalization were the statistics most frequently quoted by researchers. Little

or no attention was paid to the psychological and more intangible adverse consequences of TMC such as stigma.

The theme of the symbolic, cultural, and social meanings of TMC showed that there is considerable social pressure and stigma associated with TMC, to the extent that informed consent as we know it becomes subverted. The literature also lamented the decay of social structures and institutions that used to support the positive contribution of TMC in communities in the past.

The sixth theme of the literature review tackled the contentious topic of the relationship between male circumcision and HIV transmission, and whether mass male circumcision was a suitable tool to utilize in the public health attempt to reduce heterosexual transmission of HIV from infected females to uninfected males. It was assessed that, thus far, there were still significant outstanding questions that needed to be settled before an affirmative answer could be given to the question posed.

The seventh and last theme of the literature review explored the justifiability and limit of public authority to encroach on private liberty. Based on the works of Berlin (1995) and Mill (2010) on the liberty of the individual, it was concluded that society is justified to intervene in traditional male circumcision.

In the discussion chapter of the study, I proposed, based on aspects of the works of Bishop (2004) and Crocker (1991) a model for intra-cultural and intercultural understanding, communication, and influence. I suggested that it is prudent to gather as much information as possible about an alien culture we wish to influence and judge in order to gain an understanding of its starting points, milieu, and desired goals. This would serve to sharpen our perspective, broaden our understanding, and enhance the quality of our engagement and judgments. Familiarizing oneself with the practices and institutions of an alien culture does not imply that subsequent moral judgment of those artefacts would be carried out solely based on the criteria internal to the culture, but it assists in the rational evaluation of the culture when we have at our disposal the maximum pertinent information in order to serve the

requirements of rationality. Among other issues, I also highlighted the problematic status of pain during traditional male circumcision. I suggested that society does not have a moral right to legislate a threshold for pain that competent individuals may permissibly endure, beyond which it became mandatory to abolish pain.

I believe that the goal of theoretical ethics is to arrive at rationally defensible conclusions about how we ought to live following extensive reflection on all pertinent factors that require examination. I also believe that the goal of practical ethics is to make recommendations about how the conclusions of theoretical ethics should be incorporated into and inform the lived experiences of human beings. Although interdependent, the two goals are not identical and the former may not inherently and inevitably imply the latter. The conclusions derived from theoretical ethics may sometimes not, based on practical considerations, be amenable to be incorporated into the lives of people, at least not in their entirety or in an unmodified form. I conclude that traditional male circumcision, in its current form, based on considerations that are amenable to rational evaluation, ought not to be allowed to continue to be practiced. But I do not think that my assessment should end there. I feel justified to advise that, because of the significant potential risk of catastrophic consequences of a total ban of traditional male circumcision, and because of the evidence derived from modified TMC and non-traditional medical male circumcision (MMC) – that MMC is either neutral or could conceivably confer a small net benefit, TMC may continue to be practiced in a modified form by those who are competent voluntarily to choose it if they so desire.

The demand for traditional male circumcision within the traditionally circumcising communities in South Africa is likely to remain strong for the foreseeable future. Many commentators have catalogued the complications associated with the ritual of TMC. The challenge for society, in its varied formations, is to work together in order to eliminate the preventable complications of the ritual. The first step towards this goal is for all interested stakeholders to engage in open, honest, and inclusive dialogue with one another in order to produce collaborative and workable solutions.

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**TABLES and APPENDICES**

Table 1: Reported cases of hospital admissions, penile amputations, and deaths of initiates in the Eastern Cape Province 1995-2005. (Kepe, T. 2010)

Year	Hospital admissions	Penile amputations	Deaths
1995	1042	42	55
1996	801	22	16
1997	555	34	17
1998	357	8	17
1999	612	33	26
2000	384	23	22
2001	324	31	36
2002	447	33	50
2003	311	29	41
2004	391	6	14
2005	589	20	48

## **Appendix A. The Application of Health Standards in Traditional Circumcision Act, No. 6 of 2001**



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**PROVINCIAL NOTICE**

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No. 56

22 November 2001

PROVINCE OF THE EASTERN CAPE

OFFICE OF THE PREMIER

**PUBLICATION OF APPLICATION OF HEALTH STANDARDS IN TRADITIONAL CIRCUMCISION ACT  
(EASTERN CAPE) (ACT No. 6 OF 2001)**

It is hereby notified that the Premier has assented to the following Act which is hereby published for general information:

**No. 6 of 2001 (EC): Application of Health Standards in Traditional Circumcision Act, 2001 (Eastern Cape)**

# ACT

To provide for the observation of health standards in traditional circumcision; to provide for issuing of permission for the performance of a circumcision operation and the holding of circumcision school; and to provide for matters incidental thereto

*(English text signed by the Premier)  
(Assented to on 15 November 2001)*

**B**E IT ENACTED by the Legislature of the Province of the Eastern Cape, as follows—

## Definitions

1. In this Act, unless the context indicates otherwise—

"circumcision" means the circumcision of a person as part of a traditional practice;

"circumcision school" means a place where one or more initiates are treated;

"Department" means the Department of Health in the Province;

"gazette" means the *Provincial Gazette* of the Province;

"initiate" means a person who is in any stage of the circumcision process as contemplated in this Act;

"MEC" means the Member of the Executive Council responsible for Health in the Province;

"medical officer" means an officer designated or a person appointed in terms of section 2;

"medical practitioner" means a person registered as such under the Health Professions Act, 1974 (Act No. 56 of 1974);

"permission" means permission in the form of a document prescribed by Annexures A and B, issued by the medical officer in terms of section 3 (a);

"Province" means the Province of the Eastern Cape established by section 103 of the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996);

"surgical instrument" means an instrument used for the performance of circumcision, and "instrument" has a corresponding meaning;

"this Act" includes regulations made hereunder;

"traditional authority" means a traditional authority established in terms of a law recognised by section 211 of the Constitution; and

"traditional practice" includes a practice according to the custom, religion or any other rules of similar nature.

## Designation of medical officer

2. The MEC must designate in writing one or more officers of the Department or appoint one or more persons, on such conditions and qualifications as may be prescribed, as medical officers for the purposes of exercising and performing powers and functions conferred or imposed on them by this Act.

## Powers and functions of medical officer

3. The medical officer must, in addition to any other power and functions entrusted to him or her by this Act, exercise and perform the following powers and functions:

(a) Issuing of permissions to circumcise or treat an initiate;

(b) Keeping of records and statistics pertaining to circumcision and reporting thereon as prescribed.

- (c) A right of access to any occasion or instance where circumcision is performed or an initiate is treated.

#### Permission to perform circumcision

4. (1) No person, except a medical practitioner, may perform any circumcision in the Province without written permission of the medical officer designated for the area in which the circumcision is to be performed.

(2) (a) A person may apply as prescribed for permission to perform circumcision and such permission may not be given unless all the conditions set out in Annexure A of the Schedule have been complied with.

(b) A medical officer may, as part of the condition provided in item 7 of Annexure A of the Schedule—

- (i) disallow the use of a surgical instrument that the traditional surgeon intends to use; and
- (ii) prescribe or supply a proper surgical instrument where the use of a particular instrument has been disallowed in terms of subparagraph (i).

(c) Where a proper surgical instrument has been prescribed or supplied in terms of paragraph (b)(ii), the medical officer concerned must demonstrate to, or train, the traditional surgeon as to how the instrument should be used.

(3) A medical officer must, in the following manner, present the conditions set out in Annexure A, to the person applying for permission in terms of subsection (2)(a):

- (a) The medical officer, or any other person assisting such medical officer, and in the presence of the medical officer, must read the conditions in the official language understood by the person applying for permission;
- (b) both the medical officer and the person applying for permission to perform a circumcision, must write their full names and signatures, and the date, on the document containing the conditions.

(4) A person who has applied must within one month of the date of such application, submit proof of compliance with the conditions referred to in subsection (2), failing which the application of such person shall lapse.

(5) A person whose application has lapsed as contemplated in subsection (4), is eligible to make a new application for permission to the medical officer concerned, and the provisions of this Act apply to such person as if application for permission is made for the first time.

#### Permission to hold circumcision school or treat initiates

5. (1) In the Province, no person may hold any circumcision school or treat any initiate without written permission of the medical officer designated for the area in which the circumcision school is to be held or the initiate is to be treated: Provided that this subsection does not apply to the treatment of an initiate in a hospital or by a qualified medical doctor outside the traditional context.

(2) A person may apply, as prescribed, for permission to hold a circumcision school or to treat an initiate, and such permission must be given subject to the conditions set out in Annexure B of the Schedule.

(3) A medical officer must, in the following manner, present the conditions set out in Annexure B, to the person applying for permission in terms of subsection (2):

- (a) The medical officer, or any other person assisting such medical officer and in the presence of the medical officer, must read the conditions in the official language understood by the person applying for permission;
- (b) both the medical officer and the person applying for permission to hold a circumcision school or treat initiates must write their full names and signatures, and the date, on the document containing the conditions.

(4) A person who has applied, must within one month of the date of such application, submit proof of compliance with the conditions referred to in subsection (2), failing which the application of such person shall lapse.

(5) A person whose application has lapsed in terms of subsection (4), is eligible to make a new application for permission to the medical officer concerned and the provisions of this Act apply to such person as if application

## HEALTH STANDARDS IN TRADITIONAL CIRCUMCISION ACT (EASTERN CAPE)

Act No. 6, 2001

**Restriction of persons to treat an initiate**

6. (1) No initiate may treat or attempt to treat another initiate at any stage during or after the holding of a circumcision school.

(2) No person other than the traditional nurse, medical practitioner, the medical officer or any other person authorized by the medical officer, may within a traditional context, treat an initiate.

**Consent by parent or guardian**

7. (1) The parent or guardian of a prospective initiate must, in respect of a prospective initiate below the age of 21 years, complete and sign a consent form in the format set out in Annexure C.

(2) The parent or guardian of an initiate must, in addition to all other responsibilities which such parent or guardian has in respect of the initiate, render such assistance and co-operation as may be requested by the medical officer in the interest of the good health of the initiate.

(3) No person, including the parent or guardian of an initiate, may interfere with or obstruct the medical officer in the performance of his or her duties under this Act.

**Amendment of Schedule**

8. (1) The MEC may, by notice in the Gazette, amend the Schedule.

(2) The MEC must, within a period of thirty days after the publication of the notice contemplated in subsection (1), submit a copy thereof to the Legislature of the Province.

**Punished**

9. (1) Any person who contravenes the provisions of sections 6, 7(2) and 7(3) is guilty of an offence and liable on conviction to a fine of R1 000,00 or to imprisonment for a period not exceeding six months.

(2) Any person who contravenes the provisions of sections 4 (1) and 5 (1) or who fails to comply with any condition imposed by a medical officer in terms of sections 4(2) and 5(2), is guilty of an offence and liable on conviction to a fine not exceeding R10 000,00 or to imprisonment for a period not exceeding ten years, or to imprisonment for a period of five years without the option of a fine.

**Regulations**

10. (1) The MEC may make regulations in regard to any of the following matters:

- (a) The issue of permission under this Act and the form of such permission;
- (b) the form and manner of application for such permission;
- (c) the requirements to be complied with by the applicant for such permission;
- (d) the prohibition or restriction of the issue of such a permission in appropriate circumstances;
- (e) the duration of any circumcision school;
- (f) generally the conditions subject to which permission may be issued;
- (g) the conditions and qualifications which an officer or a person referred to in section 2 must satisfy or possess; and
- (h) any other matter, the regulation of which may in the opinion of the MEC, be necessary or desirable for the purpose of achieving the objects of this Act.

(2) Any regulation made under this Act may prescribe a penalty for the contravention thereof, or default in complying therewith: Provided that regulations may not prescribe a penalty in excess of the penalty imposed by section 9(2).

**Short title**

11. (1) This Act is called the Application of Health Standards in Traditional Circumcision Act, 2001