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# Why did the Wold Health Organization (WHO) and Joint United Nations Programme on HIV/AIDS (UNAIDS) endorse male circumcision as a public health initiative for HIV prevention in sub-Saharan Africa?

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**2009-09-17T11:49:43Z**
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# Why did the World Health Organization (WHO) and Joint United Nations Programme on HIV/AIDS (UNAIDS) endorse male circumcision as a public health initiative for HIV prevention in sub-Saharan Africa?

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This research report was submitted on September 6, 2008 as a requirement for achieving a Masters in Development Studies from the Faculty of Humanities at the University of the Witwatersrand in Johannesburg, South Africa.

## Abstract

The debates surrounding male circumcision and HIV prevention have been diverse ranging from religious, medical, ethical, cultural, political and financial. The arguments have been complex and varied depending on what academic and medical discipline one prescribes to and furthermore one's ideology of the epidemic in sub-Saharan Africa. This research will explain why on March 28, 2007 WHO and UNAIDS endorsed male circumcision as a public health initiative for HIV prevention in sub-Saharan Africa. By understanding how WHO and UNAIDS assessed and evaluated the evidence, it may clarify if all or some of the debates and concerns associated with male circumcision and HIV prevention were justified and warrant further analysis. Furthermore, the research may provide insight into how male circumcision will affect the universal fight towards improving overall population health in Africa.

## Declaration

The following statement serves to declare that this research was conducted by Tami L. Stainfield and followed all ethical guidelines issued by the University of the Witwatersrand in Johannesburg, South Africa. Furthermore, this research has only been submitted to the Faculty of Humanities at the University of Witwatersrand for the purpose of achieving a Masters in Development Studies.

_____ _____

Tami L. Stainfield Date (2008)

## Dedication

This research is dedicated to my mother Helen M. Stainfield who passed away on January 9, 2007. My mother loved children she saw them as innocent and independent souls, she felt that every child deserved a chance for happiness.

On behalf of my mother may we continue to search for solutions that will provide children and their parents with consistent and safe healthcare and education in sub-Saharan Africa. The foundation for giving more children a chance at experiencing long-lasting and healthy lives.

For my mom – A woman I will miss forever.

Happy Birthday Mom!

## Acknowledgement

Dr. Noor Nieftagodien, thank you for your academic supervision and guidance. Noor, I am especially grateful for your will to stick with me during some difficult times, you always tried to find words of kindness and encouragement even when others questioned my academic worth. Your thoughtfulness did not go unnoticed - in time the education I have gained from WITS will fade, new experiences and knowledge will occupy my mind; however, your compassion and perseverance will never be forgotten, it will stay with my spirit forever.

I would also like to extend my gratitude to those individuals who participated in the interviews; the knowledge gathered was relevant and contributed to the final research.

To my family – thanks for your support and love.

## Abbreviations

| | |
|---|---|
| ABC | abstinence; be faithful; use condoms |
| AIDS | acquired immunodeficiency syndrome |
| ART | antiretroviral treatment |
| ARV | antiretroviral (drug) |
| CHPP | comprehensive HIV prevention programs |
| HIV | human immunodeficiency virus |
| IDUs | injecting drug users |
| ILO | International Labour Organization |
| MC | male circumcision |
| MDG's | Millennium Development Goals |
| MoH | Ministry of Health |
| NAC | National AIDS Council |
| NGOs | non-government organizations |
| NIH | United States National Institute of Health |
| NSP | National Strategic Plan |
| PEPFAR | The United States Presidents Emergency Plan for AIDS Relief |
| PMTCT | prevention of mother-to-child transmission |
| RCT's | randomized controlled trials |
| RSTESA | Regional Support Team for Eastern and Southern Africa UNAIDS |
| SADC | Southern African Development Community |
| STD's | sexually transmitted diseases |
| STI | sexually transmitted infection |

| | |
|---|---|
| TB | tuberculosis |
| UN | United Nations |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNHCR | United Nations High Commissioner for Refugees |
| UNICEF | United Nations Children's Fund |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNODC | United Nations Office on Drugs and Crime |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| WFP | World Food Programme |
| WHO | World Health Organization |

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# Chapter One: Introduction

## 1. Background

It was 1981 when the world was first introduced to AIDS, a disease that accounts for approximately 2.5 million new HIV infections and 2 million deaths annually.[1] During the last 27 years, HIV/AIDS has shown no mercy attacking those populations most vulnerable to poverty and disease, resulting in more than 25 million deaths. The region most affected by the epidemic has been sub-Saharan Africa with an estimated 22 million people living with the disease and 1.6 million dying each year.[2] At present 68% of all new HIV infections and 76% of all HIV/AIDS related deaths recorded globally are from sub-Saharan Africa, and predominately associated with heterosexual relationships.[3]

Over the last decade, the world has witnessed significant advancements in the amount and types of research targeted at HIV and AIDS. Donor funding has increased dramatically, accessibility to antiretroviral therapy has improved for marginalized groups, and public consciousness has grown through global HIV awareness programs. Furthermore, political leaders, celebrities, and corporations now lend a voice to the cause.

Some of the progress made in sub-Saharan Africa can in part be attributed to the establishment of UNAIDS, an international humanitarian agency formed under the resolution of the United Nations Economic and Social Council in 1994 and made operational in 1996. UNAIDS' mandate has been to coordinate and support the efforts of the 10 UN co-sponsors[4] and to assist governments, civil society, donors and those living with HIV/AIDS by educating, mobilizing and monitoring the necessary resources to combat the disease. Furthermore in June 2001 and 2006 the United Nations General Assembly put forth resolutions for the 'Declaration of Commitment on HIV/AIDS' and 'Political Declaration on HIV/AIDS'. The resolutions were based on the principle that the epidemic "constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines social and economic development throughout the world and affects all levels of society – national, community,

[1] UNAIDS and WHO 2007:1. AIDS epidemic update
[2] Ibid:7.
[3] Ibid:6.
[4] UNAIDS cosponsors are UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank; UNAIDS 2007. Overview brochure.

family and individual."[5] These resolutions started a framework to develop a long-term political and international commitment towards the epidemic.

UNAIDS in many ways became the most visible international mainstream voice for AIDS. Cautiously explaining the moral obligation to assist those who were unable to gain access to knowledge or treatment due to their governments' lack of political will and/or because social and economic determinants hindered their ability to act. UNAIDS legacy of advocacy, may be seen today when observing the quantity of daily international and local media coverage given to topics relating to AIDS and furthermore evident in the amount of financial resources made available. In 2007 UNAIDS reported that their funding increased by 30% with the majority (70%) of the annual resources being donated by the Netherlands, Norway, Sweden, United Kingdom and the United States, which underscores UNAIDS ability to garner support for the fight against AIDS.[6] In total, international aid has grown to approximately United States Dollar (USD) 10 billion annually compared to USD 300 million in 1996, which can largely be attributed to UNAIDS and their 10 co-sponsors and partners.[7]

The other organization that has played a pivotal role in assisting the health sector in sub-Saharan Africa has been the World Health Organization (WHO). As the world's recognized authority on international health and one of the 10 co-sponsors of UNAIDS, its mandate has been to lead the UN health sector's response to the AIDS epidemic.[8] Some of WHO's key responsibilities in relations to the health sector in sub-Saharan Africa include: assisting the Ministries' of Health (MoH) with guidance on any evidence-based science relating to HIV/AIDS, providing support and technical assistance for scaling up interventions to prevent, care, treat and support individuals at risk or living with HIV/AIDS, assisting policy-makers in building a framework for assessing and strengthening their health strategies relating to HIV - such as health promotion and health safety standards and lastly providing support on capacity building and training for health sector workers.[9]

However dramatic the achievements and contributions WHO and UNAIDS have made towards furthering the progress of HIV/AIDS in sub-Saharan Africa, the discouraging news

[5] United Nations 2001:1.S-62/2 Declaration of commitment on HIV/AIDS; United Nations 2006. 60/262 Political declaration on HIV/AIDS.
[6] UNAIDS 2007:33. Annual report: Knowing your epidemic.
[7] UNAIDS 2008:1. Progress in AIDS response but still a long way from meeting global target; UNAIDS 2008:1. Global AIDS epidemic far from over.
[8] UNAIDS 2008. www.uanids.org/en/cosponsors WHO-World Health Organization; WHO 2008. www.who.int about us.
[9] WHO 2008. www.who.int about us.

remains, there still has not been a significant reduction in HIV incidence[10]rates.[11] Furthermore, the Global HIV Prevention Working Group in 2007 reported that the heightened global focus on providing access to treatments for AIDS adversely distracted attention away from HIV prevention efforts.[12] The President of the United Nations General Assembly, H.E. Srgjan Kerim recently reiterated this assertion when he stated in his June 12, 2008 statement at the UN General Assembly High Level Meeting on AIDS "for every two people that begin HIV treatment there are five new HIV/AIDS infections."[13] This statement in conjunction with the acknowledgement that vaccine trials have had limited success re-emphasized the urgency to implement and scale up successful HIV prevention methods. For it would seem improbable that the world has the capacity to fund or manage widespread distribution of medical treatments if new HIV infections continued at the pace H.E. Srgjan Kerim outlined.

WHO and UNAIDS argued in 2006 that those most vulnerable to HIV have had limited access to prevention strategies due to the fact that several policy-makers have chosen to refrain from implementing methods that have been proven to be effective.[14] However, AIDS activists and researchers have argued that the lack of improvement in reducing HIV incidence rates has been in part due to the excessive focus and funding placed on of the Western world's ABC (Abstinence, Be faithful, and use Condoms) behaviour change program.[15]

Nonetheless after 27 years of experience, whether due to the lack of political will or ineffective prevention strategies, the following findings are dismal and of grave concern, if prevention remains the only known cure for HIV. Only 12% of men and 10% of women in sub-Saharan Africa know their HIV status, men's condom use and acceptance levels remain extremely low for the magnitude of the epidemic.[16] Women condoms remain in short supply with almost non-existent usage rates and still only 31% of HIV-infected pregnant women

[10] HIV incidence (sometimes referred to as cumulative incidence) is the number of new cases arising in a given period in a specified population. UNAIDS normally refers to the number of people (of all ages) or children (0–14 years) who have become infected during the past year. UNAIDS 2008. Terminology Guidelines.

[11] Connor, Steve and Chris Green 2008. Is it time to give up the search for an Aids vaccine?; Santini, Jean-Louis 2008. Researchers despondent as AIDS vaccine still out of reach; USA Today 2008. Experts: Africa AIDS funds wasted; UNAIDS 2005:53. *AIDS in Africa: Three scenarios to 2025*.

[12] Global HIV Prevention Working Group 2007:1. Bringing HIV prevention to scale: an urgent global priority.

[13] United Nations 2008:4. Closing of the high-level meeting on HIV/AIDS, statement by H.E. Srgjan Kerim.

[14] UNAIDS and WHO 2006:124. Report on the global AIDS epidemic: A UNAIDS 10th anniversary special edition.

[15] Potts, Malcolm et al. 2008. Reassessing HIV prevention; Epstein, Helen 2007: The invisible cure; Whiteside, Alan 2008. HIV/AIDS: A very short introduction.

[16] Global HIV Prevention Working Group 2007:2. Bringing HIV prevention to scale: an urgent global priority cited from WHO, UNICEF, and UNAIDS 2007, Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector.

receive antiretroviral prophylaxis to prevent mother-to-child transmission.[17] These factors may underscore why 90% of all children infected with HIV live in sub-Saharan Africa and how 420,000 children became newly infected with HIV in 2007.[18]

The prevention findings outlined above highlight the assertions for why there has been a growing urgency for accelerating National HIV prevention campaigns in vulnerable regions and the need for providing universal access programs that include prevention, treatment, care and support.[19] An example of this movement towards targeting prevention can be observed in South Africa. Where a country many have found to be evasive or cautious in their approach to HIV/AIDS, unequivocally defined Accelerated Comprehensive HIV Prevention Programs as a strategic priority in their 2006/07 South African National Healthcare Plan.[20] In part, South Africa's efforts can underscore the growing anxiety surrounding the belief that countries and donors cannot rely on treatment alone and therefore the need to strengthen and maintain HIV prevention strategies must remain a complementary goal.

Brazil, Thailand and Uganda all were recognized for their early successes in reversing the spread of HIV and AIDS. These stories have been well documented and highlighted how HIV prevention works when there was strong political leadership sending an ongoing message of awareness and prevention.[21] However, the recent reversals witnessed in some of Uganda and Thailand's gains can only support the evidence, which claims HIV prevention efforts need consistent and well funded prevention strategies, defined by a country' unique epidemic and available resources.[22]

In response to the evidence and concerns regarding new HIV infections, WHO and UNAIDS stated, "prevention must be greatly prioritized in the response to AIDS and efforts are being made to find new prevention technologies to bolster the package of already know effective prevention methods."[23] Potential new prevention methods discussed by the Global HIV Prevention Group in 2006 were female microbicides, HIV vaccines, male circumcision, pre-exposure prophylaxis with antiretroviral medication, herpes suppressive therapy and cervical

[17] UNICEF, UNAIDS and WHO 2008:1. Children and AIDS: Second stocktaking report, actions and progress, fast facts.
[18] Ibid:1.
[19] WHO/AFRO 2006. The year to accelerate HIV Prevention in Africa; UNAIDS 2007. Practical guidelines for intensifying HIV prevention: Towards universal access; United Nations 2008:8. Declaration of commitment on HIV/AIDS and political declaration on HIV/AIDS: midway to the millennium development goals.
[20] South Africa Department of Health 2006. Annual National Health Plan 2006/07.
[21] UNAIDS and WHO 2006: 124. Report on the global AIDS epidemic: A UNAIDS 10th anniversary special edition.
[22] UNAIDS 2007:5. UNAIDS Annual Report: Knowing your epidemic; United Nations 2008:8. Declaration of commitment on HIV/AIDS and political declaration on HIV/AIDS: midway to the millennium development goals.
[23] WHO and UNAIDS 2007:2. New data on male circumcision and HIV prevention: Policy and programme implications.

barrier methods, many of which had trials pending or were currently in progress.[24] However, by 2008 the overwhelming majority of those trials were stopped for lack of efficacy, which sent a disappointing message to many in the AIDS community.[25] The only prevention method that showed strong evidence based outcomes was male circumcision.

Male circumcision occurs when the foreskin of a man's penis has been fully or partially removed. This procedure had been discussed as a possible medical intervention for HIV prevention for at least 15 years, due to numerous ecological and observational studies showing an association between male circumcision and the reduced risk of HIV infection in men.[26] Although the body of research had been significant, numerous critics argued the evidence demonstrated only an association between male circumcision and HIV, because the majority of the studies could not account for possible confounding factors such as religion, culture, and behaviour.[27] Thus, in order to validate the previous findings, researchers at the start of the 21st century planned and designed three randomized controlled trials (RCT's) to evaluate the effect of male circumcision on HIV infections.

At the end of 2006, the three RCT's on male circumcision were all officially terminated, each having been stopped early by their respective data safety monitoring boards (DSMB) because interim findings showed that the group of men circumcised had a significantly lower rate of HIV infections than the group not circumcised. The three trials were conducted in Rakai, Uganda, Kisumu, Kenya and Orange Farm, South Africa. The final research findings demonstrated that there was a 51% to 60% reduction in the risk of men becoming infected with HIV during vaginal intercourse if they were circumcised.[28]

In direct response to the research findings presented from the Kenya and Uganda RCT's media, academic researchers, medical and humanitarian communities shifted their attentions to the how and why's of male circumcision and the feasibility and acceptability of using it as a tool for HIV prevention is sub-Saharan Africa. With the renewed focus and emphasis on

[24] WHO and UNAIDS 2007:3. New data on male circumcision and HIV prevention: Policy and programme implications; Global HIV Prevention Working Group 2006:2. New approaches to HIV prevention: Accelerating research and ensuring future access.
[25] WHO, UNAIDS and UNICEF 2008: Towards universal access: scaling up priority HIV/AIDS interventions in the health sector; Timberg, Craig 2007. The rethink of AIDS policies.
[26] Siegfried, N. et al. 2003. Male circumcision for prevention of heterosexual acquisition of HIV in men; Gray, Ronald et al. 2007. Male circumcision for HIV prevention in young men in Rakai, Uganda: a randomized controlled trial.
[27] Howe, R.S. Van 1999:8. Circumcision and HIV infection: Review of the literature and meta-analysis; Siegfried, N. et al. 2003. Male circumcision for prevention of heterosexual acquisition of HIV in men.
[28] Auvert, Bertran et al. 2005 Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk; Gray, Ronald et al. 2007. Male circumcision for HIV prevention in young men in Rakai, Uganda: a randomized controlled trial; Bailey, Robert et al. 2007. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial.

accelerating and providing comprehensive HIV prevention strategies and the reportedly low percentages of circumcised men in many parts of sub-Saharan Africa WHO and UNAIDS took immediate action to evaluate and confirm the findings on male circumcision. They initiated a review of the trials and any other relevant evidence surrounding male circumcision, with the objective to discuss policy and programme implications and to make recommendations regarding public health issues.[29]

On March 28, 2007 WHO and UNAIDS published their recommendations from the international consultation that convened on March 6-8, 2007 in Montreux Switzerland. Their findings supported the evidence put forth from the three medical trials. Male circumcision was recognized as "an efficacious intervention for HIV prevention."[30] Furthermore, they asserted, "the three randomized controlled trials showed that male circumcision performed by well-trained medical professionals was safe and reduced the risk of acquiring HIV infection by approximately 60%."[31] Modeling forecasts were utilized to determine where the intervention would have the greatest benefit, they concluded it was regions with hyper-endemics,[32] and less than 20% of its men circumcised.[33] Based on those assumptions male circumcision was targeted for countries in sub-Saharan Africa and predominantly in the sub-region of Southern Africa. Thereafter the statements made by WHO and UNAIDS, were reported by numerous international media sources emphasizing the impact mass male circumcision programs would have on reducing the amount of new infections in African countries.

During this same time period AIDS Vaccine Advocacy Coalition, UCLA AIDS Policy Development Center, WHO and UNAIDS all documented significant social and behavioral factors that could impede the effectiveness of male circumcision as a public health prevention strategy for HIV. The areas that posed the greatest concern were the messaging of circumcision, social and economic factors, cultural implications, human rights, legal and ethical implications, consequences relating to unskilled professionals and inadequate physical infrastructures and lastly the effect on women.

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[29] WHO and UNAIDS 2007:2. New data on male circumcision and HIV prevention: Policy and programme implications.
[30] Ibid:3.
[31] Ibid:3.
[32] Hyper-endemics are HIV prevalence in the general population exceeds 15%.
[33] WHO and UNAIDS 2007:7. New data on male circumcision and HIV prevention: Policy and programme implications.

Although there were calls for additional research on the social, behavioural and economic effects of male circumcision, it had a minimal impact on the growing momentum for implementing and funding male circumcision at a public health level. On August 20, 2007, US Secretary Mike Leavitt announced that The President's Emergency Plan for AIDS Relief (PEPFAR) would start funding male circumcision programs in some African countries in an effort to reduce the spread of HIV.[34] Furthermore, in September 2007, Rwanda's Health Ministry officially announced the launch of a mass male circumcision campaign, with the initial rollout targeting the army, police, and university students.[35] Additionally some countries made plans for widespread male circumcision programs and started to initiate guidance through establishing National Policy Programs for Male Circumcision, such as: Zimbabwe, Mozambique, Tanzania, Kenya, Swaziland and Malawi.[36]

Interestingly in response to the male circumcision research conducted in his country, President Yoweri Museveni of Uganda argued that he feared his country could regress in HIV prevention if people do not comprehend that circumcision was not a cure. Emphatically President Museveni stated "These days, there are many confusing messages: one of them is that if you are circumcised, you are less likely to catch AIDS even if you behave recklessly – now what sort of message is that?"[37] The President surmised that the outcome sends the wrong message and creates apathy. [38] Furthermore, Museveni stated, "I am worried that HIV infection rates have started to rise, and people think that HIV is no longer there. The way we controlled AIDS was because of an unequivocal message that there is a sickness, which is not curable, you get it through sex, and when you get it, you die. Therefore, avoid all risky sexual behaviours."[39]

The debates concerning male circumcision have taken on many diverse points of view from religious, medical, ethical, cultural, political and financial. The arguments have been complex and varied depending on what academic and medical discipline one prescribes and furthermore ones ideology of the epidemic in sub-Saharan Africa. In seeking to understand the debates surrounding male circumcision it was evident that to have any clarity on the significance of the arguments one needed to understand the substantive factors that

[34] Timberg, Craig 2007. Anti-AIDS program to fund circumcision.
[35] Musoni, Edwin 2007. Rwanda: Government readies for mass male circumcision.
[36] News24.com 2007. SA needs mass circumcision.
[37] IRIN PlusNEWS 2007. UGANDA: Findings on circumcision my derail HIV/AIDS fight-President.
[38] IRIN PlusNEWS 2007. UGANDA: Findings on circumcision my derail HIV/AIDS fight-President.
[39] Ibid:1.IRIN PlusNEWS 2007. UGANDA: Findings on circumcision my derail HIV/AIDS fight-President.

influenced and compelled WHO and UNAIDS to endorse male circumcision at the time they did.

## 2. Research Question

Why did the WHO and UNAIDS endorse male circumcision as a public health initiative for HIV prevention in sub-Saharan Africa?

Hypothesis

WHO and UNAIDS decision was in direct response to the increasing rates of HIV incidence in sub-Saharan Africa and their knowledge that HIV prevention efforts focused on behavioural modification have not produced the results experts projected, even when African governments supported and endorsed prevention.

## 3. Aims of Research

- Clarify what WHO and UNAIDS function is in relation to HIV prevention in sub-Saharan Africa.
- Critically analyze the factors that have influenced WHO and UNAIDS to support male circumcision as a public health initiative.
- Explain how WHO and UNAIDS utilized their historical findings on why social and behaviour factors hinder HIV prevention in sub-Saharan Africa when evaluating the effectiveness of male circumcision.
- Examine the views of HIV/AIDS and male circumcision experts and organizations, relating to how they interpreted why WHO and UNAIDS made their recommendations for male circumcision in sub-Saharan Africa.
- Explore how WHO and UNAIDS assessed the impact of male circumcision on women.

## 4. Rationale

In recent years, it has been stated that the sub-Saharan Africa's AIDS epidemic has reached a level of "maturity",[40] however the region remains the worst affected area in the world. We have seen Botswana and Uganda, two countries who have benefited from state support and leading international AIDS initiatives, struggle to combat the deadly epidemic. Moreover, evidence shows the significant gains in providing ARV services has not resulted in a substantial reduction in new HIV infections.[41]

These discouraging observations can only re-emphasize the need for promoting prevention methods that could have an immediate impact on reducing the transmission of HIV while still having a lasting effect towards combating the overall epidemic. Thus, when we witness the two most recognizable AIDS and health organizations in the world, making commanding endorsements to have male circumcision incorporated into public health HIV prevention strategies we should be compelled to question and understand why and how they made their recommendations. Furthermore, through knowing why they made a confident endorsement for male circumcision, we might gain insight into how their approach towards HIV prevention will influence the immediate and future direction of HIV/AIDS in Africa.

In addition by seeking to clarify the process WHO and UNAIDS undertook to evaluate male circumcision, it would seem appropriate to question why male circumcision has been endorsed and how it will affect the universal fight towards improving overall population health in Africa with the limited infrastructures, budgets and human resources available for healthcare. The research may also provide a perspective for learning how WHO and UNAIDS evaluate and balance funding, research and policy actions when making recommendations.

Lastly, the researcher hopes the outcomes of this research will further the debates surrounding how best to utilize behavioural and social factors in assessing, evaluating and understanding the overall effectiveness a biomedical intervention will have on a disease that's "social" in nature.

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[40] Maturity – the high levels of reporting deaths and new infections has leveled off

[41] Global HIV Prevention Working Group 2007:1. Bringing HIV prevention to scale: an urgent global priority, cited from WHO, UNICEF, and UNAIDS 2007. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector; United Nations 2008:4. Closing of the high-level meeting on HIV/AIDS, statement by H.E. Srgjan Kerim.

## 5. Research Design & Methodology

Intrinsic to the research question and the aims put forth in this study was the need to explain how WHO and UNAIDS processed, analyzed and formulated ideas and strategies when presented with information on male circumcision. The design strategy that provided the most appropriate means for collecting, interpreting and reporting the data necessary to answer the research question was a qualitative method of research. Strauss and Corbin defined qualitative research, as "any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification."[42]

The approach used for presenting the final findings of this research was the synchronic style of reporting defined by Weiss as a report that achieves coherence without a focus on time; the structure was based on presenting the report using significant sectors, which flow in a logical sequence.[43] The researcher used this principle of design to present the complexity of factors surrounding male circumcision and HIV prevention into an integrated logical cohesive story by categorizing the data.

### 5.1. Data-Collection

The goal at this stage of the research was to gather and organize various types of empirical evidence for analysis and review. There are various methods and techniques of observation available to facilitate the collecting of data, such as, document analysis, interviewing, surveys and ethnography.[44] The two methods of collection that were best suited to address the aims of this study were *Document Analysis* and *Semi-Structured Interviews*.

**Document Analysis**

The key pieces of literature analyzed were: WHO and UNAIDS position papers on male circumcision, HIV prevention and gender in sub-Saharan Africa, the general periodicals and research focused on male circumcision and HIV prevention, biomedical influences on HIV/AIDS, WHO and UNAIDS position papers aimed at understanding HIV prevention in sub-Saharan Africa, the politics and power of AIDS and lastly the historical findings on why

[42] Strauss, Anselm and Juliet Corbin 1990:17. "Basic considerations" in *Basics of qualitative research: grounded theory procedures and techniques.*
[43] Weiss, Robert 1995:44. *Learning from strangers: the art and method of qualitative interview studies.*
[44] Mouton, Johann 2006. *Understanding social research.*

women are disadvantage to men in sub-Saharan Africa. The majority of the documents were obtained through utilizing the University of Witwatersrand library, Yahoo's World Wide Web search engine and through reviewing the bibliographies of previous literature.

The collection of documents and their subsequent analysis was a critical factor in determining the most relevant questions for the interviews and for deciding which candidates were the most ideal to request participation. The researcher reviewed and analyzed key pieces of literature before conducting the interviews. This strategy helped to structure and organize the interviews into a clear and concise format, thus maximizing the time of the participants and researcher.

During the interviews, it became immediately evident to the researcher that the majority of the literature reviewed up to this point had a perspective that supported male circumcision and furthermore the authors of these documents consistently referenced each other's work. At this stage of the research, it became apparent that additional efforts were needed to expand the scope of documents reviewed. After taking recommendations from participants the researcher engaged in a new document collection search by using new key words and authors to locate additional views and knowledge. The literature included content on clinical trials, religion and culture of male circumcision, neonatal circumcision, policy and health in Africa, ethics, women and male circumcision and the views of leaders from UNAIDS and WHO.

Furthermore, it was discovered after conducting some of the interviews with WHO and UNAIDS that a more rigorous evaluation of their respective organizations was needed. Thus, a second analysis of WHO and UNAIDS male circumcision documents transpired, and included: regional consultation on male circumcision and HIV prevention (Nairobi, November 20-21, 2006), strategies and approaches to male circumcision programming (Geneva, December 5-6, 2006), perspectives from social science on male circumcision for HIV prevention (Durban, January 18-19, 2007) and the UN Work Plan for Male Circumcision. Furthermore a review of both organizations websites and their respective literature on male circumcision was conducted, and lastly an examination was undertaken to locate any male circumcision research authored or co-authored by WHO and UNAIDS employees.

In addition to collecting additional data on male circumcision from WHO and UNAIDS it also became imperative to understand their leaderships ideology and strategies. Lastly, a

search was completed to locate how previous biomedical interventions such as mother-to-child transmission and ARV programs were documented and if there was guidance for biomedical trials.

The data that was collected and analyzed during the second phase was then utilized as a foundation for the interviews with Catherin Hankins, UNAIDS Chief Scientific Adviser and Kevin De Cock, WHO Director of HIV/AIDS Division. Furthermore, the data was used as the basis for the follow-up questions, which were sent to UNAIDS at the completion of all the interviews, it should be noted the researcher requested the participation of Dr. Peter Piot, UNAIDS Executive Director, however based on to his schedule he declined.

**Semi-Structured Interview**

The semi-structure interview was the method used to collect primary data needed to accomplish the aims of this research. The semi-structured style provided the framework needed to ask well-defined guiding questions while still providing for the flexibility to ask questions as the interview progressed.

By choosing the semi-structured style of interview, the risk of producing biased assumptions was reduced by enabling the researcher to ask additional questions. Likewise, the defined group of guiding questions provided the foundation for allowing a comparative analysis of the data collected from the interviews. See Appendix A for a list of guiding questions utilized during this research.

The critical criteria for selecting the sample were expert knowledge surrounding the debates on male circumcision, the respondents influence on creating policies for HIV prevention programs, and lastly availability and willingness to participate. The master list of possible respondents was originally developed by reviewing the documents published on the male circumcision; the United Nations task forces that cover topics on HIV/AIDS, education and gender; all media accounts; the websites of sub-Saharan Africa countries specific to the Ministry of Health and HIV/AIDS; and the employees of UNAIDS and WHO that cover the region of Southern Africa.

To achieve the aims outlined for this study it was necessary to construct two groups of potential respondents, see Appendix B for list of participants.

Group 1

Group 1 comprised employees from WHO and UNAIDS or one of its 10 co-sponsors. The selection criterion was based on their experience in one or all of the following topics: involvement in the creation of the male circumcision positioning document, an understanding of gender and HIV/AIDS, and/or expertise in the field of HIV prevention in sub-Saharan Africa. The initial contact was made with senior management, to ensure that all ethical considerations were adhered to and the proper political etiquette was followed.

Group 1 had 6 completed interviews, versus the 8 forecasted. This in many ways appeared to be based on the two organizations' structure of referring any requests relating to male circumcision back to the key players responsible for managing the program at WHO and UNAIDS. From the researchers perspective unless additional participants had opposing views a greater number of respondent did not appear likely of furthering the quality of this research.

Group 2

Group 2 included experts from NGO's, universities, governments and medical practitioners and will be referred to as 'experts'. The selection criterion was based on their experience and reputation in one or all of the following topics: experience in the medical field of male circumcision, an understanding of gender and HIV/AIDS, and expert familiarity with HIV prevention in sub-Saharan Africa. Participants from Group 2 were contacted in the following order, trial researchers, South Africa experts, Governments, and international experts.

Group 2 had 21 completed interviews, which was consistent with the original objective of the research set at achieving between 20 to 25 interviews. Another objective the researcher had for Group 2 was to achieve a broad scope of representation; the aim was to have at least 15 unique organizations, at the conclusion of the interviews 20 unique organizations were represented. In addition to the respondents originally selected, the snowball technique of sampling was successfully used to broaden the diversity of opinions amongst participants.

The interviews occurred from March 19, 2008 and ended May 9, 2008, 27 interviews were completed in total. Group 1, 'WHO and UNAIDS' had 6 participants their respective residential locations were: 3 Switzerland and 3 South Africa. Group 2, 'experts' had 21 participants and their respective residential locations were 11 South Africa, 6 United States, 1 Kenya, 1 Zambia, 1 Australia, and 1 France.

The interviews that were completed with a face-to-face format were done so at four major urban locations in South Africa: Durban, Cape Town, Johannesburg and Pretoria. The remaining interviews were conducted via telephone. Within Group 1 'WHO and UNAIDS': 2 interviews were conducted via telephone, and 4 in person, and within Group 2 'experts': 9 interviews were conducted via telephone, and 12 in person.

Each interview was scheduled for 45 minutes and the shortest was 35 minutes, the longest lasting 1 hour 30 minutes, and the majority lasting 50 minutes. Only one interview was not completed in full due to scheduling issues. No follow-up interviews were conducted and when clarification of interview content was required, the researcher contacted the participant through email. The researcher tape-recorded all interviews except for three, which were not recorded due to poor site or time constraints. To assist in the transcribing of the interviews the researcher hired a transcription services for 19 of the interviews.

### 5.2. Data-Analysis and Reporting

This phase of the research focused on utilizing the most appropriate data analysis techniques for producing an unbiased explanation and/or conclusion to the research. As outlined previously a qualitative method of data analysis was utilized to analyze the data gathered through interviews and document analysis. Utilizing the principles outlined by Weiss, the strategy best suited to report the data collected in this research was an issue-focused and concrete approach to the analysis, including a comparison between WHO and UNAIDS, and the expert's data.

Weiss explained four distinct analytic processes involved in producing issue-focused analysis in relations to interview material they are coding, sorting, local integration and inclusive integration.[45] These principles of issue-focused analysis were the framework for analyzing and reporting the data collected in this research. The final report was presented in a synchronic structure, focused on presenting the findings in a logical method using sectors.

The data-analysis phase occurred simultaneously with the data-collection phase, which assisted the researcher in reducing the overall time required to complete the study.

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[45] Weiss, Robert 1995:154. *Learning from strangers: The art and method of qualitative interview studies.*

## 5.3. Limitations

The complexity of the debates surrounding male circumcision created the greatest challenge within the context of this research. The expertise required from epidemiology, social science, cultural and religious practices relating to male circumcision, the medical procedures for male circumcision, neonatal circumcision, HIV prevention programs and strategies, the epidemic in sub-Saharan Africa, public health policies, biomedical critiques, psychology, behavioural science, RCT's, ethics, healthcare in less developed regions, gender and the politics and power of HIV/AIDS were a few but not limited in scope. Additionally, it could be argued that by not having the necessary education and specialization in the respective fields the researcher's ability to comprehend or assimilate the findings could be viewed as a limitation.

In recognizing the research was qualitative in nature the evidence gathered from the interviews may not reflect the opinion of the organization they represent or it may also be their policy not to voice opinions, thus there was the limitation of biased or extenuating factors which could have influenced individual's responses.

This research was limited by the constraints of having to consolidate the extensive breadth of knowledge into a format and timeframe suitable for a Master Degree. Furthermore, the inability to engage views and opinions from MoH's could be viewed as a weakness.

## 5.4. Ethical Considerations

One of the goals of this research was to conduct a study that was objective and sensitive to the participant's rights, while still ensuring the final findings were accurate, reliable and unbiased. Furthermore, it should be stated that this research did not involve any vulnerable persons, groups or populations.

### Interviews

In accordance with following the ethical standards outlined by the University of the Witwatersrand, the researcher ensured all potential respondents were aware of their responsibilities, rights, and obligations before participating in this research. The following events occurred during the interview phase, which provided the framework required to ensure all ethical requirements were achieved when planning and conducting the interviews.

Introduction

Each potential respondent was notified of the research through email and where necessary a follow-up phone call or email occurred, see Appendix C for a copy of the letter sent. The introduction and follow-up conversations included outlining the scope of the research and the estimated time forecasted to conduct the interviews. Furthermore, a letter from the researcher's advisor was included in the original invite to assist with ensuring the validity and relevance of the research.

If a potential respondent confirmed they were unavailable the researcher most often sent a thank you note for their consideration and when no response was received the researcher followed-up 2 to 3 additional times by telephone or email and upon no response from the potential respondent the researcher would deemed them not interested in participating.

The Interview

Before an interview started, the researcher asked each participant if the conversation could be recorded and inquired into their preference on how to be referenced (cited) within the research, anonymous or with their professional title and respective organization. The researcher proceeded by outlining that any quotes or references utilized in published research would be submitted to them for approval and furthermore if they did not want to answer any questions during the interview that was their choice.

All participants allowed the researcher to reference their participation and 5 respondents asked for specific quotes to be regarded as anonymous.

**Document Analysis**

Throughout the research, various public and private documents were utilized to enhance or confirm the research findings. To ensure the documents were protected and referenced in an ethical and unbiased method the following guiding principles were used throughout the research:

- Ensure all documents presented in the in-text and references were accurately acknowledged through the Chicago (history) Style of citation.

- Receive written or verbal confirmation from any organization that provided private documents and adhere to all confidentiality requirements placed on such documents.
- Protect all interview transcripts during and after submitting the final research.

# Chapter Two: Literature Review

## 1. Background

The key literature used to critically explain WHO and UNAIDS' decision to endorse male circumcision as a public health initiative in sub-Saharan Africa included the *politics of HIV/AIDS, medicine and HIV/AIDS, public health and policy,* and *barriers to greater equality for women.*

## 2. Politics of HIV/AIDS

In seeking to explain why WHO and UNAIDS made various decisions relating to their endorsement for male circumcision the researcher chose to engage some of the most recent literature that described the various ways HIV/AIDS stakeholders have influenced and challenged AIDS policymaking in Africa. It was also important to examine how the structures of international and local stakeholders promote or impede mutual collaboration when developing and implementing AIDS policies.

Patterson argued that there were four key factors that have influenced AIDS policymaking in Africa: democratic transitions, donors, the state, and civil society.[46] In her opinion, the "variation in state development, the unevenness of democracy, the tenuous power of civil society and the uncertain outcomes of donor programs causes the AIDS fight to be insufficiently institutionalized into African politics."[47] Patterson defined the "institutionalizing of AIDS" as an approach which viewed decision making as a long term accountable process that recognized all key stakeholders (donors, state, civil society and those infected) as supportive partners in the struggle to combat AIDS. She further asserted that institutionalizing the AIDS fights would change the short-term humanitarian perception that AIDS was an emergency to solve, to one that was centered on the long-term ideology of the disease.[48] The author maintained that leaders needed to address the inequality of power and representation that existed in AIDS decision-making if there was to be an environment where AIDS policies and programs were defined and managed on the principles of

[46] Patterson, Amy 2006:1. *The politics of AIDS in Africa.*
[47] Ibid:1.
[48] Ibid:2.

sustainability and accountability.[49] Patterson believed the ideal way to address the inequality in power and representation was through empowering civil societies with the means to engage in substantive policy discussions.[50]

De Waal contended that AIDS organizations and activists have shaped the character and structure of the AIDS response through promoting a human rights and voluntary participation based approach.[51] He explained how the powerful international AIDS organizations have the potential to utilize their influence on local African communities either through communicating positive or negative strategies when responding to the epidemic. He discussed how international AIDS activists and donors have the power to utilize their collective voices and funds to raise awareness and give support to marginalized communities.[52] Conversely, De Waal warned that the same international AIDS community have also shown the capacity to solidify into an "introverted bureaucracy that soldiers on, pushing certain formulae on African societies", resulting in policies and programs that become inadequate or inappropriate for combating the AIDS epidemic.[53]

According to De Waal, institutional and political interests have driven the AIDS strategies in sub-Saharan Africa.[54] To support his assertion De Waal discussed how AIDS policies and national plans have not been translated or implemented into sustainable and effective community based programs.[55] De Waal blamed this lack of action on the fact that "African rulers, with a sound appreciation of how power functions, know that they won't be removed from office or even face political threats on account of AIDS."[56] Furthermore, De Waal argued that the chronic nature of HIV/AIDS allowed politicians in countries where there have been term limits to avoid the long-term implications and responsibility for managing the epidemic.[57] For AIDS experts have agreed that the delayed diagnosis of the disease from infection to illness (approximately 8 years) has provided leaders with a mechanism for justifying the resources allocated to the economy, crime, war, and poverty.[58]

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[49] Patterson, Amy 2006:18. *The politics of AIDS in Africa*.
[50] Ibid:18.
[51] De Waal, Alex 2006:121. *AIDS and power.*
[52] Ibid:121.
[53] Ibid:121.
[54] Ibid:123.
[55] Ibid:2.
[56] Ibid:2.
[57] Ibid.
[58] Patterson, Amy 2006:18. *The politics of AIDS in Africa*; De Waal, Alex 2006. *AIDS and power*.

Beside the fact, political leaders have had little economic incentive to support pervasive HIV/AIDS efforts; De Waal believed inertia was also caused by the absence of political leaders constituents demanding action.[59] When recognizing many of the economic and social conditions that shape life in sub-Saharan countries are immediate in nature, it becomes obvious for one to understand why the majority of politicians and their constituencies still cannot justify putting AIDS at the top of the political agenda.

In responding to the evidence that the AIDS epidemic has not adversely affected sub-Saharan Africa economies, Whiteside recently raised an opposing and moral view to the dilemma. He expressed his concern that there may be situations where individuals are dying unnoticed due to their lack of contributions to the national economy.[60] By examining Whiteside's concern, we can begin to develop a sense of awareness to the complexity and challenges governments face when aiming to balance human rights, politics, economic growth and AIDS.[61]

Whiteside also gave insight into the possible shift that may be happening in African politics and AIDS. This shift was in response to the number of politicians that have died from the disease, which has resulted in loss of intellectual capital and growing financial costs associated with re-election campaigns.[62] Thus, he concluded these financial and productivity losses might influence political leaders to take a more active role in the management of AIDS.

The literature on politics and AIDS starts to explain why organizations like WHO and UNAIDS might take an active role in developing and endorsing strategies that could possibly facilitate governments towards action. The historical difficulty of organizing and coordinating AIDS stakeholders towards a unified direction offers an insight into the challenges and politics of establishing a cohesive and unbiased response to AIDS. The literature also sheds light on the potential influence and power international organizations could use to assist those communities most vulnerable, especially when governments and their constituencies may be absent or enable to provide support. Each one of these viewpoints starts the process towards explaining why certain actions were taken by WHO and UNAIDS during the evaluation and endorsement for male circumcision.

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[59] DeWaal, Alex 2006. *AIDS and power.*
[60] Whiteside, Alan 2008:93. *HIV/AIDS: A very short introduction.*
[61] Ibid:93.
[62] Ibid:94.

## 3. Medicine and HIV/AIDS

To explain why WHO and UNAIDS proceeded with evaluating male circumcision in the manner they did, the researcher had to establish the prevailing and historical framework used to manage HIV/AIDS. Upon concluding, the prevailing ideologies were established through a medical lens, the researcher examined literature to understand how this discipline might have influenced WHO and UNAIDS and their consultative process.

### Response to HIV/AIDS

Panem outlined three stages that commonly occur when managing a new epidemic.[63] The stages were defined as follows, "the initial period always is characterized by unknowns. A second period begins when effective medical treatment or prevention becomes available. A third period, devoted to fine-tuning prevention and intervention, follows."[64] Each one of these stages relied heavily on the medical network of scientists, researchers and public health institutions that managed the definition of the disease, the cure of the disease and the appropriate education and intervention strategies to prevent the disease. Another key principle outlined in Panem's work was the understanding that AIDS was discovered and defined by Western medical institutions, which influenced how each stage of the epidemic was developed. The characteristics of the Western epidemic at that time were homosexual intercourse, drug users, and unsafe medical practices.[65]

Panem's thesis relied heavily on the bureaucracy of AIDS and defining the types of institutions that manage epidemics classified as a health emergency. Her work focused on two agencies the National Institutes of Health (NIH) and the Center for Disease Control (CDC), her rationale was premised on the fact that these organizations had directed the largest portion of the initial response.[66] Furthermore, Panem maintained that the inability of the different agencies to effectively communicate "exacerbated the effort to manage the AIDS epidemic."[67] In addition to her concerns relating to NIH and CDC she explained how the biomedical research establishment "was criticized for slowness in its response to the crisis

[63] Panem, Sandra 1988:2. *The AIDS bureaucracy.*
[64] Ibid:2.
[65] Ibid:2, 18-22.
[66] Ibid:4.
[67] Ibid:5.

and for reliance on a peer review system whose incentives may encourage personal ambition at the expense of the overall scientific effort."[68]

Twenty years later when Whiteside discussed the characteristics of the African AIDS epidemic, he described many of the same bureaucratic challenges Panem witnessed in 1988. For each emphasized the role of Western science and institutions, and both described the preoccupation with finding a medical vaccine.[69] The types of institutions varied over the twenty-year period, however the common characteristic remained, they were all founded in the science of biology and medicine. In recent years, there has been a concrete effort to expand the scope of contributors, for example economics and development; however, the response, people, skills, resources and management of AIDS has remained a product of public health and medicine.

Each of these factors assists in clarifying and understanding of how AIDS had been directed and managed in Africa. For the literature has positioned that the knowledge, power, and expertise on AIDS was originally constructed from Western medical structures, which subsequently influenced decisions on research, media and the overall management of the disease. [70] Furthermore, the literature has established that the management of AIDS was grounded in the doctrine of medicine and public health. Schneider explained in the *Introduction to Public Health* the differences between medicine and public health; this was helpful in categorizing the literature and debates relating to male circumcision.

> While medicine is concerned with individual patients, public health regards the community as its patient, trying to improve the health of that population. Medicine focuses on healing patients who are ill. Public health focuses on preventing illness.[71]

**Critique of the Biomedicine**

This section will engage literature that critiques the science of medicine, with special emphasis on understanding how these views, attitudes and opinions may have shaped and influenced the discourse on male circumcision. The literature on the biomedical model of health was broad in scope, although the field comprised mainly of the methods and principles

[68] Panem, Sandra 1988:5. *The AIDS bureaucracy.*
[69] Ibid. Whiteside, Alan 2008. *HIV/AIDS: A very short introduction.*
[70] Ibid:4.
[71] Schneider, Mary-Jane 2004:6. *Introduction to public health.*

established in biological sciences.[72] There were various definitions of biomedical provided however, for this study the researcher will rely on the characteristics Annandale outlined in the *Sociology of Health and Medicine,* which in her opinion was one of the universal definitions of biomedicine.

The three characteristics of biomedicine defined by Annandale included the reductivist approach, the doctrine of specific aetiology and the claim to scientific neutrality.[73] The reductivist approach "assumes that health and disease are natural phenomena which exist in the individual body, rather than in the interaction of the individual and the social world".[74] The doctrine of specific aetiology was seen as an outcome of the reductivist approach, which Rene Dubos defined in the 1960s while seeking to explain the movement from viewing disease as the result of an imbalance between a sick person and their environment to a perspective in which a disease was caused by an identifiable micro-organisms (germs, parasites, bacteria, etc).[75] Lastly, scientific neutrality Annandale defined, as "medicine can be rational, objective and value-free, treating each individual according to their need and irrespective of any sense of moral work."[76]

In the context of HIV prevention the most commonly used biomedical intervention to date has been the condom, "a barrier method that stops live virus from touching the genital mucosa, the treatment of other sexually transmitted diseases (STDs) that are cofactors for HIV transmission."[77] The second most discussed biomedical intervention in AIDS was ARV's - a drug used to prolong life and may indirectly assist with preventing future HIV infections. The literature reviewed on medicine and prevention, supports the claims that male circumcision was a biomedical intervention and of which was surgical in nature. These definitions justify the rationale and need to explore the literature on the critiques of biomedicine in order to explain and understand why WHO and UNAIDS made their recommendations. The analysis of biomedicine was as vast and complex as the definition; therefore, to address the aims of this study the critiques will include the models perceived

[72] Blaxter, Mildred 2005:11. *Key concepts health.*
[73] Annandale, Ellen 1998:6. *The sociology of health and medicine.*
[74] Ibid:6.
[75] Ibid:6; Blaxter, Mildred 2005:11. *Key concepts of health*.
[76] Ibid:7.
[77] Gibney, Laura et al. 1999:2. Preventing HIV in developing countries, cited from Zenilman, JM et al. 1995. Condom use to prevent incidence STD: The validity of self-reported condom use.

inflexibility and adaptability, notion of neutrality, male dominance and the authority over research and media.

Inflexibility and Adaptability

Gerhardt writings on the criticisms of biomedicine discussed how Rene Dubos believed the rigidity of biomedicine hindered its ability to address many of the illnesses and diseases present today.[78] Dubos criticism emphasized medicines need to be more adaptable and aware of how people's environments affect their health which meant medicine needed to be more willing to adapt and explore new socially appropriate solutions to manage health and illnesses.[79] In seeking to express his concern that medicine was to focused on the micro-organisms that caused a disease Dubos stated "to ward off disease or recover health, men as a rule find it easier to depend on healers than to attempt the more difficult task of living wisely."[80]

An example of Dubos suggestions was explored by Campbell where she described the challenges her team encountered when implementing and evaluating HIV prevention programs in the mining town Summertown, South Africa. The author's research focused heavily on promoting the biomedical intervention known as condoms with the supporting safe sex education. However, she argued the program failed due to their inability to change the societal and cultural norms. Furthermore, she discussed how the studies prevention efforts were repeatedly undermined by the poverty and gender inequalities that plagued the community.[81] Campbell explained in detail how these factors facilitated HIV infections and weakened the projects prevention efforts and its ability to produce positive outcomes.[82]

Scientific Neutrality

The critiques on scientific neutrality focused on whether medicine remains neutral when its practices have been fully established and ingrained as a construct of society as a whole. Blaxter argued, "It cannot be neutral, for there are wider social, political and cultural forces

[78] Gerhardt, Chloe 1995:67. *Society and health,* Criticisms of biomedicine.
[79] Ibid:68.
[80] Gerhardt, Chloe 1995:56. *Society and health,* Criticisms of biomedicine, cited from Black et al. 1987. *Inequalities in health*.
[81] Campbell, Catherine 2003:195. *Letting them die: Why HIV/AIDS intervention programmes fail.*
[82] Ibid:195.

dictating how it does its work and how the unhealthy are dealt with."[83] In the context of HIV/AIDS, scientific neutrality becomes ever more complex for the social, political and cultural factors of local communities cannot be viewed in isolation from the international medical ideologies and cultures that have influenced and funded a large portion of AIDS programs in sub-Saharan Africa.

Male Dominance

The feminist critiques of the biomedical model argued that medicine was an extension of the generalized societal roles that influenced women and viewed gender as biological in nature.[84] Blaxter argued in *Key concepts of Health* that the rationale behind the feminist's negative view of biomedicine was the fact women's health had been constructed by the male-dominated medical profession.[85] Thus, feminist believed this presence of male authority provided the framework to manipulate how health roles and problems were defined and managed for women.[86] Another perspective of the feminist critiques came from Lupton's work in *Foucault and the medicalisation critique.* She argued feminist "have viewed the medical profession as a largely patriarchal institution that used definitions of illness and disease to maintain the relative inequality of women by drawing attention to their weakness and susceptibility to illnesses."[87]

The feminist perspectives may help to explain some of the assumptions and statements issued on the concerns and affects male circumcision might have on women's health. Another theoretical concept used to understand and clarify WHO and UNAIDS actions relating to women were the principles of gender mainstreaming. Gender mainstreaming was defined by UNDP as "taking account of gender relations in all policy, programme, administrative and financial activities and organizational procedures. It comprises two processes, (a) being informed about relevant gender issues and (b) incorporating this information into our work."[88] By analyzing how gender mainstreaming principles were incorporated into the research, planning and evaluations of male circumcision, we can possibly gain insight into the how gender and patriarchal factors influenced WHO and UNAIDS recommendations.

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[83] Blaxter, Mildred 2005:14. *Key concepts health.*
[84] Cockerham, William 2001. *The Blackwell companion to medical sociology.*
[85] Blaxter, Mildred 2005:37. *Key concepts health.*
[86] Gerhardt, Chloe 1995:69. *Society and health,* Criticisms of biomedicine.
[87] Lupton, Deborah 1997:97. *Foucault health and medicine,* Foucault and the medicalisation critique.
[88] Prince, Bridgette et al 2005:2. *Gender mainstreaming in HIV/AIDS*: *Seminar proceedings.*

Research, Media and Messaging

The final critique of the biomedical model was framed in the perceived dominance and legitimacy of biomedical research compared to other sciences. One of most notable critiques of medicine and research comes from Cochrane, he believed medicine relied too heavily on untested assumptions and advocated for a greater use of RCT's when evaluating medical procedures.[89] Experts have concluded that Cochrane wanted to see medicine implemented only after appropriated RCT's and cost-benefit analysis were conducted.[90] By utilizing such an approach it would improve the "effectiveness and efficiency" of medical interventions while reducing financial waste and improving patient care.[91]

In the context of AIDS research, the field has been predominantly led by biology and medicine with the majority of funds allocated to biomedical research. De Waal argued that a growing challenge within the context of AIDS was "the premature policy consensus based on poor evidence and analysis" and how biomedicine has dominated research agendas.[92] This imbalance in funding and research may be attributed to the medical structures that have historically directed the AIDS epidemic.

Another critique of biomedical research was its tendency to not address or confront the unique needs and conditions of the female population. Specific to the AIDS epidemic, Lorraine Sherr, asserted if the epidemic affects women differently than there should be a corresponding level of analysis targeted at understanding these differences.[93] To explain the perceived bias, Levine, Travers and Bennett argued "the view of the male body as the norm assumes that gender is not a crucial variable (except for exclusionary purposes), and consequently the knowledge base regarding HIV/AIDS is almost exclusively based on male-derived data."[94] Evidence shows there has been significant gains in providing a more gender balanced view of research, however feminists believe the challenge remains embedded in the historical structures of female health, which have been predominately constructed by men.

Panem focused a significant part of her book on how biomedical research institutions influenced and directed AIDS research. Three key players emerged from her narrative on

[89] Gerhardt, Chloe.1995:67. Criticisms of biomedicine. *Society and health.*
[90] Ibid:67.
[91] Ibid:67.
[92] De Waal, Alex 2006:123. *AIDS and power.*
[93] Sherr, Lorraine. 1996:16. *AIDS as a gender issue.*
[94] Travers, Michele and Lydia Bennett 1996:66. *AIDS as a gender issue* and cited from Levine, C 1990. *Women and HIV/AIDS research*.

biomedical research first, public health institutions and most notably NIH, second the medical universities and lastly private or not-for-profit foundations. [95] In addition to the key research institutions she highlighted the various sources of funding that has dominated AIDS research, they were, lobbying, special interest groups and foundations, with a large part of US federal funds disbursed through NIH.[96] Interestingly Panem's account of the key stakeholders in AIDS research and funding in 1988 appears relevant today when considering the various actors involved in the decisions relating to the research, funding and planning of the trials and UN work plan for male circumcision were from these disciplines.

Another concept presented by Panem was how biomedical research was positioned in the media. The public most often learns about biomedical research through radio, television, newspapers, weekly magazines, science magazines, and the internet. Panem discussed how in the early 1980s the media was continuously challenged by having to accurately communicate research findings and policy implications to a public that was largely unaware and/or often already misinformed about AIDS.[97] She further discussed how at the start of the AIDS epidemic media sources were often criticized for underplaying AIDS, providing false information and in some cases creating public anxiety.[98] The following statement from Panem draws attention to the importance of context and meaning when releasing information to the public.

> First, the simplification of technical material as it goes through the media from presentation to the public can result in its complete distortion. Second, matters that appear neutral to scientists may have highly offensive connotations to one segment of the public or another, including the groups at highest risk. And, third, professional medical literature is read by a wider audience then it is aimed for – a readership that may easily lose sight of important caveats like 'maybe' and 'possibly'.[99]

The use of caveats can be witnessed in the concerns relating to the messaging of male circumcision especially around the definition of 'partial' protection. According to Panem, there was also a need to recognize the potential for biased reporting; first, she highlighted the fact that health organizations have the natural desire to design health messages in such a

[95] Panem, Sandra 1988:50-63. *The AIDS bureaucracy.*
[96] Ibid:50-63.
[97] Ibid:120.
[98] Ibid:120.
[99] Ibid:128.

manner that it will have an impact on public health. Secondly, she discussed how the media's preconceived ideals and beliefs could influence what they write, which affects how the public interprets and acts on AIDS stories and news.[100]

Witte and colleagues supported many of Panem views in *Effective Health Risk Messages,* where they argued, "Because individuals make so many decisions based on their emotions, instead of logic, it is useful to look into the research on how emotional, persuasive messages work."[101] The authors explained how the majority of successful health messaging campaigns have been designed on "fear appeals", or they aroused fear by utilizing persuasive messages to gain compliance. They provided examples of how media utilized horrific drunk driving advertisements to instill fear into school students, in hopes to stop children from drinking and driving. These "fear appeals" were also witnessed in the Presidents of Uganda's statements (chapter 1), when he discussed his concerns on the mixed messaging of male circumcision and HIV prevention. Furthermore, when President Museveni stated, "the way we controlled AIDS, was because of an unequivocal message that there is a sickness which is not curable, you get it through sex, and when you get it you die. Therefore, avoid all risky sexual behaviours."[102] In this example the President was delivering an explicit fear message, defined as "it is so clearly stated, there is no doubt to its meaning."[103] Implicit fear messages "are thought to be understood from the context of the message, although they are not clearly expressed."[104] The authors believed that explicit fear messages work better than implicit, for the reason that people most often do not draw out the conclusion from implicit messages.[105]The authors discussed that an important component of successful "fear appeal" messaging campaigns was premised on utilizing the appropriate culturally based colloquialisms, which Panem earlier discussed as caveats.

Panem's writings also drew attention to the system and use of medical experts, and how they influence the public, media and policymakers' perceptions of AIDS.[106] In her opinion, this "star status" (expert) was often undeserving and unfounded.[107] When considering the status of an expert Panem discussed how lay people most often did not distinguish between medical

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[100] Panem, Sandra 1988:133. *The AIDS bureaucracy*.
[101] Witte, Kim et al. 2001:1. Effective health risk messages.
[102] Ibid:1.IRIN PlusNEWS 2007. UGANDA: Findings on circumcision my derail HIV/AIDS fight-President
[103] Witte, Kim et al. 2001:7. *Effective health risk messages.*
[104] Ibid:7.
[105] Ibid:7.
[106] Panem, Sandra 1988:130. *The AIDS bureaucracy*.
[107] Ibid:130.

expertise, thus giving all MD's equal status independent of their training in AIDS, public health or epidemiology.[108] In her view "when expert opinion contradicts the government's position, public skepticism and confusion result."[109] Panem's observations relating to the media will assist in explaining some of the findings relating to the messaging of male circumcision and how certain events relating to WHO and UNAIDS announcements were managed and reported to the media. Furthermore, how these media stories influenced AIDS professionals and the public's responses, actions, and decisions relating to the information reported on male circumcision.

Nettleton and colleagues argued that the explosion of data on the internet has allowed biomedical establishments to promote their standard of good health as the accepted and preferred norm.[110] For research have shown lay people preferred accessing accurate and trustworthy health information through familiar and well-established names in health.[111] Furthermore, biomedical sites have the financial advantage to develop user-friendly web sites and utilize companies such as Google and Yahoo to locate their organization at the top of consumer searches, thus enabling them to extend their message to global audiences.

**Power and Medicine**

To further explore how the biomedical model of healthcare impacts or influences AIDS ideologies, policies and programs the study needed to review literature that explains why medical establishments have the ability to exert power. The use of power can be discussed in very broad terms throughout all aspects of human existence, economics, culture, education, relationships etc. This study will engage literature that discusses how medical power effects decision making, provides a sense of empowerment over others, and perpetuates existing inequalities.

Foucault and Medicine

A number of authors have utilized the Foucauldain framework to examine the influence of power in medicine these Foucault's critiques will be used to analyze the findings in this

[108] Panem, Sandra 1988:130. *The AIDS bureaucracy*.
[109] Ibid:130.
[110] Nettleton, Sarah et al. 2005:972. The mundane realities of everyday lay use of the internet for health, and their consequences for media convergence.
[111] Ibid:972.

study. One important concept of Foucault's work in relations to understanding WHO and UNAIDS actions, was his analysis of the relationship between power and knowledge. In *Foucault health and medicine,* Turner concluded, "Foucault saw that power and knowledge were always inevitably and inextricably interconnected so that any extension of power involved an increase in knowledge and every elaboration of knowledge involved an increase in power."[112] Foucault maintained that power exists "through the disciplinary practices which produce particular individual, institutional and cultural arrangements."[113]

This specific field of Foucault provides insight into how those with knowledge can influence those without knowledge by utilizing their knowledge as power. Foucault argued that the entire biomedical model of healthcare was structured within this framework of knowledge and power, which consequently influences how the vulnerable populations of society receive and view healthcare.[114] Likewise, the Foucauldain perspective also believed it was improbable to simply remove power from the medical profession and hand it over to patients.[115] Lupton explained "power is not a possession of particular social groups, but is relational, a strategy which is invested in and transmitted through all social groups", which she believed was Foucault's method of expressing the collusive nature of power in relation to medicine.[116] The last dimension within Foucault's work was his emphasis on how the "dispersed nature of power" influenced the complex framework of healthcare.[117] Lupton summarizes Foucault's view as follows:

> Foucauldain scholars tend to argue that the clinical gaze is not intentional in terms of originating from a particular type of group seeking domination over others. The state is, of course, involved in the reproduction of medical dominance, including regulating the conditions for the licensing of medical practitioners but there are also other agencies and institution involved beyond the state, and indeed the interest of the medical profession and those of the state often clash.[118]

Foucault has often been criticized for his work in medicine because he altered his views and thoughts over the years. However, it seems important to note that his later work moved from

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[112] Turner, Bryan 1998: xiii. *Foucault health and medicine.*
[113] Ibid: xii.
[114] Cockerham, William 2001. *The Blackwell companion to medical sociology.*
[115] Lupton, Deborah 1997:99. *Foucault health and medicine,* Foucault and the medicalisation critique.
[116] Ibid:100.
[117] Ibid:100..
[118] Ibid:100.

the institutional view of domination and power to the influence of power on oneself and others, thus maybe the concept of power relations.[119] This view was never explored in depth for he died shortly after his initial theoretical findings. However, Foucault's work on power and its influence cannot go unnoticed when seeking to explain many of the decisions WHO and UNAIDS and others carried out during the evaluations and research on male circumcision.

Lupton argued that Foucault never classified his work as a medicalisation critique and furthermore many of his thoughts varied in stance from the orthodox critique of medicalisation. Thus, the orthodox critique of medicalisation has been separated from Foucault's work on power and medicine and follows.

Medicalisation critique and power

Another key piece of literature relating to power and medicine was the orthodox medicalisation critique developed from the field of sociology of health. The medicalisation critique has been regarded as one of the catalysts for drawing attention to possible inequalities in medical relationships and within the structures that deliver health care. Lupton maintained that the medicalisation critique was premised on the notion that individuals should not be influenced or constrained by the powerful actors within medical disciplines.[120] She argued that the proponents of the critique most often take "an overwhelmingly negative view of members of the medical profession, seeing doctors as attempting to enhance their position by presenting themselves as possessing the exclusive right to define and treat illness, thereby subordinating the opinions and knowledges of lay people."[121]

Another key concern presented form the medicalisation critique was the difficulty for patients to challenge the medical professions opinions or decisions relating to care, for patients most often lacked the medical knowledge to engage in such debates.[122] Lupton described how this inherent power within medicine facilitated the mechanism to promote inequality, especially for those groups who were already considered disempowered or vulnerable. [123] However, Lupton believed there was a weakness within the sociological critique for she felt it had not

[119] Lupton, Deborah 1997:103. *Foucault health and medicine,* Foucault and the medicalisation critique.
[120] Ibid:96.
[121] Ibid:96.
[122] Ibid:96.
[123] Ibid:96.

adequately considered how emotions and desires influence and motivate behaviours, which can create an environment where there can be a mutual dependency between doctors and patients.[124]

Women and Power within Medicine

This section of the literature will be brief for the section on *barriers to greater equality for women* will cover many of the theoretical concepts relating to patriarchy, participation and inequalities. However, it was important to note the role of power in the debates on health, AIDS, and women. The statement made by Travers and Bennett highlights many of the challenges.

> Throughout the health care structures, women living with HIV/AIDS experience numerous barriers to exercising their power and control. Such practices as excluding women from drug trials, inequalities in the power relationship between doctor and client, the gender-defined roles that promote compliance and passiveness among women, and the assumption of the male norm serve to restrict the choices available to women, and consequently power over their health.[125]

As the statement above concluded, the historical structures of medicine can perpetuate inequalities, especially in locations where women already live as subordinates and void of power.[126] It has been widely published that when social structures exclude women from participation it disempowers them from effectively communicating their concerns, needs and expectations sometimes resulting in programs and policies for women that are male engendered or inappropriate. The historical gap in funding, usage, production and promotion of male and female condoms may serve as an example of how social and power structures are mutually dependent when discussing the issues of women's health.

## 4. Public Health and Policy

The primary sources of literature to explain how male circumcision was positioned within the context of population health included these themes: *priorities of public health* and *evidence based policymaking.* The goal of this literature was to explain the purpose of public health,

[124] Lupton, Deborah 1997:104. *Foucault health and medicine,* Foucault and the medicalisation critique.
[125] Travers, Michele and Lydia Bennett 1996:71. *AIDS as a gender issue*.
[126] Ibid:74.

the prevailing practices used to evaluate policy recommendations and furthermore the tools used to priorities health interventions.

**Priorities of Public Health**

Recent definitions of public health evolved out of the 1988 report *The Future of Public Health* produced by the US Institute of Medicine. In simple terms public health has been established to protect the entire population with "organized community efforts aimed at the prevention of disease and the promotion of health."[127] The core functions have often been defined as the assessment of health, policy development and assurance.[128] Assessment can be defined as the process of collecting, analyzing, and presenting data on a population's health. The function of policy development "involves the scientific knowledge to devise a strategic approach to improving the community's health."[129] Lastly, assurance as it implies includes assuring the appropriate health services are available and accessible to the general population.

In the context of developing countries, The Global Health Watch Report argued that poverty alone does not create poor health, the need to address the power relationship between men and women, rich and poor, educated and uneducated; were all critical elements of tackling the issues relating to health.[130] Furthermore, in developing countries where political and economic structures "reinforce unfair advantages and widen socio-economic disparities" health services have often been crippled.[131] This dynamic coupled with the limited resources, infrastructures, and budgets to deliver public health can result in an environment where political and economic agendas set the priorities of health.

Schneider argued that little movement occurs in public health without the involvement of government, it has been their role to approve or deny the interventions and recommendations presented by their health experts.[132] She explained that politics usually enters at the policy development and assurance phases since the responsibility for funding, and how much was determined during this time. Many in the medical field have contested this political

[127] Schneider, Mary-Jane 2004:5. *Introduction to public health*, cited from Institute of Medicine, Future of public health: 1988:40.
[128] Schneider, Mary-Jane 2004:5. *Introduction to public health*.
[129] Ibid:6.
[130] People's Health Movement 2005:4. *Global Health Watch*.
[131] Ibid:4.
[132] Schneider, Mary-Jane 2004:7. *Introduction to public health*.

involvement, instead of viewing it as a critical component of democratic governance; they argue that governments impede the decision-making process.[133]

She further argued that one of the main duties of public health was to develop and implement interventions in order to prevent the undesirable health outcomes that facilitated the need for the intervention. Schneider presented a five step approach that public health experts commonly use to define health problems in communities. They were (1) define the problem, (2) identify the risk factors (3) develop and test community level interventions (4) implementation of the interventions and (5) monitor the overall effectiveness of the intervention.[134]

The literature showed that epidemiology was the dominant science used by public health to investigate disease. Schneider defined epidemiology as a method "used to investigate causes of disease, to identify trends in disease occurrence that may influence the need for medical and public health services, and to evaluate the effectiveness of medical and public health interventions."[135] Conversely, she discussed the concerns relating to the sciences susceptibility to various errors, she argued, "epidemiology cannot prove cause and effect."[136] However, in her opinion the fact that observational studies do not have the same susceptibility to potentially harm people unlike clinical trials, she concluded even with its flaws epidemiology remains a necessity for the basic science of public health.[137] In the context of AIDS, *Priorities in Health* argued that guidelines relating to endorsing appropriate HIV prevention and treatment strategies to date have been largely influenced by the epidemiological profiles of countries.[138]

In addition to the statistical findings computed from epidemiology studies, public health officials rely heavily on statistics to assess the public needs and to evaluate the progress of population level health. For example, figures on cause of death, mortality, births, and occurrences of infectious disease can all be used to guide public health responses.

When establishing how interventions should be prioritized, public health utilizes tools such as cost benefit analysis and other methods to inform the decision-making process. From The

[133] Schneider, Mary-Jane 2004:8. *Introduction to public health*, cited from Institute of Medicine, Future of public health: 1988:5.
[134] Schneider, Mary-Jane 2004:13. *Introduction to public health*.
[135] Ibid:45.
[136] Ibid:87.
[137] Ibid:87.
[138] World Bank 2006:65. *Priorities in health.*

World Bank perspective priorities in health have been clearly defined, first "identify the cost-effective interventions for those diseases that impose the largest burdens around the globe or in target regions or populations that exhibit grave need or inequity and determine how to deliver these interventions effectively, efficiently, and equitably."[139] Furthermore, they went on to explain how many interventions can be effective, however it is the combination of knowledge and economic cost effectiveness, which determine which interventions can have the greatest impact with a given level of resource commitment. The World Bank definition of cost effectiveness analysis was the tool used "for weighing different costs and health outcomes when policy-makers have to make resource allocation decisions.[140]

The cost effective analysis of interventions in developing countries can be critical in mobilizing solutions that are inexpensive and can result in reducing disease burden. The World Bank reasoned that the cost effectiveness of an intervention was one factor in working towards providing policy guidance, other factors such as prevailing burden of diseases, the existing coverage and lastly the capacity of the health system.[141] Furthermore they believed the relative costs to determine which combination of interventions would yield the greatest improvements in health was critical for making the best use of public funds.[142] In discussing the nature of collective analysis, The World Bank mentioned factors such as; ranking the interventions in broad categories, how would statistics vary in different demographic areas, does the interventions address the major sources of disease burden, and the feasibility - based on resources and experience.[143]

Risk assessment was a second important tool that public health officials have utilized for assessing population level health. Schneider defined risk assessment as a formal process that "identifies events and exposures that may be harmful to humans and estimates the probabilities of their occurrence as well as the extent of harm they may cause."[144] Researchers have classified how a person perceives risk from two perspectives "dreadness" – the more dread the less acceptable, and "knowability" – a person's known risks were considered the more acceptable. [145] Researchers argue that sometimes people's perception of

[139] World Bank 2006:23. *Priorities in health*.
[140] Ibid:56.
[141] Ibid:52.
[142] Ibid:56.
[143] Ibid:57.
[144] Schneider, Mary-Jane 2004:103. *Introduction to public health.*
[145] Ibid:103.

risk conflict with the scientific assessment of the risk. Based on that false dynamic Schneider argued that sometimes public health in efforts to protect the population could require risk assessment, especially in the context of injurious behaviour.[146] When analyzing all these components for assessing population health we can begin to develop a sense of why "scientific knowledge alone does not determine which interventions will have the most impact."[147]

In addition to the literature discussed the WHO's white paper on the *Strategies and Approaches for Male Circumcision Programming* clarified some of the attitudes WHO had towards the complexity of implementing male circumcision.[148] In response to the possible rollout of male circumcision, WHO stated, "perhaps the most critical lesson we have learnt about introduction of a new clinical procedure, method or technology, is that it is more than just the innovation itself. Other health systems issues need to be considered and addressed."[149] The paper also supported the widely held concern for implementing interventions in public health settings where resources are limited. They provided examples of various interventions that had been introduced on a wide scale in the developing world, such as clinical contraceptives and other reproduction health technologies.[150] WHO argued that the lessons they had gained from the introduction and scale-up of reproductive health technologies demonstrated that "inadequate attention to introduction may lead to a host of problems."[151]

The following potential barriers were highlighted by WHO as obstacles to effective implementations: poor quality services resulting in post-procedure infections; inadequate counseling resulting in uniformed decision making (coercion in the worst case scenario); poor communication strategies and inadequate counseling leading to confusion and misunderstanding; low use due to poor reputation of the services or inadequate availability of access; cultural or religious-based opposition from, for example the community, political or religious leaders, and service providers; and services were not sustainable in terms of coverage and / or quality.[152]

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[146] Schneider, Mary-Jane 2004:106. *Introduction to public health*.
[147] World Bank 2006:10. *Priorities in health.*
[148] WHO 2067:39. Strategies and Approaches for Male Circumcision Programming.
[149] Ibid:39.
[150] Ibid:38.
[151] Ibid:38.
[152] Ibid:38.

The literature on public health established the framework to understand how male circumcision was located within this context. Through understanding how public health officials utilize statistical data to assess the impact of an intervention on population level health we can begin to explain some of the arguments associated with male circumcision and mass population roll outs.

**Evidence based Policymaking**

The concept of 'evidence based' emerged in the 1990s, when researchers pondered if medicine needed to be evidence based, shouldn't health policies be developed on this same principle.[153] The framework of evidence-based research has grown steadily as a standard within the context of Africa public health policies. Bowen and Zwi outlined in their research that the "theory on translation of research findings into policy and practice, and on knowledge utilization, offers only part of the solution to this complex task."[154] The complexity of policymaking challenges the assumptions that evidence based research will result in effective policy action. The scope of literature relating to evidence based research and policymaking was broad and has been situated without various models which included rationalist, implied, knowledge-driven, problem-solving, interactive, political, enlightenment, and tactical model to name a few.[155]

Black, Bowen and Zwi each highlighted how the external factors such as politics, social, funding, bias, personal values and relationships, influence policymakers and their actions.[156] Black argued if researchers seek to gain a greater influence over policy decisions they needed to have a more substantial understanding of the policy process, funding sources and how they should engage collaboratively with policy-makers.[157] Furthermore, he viewed the involvement of policy-makers in the "conceptualization and conduct of the research" as critical elements to increasing the probability of turning evidence based research into effective policymaking.[158]

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[153] Black, Nick. 2001:1. Evidence based policy: proceed with care.
[154] Bowen Shelley and Anthony Zwi. 2005:1. Pathways to evidence-informed policy and practice: A framework for action.
[155] Ibid:6.
[156] Black, Nick. 2001:1. Evidence based policy: proceed with care, cited from J. Lomas 2000. Connecting research and policy. Bowen Shelley and Anthony Zwi. 2005:1. Pathways to evidence-informed policy and practice: A framework for action.
[157] Black, Nick. 2001:1. Evidence based policy: proceed with care.
[158] Ibid:1.

## 5. Barriers to Greater Equality for Women

The issues surrounding women draws special attention based on the historical vulnerability of women in sub-Saharan Africa. Currently 61% of those living with HIV are women and in some Southern Africa countries, that number remains higher.[159] Furthermore, women typically have had to bear a significant portion of the emotional and financial burdens associated with the care or death of a child or family member infected with AIDS.[160] UNICEF reported that in 2007 sub-Saharan Africa had 420,000 children newly infected with HIV and 290,000 died of AIDS.[161]

Recent evidence has shown that young women between the ages of 15-24, represent approximately two thirds of all people newly living with HIV in developing countries "making them the most-affected group in the world."[162] Additionally UNICEF presented that in 2007 that 15-24 year olds were responsible for approximately 40% of all new infections in the category defined as adults - 15 and above.[163] The figures relating to the age group 15-24 maintain importance for experts argued the number of new HIV infections in this age range most accurately predicts the state of the epidemic.[164]

During the 2008 United Nations General Assembly High Level meeting on the status of AIDS, Executive Director Dr. Peter Piot insisted, "it is time now to speak out and take concrete action to address gender inequality and special vulnerabilities of women."[165] Hence, to understand how UNAIDS and WHO assessed the affect mass male circumcision would have on women's health, rights, and choices, the researcher utilized literature that discussed societal inequalities, barriers to participation and how the framework of universal citizenship can restrain oppressed or vulnerable populations from accessing the privileges of citizenship.

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[159] UNAIDS 2007:8. AIDS epidemic update; UNITED Nations 2008:14. High Level Meeting on AIDS, Panel 3: Making the response to AIDS work for women and girls: gender equality and AIDS.
[160] Gibney, Laura et al. 1999:358. Preventing HIV in developing countries; Travers, Michele and Lydia Bennett 1998:64. AIDS as a gender issue.
[161] UNICEF, UNAIDS, and WHO 2008. Children and AIDS: second stocktaking report, fast facts.
[162] UNITED Nations 2008:14. High Level Meeting on AIDS, Panel 3: Making the response to AIDS work for women and girls: gender equality and AIDS.
[163] UNICEF, UNAIDS, and WHO 2008. Children and AIDS: second stocktaking report, fast facts.
[164] Dorrington, Rob et al. 2006:29. The demographic impact of HIV/AIDS in South Africa: National and provincial indicators.
[165] UNAIDS 2008:2. Statement at the UN general assembly high level meeting on AIDS, Peter Piot.

## Patriarchy

It has been widely acknowledged, "that patriarchal social structures have historically and systematically excluded women from those aspects of society that are responsible for leadership, policy information, resource allocation and decision making."[166] Pateman argued that the historical power relationships that limit women went beyond colonialism in scope; she believed it was a direct outcome of the social contract that was based on a fraternal pact that constituted civil society as a patriarchal or masculine order.[167] Feminist have agreed that the traditional patriarchy of our fathers has been transformed into the fraternal modern patriarchy of civil society. However, the ability to develop a modern political theory that incorporates both the feminine and masculine individuality into political and civil life remains a challenge.[168]

Pateman further argued that it was not only the patriarchal foundations of the social contract that limited freedoms it was a condition of the sexual contract, which was the subjection of women.[169] Pateman described the original pact as a sexual as well as a social contract that established men's political right over women and sexual in the sense of establishing orderly access by men to women's bodies. This historical subjection of women as property has developed into a legacy of male dominance over women's bodies and rights. Within the Africa context the evidence of such beliefs of dominance over women's bodies and rights are witnessed in the Marriage Act Policies that define women as property and allows the man rights to sex. The subjection of women policies have been further perpetuated in the tribal Customary Law practices found in many African countries. Pateman argued that unless this legacy of subjection of women as bodies for sex and viewed as a male-right was restructured, women would never gain full citizenship rights.[170] Pateman's writings also reflected on the challenges and accountability of whether it was possible to change the structures that existed within modern politics, and if modified would it positively influence women rights.

[166] Sherr, Lorraine 1996:64. *AIDS as a gender issue.*
[167] Pateman, Carol 1989. *The disorder of women.*
[168] Ibid:52.
[169] Ibid.
[170] Ibid.

## Citizenship

The modern political and academic definition of universal citizenship has been constructed on the principles of inclusion and participation for everyone in public life premised on establishing the universal point of view.[171] Young argued that "the assumed link between citizenship for everyone, on the one hand, and the two other senses of citizenship – having a common life with and being treated in the same way as the other citizens – on the other, is itself a problem."[172] Young discussed how oppressed groups were concerned with the universality of citizenship being understood as the 'same' in the majority view, for their unique differences were the defining characteristics that viewed them as 'different' in the first account.[173] These observations of Young's assisted with providing a framework to understand many of the challenges relating to women and participation, especially when seeking to explain some the events that transpired during the evaluation of male circumcision.

In many countries, laws have provided full citizenship to all; however, the societal structures and beliefs that are embedded in their civil societies hinder those who are oppressed from fully accessing citizenship rights. The movement towards democracy in many sub-Saharan countries provided those who had been marginalized with a sense of hope, a belief that winning full citizenship status - equal political and civil rights would lead to their freedom and equality.[174] However, time has shown full citizenship by law does not equate into full agency to those rights, "social movements of oppressed and excluded groups have recently asked why extension of equal citizenship rights has not led to social justice and equality."[175]

When looking to gain an understanding of what factors within a society limit the effectiveness of laws for full citizenship rights we can look to Young's definition of oppression, this clearly establishes a framework for understanding the conditions which create and perpetuate inequalities:

> (1) the benefits of their work or energy go to others without those others reciprocally benefiting them (exploitation); (2) they are excluded from participation in major social activities, which in our society means primarily a workplace (marginalization); (3) they

[171] Young, Iris Marion 1990. *Throwing like a girl and other essays in feminist philosophy and social theory*; Pateman, Carol 1989. *The disorder of women.*
[172] Young, Iris Marion 1990:115. *Throwing like a girl and other essays in feminist philosophy and social theory.*
[173] Ibid.
[174] Ibid.
[175] Ibid:114.

> live and work under the authority of others and have little work autonomy and authority over others themselves (powerless); (4) as a group they are stereotyped at the same time that their experience and situation is invisible in the society in general and they have little opportunity and little audience for the expression of experience and perspective on sol events (cultural imperialism); (5) group members suffer random violence and harassment motivated by group hatred or fear.[176]

These factors help to articulate the social and cultural influences that contribute to oppression and limit a society's ability to have its citizens practice the laws defined by their Nation.

Young argued that the "inclusion and participation of everyone in public discussion and decision-making requires mechanisms for group representation, where differences in capacities, culture, values, and behavioral styles can be put forth without judgment or discrimination.[177] The challenge with changing this idealist version of democracy was in part historical, since the classical period our civil society theories of contracts have been defined on a masculine experience, non-emotional, dispassionate, and universal in values and norms.[178] Again, one may question if the unraveling of these patriarchal foundations can realistically be accomplished.

The debates on gaining full citizen rights has led many to believe that social and economic equality must be achieved before political equality can be instituted, while others argue that it takes both including a substantial change to the representation in the political spheres to promote policy changes. However, within both arguments those that are oppressed still have limited capabilities in accessing their full citizenship rights based on their inability to have a voice and their limited powers to influence or change the majority view. A significant amount of literature highlights the underlining historical factors that define why oppression exists, however, there are few antidotes for how to change a legacy of cultural and institutional structures that influence and perpetuate inequalities.

[176] Young, Iris Marion 1990:123. *Throwing like a girl and other essays in feminist philosophy and social theory.*
[177] Young, Iris Marion 1990:115. *Throwing like a girl and other essays in feminist philosophy and social theory.*
[178] Pateman, Carol 1989. *The disorder of women.*

## Equality for Women

In the last 25 years living conditions for many people residing in sub-Saharan Africa have improved dramatically based on investments put forth to improve practical needs.[179] However former President Paul Wolfowitz, of the World Bank argued, "income levels do not measure accurately levels of development or reflect social or geographical inequalities" highlighting the enormous challenge women face in gaining equality in Africa.[180] Nussbaum argued "it is very clear that there are dramatic cultural and societal differences and that the life of a female individual is from birth shaped by social expectations and norms regarding femaleness", which influences both men and women's actions and choices."[181] Nussbaum suggestions can be observed in the awareness that sub-Saharan Africa women remain the population most at risk for contracting diseases such as AIDS, malaria, TB and cholera[182]and traditionally retained the responsibility of care when illnesses or deaths occurs in the family.[183] Nettleton supported Nussbaum argument when she discussed how poor health and inequalities were often associated with men who live with a constant lack of empowerment, feeling of inadequacy, and a fatalist view developed from living in conditions where life expectancy and employment remain low.[184]

In Botswana's 2004 MDG Status Report the authors argued, "that over the past two decades substantive areas of life, including control of productive resources have improved in Botswana, however even when legislation may be gender neutral, traditional and institutional cultures perpetuate practices that disadvantage women in relation to men."[185]Botswana's government publicly recognised the "substantive challenge lies in bridging the gap between progressive policy and legislative reforms on the one hand and traditional and deep-seated institutional cultures that stand in the way of equal rights of citizenship for men and women on the other."[186] The key challenge therefore becomes transformations, the ability to change culture, individuals, institutions, socio-economic disparities and society for the in betterment of all.[187] Furthermore, in various parts of sub-Saharan Africa tribal customary laws and

[179] United Nations 2005. The millennium development goals report.
[180] Wolfowitz, 2006:1. Learning from the Czech Republic, remarks on the Czech Republic graduation from the World Bank group.
[181] UNDP 2003:2 Gender and Governance.
[182] People's Health Movement et al. 2006. *An alternative world health report.*
[183] Sherr, Lorraine 1996:64. *AIDS as a gender issue.*
[184] Nettleton, Sarah 1995. *Lay health beliefs, lifestyles and risk.*
[185] Botswana Government and United Nations 2004:37. Millennium development goals status report.
[186] Ibid:40.
[187] Ibid:40.

actions have in many cases perpetuated inequalities towards women even when adequate civil laws, state laws and policies have been put into practice to protect women's rights.[188]

In aiming to understanding how these debates surrounding culture influences inequalities and HIV/AIDS, we can look to former President of Botswana, Fetus Mogae 2006 State of the Nation speech. The President passionately expressed his concern with the number of cases reported on male deviant behaviour; he explained how alcohol abuse was in part responsible for the increased rates of violence against women, unnecessary rapes, passion killings and infections of HIV/AIDS.[189] The President vehemently stated this behaviour was harmful to society and needed to stop.[190]

With the increased concern that HIV/AIDS has become feminized in sub-Saharan Africa, it could be argued that these casualties will continue to affect societies as a whole if socio-economic environments and polices cannot be implemented or targeted at improving the well-being of those most vulnerable to infection.[191] Recently, a renewed emphasis has been placed on the need to change deep rooted cultural and societal norms if women are to achieve equality and thereafter prevail over HIV/AIDS, which questions where male circumcision will fit within this context.[192]

**Representation and Participation**

In looking for solutions to improve equality within developing countries, it was understood that through gaining a greater diversity of representation in governments and civil society it would promote and transform the male patriarchal class of politics into one that was more representative of the overall society's needs and interests.[193] Feminists argued that greater representations of woman would influence the policies and rights for women based on common interests.

Anne Phillips outlined the following four positions as the primary arguments put forth for justifying increasing the levels of women in elected office.

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[188] Matemba, Yonah 2005. A chief called 'woman': Historical perspective on the changing face of bogosi (chieftainship) in Botswana.
[189] Botswana Government 2006. State of the Nation Address.
[190] Ibid.
[191] UNAIDS 2008:2. Statement at the UN general assembly high level meeting on AIDS, Peter Piot.
[192] Ki-moon, Ban 2008. AIDS war on the right track.
[193] Pateman, Carol 1989. The *disorder of women.*

> There are those that dwell on the role model successful women politicians offer; those that appeal to principles of justice between the sexes; those that identify particular interests of women that would otherwise be overlooked; and those that point towards a revitalised democracy that bridges the gap between representation and participation.[194]

This rapid movement towards representation in African countries has been in contrast to the Scandinavian and Northern European countries who achieved significant participation over an 80-year period through slow and continuous social and civil movements. Hassim and Goetz questioned how the rapid and significant rise in women in African parliament correlated to effective gender policies and have their voices been representative of woman as a collective whole.[195] In support of this apparent paradox Bauer and Britton stated, "Bringing women into national office does not necessarily translate into a consistent voice for women's rights."[196]Furthermore they went on to argue that in most cases where electoral quotas have influenced minority representation the participation has been limited in voice due to the majority rule influence that dominants most political structures of democracy.[197]

Bauer and Britton further explained how "legislating policy is a necessary but not sufficient condition for ensuring the adequate implementation of polices to advance the status and position of women."[198] The authors provided an example of where in Rwanda women held a 48.8% representation in government, which at the time was the largest percentage in the world, however many questioned if these women were able to effectively exert power independent of their male majority leadership. For there were reports that a land draft policy developed by women MP's for expanding women's ownership and inheritance rights was modified and limited in scope by the male ruling party,[199] resulting in a final land policy reform act that was male engendered. This example demonstrates the challenges that women of affluence have in gaining agency for it has been argued that in sub-Saharan Africa politics, women in government have often been associated with the male political leaders and in many cases serve more as a "first lady" rather than an independent representative.[200] This common occurrence in politics underscores the difficulty that women of poverty and marginalized

[194] Phillips, Anne. 1998:228. Feminism and Politics.
[195] Hassim, Shireen 2006. Paradoxes of representation: the impact of quotas for women on democratization.
[196] Bauer, Gretchen and Hannah Britton 2006. *Women in African Parliaments*, Women in African Parliaments: A continental shift?
[197] Ibid.
[198] Ibid.
[199] Ibid.
[200] Molomo, Mpho 2004. The need for electoral reform in Botswana; Selolwane, Onalenna 2004. The Emang Women's Association.

groups have in being heard or represented by women in politics.[201] Bauer and Britton concluded that women may represent women in politics however, their ability to advance the status and position of gender issues in society as a whole has been limited due to their inability to act independent of political pressures of the majority party.[202] Goetz and Hassim provided a perspective from South Africa, where they saw a growing dissociation between the women in government and those in civil society based on a perception of elitism and the beliefs that MP's do not understand or care about the needs of the common women.[203] With male circumcision positioned as masculine and cultural, one would have to question how women MP's might pressure the majority rule on the subject of male circumcision, especially if he was circumcised.

It is clear that women have been represented in many sub-Saharan African governments, however their ability to act appears to be limited based on the historical power structures that persist in African cultures. Pateman argued that if change was to occur in participation and democracy then "it is clear that if women are to be citizens as women, as autonomous, equal, yet sexually different beings from men, democratic theory and practice has to undergo a radical transformation."[204] Pateman's assists in framing another disappointing and consistent occurrence in governments the practice of absorbing powerful women and women's organizations into their own formal governmental parties, where the majority rule can steadily diminish their voices and powers to influence policy and their society.[205]

The literature also drew attention to an emerging perspective that equality agendas need to broaden their scope form health, welfare and education to including strategies that address gender inequalities related to equity distribution, economics of reproduction and the role of women in development planning and implementation.[206] Pearson explained how there needed to be a refocus on the material inequalities and on social policies of redistribution, she wanted to see more effective feminist political action that would drive policies for reducing the marginalization and subordination of women.[207]

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[201] Molomo, Mpho 2004. The need for electoral reform in Botswana; Selolwane, Onalenna 2004. The Emang Women's Association.
[202] Bauer, Gretchen and Hannah Britton 2006. *Women in African Parliaments*, Women in African Parliaments: A continental shift?
[203] Goetz, Anne-Marie and Shireen Hassim 2003. *No shortcuts to Power*, Women in power in Uganda and South Africa.
[204] Pateman, Carol 1989:14. *The disorder of women*.
[205] UNDP 2003. Gender and Governance; Alvarez, Sonia 1990. *Engendering Democracy in Brazil*.
[206] WDR 2006. World development report, equity and development; Pearson, Ruth 2004. The social is political: towards the re-politicization of feminist analysis of the global economy.
[207] Pearson, Ruth 2004. The social is political: towards the re-politicization of feminist analysis of the global economy.

## Conclusion

The literature on patriarchy, citizenship, gender equalities and representation provided a means to explore why women remain the most vulnerable population for HIV infections in Africa. However, on a broader scale the content established the framework to explain why certain decisions were made relating to male circumcision and women. Furthermore, as the literature discussed many of the existing patriarchal cultures and structures that exist today in politics and society's in sub-Saharan Africa limit a woman's ability to influence change. This challenge was expressed by Hassim, who argued "that a strong notion of equality would rest on the extent to which overall poverty is reduced, the degree to which women have autonomy and are able to make choices free of the constraints of care work within families and communities, as well as free of the pressure to remain in oppressive and violent relationships and the extent to which women feel safe in society."[208] Hassim's argument exposes a weakness in the literature, if social, political and sexual relationships hinder a women's ability to feel safe, what would give her the power to act or engage in constructive debates on male circumcision, especially in the instances where the media and AIDS agencies have already had an opportunity to influence her partner(s).

[208] Hassim, Shireen 2006:16. Paradoxes of representation: the impact of quotas for women on democratization.

## Chapter Three: HIV prevention and Male Circumcision

In seeking to explain the question and aims related to why WHO and UNAIDS endorsed male circumcision as a public health initiative for HIV prevention in sub-Saharan Africa the researcher needed to position male circumcision into the overall framework of HIV prevention. By understanding how HIV prevention efforts have been historically managed and implemented in sub-Saharan Africa we can begin to establish how male circumcision was situated within this context.

The second key component to explaining why WHO and UNAIDS made their endorsement was achieved through constructing a historical timeline comprising the significant milestones up to the point of WHO and UNAIDS recommendation. The objective of this research was not to analyze or debate the medical efficacy of male circumcision. Thus, the timeline focused on reporting the processes and methods used to establish how male circumcision was evaluated and positioned. This process provided a structure to determine and evaluate how the events and decisions WHO and UNAIDS commenced influenced the timing, urgency and support for the endorsement.

### 1. Historical perspective of HIV prevention in sub-Saharan Africa

The literature review of HIV prevention assists in clarifying the research aim targeted at understanding how WHO and UNAIDS used historical factors to weigh the evidence on male circumcision. The literature strongly suggests that the prevailing response for managing HIV prevention in sub-Saharan Africa has been from the perspective of an 'emergency'.[209] The most common strategies that were discussed for promoting HIV prevention were: firstly, changing individual behaviour through the ABC approach of prevention, which was marketed by community and national AIDS campaigns; and, secondly, from a biomedical approach of providing treatment, which would consequentially reduce the spread of HIV by counseling ARV patients on testing and safe sex practices during consultations.

Although, prevention efforts have emphasized and promoted the individual behaviour change concept, the strategy has been highly contested by many AIDS experts. Mary Crewe,

[209] United Nations 2008:23. Declaration of commitment on HIV/AIDS and political declaration on HIV/AIDS: midway to the millennium development goals; Whiteside, Alan 2008. HIV/AIDS: A very short introduction; Patterson, Amy 2006. The politics of AIDS in Africa; Wroughton, Lesley 2008: World Bank shifts HIV/AIDS focus in Africa.

Executive Director of Pretoria University's Centre for Study of AIDS, shared her thoughts "everybody keeps on saying let's reinforce the ABC message and let's make its stronger because it isn't working, surely the question, is why isn't it working, rather than saying we need to reinforce it."[210] David Harrison, Executive Director of Love Life, expressed his concerns with the strategy, "there is far too much of a preoccupation with the mechanics of transmission of HIV transmission and not enough focus on the dynamics of transmission."[211]

Historically, prevention efforts have been delivered with short term messaging campaigns, with the expectation that individuals would uniformly change their behaviour irrespective of their community, economic status, and education.[212] The following comment taken from the UNAIDS Africa 2025 project helps to underscore the complexity surrounding HIV prevention, the authors stated "transmission of HIV happens because of the choices that individuals perceive they have-or do not have-and the actions they take as a result."[213] Warren Parker, Executive Director of CADRE provided his insights, "interventions have to be behavioural and in relation to who people have sex with and when, in other words in relation to relationships, a lot of the emphasis on interventions has been on the intricacies of sexual behaviour and not the dynamics of sexual relationships."[214] These statements serve as an example of the historical preoccupation with individual and sexual behaviour change irrespective of the context of social, behavioral, and economic factors.

Some of the key strategies relating to HIV prevention efforts in sub-Saharan Africa were discussed at the Southern Africa Development Committee (SADC) Expert Think Tank Meeting on HIV prevention in Southern Africa held on May 10-12, 2006 in Maseru, Lesotho with 38 participants, 33 of which resided in African countries.[215] The objective of the Expert Think Tank was to reflect and expand upon the key drivers of the epidemic in the SADC sub-region. Think Tank participants concluded that the key drivers of the epidemic were "high levels of multiple and concurrent sexual partnerships by men and women with insufficient consistent, correct condom use, combined with low levels of male circumcision."[216] Additionally, attitudes and behaviours, intergenerational sex (5 year age gap), violence,

[210] Crewe, Mary April 15, 2008. Pretoria University, Centre for Study of AIDS, Executive Director. Interview.
[211] Harrison, David April 24, 2008. Love Life, Executive Director. Interview
[212] Whiteside, Alan 2008. *HIV/AIDS: A very short introduction*; Campbell, Catherine 2003. *Letting them die: Why HIV/AIDS intervention programmes fail.*
[213] UNAIDS 2005:28. *AIDS in Africa: Three scenarios to 2025*.
[214] Parker, Warren March 27, 2008. CADRE, Executive Director. Interview.
[215] SADC 2006:13-14. Expert think tank meeting on HIV prevention in high-prevalence countries in southern Africa.
[216] Ibid:5.

stigma, lack of openness, untreated sexually transmitted infections (STI's) and lack of condom usage in long-term concurrent partnerships were all presented as key but secondary drivers of the epidemic. Thought was also given to defining social and structural drivers of the epidemic, which were gender inequality, women's vulnerability to HIV, cultural influences on gender relationships and high mobility.[217]

The Expert Think Tank meeting concluded by outlining the HIV prevention strategies that should be given priority. The priorities were: reduction in multiple and concurrent partners; preparing for the possible roll out of male circumcision; address the responsibility and involvement of the male in relations to sexual and reproductive health; improve condom usage and with consistent and proper use; and lastly continued programming focused on delaying sexual debut within the context of condom programming and reduced partnerships.[218] UNAIDS Regional Adviser for HIV prevention in Eastern and Southern Africa, Tomas Lundstrom reflected on the importance of the Think Tank meeting,

> We had a think tank meeting in 2006 and it felt like for the first time people really started looking at what's really driving this epidemic. Only when you do that you can actually try to find the programs to actually prevent HIV infection. I think a lot of the research is needed but there are a lot of things we already know but we are still not moving. I think HIV prevention is mainly driven by the gender imbalance we talk about gender, inequality for a number of years but it is not tackled, at all, because we have a fundamental resistant of actually doing it. We do not need any more evidence saying that gender is driving the epidemic, or we high levels of multiply concurrent partners, but it's how we tackle it, its deep down roots in the culture and everything and it's so difficult to deal with and I am afraid we don't change that by more evidence or more research.[219]

The literature that covered the subject of successful HIV prevention programs in the context of sub-Saharan Africa focused predominantly on one country, Uganda and it's early successes with the 'zero grazing' program.[220] The program resulted in a significant reduction in HIV prevalence[221] in the 1980s and 1990s and defined Uganda as a model AIDS success story. The 'zero grazing' prevention campaign was led by President Museveni and was based

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[217] SADC 2006:5. Expert think tank meeting on HIV prevention in high-prevalence countries in southern Africa.
[218] Ibid:3.
[219] Lundstrom, Tomas April 23, 2008. UNAIDS, Regional Adviser HIV prevention. Interview.
[220] Epstein, Helen 2007. *The invisible cure; DeWaal, Alex 2006. AIDS and power.*
[221] HIV prevalence quantifies the proportion of individuals in a population who have HIV at a specific point in time. UNAIDS normally reports HIV prevalence among adults, aged 15–49 years. We do not write prevalence rates because a time period of observation is not involved.

on the principle of staying faithful; however, if you choose to engage in additional partners stay close to home and use condoms. The other significant component of the campaigns success was the President's unique ability to tailor his message of prevention depending on the audience he was addressing.[222]

The literature covering Uganda also tended to focus on academics' assumptions that when Uganda moved to the United States' ABC campaign, which focused heavily on abstinence, President Museveni's messaging strategy moved away from the principles of 'zero grazing' which caused many of the gains in the epidemic to diminish.[223] However, others have suggested that the results were likely due to the political unrest at the time, the highly questionable prevalence statistics and if the concepts of 'zero grazing' would have the same effect on today's youths.[224] Uganda's story can be seen as an example of the how the lack of concrete measurable outcomes hinders prevention strategies and creates doubt and uncertainty.

Countries such as Kenya, Tanzania, and Zimbabwe have also experienced ups and downs in their respective epidemics, however there was minimal literature on the programs utilized during these periods and the reasons for the variations in outcomes.[225] The literature has established a trend for relying on Uganda's early successes; this reliance can be observed in Daniel Halperin, Senior Researcher Scientist and Lecturer, Harvard University statement on the outcomes from the 2005 SADC Think Tank meeting. Halperin surmised:

> SADC has officially endorsed the position that they have to focus, or in that region they need to focus, on various things, but the main priority needs to be on encouraging behaviour change especially on reducing the levels of multiple and concurrent sexual partnerships and also on scaling up male circumcision. Whether they actually implement and do this is another question of course, but that is what they are saying they are going to do, and part of that is based on the experience of Uganda, where HIV has gone down.[226]

The success story of Uganda can also be replaced with the negative influences of corruption and AIDS, which was not unique to Uganda, it was a disappointing issue that many sub-

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[222] Epstein, Helen 2007. *The invisible cure; DeWaal, Alex 2006. AIDS and power.*
[223] Ibid.
[224] Ibid.
[225] SADC 2006:5. Expert think tank meeting on HIV prevention in high-prevalence countries in southern Africa; De Waal, Alex 2006:18,20,71,84. AIDS and power.
[226] Halperin, Daniel May 6, 2008. Harvard University. Senior Research Scientist and Lecturer. Interview.

Saharan countries needed to confront.[227] Corruption created a greater awareness for accountability and created a movement towards stronger management and financial processes to ensure those who need help were the ones benefiting from donor support.[228]

Funding has grown significantly from approximately USD 300 million in 1996 to USD 10 billion in 2007. However, the allocation towards prevention programs and research on related topics has been substantially less than its peer program of treatment. Programs such as The United States Presidents Emergency Plan for AIDS Relief (PEPFAR) have been heavily weighed and executed on set amounts to be allocated towards the treatment and science of AIDS.[229] The criteria for distribution of donor funding has also appeared to benefit treatment programs, for allocations have been linked to ideology of prevention methods (religion, abstinence, etc) and approved as vertical programs. Robert Bailey, Professor, University of Illinois Chicago shared his opinion on the challenges of donors and prevention in Africa, he remarked:

> The greatest challenge in prevention is getting countries and donor agencies to put more resources into prevention and to come up with an integrated approach to prevention, not a vertical program. Donors now tend to have their favorite intervention and to want to fund that intervention, but not a full package of intervention. I think the challenge has been to get countries to come up with plans that then sort of force donors into a much more integrated approach and to want to put more funding into prevention, hopefully not sacrificing care and treatment, but given prevention a higher priority. That is the biggest challenge at this point. As I have said, we cannot treat our way out of this epidemic so the most effective approach is to try to prevent new infections, in the long run that is cost effective and it is going to save us money and ultimately lives.[230]

He also argued that "HIV prevention measures have really been dictated from Western culture, from the big donors and from the multilateral, multinational agencies and many of the prevention strategies have not come from the communities themselves", which has established a top down approach versus the bottom up approach that originates from the

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[227] People's Daily Online 2008. Donors stress accountability of HIV/AIDS funds at global AIDS meet in Uganda; Epstein, Helen 2007. *The invisible cure.*
[228] Vandenbruaene, Marc 2007. Interview with Peter Piot STI.
[229] Abrams, Jim 2008. Senate still deadlocked over $50B global AIDS bill; Medical news today 2008. 50 billion dollars needed for global AIDS control.
[230] Bailey, Robert March 20, 2008. University of Illinois Chicago, Professor. Interview.

community.[231] Thus, in 2006 when evidence showed that for approximately every two people that began ARV treatment, five new people became infected with HIV,[232] it was of no surprise to many that the focus on treatment programs and poorly managed prevention efforts had contributed to this predicament.[233]

The literature revealed that the most common obstacles in addressing why HIV prevention efforts had lagged in comparison to treatment were: individuals did not modify their behaviour; governments lack of incentives or risk to confront the epidemic and/or the delay in acknowledging the epidemic existed; the concentration on and belief that a vaccine was achievable; the assumption that treatment would contribute to altering the course of the epidemic and lastly stigma.[234] One of the most significant arguments put forth by academics in understanding the framework of why individuals and societies deny knowledge was developed by Stan Cohen.[235] Cohen outlines three type of denial; "'literal' people simply refuse to accept what is happening, 'interpretative' in which the basic outline of events is acknowledged but the patterns and meanings are disputed, 'implicatory' denial in which people absolve themselves of responsibility for what has happened."[236] The next two compelling quotes provided insight into the drivers and difficulty of overcoming denial within African communities. Glenda Gray, Executive Director HIVSA, provided the first narrative:

> As far as the previous generation or generations are concerned, behaviour change is erratic, condom use is erratic and people do not perceive themselves to be at risk. And so they never think they are going to get infected and so they never ever really do effective prevention. There is competing risks, you are unemployed, you are hungry, you could be killed in a car accident or shot or hijacked and so the competing risks of death are far more real than an abstract reason or cause of dying in 10 years time, so those are also the kind of issues, so I am going to die tomorrow so why should I worry about 10 years. I think we need to look at the next generation to see whether the experiences they had will change the way they do things.[237]

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[231] Bailey, Robert March 20, 2008. University of Illinois Chicago, Professor. Interview.
[232] Global HIV Prevention Working Group 2007:1. Bringing HIV prevention to scale: an urgent global priority, cited from WHO, UNICEF, and UNAIDS 2007. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector; United Nations 2008:4. Closing of the high-level meeting on HIV/AIDS, statement by H.E. Srgjan Kerim.
[233] Ibid:1; Ibid:4.
[234] Whiteside, Alan 2008:103. *HIV/AIDS: A very short introduction*; DeWaal, Alex 2006. *AIDS and Power*; UNAIDS and WHO 2006. Report on the global AIDS epidemic; Global HIV Prevention Working Group. 2007. Bringing HIV prevention to scale: An urgent global priority; UNAIDS and WHO 2006. Report on the global AIDS epidemic 2006: A UNAIDS 10th anniversary special edition.
[235] DeWaal, Alex 2006:13. *AIDS and power*.
[236] Ibid:13.
[237] Gray, Glenda April 2, 2008. HIVSA, Executive Director. Interview.

The second quote was in response to the empirical evidence gathered from a 2005 National Survey conducted in South Africa by the Human Sciences Research Council (HSRC), Social Aspects of HIV/AIDS & Health Programme. Leickness Simbayi, Executive Director provided this narrative:

> Even in this day and age, there are some people who still do not believe that they are at risk of HIV infection, coupled with the fact that very few people have tested and know their status. We conducted anonymous testing, we go to people's homes ask them to participate in a survey, we don't take down their names, we just know their sex, their race and where they are so we have an idea of geographical location whether it is urban, rural, formal or informal. In that study, which is now being used to estimate national prevalence in the country about half the people we found to be HIV positive, when asked the question whether they thought they are at risk of becoming infected, they actually believed they were not. I am saying they were actually already infected. Now that says something about the problem. At least the half that believe that they are at risk maybe they are doing something, whereas the other half that are already infected and do not believe they are at risk are carrying on behaving as if they are not at risk, that is their perception. So their behaviour probably is in line with that perception, so they are probably not taking precautions whatsoever.[238]

In addition to Gray and Simbayi accounts of the presence of denial, Campbell also argued in her research on the mining town in Summertown South Africa, that the lack of community support and denial of the gender inequalities was a major contributing factor to understanding why the HIV prevention program conducted and researched in that community failed.[239] Campbell, further underscored the need for greater community involvement if individual behaviour, values, and beliefs were to be altered for the long-term; she reasoned that there was a needed for corporations, community leaders, and families to support and encourage change.[240]

Corporations, governments, and major international humanitarian agencies have most often executed and implemented the HIV prevention programs offered at a population wide level in sub-Saharan Africa. While NGO's have focused their efforts on treatment, human rights advocacy, support, care, and prevention at a community level. Furthermore, the health care sector has historically led the majority of AIDS initiatives with a heavy dependency on

[238] Simbayi, Leickness April 14, 2008. HSRC, Social Aspects of HIV/AIDS & Health Programme, Executive Director. Interview.
[239] Campbell, Catherine 2003:195. *Letting them die: Why HIV/AIDS intervention programmes fail.*
[240] Ibid.

scientific evidence and funding coming from the Western world, this in part can be attributed to the emphasis on ARV treatment and care. This over emphasis on the biomedical approach has been widely criticized by many in the field of AIDS; many believe this dominance has hindered HIV prevention efforts. Professor Simbayi's observation was reflective of those who argued for a more neutral approach, he concluded that the biomedical approach has "ignored a large body of scientific knowledge about other non medical or basically behavioural and social interventions that have been developed primarily by social scientists" and have often shown more promising hope in the short term.[241]

It appears thus far that the most significant broad range action taken towards accelerating HIV prevention strategies in sub-Saharan Africa has occurred from the commitments made by the UN and its member states. The first commitment was the establishment of The Millennium Development Goals (MDG's) in 2000, which was followed by a series of time-bound targets established in the 2001 'Declaration of Commitment on HIV/AIDS'.[242] Thereafter the UN and its member states passed in 2006 the 'Political Declaration on HIV/AIDS' which perhaps was regarded as the most significant endorsement given to encourage action in relation to HIV prevention efforts. For the 'Political Declaration on HIV/AIDS' reconfirmed the time-bound targets passed in 2001 and established a new agreement to achieve universal access for HIV prevention, treatment, care and support by the year 2010.[243]

In conclusion, although there has been a very clearly defined model for delivering and messaging HIV prevention efforts in sub-Saharan Africa, the consensus on whether this approach has been effective remains highly contested.

**Examples of Biomedical Interventions for HIV prevention**

To understand how male circumcision was positioned compared to other HIV prevention strategies, it was important to review previous biomedical interventions. Historically, new biomedical interventions have been evaluated and endorsed by WHO and UNAIDS, with subsequent normative guidance on how best to implement and market the respective

[241] Simbayi, Leickness April 14, 2008. HSRC, Social Aspects of HIV/AIDS & Health Programme, Executive Director. Interview.
[242] United Nations 2001. S-62/2 Declaration of commitment on HIV/AIDS.
[243] United Nations 2006:7. 60/262 Political declaration on HIV/AIDS; United Nations 2008:5. Declaration of commitment on HIV/AIDS and political declaration on HIV/AIDS: midway to the millennium development goals.

interventions. However, the execution and implementation of the interventions have been left to a complex network of government officials, NGO's, international funders, academics and activist to priorities and implement.

Two prevention programs that have received recommendations from WHO and UNAIDS are the prevention of mother-to-child transmission and co-trimoxazole prophylaxis for HIV-related infections. Currently, only 31% of HIV-infected pregnant women receiving antiretroviral prophylaxis[244]and 90% of all the HIV infections relating to children under the age of 15 have come from mother-to-child transmission.[245] Research has shown that the majority of these infections occur during the pregnancy, at delivery or from breastfeeding. Data has also shown that more than half of the children infected perinatally die before they reached the age of two.[246]

Secretary-General of the UN, Ban Ki-moon argued in his April 2008 report to the General Assembly on the status of AIDS, that "although the cost-effectiveness of mother-to-child HIV transmission prevention programmes was demonstrated in the 1990s, children still accounted for one in six new infections in 2007."[247] UNAIDS provided their first strategic guidance on the prevention of mother-to-child transmission in 1999 and WHO convened a consultation in December 2001.[248] Thereafter, WHO and UNICEF convened the first high level global partner forum on the prevention of mother-to-child transmission in December of 2005 with the objective of encouraging scale-up due to the discouraging progress.[249] In follow-up to the 2005 meeting, WHO in November 2007 issued a consensus statement, which further emphasized the challenges of scaling up quality, programs for mother-to-child transmission services.[250]

In 2008, the UN reported that developed countries had almost completely eliminated the risk of mother-to-child HIV transmission, "through the implementation of comprehensive prevention measures, including primary prevention of HIV infections; fewer unintended pregnancies among HIV-positive women; provider-initiated HIV testing and counseling in

[244] UNICEF, UNAIDS and WHO 2008:1. Children and AIDS: Second stocktaking report, actions and progress, fast facts.
[245] WHO 2007:7: Guidance on global scale-up of the prevention of mother-to-child transmission of HIV.
[246] United Nations 2008:14. Declaration of commitment on HIV/AIDS and political declaration on HIV/AIDS: midway to the millennium development goals. WHO, UNAIDS and UNICEF 2008:9. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector; UNICEF, UNAIDS and WHO 2008:1. Children and AIDS: Second stocktaking report, actions and progress, fast facts.
[247] Ibid:14.
[248] UNAIDS 1999. Prevention of HIV transmission from mother to child: WHO 2001. Prevention of mother-to-child transmission of HIV.
[249] WHO 2007:9: Guidance on global scale-up of the prevention of mother-to-child transmission of HIV.
[250] WHO 2007. Consensus statement: Achieving universal access to comprehensive prevention of mother-to-child transmission services.

antenatal settings; timely delivery of antiretroviral prophylactic regimens; and safe infant-feeding."[251] In the same UN report, they documented that in 2007 Botswana had achieved a 91% uptake of mother-to-child services, resulting in only 4 % of children born to HIV positive mothers becoming infected with HIV.[252] The success in Botswana demonstrated that HIV interventions with proven effectiveness could work when political will, support and financial resources are managed accordingly.[253]

WHO and UNAIDS made a provisional statements relating to the usage of co-trimoxazole in 2000 and during 2006 WHO provided further guidance after receiving additional evidence-based research supporting the drug's efficacy in resource-limited settings.[254] In 2007 WHO reported that of the 1.5 million children born to pregnant women with HIV, only 4 % initiated co-trimoxazole during the first two months of birth.[255] Furthermore data from RCT's and observational studies showed the effectiveness of co-trimoxazole in preventing Pneumocystis jirovecii pneumonia (PCP)[256] in infants and reducing morbidity and mortality in children and infants living with or exposed to HIV.[257] In 2008, a study published in Lancet and conducted in Uganda further underscored the drug's effectiveness by demonstrating "an 81 % reduction in mortality among uninfected children over a 31-month period if their HIV–infected parents were receiving antiretroviral therapy and co-trimoxazole preventive therapy."[258]

From the perspective of prevention it was argued that based on the difficulty of diagnosing HIV infections in infants, co-trimoxazole could be beneficial for infants who's mothers are HIV-positive, it was recommended to start the drug 4-6 weeks after birth and continued until the infant is no longer at risk of acquiring HIV.[259] Furthermore, the treatment has been the standard of care for both children exposed to or living with HIV for many years in developed countries, however, in sub-Saharan Africa, many countries have included this inexpensive drug co-trimoxazole into their national policies but the implementation has been poor.[260]

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[251] United Nations 2008:14. Declaration of commitment on HIV/AIDS and political declaration on HIV/AIDS: midway to the millennium development goals.
[252] UNAIDS 2008. Responding to AIDS: assessing progress in eastern and southern Africa.
[253] United Nations 2008:14. Declaration of commitment on HIV/AIDS and political declaration on HIV/AIDS: midway to the millennium development goals.
[254] WHO 2006:8. Guidelines on co-trimoxazole prophylaxis for HIV-related infections among children, adolescents and adults.
[255] WHO, UNAIDS and UNICEF 2008:96. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector.
[256] (PCP) is Pneumocystis jirovecii pneumonia and has been identified as the leading cause of death for infants infected with HIV.
[257] WHO 2006:8. Guidelines on co-trimoxazole prophylaxis for HIV-related infections among children, adolescents and adults.
[258] WHO, UNAIDS and UNICEF 2008:94. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector universal access in the health sector 2008 cited from Mermin J et al. Mortality in HIV-infected Ugandan adults receiving antiretroviral treatment and survival of their HIV-uninfected children: a prospective cohort study. Lancet 2008.
[259] WHO 2006:5. Guidelines on co-trimoxazole prophylaxis for HIV-related infections among children, adolescents and adults.
[260] WHO, UNAIDS and UNICEF 2008:96. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector.

Reasons given for the minimal coverage were "lack of national-level guidance to health care providers on co-trimoxazole prophylaxis, the lack of opportunities to document its provision in registers or child health cards and erratic supply and frequent stock-out of drug."[261]

Additional prevention statistics on pregnant women and HIV prevention efforts that seemed notable were, only 12% of HIV-positive pregnant women were evaluated to determine if they were eligible for ARV therapy when attending antenatal care sessions.[262] Secondly, in 2004, only 8% of pregnant women in low and middle-income countries received a HIV test and in 2007, that number reached 18%.[263] Lastly, HIV-positive pregnant women receiving antiretrovirals to prevent mother-to-child transmission in low and middle income countries increased from 9 % in 2004 to 34% in 2007, the universal access goal set for 2010 is 80%.

**AIDS in Africa: Three scenarios to 2025**

In 2005 UNAIDS in conjunction with the support of the African Union initiated a project to develop three possible scenarios for how AIDS may exist in Africa by the year 2025.[264] The team comprising of men and women mainly from Africa used their collective experiences and knowledge to help guide the making of the scenarios.

This study decided to utilize the UNAIDS report as a source of knowledge to further clarify why HIV prevention strategies and programs have not produced substantive results in sub-Saharan Africa. The three scenarios will help to broaden and support the HIV prevention findings discussed earlier in this chapter. The projects scope was extensive; however, it was the content that focused on the key drivers and challenges to overcome AIDS in 2025 that helped to establish the popular beliefs, assumptions, and theories relating to Africa and the AIDS epidemic. Furthermore as discussed previously, this literature review assisted with defining a framework for HIV prevention in sub-Saharan Africa, which allowed the researcher to evaluate and position male circumcision within these defined beliefs.

The three scenarios developed for the project were 'Traps and legacies: The whirlpool' – the foundation was based on utilizing current HIV/AIDS trends until 2025. 'Tough choices: Africa takes a stand' – this scenario was based on utilizing what had worked thus far, which

[261] WHO, UNAIDS and UNICEF 2008:96. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector.
[262] Ibid:94.
[263] Ibid:86.
[264] UNAIDS 2005: *AIDS in Africa: Three scenarios to 2025.*

was based on the principles of Uganda. Lastly, 'Times of transition: Africa overcomes' this scenario utilized the framework for universal access – rapidly scaling up comprehensive treatment and prevention programs for all.[265] All three scenarios were based on two key assumptions, first AIDS was not a short-term challenge and the disease will exist in 2025, and secondly what occurs now will shape how the future will look.[266]

The project identified five critical drivers that could impede future efforts or if managed appropriately would produce successful outcomes. They were "the growth or erosion of unity and integration; the evolution of beliefs, values, and meanings; the leveraging of resources and capabilities; the generation and application of knowledge and lastly the distribution of power and authority."[267]

Researchers argued that in the future, those societies that have poor unity would also most likely have difficulty in providing comprehensive prevention, care and treatment programs for their respective communities or nations.[268] Furthermore, high levels of inequality, or tensions surrounding ethnic and religious beliefs could influence action towards violence, which would further impede efforts relating to care, treatment and prevention of HIV/AIDS. However, if there was a sense of collective unity within the society efforts would most likely result in success.[269] For example, the project asked, "will rural communities across Africa feel integrated in national development or feel marginalized?"[270] When positioning this statement within the context of HIV/AIDS it demonstrates the need to have participation from all groups within a society, if a sense of unity remains the goal.

The driver relating to beliefs, values and meanings was constructed based on the theory that one's beliefs surrounding religion, sexuality, death, life, morality and values creates and influences a person's identity. This would consequentially have a positive or negative impact on how topics and solutions relating to HIV/AIDS will be perceived and acted upon.[271] Providing programs on condom use without the awareness of religious beliefs, marketing abstinence without a sense of cultural practices, and offering voluntary HIV testing without

[265] UNAIDS 2005:12. *AIDS in Africa: Three scenarios to 2025.*
[266] Ibid:12.
[267] Ibid:13-15.
[268] Ibid:14.
[269] Ibid:14.
[270] Ibid:52.
[271] Ibid:14.

acknowledging the social implications, all underscore the importance of recognizing the influences that cause a person to act.

The driver that focused on the leveraging of resources and capabilities emphasized the need and concerns for providing funding strategies that were short and long term in nature, while managed with a sense of fiscal accountability.[272] Without adequate sources of funding HIV/AIDS programs cannot succeed, however it has also become paramount to produce quantifiable outcomes which benefit those most in need. Furthermore, this driver emphasized the need to capitalize and maximize the financial recourses available to each community or country.

The next driver was the generation and application of knowledge, which was based on interpreting how biomedical, sexual behaviour and people living with AIDS share and apply their knowledge to the epidemic. The project emphasized the importance of biomedical interventions; however, researchers also argued that the development and uptake of successful new technologies does not always "guarantee their effective deployment."[273] Furthermore, this driver highlighted the importance of gaining participation from those living with AIDS, with hopes to reduce stigma and bring awareness to the struggles and obstacles of those living or dying from the disease.

Lastly, the distribution of power and authority was identified as a key driver, which focused attention on how the use of power and authority can potentially impede the voices and actions of vulnerable populations.[274] Possible sources of authority included governments, donors, academics, activists, international AIDS agencies and medical practitioners. The project used the distribution and access to AIDS treatments and HIV prevention programs as an example to show how power could negatively influence a program.[275] This highlights the need for adequate controls to ensure power does not negatively influence the types of solutions offered and furthermore who has access to those services.

In addition to the drivers outlined above there was another key concept that developed from the discussions relating to the Myths and Assumptions of HIV/AIDS.[276]The literature

[272] UNAIDS 2005:14. *AIDS in Africa: Three scenarios to 2025.*
[273] Ibid:53-54.
[274] Ibid:15.
[275] Ibid:54.
[276] Ibid:43.

highlighted how the wealth of knowledge and information now available on the epidemic has at times made it difficult to ascertain the difference between myths and reality. Interestingly within the report, the following myth and corresponding reality were documented. Myth: "Providing free and wide access to antiretroviral drugs will undermine prevention efforts. Reality: Evidence shows the contrary, e.g., people receiving antiretroviral therapy in Cote D'Ivoire use condoms more frequently than untreated HIV positive people."[277] This example firmly highlights the challenge of communication and the risk of presenting one-line catch phrases, for it has now been argued by WHO and UNAIDS that in concept the focus on ARV treatments has hindered prevention efforts.

The last piece of valuable information gathered from the AIDS in Africa document were some of the outcomes produced from the final 2025 project. These factors were presented as the key components to moving towards a future where Africa overcomes the AIDS epidemic irrespective of the three scenarios. Some of the key concepts outlined from the project were: "prevention of AIDS fatigue; ensuring the crisis is defined and backed by all players; policies should be shape by ensuring the inclusion of local cultures, values, and meanings if results are to be effective; the need to reflect on national or international capacities without the pressure for results, otherwise it could create an environment where the priorities of stronger voices prevail; no magic bullet strategies; there must be a wide range of actors in implementing and proposing solutions; comprehensive understanding of social, physiological and economic issues that impact women; the necessity to care and provide treatment for orphaned children; and lastly a greater understanding of the psychological impact of the epidemic."[278]

If these key components could be overcome, Africa would have a higher likelihood of overcoming the epidemic. Even though the list was extensive, the concepts provided the researcher with an opportunity to analysis how these principles were used during WHO and UNAIDS evaluation of male circumcision. Furthermore the researcher utilized the projects overall assumptions and views to explore and analyze how the decisions and actions relating to male circumcision were processed compared to the principles defined from the AIDS in Africa project.

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[277] UNAIDS 2005:43. *AIDS in Africa: Three scenarios to 2025* cited from Moatti JP, et al (2003) Access to antiretroviral treatment and sexual behaviours of HIV infected patients aware of their serostatus in Cote d'Ivoire. AIDS.
[278] UNAIDS 2005:20-21. *AIDS in Africa: Three scenarios to 2025*.

**Recent developments in HIV Prevention Efforts**

Recently, significant attention was placed on the current and future state of HIV prevention most notably due to the June 10-11, 2008 UN General Assembly High Level Meeting on AIDS, which reported on the MDG's for 2015 and the universal access goals set for 2010. When seeking to locate male circumcision within the overall framework of HIV prevention it seemed appropriate to outline the recent developments relating to HIV/AIDS. These findings not only help to establish the current priorities and concerns relating to HIV/AIDS, they assist in clarifying the challenges and shifts in prevention ideology.

Some of the key strategic themes that transpired from the UN meeting were the recognition that HIV/AIDS was both a public health and development concern, furthermore AIDS should be seen as a "central theme of development efforts."[279] The epidemic must move from an 'emergency' response to a phase where we treat AIDS as an "immediate crisis and as a long-wave event."[280] An overwhelming sense that sub-Saharan Africa will probably not treat itself out of the epidemic, thus prevention methods proven to be effective must be maximized.[281] Lastly the awareness that greater efforts must be made to strengthen public health systems if the goal for universal access was to be achieved.

Other key views taken from the UN meeting were premised on the realization that action was needed; having established policies or visions was no longer an acceptable norm. Furthermore Dr. Piot, UNAIDS Executive Director argued that in addition to just establishing policies, there was a concrete need for action if gender inequalities were to be realistically addressed.[282] There appeared to be a renewed emphasis placed on the need for greater collaboration between social science and medical research – with expectations that it would help to explain how cultural norms and attitudes increase the risk of infection.[283] Lastly, attention was also drawn to the need for greater protection of health worker and the necessity to tackle brain drain - Botswana, for example had lost approximately 17% of its healthcare workforce to AIDS between 1999 and 2005.[284]

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[279] United Nations 2008:1. Closing of the high-level meeting on HIV/AIDS, statement by H.E. Srgjan Kerim.
[280] United Nations 2008:23. Declaration of commitment on HIV/AIDS and political declaration on HIV/AIDS: midway to the millennium development goals; UNAIDS 2008. Statement at the UN General Assembly High Level Meeting on AIDS, Dr. Peter Piot; Wroughton, Lesley 2008. World Bank shifts HIV/AIDS focus in Africa.
[281] United Nations 2008:16. Declaration of commitment on HIV/AIDS and political declaration on HIV/AIDS: midway to the millennium development goals.
[282] UNAIDS 2008:3. Statement at the UN General Assembly High Level Meeting on AIDS, Dr. Peter Piot.
[283] Ki-moon, Ban 2008. AIDS war on the right track.
[284] UNAIDS 2008:2. The Global health workforce alliance global forum on human resources for health, Dr. Peter Piot.

Secretary-General Ban Ki-moon acknowledged at the UN meeting that there had been significant gains in the commitment, will and courage from many Africa leaders. Thereafter, he also reminded the assembly that "serious challenges remain, in several countries; prevalence is rising among young people as well as women and girls."[285] These findings outlined by Mr. Ban Ki-moon had also been considered by Whiteside, for he believed that there had been a shift in the growing importance and role of African governments in the battle to overcome AIDS.[286] Additionally Whiteside argued that it was not only critical to address gender concerns but there was a need for men to actively participate in these debates through encouragement and as positive role models.[287] Whiteside also drew attention to the situation where grandmothers and older women were carrying a substantial portion of the burden of the epidemic through having to support and care for those infected or orphaned by the disease.[288]

Concerning prevention, there appeared to be a renewed emphasis on providing more effective messaging and promotion campaigns tailored to community's unique epidemics and for rapidly scaling up interventions that are evidence-based. Another key debate that emerged in recent literature was the feasibility of utilizing HIV testing and counseling to manage the spread of the HIV, for evidence showed that the overwhelming majority of individuals living in sub-Saharan Africa still did not know their HIV status 25 years into the epidemic. The last significant topic was the growing health risks associated with tuberculosis (TB) and AIDS, and the subsequent risk TB poses to the entire population.[289]

In summary, the recent findings provided an additional source of knowledge to assist in explaining how and why recent decisions were made relating to male circumcision. Furthermore, by understanding the historical and current perspectives relating to HIV prevention in sub-Saharan Africa the researcher can evaluate how the decisions and choices relating to male circumcision fit within these points of view. Which also assists with explaining why WHO and UNAIDS made their recommendation.

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[285] Ki-moon, Ban 2008. AIDS war on the right track; CBS News 2008. U.N.: Fight against AIDS can't keep up.
[286] Whiteside, Alan 2008. *HIV/AIDS: a very short introduction*.
[287] Ibid:127.
[288] Ibid:81
[289] Ibid:35. Yahoo 2008. Treating TB is key to saving lives of AIDS patients: activist; Zimbabwe HIV/AIDS organizations call for integration of TB interventions into country's HIV/AIDS program; CBS News 2008: U.N.: Fight against AIDS can't keep up.

## 2. Timeline of key milestones relating to male circumcision

The debates surrounding male circumcision and HIV prevention have been a long and tenuous process. The catalyst for linking male circumcision with HIV infections developed out of the interest to explain why certain regions in Africa, the "AIDS belt",[290] had higher HIV prevalence than other regions in Africa.[291] There have been over 37 ecological, cross-sectional, and cohort studies conducted from 1986 to 2000, with the majority demonstrating an inverse correlation between HIV prevalence and male circumcision.[292] However, the significance of the findings had little impact on establishing male circumcision as a prevention tool in the 1990s. For questions relating to the accuracy of the statistical data used in the studies, researchers' methodologies, and the inadequate utilization of confounding factors such as religion, culture, and behaviour when analyzing the data caused HIV experts to remain cautious and to insist on additional evidence.[293]

James Ntozi in 1995 argued that moving forward with policy based on observational data alone was a risk, he surmised, "if the experiment fails, Africans are likely to feel abused and exploited by scientists who recommended the circumcision policy."[294] Ntozi also argued that any intervention that could help his fellow Africans combat the AIDS epidemic should be immediately explored. Hence, Ntozi urged fellow researcher to move forward with coordinating controlled experiments based on the hypothesis of male circumcision and HIV in Africa.[295] In spite of the endorsement, it was not until the start of the 21st century when a renewed interest in male circumcision and HIV prevention occurred. This was in part associated with the growing concerns related to the disappointing state of the HIV/AIDS epidemic in sub-Saharan Africa.[296]

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[290] AIDS belt has been defined as the countries in Africa that have high rates of HIV infection, furthermore this belt accounts for 50% of the worlds case.

[291] Caldwell John and Pat Caldwell 1996:40. The African AIDS epidemic.

[292] Bailey, Robert et al. 2007. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial; Siegfried, N. et al. 2003. Male circumcision for prevention of heterosexual acquisition of HIV in men; Weiss, Helen et al. 2000. Male circumcision and risk of HIV infection in sub-Saharan Africa: a systematic review and meta-analysis; Van Howe 1999. Circumcision and HIV infection: review of the literature and meta-analysis; Caldwell John and Pat Caldwell 1996. The African AIDS epidemic.

[293] Gray, Ronald et al. 2007. Male circumcision for HIV prevention in young men in Rakai, Uganda: a randomized controlled trial; Van Howe 1999. Circumcision and HIV infection: review of the literature and meta-analysis; Caldwell John and Pat Caldwell 1996. The African AIDS epidemic; Ntozi, James 1995. The east African AIDS epidemic and the absence of male circumcision: what is the link?.

[294] Ntozi, James 1995:94. The east African AIDS epidemic and the absence of male circumcision: what is the link?.

[295] Ibid:98.

[296] Weiss, Helen et al. 2000:2369. Male circumcision and risk of HIV infection in sub-Saharan Africa: a systematic review and meta-analysis; Hankins, Catherine 2007. Male circumcision: Implications for women as sexual partners and parents; Bailey, Robert et al. 2007:643. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial

Thus at the start of 2000, Weiss and colleagues published a systematic review and meta-analysis, which included 27 observational studies previously conducted on male circumcision and HIV acquisition.[297] The authors concluded that 21 of the aforementioned studies showed men who had been circumcised had an approximately 50% reduced risk of becoming infected with HIV than those not circumcised.[298] Consequently, they argued that there was currently enough compelling evidence to associate male circumcision with HIV infections especially in areas where HIV prevalence was high. However, the researchers also cautioned that there were concerns associated with the intervention, which should be addressed through accessibility and feasibility studies. The concerns were increased incidents of risky sexual behavior based on the false sense of protection, how and who pays for the service, post surgical healing and bleeding complications and questions relating to cultural identity and acceptability.[299] The study concluded that if decision makers required reliable empirical evidence then the ideal way forward was to conduct a RCT on how and if male circumcision protects against HIV infections.[300]

During the early part of decade, the field of male circumcision started to mature into a defined group of actors. It was common to observe the same authors, academic institutions, and AIDS activist when reviewing relevant topics on male circumcision and HIV; familiar names were Agot, Auvert, Bailey, Gray, Halperin, Morris, Moses, Serwadda, Wawer and Weiss. This cohesiveness assisted in creating a powerful voice and support network for promoting male circumcision. However, activism was not enough to persuade HIV experts and public health officials, for they remained cautious and unwilling to implement policies or guidance on male circumcision.

Thus at this stage of the evolution of male circumcision the prevailing consensus was to conduct a RCT. Recognizing the need for reliable empirical evidence, three of the principal investigators involved in a number of the previous ecological and observational studies secured support and funding for three RCT's to be performed at different locations in sub-Saharan Africa. The conclusion that RCT evidence was a critical if not the decisive factor for considering male circumcision as a future prevention tool was subsequentially confirmed in

[297] Weiss, Helen et al. 2000:2361. Male circumcision and risk of HIV infection in sub-Saharan Africa: a systematic review and meta-analysis.
[298] Ibid:2369.
[299] Ibid:2369.
[300] Ibid:2369.

the 2003 Cochran Review on male circumcision. The report concluded, "It would be prudent for consumers to await the findings of ongoing randomized trials before deciding on the balance between benefits and risks of male circumcision in the context of HIV infection."[301]

**Male Circumcision RCT's: South Africa**

The first RCT for male circumcision started recruitment in July 2002 and was stopped in mid-April 2005 by the study's Data and Safety Monitoring Board (DSMB) based on interim findings demonstrating a significant health benefit for the group circumcised.[302] Subsequently the findings were published in October 2005. The study team was led by principal investigator Dr. Bertran Auvert of France and supported by the French Agence Nationale de Recherches sur le SIDA (ANRS). This trial was conducted at the site of Orange Farm, a semi-urban neighborhood outside of Johannesburg, South Africa. Interestingly the RCT was considered the first study that used a surgical procedure to prevent an infectious disease.[303]

The Orange Farm trial comprised 3274 uncircumcised men ranging from the age of 18 to 24 who were randomized into two groups.[304] The control group was not circumcised and consisted of 1582 HIV negative men, which had 49 cases of HIV infections during the study period. The intervention group consisted of 1546 HIV negative circumcised men, which had 20 incidences of HIV infections during the study period. The study found that men who were circumcised had a 61% protection effect against acquiring HIV compared to those men not circumcised.[305] The authors concluded that in countries where there was a high percentage of males not circumcised and high levels of heterosexual related HIV infections, male circumcision should be rapidly integrated into public health plans.[306]

The South Africa study created excitement and contention. Many in the scientific community questioned the accuracy of the findings. Their concerns ranged from the investigators' methodology, the obstacles associated with conducting a RCT that was surgical (participants are fully conscious that they have been circumcised), the limited scope and details relating to assessing behavioral factors and lastly the consequence of stopping the trial early (the findings were short term in nature with no long term protective knowledge). At this stage, it

[301] Siegfried, N. et al. 2003:14. Male circumcision for prevention of heterosexual acquisition of HIV in men.
[302] United Nations 2005:1. Work plan on male circumcision and HIV.
[303] Auvert, Bertran et al. 2005:1120. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk.
[304] Ibid:1112.
[305] Ibid:1112.
[306] Ibid:1120.

appeared that the Orange Farm trial had become a source of encouragement for those who historically had supported the association between male circumcision and HIV prevention. However, the consensus was still for delaying any policy recommendations until the two trials being conducted in Kenya and Uganda were concluded. Furthermore, Orange Farm's principal investigator confirmed this position during an interview from the 3rd IAS Conference on HIV Pathogenesis and Treatment when he stated:

> For sure, we have demonstrated that in South Africa and this part of the world, we did see a population level reduction of HIV infection in this trial, but we are not ready to use this as a prevention method right now. The situation in Africa is quite complex—you've got a lot of different cultural situations and it's not possible. We also have 2 ongoing trials in Uganda and Kenya, and we have to wait for these results to be available in order to understand if this can be used as a prevention method.[307]

WHO and UN agencies also issued a statement highlighting the positive outcomes of the Orange Farm trial, however any future prevention strategies would be subject to the results obtain from the Kenya and Uganda male circumcision studies.[308]

**UN Work Plan on Male Circumcision: November 2005**

The UN Work Plan on Male Circumcision was established in the August 2005 timeframe with support from the UNAIDS secretariat, WHO, UNICEF, UNFPA, and the World Bank, funding assistance was provided by the Bill and Melinda Gates Foundation, US National Institutes of Health (NIH), UNAIDS Secretariat and the French Agence Nationale de Recherches sur le SIDA.[309] Each of the funders involved in the UN Work Plan were also involved in funding research related to male circumcision and HIV.

Although the UN was cautious in proceeding towards making guidance or policy recommendations, they believed that there was merit in coordinating a UN Work Plan on male circumcision. Irrespective of the Kenya and Uganda results, the UN argued that the

[307] Wainberg, Mark 2005:2. Randomized clinical trial shows male circumcision has great potential to curb HIV infections in Africa.
[308] UNAIDS et al. 2005. Statement on South African trial findings regarding male circumcision and HIV; Bailey, Robert et al. 2007:644. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial.
[309] UNAIDS 2006:6. Regional consultation on safe male circumcision and HIV prevention; United Nations 2005:2. Work plan on male circumcision and HIV.

findings from the Orange Farm trial could lead to an increased demand for safe circumcision services, thus the initiation of an action plan seemed prudent and timely.[310]

The UN Work Plan was focused on developing practices for ensuring safety and establishing a policy and programming framework based on sound scientific, ethical and technical parameters.[311] In addition to strengthening existing circumcision services, the plan would allow for timely and relevant guidance on male circumcision services upon the completion of the RCT's in Kenya and Uganda.[312]

From July to September 2006, the UN Work Plan group held country level consultations with five countries in sub-Saharan Africa (Lesotho, Kenya, Swaziland, Tanzania and Zambia) as these countries had shown an interest in learning more about the subject of male circumcision and HIV.[313] The UN group also assisted in coordinating four major consultations on male circumcision, which took place from November 2006 to March 2007.

The literature also highlighted that a second UN Work Plan for male circumcision was introduced, the plan was to of have been led by the WHO. The second work plan was expected to provide the necessary framework and guidance to assist countries with providing safe male circumcision services for their respective populations.[314]However, the researcher was unable to locate further information relevant to this second plan, thus further clarification was not possible.

**First International Consultation: UNAIDS November 20-21, 2006 - Nairobi**

On November 20-21, 2006, UNAIDS and its partners hosted the first of four consultations on male circumcision. The meeting held in Nairobi, Kenya provided participants with a venue to openly discuss male circumcision and HIV prevention. The consultation had 50 participants with approximately 40% represented from African governments and civil society; the remaining attendees came from WHO, UN agencies, international AIDS organization and academic institutions. The purpose of the gathering was to initiate progress towards developing policies and action plans premised on the assumption that Kenya and Uganda

[310] United Nations 2005:2. Work plan on male circumcision and HIV.
[311] Ibid:2.
[312] UNAIDS 2006:3. Regional consultation on safe male circumcision and HIV prevention.
[313] Ibid:5.
[314] WHO 2006:9. Strategies and approaches for male circumcision programming.

RCT's would produce the same results as Orange Farm.[315] Furthermore, participants agreed that it was an appropriate time to progress from "learning of the evidence to active planning to meet increasing demand for safe male circumcision services."[316]

The UN argued in the follow-up report that it was a "country's responsibility to act on the compelling evidence of the protective effect of male circumcision on HIV infection – inaction is unethical for a number of reasons ranging from safety concerns to depriving young men of prevention services in high incidence settings, and is therefore not an option."[317] Thereafter the UN concluded that if the Kenya and Uganda trials were stopped at the next DSMB review (December 13, 2006) the UN would proceed immediately with next steps including, scheduling a policy meeting, release of briefing packages, presentation of modeling data (i.e. numbers of HIV infections and deaths averted), and lastly normative and technical guidance.[318] Thereafter, the UN set March 2007 as their target date for issuing the normative and technical guidance on male circumcision.

**Second International Consultation: WHO December 5-6, 2006 - Geneva**

The next consultation took place two weeks later on December 5-6, 2006, in Geneva Switzerland. This meeting was led by WHO representatives and the subjects discussed included: the safe delivery of male circumcision services, service strategies located in the framework of human rights and ethics, utilization of male circumcision to broaden male sexual and reproduction health, and lastly the roles of service providers.[319] The meeting had 50 participants as was the case in Nairobi, with approximately 26% from African governments and civil society; with the remaining attendees coming from WHO, UN agencies, international AIDS organizations and academic institutions.

Some of the key topics that were discussed during the meeting report included, the appropriate strategies for HIV positive men, definition of high risk groups, approach for neonates, role of traditional healers and lastly a recommendation that "non-physician (mid-level) providers be trained in surgical techniques for male circumcision."[320] Another key issue taken from the Geneva consultation was the emphasis placed on learning from the past

[315] UNAIDS 2006:5. Regional consultation on safe male circumcision and HIV prevention.
[316] Ibid:5.
[317] Ibid:5.
[318] Ibid.
[319] WHO 2006. Strategies and approaches for male circumcision programming.
[320] Ibid:6.

to ensure a successful field implementation for male circumcision and HIV prevention. WHO supported this position based on citing examples of other family planning and reproductive health service programmes that had failed when not adequately prepared to introduce new technologies.[321]

Lastly, the consultation introduced the need for adequate costing and modeling forecasts to accurately assess the impact of male circumcision on population level HIV prevalence with the associated financial cost for the program. The report went on to highlight how Lesotho, Swaziland and Zambia had already started to analyze the potential impact of male circumcision on their respective populations.[322] The expected outputs from the financial analysis were the cost of circumcision per individual; the financial resources, required number of infections averted, and the cost per infection averted under various scenarios; and lastly a report on the status of male circumcision in Lesotho."[323]

Demand Creation

One of the key themes that emerged from the literature was the concept of 'demand' this word was frequently used in publications and quotes relating to male circumcision and HIV prevention. WHO argued in the Geneva meeting report that the principles of demand management and demand creation should be recognized when considering roll out strategies for male circumcision. [324] For if there was demand created for male circumcision, without the structures in place to deliver the services it could possibly result in negative outcomes.[325] However at the same time "if only demand management is done, it might for example make male circumcision safer, but it would not change the overall circumcision prevalence over many years, and therefore would not affect HIV incidence."[326]

Thus, WHO and the meeting participants concluded that demand creates action, therefore when considering male circumcision a "proactive and reactive approach" should be considered.[327] Furthermore, it was concluded, "that in the absence of real action, the increase in male circumcision demand would probably be modest."[328] This was the case in South

[321] WHO 2006:56 Strategies and approaches for male circumcision programming.
[322] Ibid:26.
[323] Ibid:26.
[324] Ibid:20.
[325] Ibid:21.
[326] Ibid:21-22.
[327] Ibid:21.
[328] Ibid:22.

Africa, where little demand was created for male circumcision services even with significant amounts of media attention reporting on the findings of the Orange Farm trial.[329]However, the opposite occurred in Swaziland, here WHO argued that the demand was created because of public discussions and engagements on male circumcision[330] Thus, it was established within the meeting report that the role of advocacy was a critical component in creating demand and for gaining support for the services required to implement male circumcision programs. The authors of the report also highlighted how if it was not for advocacy efforts, ARV treatments would have never been rolled out, furthering the rationale for demand creation through advocacy.[331]

Relating to this topic of demand creation another key document highlighted the emphasis and strategy of utilizing demand to advocate male circumcision services. Before the Geneva meeting WHO had released a statement with the headline:

> Demand for male circumcision rises in a bid to prevent HIV: Demand for male circumcision as a method of combating HIV/AIDS is likely to increase dramatically if the results from two studies, in Kenya and Uganda, are positive. Public health experts are warning men, however, that circumcision may reduce the risk of HIV infection but it does not provide full protection.[332]

The press release highlighted how the demand for affordable and safe male circumcision services was growing and named the following countries in reference Botswana, Lesotho, Swaziland, Tanzania, Zambia and South Africa.[333] The article went on to provide statements from African leaders and medical researchers to substantiate the growing excitement for male circumcision.[334] The following were affirmations made: Marwick Khumalo, a Member of Parliament (MP) in Swaziland urged his fellow citizens "All male children should be circumcised. To show my seriousness, I have taken all my sons for circumcision."[335] MP Jimmy Angwenui from Kenya pronounced, "In order to stop the spread of HIV/AIDS male circumcision should be made mandatory by the government."[336] Lastly, Dr. Venter, Clinical Director of Reproductive Health and HIV-Research at the University of Witwatersrand

[329] WHO 2006:21-22. Strategies and approaches for male circumcision programming.
[330] Ibid:22.
[331] Ibid:22.
[332] WHO 2006. Bulletin: Demand for male circumcision rises in bid to prevent HIV.
[333] Ibid:1.
[334] Ibid:1.
[335] Ibid:1.
[336] Ibid:1.

advocated "male circumcision as one of the best protective measures. One of the beauties of circumcision is that it is a one-off operation, which takes 16-20 minutes but then has a profound effect on the rest of a man's life. Whereas to promote condom use or microbicides, repeated long-term promotion is needed."[337]

When considering the overall effectiveness of utilizing male circumcision as a method to reduce population level prevalence was premised on a formula that required a rapid scale up of circumcised men.[338] It becomes strikingly obvious the apparent conflict and challenge of creating demand while remaining sensitive to culture, religious, gender and societal factors.

**Male Circumcision RCT's: Uganda and Kenya**

On December 12, 2006, one week after the Geneva consultation and three weeks after the Nairobi consultation the DSMB declared that the evidence from the Uganda and Kenya trials demonstrated that male circumcision was highly effective and it was unethical to continue withholding circumcision from the uncircumcised participants.[339] The Uganda RCT for male circumcision started enrollment in July 2005, and on December 12, 2006, the study was stopped early. Findings were published in February 2007. The study team was led by principal investigator Dr. Ronald Gray, from Johns Hopkins University, Baltimore, MD USA and funded by NIH. Furthermore, the trial was conducted at the site of Rakai, a rural region of Uganda.

The Rakai trial comprised 4966 uncircumcised men ranging from the age 15 to 49 years who were randomized into two groups.[340] The control group was not circumcised and consisted of 2522 HIV negative men, which had 43 cases of HIV infections during the study period. The intervention group consisted of 2474 HIV negative circumcised men, which had 22 incidences of HIV infections during the study period.[341] The study's authors concluded, "male circumcision reduced HIV incidence in men without behavioural disinhibition. Circumcision can be recommended for HIV prevention in men."[342] It was also noted that the circumcised group of men had a 51% efficacy protection compared to the group not circumcised.

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[337] WHO 2006:1 Bulletin: Demand for male circumcision rises in bid to prevent HIV.
[338] Williams, Brian et al. 2006. The potential impact of male circumcision on HIV in sub-Saharan Africa.
[339] UNAIDS, WHO and UNICEF 2008:2. Male circumcision: Africa's unprecedented opportunity.
[340] Gray, Ronald et al. 2007:657. Male circumcision for HIV prevention in young men in Rakai, Uganda: a randomized controlled trial.
[341] Ibid:657.
[342] Ibid:657.

The Kenya RCT for male circumcision started enrollment in September 2005, and was stopped early on December 12, 2006 by the study's DSMB for the interim findings showed a substantive health benefit to the group circumcised. The findings were published in February 2007. The study team was lead by principal investigator Professor Robert C. Bailey University of Illinois at Chicago, USA and funded by NIH. The trial was conducted at the site of Kisumu; a city located in western Kenya that was mainly comprised of members of the Luo culture. In 2003, the MoH reported a HIV prevalence of 25% in Luo women and 18% in Luo men.[343]

The Kisumu trial comprised 2784 uncircumcised men ranging from the age 18 to 24 who were randomized into two groups.[344] The control group was not circumcised and consisted of 1393 HIV negative men, which had 47 cases of HIV infections during the study period. The intervention group consisted of 1391 HIV negative circumcised men, which had 22 incidences of HIV infections during the study period.[345] At the conclusion of the study, all male participants were immediately circumcised. The trial concluded that male circumcision significantly reduced a young man's risk of becoming infected with HIV providing a protective effect of 53%.[346]

On December 13, 2006 one day after the trials were closed the sponsoring agent of the Kenya and Uganda trials NIH held a telebriefing in the United States. The primary attendees at the conference briefing included all primary investigators involved in the Kenya and Uganda trials, Dr. Anthony Fauci, Director of National Institute of Allergy and Infectious Diseases of the United States National Institutes of Health (NIAID), Kevin De Cock, WHO HIV/AIDS Division, Kim Dickson, WHO, and Catherine Hankins, UNAIDS.[347] The telebriefing highlighted the findings of the trials and discussed subjects relating to efficacy, risks, costs behavioural modifications, and the role countries must play in rolling out male circumcision.

Dr. Anthony Fauci during the press conference discussed the impact of male circumcision and the forecasts relating to new infections and preventable deaths. However he also urged caution when discussing the possible impact of male circumcision he argued that "you could possible avert, you know up to two million infections. But again having said that, I'd like to

[343] Bailey, Robert et al. 2007:644. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial.
[344] Ibid:643.
[345] Ibid:643.
[346] Ibid:653.
[347] NIAID 2006:1. Update on NIAID-sponsored adult male circumcision clinical trials.

please caution the press on this call that we've got to be very careful when you talk about mathematical models. OK."[348] During the briefing the role of donor funding emerged, it was highlighted that there was an immediate need to engage donors with the results and to discuss possible plans forward, including discussions with PEPFAR and the Global Fund.[349]

In response to a question on cultural barriers and male circumcision, Kevin De Cock discussed the importance of getting the opinions and involvement of communities.[350] He argued that male circumcision was a topic that drew controversy and strong opinions across the world, and for that reason it was critical to engage those countries's affected by the recommendation and to ensure local communities and governments were engage in the acceptability of male circumcision.[351]

Another key discussion related to a question on the risk of men engaging in sex before their circumcision wound had fully healed. Dr. Maria Wawer from the Uganda research team clarified the findings from the Rakai study; she stated that approximately 10% of the men who had engaged in sex before the designated healing period did so just a few days before it was considered acceptable. Furthermore, Wawer acknowledged, "overall, men really did comply well." [352]

Interestingly, another clinical trial conducted in Rakai and funded by the Bill and Melinda Gates Foundation was notified to stop enrolling participants on December 12, 2006, for the study's DSMB had "determined futility with respect to the female HIV outcome."[353] The reason given for stopping enrollment was the study's findings showed a significantly higher rate of HIV infections in the women partners of HIV-positive men, for couples had resumed sex before the recommended healing period.[354] These findings were not discussed during the NIH telebriefing and outside of the NIH online clinical trial database the researcher was unable to locate any further confirmation specific to the December 12, 2006 notification date. Furthermore, the NIH trial summary stated the DSMB report was defined as closed, thus unavailable for the public review.

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[348] NIAID 2006:6. Update on NIAID-sponsored adult male circumcision clinical trials.
[349] Ibid:11.
[350] Ibid:10.
[351] Ibid:10.
[352] Ibid:12.
[353] NIH 2008:1. Trial of male circumcision: HIV sexually transmitted disease (STD) and behavioral effects in men, women and the community.
[354] Ibid:1.

**Third International Consultation: UNAIDS and CAPRISA January 18-19, 2007 - Durban**

On January 18-19, 2007, the third consultation was organized by UNAIDS and CAPRISA, in Durban, South Africa. The event was organized to engage social scientist perspectives on male circumcision for HIV prevention and was designed to explore the cultural and social implications related to the scale up of male circumcision. The event had about 30 participants with approximately 53% from African governments or civil society.[355]

The limited report from this event highlighted the concern that social science research had not been adequately included during the process of evaluating male circumcision. It appeared from the summary report that a significant portion of the meeting was focused on discussing the reasons for the limited role of social sciences within the debates of HIV prevention. The following quote taken from the meeting report assists to clarify these observations "social science seems to have been a somewhat neglected area of science in relation to HIV, in contrast to biomedical science."[356]

In conclusion, the meeting participants identified that there was a need for a greater awareness of the contextual issues relating to male circumcision and how these factor may vary by society. Furthermore, they recommended that a multi-disciplinary approach should be considered when planning male circumcision and HIV prevention programs.[357] For this approach would provide the means to establish participation from a broader range of scientific disciplines, which in principle would improved the probability of implementing male circumcision programs that are effective.[358]Lastly, it was argued that there was a need to build social science research capacity if serious efforts were to be made to address the topics relating to male circumcision and HIV prevention.

**Fourth International Consultation: WHO and UNAIDS March 6-8, 2007 - Montreux**

The final consultation conducted before WHO and UNAIDS made their March 28, 2007 policy recommendation was held on March 6-8, 2007 in Montreux, Switzerland. The meeting was convened approximately 3 months after the first consultation and one month after the

[355] UNAIDS and CAPRISA 2007:20-22. Consultation on social science perspective on male circumcision for HIV prevention.
[356] Ibid:15.
[357] Ibid:15.
[358] Ibid:15-16.

findings of the Kenya and Uganda RCT's were published. The number of participants was estimated from an interview to be approximately 80 and the types of attendees included government, researchers, gender experts, human rights and health advocates, donors, youth and implementation partners. The objective of the event was to present the evidence and achieve consensus that male circumcision should be recommended as part of an overall comprehensive HIV prevention programme. Catherine Hankins, Chief Scientific Officer, UNAIDS provided the following account of the Montreux consultation:

> It was done in a meeting with over 80 people. It was done in a traditional consultation like we have all the time that weighs the evidence, the evidence is presented, people argue about it, they question the data and then we come up, the meeting comes up with recommendations. So in that meeting there were human rights' experts, there were gender experts, women's groups, activists, people with HIV – it was a broad range, we brought everybody who could have anything to say into the room including people who were completely opposed to male circumcision, totally opposed to it, and it's only in doing that, it is not one person that sits somewhere and decides something.[359]

In the meeting report WHO and UNAIDS identified two conditions that would most likely need to exist if male circumcision was to be considered as a tool to prevent HIV infections. First, the state of the epidemic and second, the number of men circumcised in a region. To further clarify their position the following quote was taken from the WHO and UNAIDS meeting report, "the greatest potential public health impact will be in settings where HIV is hyper-endemic (HIV prevalence in the general population exceeds 15%), spread predominantly through heterosexual transmission, and where a substantial portion of men (e.g. greater than 80%) are not circumcised."[360] In addition to the two conditions just discussed, WHO and UNAIDS further clarified that male circumcision would most likely not have a significant impact on reducing population level HIV prevalence unless it could be scaled up rapidly.[361]

To assist in providing participants with the relevant knowledge to make an informed decision on male circumcision and HIV prevention the consultation provided various forms of evidence. Presentations on the efficacy of male circumcision focused primarily on the

[359] Hankins, Catherine April 22, 2008. UNAIDS, Chief Scientific Officer and Associate Director Evidence, Monitoring and PolicyInterview.
[360] WHO and UNAIDS 2007:7. New data on male circumcision and HIV prevention: Policy and programme implications.
[361] Ibid:7.

evidence gathered from the three RCT's with support from earlier observational studies. Significant emphasis was placed on the acceptability of male circumcision, for it was argued that numerous studies had been completed with the majority demonstrating both men and women approved of the procedure and would recommend it for their children and partners.

Lastly, there appeared to be a focus on introducing the modeling data that had been completed on the feasibility and cost effectiveness of male circumcision. The cost-effectiveness studies compared the cost per infection averted to the cost of lifetime ARV treatments, and surmised that male circumcision could have substantial cost-benefits.[362] Furthermore, the modeling forecasts presented at the consultation suggested that, "universal male circumcision in sub-Saharan Africa could prevent 5.7 million new cases of HIV infection and 3 million deaths over 20 years."[363]

Another key event that occurred during the Montreux consultation was the announcement of interim results from a study that was also being conducted in Rakai, Uganda.[364] The research was led by principal investigator Maria Wawer from Johns Hopkins University, Baltimore, MD USA and funded by the Bill and Melinda Gates Foundation.[365] The study evaluated the effect of male circumcision on HIV-negative women who had HIV-positive male partners, in 70 couples - the men were circumcised and in 54 couples - the men were not circumcised.[366] The six-month review found 11 cases of HIV infections in the female partners of the 70 men circumcised and only 4 incidents of HIV infection in the female partners of the 54 men not circumcised.[367]

The Associated Press reported a headline '*Circumcision may lift HIV risk for women*', they went on to present the preliminary findings from Uganda and highlighted that the increased risk to women was as a result of men engaging in sex before the healing period had ended.[368]

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[362] WHO and UNAIDS. 2007:33. Draft Male circumcision: global trends and determinants of prevalence, safety and acceptability; WHO 2006:26. Strategies and approaches for male circumcision programming.
[363] WHO and UNAIDS 2007:7. New data on male circumcision and HIV prevention: Policy and programme implications.
[364] Rakai 2007. Study presents new information on male circumcision to prevent spread of HIV in Africa; New Scientist Tech. 2007. Male circumcision to fight HIV poses risk to women..
[365] New Scientist Tech. 2007. Male circumcision to fight HIV poses risk to women; Roberts, Anne 2007. Male circumcision could increase AIDS risk for female partner: Study.
[366] Rakai 2007. Study presents new information on male circumcision to prevent spread of HIV in Africa; Cheng, Maria 2007. Circumcision may lift HIV risk for women; New Scientist Tech. 2007. Male circumcision to fight HIV poses risk to women. Roberts, Anne 2007. Male circumcision could increase AIDS risk for female partner: Study.
[367] Ibid.
[368] Cheng, Maria 2007. Circumcision may lift HIV risk for women.

The lead investigator remarked, "We need to err on the side of caution to protect women in the context of any future male circumcision programme."[369]

The study was reported to have been the first clinical trial conducted to produce scientific evidence on the effects of male circumcision on their female partners.[370] Furthermore, the findings varied significantly from the previous observational studies completed by Johns Hopkins University on male circumcision and its effect on women. For in 2006, a statistical review of 300 couples medical records in Uganda resulted in the authors concluding that HIV-negative females had a 30% reduced chance of becoming infected with HIV if their HIV-positive male partners were circumcised.[371]

These findings from the Uganda clinical trial were in part supported by the concerns outlined in Williams et al. modeling study.[372] Within the studies, methods and findings section the authors argued that male circumcision would increase the proportion of women infected from the current 52% to 58% (UNAIDS 2004 statistics).[373] Furthermore, Catherine Hankins UNAIDS also claimed in her published article "already mathematical modeling suggests that in the medium term the proportion of people living with HIV in sub-Saharan Africa who are women may rise as male circumcision programmes are scaled up in high HIV prevalence settings, due to the lag time for indirect effects for women to be felt."[374]

The consensus reported from the Montreux consultant in response to the new clinical evidence on male circumcision and women's HIV risk was - the findings would not impact the decision to proceed with male circumcision, however proceed with caution.[375] The following statement by Kevin De Cock was an example of the majority view "while male circumcision has extraordinary potential to prevent HIV infection, these new findings remind us that we must proceed with thought and care in developing strategies to explain male circumcision in Africa."[376]

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[369] Cheng, Maria 2007:2. Circumcision may lift HIV risk for women; New Scientist Tech. 2007. Male circumcision to fight HIV poses risk to women.
[370] Altman, Lawrence 2008. Male circumcision no aid to women in study.
[371] Johns Hopkins University 2006. Review shows male circumcision protects female partners from HIV and other STDs.
[372] WHO and UNAIDS 2007. New data on male circumcision and HIV prevention: Policy and programme implications
[373] Williams, Brian et al. 2006. The potential impact of male circumcision on HIV in sub-Saharan Africa.
[374] Hankins, Catherine 2007:63 Male circumcision: implications for women as sexual partners and parents.
[375] Cheng, Maria 2007. Circumcision may lift HIV risk for women; New Scientist Tech. 2007. Male circumcision to fight HIV poses risk to women. Roberts,
[376] Cheng, Maria 2007. Circumcision may lift HIV risk for women.

**WHO and UNAIDS March 28, 2007 – Issued Endorsement for Male Circumcision**

Two weeks later on March 28, 2007 a commanding endorsement for male circumcision was issued jointly by WHO and UNAIDS, the policy paper reviewed the findings from the trial and stated, "The efficacy of male circumcision in reducing female to male transmission of HIV has been proven beyond reasonable doubt. This is an important landmark in the history of HIV prevention."[377]

The report highlighted 11 conclusions and recommendations which were developed from the WHO and UNAIDS consultation in March: "1) The research evidence is compelling, 2) Male circumcision does not provide complete protection against HIV, 3) Correct communication and messages on male circumcision are critical, 4) The socio-cultural context should inform male circumcision programming, 5) Human rights, legal and ethical principle must guide service delivery, 6) The gender implications of male circumcision as an HIV prevention method must be addressed, 7) Programmes should be targeted to maximize the public health benefit, 8) Health services need to be strengthened to increase access to safe male circumcision services, 9) Additional resources should be mobilized to finance the expansion of safe male circumcision services, 10) Promoting circumcision for HIV-positive men is not recommended and 11) research is needed to guide programme implementation."[378] The document provided summary conclusions relating to each of these factors, however the report was 10 pages in total, thus it appeared that the endorsement was primarily issued to confirm the decisions made from the consultation in March 2007.

Furthermore, in a press release covering the announcement WHO and UNAIDS emphasized the need to incorporate male circumcision into a comprehensive HIV prevention package.[379]Significant emphasis was placed on ensuring there was an appropriate messaging strategy when rolling out male circumcisions. The rationale was premised on the concern that a man would engage in risky sexual behaviours due to a false sense of protection and the belief he no longer become infected with HIV, which might undermine the partial benefits of male circumcision.[380] WHO and UNAIDS also presented that experts at the consultation felt

[377] WHO and UNAIDS 2007:3. New data on male circumcision and HIV prevention: Policy and programme implications.
[378] Ibid:3-10.
[379] WHO 2007. WHO and UNAIDS announce recommendations from expert consultation on male circumcision for HIV prevention.
[380] Ibid.

it was prudent to try to provide male circumcision services free to the public or at the lowest cost possible.[381]

Lastly, five key areas of additional research were recommended to assist with developing further programs, they included: impact on HIV-positive men to women; benefits of male circumcision on women's health; risk and possible benefits of male circumcision on HIV-positive men; the effect of male circumcision on homosexual and heterosexual anal intercourse; and additional knowledge on the methods, resources and services required to produce quality and effective male circumcision programs.[382]

**Conclusion**

The task of establishing a timeline with key milestones provided the researcher with a method to gain insight into how each event and decision relating to the endorsement of male circumcision transpired. There has been significant literature narrating the chronological history of the scientific evidence supporting male circumcision. However, what was unique about this review was the use of data to establish how the processes and decisions relating to the science possibly influenced the urgency and veracity of WHO and UNAIDS recommendation.

By evaluating WHO and UNAIDS role within this process the researcher can better evaluate how male circumcision was position compared to previous interventions. It also established a means to critique WHO and UNAIDS role and authority. Furthermore, it provided the evidence to verify statements and claims relating to why certain decisions were made and how certain events transpired.

[381] WHO 2007. WHO and UNAIDS announce recommendations from expert consultation on male circumcision for HIV prevention.
[382] Ibid.

## Chapter Four: Why did WHO and UNAIDS endorse Male Circumcision

The data collected from the interviews and documents analysis phase of this research have produced the framework for explaining why WHO and UNAIDS endorsed male circumcision as a public health initiative for HIV prevention in sub-Saharan Africa. The findings from this study showed that the *evidence-based research, their consultative process*, and the *state of the epidemic* in sub-Saharan Africa collectively constituted the rationale behind why WHO and UNAIDS issued an endorsement for male circumcision. Additionally this research will argue that the modeling studies were the catalyst and justification for understanding why the intervention was promoted as a public health initiative.

Furthermore, when questioned on the urgency and motivation behind their decisions WHO and UNAIDS often responded with a 'why wait' approach. Through defining the principles behind this point of view, it provided the means to examine how their ideologies might have influenced the process used to evaluate male circumcision. The following sections will provide evidence to support these arguments.

### 1. Evidence-based Research

This research concludes that one of the reasons why WHO and UNAIDS endorsed male circumcision as an intervention for HIV prevention in sub-Saharan Africa was the comprehensive body of evidence collected over the last 20 years. There were various methods of research conducted during this time including, RCT's, observational, ecological, modeling and acceptability studies. However, the evidence that appeared to have the greatest influence on WHO and UNAIDS announcement was the RCT's, modeling and acceptability studies. When Catherine Hankins UNAIDS Chief Scientific Officer and Associate Director Evidence, Monitoring and Policy was asked why they had made their endorsement, she stated:

> We do not have another example in HIV prevention, we certainly do not and you would have to look pretty far and wide to find something else where you have 20 years of observational and ecological data followed by 3 trials not 1. Many people would make a move on 1 trial but 3 trials, all saying the same thing, incredibly confirmatory of the same findings.[383]

[383] Hankins, Catherine April 22, 2008. UNAIDS Chief Scientific Officer and Associate Director Evidence, Monitoring and Policy.Interview.

Her view that WHO and UNAIDS had considered a broad range of evidence before making their final endorsement was also supported in chapter 3. When responding to why the endorsement was made, Professor Robert Bailey the lead principal investigator for the Kenya trial provided this assessment of their comprehensive approach,

> Because the evidence is overwhelming. We have not just the Orange Farm and the Kisumu and Rakai trials, which were remarkably consistent in their results and showed a very large effect, a 60% effect. We also have over 40 observational studies, we had strong biological evidence, in the face of all that evidence, I do not think they had a choice. I think they kind of acted slowly, but staring all that evidence in the face, they had no choice but to finally declare that male circumcision is effective in reducing HIV incidence.[384]

Each method will now be discussed to clarify why this study concludes that the RCT's, modeling and acceptability studies were key components of WHO and UNAIDS decision.

**Randomized controlled trials**

The scope of evidence on male circumcision was comprehensive. However, this study suggests that the three RCT's forced the change from theory to considering male circumcision as an important intervention for HIV prevention. Matthews defined the RCT method of research as an "experiment performed on human subjects to assess the efficacy of a new treatment for some conditions."[385] The narrative from chapter 3 and the data collected from the interviews explain why the RCT's were considered a catalyst for proceeding forward.

The most important reason for arguing that the RCT's were the factor that moved male circumcision from a research to a potential policy agenda was the fact health experts were unwilling to proceed without the clinical evidence. Although there was support for male circumcision the majority of experts still questioned the historical findings and demanded RCT evidence. This view was clarified in chapter 3 and additionally Catherine Hankins argued, "the reason the trials were done was because of the fact that people couldn't control for confounding variables such as behaviour associated with religion."[386]

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[384] Bailey, Robert March 20, 2008. University of Illinois Chicago, Professor. Interview.
[385] Matthews, John 2006:1. Introduction to randomized controlled clinical trials.
[386] Hankins, Catherine April 22, 2008. UNAIDS Chief Scientific Officer and Associate Director Evidence, Monitoring and Policy.Interview.

RCT's have achieved elite status in the research fraternity because experts regard them as the most reliable and valid form of evidence. Furthermore, when considering the three standards of research generalizability, validity, and reliability the RCT's basic design takes advantage of these principles by limiting the influence of participant's behaviour on a study's outcome. RCT's have primarily been used in conducting drug trials where a placebo was administered to the control group and the medicine to the intervention group, providing an environment where all participants remain unaware of whether they have been given the medicine or the placebo.[387] This lack of knowledge ultimately reduces the effects of behavior on the trials outcomes. In the instance of the male circumcision trials the surgical element eliminated the ability for 'procedure anonymity' however, the clinical nature of the study was still believed to be far more reliable, valid and generalizable then study's based on observation or medical records.

The scientific and medical communities have historically classified RCT's as the gold standard of medical research. Kevin De Cock, Director of WHO HIV/AIDS Division and Sibongile Dludlu, Male Circumcision Consultant for UNAIDS verified this view existed amongst AIDS professionals when they stressed, "randomized controlled trials were the gold standard"[388] of evidence. Furthermore, expert Warren Parker, Executive Director of CADRE remarked, "when one of these randomized controlled trials comes out, it is supposedly the gold standard of evidence."[389] When Kevin De Cock was asked why they made their endorsement, he emphasized many of the characteristics that have made RCT's the gold standard,

> The fact that three were done and are so consistent in different geographic context, different social context and so consistent with the previous data that I think it is very, very persuasive and convincing. I think we have adequate data to strongly make those recommendations, which it is all about.[390]

Catherine Hankins earlier discussed that WHO and UNAIDS held off on their endorsement until all three trials were completed. The weight they gave to the collective results of the RCT's was also confirmed when WHO, UN agencies and Bertran Auvert stated at the

[387] Matthews, John 2006:1. Introduction to randomized controlled clinical trials.
[388] Dludlu, Sibongile April 23, 2008. UNAIDS Consultant Male Circumcision. Interview.
[389] Parker, Warren March 27, 2008. CADRE, Executive Director. Interview.
[390] De Cock, Kevin March 23, 2008. WHO, Director of HIV/AIDS. Interview.

completion of his Orange Farm trial that any future policy considerations would be subject to the results of the Kenya and Uganda male circumcision studies.[391]

The emphasis given to the three trials consistency and generalizability was unanimously supported by all WHO and UNAIDS participants, Catherine Hankins provided an example of this passion when she proclaimed the evidence was "so compelling you do not walk away from it, it is unethical to walk away from it."[392]Hankins' opinion was also expressed in the 2006 Nairobi consultation report, where the UN stated that it was a "country's responsibility to act on the compelling evidence of the protective effect of male circumcision on HIV infection – inaction is unethical for a number of reasons ranging from safety concerns to depriving young men of prevention services in high incidence settings, and is therefore not an option."[393]

An important element for constructing the argument that WHO and UNAIDS decision was heavily influenced by the RCT evidence was achieved through examining the experts responses to why they believed WHO and UNAIDS made the endorsement. When Keymanthri Moodley, Professor at Bioethics Unit Tygerberg Division, was asked why, she replied, "the scientific evidence from all three trials was regarded as reliable, valid, and generalizable within the sub-Saharan setting."[394] Her response was reflective of the majority view that the RCT's were a decisive factor in explaining why WHO and UNAIDS issued their endorsement, irrespective of whether the expert agreed with their decision. Leickness Simbayi, Executive Director of HSRC HIV/AIDS & Health Programme, provided another perspective, he responded:

> The major reason why they are recommending their position is really having 3 randomized controlled trials suggest the efficacy of something, albeit partially, because they say its 60%. It is really one of the best news that has come out of prevention research for a long time. So it is the quality of the evidence that is available, randomized controlled trials are meant to offer definitive proof about casual relationships or particularly how effective an intervention is and here were 3 RCT's which are basically in agreement.[395]

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[391] UNAIDS et al. 2005. Statement on South African trial findings regarding male circumcision and HIV; Bailey, Robert et al. 2007:644. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial.
[392] Hankins, Catherine April 22, 2008. UNAIDS Chief Scientific Officer and Associate Director Evidence, Monitoring and Policy Interview.
[393] UNAIDS 2006:5. Regional consultation on safe male circumcision and HIV prevention.
[394] Moodley, Keymanthri April 14, 2008. Bioethics Unit Tygerberg Division, Professor. Interview.
[395] Simbayi, Leickness April 14, 2008 HSRC, Social Aspects of HIV/AIDS & Health Programme, Executive Director. Interview.

Another aspect of the RCT evidence that drew attention was the efficacy percentage derived from each trial. Both WHO and UNAIDS emphasized the efficacy outcomes and furthermore reasoned it was equivalent to a vaccine. Kevin De Cock explained why he believed the efficacy percentage was important, he stated:

> It is extremely unusual to come up with a once only biomedical – a once only medical intervention with 60% efficacy to prevent transmission acquisition in men; it is very unusual to come up with something like that in HIV prevention science. I think people are underestimating what this actually represents. If you had a vaccine that had a 60% efficacy and we suddenly said, we will give people one dose of a vaccine and this is the reduction of HIV incidents you would get – people will say this is extraordinary, this is a major advancement. There has been this skepticism around circumcision because of everything around it and what it represents.[396]

A significant number of the experts also agreed with De Cock's opinion that the efficacy rating was a scientific accomplishment. The association to the equivalency of a vaccine was not as widely supported; however, there was a group of experts who did share his point of view. One of them was Professor Miriam Were, Chairperson of Kenya's National AIDS Control Council she remarked "male circumcision reduces the acquisition of HIV by more than 60% in otherwise it is as effective as the most effective vaccines."[397]

Expert concerns were predominately directed at the methodology and accuracy of the RCT findings, most often emphasizing the lack of planning, monitoring and reporting of participant's behaviour. Mary Crewe, Executive Director of the Centre for Study of AIDS highlighted several of the concerns,

> I think that the methodology of the trails is extremely flawed. I think you cannot do those kinds of randomized controlled trials on something like circumcision it just does not lend itself to that. We don't know enough about those trials, we don't know enough about what type of men were counseled we don't know enough about how the men were recruited we don't know enough about what kind of messages the men we're given. We do not know where this alleged demand for circumcision came from that they say these trials created, this great demand for circumcision, where did it come from, how was it created. We do not know anything about why the men believed it to be an advantaged to be circumcised, when they still

[396] De Cock, Kevin March 23, 2008. WHO, Director of HIV/AIDS. Interview.
[397] Were, Miriam April 11, 2008. Kenya National AIDS Control Council, Chairperson. Interview.

> have to use condoms; because it does not prevent infection, it simply lowers your risk. Why would men then be circumcised? What was the compelling reason that they gave as to why men should be circumcised if it merely lowers your risk, it does not prevent.[398]

During the interview with the lead principal for the Orange Farm trial, he clarified why some concerns may still exist even when conducting research with the gold standard of medical science. Dr. Auvert argued that behaviour rarely impacts drug clinical trials, however "circumcision of course they knew they were circumcised, so you can imagine that they could of changed their behaviour and they reported something different then what they have done."[399]

Another concern expressed by some experts was the need for additional reporting on the RCT's outcomes and furthermore the resources to gain clarification on such concerns. Anton van Niekerk, Professor at the University of Stellenbosch and Director for the Center for Applied Ethics shared an example, he remarked:

> One thing about the Orange Farm trial that I do not understand: Why was the six week period after the circumcisions took place not taken into consideration in terms of outcomes. One would have thought that because people were very strongly urged to refrain from sexually activities six weeks after the circumcisions took place that could well have had a significant influence on the reduced rates of infections. I have asked this question to many people, nobody seemed to come up with an answer, and it was not discussed in the literature I read.[400]

One of the themes that emerged out of the experts concerns was this balance between the need for excitement and a sense of realism, this distinction was captured in Professor van Niekerk reflection on the importance of the RCT findings. The Professor said:

> Look, I think those trials yielded significant information and I think one must act on that information. What is not negotiable is you make the recommendation with full counseling as to the complete picture, so people get a very, very well informed look, in the long run, this is a preventive measure but it is not full proof. [401]

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[398] Crewe, Mary April 15, 2008. Pretoria University, Centre for Study of AIDS, Executive Director. Interview.
[399] Auvert, Bertran March 19, 2008. University of Versailles French Institute of Health, Director. Interview.
[400] van Niekerk, Anton April 14, 2008. University of Stellenbosch and Center for Applied Ethics, Professor and Director. Interview.
[401] van Niekerk, Anton April 14, 2008. University of Stellenbosch and Center for Applied Ethics, Professor and Director. Interview.

In summary, WHO and UNAIDS considered the entire body of scientific evidence on male circumcision as instrumental in their overall analysis. Furthermore, the historical pessimism to proceed with policy discussions based on observation and ecological evidence alone was clearly documented in chapter 3 and supported by the interviews. In addition Cochrane explained the rationale behind the medical pessimism and highlighted that when used appropriately RCT's and cost-benefit analysis can improve the "effectiveness and efficiency" of medical interventions.[402] Thus, in conclusion the reason male circumcision transitioned from a research agenda to a policy agenda was the consistent and collective outcomes of three RCT's.

**Modeling**

This study has now shown that one of the pivotal reasons for understanding why WHO and UNAIDS initiated a process to evaluate male circumcision as a possible public health intervention for HIV prevention was the validity, consistency and reliability of the RCT evidence. This section will explain why the RCT evidence in isolation lacked the power to justify male circumcision as a public health initiative. The RCT's could kick off action but it took a far more complex analysis to justify a massive rollout at a population level.

At the start of this chapter, it was argued that the modeling evidence was the catalyst behind why WHO and UNAIDS recommendation was targeted at the public health establishments of sub-Saharan Africa. To rationalize this argument we must first establish the intent behind WHO and UNAIDS endorsement. The objective stated in the March 28, 2007 WHO and UNAIDS endorsement document, was to provide "policy and programme implications and to make recommendations regarding public health issues," and male circumcision.[403] WHO supported this stated objective during an interview, they argued, "the intent is to provide information to countries so that they can make their policies and programming accordingly."[404]

When experts were asked what was the intent behind WHO and UNAIDS endorsement it evoked various responses, however the dominant response emphasized policy guidance that was premised on the assumption that "they [WHO and UNAIDS] would like to see national

[402] Gerhardt, Chloe.1995:67. Criticisms of biomedicine. *Society and health.*
[403] WHO and UNAIDS 2007:2. New data on male circumcision and HIV prevention: Policy and programme implications.
[404] WHO, Anonymous. Interview.

scale circumcision programs in countries that are heavily affected."[405] Some of the confusion experts expressed relating to the actual intent of WHO and UNAIDS endorsement was reflected in two of the National AIDS Councils interviews. The following statements were provided in response to the question: What do you believe was WHO and UNAIDS intent in relation to male circumcision and policy? Dr. Ben Chirwa, Director General of Zambia National AIDS Council replied:

> Policy is a strong word, in fact, it has confused a lot of people, because when you say policy it is a government intent, which is not a specific specialty activity, it is a broad government intent of action for many years to come. So, for us we use policy with caution. What we are talking about are basic guidelines, maybe that is a caution I would like to give even to you, because immediately you start talking about circumcision policy you are giving broad and very strong intention to circumcision.[406]

Professor Miriam Were, Chairperson of Kenya's National AIDS Control Council, provided an alternative response to the same question, she remarked:

> I think it is for every country to make their policy and so that it becomes relevant, I think that is the intention. Hopefully, we in Africa hope that they will support us in doing this. How will the global community respond to this challenge by helping Africa to strengthen systems, I see it as a challenge to all of us rather than just WHO and UNAIDS.[407]

Once clarifying the endorsement was viewed as a public health initiative, we can begin to explain how modeling studies influenced various elements of WHO and UNAIDS recommendation. The literature review on public health discussed the rationale behind why modeling tools such as cost benefit analysis and other statistical methods have been used to inform decision-makers. Both Schneider and The World Bank argued that the only way to analyze the potential impact on population health and the corresponding justification for that expense was through statistical modeling. Therefore whether male circumcision was "worth pursuing at a public level was really driven by modeling."[408]

The timeline of male circumcision key milestones (chapter 3) highlighted how modeling was used to forecast the potential number of saved lives and adverted deaths. Williams and

[405] Harrison, David April 24, 2008. Love Life, Executive Director. Interview.
[406] Chirwa, Ben April 16, 2008. Zambia National AIDS Council, Director General. Interview.
[407] Were, Miriam April 11, 2008. Kenya National AIDS Control Council, Chairperson. Interview.
[408] Abdool Karim, Salim March 20, 2008. CAPRISA, Executive Director. Interview.

colleagues modeling forecast suggested that, "universal male circumcision in sub-Saharan Africa could prevent 5.7 million new cases of HIV infection and 3 million deaths over 20 years."[409] The outputs from these forms of models (most significantly the 2006 Williams and colleagues study) provided WHO and UNAIDS with the data needed to establish the framework to define where male circumcision would have the greatest impact on reducing population level infection rates. They concluded that if there was to be a significant impact on reducing new HIV infections the intervention would need to be scaled up rapidly; and in locations with hyper-epidemics and low levels of circumcision.[410]

The Williams and colleagues paper drew significant attention from the media. The majority of press coverage, which transpired between the NIH teleconference and Montreux consultation, consistently referenced their projected number of saved lives and adverted infections statistics. Another key component of their modeling findings centered on the extensive period of time that it would take before population level benefits might be incurred. Warren Parker, Executive Director of CADRE provided a critique of the modeling process,

> I saw the most appalling modeling going on around circumcision, which implied this sort of massive impact usually done by economic models, which have absolutely no idea of the complexity of the context. With that said, I think the WHO report by Williams raised as an important point that it is a 20 to 30 year project and not a quick fix. At the time it came out, it contradicted many of the sorts of glory parades around this intervention. They were predicting massive impact much sooner.[411]

Dr. Salim Abdool Karim, Executive Director of CAPRISA who participated in the Montreux consultation and hosted the Social Sciences consultation in Durban with UNAIDS, discussed the importance of William and colleagues modeling projections. He, as did Parker pondered if and how the projections could be achieved at a population level. He stated:

> Well there is no question that it [male circumcision] is effective, it is a question of whether it actually turns the epidemic, as we are hoping it to and I do not think it is going to do that, because I do not think we will be able to get it out - implement it in the scale required to have an impact. That is not to say it does not work at an individual level, if I am circumcised I am less at risk, we are not talking about an individual level, we are talking about population level.

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[409] WHO and UNAIDS 2007:7. New data on male circumcision and HIV prevention: Policy and programme implications.
[410] Ibid:7.
[411] Parker, Warren March 27, 2008. CADRE, Executive Director. Interview.

> To turn an epidemic at a population level you really have to do this to a very large scale. If you take South Africa, where 34% of men are already circumcised, that means we need to get another 50 to 60% of men circumcised.[412]

WHO and UNAIDS agreed with Dr. Abdool Karim and argued that individual benefits might occur in the short term, however to impact population level infections it would take a massive scale up. In their Montreux recommendation paper, they detailed the complexity of achieving population level impact through the prioritization of various groups. They provided these scenarios "boys and young men before sexual debut are a relatively easy group to reach but measurable impact is not likely to be realized for over 10 years; if older boys and men up to the age 30 years are prioritized a more rapid effect can be expected. Circumcision of neonates, in whom the procedure is simpler and less risky, can be considered as a longer-term strategy to promote circumcision in the general population, but impact of this strategy on HIV incidence would not be expected for at least 20 years."[413]

The interviews provided additional evidence that WHO and UNAIDS placed significant importance on the need for a rapid scale up of male circumcision if the forecasts to reduce HIV infections were to be achieved. Kevin De Cock when asked: Do you believe strongly that in 10 years from now that male circumcision will make a quantifiable and identifiable reduction in HIV infections? He stated, "Only if it is scaled up to very high levels."[414] UNAIDS response to the issues of scale up remained consistent with De Cock's point of view, Catherine Hankins explained:

> If scaled up was slow you would not get the effects you would get if scale up was fast, and that is because there are indirect effects for women being less likely to encounter an HIV positive partner. So if you scale up very, very slowly and get to a target in 2015 as opposed to scaling up quickly and reaching your target in 2015 you get way more effectiveness if you do it faster. The limiting factor is as you say it is safety, making sure people are adequately trained and so on and so forth.[415]

The complexity of the balance between safety and having an impact on future HIV infections was expressed when WHO discussed possible roll out strategies for male circumcision, WHO

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[412] Abdool Karim, Salim March 20, 2008. CAPRISA, Executive Director. Interview.
[413] WHO and UNAIDS 2007:7. New data on male circumcision and HIV prevention: Policy and programme implications.
[414] De Cock, Kevin March 23, 2008. WHO, Director of HIV/AIDS. Interview.
[415] Hankins, Catherine April 22, 2008. UNAIDS Chief Scientific Officer and Associate Director Evidence, Monitoring and Policy.Interview.

argued "if only demand management is done, it might for example make male circumcision safer, but it would not change the overall circumcision prevalence over many years, and therefore would not affect HIV incidence."[416]Furthermore Sibongile Dludlu, UNAIDS Consultant for Male Circumcision added that the rate of scale up should not be at the cost of "encouraging stigma and discrimination" she asserted that this was not how the intervention was being put across and she did not think that this was how male circumcision should be scaled up.[417]

One of the most highly contested debates involving the scale up of circumcision was the inclusion of infants. Kevin De Cock argued, "We need to change societal norms to move towards infant circumcision, because infant circumcision is easier, it is less of a big deal and also it means eventually you will end up with higher levels of circumcision across a society and it will become the normal thing to be or to have."[418] Some experts agreed with De Cock's suggestion, premised on the awareness that a rapid scale up was required to achieve any measurable impact. Glenda Gray, HIVSA, Executive Director stated:

> Despite the fact that you do need a military operation and you need skills and healthcare workers to roll it out. We should be looking at ways of being able to roll it out in an easy fashion, like one should consider infant male circumcision, which is much easier than adult male circumcision.[419]

As mentioned previously the issues relating to infant circumcision have resulted in some heated debates, which at times casted a negative light on WHO and UNAIDS strategies. The following observation given by George Denniston, President of Doctors Opposing Circumcision should serve as example of some of the doubts and bewilderment that exists surrounding neonates, male circumcision and HIV:

> It is very important to know that there is a not a single national medical organization in the entire world including Israel and other Muslim countries that approve of routine infant circumcision and the reason they don't, my God, it's because there is no reason for it and nobody has the gall to go against that fact.[420]

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[416] WHO 2006:21-22. Strategies and approaches for male circumcision programming.
[417] Dludlu, Sibongile April 23, 2008. UNAIDS Consultant Male Circumcision. Interview.
[418] De Cock, Kevin March 23, 2008. WHO, Director of HIV/AIDS. Interview.
[419] Gray, Glenda April 2, 2008. HIVSA, Executive Director. Interview.
[420] Denniston, George March 31, 2008. Doctors Opposing Circumcision, President. Interview.

In addition to the concerns raised by Dr. George Denniston, he and others questioned how three RCT's on young and middle age men resulted in an endorsement for infant circumcision. The literature on evidence-based research, along with WHO and UNAIDS own assertions that policy should be based on solid evidence, does cause one to question the rationale behind this decision. Furthermore as discussed at the start of this section WHO and UNAIDS argued that neonates would have the slowest impact on the reduction of new HIV infections.[421] Daniel Sidler, a Pediatric Surgeon for Tygerberg Children's Hospital in Cape Town South Africa shared his frustration:

> At the moment, I am in a situation where I really puzzled with what is going on. I am sure that most of the people have good intentions; they are trying to prevent as many people from acquiring HIV/AIDS. We all want that, but one just does not understand how this has got anything to do with neonates. If I have a position, a clear cut position it is that neonatal circumcision is definitely not a tool for HIV/AIDS prevention. What adult men do with their genitals and their foreskin to prevent HIV/AIDS that is their own decision, as long as they get the information and they are not pushed to do it for whatever purposes. For example in Rwanda, I suppose you cannot make a career if you are not circumcised in the army, I have no problem with that.[422]

The last concern expressed in the context of neonates was the potential burden it would have on the currently resourced constrained medical establishments of sub-Saharan Africa. Dr. Sidler expressed his apprehension "if I would have to now do neonatal circumcisions on top of everything it would just not be possible."[423] Dr. Sidler shared his concerns with respect to neonates, however the majority of experts also questioned if the weak healthcare infrastructures in sub-Saharan Africa could deliver safe and massive scale ups of male circumcision in the general population. Professor Simbayi shared his view:

> In terms of capacity of health systems, already even without HIV the health systems in many of these countries are basically struggling, they do not have the capacity and they do not have enough manpower for human resources just to deal with the diseases that were there previously. Now if you throw HIV/AIDS on top of that it is also really affecting how the system functions, not only by drawing in critical resources that are needed to address

[421] WHO and UNAIDS 2007:7. New data on male circumcision and HIV prevention: Policy and programme implications.
[422] Sidler, Daniel April 13, 2008. Tygerberg Children's Hospital, Pediatric Surgeon. Interview.
[423] Sidler, Daniel April 13, 2008. Tygerberg Children's Hospital, Pediatric Surgeon. Interview.

> other issues. But really, when it comes to there not being enough medical health providers that presents another challenge.[424]

To address the issues of resource constraints, WHO, UNAIDS and male circumcision supporters recommended training nurses, clinical workers, flying in international doctors, and/or teaching traditional healers how to perform safe and proper male circumcisions.[425]

As discussed earlier, Professor Were alluded to another key influential element of modeling, when she discussed the hope that WHO, UNAIDS and the international community would support Kenya's efforts in rolling out male circumcision programs. Another example, which demonstrates how modeling projections influenced the need for financial support was observed in the international movement towards publicly affirming funds for male circumcision. In 2006, The National Edition of the New York Times reported that Dr. Richard G. A. Feachem the Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, stated "I think it's a very likely that our technical panel would approve it [male circumcision]."[426] A second quote from the same article reported that Dr. Mark Dybul, the Executive Director of PEPFAR stated, they would "support implementation of safe medical male circumcision for H.I.V./AIDS prevention" if WHO recommended the intervention.[427]

The donor examples and the demand creation and demand management strategies outlined in chapter 3, both demonstrate how modeling influenced WHO and UNAIDS actions and priorities. Maybe the most salient account of how modeling, donors and male circumcision were closely coupled came from the Montreux consultation. Attendee Dr. Abdool Karim explained:

> Well the policy was really directed at three key role players, first governments to make it available in the public sector. The second is to aid organizations and NGO's to do this, so for example at the meeting in Montreux the person from PEPFAR was there and she said if this group, you people, you guys are the experts here, there were about 120 odd people at this meeting, you guys tell the world you think this should be done, PEPFAR is going to provide the money to do it. They made that very clear and they are evidence based, the evidence is

[424] Simbayi, Leickness April 14, 2008 HSRC, Social Aspects of HIV/AIDS & Health Programme, Executive Director. Interview.
[425] WHO 2006:6. Strategies and approaches for male circumcision programming.
[426] McNeil Jr., Donald. 2006:A21. H.I.V. Risk halved by circumcision, U.S. agency funds: more money is expected.
[427] Ibid:A21.

> compelling they will implement.[428] [Interview interrupted by cell call third role player not discussed].

The last impact of modeling was taken from the same Williams and colleagues study that appeared to influence many of WHO and UNAIDS strategies. In the studies methods and findings section on page 1, the authors argued that male circumcision would increase the proportion of women infected from 52% to 58%, base on 2004 UNAIDS figures.[429] Furthermore, Catherine Hankins drew attention to Williams and colleagues findings in her published article, where she remarked, "already mathematical modeling suggests that in the medium term the proportion of people living with HIV in sub-Saharan Africa who are women may rise as male circumcision programmes are scaled up in high HIV prevalence settings, due to the lag time for indirect effects for women to be felt."[430]

Views, which supported some of the modeling suggestions that woman may not benefit or might possibly be at greater risk, were situated within the framework that "women are the most at risk and infected people"[431]in Africa. Leickness Simbayi, argued "if one looks at the epidemiological profile, infection levels are quite high among young women between 20 and 30, if the idea let's say is to circumcise youth now. These young women are having sex with older men, at least some of them, so it will really take a generation before we reap any benefits from this intervention."[432]

Dr. Abdool Karim discussed his views on women and male circumcision:

> It is very clear to me that if you want to have an impact on the epidemic in Southern Africa circumcision is not your high priority, the epidemic in sub-Saharan Africa needs something to reduce transmission in young women, circumcision does nothing for that, there is no direct benefit of circumcision for young women. What we need is a vaccine or microbicides, we need something to empower women, and circumcision does not do that.[433]

Warren Parker provided another supporting point of view:

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[428] Abdool Karim, Salim March 20, 2008. CAPRISA, Executive Director. Interview.
[429] Williams, Brian et al. 2006. The potential impact of male circumcision on HIV in sub-Saharan Africa.
[430] Hankins, Catherine 2007:63 Male circumcision: implications for women as sexual partners and parents.
[431] Were, Miriam April 11, 2008. Kenya's National AIDS Control Council, Chairperson. Interview.
[432] Simbayi, Leickness April 14, 2008. HSRC, Social Aspects of HIV/AIDS & Health Programme, Executive Director. Interview.
[433] Abdool Karim, Salim March 20, 2008. CAPRISA, Executive Director. Interview.

> I don't think they [WHO and UNAIDS] perhaps significantly emphasized the limitation of circumcision and for me the HIV epidemic is largely and predominantly an epidemic of women in Southern Africa and something like circumcision isn't likely to have a significant impact on the epidemic in the foreseeable future. I think UNAIDS and WHO both did this as contextualized as something that is maybe a 20 or 30 year intervention and not an intervention that is going to achieve massive changes now.[434]

Additional evidence that may support the Williams and colleagues concerns included, today 61% of people living with HIV in sub-Saharan Africa are women and young women between the ages of 15-24 are three times more likely to become infected with HIV irrespective of circumcision rates. Furthermore, recent evidence has shown that young women between 15-24 years represent approximately two thirds of all people newly living with HIV in developing countries "making them the most-affected group in the world."[435]

Warren Parker expressed an opinion on why women remain the most at risk population. He states, "I think there has been very little recognition that we need to focus on the epidemiology of the disease and understand it to know its dimensions, particularly understand the risk, it is important to address the questions related to why females are so disproportionately affected."[436] Professor Moodley argued that the patriarchal society was one of the obstacles to prevention and provided an example of how "condom usage is frowned upon and women are largely unable to negotiate safe sex for themselves"[437] demonstrating how patriarchal beliefs may influence AIDS. In 2006 UNAIDS suggested that effective HIV prevention for women should include: "easy access to HIV prevention service and commodities, intensified research efforts to develop new prevention methods that women can control, policy reforms to reduce women's vulnerability to HIV infection, and longer-term efforts to develop new gender norms and influence the behaviour and attitudes of men and boys."[438]

WHO and UNAIDS decision to endorse male circumcision suggests they opposed Williams and colleagues findings but the evidence also showed that they collectively expressed concern over the potential risks to women. Nonetheless, the consensus remained that any

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[434] Parker, Warren March 27, 2008. CADRE, Executive Director. Interview.
[435] UNITED Nations 2008:14. High Level Meeting on AIDS, Panel 3: Making the response to AIDS work for women and girls: gender equality and AIDS.
[436] Parker, Warren March 27, 2008. CADRE, Executive Director. Interview.
[437] Moodley, Keymanthri April 14, 2008. Bioethics Unit Tygerberg Division, Professor. Interview.
[438] UNAIDS and WHO. 2006. Report on the global AIDS epidemic 2006: A UNAIDS 10th anniversary special edition. Chapter 6 pg. 136

additional research would be addressed after the endorsement; a WHO respondent discussed their assessment of the concerns relating to women:

> We looked at the evidence that we had at the time, which in the time that we had, was quite constrained, and the evidence we had was not a lot. Based on that we are looking to have a whole consultation that will actually look at this in more detail and make some clear recommendations as to what needs to be done whilst programs are scaled up.[439]

Kevin De Cock shared his perspective on women and male circumcision.

> Gender issues, I am not sure I entirely get them. The gender dimensions of this are very real, but there, but I personally view them as potentially downstream rather than from the very active male circumcision itself, but what is the question? We have an intervention, it is what it is, and we shouldn't use it because of this, like I said it is very unusual to get a 60% efficacy with a biomedical intervention. The last time we had something, I think this is probably the most important development in prevention science since the introduction of interventions for mother to child transmission. It's at that level of importance and it actually interestingly has a somewhat similar efficacy to the initial regimen that was studied, for mother to child transmission prevention.[440]

To try to explain WHO and UNAIDS decision to proceed with the endorsement, one could rely on the literature that discusses why women have historically been excluded from research agendas. Levine, Travers and Bennett argued that some of the perceived bias was premised on "the view of the male body as the norm assumes that gender is not a crucial variable (except for exclusionary purposes), and consequently the knowledge base regarding HIV/AIDS is almost exclusively based on male-derived data."[441] The second explanation may fall within the context of the biomedical approach that views health and disease as a condition that exist in the individual body and of which can be cured by medicine, absent of the individual and society. The belief that male circumcision was a biomedical cure, which stood apart from "any sense of moral work"[442]could have influenced WHO and UNAIDS to proceed with the endorsement.

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[439] WHO, Anonymous. Interview.
[440] De Cock, Kevin March 23, 2008. WHO, Director of HIV/AIDS. Interview.
[441] Travers, Michele and Lydia Bennett 1996:66. *AIDS as a gender issue* and cited from Levine, C 1990. *Women and HIV/AIDS research*.
[442] Annandale, Ellen 1998:6-7. *The sociology of health and medicine*.

The evidence shows that WHO and UNAIDS appeared to position the Williams and colleagues findings as a positive outcome versus a possible risk. The following statements made by Catherine Hankins and Kevin De Cock supported this observation: "the point about male circumcision is, the way it is going to have a public health impact is by lowering the proportion of men who are infected and there will slowly be a reduction in transmission to women"[443] and "that's because there are indirect effects for women of being less likely to encounter an HIV positive partner."[444] Furthermore, this style of messaging was also used in the WHO and UNAIDS recommendation document, they stated:

> It is not know whether male circumcision reduces the sexual transmission of HIV from men to women. Although a reduction in HIV incidence among men will eventually result in lower prevalence in men and therefore less likelihood that women will be exposed to HIV, currently there are insufficient data to know whether male circumcision results in a direct reduction of transmission from HIV-positive men to women.[445]

The position of an 'indirect benefit' was a widely held view amongst experts who supported male circumcision, Professor Robert Bailey provided a statement that was consistent with WHO and UNAIDS opinion:

> If you lower prevalence of HIV in men, you are going to lower the prevalence in women. So we can see in modeling and it just makes logical sense that circumcision has the potential for reducing HIV prevalence in men by more than 50%. If you lower the HIV in the male population, you are going to be lowering transmission to women and it is going to have a very significant effect on women at a population level.[446]

Another example of the 'indirect benefit' was the position that a majority of sub-Saharan men do not use condoms now and most likely will not alter that behaviour in the future, thus circumcision would help women. Marge Berer in *Male Circumcision for HIV Prevention: Perspective on Gender and Sexuality* suggested that "there was an unstated assumption in the WHO/UNAIDS consultation that unprotected, unsafe sex on the part of men in sub-Saharan Africa cannot be changed."[447] In addition to the indirect benefits, UN and experts referenced another study on women and male circumcision, the article *UN urges circumcision in AIDS-*

[443] De Cock, Kevin March 23, 2008. WHO, Director of HIV/AIDS. Interview.
[444] Hankins, Catherine 2007:63 Male circumcision: implications for women as sexual partners and parents.
[445] WHO and UNAIDS 2007:3. New data on male circumcision and HIV prevention: Policy and programme implications.
[446] Bailey, Robert March 20, 2008. University of Illinois Chicago, Professor. Interview.
[447] Berer, Marge 2007:46. Male circumcision for HIV prevention: perspectives on gender and sexuality.

*hits southern Africa*, published on December 19, 2006 stated, "one US-Ugandan study found male circumcision also reduces infections in female partners by 30 percent.[448] On December 14, 2006, New York Times reported, "Male circumcision also benefits women. For example, a study of the medical records of 300 Ugandan couples last year estimated that circumcised men infected with H.I.V. were about 30 percent less likely to transmit it to their female partners."[449] One expert discussed the potential risk in having messaging that appears to be confusing. They suggested:

> The other thing I think is a potential risk is that, it's hard to understand what this all means. I think a lot of people have a misconception that male circumcision has been shown already to prevent the risk of women becoming infected. When that is not what the trials up to date have been looking at, they have been looking at the transmission reduction from women to men.[450]

Explanations for why the media reported the research findings that showed male circumcision benefited women's health despite the clinical evidence that showed a possible risk to women, remain opaque. However Panem's accounts on how the media was continuously challenged by having to accurately communicate research findings and policy implications to a public that was largely unaware and/or often already misinformed about AIDS may partially explain some of the confusion.[451]

It should be noted that in addition to the indirect benefits for women, WHO and UNAIDS referenced research that showed male circumcision provided secondary health benefits for women irrespective of HIV. Such as, the reduced risks of Chlamydia trachomais infections, cervical cancer and urinary tract infections.[452]

Another key topic in relationship to women was the role of men, a significant number of experts argued, "In sub-Saharan Africa there must be a lot more attention on the role of the African men in preventing and reducing the spread of HIV/AIDS."[453] David Harrison explained, "I think that undoubtedly the position of women in society continues to make our work very, very difficult."[454] He reasoned that "probably by getting to men more than we

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[448] Zaheer, Kamil 2006. UN urges circumcision in AIDS-hit southern Africa.
[449] McNeil Jr., Donald. 2006:A21. H.I.V. Risk halved by circumcision, U.S. agency funds: more money is expected.
[450] Anonymous Respondent One. 2008. Interview.
[451] Panem, Sandra 1988:120. *The AIDS bureaucracy*.
[452] WHO and UNAIDS. 2007:21. Draft Male circumcision: global trends and determinants of prevalence, safety and acceptability; The Body Pro 2008. HIV prevention in the developing world: expert panel previews CROI 2008 research.
[453] Were, Miriam April 11, 2008. Kenya's National AIDS Control Council, Chairperson. Interview.
[454] Parker, Warren March 27, 2008. CADRE, Executive Director. Interview.

have done in the past" we could possibly assist women.[455] This argument rests on the hypothesis that the newly circumcised man would alter his behaviour after receiving the complementary counseling on safe sex practices, STD's, HIV testing, gender violence and empowering women. Mary Crewe raised an alternative position, which questioned if clinics were the appropriate or ideal location to administer effective HIV prevention programs,

> Everybody talks about the fact that people have turned away from prevention towards treatment and care and that the whole testing thing has undermined prevention quite a lot. I think that one of the problems is that people erroneously believe that you can put prevention back into the clinic which I don't think you can do, so if you had people going for testing they would be getting a prevention message that the whole counseling for testing would some way act in a way of prevention and I think that turned out not to be the case and I think the clinic isn't a good place to try to do prevention work. [456]

This study has outlined how modeling shaped the profile for the determination of where male circumcision should be rolled out and to whom; established the justification for a rapid and massive scale up approach; facilitated the need to solicit international funds and support; and compelled activists and the media to promote and create demand. These critical outcomes assisted with demonstrating how modeling influenced the planning, marketing and funding of male circumcision. Furthermore, the findings explained how modeling studies directed public health and policy discourse. The RCT evidence was powerful, however "scientific knowledge alone does not determine which interventions will have the most impact"[457]modeling was required to determine how and if male circumcision could impact population level infections. This section concludes that WHO and UNAIDS endorsed male circumcision as a public health initiative because of the modeling evidence.

**Acceptability**

The last major form of evidence-based research that contributed to why WHO and UNAIDS endorsed male circumcision was the acceptability of male circumcision. Acceptability studies were conducted in various locations in sub-Saharan Africa to assess how traditionally non-

[455] Parker, Warren March 27, 2008. CADRE, Executive Director. Interview.
[456] Crewe, Mary April 15, 2008. Mary Crewe, Pretoria University, Centre for Study of AIDS, Executive Director. Interview.
[457] World Bank 2006:10. *Priorities in health.*

circumcising communities would respond and whether women would be supportive of the procedure for their male partners and children.

WHO and UNAIDS documents referenced Westercamp and Bailey comprehensive review of 13 acceptability studies from 9 countries of which 10 included female participants.[458] The review found that "the median proportion of uncircumcised men willing to become circumcised was 65% (range 29-87%). Sixty nine percent (range 47-79%) of women favored circumcision for their partners, and 71% (50-90%) of men and 81% (70-90%) of women were willing to circumcise their sons."[459] Furthermore, the authors concluded that based on the consistency of the findings across all 9 countries that "additional acceptability studies that pose hypothetical questions to participants are unnecessary."[460] WHO and UNAIDS concluded from the review that, "the three most salient barriers to the acceptability of male circumcision were fear of pain, concerns for safety, and the cost of the procedure."[461] Other key outcomes gathered from the acceptability studies, was the participant's desire for the procedure to be done by medical practitioners at a public health clinic or hospital, and for a minimal cost or free.

Thereafter this section will demonstrate that the acceptability studies were viewed as another important source of evidence that WHO and UNAIDS used to rationalize their endorsement. Furthermore WHO and UNAIDS relied on the acceptability findings as a validation of their existing points of view and for gaining support from international donors, the public, and governments.

To construct this argument we need to explain why acceptability studies would be important to the public, AIDS agencies and governments. During the 2006 NIH teleconference outlined in chapter 3, Kevin De Cock responded to questions concerning possible cultural barriers and male circumcision.[462] He discussed the importance of getting the opinions and involvement of communities and argued that male circumcision was a topic that drew controversy and strong opinions from across the world.[463] To address the challenges he reasoned it was

[458]Westercamp N and Bailey, Robert 2006:341. Acceptability of male circumcision for prevention of HIV/AIDS in sub-Saharan Africa: A review.
[459] WHO and UNAIDS 2007:29. Draft Male circumcision: global trends and determinants of prevalence, safety and acceptability cited from Westercamp N. and Bailey, Robert. 2006. Acceptability of male circumcision for prevention of HIV/AIDS in sub-Saharan Africa: A review.
[460] Ibid:29.
[461] WHO and UNAIDS 2007:30. Draft Male circumcision: global trends and determinants of prevalence, safety and acceptability.
[462] NIAID 2006:10. Update on NIAID-sponsored adult male circumcision clinical trials.
[463] Ibid:10.

critical to engage those countries affected by the recommendation and to ensure local communities and governments took ownership of male circumcision.[464] However, Dr. De Cock also shared another perspective, he questioned if a person's foreskin was more important to one's identity than having their culture die of AIDS.[465] The following statement may assist to understand why De Cock believed the foreskin was less important than culture:

> I started off saying, I am just a doctor, my view is perhaps reductionist, and excessively biomedical, if you want to talk about cultural attitudes to circumcision of course they are important. We operate in a political and cultural world, but people have to make choices. I mean, is HIV good for your culture? Is it good to have these astonishing rates of death and child mortality and maternal mortality etc. etc. that is what HIV is doing? Robbing your particular cultural group of 20 or 30 years of life, is that good for your culture? So people have to make choices. I think health system issues, personnel, doing it safely, are immensely important and worrying – worrying also. Because it has to be done safely and has to be monitored.[466]

Glenda Gray, an expert in the field of AIDS provided an alternative, but supportive view to De Cock's argument:

> They [men] need to make the decision themselves; it is cruel to not offer them this intervention, because you are going to offend the culture, the religion or the ethnicity of the people. It is too difficult, that we don't care about offering these interventions to men, because we don't want to upset the elders or the customs of the country. I mean I think that is ridiculous, because we are going to have the arguments until kingdom come, they will never be resolved and we cannot move forward. Why do we care about pussyfooting around culture in this issue and not about other issues and so, I think that it is a shame that we are not rolling out circumcision faster, it's a shame for men in Africa.[467]

These views start to demonstrate the contradiction between using acceptability studies to inform a decision versus already having a position and using the evidence to retain support. To explain why culture remains a concern for HIV/AIDS, Mary Crewe commented, "I think the main obstacles are we do not know how to address things like tradition and culture, we do not understand the difference between traditional modernity, we do not understand the very

[464] NIAID 2006:10. Update on NIAID-sponsored adult male circumcision clinical trials.
[465] De Cock, Kevin March 23, 2008. WHO, Director of HIV/AIDS. Interview.
[466] De Cock, Kevin March 23, 2008. WHO, Director of HIV/AIDS. Interview.
[467] Gray, Glenda April 2, 2008. HIVSA, Executive Director. Interview.

deep forces that work in relations to gender and those kind of things."[468] Furthermore, Gary Dowsett, Deputy Director of Australian Research Centre in Sex, Health & Society argued that HIV prevention programs and policies would change considerably if international public health organizations had a greater understanding and appreciation of how social and contextual factors influence people's actions.[469]

Some of the concerns experts expressed over the acceptability studies were associated with the context of how the questions were constructed and if they adequately illustrated the potential risk to men, risk to women and the partial effect of male circumcision. Gary Dowsett highlights the difficulty of translating complex subjects into accurate and meaningful questions, he explains:

> The complexity of the consequences of circumcision is far too difficult to put in a pamphlet, or a small briefing or an informed consent process. You should have a look at what the acceptability question was in the Orange Farm trial, but it went something like: if male circumcision were shown to be effective in protecting you against HIV transmission, would you find it acceptable, would you allow yourself to be circumcised? If that isn't a loaded question, I do not know what it is. Basically, it says if I can show you that chewing gold is going to make you rich, will you chew gold? Of course you will. This is not an acceptability question, this is a loaded question. That is an example of how these people think the whole process of informed consent and information provision is learned and understood. They were talking and explaining to people here some quite complicated stuff, not only simply the surgical technique, the post-surgery care that's required, the wound care that's required, the risk for transmission while the wound is not healed-- all the stuff that we know that the trials have yet to tell us.[470]

Expert Dr. Daniel Sidler provided a similar critique to Dowsett's observations, "What information has been given to these Africans and under what pretense were they actually willing to circumcise themselves. Particularly people who are not coming from a background of circumcising culture."[471]

Another topic examined was the need to accurately communicate the partial effect of male circumcision – the fact one can still get HIV even after circumcision. A significant portion of

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[468] Crewe, Mary April 15, 2008. Pretoria University, Centre for Study of AIDS, Executive Director. Interview.
[469] Dowsett, Gary May 9, 2008. Australian Research Centre in Sex, Health & Society, Professor, Deputy Director. Interview.
[470] Dowsett, Gary May 9, 2008. Australian Research Centre in Sex, Health & Society, Professor, Deputy Director. Interview.
[471] Sidler, Daniel April 13, 2008. Tygerberg Children's Hospital, Pediatric Surgeon. Interview.

experts discussed this condition, including how participants were informed of this partial effect. Professor Anton van Niekerk, and Mark Heywood, Executive Director AIDS Law Program both expressed hesitation with the original hype of male circumcision; they believed the messaging had the potential to create a false impression or the perception of a magic bullet. [472] Professor Simbayi shared his concerns with the messaging of the partial effect, he believed there was a "potential danger of deemphasizing the partial efficacy or effectiveness of the intervention" however at the same time he argued that this factor complicated the communication with potential recipients because to tell a person an "intervention is partially effective what does that mean."[473] He also explained how these challenges have impacted WHO and UNAIDS, "in some countries when organizations like UNAIDS and WHO have said that this intervention is partially effective some countries have not wanted to hear, because they say what are you saying."[474] The complexity of these issues suggests why experts had concerns relating to the types of questions asked in the acceptability studies.

An example of UNAIDS style of presenting the acceptability study's findings came from Catherine Hankins, who stated, "It has become culturally so strong and acceptability studies show 70% of women would prefer – this is all hypothetical, but 70% of women in these I think 8 countries would prefer their male sexual partners to be circumcised."[475] The acceptability questions for women appeared to predominately focus on their children and partner(s), with limited attention placed on a woman's health and safety. This omission may pose a concern in light of the findings disclosed from a clinical trial conducted in Rakai, which showed an increased risk for women with HIV-positive circumcised male partners if they engaged in sex before the man's wound had healed; the results of this study were outlined in chapter 3.[476] Professor Moodley shared her concern:

> In one of the trials, it actually showed an increase risk of contracting HIV/AIDS after circumcision if men become sexually active prematurely after the circumcision. I think that is something that needs to be addressed in further research and certainly, it needs to be. It points to a weakness within a clinical trial where perhaps inadequate counseling was given to men. So while we are seeing benefit in terms of prevention in males the actual benefit that goes

[472] van Niekerk, Anton April 14, 2008. University of Stellenbosch and Center for Applied Ethics, Professor and Director. Interview; Heywood, Mark April 25, 2008. ALP, AIDS Law Program, Executive Director. Interview.
[473] Simbayi, Leickness April 14, 2008 HSRC, Social Aspects of HIV/AIDS & Health Programme, Executive Director. Interview.
[474] Simbayi, Leickness April 14, 2008 HSRC, Social Aspects of HIV/AIDS & Health Programme, Executive Director. Interview.
[475] Hankins, Catherine April 22, 2008. UNAIDS Chief Scientific Officer and Associate Director Evidence, Monitoring and Policy.
[476] Cheng, Maria 2007. Circumcision may lift HIV risk for women; New Scientist Tech. 2007. Male circumcision to fight HIV poses risk to women. Roberts, Anne 2007. Male circumcision could increase AIDS risk for female partner: Study.

> over to females is not very clear to my knowledge and is worrying if it is going to result in an increase risk.[477]

Additional evidence which may further explain why the Rakai HIV-positive trial raised concerns with the scope of the acceptability studies was the data showing that only 13% of men in sub-Saharan Africa know their HIV status[478]and HIV testing was not expected to be a prerequisite for circumcision. These factors might also question some of the generalizability and assumptions derived from the acceptability findings on women.

To clarify how culture and inequalities could hinder women's ability to voice concerns or opposing views relating to male circumcision, we can look to Nussbaum's explanation that "family policy and the nature of the family are an important part of what renders women able, or unable, to function productively in the public realm" and which could also result in bad behavior being insulated or perpetuated in cultures.[479] When examining the evidence gathered on the acceptability and the potential risk of male circumcision on women, Nussbaum's insights help to explain why women need to be accurately informed of their possible risks.

Another important concept to consider when discussing risk was the evidence that showed that individuals most often do not accurately assess their own risk compared to a scientific assessment of the risk.[480] This would explain why various experts were concerned with the reliability of the acceptability studies outcomes and the excessive weight given to these findings.

An example of the difficulty in communicating effective messaging within the complex dynamics of culture, sex, gender and male circumcision was conveyed in Catherine Hankins narrative on why some men still get HIV, after becoming circumcised, she said:

> Secondly, this is the other thing I forgot to say about how circumcised men can acquire it [HIV], if they resume sex early and in many traditionally circumcising cultures, you are supposed to complete the circumcision process by having sex as soon as possible with a woman. In many settings there are specific women that offer this service to young men, so that's a way in which you can get infected. In the trials some of the men who resumed sex

[477] Moodley, Keymanthri April 14, 2008. Bioethics Unit Tygerberg Division, Professor. Interview.
[478] Global HIV Prevention Working Group 2007:2. Bringing HIV prevention to scale: an urgent global priority cited from WHO, UNICEF, and UNAIDS 2007, Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector.
[479] UNDP 2003:9. Gender and Governance.
[480] Schneider, Mary-Jane 2004:106. *Introduction to public health*.

> early (that is why we say wait until certified healing) - became infected, because they resumed sex early. I mean it just makes common sense if you have a partially open wound it is very likely that you will be able to get infected through it.[481]

The difficulty and concerns with the messaging of male circumcision were best explained by Witte and colleagues' discussions on implicit versus explicit fear messages. They argued that explicit messaging style was far more effective in delivering a message on health because people do not always draw out the conclusion from implicit messages.[482] Furthermore, both Witte and colleagues and Panem highlighted that an important component of successful messaging was the need to ensure appropriate cultural colloquialisms were utilized.[483] These factors help to explain why WHO, UNAIDS and other experts believed the partial effect of male circumcision was a difficult concept to deliver and could impact the overall effectiveness of male circumcision if people did not grasp and act on the meaning of partial.

Another critique was provided on how the acceptability studies might have been more effective if they had included the community impact in addition to the individual perspective. Leickness Simbayi shared the potential risks associated with implementing male circumcision programs without community leadership and a sense of cultural legacy, he explained:

> As far as I am aware there has not been an attempt to engage with communities, particularly those that do not practice traditional ways of doing it, because that will be really fatal going for medical or clinical circumcision. There has been no engagement with traditional leadership, so that they can engage. In my view, it would be much easier, if you can have the buy in from the traditional leaders on the benefits of male circumcision. Because that would be a context within which it would be much easier actually to get individuals later, than the other way around. Perhaps the best way, they need to find a way to do both, talk to the individuals and talk to community leaders. If we don't I mean whilst you have these guys circumcised, they go into those communities where they may actually be stigmatized because they are circumcised, they will be marginalized, isolated, it would be counterproductive.[484]

Professor Were supported Professor Simbayi's narrative and she spoke of the community and cultural challenges they have faced in Kenya since the trials concluded and issuing their National Policy on Male Circumcision. She provided an example of how stigma and culture

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[481] Hankins, Catherine April 22, 2008. UNAIDS Chief Scientific Officer and Associate Director Evidence, Monitoring and Policy.Interview.
[482] Witte, Kim et al. 2001:7. *Effective health risk messages.*
[483] Witte, Kim et al. 2001:7. *Effective health risk messages;* Panem, Sandra 1988:128. *The AIDS bureaucracy*.
[484] Simbayi, Leickness April 14, 2008 HSRC, Social Aspects of HIV/AIDS & Health Programme, Executive Director. Interview.

were used negatively in her country, "in some of our communities in Kenya, circumcision is part of their culture so we have heard people saying that you know, they were beginning to point fingers, to say that people who don't have circumcision are going to have AIDS and all that, so that has been a lot of the negative conditions." [485] Kenya, has also received some negative media attention, it was reported that the "Luo were forcibly circumcised in the violence"[486] when the country was faced with political unrest. There were also reports that "a Kenyan secondary school has sent home 20 boys because they were not circumcised, saying it feared they would be bullied by other students because they were not circumcise."[487]

Recognizing with any medical procedure there will have challenges to overcome, these findings did however support the concerns raised in the *AIDS in Africa: Three scenarios to 2025,* discussed in chapter 3. Where "the growth or erosion of unity and integrations," "the evolution of belief, values, and meanings" and "the distribution of power and authority" were identified as three of the critical drivers that could impede future efforts or if managed appropriately produce positive outcomes.[488]Specific to the issue of unity, the authors asked "will rural communities across Africa feel integrated in national development or feel marginalized?,"[489]which could explain Simbayi and Were's observations and concerns.

The last area to substantiate the argument that acceptability studies were used primarily to gain support versus informing their decision, was the fact that WHO and UNAIDS believed any additional research on social and cultural factors could be completed after the endorsement. Catherine Hankins shared her thoughts:

> There are people that would argue we need more evidence about cultural meaning and so on and we argue that that is exactly what countries need to do now. We need to do it from March 2007 - if they hadn't already been doing it under the first work plan, to look at cultural acceptability, to look at the meanings of it in their culture, what this would cause and not cause, what concerns there might be.[490]

Sibongile Dludlu shared her view on waiting for additional research,

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[485] Were, Miriam April 11, 2008. Kenya's National AIDS Control Council, Chairperson. Interview.
[486] USA Today. 2008. Male circumcision gains ground as anti-AIDS weapon.
[487] BBC News 2007. Uncircumcised pupils sent home.
[488] UNAIDS 2005:13-15: AIDS in Africa. Three scenarios to 2025.
[489] Ibid:52.
[490] Hankins, Catherine April 22, 2008. UNAIDS Chief Scientific Officer and Associate Director Evidence, Monitoring and Policy.

> I think there is the question of when do you. When are you then able to say there is enough evidence? I think what they did is they reviewed the evidence and decided there was enough evidence and decided that the evidence was compelling enough to be able to make these statements. It [Montreux Recommendation] also said that there are certain research issues that are missing, amongst HIV positive, etc. Those particular research questions still need to continue, it is not - we have the evidence, you can stop. No. There are still more questions that need to be answered.[491]

Dr. Ben Chirwa, Director General of the Zambia National AIDS Council supported Hankins and Dludlu position. He discussed how his country had engaged in acceptability studies with their local university in order to prepare for the endorsement. He explained his views on where social and cultural research should be situated within the process:

> The initial decision about this should not be based on culture, on religion and so on, it should be based on scientific basis, but ultimately when you are making the program that is when you bring in those other sensitivities. I think we mixed it, we started to discuss this issue initially on a cultural basis, on a gender basis, or on a sexual basis and therefore you gloss over the compelling scientific evidence. We need to separate the two issues first as a country we need to have our scientific community to agree, do we have compelling evidence - yes or no. Do we think this will make a difference - yes or no, and once you have made that decision then we can begin to deal with the cultural issue, the gender issue, the social issue and for us in Zambia that is the kind of approach we have taken.[492]

In response to the question did WHO and UNAIDS have enough evidence, Professor Bailey proclaimed:

> More than enough. You are facing three randomized control trials, over 40 epidemiological studies, strong biological evidence, very strong ecological evidence looking at patterns across populations, across Africa and the world. There is nothing in public health, forget HIV prevention, there is nothing in public health with this much evidence to support an effective intervention.

Other experts expressed concern over the need for additional evidence from the field of social sciences, Professor Moodley said, "I think there are several gaps that have been identified in relating to the challenges and clearly those gaps in the knowledge have not

[491] Dludlu, Sibongile April 23, 2008. UNAIDS Consultant Male Circumcision. Interview.
[492] Chirwa, Ben April 16, 2008. Zambia National AIDS Council, Director General. Interview.

been explored or researched sufficiently."[493] Warren Parker shared a similar view he stated, "I mean really something like circumcision is a 15 to 20 year project if you like. We need much more research around the implications of these things the systems effects, the practicalities, the relevance and so forth. I suppose they [WHO and UNAIDS] did not really do that, they did to some extent, they needed to emphasize much more social science research."[494] Responding to the question of whether WHO and UNAIDS had enough research evidence, Professor Simbayi stated, "Not when they did it, but subsequently they have. Yes, not at the time, it was just put out as a medical procedure you know in isolation devoid of cultural settings, but subsequently over the past year there have been robust discussions taking place on a global level as well as regionally and within countries."[495]

Lastly, a widely held opinion amongst those who opposed the timing and urgency of the endorsement, was the evidence may be compelling, however let's take some time to assess some of the challenges and concerns to ensure we get it right. One respondent shared their impression that "the horse was already out the door,"[496] in other words the decision had already been made and was not up for critical debate. Mary Crewe expressed some of the collective frustration,

> There was a letter sent to Peter Piot [UNAIDS executive director] from a whole range of organizations and social scientists saying, hey just slow down on this, we are not saying you should not do it, slow down, reflect more, take more cognizance of social scientists; they just did not do it. They held a consultation in Durban and Montreux it was basically talking about a fait accompli. They did not say okay let us put it on hold for six months while we commission some classy social scientific research to either support or challenge our views.[497]

The apparent emphasis placed on the biomedical research versus social science research was discussed at various times in the literature review. However, the interviews and discussions in this section clearly support the arguments that the biomedical evidence dominated the discourse on male circumcision. During the Social Sciences consultation, the participants argued that "social science seems to have been a somewhat neglected area of science in

[493] Moodley, Keymanthri April 14, 2008. Bioethics Unit Tygerberg Division, Professor. Interview.
[494] Parker, Warren March 27, 2008. CADRE, Executive Director. Interview.
[495] Simbayi, Leickness April 14, 2008 HSRC, Social Aspects of HIV/AIDS & Health Programme, Executive Director. Interview.
[496] Anonymous Respondent Two. 2008. Interview.
[497] Crewe, Mary April 15, 2008. Pretoria University, Centre for Study of AIDS, Executive Director. Interview.

relation to HIV, in contrast to biomedical science"[498] and furthermore they had not been part of the male circumcision process. The evidence presented in this section supports many of these claims and observations. De Waal argued that a growing challenge within the context of AIDS was "the premature policy consensus based on poor evidence and analysis" and how biomedicine has dominated research agendas.[499] In the instance of male circumcisions, the biomedical structures do appear to have influenced the process, participants and research, including how acceptability studies were evaluated and interpreted.

This section has demonstrated that the acceptability studies were viewed as an important source of evidence, which WHO and UNAIDS used to rationalize their endorsement. The evidence shows that the acceptability studies were primarily used as a resource to retain support from international donors, the public, and governments. Furthermore, the decision to endorse male circumcision was not reliant on acceptability studies but they helped in supporting the movement towards public policy and support. This was supported by the evidence collected from the Rakai HIV-positive trial, which showed a possible risk to women, however additional acceptability studies were not required before issuing the endorsement. The last factor that supports this argument was WHO and UNAIDS own statements regarding the quantity, prioritization and importance of acceptability studies compared to the clinical evidence on male circumcision. Thus, this section concludes, the acceptability studies played a critical role in gaining support from international donors, the public, governments and the media.

## 2. Consultative Process

The evidence based research was the first reason behind WHO and UNAIDS' endorsement and the second was the consultative process modeled from the UN Work Plan for male circumcision. The plan provided WHO and UNAIDS with the means to coordinate, direct and influence the process. This included selecting participants, location of consultation sites, prioritization of research, media announcements, website messaging and proposed allocations of funds. Another theme that has emerged from the evidence collected was this sense that the year and a half consultative process was used as a period to plan, coordinate, create demand and gain support versus critically analyzing the evidence and the feasibility of rolling out

[498] UNAIDS and CAPRISA 2007:15. Consultation on social science perspective on male circumcision for HIV prevention.
[499] De Waal, Alex 2006:123. *AIDS and power.*

male circumcision at a public health level. Lastly, the evidence supports the conclusion that their consultative process was closed and managed by a powerful network of male circumcision supporters, researchers and funders. The following evidence will support these positions.

**UN Work Plan**

The comprehensive chronological history of WHO and UNAIDS process was outlined in chapter 3. However, Catherine Hankins provided a narrative on why the Work Plan was originally conceived, she explained:

> The whole thing started for me really in April 2005. When Mark [Stirling] called me and said that he has heard a rumor that the South African Orange Farm male circumcision trial has been stopped. We did not have the results, but he thought we should be doing something. So we agreed that we would convene a closed meeting in June in Johannesburg and we would invite to that meeting the researchers from the 3 trials, government counterparts in those 3 countries, a few other countries that would be interested and some NGO's. We would bring to the table WHO, UNICEF and UNFPA from the UN family.[500]

In addition to the UN Work Plan participants outlined in Chapter 3, Catherine Hankins provided a detail assessment of the types and kinds of leaders that were asked to participate and fund the year and a half process.

> We pulled together a steering group that was made up of both funders so ANRS, NIH, Gates and Clinton Foundation; and with the 4 UN partners, UNAIDS, WHO, UNFPA and UNICEF - and that group we added to it PEPFAR as a big funder. And that group met about every 6 weeks by conference call and briefed each other on what was happening with the trial that was completed, with funding programs, with the work plan, they acted as a kind of as the oversight committee for the first UN Work Plan on male circumcision and HIV. I also convened what is called an inter agency task team on male circumcision that had 1 regional representative and 1 headquarter representative from the 4 UN partners. So 8 people on the call which we held always a couple of days before the steering group call so that the UN understood, we were all briefed about what was happening and we decided what we were

[500] Hankins, Catherine April 22, 2008. UNAIDS Chief Scientific Officer and Associate Director Evidence, Monitoring and Policy. Interview

> presenting to the steering group and we could report on everything that was going on. That worked extremely well, extremely well.[501]

Some observations that should be drawn from her narrative were the characteristics of the members that were asked to participate, they included: donors, financial supporters of the three trials and UN Work Plan, and lastly international biomedical health institutions. Based on the evidence from chapter 3 and Hankins narratives, the steering committee appeared to have no representation from the field of social sciences or African public health institutions. This evidence starts to form the basis for the argument; was UN's Work Plan an evaluation and assessment of the evidence or a process to prepare for the endorsement of male circumcision. Furthermore, the following account by Catherine Hankins implies the process may have leaned towards preparing for an endorsement. Her narrative continues,

> When it did [male circumcision trials] come in (December 2006) we had basically a one year, a full year funded work plan in which we had accomplished quite a number of things, including as I said these stakeholder meetings, a meeting on modeling, the impact of male circumcision, a meeting on programming, guidance for male circumcision, a couple of meetings and a draft manual on 3 surgical techniques under local anesthesia that could be done for adult male circumcision. It was great because it gave us the chance really to prepare all this stuff, so by the time we came to holding the meeting in March 2007 at Montreux, where the recommendations emerged, we had done a lot of preparation and we weren't just looking at the results of the 3 trials and saying okay now what do we do. We also had the stakeholder reports from countries, which brought out a lot of rich cultural, gender issues, ethical issues and so on that could be discussed and debated and that's why when you look at the recommendations they are really quite rich and they stand the test of time. There still very, very apropos today, you know the sections on gender, the sections on what you do about HIV positive men, the sections on safety and behavioural issues and risk compensation and avoiding it and the link to HIV testing. It is all there.[502]

The UN Work Plan process relied heavily on various consultations and from those meetings reports the evidence supports the argument that the plan was used more as a preparation tool for an endorsement versus an assessment of the risk and feasibility of the intervention. The meeting report from the first consultation held November 20-21, 2006 stated the purpose of

[501] Hankins, Catherine April 22, 2008. UNAIDS Chief Scientific Officer and Associate Director Evidence, Monitoring and Policy.
[502] Hankins, Catherine April 22, 2008. UNAIDS Chief Scientific Officer and Associate Director Evidence, Monitoring and Policy.

the consultation was to initiate progress towards developing policies and action plans premised on the assumption that Kenya and Uganda, RCT's would produce the same results as Orange Farm.[503] Furthermore, the report concluded that participants had agreed that it was an appropriate time to progress from "learning of the evidence to active planning to meet increasing demand for safe male circumcision services."[504] However, the evidence to explain what transpired during the steering group meetings and in the five country stakeholder meetings was not available, and posed a gap in the findings.

WHO and UNAIDS strategy to create demand was viewed in various forms, including their communication strategies, UNAIDS regional website, revised funding projections and advocacy through the media. Press releases were often used to announce the excitement of the pending trials, an example was WHO 2006 Press statement: *Demand for male circumcision rises in a bid to prevent HIV: Demand for male circumcision as a method of combating HIV/AIDS is likely to increase dramatically if the results from two studies, in Kenya and Uganda, are positive. Public health experts are warning men, however, that circumcision may reduce the risk of HIV infection but it does not provide full protection.*[505] Within the press release, they used quotes from various leaders in African governments and academia, which demonstrated the strong support and movement towards circumcision, (chapter 3, has the quotes). In August of 2006, Nolen provided this commentary from a conference, he stated, "Circumcision was the hot topic of the day at the international AIDS conferences yesterday, when a variety of researchers and even former U.S. President Bill Clinton endorsed it as an effective way to stop the spread of the disease."[506]

Others forms of demand creation were observed in UNAIDS regional website media page (Table 1) which allocated a significant amount of content to the topic of male circumcision.

[503] UNAIDS 2007:5. Regional consultation on safe male circumcision and HIV prevention.
[504] UNAIDS 2007:5. Regional consultation on safe male circumcision and HIV prevention.
[505] WHO 2006. Bulletin: Demand for male circumcision rises in bid to prevent HIV.
[506] Nolen, Stephanie. 2006. Male circumcision not an easy answer for HIV.

**Table 1: UNAIDS Regional Website for Eastern and Southern Africa**

| Table of Contents: Press Center – www.unaidsrstesa.org (up till April 21, 2008) |
|---|
| Guidance on communications to support the scale-up of male circumcision programmes |
| 2007 AID Epidemic Report |
| Special Representative<br>61st Session of the UN General Assembly session focused on the AIDS response<br>- UN Secretary General speech at the General Assembly Review of Declaration of Commitment on HIV/AIDS<br>- UN Secretary General's Progress Report |
| Male Circumcision for HIV Prevention<br>- Male circumcision: Africa's Unprecedented Opportunity<br>- Press Release<br>- WHO/UNAIDS-Technical Consultation Report<br>- Statement on Kenyan and Ugandan Trial Findings Regarding Male Circumcision and HIV<br>- Documents on Male Circumcision and Risk of HIV Acquisition<br>- Epidemic Update 2006 |
| UNAIDS 2006 Report on the Global AIDS Epidemic- A UNAIDS 10th anniversary special edition |
| Launch of Media Desk |
| SADC Report on the Expert Think Tank Meeting on HIV Prevention |
| Treatment Access Report WHO |
| 25 years of HIV in Africa |
| UNAIDS/WHO Statement on Data |

The evidence gathered from the documents also appeared to demonstrate a trend towards positioning male circumcision as the dominant intervention in brochures, meetings and statements. An example of this trend was viewed in the 2006 SADC *Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa,* where male circumcision was presented as one of the three key drivers of the epidemic, along with multiple and concurrent partners and poor condom use. Another method that appeared to support the movement towards isolating male circumcision was the tendency to promote it in a manner that was urgent or special compared to other HIV interventions.

A recent example of this tendency was taken from a UNAIDS document, they stated "in countries experiencing generalized or hyper-endemic scenarios, UNAIDS estimates of resource needs are very different – with a strong emphasis on youth, community mobilization, communication, and workplace interventions, which primarily focus on delayed sexual debut, decreasing multiple partnerships and condom use in casual sex, as well as the resources needed to bring about the most rapid feasible scale up of male circumcision in young adults (estimated to be 2.5 million circumcisions per year by the year 2010 in the 12

most highly affected countries).[507] Another example, which appears to create an impression that male circumcision could be a magic bullet for HIV prevention was, "Male circumcision, integrated into the spectrum of HIV prevention practices, can be compared with childhood immunization, which has saved millions of lives world-wide."[508]

Numerous experts, who expressed caution over male circumcision, discussed their concerns over the role of the media, and the impression that "we found sort of the golden bullet in the media."[509] Gary Dowsett shared his frustration:

> Most people only have headline information about circumcision, about what these trials did and what they found and that's all anyone is interested in telling them. It's the press release and sound bite version of what these trials achieved, rather than the complexity of what these trials revealed, which was just how complex this issue actually is and how shaky efficacy actually is as a measure. [510]

Another view discussed in the interviews and observed in the analysis of the data was the tendency for WHO and UNAIDS to rely on the same researchers and authors in publications relating to male circumcision. This was especially evident in the published research on male circumcision and their own publications. Recognizing researchers commonly specialize in fields, the critiques were centered on WHO and UNAIDS tendency to discount or ignore opposing opinions or research. Dr. Sidler shared his observations, "the other thing, which I find intriguing is when you read all these publications they sound all alike, they all publish only literature or they only reference literature, which is suitable for their own opinion and leave out any other literature, which is critical to their stance." [511]

The evidence also showed that the UN Work Plans strategy to create demand and secure a massive scale up might have also influenced UNAIDS to revise their funding allocations. Evidence of the effects of this movement was best demonstrated in an updated 2008 Financial Resource Chart (Table 2), showing a 2010 budget of USD 147 million for male circumcision and USD 153 million for mother-to-child transmission programs, when in 2007 the number

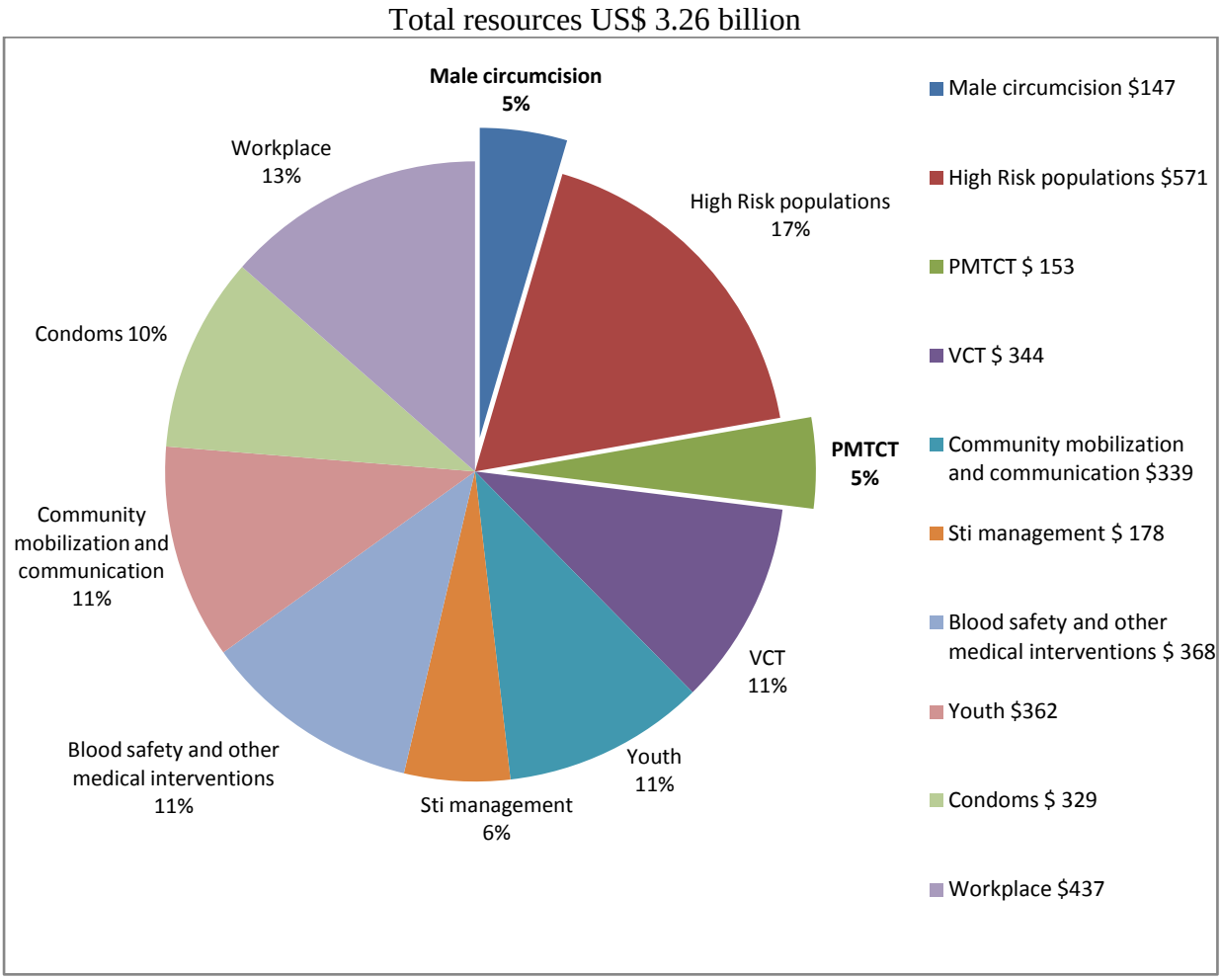
[507] UNAIDS 2008. Points for response to "reassessing HIV prevention" in science.
[508] UNICEF, WHO, and UNAIDS. 2007:7. Male circumcision: Africa's unprecedented opportunity.
[509] Sidler, Daniel April 13, 2008. Tygerberg Children's Hospital, Pediatric Surgeon. Interview.
[510] Dowsett, Gary May 9, 2008. Australian Research Centre in Sex, Health & Society, Professor, Deputy Director. Interview.
[511] Sidler, Daniel April 13, 2008. Tygerberg Children's Hospital, Pediatric Surgeon. Interview.

forecasted for 2010 was 157 million for male circumcision and 662 million for mother-to-child transmission.[512]

The literature has firmly positioned women as the most at risk population in Africa and then children. The data has shown that only 31% of HIV-infected pregnant women received antiretroviral prophylaxis[513]and 90% of all the HIV infections relating to children under the age of 15 have come from mother-to-child transmission.[514] In 2008, the UN reported that developed countries had almost completely eliminated the risk of mother-to-child HIV transmission[515] and "although the cost-effectiveness of mother-to-child HIV transmission prevention programmes was demonstrated in the 1990s, children still accounted for one in six new infections in 2007."[516] Significantly, in 2007, Botswana achieved a 91% uptake of mother-to-child services resulting in only 4 % of children born to HIV-positive mothers becoming infected with HIV.[517] Table 2 demonstrates how the UN Work Plan demand creation strategy may have indirectly affected other interventions.

[512] UNAIDS. 2007: 22. Financial Resources required to achieve universal access to HIV prevention, treatment, care and support.
[513] UNICEF, UNAIDS and WHO 2008:1. Children and AIDS: Second stocktaking report, actions and progress, fast facts.
[514] WHO 2007:7: Guidance on global scale-up of the prevention of mother-to-child transmission of HIV.
[515] United Nations 2008:14. Declaration of commitment on HIV/AIDS and political declaration on HIV/AIDS: midway to the millennium development goals.
[516] United Nations 2008:14. Declaration of commitment on HIV/AIDS and political declaration on HIV/AIDS: midway to the millennium development goals.
[517] UNAIDS 2008. Responding to AIDS: assessing progress in eastern and southern Africa.

**Table 2: Financial Resources needed in 2010**[518]




When questioning Kevin De Cock on the possibility that funds allocated for male circumcision might have a greater impact if used on other interventions, such as mother-to child (PMTCT), he stated: "I think it's a false dichotomy to pose these kinds of questions. The AIDS response needs a comprehensive response for prevention, treatment and care and all of the modes of transmission need to be addressed. And to put mother-to-child transmission against male circumcision is just I think a completely false kind of dilemma both need to be done." [519] Dr. Auvert responded "I think first all maybe that's it's not the same money, but that's another problem" he also stated "it [male circumcision] only has to be

[518] UNAIDS 2008. Points for response to "reassessing HIV prevention" in science.
[519] De Cock, Kevin March 23, 2008. WHO, Director of HIV/AIDS. Interview.

done once, which is a big change in comparison to ARV and PMTCT. [520] Tomas Lundstrom provided his thoughts on the subject:

> Why do we have only 31 percent of pregnant women reaching any kind of PMTCT services in Lesotho, because there is no will or interest. If you look at that of course, you can say it will be a one time off. But I am saying it's better than nothing and I am not saying that we shouldn't focus on PMTCT to get it up, but the fact of the matter is we are not doing enough and we have money in these countries not being used.[521]

Professor Leickness shared his thought on the difficulty of allocating funds for an intervention that may take 20 years to show any measurable gains, he explains:

> Given the fact that the effects or impact on a population level will only be seen like in 20 years. Where there are needs today and now, people who don't have a meal to eat and this is happening worldwide now, if you're watching what's happening in terms of high cost of food it is going to be extremely difficult actually to find money to do this. Even those who have modeled this, they said the impact is actually going to be minimal in the short term. Again if it does protect anyone it's just men for now that is what we know, so we have no idea whether this will be helping women in the long run as well, that remains to be seen.[522]

Professor Leickness observation draws attention to a possible gap in the cost analysis modeling. It appears from the evidence collected that little emphasis was placed on comparing all HIV interventions collectively - based on number of lives saved and adverted deaths over specific intervals of time. The modeling appeared to concentrate on male circumcision in isolation, with its costs and adverted deaths compared to each intervention, but not collectively as a group, in other words which proven interventions would have the greatest impact on population health in the shortest interval of time. Recognizing that funds and resources are not unlimited, this gap in the evidence appears to be significant.

The final example of how the UN Work Plan influence the male circumcision agenda was observed through the number of news stories criticizing the efforts of African governments. An editorial from AllAfrica.com discussed President Museveni hesitation to proceed with male circumcision they reported, "He was quoted last week saying he would not promote

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[520] Auvert, Bertran March 19, 2008. University of Versailles French Institute of Health, Director. Interview.
[521] Lundstrom, Tomas April 23 2008. UNAIDS Regional Adviser HIV Prevention. Interview
[522] Simbayi, Leickness April 14, 2008 HSRC, Social Aspects of HIV/AIDS & Health Programme, Executive Director. Interview.

male circumcision as a means to prevent HIV transmission unless scientific evidence on its effectiveness was available. What more scientific proof do you want, Mr. President?"[523] News 24 in June of 2007 reported that Neil Martinson, WITS Prenatal HIV/AIDS Research Unit, stated 3 months after the endorsement "There has been a deafening silence from policy people in this country, what else should we do, what else is there?."[524] Another media source in 2008 discussed Activist Stephen Lewis opinion of the slow progress of male circumcision in South Africa:

> There is just so much more to be done. Frankly, one of the things that is inadequate is the United Nations agencies. Some of it is bewildering. For example, you get the Minister of Health in South Africa (Dr. Manto Tshabalala-Msimang) attacking and dismissing circumcision as a preventive technology. Here you have three determinative studies, definitive studies, we have UNAIDS and WHO encouraging male circumcision as a way of reducing transmission and you get an attack on it by the minister of health in South Africa. Where is the United Nations' voice? Why haven't they taken on the minister? Why haven't they said what should be said, which is that she's effectively dooming people to death and it need not be done? You have to have a much stronger voice of advocacy from the United Nations in dealing with disease and related matters".[525]

Lewis critiqued both South Africa and the UN on their progress, however his theme was universal, for he was aware of the evidence and was advocating for action, which has been the historical responsibility of activists. Alternatively, however these statements may actually be the consequence of the international marketing campaign formed under the guidance of the UN Work Plan, which requested or demanded advocacy if male circumcision was to have any population benefits. Bertran Auvert's statement from a June 2007 article highlights the inherent power attributed to an international endorsement "It's not even my opinion. It's now a WHO recommendation," he said.[526]

Furthermore, the literature explained that advocacy has been a critical component for getting governments to proceed with action in sub-Saharan Africa, which could be a reason for the need to create demand. However, conversely De Waal argued that international organization had the potential to solidify into an "introverted bureaucracy that soldiers on, pushing certain formulae on African societies", resulting in policies and programs that become inadequate or

[523] AllAfrica.com 2008. Aids-High time men got the cut.
[524] News24 2007. SA needs mass circumcision.
[525] Shiner, Cindy 2008:2. Activist Praises Europe, Slams U.S. on Aids
[526] Soweto. 2007. SA needs 'mass circumcision programme'.

inappropriate for combating the AIDS epidemic.[527] Additionally Patterson suggested that substantive policy development should be achieved through empowering civil societies with the means to engage in discussions. Both De Waal and Patterson historical observations on why community participation has not been effective might question the principles and logic behind demand creation.

**Consultations**

As previously mentioned the consultations were considered a key element of why WHO and UNAIDS were able to act in the manner and timing they did and according to experts they provided the justification needed to issue an endorsement. From July to September 2006, the UN Work Plan group held country level consultations with five countries in sub-Saharan Africa (Lesotho, Kenya, Swaziland, Tanzania and Zambia).[528] The UN group also assisted in coordinating four major consultations on male circumcision, which took place from November 2006 to March 2007.

Catherine Hankins outlined the consultation process thus,

> It was done in a meeting with over 80 people. It was done in a traditional consultation like we have all the time that weighs the evidence, the evidence is presented, people argue about it, they question the data and then we come up, the meeting comes up with recommendations. So in that meeting there were human rights' experts, there were gender experts, women's groups, activists, people with HIV – it was a broad range, we brought everybody who could have anything to say into the room including people who were completely opposed to male circumcision, totally opposed to it. It is only in doing that, it is not one person that sits somewhere and decides something. [529]

Dr. Abdool Karim who attended the Montreux meeting provided a narrative of the process he experienced:

> The first day in Montreux we just reviewed the evidence, so we had each of the teams present to us in detail all their data we were able to quiz them and really hone in on it and poke every kind of loophole we could find and then at the end of that we had to say does this hold up to

[527] De Waal, Alex 2006:121. *AIDS and power*.
[528] UNAIDS 2007:5. Regional consultation on safe male circumcision and HIV prevention.
[529] Hankins, Catherine April 22, 2008. UNAIDS Chief Scientific Officer and Associate Director Evidence, Monitoring and Policy.

> scrutiny and the answer was an unequivocal yes. When you put it under the microscope, these trials are all solid, you can rely on that outcome that finding is solid, and it's solid by itself, and it's solid in relationship to the other three trials. That makes the difference, this evidence is now incontrovertible, and you can't sit on the side now.

The following expert opinion supported WHO and UNAIDS argument that their recommendation was seen as a collective decision.

> UNAIDS and WHO held many consultations with researchers, scientists, reviewed the evidence, talked to many different entities and didn't make the decisions on their own. They made it with lots of expert, based on the evidence we believe that this is an additional strategy that is important for HIV prevention. They have never said that it is the only strategy, they have never said that other strategies should not pursue, they have just said it is another tool in the toolbox, so based on the evidence and the randomized control trials had strong results and they were well done trials.[530]

However, the evidence collected from the attendees list given in each consultation report opposes the concept of collective and representative. The attendees for the Montreux consultation was not provided and the number of attendees that participated ranged from 80 to 120, based on accounts from UNAIDS and an expert.

**Table 3**: African Participants in Consultations

| Consultation | Nairobi, Kenya Participants (50) Safe MC and HIV Prevention November 20-21, 2006 | Geneva, Switzerland Participants (50) Strategies and Approaches MC Programming December 5-6, 2006 | Durban, South Africa Participants (30) Social Science Perspective MC January 18-19, 2007 | Montreux, Switzerland Participants (n/a) Recommendation March 6-8, 2007 |
|---|---|---|---|---|
| Ghana | | 1 | | |
| Kenya | 6 | 3 | 1 | |
| Lesotho | 2 | 1 | | |
| Malawi | 1 | | | |
| Mozambique | 1 | | | |
| Senegal | | 1 | 1 | |
| South Africa | 1 | 3 | 13 | |
| Swaziland | 3 | 1 | | |
| Tanzania | 3 | 1 | | |
| Uganda | | 1 | 1 | |
| Zambia | 2 | 1 | | |
| Zimbabwe | 1 | | | |
| | 20 | 13 | 16 | |

[530] Anonymous Respondent One. 2008. Interview.

The findings showed that the majority of participants were international and/or from WHO and UN agencies. Young argued that the "inclusion and participation of everyone in public discussion and decision-making requires mechanisms for group representation, where differences in capacities, culture, values, and behavioral styles can be put forth without judgment or discrimination.[531] Young's statement suggests the decision to conduct back-to-back consultations could have limited the style and diversity of participants, through imposing possible constraints on participant's time and resources to incur such expenses. Furthermore, by having the final consultation in Montreux it could have limited the number and style of participants from sub-Saharan Africa.

Various experts expressed concern with WHO and UNAIDS' consultation process. Mary Crewe shared her observations:

> I have been at a couple of UNAIDS consultations which actually are not really consultations. They are processes where you are told, that this is what UNAIDS wants to do and wants to recommend and you get a chance to comment, but you kind of know that unless you are supporting them, your views are going to be regarded as dissident.[532]

Warren Parker also shared his experiences with the consultation process and their propensity to be exclusive and potentially lacking of critical thinking:

> Well I was part of those processes, it really has to do with what you might call the Geneva "jification" if that can be a word of AIDS policy. How do these discourses happen and who has the voice, and who is organized around having a voice in Geneva, well it sure as hell isn't people in Africa. With that said, I injected a whole bunch of ideas into the debate when they had that policy discussion, but it was by virtue of having access to the mechanisms to do that and (a) knowing about the meeting (b) being part of it - one of the normal groups that is called for input and having the technology to do it. But that is certainly not a comprehensive voice from the region and that is really how these things are structured so they can go through a process, say that there was consultation and off you go.[533]

[531] Young, Iris Marion 1990:115. *Throwing like a girl and other essays in feminist philosophy and social theory*.
[532] Crewe, Mary April 15, 2008. Pretoria University, Centre for Study of AIDS, Executive Director. Interview.
[533] Parker, Warren March 27, 2008. CADRE, Executive Director. Interview.

Gary Dowsett who attended the Montreux consultation supported Crewe and Parker's observations and explained how WHO and UNAIDS might benefit from this type of process. He explained:

> That [this kind of meeting] is what covers their backs and that's what allows them to move forward. It's what allows them to say to people who get up and say 'no', who weren't involved in the process, that we have been through a consultation process with the world experts on this issue and the evidence says in their view this is the way to proceed.[534]

Dr. Daniel Sidler expressed the frustration he experienced when trying to present his concerns, he shared his thoughts:

> What has happened, which I am saying again and again is that this whole debate has become polarized, it is not constructive and that is one of the previous questions this is direct and a very negative outcome of how this discussion has happed. It should not be polarized, it should be constructive but critical, so that actually everybody who has got something to say is on board and hopefully finally one can come to a conclusion at the end and not that one labels each other with terminology, which is more ideological and discussed in a very polarized way.[535]

Two consistent themes emerged from the literature and interviews, WHO and UNAIDS sense of justification based on the consultations and the practicality that they had only issued guidance; however, the choice remained with the governments, communities and individuals to decide. Dowsett, argued even though the governments may be the implied decision makers, "it doesn't work that way, when WHO support a UNAIDS endorsement vast amounts of money are going to be thrown at impoverish governments to go down this path if they'll do circumcision. And, of course, they will take—well, most of them will take it, some of them won't."[536] Dowsett's observation was supported by the 2006 New York Times article where Dr. Mark Dybul, the Executive Director of PEPFAR, said we "will support implementation of safe medical male circumcision for H.I.V./AIDS prevention" if WHO recommends the intervention.[537] Furthermore, in 2007 during the Montreux consultation Dr.

[534] Dowsett, Gary May 9, 2008. Australian Research Centre in Sex, Health & Society, Professor, Deputy Director.
[535] Sidler, Daniel April 13, 2008. Tygerberg Children's Hospital, Pediatric Surgeon. Interview.
[536] Dowsett, Gary May 9, 2008. Australian Research Centre in Sex, Health & Society, Professor, Deputy Director
[537] McNeil Jr., Donald. 2006:A21. H.I.V. Risk halved by circumcision, U.S. agency funds: more money is expected.

Salim Abdool Karim recalled PEPFAR stating, "You guys tell the world you think this should be done, [then] PEPFAR is going to provide the money to do it."

The following two quotes provided by Kevin De Cock and Tomas Lundstrom could be viewed as examples of an implied assumption of choice with a subtle component of why not:

> Those are the choices society needs to make and individuals need to make and I do believe it is people's choice. But it gets back to, the early part of this discussion, what do you think are the obstacles the obstacles are community ownership and political ownership saying look AIDS is unacceptable, what it is doing in Southern Africa with its rampant epidemic of tuberculosis to which now we have had a drug resistance as well, this is unacceptable. [538]

Tomas Lundstrom explained how he viewed UNAIDS response to the endorsement,

> We tried to be careful not to say everybody should circumcise, we also said that this is mainly something we are pushing in hyper-endemic countries where you have more that 15% prevalence, where it can really have an impact. I think whenever there's something out there that's proven to work we need to really push it, we need to push it carefully, and I think we did that and that's why we had situational analysis and discussions in countries about how it works.[539]

Many of the principles of the consultative process used for male circumcision may conflict with the obstacles UNAIDS argued were crucial to overcome, if Africa's was to succeed in combating AIDS. The following aims were presented in the AIDS in Africa: Three scenarios to 2025 report: Ensuring the crisis is defined and backed by all players; policies should be shape by ensuring the inclusion of local cultures, values, and meanings if results are to be effective; the need to reflect on national or international capacities without the pressure for results, otherwise it could create an environment where the priorities of stronger voices prevail; no magic bullet strategies; there must be a wide range of actors in implementing and proposing solutions; comprehensive understanding of social, physiological and economic issues that impact women; and a greater understanding of the psychological impact of the epidemic.[540]

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[538] De Cock, Kevin March 23, 2008. WHO, Director of HIV/AIDS. Interview.
[539] Lundstrom, Tomas April 23, 2008. UNAIDS, Regional Adviser HIV prevention. Interview.
[540] UNAIDS 2005:20-21. AIDS in Africa: Three scenarios to 2025.

This section has demonstrated that the authority WHO, UNAIDS, and the steering group held allowed them to direct and influence the discourse on male circumcision. The evidence illustrates how the process was managed under the guidance of UN agencies, international organizations, and the financial supporters of the trials and Work Plan. Furthermore, the ability to engage in critical debate was highly contested by experts who questioned certain aspects of the endorsement. Additionally the evidence has shown how the principles of the Work Plan influenced, press, advocacy, and resource allocations. Lastly, the evidence cast doubt on the openness and participatory element of the UN Work Plan and Consultations. This section demonstrated that the consultative process was critical to understanding why WHO and UNAIDS endorsed male circumcision and suggest that their internal endorsement was made in April 2005, the day Catherine Hankins stated the UN Work Plan for Male Circumcision was established.

## 3. State of the Epidemic

The final reason for explaining why WHO and UNAIDS issued their recommendation was the current state of the epidemic in sub-Saharan Africa. This study has clearly outlined in chapter 3 and throughout this chapter that the endorsement was directed at regions with hyper-endemics and low levels of circumcised men. This signified that countries or regions located in sub-Saharan Africa were the populations targeted for mass circumcision.

The state of the epidemic will be defined as the amount of new HIV infections, because experts have argued that these figures most accurately reflect current trends.[541] In simplest terms, this final explanation was based on the premise that there would be no need for funding or mobilization of international resources for male circumcision if the epidemic were perceived as under control. Therefore, this section will argue that in the absence of any sizeable decline in new HIV infections or workable vaccines a sentiment of pessimism developed amongst the community of AIDS, which influenced WHO and UNAIDS decision.

Gary Dowsett who attended both the Social Science and Montreux consultations discussed the association between male circumcision and the epidemic. He explained, "people advocating that circumcision be added to the list [of prevention activities], argued that none of the other preventions methods are working or working fast enough to make a difference,

[541] Dorrington, Rob et al. 2006:29. The demographic impact of HIV/AIDS in South Africa: National and provincial indicators.

and prevalence continues to rise. Therefore, there has got to be something to break the cycle."[542]

In addition to the evidence presented on the current state of the epidemic in chapters 1 and 3, Dr. Abdool Karim explained how a sense of pessimism has emerged within the Africa AIDS epidemic.

> I think if you look at where we were 2 years ago, we were very excited we had all these trials underway, we had microbicides trials, we had vaccine trials, we had trials on herpes simplex virus suppression, and we had trials for diaphragms. We had just so much hope that some of these were going to be successful. The reality today is very different, the reality today is that none of these have shown to be efficacious except for male circumcision.[543]

Another form of pessimism emerged from the social science experts, there was a sense of frustration that their ideas and points of views were not adequately being heard or considered. Gary Dowsett shared his thoughts on why the pessimism existed:

> Well I think there's a profound pessimism out there at the moment in my game, the social science game. I think we have been beaten around the ears for the last years globally in the rise of biomedical scientific hegemony.[544]

Warren Parker statement merged the thoughts shared from Dr. Abdool Karim and Gary Dowsett; he discussed how male circumcision could potentially be a symbolic representation of why HIV prevention efforts have historically failed. He said:

> We are sitting in an epidemic that is severe, massive prevalence, and I am talking largely about the Southern Africa epidemic and you have got to ask yourself the question, what is pretty much an emergency situation. We pretty much have gotten here through everyone's great ideas not working. So what do you do in that kind of context? And the problem with something like circumcision it is basically saying look don't change the dynamics of the society in relation to this disease don't explore the implications of the fact this disease exists for a societal level intervention, just add a technology, which is exactly why condoms didn't

[542] Dowsett, Gary May 9, 2008. Australian Research Centre in Sex, Health & Society, Professor, Deputy Director. Interview.
[543] Abdool Karim, Salim March 20, 2008. CAPRISA, Executive Director. Interview.
[544] Dowsett, Gary May 9, 2008. Australian Research Centre in Sex, Health & Society, Professor, Deputy Director. Interview.

> work, it is exactly why circumcision is not going to work and exactly why non bio technologies have actually been effective in other contexts and strategies.[545]

The majority of experts interviewed were profoundly concerned with the current state of HIV prevention in sub-Saharan Africa. When asked: Why in your expert opinion did WHO and UNAIDS make their recommendation; the overwhelming response was situated within the context of the current state of the epidemic. Themes that emerged from the expert responses were urgency, silver bullets, emergency, pessimism and a sense that nothing else was working. Leickness Simbayi expressed his frustration:

> Again, it goes back to where we started talking about prevention that although certain inroads have been made the epidemic continues unabated, meaning that something else needs to be done. So I think we have all been looking for the silver bullet, the solution to how we would really defeat this disease and since there is no vaccine out there. If this had been a vaccine with a 60% efficacy that would be good. This is the closest that we get to anything like a vaccine and it has been shown to work convincingly in those three randomized controlled trials and there is ample evidence from other sources (ecological research that has been done) that it is protective against HIV. So I think it is in this desperation to really turn the tide that here they had something that appeared to be the answer we have been looking for.[546]

David Harrison shared his opinion on WHO and UNAIDS decision to proceed:

> Well I will think there are a couple reasons one is we are all desperate for the silver bullet were all certainly desperate to know where the next big gains are coming from. The desperation that there has been such limited success in terms of research, with stuff that works that it would be remiss of us not to try and act on positive findings. So circumcision has been shown to reduce transmission therefore we need to find a way to act on it.[547]

Dr. Bertran Auvert believed there were two important reasons for WHO and UNAIDS endorsement, the epidemic and the trials.[548] Profession Moodley also concluded the key drivers were the trials and the epidemic; she shared her concerns over the state of prevention:

> The scientific evidence from all three trials was regarded as reliable, valid, and generalisable

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[545] Parker, Warren March 27, 2008. CADRE, Executive Director. Interview.
[546] Simbayi, Leickness April 14, 2008 HSRC, Social Aspects of HIV/AIDS & Health Programme, Executive Director. Interview.
[547] Harrison, David April 24, 2008. Love Life, Executive Director. Interview.
[548] Auvert, Bertran March 19, 2008. University of Versailles French Institute of Health, Director. Interview.

> within the sub-Saharan setting. I also think that there's an incredible urgency to do something to prevent HIV/AIDS from escalating any further than it already has and I think part of their rapid response was related to the fact that they like all of us want to find something that is going to work, given the fact that so many other preventive methods have been unsuccessful or have outright failed in clinical trials.[549]

Experts also highlighted how the state of the epidemic had the tendency to cause international AIDS organizations to become frustrated and promote these "flavors of the month" or "flavors of the year" campaigns to combat the epidemic.[550] Mary Crewe, also agreed with this observation, and stated:

> I think they endorsed it because again, they were looking for something, they had a lot of AIDS panic attacks around prevention and they believed that this is a way of getting to men who have been neglected traditionally in AIDS prevention work and this is a way that men could be brought into the whole system. I do not think they understand a lot of the social and cultural implications.[551]

The following statements from WHO and UNAIDS support the experts findings that, the epidemic was a critical component of why they made their decision. Kevin De Cock shared his perspective:

> We're [WHO] not forcing anybody to get circumcised, but I am saying the evidence is overwhelming that HIV is killing your society, it is not good for your culture to lose 20 to 30 years of life expectancy across your population, it is not good for your infant mortality to have trebled (or whatever it is) or to have an epidemic of orphans. It is not good for your society, now if you think that well none of that matters but my foreskin is much more important for my identity, those are the choices people need to make. Those are the choices society needs to make and individuals need to make and I do believe it is people's choice. [552]

Furthermore, Tomas Lundstrom shared his frustration with epidemic and the progress:

> We [UNAIDS] can create more strategies, why aren't people saying, I love for someone to come up and say listen should we do more strategies, should we have another policy, instead people are saying no we shouldn't circumcise it's too costly, it's too that, criticize the fact that

[549] Moodley, Keymanthri April 14, 2008. Bioethics Unit Tygerberg Division, Professor. Interview.
[550] Harrison, David April 24, 2008. Love Life, Executive Director. Interview.
[551] Crewe, Mary April 15, 2008. Pretoria University, Centre for Study of AIDS, Executive Director. Interview
[552] De Cock, Kevin March 23, 2008. WHO, Director of HIV/AIDS. Interview.

> nothing is happening in these countries, why aren't governments taking gender issues seriously why aren't they doing that, that is what we should criticize.[553]

This section has argued that the epidemic was the universal driver for WHO and UNAIDS endorsement, which was supported by the literature on HIV prevention in chapter 3 and throughout the interviews. Furthermore, the fact that male circumcision was targeted for certain regions in sub-Saharan Africa supports the argument that the state of the epidemic was a critical factor to explaining why the endorsement was made and with a sense of urgency.

## 4. *Why Wait*

The evidence-based research, consultative process, and the state of epidemic explained why WHO and UNAIDS believed they had weighed the evidence and assessed that they were justified in making their endorsement. However, at the start of this chapter it was argued that when questioned on the urgency and motivation behind their decision, WHO and UNAIDS maintained an attitude of 'why wait'. Kevin De Cock provides an example of this position:

> Is the evidence good, yes, the evidence is very good. It is very very strong. It is almost a teaching example in terms of cause and effect and the caveats around it (which you are pushing very hard) they are described in our recommendations. I think WHO and UNAIDS have done what they have to do as far as the normative work that we do with those recommendations - yes. Should Southern Africa scale this up absolutely, I mean you know the fact you have countries with levels of prevalence of 35% or so amongst adults is astonishing. I mean what more do we - I mean really you need to ask the question, in a way, I think you need to ask the question, how do you not justify – how do you justify not using this intervention in the face of such a public health disaster. [554]

The rationale for engaging this concept of 'why wait' was based on the evidence collected from the expert's responses to the question: In your opinion did WHO and UNAIDS have enough research evidence put forth on the challenges and concerns of male circumcision before issuing the policy statement? The group of 20 experts from diverse professions and regions throughout the world produced the following results: 8 experts said 'yes' and the remaining responses ranged from 'no' to "not sure". The argument of 'why wait', explains

[553] Lundstrom, Tomas April 23, 2008. UNAIDS, Regional Adviser HIV prevention. Interview.
[554] De Cock, Kevin March 23, 2008. WHO, Director of HIV/AIDS. Interview.

why WHO and UNAIDS were justified in proceeding with the endorsement when concerns relating to risk compensation, engaging in sex before proper healing, healthcare infrastructures, feasibility of conducting a mass scale up, social and cultural readiness and the possible risks to women, had not been fully addressed. WHO and UNAIDS argued the process was justified for the following reasons: the trials created demand which necessitated a need for safe circumcision guidelines, the intervention was just one in a comprehensive package of HIV prevention strategies, it would be unethical not to offer this service, we have already proven the effectiveness in the observational data and people are dying.

This section will explain why WHO and UNAIDS believed they were justified in making their endorsement. The first approach came from Catherine Hankins, who argued, there may be people who don't agree, however "some people do call it a kind of best practice model of moving quite rapidly on emerging findings to come up with guidance for countries"[555] and there was a group "that basically says we acted way too late. Millions of infections could have been averted had we moved on the observational and ecological data"[556] Additionally when an expert from WHO was asked about some of the potential concerns raised on male circumcision, they stated,

> Well a lot of the concerns that people expressed, one were not evidence based and two it was mainly expressed from people outside of Africa and we also had concerns from groups these recommendation didn't even affect. So for example gay men, this recommendation does not apply to gay men. An two if you have a lot of concerns coming out of the US or Australia, where these interventions are not going to be scaled up then of course one must listen to the concerns, but from within Africa, the African people, I really haven't heard the kind of concerns. I haven't heard these kind of big concerns at all personally. Also of course, when one is looking at concerns or suggestions there needs to be some evidence or some strong basis for the concern, but we haven't had that. So what we have done is look at the trials and in looking at some of the trials, for example - there was a trial at the time on looking at transmission from HIV positive men to women we didn't have enough evidence at the time and therefore this is something that we are now following up, now we have additional evidence as to whether we have sufficient evidence we can't say. I think it is really a problem when you have a lot of outcries from people who are not at all affected by the prevention and they don't provide information to people who are directly affected

[555] Hankins, Catherine April 22, 2008. UNAIDS Chief Scientific Officer and Associate Director Evidence, Monitoring and Policy.
[556] Hankins, Catherine April 22, 2008. UNAIDS Chief Scientific Officer and Associate Director Evidence, Monitoring and Policy.

> People need to be told of what the evidence is, people need to be cautioned about what the evidence does and does not say and people have to make their own decisions. because in the African region people have the capacity to do that, and everyone needs to recognize this as well.[557]

Tomas Lundstrom, UNAIDS Regional Adviser for HIV Prevention stated in response to a inquiry into understanding if the low levels of HIV infections in some countries were a result of the sexual customs of Muslims, versus the fact that they are circumcised. Lundstrom responded:

> We don't know enough, we need to look into everything but this is a dire situation where people are dying like flies, and I don't want to sit back and say oh you know it could be this, but it could also be that, Muslims are you know are a different type of sexually so we shouldn't do anything here. I think it, that would be ethically, ethically wrong. If we know that something would could work then let's do it, let's try it, that what I would say. I am starving for interventions I cannot tell you one good thing to tell everybody to do.[558]

One of the popular concerns expressed, was whether the intervention would be effective in a real world setting compared to the controlled environment of a RCT setting. In response to these concerns, Kevin De Cock provided the following argument:

> With circumcision, I wonder whether in a different situation, because I wonder whether paradoxically we have not had previously the real life experience already, because you know all of the observational data and the analytic data on male circumcision from Africa are real life situations where people were circumcised. The epidemiology is what it is, so in a way we sort of – it is a very interesting situation where in a way we did the clinical trials after we had a lot of real life situations. It's a funny example of epidemiologically having the cart before the horse. Normally when you have a new intervention like a vaccine or a drug, the clinical trials get done and the results are wonderful and when you use it in real life, it often is not quite as good as you had hoped from your original clinical trials.[559]

The experts that agreed with the decision to move forward provided three primary reasons. First, one can never wait for everything to be perfect in the context of Africa and if we had waited with ARV's millions of lives would have been lost. Second, the epidemic justifies the

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[557] WHO, Anonymous. Interview.
[558] Lundstrom, Tomas April 23 2008. UNAIDS Regional Adviser HIV Prevention. Interview
[559] De Cock, Kevin March 23, 2008. WHO, Director of HIV/AIDS. Interview.

response. Third, nothing else is working, so why not try it. Mark Heywood argued it was their "duty to put it out" however the way a country integrates and operationalizes the intervention was a different matter.[560] He explained, that when you do have research evidence, the intervention should be offered universally, because of what they learnt when rolling out ARV programs.[561] Robert Bailey explained his justification for not waiting for additional social science research was the number of lives that would be adverted, he explained:

> Now of course there are challenges and potential problems, but are you going to withhold something that has proven effective because there are a few challenges that are before us as we roll out? I mean those are going to be and should be and hopefully will be addressed as we roll out the services and we are going to do operational research, we are going to do research on risk compensation, research on the effect on women. There is going to be all that research that is going to take place, but if you wait another five or ten years think how many HIV infections could be averted in another five years of social research.[562]

David Harrison explained why the epidemic justified the action to proceed, he stated:

> Well I do not have a problem with that, I do think that in the face of such an emergency you go with the information that you have and it is about levels of confidence. So I don't have a problem with the outlining and programmatic implications, even if we don't have all the i's dots and t's crossed.[563]

Another expert discussed how the lack of any other effective prevention measures influenced her point of view to proceed forward, she commented:

> It is like a pull back position for prevention; although it will not completely protect or prevent HIV acquisition, it will definitely reduce it. In the absence of doing anything else at least, you are reducing the chances of halving the risk of HIV acquisition in men. It is a single intervention that is durable whereas the current mechanism we have, which is condoms and condoms and condoms - you're required to have them, to put them and use them properly, every time you have sex and that is sometimes harder to achieve than a circumcision.[564]

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[560] Heywood, Mark April 25, 2008. ALP, AIDS Law Program, Executive Director. Interview.
[561] Heywood, Mark April 25, 2008. ALP, AIDS Law Program, Executive Director. Interview.
[562] Bailey, Robert March 20, 2008. University of Illinois Chicago, Professor. Interview.
[563] Harrison, David April 24, 2008. Love Life, Executive Director. Interview.
[564] Gray, Glenda April 2, 2008. HIVSA, Executive Director. Interview

Dr. Abdool Karim shared his point of view on why it was appropriate to issue the recommendation:

> Yes, I mean we will never have all the information and it will never be perfect, but we have enough information to make the decision then. If the models that we believe - I mean this country it will have a huge impact here.[565]

Another position that emerged from the experts who supported male circumcision was the rationale that that if errors or concerns did arise during rollouts then they would stop and correct the errors, however it should not delay the endorsement. Alan Whiteside, Director of HEARD share this need for urgency while premised on caution:

> Well I think for me it was a statement of, this is what we know, this is what the science is telling us, and this is what we would recommend. There are all the caveats and we know those caveats, but on the basis of what we know, here is something that we know will work and therefore we would suggest you do it, as simple as that. The other thing is that people have this assumption that everything we say is written in stone forever. I think it was endlessly debated and equally again I don't think, I think we all knew, we didn't have the answers, but we certainly knew enough to say that this is something that should be issued.[566]

WHO and UNAIDS believed their positioning of the intervention as part of a comprehensive package of HIV prevention tools, was also a reason for moving forward. Dr. Ben Chirwa discussed WHO and UNAIDS integrated approach:

> Again, it has to be looked at within the framework of the recommendation. The recommendation basically is that you are adding circumcision to the broad range of more prevention choices and that is the context that they are giving. It is the same even when WHO made an earlier statement of caution was that this should not be seen as a final sphere, as an ultimate solution to the prevention of HIV infection. I think their presentation has been consistent and that is, let's look at this overwhelming and compelling evidence that it should be done within the package of prevention services.[567]

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[565] Abdool Karim, Salim March 20, 2008. CAPRISA, Executive Director. Interview.
[566] Alan Whiteside, HEARD, Executive Director March 20, 2006, HEARD, Executive Director. Interview.
[567] Chirwa, Ben April 16, 2008. Zambia National AIDS Council, Director General. Interview.

The findings show that the 'why wait' position may have created a since of polarization of opinions and the lack of will to enter into constructive debates or solutions. This was captured in Kevin De Cock's pronouncement:

> What I have always said to people, I said look, you make your judgment based on the evidence, but you take ownership of the decisions you make, of the benefits of that decision and the negatives. So if I recommend circumcision I will take ownership of the prevention benefit, but I also must take ownership of the negative things you are alluding to, the cultural problems, the gender sensitivity issues, etc. etc. Am I prepared to do that? Yes I am. If somebody goes and says male circumcision is wrong for HIV prevention then take ownership of the infections that happen, that could have been averted, take ownership of that and just convince yourself then that the benefit in terms of cultural identity and everything like that justifies those preventable HIV infections that have occurred but have not been prevented. Those are the sort of judgments we have to make in public health.[568]

Dr. De Cock's statement provides the framework for explaining the rationale behind the frustration many experts expressed when trying to engage in constructive debates. Mary Crewe shared her frustration:

> There were lots of social scientist who said hey listen to us and they simple refused. [Why?] It would mean they would have to rethink what they were doing they would have to ponder on some difficult anthropological cultural, social, and political questions, they would have to think in difficult ways about issues around masculinity and sexuality and they didn't want to do that. They didn't want anything to mess up there nice streamed line approach. The consultations they had were heavily weighted towards the biomedical and they didn't really take the concerns of social theorist seriously or seriously enough.[569]

Dr. Sidler asserted that WHO and UNAIDS approach was void of critical debate, which implied they had a magic bullet, "Science is about hopefully coming to a solution at some stage and then realizing 20 years' down the line that that solution was the wrong one. Science is dynamic, one gets the feeling that these people really feel that they have found the golden bullet and nobody is to touch it, it is taboo, it is beyond critical analysis."[570]

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[568] De Cock, Kevin March 23, 2008. WHO, Director of HIV/AIDS. Interview.
[569] Crewe, Mary April 15, 2008. Pretoria University, Centre for Study of AIDS, Executive Director. Interview.
[570] Sidler, Daniel April 13, 2008. Tygerberg Children's Hospital, Pediatric Surgeon. Interview.

Through defining the principles behind why WHO and UNAIDS was justified to proceed with the endorsement, one can start to see how these ideologies might of influenced their actions. Additionally the intensity of their statements may question if they were open to critical analysis or as some experts have argued the decision had already been made. Furthermore, the findings from 'why wait' support the argument that the state of the epidemic was a decisive factor in understanding why WHO and UNAIDS made their endorsement and why experts supported the recommendation.

## 5. Conclusion

In conclusion this chapter has argued that the evidence-based research, consultative process and the state of the epidemic were the three reasons why WHO and UNAIDS endorsed male circumcision as a public health initiative for HIV prevention in sub-Saharan Africa. The comprehensive body of evidence collected over the last 20 years on male circumcision and HIV acquisition established the framework for WHO and UNAIDS actions. Furthermore, this chapter has shown why the RCT's, modeling, and acceptability evidence-based research each had substantial influence in shaping their endorsement. For, the strength and consistency of the three RCT's transitioned male circumcision from a research agenda to a policy agenda. This modeling studies shaped the profile for the determination of where male circumcision should be rolled out and to whom; established the justification and urgency for a rapid and massive scale up; facilitated the need to solicit international funds and support; and compelled activists and the media to promote and create demand for male circumcision. Furthermore, the findings explained how modeling studies directed public health and policy discourse. Thereafter, the acceptability findings gave donors, governments, media and the public the reassurance that male circumcision was culturally accepted, and therefore appropriate to endorse and rollout.

The second reason for their endorsement was the consultative process, which was premised on the UN Work Plan for male circumcision and their consultations. These two events gave WHO and UNAIDS the resources to manage and direct a year and a half process backed by powerful male circumcision researchers, funders, and advocates. Furthermore, this process provided them with the means to control and influence research, media, participation, and funding; which explains how male circumcision was endorsed one month after the trial findings were published. The final reason for WHO and UNAIDS endorsement was the state

of the epidemic, which provided the necessary emotional environment to create a sense of urgency and attitude of ‘why not’.

This chapter concludes the evidence-based research, consultative process, and the state of the epidemic were the justification, rationale, and motivation for WHO and UNAIDS endorsement.

## Chapter Five: Conclusion – W*hy Not Wait*

The research question "why did WHO and UNAIDS endorse male circumcision as a public health initiative for HIV prevention in sub-Saharan Africa" was explained in chapters 3 and 4. In summary, their decision was collectively constituted from the evidence-based research, their consultative process, and the state of the epidemic in sub-Saharan Africa. Furthermore when WHO and UNAIDS were confronted with concerns and objections, the prevailing consensus was 'why wait'.

The evidence explained why WHO and UNAIDS made their endorsement, but it also clarified why the process has been contested. The findings suggest that the frustration, doubt and bewilderment associated with male circumcision was in part an outcome of the WHO and UNAIDS consultative process. Specifically, the evidence supports an argument that the WHO and UNAIDS consultative process (UN Work Plan and Consultations) was developed, designed, funded and executed with an intent to endorse male circumcision, versus a process to critically assess if a potentially important intervention could be effectively implemented within the framework of Africa's public health structures.

The evidence shows that the consultative process created an environment that permitted international agencies, funders and universities to direct and influence research, timelines, participants and funds required for male circumcision. The pro-circumcision influence on WHO and UNAIDS consultative process established a structure that hindered and silenced potential opposition, dispelled the need for critical thinking and assessment, and evoked an impression that male circumcision was a "magic bullet - a perfect drug to cure a disease with no danger of side effects."[571]

The rationale for this conclusion starts with WHO and UNAIDS attitude 'why wait' - the evidence was compelling, research can wait, cultures are dying, and nothing else has worked. Their conclusion at face value would seem plausible if it was not for the fact, the evidence does not support this urgency. The evidence appears to show the opposite, unless planned and

[571]Nobel Prize in Physiology or Medicine, Paul Ehrlich was the first to establish the term magic bullet in the field of medicine in 1908. The magic bullet was mentioned in connection with his work with antibodies; however, it was the time when Ehrlich and his colleagues commented on their findings that asrphenamine had a remarkable (magic bullet) effect on syphilis that prominence was given to the term. http://www.medicinenet.com/script/main/art.asp?articlekey=31953

executed to precision, investments could be lost, with no measurable reduction in new HIV infections or population prevalence.

The evidence showed that male circumcisions - required a massive scale up if population health benefits were to be obtained; gains would not be observable for at least 15 to 20 years;[572] women the most vulnerable population to the disease could be placed at risk;[573] and men are the least at risk group for HIV in sub-Saharan Africa. When reviewing this list of 'why not wait' one must ask - what was so urgent that their endorsement had to be made one month after the RCT's were published and three months after the trials had been concluded?

Moreover, the implied assumption may explain, why certain individuals and organizations concluded that male circumcision was the 'magic bullet' of prevention. Why else would two organizations that consistently promote women's rights not take another 6 months to assess how this new data might affect modeling, risk assessments, acceptability, etc.. If a risk assessment had been completed, would it have demonstrated that a 6-month delay might have had little impact on the overall project. In fact, the actual benefits of a delay might have improved the project's success by 25%, who knows, for the risk assessments were not completed. There were no answers; however, "why wait' does pose the question "why not wait", because there was no scientific evidence proving that a delay would result in more deaths.

Furthermore, the modeling evidence concluded that male circumcision could not reduce population level HIV infections for over a decade and only then if high rates (60-80%) of men were circumcised in a rapid scale up.[574] These stipulations appear significant, for they imply that there may be a breaking point, a point when male circumcision would no longer be a cost effective intervention because scale up cannot be achieved. Which questions why WHO and UNAIDS employed only basic cost effectiveness analysis.[575] Furthermore, the cost effectiveness studies were completed by some of the same researchers involved in the RCT's. One could argue this form of analysis was sufficient if male circumcision prevented HIV and

[572] Nagelkerke, Nico et al 2007. Modelling the public health impact of male circumcision for HIV prevention in high prevalence areas in Africa; Williams, Brian et al. 2006. The potential impact of male circumcision on HIV in sub-Saharan Africa.
[573] Rakai 2007. Study presents new information on male circumcision to prevent spread of HIV in Africa; New Scientist Tech. 2007. Male circumcision to fight HIV poses risk to women..
[574] Nagelkerke, Nico et al 2007. Modelling the public health impact of male circumcision for HIV prevention in high prevalence areas in Africa; Williams, Brian et al. 2006. The potential impact of male circumcision on HIV in sub-Saharan Africa.
[575] WHO 2006:26. Strategies and approaches for male circumcision programming; Gray, Ronald 2007. The impact of male circumcision on HIV incidence and cost per infection prevented: a stochastic simulation model from Rakai, Uganda; Kahn, James. 2006. Cost-effectiveness of male circumcision for HIV prevention in a South African setting

a country has the infrastructure and resources to implement. However, the evidence clearly shows that the partial efficacy requires a massive scale up, which will conservatively take 15-20 years and requires substantial resources to implement. Thus, one would question if these basic cost-effectiveness studies were adequate for the magnitude and complexity of the situation in sub-Saharan Africa.

If the objective of public health remains to prevent disease and promote health, one must question how these isolated cost effectiveness studies even started to rationalize how millions of dollars would benefit a given society. Where were the cost analysis methods that compared various parameters across all HIV interventions, providing an unbiased approach to assessing which interventions would have the greatest impact on population health and for how much. In discussing the nature of collective analysis, The World Bank mentioned factors such as; ranking the interventions in broad categories, how would statistics vary in different demographic areas, does the interventions address the major sources of disease burden, and the feasibility - based on resources and experience.[576] Furthermore, they went on to explain how many interventions can be effective, however it is the combination of knowledge and economic cost effectiveness that determine which interventions can have the greatest impact with a given level of resource commitment.

These omissions point to the weakness of WHO and UNAIDS' consultative process, the attention on justifying the endorsement versus engaging the evidence to critically assess the feasibility of male circumcision at a public health level.[577] Male circumcision may be an important and scientific breakthrough. However, whether the procedure can translate into a significant impact on population health and reducing the burden of disease remains unanswered. Because the evidence on the correlation between costs, resources, risk, interventions and benefits had not been completed and therefore raises questions about why the endorsement was issued.

WHO and UNAIDS argue that male circumcision should be part of a comprehensive approach to HIV prevention and interventions should be based on evidence-based research. However this study has shown that when WHO and UNAIDS were questioned on the cost effectiveness of male circumcision compared to other proven evidence-based interventions,

[576] World Bank 2006:57. *Priorities in health.*
[577] Ibid:56.

the argument became we must do them all to combat the epidemic. This argument however becomes a contradiction and reflects a bias towards male circumcision. Is not the question, what proven interventions can have the greatest impact on population health for the amount of resources and costs. Hypothetically, if you have 10 million dollars and cannot financially justify why male circumcision should have all or part of that 10 million dollars in comparison to other proven interventions, then one would have to question why the endorsement was issued.

The decision to endorse male circumcision before these complex cost modeling studies were completed places governments and communities under pressure to conform and to seek funding irrespective if the intervention will produce the greatest reduction of illness or promote better health. This study has repeatedly demonstrated the negative influence and pressure activists, media, researchers, WHO and UNAIDS implied and/or explicitly directed towards Africa governments and those opposed to the rationale and logic behind the endorsement. Even though WHO and UNAIDS have argued that they provide guidance, the outcomes from their guidance remains significant and questions their authority. Male circumcision does not prevent HIV, which implies that male circumcision may not be the best solution for every community. However, if governments and communities can no longer make an informed decision without pressures from international and local activists and institutions, does that not matter. If the general public can only have one month to review published research, does that not matter.

The recent developments in HIV prevention were discussed in Chapter 3, they included a few of these themes: changing from an emergency approach to a short and long-term strategy; establishing effective prevention programs vs. waiting for a "magic bullet" vaccine; involving communities in a bottom up approach; targeting solution towards those most vulnerable; providing an integrated approach based on evidence; and harmonizing social sciences and biomedical research. This study concludes that the process used to evaluate male circumcision was not representative of these strategies and may reflect why HIV prevention efforts have failed in sub-Saharan Africa.

The evidence suggests that the actions taken by WHO, UNAIDS, researchers, media and activists were not justified, undermines how public health should be administered, and was the direct outcome of an exclusive process that was not open to constructive debate or analysis and furthermore excluded public participation. The evidence supports the notion

that WHO and UNAIDS consultative process and attitude of ‘why not’ was founded on pessimism, double standards and elitism versus a strategy built on the principles of empowerment, commitment, courage, hope, critical thinking and analysis, and participation.

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## Appendix A: Guiding Questions

Below is a list of guiding questions that were utilized during the semi-structured interviews, the objective was to propose questions that could assist in explaining each aim set forth in this research.

### I. Prevention

a) What in your view is the current state of HIV Prevention in sub-Saharan Africa?
b) How do you believe the last 27 years of knowledge, experience, successes and failures will alter the future of HIV prevention?
c) What do you believe are the greatest obstacles to preventing the spread of HIV in sub-Saharan Africa?
d) Please give your thought and /or opinion after listening to each quote:

UNAIDS and WHO have argued "the steady growth of the AIDS epidemic stems not from the deficiencies of available prevention strategies but rather from the world's failure to use the highly effective tools at its disposal to slow the spread of HIV".

UNAIDS and WHO 2006: 124. Report on the global AIDS epidemic 2006.

e) Quote 2

"Furthermore they argued that "for every patient who initiated antiretroviral therapy in 2006, six other individuals became infected with HIV"

Global HIV Prevention Working Group 2007:1. Cited from UNICEF, WHO and UNAIDS 2007. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector and UNAIDS Report on the global AIDS epidemic

### II. Function

a) What in your experience is WHO and UNAIDS function in relation to HIV Prevention in sub-Saharan Africa?
b) What do you see as the distinct qualities that differentiate the two organizations?
c) Do you believe / think WHO and UNAIDS has been or is regarded as a successful leader in directing / managing AIDS in sub-Saharan Africa?
d) Today and looking forward what do you believe is WHO and UNAIDS greatest challenge with HIV prevention?

## III. Circumcision

At the conclusion of the orange farm trial WHO and UNAIDS issued caution, approximately 18 months later after 2 further trials (Kenya and Uganda) were completed they made a commanding endorsement of male circumcision.

a) Why in your expert opinion did WHO and UNAIDS make this recommendation?
b) Were there any aspects of their recommendations that surprised you?
c) What do you believe was WHO and UNAIDS intent in relation to male circumcision and policy?
d) Do you believe there have been any positive/negative consequences from their recommendations?

There has been significant literature and debates on the challenges/concerns of male circumcision, from medical, cost, gender, ethics, and culture many of which were presented in UNAIDS and WHO's position paper.

e) Do you think any of these factors have the potential to hinder the overall forecasts relating to the effectiveness of male circumcision?
f) Do you think governments in sub-Saharan Africa have the skills, budgets, and experience to address all the recommendations WHO and UNAIDS put forth enabling a successful implementation?
g) Were concerns relating to women addressed?
h) In your opinion did WHO and UNAIDS have enough research evidence put forth on the challenges and concerns of male circumcision before issuing the policy statement?

## Appendix B: Interview Schedule

### *Group 1: WHO and UNAIDS*

*Invited: 15*

*Completed: 6*

| Name | Title | Organization | Interview Date |
|---|---|---|---|
| Kevin De Cock, MD | Director of HIV/AIDS | WHO | Completed<br>May 2, 2008<br>5:00 SA/Geneva |
| anonymous | Medical Officer | WHO | Completed<br>March 26, 2008<br>10:00 SA/9:00 |
| Dr. Sibongile Dludlu | Male Circumcision Consultant | UNAIDS (RSTESA) | Completed<br>April 22, 2008 |
| Catherine Hankins, MD | Chief Scientific Advisor and Associate Director Evidence, Monitoring, and Policy | UNAIDS | Completed<br>April 22, 2008 |
| Tomas Lundstrom | HIV Prevention Strategist | UNAIDS (RSTESA) | Completed<br>April 22, 2008 |
| Mark Stirling | Regional Director HIV/AIDS | UNAIDS (RSTESA) | Completed<br>April 2, 2008 |

*No Response: 3*

*Confirmed Unavailable: 6*

| Name | Title | Organization | Interview Date |
|---|---|---|---|
| Chiweni Chimbwete | Circumcision | UNAIDS (RSTESA) | No Response |
| Kathleen Cravero | Assistant Administrator | UNDP | Unavailable |
| Deborah Landey | Deputy Executive Director | UNAIDS | Unavailable |
| Carolyn Hannan | Director for Advancement of Women (DAW) | UN | Unavailable |
| Susan Kasedde | Gender | UNAIDS (RSTESA) | Unavailable |
| Brian Pazvakavambwa | Head of WHO Inter-country Support Team | WHO (AFRO) | No Response |
| Peter Piot | Executive Director | UNAIDS | Unavailable |
| Kristan Schoultz | Director | UNAIDS (The Global Coalition on Women and AIDS) | Unavailable |
| Cream Wright | Chief, Education Section | UNICEF | No Response |

*Group 2: Experts AIDS and Male Circumcision*

*Invited: 48*

*Completed: 21*

| Name | Title | Organization | Interview Date |
|---|---|---|---|
| Bertran Auvert, MD | Director | University of Versailles<br>French Institute of Health | Completed<br>March 19, 2008<br>3:00 p.m. Johannesburg SA |
| Melanie Bacon | Epidemiology Branch | Project Officer for Grants NIAID (Kenya and Uganda) | Completed<br>March 28, 2008<br>3:30 p.m. SA/USA |
| Robert C. Bailey | Professor | University of Illinois Chicago, Division of Epidemiology and Biostatistics | Completed<br>March 20, 2008<br>1:00 p.m. SA/ Kenya |
| Ben U Chirwa | Director General | Zambia National AIDS Council | Completed<br>April 16, 2008<br>2:30 p.m. SA/Zambia |
| Mary Crewe | Executive Director | Pretoria University, South Africa, Centre for Study of AIDS | Completed<br>April 15, 2008<br>1:00 p.m. Pretoria SA |
| George Denniston MD | President | Doctors Opposing Circumcision | Completed<br>March 31,2008<br>5:00 p.m. SA/USA |
| Gary Dowsett | Professor, Deputy Director | Australian Research Centre in Sex, Health & Society, Australia | Completed<br>May 9, 2008<br>9:00 a.m. SA/Australia |
| Glenda Gray, MD | Executive Director | HIVSA, South Africa | Completed<br>April 2, 2008<br>2:00 p.m. Johannesburg, SA |
| Daniel Halperin | Senior Research Scientist and Lecturer | Harvard Center for Population and Development Studies | Completed /Partial<br>May 6, 2008<br>5:30 p.m. SA/USA |
| David Harrison | Executive Director | Love Life, South Africa | Completed<br>April 24, 2008<br>12:00 p.m. Johannesburg SA |
| Mark Heywood | Executive Director | AIDS Law Program South Africa (ALP) | Completed<br>April 25, 2008<br>10:00 a.m. Johannesburg, SA |
| Salim S. Abdool Karim, MD | Executive Director | CAPRISA (Center for AIDS Program of Research South Africa) | Completed<br>March 20, 2008<br>11:00 a.m. Durban SA |
| Jennifer Kates | VP/Director AIDS | Kaiser Foundation | Completed<br>April 10, 2008<br>3:30 p.m. SA/ USA |
| Barbara Klugman | Director of AIDS | Ford Foundation | Completed<br>April 1, 2008<br>8:00 p.m. SA/SA |
| Keymanthri Moodley | Professor | Bioethics Unit Tygerberg Division, South Africa | Completed<br>April 14, 2008<br>12:00 p.m. Cape Town SA |
| Anton A van Niekerk | Department Chair and Director | University of Stellenbosch, South Africa Center for Applied Ethics | Completed<br>April 14, 2008<br>3:00 p.m. Cape Town SA |
| Warren Parker | Executive Director | CADRE Centre for AIDS Development Research and Evaluation | Completed<br>March 27 2008<br>1:30 p.m. Johannesburg SA |
| Daniel Sidler MD | Pediatric Surgeon | Tygerberg Children's Hospital, South Africa | Completed<br>April 13, 2008<br>12:30 p.m. Cape Town SA |

| | | | |
|---|---|---|---|
| Leickness Simbayi | Executive Director of HIV/AIDS, Professor | HSRC, Human Sciences Research Council, Social Aspects of HIV/AIDS & Health Programme, South Africa | Completed<br>April 14, 2008<br>9:30 a.m. Cape Town SA |
| Miriam K. Were | Chairperson | Kenya National AIDS Council and AMREF Board , Co-Founder UZIMA Foundation | Completed<br>April 11, 2008<br>3:00 p.m. SA/Kenya |
| Alan Whiteside | Executive Director, Professor | HEARD, Health Economic and HIV/AIDS Research Division | Completed<br>March 20, 2008<br>2:00 p.m. Durban, SA |

## Appendix C: Letter of Introduction

Date: xx, 2008

Subject Header: Request to Participate in Research

Dr. xxxxx, I would like to request your participation in the research I am conducting as a requirement for a Masters Degree in Development Studies at the University of the Witwatersrand (WITS) Johannesburg, South Africa. The topic is "Why have WHO and UNAIDS endorsed male circumcision as a public health initiative for HIV prevention in sub-Saharan Africa?". The research will seek to address the following aims:

- Clarify what WHO and UNAIDS function is in relation to HIV prevention in sub-Saharan Africa.
- Critically analyze the factors that have influenced WHO and UNAIDS to support male circumcision as a public health initiative.
- Explain how WHO and UNAIDS utilized their historical findings on why social and behaviour factors hinder HIV prevention in sub-Saharan Africa when evaluating the effectiveness of male circumcision.
- Examine the views of HIV and AIDS experts and organizations, relating to how they interpret why WHO and UNAIDS made their recommendations for male circumcision in sub-Saharan Africa.
- Explore how WHO and UNAIDS assessed the impact of male circumcision on women.

Dr. xxxxx as the leader of xxxxx I cannot emphasize enough how valuable your expertise would be to the proposed research. In closing, I believe this research is important for the reason it could provide additional insight into understanding why male circumcision has been recommended as a public health initiative in sub-Saharan Africa.

If you are able to take part in my study it would be appreciated and of great value. Please contact me at (27) 83 500 4151 or through email if you have any questions. The attached letter serves as a confirmation of my studies and provides contact information for the University and my advisor. Thank you for your time, I hope you will consider my request and grant the necessary permission to be interviewed for my research.

Sincerely,

Tami Stainfield

Enclosures

Cc: Dr. Noor Nieftagodien