



Transcript provided by kaisernetwork.org, a free service of the Kaiser Family Foundation¹
(Tip: Click on the binocular icon to search this document)

XVII International AIDS Conference Male Circumcision: To Cut or Not to Cut August 7, 2008

[START RECORDING]

ALVARO BERMEJO: -overflow rooms, from which you can also follow the session on the screen if you cannot find a place in here. It is a great pleasure to be with you for this session, "Male Circumcision: To Cut or Not to Cut." My name is Avaro Bermerjo, and I am the Executive Director of the International HIV/AIDS Alliance. Unfortunately, my co-chair, Doo Aphane is not able to make it, so we are a co-chair and a speaker short. Manuel Velandia has not made it either. I really hope that that will give us time to have more dialogue, questions and answers to be able to make it a little bit more interactive, even though that is not easy in this setting.

Joining me here on the panel we have three distinguished speaker. Supreme is the Communications Officer in Gender Health in South Africa. We have been working for the past three years on a program called Men as Partners doing gender and HIV work. This program is focused on working with men to encourage behavior change of negative gender norms, destructive forms of masculinity, and to create more constructive male involvement on issues of fighting against HIV/AIDS and gender-based violence. Supreme is also a musician, and his musical and song-writing skills sent positive messages around gender and HIV/AIDS prevention and management. He works with a group of artists in South Africa. He has been active in gender and human rights for about seven years now.

Next to Supreme is Marge Berer. She is the Founding Editor of *Reproductive Health Matters*, a peer-reviewed journal that began in 1993. She has also been the chair of the International Consortium for Medical Abortion since 2002, and chair of Voice for Choice in London since 2007. She published a book on HIV and sexual and reproductive health and rights in 1993, and her journal has been publishing regularly on the intersection of these issues ever since. In 2006 her journal devoted a whole issue to condoms and in 2007 half of an issue to male circumcision and HIV prevention.

And finally, on the right is Karen Houston Smith. Karen is a U.S. national whose professional career has been spent in Southeast Asia, primarily in Indonesia, where she has spent the majority of her time since 1971. She was educated in the U.S. and Europe and holds a Masters Degree in Education and Social Change from Harvard University. Throughout the years, much of her work has focused on issues related to participatory development, with an emphasis on community empowerment, government/community cooperation, gender issues, and HIV/AIDS. She has worked for UN agencies, local community organizations, U.S.-based NGOs and the Indonesian government. She has just completed a three-year assignment in one of the two eastern most provinces of Indonesia where the place of male circumcision is part of a comprehensive response to HIV, and that has been the focus of recent discussion.

In addition to chairing this session, I was asked by the organizers to introduce what we know about male circumcision, as well as to bring up some of the question marks and some of the concerns that then each of the speakers will develop further.

The International HIV/AIDS Alliance, an organization that works across 30 countries supporting community responses, has had a very heated internal debate around male circumcision. I think that is probably one of the reasons why they asked me to present this, because they knew how much debate and how many difficulties there were coming to grips with that. One of the things I found out in that debate was how few people have actually seen both circumcised and uncircumcised penises, which does help then in the discussion when you have seen both of them, which is why I wanted to start with this slide.

Let me start with why we are discussing this at this conference. We are discussing it and there have been many sessions on it because we have come to a conclusion. The two normative organizations, WHO and UNAIDS, have issued a statement highlighting that the efficacy of male circumcision in reducing female to male HIV transmission has now been proven beyond reasonable doubt, and a recommendation to countries with high HIV prevalence, generalized heterosexual HIV epidemics and low male circumcision rates to consider implementing, or if they already have them scaling up, safe services as part of comprehensive HIV prevention packages. This happened quite

recently after the Toronto conference and this is really the first conference where we are coming together to discuss this issue since the statement was issued. That is why we felt it was a great opportunity to hear the different views and perspectives at this session.

Since this issue came out, programs have started on the ground and here I wanted to show some of the messages that are circulating around to promote male circumcision programs. Again, for those of you that have not seen it before, this slide here is to show two things, one of which is that 30-percent of adult men around the world are circumcised and about 70-percent are not. There is a correlation geographically, as you can see here, between areas of high HIV prevalence and low prevalence of male circumcision.

So, what do you we know? Well, as I have shown, we know that the observational data shows that prevalence of HIV in Africa is lower in countries where male circumcision is highly prevalent or over 80-percent. We have had three randomized trials in three African countries, South Africa, Kenya and Uganda that demonstrated reduced risk of female to male transmission by around 50- to 60-percent. I want to highlight two points. One is that these are in high prevalence epidemics. We do not know and we have not had conclusive evidence of significant protective effect for men in low prevalence settings. The other point I would like to stress is that what these studies show is that male circumcision reduces

the probability of men getting infected, but it does not shield them. It does not fully protect from infection. I think that is important for the discussion that will follow.

What else do we know for sure? We know that the risk for acquiring HIV increases in the immediate postoperative period, in the few weeks right after the operation. We are beginning to get some results, but at the moment we have few on the effects on sexual function and sexual satisfaction, and I am sure that is going to be part of the debate today. The studies that have been done in the clinics in Southern Africa clearly show high levels of acceptability—that is, people responding orally that they would have male circumcision if that had a protective effect. We have also seen high uptake, which is that people were not just saying that they would, but actually going to the clinics to have it done. And here are lengthy waiting lists right now.

We also know that there is no direct—and I emphasize the word direct—protection for women. However, mathematical models show that the risk of HIV transmission would be lowered a decade or two down the road by reduced prevalence amongst men. We also know—as I was saying, there is high uptake—that male circumcision may well bring many men into the local clinics. If that is the case, it certainly should be coupled with other prevention methods and there should be good advice and counseling.

So, that is in a nutshell what we know. What do we not really know, or what needs more research? Well, we really do not have yet any capacity to measure the impact of large-scale rollout of male circumcision and look at the real impact on HIV prevalence. The effects might be different outside of the controlled research setting and the mathematical models that have been built around that research over a longer period of time. There is a question mark there around whether increased-risk behavior following male circumcision would negate the protective effect that the clinical trials have shown. There might be what people call risk compensation. We also, because we are looking at a surgery that is to a great extent irreversible, do not really know how it will interact with novel prevention technologies that might come down the road and how that is factored into mathematical models when they look at the protective effect. And certainly the cost effectiveness measures remain theoretical until we have large-scale implementation. There are questions around limited resources and what will be the impact of male circumcision on already stretched health services and workforces. Will it be an intervention that strengthens those services, or will it be an intervention that further weakens them?

There has been a lot of controversy, a lot of challenges and I guess that is why this room is so full. Clearly, we need to start from one point, which is that states' UNGASS and many times since have made important commitments to

increasing the availability of HIV-related goods, services and information. These commitments and their fulfillment can be seen as part of the human rights obligations of these states.

We also need to understand that meeting the demands for male circumcision is not completely risk free. The country where I am working now, the U.K., there is clearly a statement from the British Medical Association that states it is now widely accepted that this surgical procedure had medical and psychological risks. That is the current position of the British Medical Association. There clearly is also a risk of message confusion via eroding safe sex campaigns—well, if I am circumcised, do I still need to use a condom? There is also another issue. This is one of the very few prevention methodologies that clearly protects men in a different way and to a different degree than it protect women. As a result of male circumcision, will circumcised men be more likely to blame their female partner if either of them becomes HIV infected? Those are some of the challenges that we have to deal with.

Again, here are some slides to also show how some of the work is being disseminated. I particularly like this one. It is summertime. Have your child circumcised.

There are additional controversies and challenges. Many people believe it causes a reduction in sexual sensation experienced by circumcised males. This is something very difficult to measure objectively, and I would say that I have not been able to see conclusive results that would support

this, but clearly many people believe that. Some argue that male circumcision causes psychological trauma. Many others believe that the interest and the resources behind male circumcision is being pushed as a medical, magical bullet in a time when we really needed something that could compensate for the limited success in the last two years of the research around microbicides and vaccines. And there are a lot of question marks around the extrapolation of male circumcisions to newborns which raises lots of ethical and moral issues.

I would like to finish here with this presentation of what we know, what we do not know, and giving some questions to the next panelists. I would like to thank Mercy [misspelled?], sitting here in front, who manages a blog and a website on male circumcision and who has been very helpful in putting this session together. Thank you [applause].

MOGOMOTSI SUPREME MAFALAPITSA: I would like to say greetings to all of the wonderful people of the world gathered here today. I would also like to thank the AIS for granting me the opportunity to render a presentation on how male circumcision affects young men and what it means for young men.

Male circumcision has been practiced by humanity for millennia and the practice has spread to many parts of the world. There is evidence of the presence of the practice found in Egypt as far back as 3,000 B.C. It is amazing that this practice has survived time and is still an issue on international platforms like this one.

Based on the findings that we looked at just now with Alvaro, going forward we need to look into what this means for us and hear some of the issues that we would really need to take into consideration. The health system's preparedness to handle demand, cultural and religious implications, impact on gender norms and masculinity, behavior change post male circumcision, and possible gender-based violence increase and the implications for women, issues of stigma and consent, communication strategies and guidelines.

Now, and estimated 1.7 million HIV infections occurred during 2007 in Africa. As we know, the Sub-Saharan African Region is the most affected area by the epidemic. It is important that countries within this region consider the roll out as an additional prevention method. As more information about the benefits of male circumcision goes out to the public, we see that the demand increases and actually at the moment in some countries, you already find queues of men trying to actually access the services at health providers. Most of them are being turned away because of lack of capacity.

We will need a gender analysis in some of these places, and we will need to draft a very soft of detailed communication policy and strategy with clear guidelines on how we are going to be rolling out the process. More training is needed for practitioners in order to ensure safety and reduce complications. Training of counselors is also required to improve the quality of counseling, which should be a component

of male circumcision. More facilities will also be needed, especially taking into consideration the rural areas which already have limited existing health facilities and services. Male circumcision will also have to be integrated with other prevention methods that already exist in order to maximize effect. I believe that more funding will have to be allocated for groups that are actually working to transform gender norms and define new forms of masculinity.

It is also important to make sure the service is safe, affordable and accessible. This is very important to young men. It is possible to explore ways in which the medical and the traditional sector can also work together to strengthen this practice. Policy makers and program developers will also have to monitor and evaluate programs in order to minimize potential harmful outcomes of promoting circumcision as an HIV prevention.

This leads me into looking into a very serious component of culture and religion and what circumcision means to young men belonging to those cultural and religious groups. Throughout the years male circumcision has been an important part of culture and religion. Male circumcision is viewed as part of worship and keeping a covenant between humans and God. Circumcision takes place before the baby's eight day, mostly within the Jewish faith, and it takes place between the ages of 10 and 12 within Muslim cultures. Some cultures, especially in Africa, equate the sacrifice of circumcision to the sacrifice

that women make when they lose their virginity, mostly after marriage. And male circumcision is also seen as a form of blood sacrifice which is offered to the ancestors who are represented by the ground on which the circumcision blood falls. And circumcision, to a large extent, is seen as part of a boy's right of passage into manhood in many cultures, especially in Africa where most of the cultures who practice this circumcise adolescent males.

This forms part of a boy's socialization for their transition into manhood, emphasizing certain gender norms and ideas of masculinity. Circumcision is also seen as a way of enforcing masculine characteristics within males and limiting feminine characteristics, which are seen to be represented by the foreskin of the male's penis. This also means that some communities that practice female practice female circumcision, now called female genital mutilation, see it as the repression of masculine characteristics, which are actually represented by the female clitoris. That is why some of the cultures would remove it. It is clear that this has no benefits for women and rather poses a health risk.

Many cultures who are actually circumcising adolescent males do not take kindly to the possibility of alteration of their culture by medical circumcision and neonatal circumcision because if the boy is circumcised while he is a baby, than what ritual will be performed when he reaches adolescence? In many cultures, you are still viewed as a coward if you actually go

to a clinic or a hospital to be circumcised because pain is actually part of the right. As we know, the medical sector actually is committed to pain reduction, if not the eradication of pain. So, a lot of cultures do not see that very kindly.

Within circumcision in cultural groups, a lot of young males are actually isolated and discriminated against if they are not circumcised in the cultural way, and their families face a lot of shame and disgrace if they are unable to have their sons circumcised in this way. And if you are not circumcised, in these cultures you are called a boy no matter how old you are and you are not allowed to sit in gatherings where there are elders. And in some communities your funeral will not even be announced by elderly men, but instead be announced by youth. Some cultures actually associate the foreskin with disease and a lack of hygiene, and the foreskin is also associated with diseases that women who have sex with men who are uncircumcised will have.

While there are circumcising tribes in Sub-Saharan Africa, there are also cultures that do not circumcise and see it as a disgrace to have a member of their family circumcised. For example, the Zulus of Southern Africa—within this culture, a circumcised man is viewed as an incomplete man because of the missing foreskin and it is also believed in these cultures that circumcision makes a man weak. And although some men within these cultures would like to be circumcised for health reasons,

they are unable to get support and they find it very hard to inform their families.

Now, the age of adolescence is an age where young people go through a lot of transitions, both physical and mental, and there are a lot of pressures that take place during that time. To many young men, traditional circumcision still adds a greater pressure because not all young men would like to go and be circumcised. Actually, a lot of them are scared of this practice because there is also mortality involved. During the month of June in my country of South Africa, 22 boys lost their lives in the former Transky [misspelled?] Area, which is in the Eastern Cape Region. A lot of boys are still scared to go to the mountain, but they really have to go in order for them to be accepted as men. And though the government has actually set out an act to try to regulate traditional circumcision, a lot of noncompliance still leads to high mortality rates within the circumcising groups.

Here is some of what young men actually might learn also at the circumcision schools. You have to be a man. You have to be strong. You do not have to cry. Do not get help. Some of the other messages taught are that you are superior to a woman and you have the right to have a lot of sexual partners. Some men also believe that, as I mentioned, is a seriously important part of this, so you need to feel pain. That can also lead them to being violent many times.

Another issue I would like to look at here are the implications for women, as women are also very much affected. Many times women are blamed for actually bringing the disease into the family, and women are mostly affected by HIV. The resumption of sex after circumcision is another issue that puts women at risk. I would like to say that not all young men will resume sex after being circumcised. A great deal of men that I have talked to in focus group sessions actually mentioned that they would obey the doctor's rule and actually sort of wait until they have healed. But in some traditional areas, this is very much encouraged. As we know, women are also the caregivers a lot, so they have the burden of taking care of some of these men as well.

And another issue is that there is a lot of stigma around this. As I said, women are seen as transmitters and uncircumcised men can further experience a lot of discrimination, as they are seen not to be men in their societies. And HIV-positive men who are unable to be circumcised due to their compromised immune system may also actually receive a lot of discrimination.

Other challenges are that many young men actually believe that this affects your pleasure and sensitivity and also causes psychological trauma. Some men might have a false sense of security and think it offers full protection. Those complications also lead to male circumcision as it is a surgical operation.

I will not go through all of these challenges, but my recommendations would be that male circumcision should be part of a greater SRH package and gender transformative approaches are needed to challenge harmful ideas of masculinity. We need further research into how male circumcision will affect men's behavior postoperatively and outside of the research environment. More consultations with traditional leaders and communities are very important in rolling out this process. Clear and simple messages which are straightforward are needed to make sure that people do not misinterpret these messages.

My conclusion is that male circumcision has created an opportunity to for the first time really focus on male sexuality, and male circumcision could really prove effective if the medical and traditional worlds work together. We should take all issues into consideration when we communicate this. I thank you [applause].

KAREN SMITH: Good morning, ladies and gentlemen, friends. All of us have come to inquire and I would like to try to add some grist to the mill on our topic of "To Cut or Not to Cut" this morning.

Specifically, I have been asked to talk about religious and cultural sensitivities. We have had some very, very helpful information from Supreme before I spoke, which obviously is in the same field, but I will proceed with the more general framework that I had prepared.

I have divided my talk into three parts. First I have a brief introduction, second with reference to religious and cultural sensitivities. I am focusing my comments primarily on why these sensitivities matter and how one can work with them. In part three, I will return to our title "To Cut or Not to Cut," and I will share some conclusions.

There are various different ways that this topic could be put together. What I will be presenting today is very much coming out of my experience as a practitioner, development manager of various different kinds of support, various different kinds of activity. And on the other hand, bearing in mind the fact that we have all gathered this week to think together, among other things, about how we can lower the number of new HIV infections going forward. It is in that context that we are talking about male circumcision.

Let us consider why religious and cultural sensitivities matter. I would like to suggest four issues which are particularly important to consider, and I will give some illustrations thereafter. Let me introduce my four points first.

Obviously, religious and cultures dictates influence and control, either directly or indirectly, many aspect of daily life relevant to circumcision. For some people, it is every day, every activity. For many of us, it is only an echo further away, but it continues to have some impact.

Secondly, the nature of the influence of religion and culture and our behavior based on them is very often location-specific and therefore it calls for location-specific responses.

Thirdly, although religious and cultural prescriptions related to life often seem immutable, in fact, we know they can change. There is often room for negotiation related to issues in daily life as they rise and set, for example, activity like circumcision, which may or may not be traditional.

Fourth, understanding cultural and religious sensitivities is complicated because the interface of culture and religion with daily life often is at odds so that in the end, doctrine and practice are not in harmony with each other.

Let us look at the examples. In daily life, religious belief and cultural systems organize social relations and structure our value systems and norms. Historically, they have told us, for example—and we had some discussion of that earlier—who we could marry and how we would treat our bodies. They defined gender behavior patterns and so forth. These are all issues that will influence attitudes to circumcision and to a greater or less extent they still influence public attitudes on many issues that are related.

Secondly, these values and belief systems are, as I said earlier, situation-specific and location-specific. For example, in Indonesia, as was mentioned earlier, most people associate circumcision with Muslim coming of age for young boys. Because of this, there are many Christians who feel that

if they should decide they wanted to be circumcised, it casts some doubt on the validity of their Christianity. There are other people who for their own purposes have politicized the issue and if someone is circumcised, it is turn into a issue related to Islamization, which is not well-accepted, forcing the religion on others in the community.

On the other hand, in the Philippines, a country which is largely Christian, circumcision is common. As we were told earlier, it is seen as a symbol of the covenant between man and God, and it is supported with references from the bible. It depends completely in this case where one is as to how that is seen.

Values are changeable and sometimes negotiable. For example, we all know—and I say in quote “we know”—that the Catholic Church does not accept condoms. But in various areas, the one that I am most familiar with at the moment is in Eastern Indonesia in Papua, four Catholic bishops have issued and instruction requiring the use of condoms if there is a married couple where one or both partners is infected with HIV. They discussed it at some length, and they came to the conclusion that the church had no right to create obstacles for the members of the church who wanted to avoid transmission of the infection to another person. They could not do that, and so they have said yes to the condom. Not only are they accepting it, but they have required it.

But the pace of change, obviously, is uneven. In recent discussion with some Protestant ministers that I took part in, which was talking about circumcision, there were two ministers who were extremely positive and there was an additional minister, a woman who after some time shook her head and she said, all this time I have been struggling to come to terms with the condom and now you bring me another issue. Now I have to start on circumcision. So, change comes over time. It does not happen instantly. On the other hand, this woman is one of the leading theologians in Indonesia. She is also an AIDS activist and through her work a great many Protestant ministers have, on the other hand, become very active related to HIV/AIDS.

The fourth point from my list above was saying that dealing with religious and cultural sensitivities can be complicated. Lack of congruence between values and action can be quite confusing. Working with these issues, we need to be alert to these kinds of differences. If we are not aware of the distinction, we can assume opposition or support when, in fact, there is none and in the process we lose allies. For example, when I previously mentioned condoms, we assume Catholics are anti-condom, but, in fact, that is not always the case. So, we need to be careful.

In conclusion, I would come back to our theme "To Cut or not to Cut." I find the public health aspect, notwithstanding some of the uncertainties, is straightforward.

We see that circumcision has a potential effect in reducing vulnerability to infection and, I would say, it should be part of a comprehensive program if the cost/benefit side of it works out. At the same time, those of us who are involved and who are advocates need to work with public health authorities to assure desirable health outcomes. This issue was raised earlier and I again underscore it—there is no point on moving forward on this if one cannot guarantee the health outcomes.

What about the cultural and religious sensitivities in this case? Having said that yes we think it is appropriate to move forward on integration of circumcision in a comprehensive package, one needs to consider how the cultural and religious sensitivities can be addressed. I would suggest that before worrying about the cultural sensitivities, first we need to find people who want service and provide them with good service. They will become good advocates. Next we need to determine if there are real religious or cultural obstacles which hinder service. If there are, then we mobilize, leaders from those respective communities who can help address that issue. I believe firmly that the combination of authoritative information champions satisfied men and women in the community, and good service will move the program forward.

Thank you very much. I am going to take the liberty of one more slide. I want to say on behalf of the local organizing committee for the ninth ICAP meeting, which is going to take place next year in Bali, you are all invited. We hope

very much that many of you will be able to come. I would like to suggest that we agree now that we will talk then about what progress has been made on this subject. Thank you [applause].

ALVARO BERMEJO: Thank you, Karen. Before I give the floor to Marge, who is going to be the last speaker, I wanted to highlight that when she finishes we are going to open the floor for questions. There are going to be two ways of providing questions. One is, for those of you can get there, standing up behind these microphones to speak. The alternative is that you raise your hand and you will be given a little card like this that will then be brought to the front. You need not wait until the end of Marge's presentation. You can raise your hand as she is speaking and the cards will get to you, I am told. Thank you. Marge?

MARGE BERER: Thank you, Alvaro. Can you hear me? Okay, good morning. My talk is on male circumcision, gender and sexuality considerations. Clearly, this is one of the hot topics of this AIDS conference, and I think that is terrific. Everywhere male circumcision has been raised, widely differing views have been expressed, and that means we can confront the issues and hopefully move towards some kind of consensus about it.

My expertise is women's sexual and reproductive health and rights, including in relation to HIV. I am not up here to condemn male circumcision, though some of you may think that is why I was put here. I accept the reasons why it is being

promoted and sought after, but it is early days to know what will contribute to reducing the HIV epidemic, and I am mindful of comments such as these regarding the very men who might benefit from male circumcision. This comes from a UN News Agency report last week, not from Reproductive Health Matters. "My husband did not believe he could be HIV-positive because he was circumcised." "Many of the men I speak with think circumcision is like an AIDS vaccine." "I do not want to give up sex, so I am getting circumcised." But when two counselors would advise this young man that he would have to carry on using condoms, even after the operation, he said, "If I have to wear a condom anyway, what's the point?"

So, here are some of the gender and sexuality issues that I believe male circumcision raises. First and most important is that partners of circumcised men have an equal right to protection. Male circumcision for HIV prevention is partially protective for HIV-negative men, but not for their partners, whether male or females, unless they also use condoms. It is the only HIV prevention intervention that does not protect both partners, at least to some extent. This is highly problematic.

Male circumcision can reduce population-level HIV transmission only after about 70-percent of the male population, which is predicted to take up to 10 years, even in a highly successful program. A public health perspective says that 60-percent protection for circumcised men is far better

than nothing where there is sexual risk taking and unprotected sex. Many women and men in high-HIV prevalence countries welcome male circumcision because they are desperate for something more.

I am acutely aware that I am not in their shoes, and I approach male circumcision as a women's advocate. My question is whether male circumcision is good enough for women. Not in 10 years time if herd immunity is achieved, but right now. Male circumcision is useless of HIV-positive men, tested or untested. What does this mean for their partners? If a man seeking circumcision refuses an HIV test and he is circumcised and he thinks he is protected and he continues depositing semen in his partner's body every time they have sex, as I see it, his partner is in a worse position than he or she was before. Ironically, male circumcision does not require behavior change in the man for himself. But for his partners to benefit, safer sex is still required. Therefore, equity needs to be created in other ways for partners.

Safer sex is a way of thinking about and acting on sexuality, not just the activity of using condoms or having a bit of foreskin cut off. The promotion of safer sex has never received sufficient resources. The focus on male circumcision, ARVs and other technical solutions is crucial to that failure. Could safer sex still succeed with a sufficiently renewed effort, or do we think deep down that it is impossible in practice. This is the question: If positive people are tired

of protected sex and are giving it up, and if untested people are still engaging in risk taking more often than not, than other prevention interventions are absolutely needed, but which ones? We need to get more sophisticated about what is appropriate for whom, including male circumcision. Are we going to circumcise men indiscriminately because they ask for it? We must insist, at the least, that HIV-positive men are not circumcised, if for not other reason than it is a waste of resources.

This is a wheel that was prevented at the last AIDS conference in the prevention plenary in Toronto. Several of these options, including vaccines, non-ARV microbicides, HSV suppression therapy, and mass STI treatment are still far off or have been proven not to be effective. Thus, we are pretty much left with voluntary counseling and testing, behavior change, barrier methods and male circumcision, but importantly also the growing potential of antiretroviral solutions. Male circumcision is 50- to 60-percent protective. If I proposed a contraceptive method to the world today that was only 60-percent effective, I would be laughed out of the room, but because there are so few solutions for preventing HIV and the most effective ones are not accessible or are not being used, less effective solutions have been found to be necessary. If we compare male circumcision to a cheap condom that will break 40-percent of the time, it will not sound quite so attractive,

but maybe a lot of men who think it is a vaccine will understand it better in those terms.

What about ARVs? Well, I say all praise to the Swiss. The equation "treatment equals prevention" means protection not just for positive people on highly active therapy with low viral loads, but also antiretroviral prophylaxis. Prophylactic ARVs will take some years to develop and disseminate, but circumcising 70-percent or more of Sub-Saharan Africa will take a long time, too. When ARV options are available, what will happen to barrier methods, behavioral change and male circumcision? Look what happened to condoms for family planning when oral contraceptives arrived in 1960. There are short-term and longer-term perspectives to be had here.

All right, what is the value of male circumcision? Male circumcision has been practiced for centuries by at least two of the world's major religions and many cultures for hygienic, initiation and other reasons and has been shown to reduce certain STIs in both partners. I have to say that if, as a woman, I do not think men have a right to tell me what to do with my body, I do not feel I have the right to tell them what to do with theirs. However, this is also about men as sexual partners and about social norms for sexual relations. And as with safer sex and condom use, if most people do not do it, the public health impact of male circumcision will be low. So, how many men will do it? That is my question. This is a gamble, especially for women, and it is too large a gamble in

the absence of other protection. In discussions of this issue, I am stuck by the concerns expressed by women's health advocates and how diverse these are. These concerns must be acted upon.

I want to ask whose input was sought before programs began. Most of the interventions for fighting HIV were either invented by or widely advocated and supported by people living with HIV. Have those organizations of key populations, especially women, MSM and sex workers been involved in this? Why were women not consulted until after the train left the station? Can we really be asked to acquiesce in the imposition of a top-down, narrow, vertical prevention intervention 25 years into this epidemic? We deserve better. We need something that will work.

How to assess male circumcision programs—this is a list of some of the things that we need to know about how male circumcision is playing out in real life as it is provided. How many men, where, who, younger, older, married, single, socioeconomic status—why did they seek circumcision? What were their partner's views? How many men were tested and found to be positive? How many were negative and what is their status several years down the line, not one, not two, but five or ten? How many commenced sex before they healed? How many complications did they have and what kind? Have they changed their sexual behavior? Are they using condoms? How many had STIs that were treated at circumcision and how many have STIs

now? What was the HIV status of their partners at circumcision, and how many have become positive since? What difference has circumcision made? Monitoring and evaluation need to include far more than just how many men have had the snip.

Here are some proposals about involving women centrally in the roll out of male circumcision. First of all, programs should be for men and their partners, including information, couples counseling and testing, and promotion of safer sex to couples. That also includes extra support for women in negotiating safer sex. Secondly, as women's health advocates at a policy-making level in countries and as advisors on including partners in service delivery, no one is going to pull out the red carpet for women's involvement in male circumcision. It is up to women to insist on this in our own countries and to ensure that women at the community level have the information to be able to take their own decisions. We need more resources to increase grassroots programs for women on sexuality and sexual relationships. Women have to stop being victims and stop being described as victims in this epidemic. There are positive women and discordant couples. Many women also have more than one partner. Women are having unprotected sex and rejecting condoms, not just men. And like men, women have to confront these realities and their options.

Finally, I have some conclusions. I have 45 seconds left. Prevention needs major investment, especially in condoms

and antiretroviral prophylaxis in my opinion. It seems that male circumcision will not suffer from lack of funds. Priority setting at the country level may or may not include male circumcision. Where it is included, if it gets more people practicing safer sex, then all those snips will have been worth it, but the snip alone will not do it. There must be a link between the penis and the brain. Partners of circumcised men have an equal right to immediate protection, and safer sex promotion is needed now more than ever, so let us call for the Pleasure Project to open an office in every country. Thank you very much [applause].

ALVARO BERMEJO: Thank you, Marge, and thank you to all panelists for sticking to time and making sure that there is enough time to field questions. Please line up behind the microphones and I will be taking questions three or four at a time, then giving the panel the chance to answer. Before I give the first person the microphone, let me just address one question that has come in repeatedly through the cards, which is around why there was not a panelist to discuss issues of MSM and male circumcision. I would like to say on behalf of the organizers that that was precisely the title of the presentation that Manuel Velandia was going to make, had he been able to be here with us. Please introduce yourself and your organization.

GEORGEANNE CHAPIN: Yes, good morning. Thank you very much for the opportunity. My name is Georgeanne Chapin, and I

am here with the International Coalition for Genital Integrity. You might have seen our booth in the exhibit hall.

Essentially, we are a group of people who have been working against medicalized male infant circumcision in the United States for about 30 years. We have made enormous progress and we have mobilized around this issue. Principally around many of the issues raised in particular by Marge Berer and by some of the other panelists in other ways.

I have one comment and one question. One of my comments is that despite some really excellent points about the reservations around male circumcision, no point at all has been made of the value of the intact male body and the value of the foreskin and the value of leaving people—as we promote with anti female genital alteration—the way they were born, natural sexuality and natural body parts. That has not been in the dialogue at all that perhaps the penis and the foreskin have more of a value than something to just be so-called snipped off. And I challenge anyone who has seen a circumcision to really call this a snip. This is an invasive surgery.

My question is that given that the massive resources of the international health organizations have already been placed on this train toward circumcising males and, in fact, a previous session this week even called for spreading the intervention to infants in Sub-Saharan Africa and then getting to other parts of the world, what can we who believe that all of these cultural issues are valid, that women's empowerment is

a critical part of this—we are all at the grassroots level. What can we do to slow down this train and call for a more sensible, comprehensive look at what we are actually proposing? Thank you.

ALVARO BERMEJO: Thank you. There are about 12 people lining up and about 40 questions here. If I could ask you to really not make another presentation, but just a question to the panel.

RICK PEROT: I have been listening to a lot of cultural—

ALVARO BERMEJO: Can you say your name?

RICK PEROT: My name is Rick Perot. I am from the United States. I have been listening to a lot of cultural and religious reasons for circumcision, but I have heard nothing in terms of the empirical evidence that would substantiate circumcision. That is my question—what evidence is there?

FEMALE SPEAKER: Mine is really a comment and I hope it is well accepted. The comment is just to say that applaud Marge. I think you raised some very valid questions and gave direction on what we should be doing. I would just mention that WHO and UNAIDS are actually looking at this issue about male circumcision and the implications for women. We have already had one consultation in Africa and comments and suggestions like Marge's are what we need so that we can actually get further suggestions as to what we should be doing. And also just to address some of the issues, we need to be

consulting with countries. We need to be consulting with people within countries. That is what we should be doing. We need to let others in countries have their voices be heard. Again, the WHO and UNAIDS is doing that. We are going to countries, we are facilitating stakeholder consultations, and we are consulting with countries and their governments as to what they want to do, not what others think they should be doing, but what decisions they want to take to improve the health and the lives of their own people. Thank you.

ALVARO BERMEJO: Thank you. Before asking the panel to respond to these comments, can I add two questions that are coming from the cards also? There are a couple of questions here that are more or less saying, well, we have known that it works for a long time. Why have we not implemented it earlier? You might want to react to that. Somebody might want to comment on another question that has come a couple of times, which is around male circumcision and its role in multiple concurrent partners and how if we look at it in that context, it might have an effect in women. Thank you. Do any of you want to react to this?

MOGOMOTSI SUPREME MAFALAPITSA: If I may say so, within the cultural concept, it is most of the time actually sort of encouraged for males to have more partners. Within that context, we do have a problem with implications for women. But I believe if we have a very strong gender transformative programs that go with the medical circumcision, we can be able

to actually show men that they actually still have to take care of themselves and protect their women and their partners as well.

MARGE BERER: I think a couple of the questions may not be totally appropriate for this particular group of panelists, but the proof that is effective was presented by Alvaro at the beginning of this session. There were three randomized trials that showed public health effect, so I do not think we need to go over that again.

Why was it not done earlier? I think it is because those randomized trials were considered necessary and a consensus meeting by the WHO and UNAIDS was also considered quite necessary. There are lots of HIV interventions that have been implemented a lot longer after they should have been, so this is no exception.

I think the question of multiple concurrent partners is an extremely important one, and I think that my presentation actually explained why that was so important and why safer sex with male circumcision remains extremely important. The only issue is going to be reaching those partners through the man who has been circumcised. I think this is a major challenge for programs.

ALVARO BERMEJO: Karen, do you want to add? Okay, we will take more questions.

DR. MARSHALL D'SOUZA: My name is Dr. Marshall D'Souza.

I practice medicine in Fort Meyers, Florida in the United

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

States. By the way, thank you very much to the panelists for an enlightening discussion. My question is to Alvaro. You made a statement at the beginning. Can you qualify that statement for me? You said that there is no direct benefit to women from circumcision. It is very well known that there are many benefits to women from circumcision and also to men. In those countries where circumcision is practiced as a religious ritual, the incidence of cervical cancer is very low. And celibate nuns, nuns who never have had sexual intercourse, in them cervical cancer is unknown. Male circumcision is known to reduce the risk of penile cancer, besides reducing sexually transmitted diseases. Thank you [applause].

ALVARO BERMEJO: If that is what I said, I do apologize. What I meant is that there was no direct protection from HIV transmission.

JOHN GEISHEKER: My name is John Geisheker, the Executive Director of the international children's charity, Doctors Opposing Circumcision, based on Seattle, Washington. My members around the world want to ask the panel a fairly simple question. We know that the circumcision industry is a \$1 billion industry in the initial intervention. However, it is also a \$2 billion industry in the follow-up care, the infection issues, botches, re-dos and any numbers of problems that I could mention to you. So, my members would wish to know what allowances have been made for the follow-up care of Africans who might volunteer for circumcision. We believe that

this is a stalking horse, the adult male circumcision campaign, for a later campaign for infants. What provisions have been made for follow-up care for those infants? Thank you.

ALVARO BERMEJO: Thank you. I will take one more.

LUCY: Thank you very much. My name is Lucy. I am from South Africa from the City of Tshwane, the former Pretoria. I am from the rural area. I am a mother. I am a grandmother. I am a community worker. I just want to highlight something because I heard a chairperson say that we must not elaborate further the [inaudible]. I think it is relevant and important to come with some solutions so that maybe, in the experiences that we have had, some can address some questions that have been raised before.

In our area, all initiation schools are required to register. You cannot operate without registration. Number two, there is a public participation whereby there is a bylaw that must be implemented by the council itself at the local level. In our culture, if you are not from the mountain, you cannot talk anything about the initiation schools. Therefore, in that public participation, the stakeholders will be the traditional leaders. They will be the officials from environment health. They will be politicians, medical doctors and police. Those people are the people who are from the mountain, not each an every one of which will go and participate in that bylaw. And therefore, if there is bylaw

infractions there are fines. There is constant monitoring of those initiation schools by this team that I have mentioned.

We do have challenges whereby there are many new initiation schools and then there is a time frame—you cannot open an initiation school before you finish three years. It is a bylaw. Disruption of school children during school days is also a challenge. Uncontrollable behavior from those children when they come from the mountain is also a challenge.

I think I will come with my proposal here that Mogomotsi, with due respect, my dear brother, I believe you are from South Africa, and therefore we need more coordination from the provisional level and the local level. We must develop a chapter for initiation schools. I think all those challenges will be—thank you.

ALVARO BERMEJO: I am going to give the panel a chance to react, but I want to add two questions, one of which is directed to Marge. It basically asks have we given up on condoms and safer sex. The other one is somebody who writes, as a circumcised adult male, I believe that long-term trauma may have resulted from my circumcision, which was performed shortly after birth. My question is, is there sufficient understanding of the long-term emotional and psychological trauma as a result of newborn male circumcision?

MOGOMOTSI SUPREME MAFALAPITSA: I would just like to respond to the mother from South Africa. With due respect, I acknowledge what the government has done so far to actually

regulate around traditional circumcision, but you mentioned exclusivity in the gatherings from people who are not circumcised. I believe for us to actually reach our desired goals, we need to involve the other voice, the voice of opposition of people who are not circumcised. We need to make sure that in those communities young men have the chance to have their own consent whether they would like to circumcise or not. Already by saying that only circumcised men are allowed in these meetings, it means that we are already setting a stigma and discriminating. We are virtually saying that if you are not circumcised, you cannot participate in that gathering because you are not respected as a man. So, I think that within the same circumcising communities, there are people who choose not to and parents who would choose not to circumcise their sons.

Another question to throw back at you is what impact or what role do we have to play in the curriculum that is actually taught in the circumcision schools? I did not hear you mentioning anything around that, and there are no regulations around the curriculum that the boys actually learn at the schools, so I believe we need to start working with our agenda components and other government initiatives to help actually strengthen their curriculum and make the men or the boys turn into better men who respect women, respect themselves and who are faithful to their partners. Thank you [applause].

MARGE BERER: To the question of whether we have given up on condoms, my person answer is absolutely not, quite the contrary, and I do not think we should ever give up on condoms. But it has been consistently my impression through the last few AIDS conferences that condoms are probably the least discussed topic in the conference. I went to a female condom workshop last night. It took me half an hour to find it. It was not sign-posted. It was in the basement somewhere where all the international agencies are hiding. There were only about 15 people there. At the last conference, I went to a UNFPA condom session and there were 50 people there. Tonight there is a condom session at 6:30 when everybody is going to be out having a meal because it is over. Have we given up as a community working on HIV on condoms? Do we get enough money for condom promotion? Do we get enough support for the social marketing organizations like Population Services International and DKT Marketing to promote condoms in countries? No, we do not. We probably have more money for everything else except condoms, and condoms are the here and now of prevention, which I have been saying and which many people have been saying for the last 25 goddamn years [applause]. So let us get out there and promote the things, let us get proper money to do it, and let us get an organization that is devoted to it. Do you know how many people are working on condoms at UNAIDS? I hate to tell you, so I will not, because it is probably no more than one.

Let us get on with this and let us demand money for condom promotion in a really, really important way [applause].

ALVARO BERMEJO: Karen, do you want to answer any of the other comments?

FEMALE SPEAKER: [Spanish Spoken] –and perhaps you could translate after, if you would be so kind. My name is Maria Christina [inaudible]. I am a physician and an anthropologist. I am concluding my doctor thesis at the Autonomous University of Barcelona. My thesis topic has to do with child genital mutilation in both boys and girls. I have a question [inaudible] on female and male genital mutilation. My subject has to do with critical anthropology and my question to the panel has to do with the issue of the naturalization of male circumcision throughout the congress and all the previous sessions. We have witnessed a constant mixed blend between religious values, cultural values and medicine, rituals and medicine and so on and so forth. And within this process of naturalization of culture or medicalization of culture, circumcision of a ritual sort is evaluated. In Spain lately, we have witnessed the death of two newborns after eight days because of ritual circumcision. If this had happened in the case of a girl, it would have been a true scandal. But since this happened with a boy child and this seems to be a medical prescription, this has not reached the papers, only in the back columns on the last page. I would like to see what your opinions to this.

ALVARO BERMEJO: -and normalization of male circumcision, the sort of denial of its religious value, cultural value and others associated to it. Maria Christina was giving the example in Spain, where she comes from, where very recently two babies under eight days old died from ritual circumcision. Because they were boys, it only occupied a third of a column in some third-class paper. Had they been girls, it would have been all over the front pages. Maria would like also to look at the reaction of the panel to that.

SETH: Hi, my name is Seth [inaudible]. I am from the Center for Communications Programs at Johns Hopkins University. First of all, I would like to thank you all for this panel. I was curious whether program managers and clinicians looking to scale up male circumcision programs have looked at the experience of male sterilization programs and vasectomy promotion programs. We know in Sub-Saharan Africa male sterilization, even though it is a cost-effective method and has few complications, it is less than 1-percent utilized. It seems like there is a similar array of problems, in terms of changing gender norms and cultural norms. It seems like it would be good to have lessons learned from that and the scale up of male sterilization, as it is one of the only male-initiated family planning methods has not been successful. I am wondering if there has been any look at that in terms of male circumcision. Thank you.

ALVARO BERMEJO: Thank you. One more please.

MARIA: I am Maria [inaudible], a French organization. We heard yesterday at a presentation by [inaudible] that the rate of acceptance of male circumcision from the men who are being offered such a procedure was very high. It was like 80-percent in this clinical trial. But what was not said was that the rate of acceptance of the test in those same men ranged between 15- and 30-percent, which is very low. And so that is a concern to us, even though they might have good reasons, like fear of discrimination, lack of treatment and care, et cetera. I guess my question is for Supreme. In South Africa, do we have a better rate of acceptance of tests in other programs? What can we do to make it better in this environment? What can we do to improve the acceptance of testing inside a circumcision program? We do not want to have all those people circumcised when they do not want to know about their status.

ALVARO BERMEJO: Thank you. In opening the answers from the panel, there are several questions that have come in, some to Karen and others to the rest of panel saying, well, if the answer to the question is yes, at what age should male circumcision happen and who should do it?

MOGOMOTSI SUPREME MAFALAPITSA: I will just take the recent question from my sister from France. I would just like to say that in South Africa in the Men as Partners Program that we just launched not long ago, a VCT mobile testing unit actually is male targeted and male friendly. Some of the reasons that men do not wish to test is because of the stigma

and discrimination that they experience in their cultures, communities, and also within the health systems themselves. We need to make sure that the clinics that we have where males are being tested are male-friendly. We need to ensure that there is support for males who do test positive, and we need to also work with the families and the communities from which those men come to help them to be more supportive. You tend to get more support as a woman if you test HIV-positive than you do as a man. What I would like to say is that we should have male-targeted, male-friendly, VCT services and give the benefits for testing. Most of the time, it seems like for men there are no benefits—I will know and I will surely die. We need to start changing that perception through programs. Thank you.

MARGE BERER: I will just say very briefly that in terms of the lessons learned from vasectomy programs, I think that is an extremely good suggestion for people involved in male circumcision. I do not know if that has been looked at, but I certainly think it will be taken up now that it has been suggested.

With regard to age of male circumcision and who should do it, I think this is a very sensitive question. It is an area of this topic on which there is possibly the least agreement. It might be extremely important for WHO and UNAIDS to actually call a meeting that looks at that question exclusively and tries to get some resolution on that topic.

KAREN SMITH: I would echo what Marge has said in terms of the issue of age and certainly there are different issues that need to be looked at, the two different ends of the spectrum that have been discussed, which is whether we are talking about infant circumcision, or whether we are talking about adult males, which is certainly what the most frequent discussion has been about more recently. In terms of who should do it, obviously there have to be local decisions made about that because that will vary to some extent, but there does need to be agreement about standards of the health outcomes. There may be very different ways of achieving those positive health outcomes that one is looking for. There may be a place where there are traditional circumcisers who can be trained and it can be done very well. There may be places where that is not an option. There may be places where there are nurses who would be appropriate. There needs to be agreement about who is responsible for setting the standards and who is doing the follow up. Somebody previously raised a question about follow up, and I think that is a very good issue.

I would add that I 100-percent endorse the comments that were made about the importance of giving additional attention to the issue of condom promotion. This is a thing indeed which is going to reach more people with more benefits to more people. One of the things that needs to be done, I believe related to the circumcision issue in different

locations, is looking at the payoff, looking at the cost effectiveness and that it is available and included in a comprehensive package. Whether or not enormous amounts of money are invested in a large-scale program, I think that is a very different issue because that then is an issue of, okay, we are going to use resources for this and not for that. I think that is a very different issue that needs to be weighed heavily at something more, further down the system, than the global level. The global level cannot make that decision for different countries and different communities.

ALVARO BERMEJO: Thank you. There are six people lining up right now. That means we are going to try and take those six and no more from there, then a couple more from here. But in order to do that, you have to be very, very brief so I can then let the panel give some concluding remarks in response to your questions.

VERONICA: Yes, I am Veronica from France. A couple of days ago I heard a WHO representative, Catherine Hankins, who is just behind me raise a lot of concerns about the reduction of transmission through ART in the developing countries, especially because of the possible misunderstanding of the message. We raised those concerns about circumcision and Catherine Hankins is very keen on circumcision. My question is whether African men are good for circumcisions and not good for treatments.

CATHERINE HANKINS: I am Catherine Hankins from UNAIDS. Just to reply to that thing, we are very much in favor of ART for prevention, but in order to make that work, we are going to have to increase access to viral load testing and have better STD treatment. We do not want a north-south difference in terms of the use of ART for prevention. That allows me to say one thing I wanted to say about male circumcision, which is that we are talking about combination prevention. We have been talking about it the whole conference. It has to be additive. It has to be increasing the choices for individuals and couples. It cannot be replacing things. I think all of us have to get clearly on message and that will apply as well when we see what happens with ART for prevention.

I just wanted to clear up on thing in Marge's presentation. Marge, you said that there would have to be 70-percent coverage for any effect. We have had six modeling groups come together and already at a 5-percent coverage in the beginning of scale up, you begin to see population-level effects, so there is not some threshold of 70-percent you have to get to.

Finally, I would like to just say that there is a late-breaker session today at 4:30. It is in session room 11. It will be providing more long-term follow-up information from Orange Farm [misspelled?], 42 months of follow up looking also at HPV and trichomonas. Thank you.

MALE SPEAKER: My name is [inaudible] from the Democratic Republic of Congo. I have heard about the fact that male circumcision reduces the transmission of HIV and AIDS, but I did not hear about the mechanism. How does the actual removal of the foreskin reduce the transmission of HIV/AIDS? Does it have to do with the anatomy of the foreskin or other things? Thank you.

KELLY CURRAN: Good afternoon. My name is Kelly Curran from Jhpiego. Many of you may know that we have worked very closely with WHO and UNAIDS to developed a reference manual on male circumcision under local anesthesia. I just wanted to address the question about age because I think this is a very important question. The title of the manual is "Male Circumcision under Local Anesthesia." We at Jhpiego feel very strongly that male circumcision should be provided under local anesthesia and that elective male circumcision should be done under local anesthesia, rather than general anesthesia. That has a lot of implications for the age at which the person can be served. We wanted to make it clear that this should be under local anesthesia, not general anesthesia, which may rule out certain age groups of children who may be unable to sit still for a male circumcision procedure under local. Thanks.

PAUL PERCHAL: Good afternoon. My name is Paul Perchal from EngenderHealth. We are one of the organizations that is supporting roll out of male circumcision at the country level right now. Believe me, a lot of the challenges that have been

identified today are things that we are coming up against. However, I believe that that is no reason to prevent us from moving forward. We have to ensure that do it in a way that is safe and respects the rights, values and beliefs of individuals.

A couple of other challenges that we have come up against at the country level that I did not hear addressed are how to engage traditional religious leaders. I was wondering if Karen and Supreme could maybe comment on that. The other one is the potential for male circumcision to stigmatize potentially HIV-positive men. I just wanted to come back to the comment that Marge made that it should not be a procedure offered to HIV-positive men. I disagree because of the potential to stigmatize. I was wondering if you could comment on that.

ALVARO BERMEJO: Just to add to that, Marge, when you respond there have also been several questions coming in on the same issue saying that if male circumcision protects against STIs, why should it not be performed on HIV-positive men?

TIM VALLEY: Good afternoon. I am Tim Valley [misspelled?] from the World Health Organization and I am working with my colleagues on the implementation of programs and the normative issues. I would just like to say that these discussions that we have heard today and the comments and concerns that have been raised are extremely important. I welcome and I congratulate the organizers for having this

particular session. I would also like to emphasize a point that Karen made early on, which is that we need to have these discussions at the regional, country and community levels. That is where they really belong. We would like to enroll the help of all of you in facilitating those discussions at the level at which they really have to take place. Thank you very much.

ALVARO BERMEJO: Thank you. If I can have a final comment from each of you, but pretty quickly because we have four minutes to go.

MOGOMOTSI SUPREME MAFALAPITSA: Just on the question of how we can involve traditional leaders. I am from EngenderHealth and we believe that life should be healthy and we promote health, so I acknowledge that some aspects of culture are not healthy. I think that is the focus that we can use, though with the approach of cultural sensitivity, while also acknowledging that there are some aspects of culture that are good and that should be maintained and that can be used. Actually, we are working on developing a program, a project that is called IKS, which is Indigenous Knowledge Systems, because there are a lot of good things within indigenous cultures that are very good and that can be used to promote healthier lifestyles. But it is important for us to look at the aspects that are unhealthy as well and look at how we can improve it, but not try to be sort of international or foreign

people coming into their culture and saying that this does not work and this is the solution.

MARGE BERER: To Catherine, I thought the 70-percent figure came from information in last year's consultation. If it is actually incorrect, I will stop putting it about. I apologize.

To Paul's question of stigma for HIV-positive men, I think this is a very important question. I do not have an answer for it, but I do believe that HIV-positive men need to get together and address this question and figure out something on this subject that is relevant, because I do not think that circumcision is the answer to preventing stigma. I think it has to be dealt with somewhere else and in some other way.

I suppose my final comment would be that I hope all the Americans in the audience go home and get the United States government to take the restrictions on condoms out of PEPFAR [applause] and that all the Catholics in the conference go home and start working with Catholics for Free Choice to get the Vatican to change their position on condoms, among other things [applause]. I will not be at the closing tomorrow, but I hope somebody will stand up and propose that the conference supports much greater attention to condoms in the next conference, including in plenary sessions and in main discussions and in discussion sessions like this where people have a good chance to participate. Thank you [applause].

KAREN SMITH: The question that was raised about involvement of religious leaders, in my most recent experience in Papua, there were two things that got the attention of religious leaders and then opened up dialogue with health providers and with many different people to begin to develop programs. The first was when their congregation began to die and they said, there is some kind of problem. I am burying more people than usual, and several of them have said that explicitly. That was what made them begin to think. The second thing was very interesting biobehavioral surveillance that was carried out and in which data was gathered at the end of 2006 on 6,300 people. The first time we began that information it also caught people's attention. They said these are our people. These are not Africans. These are not Cambodians. These are our people. Immediately it changed the dialogue. This was biobehavioral surveillance of the general population. It was the first time it has been done between the age of 15 and 49. That got people's attention. I would be happy to speak further with you about the kinds of activities that were follow up, but indeed one of the largest Protestant churches ultimately changed the curriculum in their seminary to include more information about reproductive health and HIV and to begin to look at issues related to gender. They have prepared materials for their ministers. They are providing training to all of their ministers and also training for pastoral counseling. They have paid for more of this activity

themselves than they have sought from other people. They have sought technical support. The woman minister whose picture I had has been one of the driving forces of this. She lives somewhere else, but they invite her and they then pay all of the training costs. The use of local information is one of the ways to get the system moving. And in connection with that, I would say one sentence further, which is that somebody was talking about the importance of getting more discussion of stakeholders at the national level. I put in a plea for the sub-national level. The national level is too high already in most countries, at least in large countries. It needs to be multi-level if one is really going to have the impact we are trying to have at the community level. Thank you [applause].

ALVARO BERMEJO: Thank you and thank you to all the panelists and to everybody that has filled this room. I was very nervous having to chair this session, and a colleague told me, do not worry—providing you do not tread on anybody's foreskin, you will be okay [laughter]. So if I have, I do apologize. Otherwise, thank you for having been here. As you leave, please listen to a final announcement from Supreme.

MOGOMOTSI SUPREME MAFALAPITSA: I would just like to invite you to a session happening tonight between 6:30 and 8:30. It is called "Men Engaged: Boy and Men for Gender Equality." This issue will also be dealt with in detail. Men Engaged is developing a global movement to work with boys and

men for gender equality. I would like you to be there. It is
in session room seven from 6:30 to 8:30. Thank you.

[END RECORDING]