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CIRCUMCISION IN MOZAMBIQUE, DIALOGUE BETWEEN TRADITIONS, BIOETHICS AND BIOMEDICINE

CIRCUNCISÃO EM MOÇAMBIQUE, DIÁLOGO ENTRE TRADIÇÕES, BIOÉTICA E BIOMEDICINA

CIRCUNCISIÓN EN MOZAMBIQUE, DIÁLOGO ENTRE TRADICIONES, BIOÉTICA Y BIOMEDICINA

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ABSTRACT
This paper is part of a qualitative research, based on an ethnographic study, carried out with the Makonde ethnic group, in southern Mozambique. It reflects on the traditional practice of circumcision as an initiation ritual among the Makonde and the influence it suffered in contact with other ethnic groups and religions and with the biomedicine paradigm. It develops a brief historical characterization of circumcision in the cultural traditions of different ethnic groups in the country and points out challenges of the practice of traditional circumcision in dialogue with biomedical interventions related to HIV prevention. It highlights the role of health workers, bioethicists, and anthropologists in the understanding of singular stories of native ethnic groups and their forms of resistance or adherence to epistemologies from contemporary scientific medicine. Also argues the need to address informed consent and human rights of young males who participate in this type of intervention.

Keywords: Male Circumcision. Cultural Tradition. Biomedicine. HIV.

RESUMO
Este artigo é um recorte de pesquisa de natureza qualitativa, baseada num estudo etnográfico, realizada junto ao grupo étnico Makonde, que habita no sul de Moçambique. Reflexiona sobre a prática tradicional da circuncisão como ritual de iniciação entre os Makonde e a influência que sofreu no contato com outros grupos étnicos e religiões e com o paradigma da biomedicina. Desenvolve uma breve caracterização histórica da circuncisão nas tradições culturais de diversos grupos étnicos do país e aponta para os desafios da prática da circuncisão tradicional em diálogo com as intervenções biomédicas relacionadas com a prevenção do HIV. Destaca o papel dos sanitaristas, bioeticistas e antropólogos para a compreensão das histórias singulares dos povos originários e suas formas de resistência ou de adesão aos saberes provenientes das medicinas científicas contemporâneas e da observância do consentimento informado e o respeito aos direitos humanos dos jovens que realizam estes processos de intervenção.

Palavras-chave: Circuncisão. Práticas Tradicionais. Biomedicina. HIV.

RESUMEN
Este artículo es un recorte de una investigación cualitativa, basada en un estudio etnográfico, que se llevó a cabo con el grupo étnico Makonde, que habita en el sur de Mozambique.

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Reflexiona sobre la práctica tradicional de la circuncisión como ritual de iniciación entre los Makonde y la influencia que sufrió en contacto con otras etnias y religiones y con el paradigma de la biomedicina. Desarrolla una breve caracterización histórica de la circuncisión en las tradiciones culturales de las diferentes etnias del país y señala los desafíos de la práctica de la circuncisión tradicional en diálogo con las intervenciones biomédicas relacionadas con la prevención del VIH. Destaca el papel de los profesionales de la salud, bioeticistas y antropólogos en la comprensión de las historias singulares de los pueblos originarios y sus formas de resistencia o adhesión a los saberes de la medicina científica contemporánea y la observancia del consentimiento informado y el respeto a los derechos humanos de los jóvenes que las realizan estos procesos de intervención.

Palabras clave: Circuncisión Masculina. Prácticas Tradicionales. Biomedicina. VIH.

1 INTRODUCTION

Male circumcision is the most frequent surgery among men1 and, among some ethnic groups, it is a ritual practice that symbolizes the passage from childhood to adulthood2. It can be interpreted as the moment of attribution of social roles to men in many traditions3. This is a subject widely debated in the medical literature, either because of its correlation with the reduction in the risk of HIV infection4 or because of bioethical debates about autonomy and limits of body manipulation5.

In African countries, circumcision is a traditional practice in more than 400 communities or ethnic groups6 and needs to be understood from cultural perspectives and traditional medicine in its encounter with colonizing practices, whether resulting from the expansion of non-original religions (such as Islam or Christianity) or from contemporary medical practices related to HIV7 8.

In publications on the health practices of peoples in sub-Saharan Africa, there is a tendency, according to more critical researchers9, to structure narratives from the perspective of the dominator. Thus, sanitarians, bioethicists and anthropologists must be aware of the unique histories of native peoples and the forms of resistance or adherence to the knowledge coming from contemporary scientific medicines. With regard to circumcision, it is not uncommon for medical interventions unrelated to traditional practice to be refused10.

This article presents some results of an ethnographic approximation study carried out among the Makonde ethnic group residing in Mozambique. The sociocultural context of circumcision in the autochthonous tradition and the influence it suffered in contact with other traditions are analyzed. At the end, some reflections on public health and bioethics on the subject are made.

2 COLONIAL PERIOD

Mozambique is a country on the east coast of Africa that, over time, has been occupied by peoples of different origins and cultures, Africans, Arabs, Indians and Europeans. The country is predominantly inhabited by the descendants of the Bantu, a large ethnolinguistic group that populates almost all of sub-Saharan Africa sharing sociolinguistic similarities in beliefs, rituals and customs11. According to Firmino12, in Mozambique there are thirteen ethnic groups: (1) Swahilis, (2) Makuas, (3) Lomués, (4) Makondes, (5) Yao or Ajaua, (6) Maraves or Nyanja, (7) Sena, (8) Chuabo, (9) Chonas

including the Ndaus, (10) Angonis or Nguni, (11) Tsongas (divided into Ronga, Changane and Vatswa), (12) Chopes, (13) Bitongas.

Circumcision is a traditional African practice that goes far beyond a simple cut of the foreskin. It implies a conception of the world and requires techniques, instruction processes and transmission of skills for its execution. Circumcision is a cultural symbol that is nourished by religious and ethnic values and expresses mechanisms of insertion in the various societies where it is in force13. In Mozambique, it is practiced for ethnic-religious reasons by the Swahilis, Makondes, Yao or Ajaua, Makuas-Lomués, Sena, Chuabo, Chopes, Bitongas and Vatswa. The Rongas and Changanas abandoned the rite by Nguni imposition and on the side of the Arab/Persian influence that wanted to impose their circumcision, but were prevented by the Portuguese.

The Portuguese and the Catholic Church tried to extinguish the initiatory rituals of the traditional African religion and part of the Muslim traders encouraged Africans to maintain their cultural traditions and beliefs in opposition to the hegemonic role of evangelization and Portuguese civilization14 [15]. Traditional circumcision was only effectively extinguished by the Ngunes when they subjected the Rongas and Changanas in southern Mozambique to domination and the consequent replacement of the practice by the rite of piercing the ear loin using a penknife, as a new symbol of identity of those submissive to Emperor Manikusse or Sochangana of Gaza.

Schwartz16 observes that the enslaved Africans taken to the Americas were not prevented from maintaining the practice of rites of passage, even though circumcision was advised against by the clerics who submitted them to baptism, which required adherence to Christianity. However, there were forms of resistance and cultural and religious perpetuation through the maintenance of traditional African practices in captivity. Sweet17 points out that at the beginning of the eighteenth century, in Brazil, there were reports of slaves refusing to have sexual relations with uncircumcised people who could be considered uninitiated or ritually impure.

3 POSTCOLONIA PERIOD

The end of Portuguese colonial domination, with the foundation of the Republic of Mozambique in 1975, represented the emergence of a new conception of nation, of forms of political, economic, cultural and religious organization that imprinted new directions on the emerging society. In this new context, there is a revival of cultural pluriethnic resistance,

of the oral traditions of local peoples who resist processes of colonial deterioration of their sacred universe, creating strategies for maintaining traditions. Ngole18, in his anthropological analysis of the Makondes, attests that there were political tensions for religious reasons, mainly related to the imposition of the Catholic faith during Portuguese domination.

4 DJANDO YA VAMAKONDE AND YAO

The Makondes are described as invincible, indomitable and hardened warriors, for their resistance against all forces that oppose their beliefs and traditions19. The protection of the bodily practices imposed on other ethnic groups in the *Likumbi* initiatory experience is a demonstration of how much they extend their ethnic supremacy beyond their borders. In the oral tradition, the Makonde consider themselves to have a deep kinship relationship with the Yao, sharing aspects of social organization and initiation rites20. The Yao can be initiated into *Likumbi* and their ritualization can be validated by them. The Makondes, on the other hand, do not accept to be initiated into the *Unhango rite* of the Yao and do not validate it.

The Makondes keep their centuries-old traditions alive and have not allowed changes with regard to circumcision. With the HIV pandemic, some choose to take their children to medical circumcision. However, most do not fail to submit them to circumcision done through the use of knives and without anesthesia to comply with the rite of passage. The use of local anesthesia in traditional circumcision is rejected insofar as pain and bleeding are considered important experiences at the initiate's entry into adulthood.

The research revealed that some *Nalombwos* (masters of the rite) and young people who were already initiated, did not fully assume the introduction of biomedical procedures such as the individualized use of a cutting blade for each initiate. Previously, the *Nalombwos* reused cutting blades on initiates who did not bring their own blade. Throughout the fieldwork developed in the data collection of this article, it was verified that this still happened, evidencing the complexity of the dialogue between biomedical interventions and traditional practices.

Initiation is an ethnic socialization for both the Yao and the Makonde, although it is a practice carried out differently in each group20. For example, there are changes between circumcision in the *Lupanda* Yao ritual before the Arab/Islamic influence and the current

Unhango. However, despite the similar structural composition of the Yao and Makonde rituals, the categorization of the preputial cut may differ from biomedical practice21.

However, it is important to be aware of some similar procedures. Yao circumcision is also performed by *Angaliba,* the initiation master, using a single instrument that serves all initiates and without sterilization as described in the reports of Yao participants22. This author describes one of the initiatory structural differences between *Unhango and Likumbi.* At *Unhango*, parents enlist the neophytes and, after confirmation, communicate it to the regulus, a local traditional authority*,* who in turn addresses the invitation to the Association of Traditional Doctors of Mozambique (AMETRAMO). It is up to him to indicate *Ngaliba*, master of traditional circumcision, who is not only in charge of the surgery, but also of inviting health professionals for any adverse episodes in the procedure. It is up *to Nakanga* to be in charge of learning and initiatory coordination.

This composition is more democratic among the Yao, as it involves the community and its structure. In the Makondes who moved to the south of Mozambique, the participation of parents and the community is notorious, but it does not involve AMETRAMO or the regulus. The entire initiatory process is circumscribed to the functions of *Nalombwo*, the surgical master, his power in initiation is absolute.

Likumbi begins at dusk, and some of the rites that precede it are surrounded by taboos and secrecy, which is why its realization is not always announced in advance. For example, circumcision is performed suddenly on the way to *Likuta* because, in the Makonde conception, *Likuta* is an impure and unsafe place for surgery if the sorcerers anticipate setting a trap to infect the surgery of *the Vawali,* initiates21. On the contrary, the Yao, according to Namuholopa22, enter the initiatory place at dawn, after invocation of the ethnic ancestors.

5 KUSOKA AND ISLAM

Kusoka is circumcision in the Bantu languages; even before the *Nguni invasion* of southern Mozambique it was a common ritual practice. The introduction of Islam and Arab/Persian culture in Africa in the mercantile era would have fascinated Balta23. Black Islam inserted in the daily life of the communities assumed African values and traditions in their devotion, incorporating local autochthonous beliefs and practices into Islamic doctrine. Islam is rigid in the observance of its doctrinal principles, but in return, it is flexible to incorporate cultural practices and customs, except in the belief in a single god, *Allah, wāḥid*,

aḥad (one – first and only), pious and omnipotent. Their devotion rests on *Sunna* or tradition, analogical judgment *Qiyas* and Ijma *community consensus*, aimed at social embodiment and cohesion where religious life is not separated from everyday social life. This is the respect that is shown for the uniqueness of Islamic law, which serves both to legislate civil and religious life24.

The *Kusoka custom* in the indigenous traditions of Mozambique currently predominates in all the native peoples of the provinces, with the exception of Tete, Manica and Maputo. According to Alpers25, these traditions have been influenced over time by Islamic cultural and religious influence. This fact has occurred since the beginning of the seventh century in the region, when the action of Arab and Persian traders and navigators gave rise to the commercial centers of Sofala, Ilha de Moçambique, Quiloa and Pemba.

Mozambique has an undeniable and diverse presence of Muslims, who, according to reports by Newitt26, would have been descendants of Islamists from different parts of the world and from branches of Islam. The cities of Mafia, Zanzibar, Mombasa, Gedi, Melinde, Manda, Lamu, Pate, Faza Brava, Merca, Mogadishu and the states of Comoros, Madagascar, Socotra, Mecca, Yemen, Oman, Persia, India, Ceylon, Indonesia, were part of the Indian Ocean trade network in the twelfth and seventeenth centuries before the Portuguese presence.

The permanence of Muslims on the coast of Mozambique has cooperated with the expansion of an Islam of denominations and attributes of diverse geographical origins. Amide27 explains that the Arabs altered the cultural and religious scenario of the Yao by making them Muslims and made changes in the *Unhango*, an initiatory rite. In such a way, *Unhango* became *Shahada, the* initiation rite of the Islamic faith formerly called *Lupanda*, the male rite, and *Chiputo*, the female ritual. Amaral28 considers that the majority of the Yao have lost the traditional meaning of initiation into Islamic devotion and have transformed rituals from their tradition to the *um,* a community of Muslim religious life.

Maivasse29, in a study he carried out in the Neighbourhood of the Popular Forces for the Liberation of Mozambique (FPLM), one of the largest urban centres in the city of Maputo, shows that the practice of traditional circumcision is intricate in tradition and religion. On the other hand, the high urban social class has given it transformations, adjusting them to its elite status. The Islamic surgical and religious ritual with medical intervention to prevent the occurrence of HIV infections in this group of the urban center, according to the author, is a recent phenomenon.

This is where the predominance of ethnic circumcision ceases, in groups syncretized with Islam, as described in the Yao tradition. The Makondes are the only ones who separate the space of the *Djando*, ethnic circumcision, from the tradition of the *Shahada*, Islamic circumcision. They do not accept that the Islamic tradition imposes itself on the ethnic tradition. The *Djando* takes place in *Likuta*, sacred forest. Marcos30 says that the Makonde who accept Islamization attend *Mwalimo, a* traditional Koranic school that teaches the theological basis of the Koran to initiates.

6 HIV ERA AND MEDICAL CIRCUMCISION

The overview of circumcision presented here reflects the social context in which the rite is circumscribed in the cultural traditions of the peoples of Mozambique. Some effects will be seen below in the context of the HIV/AIDS epidemic and the practice of biomedical circumcision.

The recommendation of male circumcision to reduce the risk of HIV infection by the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) published in 2007, precipitated the debate around why traditional circumcision is not part of the same strategy. According to this document, observational studies showed in various contexts of countries on the African continent that the prevalence of HIV was lower among men who had undergone circumcision.

In search of more substantiated scientific evidence, three randomized clinical trials were carried out in Kenya, Uganda and South Africa, which analyzed the efficacy, safety and acceptability of the strategy, the results show that the procedure reduces the risk of contracting HIV by 60% in circumcised women31. At the same time, studies have shown that male circumcision does not completely protect against acquiring HIV infection and, therefore, does not dispense with the use of other prevention strategies. Considering these findings, it was possible to incorporate male circumcision performed by trained medical professionals as another component of the range of prevention measures available to reduce heterosexual HIV infection in men. It has been determined that proper communication of this strategy is critical and culturally sensitive. It calls for the dissemination of clear messages, accompanied by the need to take other preventive measures concomitantly with male circumcision, with a view to comprehensive HIV prevention, including sexual abstinence within six weeks of circumcision.

From a sociocultural point of view, the WHO recommendation31 recognizes the role of circumcision in communities and in some religions such as Islamic and Jewish. In this sense, the health services that will offer this intervention need to be properly structured for the appropriate execution of this strategy, which involves safe scenarios for clinical practice in aseptic conditions, adequate equipment and team skills. And, in terms of human rights and ethical and legal principles, the document warns that this intervention raises concern. It is up to health services to guarantee informed consent to participants, informing them in detail of the risks and benefits of the intervention, as well as avoiding coercion and discrimination against users, as part of adherence to good medical practices.

These recommendations also extend to young people and adolescents with whom it is necessary to contemplate aspects of their maturity in carrying out the informed consent process. In addition, the WHO/UNAIDS document urges countries to be careful that the circumcision procedure does not promote non-consensual sex, domestic violence or link male circumcision to female genital mutilation. Male circumcision needs to be seen as an opportunity to strengthen sexual and reproductive health and to expand access to health services for young people and men.

Preventive medical circumcision of HIV in Mozambique has brought about two new social models of ritual practice. The first was to shift massive initiatory circumcision from ethnic traditions to medicine. Second, clinical practice has come to be guided by the principlism of Beauchamp and Childress, following four principles of Bioethics that underlie the obligation to sign the *free and informed consent form* (ICF)[32]. The informed consent form is important because it imposes rigor in safeguarding the patient's autonomy, proves the knowledge and agreement of their participation in medical acts, clarifies the objectives of the clinical intervention and the communication of risks and benefits of their free and conscious participation in the procedure33.

Medical circumcision in Mozambique is recommended for children as young as 10 years old. In practice, it is carried out without signing the ICF and without respect for the principles of Bioethics. Children and their parents/guardians are unaware of the likely negative effects of circumcision, such as loss of sexual sensation, disabling complications, medical marketing to attract patients, and forced HIV testing. Such aspects raise criticism. Circumcision of minors without the consent of parents/guardians does not guarantee that children under 10 years of age will be excluded from the program, constituting another violation of bioethical principles34. Two-thirds of medical circumcisions occurred among

men aged 10 to 19 years in Africa[35]. In the district of Chókwé-Mozambique, 19,201 men aged 10 years or less were circumcised in the period from 2014 to 2019. This fact raises serious questions about the possible experimentation of adult circumcision on children without consent, according to Hines4, based on Jhpiego's work.

The parents described that their children were mobilized by teachers and nurses at the school, taken to the circumcision posts by health agents. Thus, under no circumstances should they refuse because it was an order of teachers and health professionals. They feared that their refusal to be circumcised could lead to punishment, barring them from attending school, as well as acts of discrimination and stigma in the school environment (*Nguyama, 56 years old*).

When it comes to specific patients, Miziara36 says that only at risk of death, medical intervention can be performed with tacit consent, and this is not the case. Svoboda37 believes that if circumcision of children is an HIV control strategy, the idea is that it should be applicable close to the age of initiation of sexual activity. For Dua38 circumcision should be postponed until adulthood, so that men can give consent for the excision of the foreskin autonomously, choosing the type of procedure. Only in these circumstances is there no violation of the rules of medical ethics.

Paternity does not attribute ownership to children, as they are beings with individual will and originality, constituting subjects of actions that guide their existence. Their choices are no longer an inheritance of cultural traditions, they are acts of personal sovereignty and the individual's own decision, who have their own will, rights and different degrees of autonomy39.

In another scenario, traditional circumcision has been pointed out as a risk practice for HIV infection, considering the limitations to ensure asepsis in the procedure, as well as the type of incision and tissue removal that is made. A challenge posed to biomedicine and traditional medicine with regard to circumcision is to find points of convergence for a dialogue that gives rise to the understanding of the medical pluralism that already exists in societies40. That is, the use of various mechanisms for the health care of people that may or may not be complementary, concomitant or excluding. It is necessary to recognize the existence and legitimacy of traditional knowledge and practices and the various etiological and therapeutic conceptions that subsist in societies, which cannot necessarily be classified in terms of efficacy and safety as predicted by biomedicine. Therefore, there is a structured tension between the official health systems and the traditional systems based on the

rationalities of the procedures that are of a very different nature and that only make sense in the specificities of their respective sociocultural references.

Hence, the success of medical male circumcision programs should not be based solely on the number of men circumcised without consent. Ensuring the protection and safety of minors should be the priority, as well as assessing the psychosocial effects, their quality of life, depression, the quality of services provided, and the stigma arising from the perceived difference between circumcised and uncircumcised children. In some circumstances, the high number of circumcised individuals who did not comply with all procedures seeks to meet the goals of the program's funders on time41.

The success of medical circumcision programs contrasts with the increasing number of negative events associated with this procedure that translate into stigma and discrimination, calling into question the cost-effectiveness of global circumcision campaigns5.

7 THE AGE OF CONSENT IN THE WORLD

The age of consent is legitimized in people legally competent to consent to sexual activity, it varies from 11 - 21 years around the world42. The universal stance on consent is a practice to be adopted in Mozambique's circumcision strategies. It would also be a legal support for minors to decide about their sex life. Many countries around the world are concerned about children's legal age of consent as part of guaranteeing their rights to health. In cases of HIV, the age of consent is a social protection of patients against discrimination and stigma. At the same time, it is a guarantee of access to health care for adolescents in prevention, treatment and care43. Such recognition would be a reflection of the country's commitment to the inclusion of ethnic minorities, children in vulnerable situations, and the protection of their health rights. Studies by Hein44 and Coyne45 argue that children have the capacity to decide about their health care.

Adherence to the circumcision program showed that children and parents/guardians do not have autonomy over the health of their children. It is alienated from the interests of third parties who act in the name of safeguarding health against HIV.

8 RISKS AND BENEFITS

The evaluation of risks and benefits in circumcision is analyzed from the perspective of surgical massification in the presumption of reducing the chances of HIV infection. The

risks should be measured based on the therapeutic effects and not by the non-therapeutic surgical massification that did not imply a discussion about the loss of the foreskin, the value it represents for the circumcised and the incalculable bodily and psychological damage it causes46. What justifies circumcision of sexually inactive children? The theory of reducing the transmission of sexually transmitted infections through circumcision is valid from the first sexual intercourse38, which begins on average at 18 years of age47. Arruda48 indicates that active sexual life begins between 7 - 18 years of age in men and in women between 7 - 17 years of age. HIV infection among men occurs more frequently between 20 and 30 years of age49.

The principle of non-maleficence stipulates that acts that may cause useless harm to children and without immediate benefits should not be performed, in this case, in the removal of functional body tissue50 [51]. Non-therapeutic circumcision imposes on the healthy child the risk of harm without benefit. This would then constitute an evil act. It also upholds the principle that physicians cannot take orders from the parents or guardians of children because the physician's duty is to the patient52. Non-maleficence is contradicted when a child is circumcised without the consent of the parents and under duress when doing something that may be considered malicious and superfluous, such as the removal of the foreskin.

The national circumcision protocol, adapted from the recommendations of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the President's Emergency Plan for AIDS Relief (PEPFAR), does not yet apply to mass surgeries in the country. It is likely that the local context may not be suitable for the ethical application of the ICF32. For Vaughn53, the absence of consent can only be justified by the inability of a minor, mental illness, psychic disturbances, anguish, fear, pain, and the inability to make decisions, as he does not always know the implications of medical acts for his health.

9 FINAL CONSIDERATIONS

The specter that non-therapeutic male circumcision is a beneficial procedure because it protects against HIV transmission fuels the debate around whether this practice should be performed on children without the consent of the children or their parents. For apologists for circumcision without consent, there is no association that balances surgery and ethics, as uncertainties are reduced to life-saving medical acts. If there is an

association between surgery and practical medical ethics, there must be a policy that results from long years of doctor/patient relationship in its actions.

The circumcision policy of the Mozambican Ministry of Health, inspired by the recommendations of UNAIDS49 of 2007, may be hampered in its implementation, according to Junqueira54, due to the lack of an ethical culture of professional-patient consent before the era of preventive circumcision of HIV. This is a difficulty inherent to the introduction of a new technology, whether light or hard.

However, there is no circumstance that justifies parents enjoying the right to choose what is best for their children's health. Nor should this decision of the parents be made by the doctors. However, the existence of ethical laws and procedures dispels the omission of medical-professional responsibility.

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