A cautious nod to the cut...

Women weigh in on medical male circumcision [1]

In 2007, the World Health Organization (WHO) and UNAIDS recommended that male circumcision be recognised as an additional intervention to reduce the risk of heterosexually acquired HIV infection in men. Since then, 13 countries in Eastern and Southern Africa have taken up the call to scale-up medical male circumcision for HIV prevention. Individual countries are at varying levels of the implementation process.

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WHO's recommendation was based on three randomised clinical trials in Kenya, South Africa and Uganda, finding that circumcised men have about a 60 percent reduced risk of acquiring HIV from women than their uncircumcised counterparts.

However, data assessing the effect of circumcision on *male-to-female* HIV transmission are conflicting. One observational and one prospective study among HIV sero-discordant couples showed reduced transmission from circumcised men, but the only randomised controlled trial (RCT) to date suggested no short-term benefit of circumcision. The RCT was stopped early, after an interim analysis showed no evidence of efficacy. In addition, the trial suggested that if a couple does not abstain from sex until the surgical wound from the man's circumcision has completely healed, the woman may be at increased risk of acquiring HIV, if her partner is HIV positive.

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In addition to potential increased rates of HIV infection for women with newly circumcised partners, there are other fears driving women's resistance and concern around medical male circumcision's implementation for HIV prevention. WHiPT (Women's HIV Prevention Tracking) was created out of response to these uncertainties, as a network to monitor prevention research and rollout and to ensure that women's overarching concerns are met. Specifically, WHiPT has documented these perceived and real fears, and is embarking on advocacy campaigns based on its findings to ensure that the scale-up of medical male circumcision for HIV prevention also benefits women.

WOMEN'S CONCERNS, WHIPT'S INCEPTION

In 2008, AVAC and the World Health Organization recognised the need, especially among positive women, for dialogue around medical male circumcision. In June of the same year, over 35 civil society representatives – the majority of whom were women living with HIV in sub-Saharan Africa – gathered in Mombassa, Kenya, to discuss the implications of male circumcision for women. The two-day meeting, named Civil Society Dialogue on Male Circumcision for HIV Prevention: Implications for Women, was organised by AVAC and directly preceded a WHO expert consultation on the same topic, held at the same location.

WHO sponsored the civil society participants from its meeting to attend the civil society dialogue, and AVAC invited and sponsored an additional group of women activists and advocates from sub-Saharan Africa to attend the civil society dialogue.

Over the course of the two-day session, positive women, researchers, WHO representatives, gender and reproductive health advocates, and a range of other stakeholders shared information and concerns around male circumcision for HIV prevention and its implications for women.

Participants recognised the need for an expanded array of HIV prevention options, alongside comprehensive care and treatment programmes. In this context, they supported male circumcision as an additional strategy, provided it was added to, and complemented and strengthened by, existing offerings, and did not weaken or remove resources from prevention services for women and/or broader health systems.

The context for this support was a set of strongly articulated concerns about the strategy, particularly as it would impact men's risk behaviours, shared sexual decision-making, spending allocations for women-focused HIV prevention, and stigma and blame directed at positive women. (See box for details.) Addressing these concerns is an essential part of any attempt to introduce male circumcision for HIV prevention.[2]

After the Mombassa civil society dialogue, delegates from Kenya (Women Fighting AIDS in Kenya), Namibia (Namibia Women's Health Network), South Africa (AIDS Legal Network), Swaziland (Swaziland for Positive Living), and Uganda (Mama's Club and Health Rights Action Group) expressed interest in putting into action safeguards that would mitigate women's vulnerabilities around male circumcision. Hence, with the support of AVAC and ATHENA, the WHiPT (Women's HIV Prevention Tracking) project was launched in November 2008.

Women's Concerns

- Resources for male circumcision should not be diverted from other HIV preventions, specifically female condoms and microbicides, as well as structural and behavioural interventions, and treatment efforts.
- Resources for sexual and reproductive health and rights programming, as well as around empowerment (or gender equality) should not be diverted to male circumcision. Rather, male circumcision should act as an entryway for men's participation in their own sexual health and education around gender equality.
- From here on, there needs to be meaningful participation of (positive) women in research, policy development, and programme planning and implementation of male circumcision.
- No conclusive evidence exists to demonstrate any direct benefit of male circumcision for women. Modelling studies suggest indirect protection will eventually accrue to women, but that in the short-term increased feminisation of the epidemic is likely.
- Male circumcision may engender an increased perception of women as vectors or transmitters of disease, and thus may lead to increased gender-based violence.
- Male circumcision may bring a false sense of protection and this will in turn compromise even further a woman's ability to negotiate conditions of sex (if and when sex happens, condom use, etc.) and increase gender-based violence.

HEARING FROM THE WOMEN: WHIPT METHODOLOGY

To inform policies and programmes related to medical male circumcision, WHiPT country teams were formed in Kenya, Namibia, South Africa, Swaziland and Uganda out of networks of women living with HIV, who work predominantly at a community level. Each team developed a work-plan tailored to their context and trained women in qualitative data collection to capture local women's impressions of medical male circumcision. WHiPT teams developed a standard interview questionnaire and focus-group template to be adapted to local contexts. Teams met to evaluate data across countries for common and context-specific themes.

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Sample survey questions include:

- What have you heard about medical male circumcision?
- Do you think male circumcision for HIV prevention can be introduced into your community?
- What are men saying and doing (attitudes to sex, sexuality, HIV risk) about male circumcision as a protective strategy against HIV infection?
- Do you think male circumcision for HIV prevention would impact on gender-based violence in your community?
- What additional services should be provided along with male circumcision for HIV prevention?
- What HIV prevention methods do you currently have access to?

Across the five WHiPT country teams, a total of 494 interviews were conducted and 25 focus group discussions were organised and carried out in various regions of each country over the past year. These included Kisumu, Kuria and Mombasa in Kenya; Katutura and Khomas in Namibia; Port Elizabeth, Eastern Cape and KwaMakhuta, Kwazulu Natal in South Africa; Manzini and Hhohho in Swaziland; and Kampala and Kapchorwa in Uganda. The different locations represent rural, peri-urban and urban settings, as well as communities practicing traditional male circumcision and those that do not. Some Ugandan and Kenyan regions surveyed practice female genital mutilation, which carries its own implications within the roll-out of medical male circumcision for HIV prevention. Most of the women surveyed across the regions had not yet experienced the advent of male circumcision roll-out – except for in parts of Kenya – so the data collected is mostly based on what women anticipate will happen once scale-up happens in their communities.

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WHIPT FINDINGS ACROSS COUNTRIES

From the outset it is important to note the distinct differences between women in circumcising communities and women in non-circumcising communities that exist across the country regions in this survey. Within the socio-cultural context of traditional male circumcision practices, women's levels of involvement in, and engagement with, the introduction and roll-out of medical male circumcision for HIV prevention is distinctly different to

women in communities in which male circumcision as rite to manhood is not an integral part of culture and tradition.

As such, women in the traditionally circumcising samples, such as South Africa's Eastern Cape, largely responded to MMC for HIV prevention in their role as mothers, with little engagement on the impact of MMC on women's sexual health and rights as partners to men who will be, or have been, medically circumcised. To the contrary, in non-traditionally circumcising communities, women engaged with the concept of MMC for HIV prevention primarily as partners and hence, were more focussed on the impact of medical male circumcision for HIV prevention on their sexual health and rights.

The socio-cultural tensions around male circumcision and the exclusion of women from gaining access to information came through clearly in the data. As traditional male circumcision is a '*sacred*' and '*secret*' male institution, women who want to access health and HIV information related to male circumcision practices face many barriers, including the control of women's information seeking behaviour. Thus, for women to access and act upon information related to MMC and HIV, the information must be specifically tailored for women, taking into account the socio-cultural context and the realities of women in both traditional and non-traditional male circumcising communities.[3]

Knowledge levels regarding MMC as an HIV prevention strategy

Data across all five countries indicate that a significant number of women at a community level have heard about traditional male circumcision, but not medical male circumcision. For those who have heard about MMC, it does not necessarily translate into having '*factual knowledge*' about MMC. Reporting varied among countries on women's understanding that MMC is only partially protective against HIV risk, the need for condom use after MMC, and the need to abstain from sex during the period of wound healing.

Interestingly, Swaziland and Kenya, the two case studies furthest along in MMC roll-out, demonstrated the least knowledge in these areas. Thus, the data arguably confirm the need for education and awareness raising about MMC for HIV prevention prior to the roll-out of MMC programmes, as well as highlight the shortcomings of current information and messaging about the benefits of MMC for HIV prevention.

...information must be specifically tailored for women...

Support for MMC

While the data clearly indicate the support for MMC to be introduced to communities, data also highlight the need for more education and awareness in the community on issues relating to advantages and disadvantages of MMC for HIV prevention.

The data further suggest relatively high levels of perceived support amongst men. They do, however, also indicate that while supporting the introduction of MMC for HIV prevention in principle, this support is qualified by the need for women's greater involvement in MMC for HIV prevention discussions and decisions; as well as the noticeable tensions between traditional and medical male circumcision practices.[4]

Perceived impact of MMC on women

Although, the data clearly highlight a general lack of

perceived benefits of MMC for women and women's protection, they also suggest that if MMC would be linked to other prevention methods, such as condoms, and to additional services, such as education and training, the introduction and roll-out of medical male circumcision for HIV prevention could have a protective factor for women.

Respondents from Namibia felt strongly that MMC should not be introduced as an HIV prevention method, but instead for hygienic purposes. This would help curb behaviour disinhibition that may accompany a new HIV prevention intervention.

The data confirm that most women are not in the position to negotiate condom use and are least in control over HIV prevention options. Taking into account that medical male circumcision for HIV prevention is not a stand alone HIV prevention method, and that MMC can only be an effective addition to available HIV prevention options when combined with other preventative methods, such as condoms, it is crucial to ensure that male and female condom promotion and distribution becomes an integral part of MMC for HIV prevention processes.

The data highlight relatively high perceived levels of gender-based violence, which arguably reflects communities' realities of high levels of violence and abuse. However, the data also strongly suggest that the introduction of MMC for HIV prevention may lead to increasing levels of gender-based violence, as men may refuse condom use after MMC and women are likely to be blamed for HIV and STIs, arguably indicating the need to address these risks as an integral part of MMC for HIV prevention initiatives and programmes.

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Another potential danger to women is the observed misperception that male circumcision is equated with female circumcision or female genital mutilation (FGM) as an HIV prevention method. Some women surveyed from Uganda and Namibia believed that FGM would be protective against HIV. Women also thought that the advent of MMC would increase the practice of FGM.

Lastly, the data point to a specific need for women to organise and mobilise around their concerns related to MMC. There was a call for increased access to, and availability and development of, women-controlled HIV prevention strategies.

WAY FORWARD

Based on the research findings, the study recommends that in light of a lack of a policy framework there is a need to engage policy makers to ensure the timely finalisation of a rights-based policy regulating MMC for HIV prevention in Southern and Eastern Africa.

It is recommended to monitor that resources are not diverted from HIV prevention programmes for women. Advocates are calling for increased HIV prevention programming and interventions for women running parallel to MMC for HIV

prevention. Existing challenges of, and barriers to, HIV prevention, such as gendered power imbalances and inequalities, must be addressed as an integral part of MMC implementation.

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Furthermore, acknowledging the need for adequate education and awareness raising campaigns on MMC for HIV prevention, it is essential to ensure the dissemination of accurate and factual information around MMC, particularly addressing women's realities, risks and potential benefits, and emphasising the partial protection from HIV infection for men.

Finally, taking into account the challenges and inherent tensions between traditional and medical male circumcision, there is a further need for broad consultations and investigation of potential mechanisms of combining the two male circumcision practices, as well as a need to engage in ongoing research, especially around women's actual and desired role and involvement in discussions and decisions about male circumcision within circumcising communities.

WHIPT ADVOCACY

The following includes some of the advocacy strategies, which are informed by the study findings:

- MMC literacy with women to build their capacity to share MMC-related information in their communities
- Development of messaging around MMC specific to women in relation to the roll-out of MMC at the country level
- Development of gender indicators for the monitoring and evaluation of MMC in national roll-out programmes
- Sharing findings of the WHiPT project with relevant policy makers
- Opportunity to build linkages to female condom advocacy
- Resource monitoring and budget-tracking of MMC for HIV prevention

FOOTNOTES:

1. This article is based on preliminary findings of a 5 country study exploring medical male circumcision and its implications for women.
2. A full report on the proceedings of the Mombassa meeting can be obtained from [www.malecircumcision.org]
3. For more information, see Arnott, J. & Kehler, J. 2010. *Medical Male Circumcision for HIV Prevention: Are women ready?*. Cape: South Africa. AIDS Legal Network.
4. *Ibid.*

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