Canadian HIV/AIDS Legal Network

HIV/AIDS POLICY & LAW REVIEW

VOLUME 12, NUMBER 1, MAY 2007

Male circumcision and HIV prevention: a human rights and public health challenge

Three recent randomized clinical trials from Africa concluded that male circumcision can lead to a significant reduction in HIV risk for men. As a result, an exponential scale-up of services required to circumcise men is already figuring in the thinking of AIDS policy-makers at many levels. At this writing, the World Health Organization (WHO) is reviewing the three studies and other evidence, and is developing policy recommendations for making this HIV prevention intervention widely available. WHO says that this policy exercise "will need to take into account cultural and human rights considerations associated with promoting circumcision," among other factors.[1] In this article, Joanne Csete identifies some of the most important human rights questions that should be taken into account in the development of guidelines for national governments. The author argues that a scale-up of services to provide male circumcision provides an excellent opportunity to address issues concerning the subordination of women.

Introduction

Results of recent research on the protective effect of male circumcision with respect to HIV transmission have taken the AIDS world by storm — and rightly so. When HIV prevention victories continue to be few and often unsustained, it is easy to be swept up in the excitement about an intervention that promises men something on the order of a 50 to 60 percent reduction in HIV risk. It is no surprise that male circumcision has been hailed as the "AIDS vaccine for the real world,"[2] especially

cont'd on page 5

Inside

Canadian HIV/AIDS Legal Network | Réseau juridique canadien VIH/sida

AMERICAN BAR ASSOCIATION Defending Liberty Pursuing Justice

Production of the *HIV/AIDS Policy & Law Review* has been made possible, in part, by the financial contributions of the American Bar Association (ABA) and the Hilda Mullen Foundation.

Male circumcision and HIV prevention: a human rights and public health challenge

cont'd from page 1

as the prospect of an effective HIV vaccine of the conventional sort continues to be years away.

Research on HIV and male circumcision is a story of high drama, as health research goes. For years, epidemiologists had noted that HIV prevalence appeared to be lower in societies where male circumcision was the norm. But it was clear that other variables — including sexual norms and practices that may be associated with the same religious differences that affect circumcision practices — might "confound" the conclusion that lower HIV prevalence was caused by circumcision. Only a randomized study — that is, one in which men were randomly assigned to be circumcised or be in an uncircumcised control group — could control for possible confounding factors, or at least come close enough to lead to policy recommendations.

It took some years to make randomized trials a reality, but three such trials in Africa — one from a French-funded research team working in Orange Farm, South Africa, and two from U.S.-funded projects in western Kenya and Uganda — have now reported results.[3] In all three cases, the studies were discontinued before their planned end dates because the HIV protective effect of circumcision was so strong that it was unethical to deny it to those in the control group.

These three studies examined only the effect of circumcision with respect to HIV transmission from women to men. A study funded by the Gates Foundation in Uganda, expected to be completed in 2008, seeks to quantify the effect of male circumcision on sexual transmission of HIV from men to women.[4] A preliminary analysis of data from this study presented at a technical WHO meeting in March 2007 indicated that women may face higher-than-normal HIV risk from having sex with recently circumcised men before the incision from the circumcision is completely healed, but WHO officials were quick to say that these findings did not negate the important preventive effect of circumcision overall.[5]

Strong views are the norm on a topic such as male circumcision, steeped as it is in religious and cultural values and sexual mores. The procedure is characterized by some as cruel and inhuman "male genital mutilation," by others as a sacred rite, and by still others as a step forward for hygiene and sexual pleasure. These divergent views make for a challenging policy discussion about scaling up male circumcision in national AIDS programs.

Male circumcision and women's vulnerability to HIV

WHO's statement on male circumcision and HIV echoes a theme that virtually every author on the subject emphasizes — that circumcision is at best only partially protective against HIV and can be regarded only as one element of a comprehensive approach to prevention.[6] As others have done, WHO notes the danger that men who are circumcised will develop "a false sense of security" and as a result might engage in "high-risk behaviours [that] could negate the protective effect of male circumcision."[7]

It is important that these caveats be well highlighted, but what is the "comprehensive" prevention approach of which scaled-up male circumcision would be part? The U.S. National Institute of Allergy and Infectious Diseases (NIAID), which funded the circumcision studies in Kenya and Uganda, was quick to note when those studies were stopped that male circumcision must be part of "a comprehensive prevention strategy that also stresses the ABCs: *a*bstinence and delay of sexual debut, overall partner reduction and reduction in number of concurrent partners ("*b*eing faithful"), and correct and consistent use of *c*ondoms."[8]

Whether ABC really represents comprehensive or, for that matter, effective HIV prevention has been widely questioned. In particular, while sexual abstinence and fidelity may be worth emphasizing for some people, many experts have noted that women and girls frequently have little control over whether they can abstain from sex or delay their first sexual experience, and certainly do not control the sexual practices or number of sexual partners of their male partners.[9] Condom use remains

low in many settings,[10] and it is clear that women's subordinate social and economic status plays a considerable role in that outcome.

WHO's experts must, therefore, grapple with the question of whether male circumcision will be one more element of a supposedly "comprehensive" strategy that still ignores the real situations of many women and exacerbates their inability in many cases to demand safer sex. If negotiating condom use is challenging for women under the best of circumstances, how difficult will it be with circumcised men who have the "false sense of security" of which WHO warns?

Is women's subordination with respect to sexual negotiations an important enough problem to preoccupy the policy-makers now shaping plans to scale up male circumcision?

Difficulty of demanding safer sex

Is women's subordination with respect to sexual negotiations an important enough problem to preoccupy the policy-makers now shaping plans to scale up male circumcision? It is difficult to quantify directly the challenge that women and girls face in demanding use of condoms. It is probably safe to assume that women who face or have faced domestic violence — an extreme but unfortunately not rare form of subordination of women in the home — are unable or unlikely to demand condom use of their sexual partners on a regular basis.

WHO's recent ground-breaking ten-country study on domestic violence may be a good place to start to understand the context of safer sex negotiations.[11] Among the sobering results of data from over 24 000 women around the world were these conclusions:

- In most countries, between 10 and 50 percent of women reported having suffered sexual abuse at some time by a husband or other partner in the home. For example, in highly AIDS-affected Ethiopia, nearly one-third of women said they had been forced to have sex against their will in the last 12 months.
- The percentage of women who reported facing physical violence in the home in the last 12 months — including being slapped, struck with a fist, kicked, dragged or threatened with a weapon — was between 11 and 21 percent in most countries. In every country, over half of women who had faced such violence experienced the act of violence more than once.
- A higher level of education among women was associated with less domestic violence in many of the countries. (WHO is still analyzing a number of other factors as determinants of violence.)
- In many countries, women themselves believe violence against women is justified when women are "disobedient" to their husbands or other partners or when a wife refuses sex with her husband.

These results indicate that women from across the world, in great numbers, face extreme barriers to autonomy about sex. And, of course, violence is only one aspect of the subordination of women and their vulnerability to HIV. Whether they face violence in or outside the household, women in many countries are limited in being able to flee difficult or dangerous unions because they cannot initiate divorce or because they do not enjoy equal rights with men with respect to marital property.[12] Discrimination based on sex may keep women from job opportunities that would also allow them more freedom in being able to leave unsafe domestic situations.

Funding and policy initiatives to address women's vulnerability

None of these problems is easy to address. But none of these problems has benefited from the considerable resources that have flowed to other aspects of combating HIV/AIDS. While there are probably hundreds of excellent gender analyses of the global AIDS epidemic, many of which offer policy recommendations, it is hard to find major funding for programs that address root causes of women's HIV vulnerability and gender-based barriers to treatment, care and support.

Many women's organizations work doggedly to improve women's social, economic and legal status and to reduce causes of inequality and violence, but they often do so on a shoestring. In 2005, the Association for Women's Rights in Development surveyed over 400 women's organi-

zations around the world and found that more than half of them had less funding and less secure funding than they had five years earlier.[13] Many of the respondents noted that "gender mainstreaming" — the practice among some donors of working gender concerns into all areas of programming, rather than having separate programs and budget lines for women's or gender issues — had made funding much less available for advancement of women's rights.

Since 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria has been a major source of new funding for national AIDS responses. The Global Fund's proposal guidelines encourage countries to submit proposals that address gender inequality and discrimination against women related to HIV/AIDS.[14]

In October 2006, the Canadian HIV/AIDS Legal Network reviewed the published descriptions of the 78 country-level AIDS projects then having received funding through the second granting phase of the Global Fund. Of them, none mentioned the rights of women; only four projects (all from Latin America) mentioned human rights at all; and only one included a program component meant to help girls develop negotiating skills with respect to safer sex.[15]

In the end, the Fund can only respond to the proposals it receives from the Country Coordinating Mechanisms (CCMs), which are meant to include government, donor and civil society representatives in each country. What is happening in CCMs that so completely leaves behind as program priorities the root causes of women's vulnerability to HIV? If scale-ups of male circumcision ignore gender inequality and subordination of women to the degree that scaling up other HIV/AIDS programs has done, a crucial opportunity will be missed for attacking the epidemic at its roots.

If scale-ups of male circumcision ignore gender inequality and subordination of women, a crucial opportunity will be missed for attacking the epidemic at its roots.

The questions, then, that should burn their way to the top of WHO's agenda are these: Will resources found for scaling up male circumcision include major support for reducing women's vulnerability to HIV, including reducing violence against women, strengthening women's capacity to demand safer sex, and supporting greater economic autonomy for women? Or will scaling up male circumcision reveal even further, and perhaps exacerbate, the gender inequalities that so effectively feed this destructive epidemic? Will male circumcision be the "quick fix" that draws enormous donor resources, while addressing structural causes of women's HIV vulnerability remains the marginalized "hard issue" that no one touches?

Male circumcision and implications for HIV prevention counselling and education

The three randomized studies of HIV and male circumcision in Africa all featured counselling and provision of basic HIV/AIDS information for the men who participated. The researchers and research funders involved in these studies saw this counselling as a crucial part of the study design[16] — and, especially, as a way to ensure that men would be reached with the message that circumcision does not afford full protection from HIV. WHO's statement on the findings of the randomized trials indicates that the agency will seek to provide guidance to ensure that "risk reduction counselling" is part of any large-scale investment in male circumcision for HIV prevention.[17]

If scale-up of male circumcision were to include a serious investment in HIV counselling, including couples counselling, it could provide an opportunity to address questions related to women's vulnerability to HIV as well. Counselling linked to HIV testing, especially testing of pregnant women, has been seen by some experts, for example, as a useful tool for helping women to mitigate the worst consequences of violence, abandonment and other abuses they may face if their HIV-positive status is disclosed.[18] Nonetheless, investments in HIV counselling capacity in many countries have been inadequate, and the lack of trained counsellors remains an impediment to access to HIV testing.[19]

Even as it underscores the importance of counselling with respect to male circumcision, WHO has proposed "provider-initiated" strategies of HIV testing that would make testing more routine (including of pregnant women) while eliminating pre-test HIV counselling in favour of a "simplified" process of giving some "pre-test information" about HIV.[20]

There seems to be little room in this new conception of the HIV testing process for ensuring that pregnant women and others seeking HIV testing have the opportunity to discuss their concerns about HIV and the possible consequences of testing HIV-positive with a well-informed counsellor, privately and in confidence.

It would be unfortunate and possibly dangerous to skimp on counselling for men seeking circumcision for HIV prevention in the same way. HIV counselling before and after circumcision, like pre- and post-test counselling, imparts information to which people have a right and contributes to people's ability to ensure the security of their person — that is, to have control over what happens to their bodies.[21] If scaling up male circumcision includes public information or mass media programs, or school-based programs, these programs should also include components that address vulnerability of women and girls and negotiating skills for them.

The fact that young men and adolescent boys will likely be among those seeking circumcision makes the scale-up of this intervention an ideal opportunity for the kind of counselling and public education that could shape their attitudes toward women and girls in important ways. Donors and governments investing in male circumcision should do everything possible to ensure that the weaknesses of support for counselling linked to HIV testing, particularly in pregnancy, are not repeated in the scale-up of male circumcision. Explicit attention should be given to advancing respect for women and women's rights as part of the counselling and education initiatives that accompany male circumcision.

Safety of circumcision and informed consent

In many societies where male circumcision is the norm, boys are circumcised soon after birth or at a very young age. Adolescent boys may also be circumcised as part of traditional rites of passage to adulthood. Circumcision of men and adolescent boys generally carries a greater risk of adverse surgical outcomes than circumcision of baby boys.[22]

A UNAIDS fact sheet notes that "where health professionals have been trained and equipped to perform safe male circumcisions," post-operative complications occur in 0.2 to 2 percent of cases.[23] In many parts of the world, however, male circumcision takes place under conditions that are less ideal than these, including circumcision by "traditional surgeons" associated with rituals of initiation into manhood. There are many reports of adverse outcomes of traditional circumcision of boys and young men, including sepsis, haemorrhage, dehydration and death.[24] HIV transmission may be another consequence, especially where the same instruments might be used for multiple circumcisions.[25]

As a matter of respecting, protecting and promoting the human right to the highest attainable standard of health,[26] ensuring sanitary conditions and technical competence of those performing the procedure should be a major concern in planning for any scale-up of this intervention.

In spite of the risk of adverse outcomes, the randomized trials and other research indicate that circumcision can be widely acceptable to men in communities where it is not the cultural or traditional norm. For example, a study in Malawi, a highly AIDS-affected country, indicated that both men and women in regions where male circumcision was not traditionally practiced would welcome male circumcision services if they were affordable, sanitary and protected by confidentiality.[27] Similar attitudes were found among men and women in a high-HIV prevalence community in South Africa.[28]

HIV/AIDS policy-makers at all levels face a human rights and public health challenge when it comes to male circumcision.

Although theoretical acceptability of male circumcision is high, informed consent is a crucial issue in consideration of scaling up male circumcision services.[29] A particular challenge is establishing ethical standards for obtaining consent from boys who have not attained the age of legal majority. The *Convention on the Rights of the Child* asserts the right of people under 18 years of age to participate in decision-making in any administrative procedures affecting them such that their voices are "given due weight in accordance with the age and maturity of the child" and the child's or young person's "evolving capacities."[30]

WHO should review existing guidance by government regulators and medical associations in this matter. The British Medical Association, for example, advises its

members that children "who are able to express views about circumcision should be involved in the decision-making process" and recommends that where parents and children disagree, "doctors should not circumcise the child without the leave of a court."[31]

WHO needs to grapple with specifying the role and rights of parents or guardians, and perhaps community or cultural leaders where parental guidance is not available. Working respectfully and in a confidential manner with young people is particularly important in communities where many young people are without parental support, as is often the case in AIDS-affected communities. In elaborating recommendations on this subject, WHO may also be guided by the debates that have occurred in many countries on consent to HIV testing for people under age 18.[32]

As the HIV prevention benefits of male circumcision are more widely known, men and boys may feel social pressure of various kinds to undergo the procedure. Strong adherence to informed consent processes and strict attention to surgical safety are crucial in an atmosphere of enthusiasm about the protective effect of this intervention.

Conclusion

HIV/AIDS policy-makers at all levels face a human rights and public health challenge when it comes to male circumcision. As a matter of ethics and good clinical practice, circumcision requires the capacities and structures to ensure the procedure is safe, comes with high-quality counselling, and ensures informed consent on the part of men and boys undergoing it. But the implications of male circumcision for women's health and human rights must figure equally prominently in policy and programs.

Without concrete, sustained attention to the many manifestations of gender inequality that fuel the epidemic, scaling up male circumcision risks becoming yet another factor that reveals and exacerbates women's subordination and vulnerability to HIV, best intentions notwithstanding. Will scaling up male circumcision be another distraction from efforts to ensure women's equal status in society and under the law, and their autonomy in their sexual relations with men?

It would be the ultimate expression of the sexism and gender inequality at the heart of HIV/AIDS to boost male circumcision without attempting through counselling and other means to use this scale-up to address subordination of women. It would be the ultimate expression of desperation for a "magic bullet" against HIV to accelerate access to male circumcision without scaling up measures to ensure both the safety of the procedure and the establishment of informed consent processes.

It would, finally, be the ultimate dismissal of the lessons of 25 years of the response to HIV/AIDS if counselling and education linked to male circumcision were not designed and adequately funded to contribute to the well-being and human rights of both men and women.

– Joanne Csete

Joanne Csete (jcsete@aidslaw.ca) is Executive Director of the Canadian HIV/AIDS Legal Network. This article was prepared with the assistance of Richard Elliott, the Legal Network's Deputy Director.

Note to readers: WHO issued policy and program recommendations on male circumcision near to the time this article went to press. The recommendations include that countries "adopt approaches to the scale-up of male circumcision services that include the goals of changing gender norms and roles and promoting gender equality." Program managers are encouraged to "monitor and minimize potential negative gender-related impacts of male circumcision programs." WHO also emphasizes the importance of safe and sanitary surgical practices in scaling up male circumcision and suggests that a minor should be given the opportunity to consent to the procedure "according to his evolving capacity," following the guidance of the *Convention on the Rights of the Child*. We look forward to further guidance from WHO on concrete actions and examples of best practice with respect to these recommendations. The recommendations are available at www.who.int/hiv/mediacentre/news68/en.

[1] WHO, *Statement on Kenyan and Uganda Trial Findings Regarding Male Circumcision and HIV: Male Circumcision Reduces the Risk of Becoming Infected with HIV, But Does Not Provide Complete Protection,* December 2006. Available via www.who.int/mediacentre.

[2] T. Rosenberg. "A real-world AIDS vaccine?," *New York Times Magazine*, 14 January 2007, p. 11.

[3] B. Auvert et al, "Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 trial," *PloS Medicine* (on-line journal) 2:e298 (2005), available at www.plosmedicine.org; R.C. Bailey et al, "A randomized controlled trial of male circumcision to reduce HIV incidence in Kisumu, Kenya: progress to date," paper presented at the XVI International Conference on AIDS, 2006, Toronto (abstract no. TUAC0201). See also, U.S. National Institutes of Health, National Institute of Allergy and Infectious Diseases (NIAID), *Questions and Answers: NIAID-Sponsored Adult Male Circumcision Trials in Kenya and Uganda,* December 2006. Available via www3.niaid.nih.gov.

[4] NIAID, *Questions and Answers.*

[5] D. Brown, "HIV study raises caution about circumcision," *Washington Post*, 7 March 2007, p. A14.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] See, e.g., "Is it churlish to criticise Bush over his spending on AIDS?" (editorial), *Lancet* 364(9431) (2004): 303–304; S.W. Sinding, "Does 'CNN' (condoms, needles and negotiation) work better than 'ABC' (abstinence, being faithful and condom use) in attacking the AIDS epidemic?," *International Family Planning Perspectives* 31(1) (2005): 38–40; S.A. Cohen, "Beyond slogans: lessons from Uganda's experience with ABC and HIV/AIDS," *Guttmacher Report on Public Policy* 6(5) (2003): e1–5. Available via www.guttmacher.org.

[10] Global HIV Prevention Working Group, *Global HIV Prevention: the Access and Funding Gap*. Fact sheet, August 2006. Available at www.kff.org/hivaids/hivghpwgpackage.cfm.

[11] WHO,*WHO Multi-Country Study on Women's Health and Domestic Violence Against Women — Initial Results on Prevalence, Health Outcomes and Women's Responses,* 2005.

[12] See, e.g., Human Rights Watch, *Policy Paralysis: a Call for Action on HIV/AIDS-Related Human Rights Abuses Against Women and Girls in Africa,* 2003.

[13] Association for Women's Rights in Development, *Where Is the Money for Women's Rights?,* 2006. Available via www.awid.org.

[14] Global Fund to Fight AIDS, Tuberculosis and Malaria, *Guidelines for Proposals — Sixth Call for Proposals*, 2006. Available via www.theglobalfund.org.

[15] Global Fund to Fight AIDS, Tuberculosis and Malaria, Phase 2 grant scorecards. Available at www.theglobalfund.org/en/funds_raised/gsc/.

[16] See, e.g., B. Auvert et al, Authors' reply (letter), *PloS Medicine* (on-line journal) 3(1): e74 (2006). Available via www.plosmedicine.org; NIAID, *Questions and Answers.*

[17] WHO, *Statement on Kenyan and Uganda Trial Findings Regarding Male Circumcision and HIV.*

[18] See, e.g., A. Medley et al, "Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: implications for prevention of mother-to-child transmission programmes," *Bulletin of the World Health Organization* 82 (2004): 299–307, especially p. 305.

[19] See, e.g., United Nations General Assembly, *Scaling up HIV Prevention, Treatment, Care and Support*, UN doc. A/60/737, 24 March 2006, especially pp. 10–11.

[20] WHO and UNAIDS, *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities (draft for comment),* November 2006.

[21] See *International Covenant on Civil and Political Rights*, 999 U.N.T.S. 171 (1966), art. 9(1) and 19(2).

[22] S. Moses et al, "Male circumcision: assessment of health benefits and risks," *Sexually Transmitted Infections* 74 (1998): 368–373.

[23] UNAIDS, *Fact Sheet: Male Circumcision and HIV*, July 2005. Available via www.unaids.org.

[24] E. Lagarde et al, "Acceptability of male circumcision as a tool for preventing HIV infection in a highly infected community in South Africa, *AIDS* 17 (2003): 89–95. See also, P. Cleaton-Jones, "The first randomised trial of male circumcision for preventing HIV: what were the ethical issues?," *PloS Medicine* (on-line journal) 2(11): e287 (2005).

[25] Lagarde, p. 94.

[26] *International Covenant on Economic, Social and Cultural Rights*, art. 12.

[27] R.C. Ngalande et al, "Acceptability of male circumcision for prevention of HIV infection in Malawi," *AIDS Behavior* 10 (2006): 377–385.

[28] Lagarde, pp. 93–94.

[29] WHO, *Statement on Kenyan and Uganda Trial Findings Regarding Male Circumcision and HIV.*

[30] *Convention on the Rights of the Child*, 1577 U.N.T.S. 3 (1989), art. 12(1) and 14.

[31] British Medical Association, Medical Ethics Committee, *The Law and Ethics of Male Circumcision — Guidance for Doctors*, 2003 (revised 2006). Available via www.bma.org.uk.

[32] The HIV testing page of the Youth Policy Project of the Constella Futures Group Policy Project and YouthNet, found at www.youth-policy.com/content.cfm?page=vct, contains links to numerous national policies related to consent by minors to HIV testing and other services.