ELSEVIER
www.rhm-elsevier.com

© 2007 Reproductive Health Matters.
All rights reserved.
Reproductive Health Matters 2007;15(29):45–48
0968-8080/06 $ – see front matter
PII: S0968-8080(07)29304-8

REPRODUCTIVE HEALTH matters
www.rhmjournal.org.uk

ROUNDTABLE

Male Circumcision for HIV Prevention: Perspectives on Gender and Sexuality

Marge Berer

Editor, Reproductive Health Matters. London, UK. E-mail: RHMjournal@compuserve.com

FOR more than a decade, those working in the field of sexual and reproductive health have been calling for "male involvement" of various kinds. When men are actually expected to do something specific, however, the success rates have been very uneven. Very few men have had vasectomies, for example, except in a handful of countries, as compared to the number of women who have been sterilised when they no longer wish to have more children. On the other hand, although millions of men in countries such as Turkey still practise withdrawal for contraceptive purposes,[1] and gay men began to use withdrawal for risk reduction against HIV transmission early on as well, that practice has received no publicity or promotion,[2] let alone randomised trials to determine its use-effectiveness, so as to promote it if it is proven effective for risk reduction.

Condom use and promotion too have a checkered history. Men have been slow to take up condom use to prevent pregnancy or HIV/STI transmission between themselves and their partners in both vaginal and anal sex. And neither the family planning world nor the HIV world have championed the condom or promoted it to men or women in anything like the way they should have been doing for the past 25 years – and should still be doing – to bring about the defeat of the HIV epidemic.[3,4]

Now, men are about to be asked to take a different kind of action to protect themselves against HIV, this time by being circumcised. Inevitably (this being about sex), as with the use of condoms and withdrawal, male circumcision affects men's penises. Unlike with condoms and withdrawal, however, this intervention involves more than just covering the penis temporarily with a condom or pulling out before ejaculation. Male circumcision is more comparable to vasectomy, because it involves an irreversible surgical procedure. Unlike with vasectomy, however, it is more than "just a snip", as it involves the removal of the whole foreskin. After the procedure, as with vasectomy, protection is delayed. With vasectomy, men have to wait until their sperm count has gone down to zero. With circumcision, before they have sex at all, men have to wait until the surgical wound has fully healed. Unlike with vasectomy, however, protection against HIV for a circumcised man will always only be partial. From a man's point of view, some protection is obviously better than nothing. But to be really protected – and in order for a man to protect his partner(s) – he will need to start or continue to use condoms or to practise safer sex in some other proven way.

Male circumcision is the only intervention intended to prevent sexual transmission of HIV that is beneficial and (partially) protective only against female-to-male transmission and only through vaginal intercourse. Whether male circumcision will ever become an effective means of preventing sexual transmission of HIV to women at a population level is highly uncertain, because it will require a majority of men to be circumcised in any given population where HIV is prevalent before women can benefit as a group from the reduced HIV prevalence. Given limited resources, is it ethical to suggest that certain countries prioritise an intervention that will (partially) protect only men in the next 10–20 years? The answer is far from clear, and the question deserves serious consideration. Others will ask whether it is ethical to withhold it, which is also a cogent and relevant question, but that is precisely what priority setting and discussion of the pros and cons of different

forms of HIV prevention have to be about, as more modes of prevention come on the scene.

Which men will seek circumcision? The randomised trials have not supplied any answers to this question to date, though programme managers need to know. So my first question is: would a man who will not use condoms to protect himself and his partner(s) from HIV and who does not practise safer sex in some other way agree to be circumcised? If so, why? Does he really understand the nature of the partial protection circumcision will give him and the lack of protection it will give his partner(s), whether they be female or male? What about men who do use condoms? And what will happen when at least some of the men who seek circumcision are already found to be HIV-positive, a likely event in the high HIV prevalence settings where male circumcision is intended to be promoted?

My second question is this: if many women are still unable to negotiate condom use or other forms of safer sex with their male sexual partners, how can male circumcision programmes help them? It seems to me that the success or failure of any male circumcision programme to contribute to HIV prevention rests on the answers to these and many other questions. Meanwhile, millions of women and men globally have been and continue to be infected with HIV as a result of unprotected, unsafe sex.

The working group on gender, rights and sexuality at the WHO/UNAIDS consultation in Montreux on male circumcision policy and programmes in March 2007 recommended this: "In any male circumcision programmes, policymakers and programme developers have an obligation to monitor and minimise potential harmful outcomes such as unsafe sex, coercive sex, sexual violence and conflation of male circumcision with female genital mutilation; in addition, policymakers and programme developers have an obligation to maximise the opportunity that male circumcision programmes afford for education and behaviour change communication by promoting shared sexual decision-making, gender equity and improved health of women *and* men."[5] But to what extent is this feasible in the dozen or so sub-Saharan African countries where male circumcision is now being recommended?

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. This is, of course, a false assumption, but it could become a self-fulfilling prophecy if male circumcision services – or any other HIV prevention activities directed at men – are not set up in such a way that safer sex and condom use rates are not greatly improved. For women, and presumably also for men who still become HIV-positive despite being circumcised, such failure would be entirely unacceptable. Yet there was no discussion of this in the consultation and few people feel they know what can be done about it.

We are now more than 25 years into the HIV epidemic. Unprotected, unsafe sex remains the norm in most countries and in the population sub-groups who are the most vulnerable to HIV, in spite of some notable exceptions. Anyone who thinks that a technical solution to a socio-sexual problem can work on its own, no matter how many millions of dollars they can throw at it is, I believe, deluding themselves.

Are sexual health services for men the answer?

The Imbizo Men's Health Project was opened in 2005 in Soweto, South Africa, by HIVSA, based in Chris Hani Baragwanath Hospital, to provide sexual health care for men, managed and staffed exclusively by men. The aim is to provide the local male population with information on men's health issues in a comfortable environment in which they feel safe seeking assistance and in which they are guaranteed privacy and confidentiality. Free voluntary HIV counselling and testing services and workshops tackling issues such as health, fatherhood, gender issues and depression are offered. In the first five months, however, only 622 men attended, 140 men were tested for HIV and 70,620 condoms were distributed.[6] According to one provider, men were coming in mainly to ask about sexual dysfunction, and HIV-related stigma was keeping men away.[7]

Such clinics are a start in the right direction, however, and worth pursuing. If they are the sort of place where male circumcision is to be promoted and offered, and perhaps ideally they should be, this project's experience indicates that attracting men is going to be a slow process. Men aren't used to being offered such services for themselves. As with vasectomy, men are likely to be the best promoters of the procedure to other men, assuming enough of them come forward. However, the whole

culture of being the focus of health care when they are not ill, of talking about sexual health, let alone sexuality and relationships – as has happened to a far greater extent for women – requires a sea-change in most men's thinking and behaviour. And that will need time.

Circumcision and sexuality

Does it matter to men how their penises look and feel? What role does a foreskin, or its absence, play in this? Does the extent of sexual sensitivity change after circumcision? Does sex feel different or more difficult or easy before or after circumcision, including for the partner? Is condom use easier or harder?[8,9] These questions do not arise for men in whom the procedure was done in infancy or early childhood, who know only what it's like to be circumcised, but they will arise if more and more men are circumcised as adolescents and adults. More importantly, perhaps, will most men's sexual behaviour be the same or different pre- and post-circumcision over the longer term? And will some men feel that circumcision gives them the right to seek sex wherever they like, creating an association between male circumcision and rape, gender-based violence or sexual violence? The working group on rights, gender and sexuality at Montreux raised this issue because several participants in the consultation from Africa mentioned that there was anecdotal evidence of this in their countries among newly circumcised men.[5]

Bonner says that some loss of sexual pleasure has been described following male circumcision; is this really an issue?[10] Do some men delay returning to sex after circumcision, even after wound healing? If so, why and for how long? Why do some men re-start sex before wound healing is complete, in spite of strong advice not to?

Does the concept of "genital integrity", which is one of the most potent reasons put forward for opposition to female genital mutilation, apply also to mens' genitals, even if there would be public health benefit from removing men's foreskins en masse? There are people who consider all genital excision as mutilation, and this perspective cannot just be dismissed.

Does the healthy prepuce have a protective effect of any kind? What about widespread perceptions of improved penile hygiene in circumcised men – are they true or not? Circumcision does not mean a man will necessarily wash himself more. So my third question is: to what extent is penile hygiene a factor in HIV and STI transmission risk?[10] What about teaching penile hygiene as a population-level intervention? A study published in 2006 claims to be the first to show an association between "sub-preputial penile wetness" and HIV. It recommends giving consideration to "providing advice about improving penile hygiene in uncircumcised men in areas where HIV is a significant problem" and making good penile hygiene a desirable social norm.[11] This represents another potential public health intervention that is closely linked to male circumcision. Will it be taken up?

Conclusion

No one can now question the potential public health benefit of male circumcision in relation to the HIV epidemic in high prevalence settings, at least to (partially) protect men having heterosexual vaginal sex. Nonetheless, as Basil Donovan suggests, the acceptability of an intervention is not necessarily related to its efficacy.[12] If this is true, then factors other than the efficacy of male circumcision will be involved in men taking it up. Nor does efficacy automatically make the procedure ethical or worthy of being prioritised over other forms of HIV prevention.

The particular technical problems created by providing male circumcision on a wide scale are not an excuse not to engage in providing it. Whether it should be prioritised alongside or instead of condom promotion and other ways of achieving safe sex should be debated and resolved. Whatever the answer, however, there is no technical shortcut to the social transformation needed in how men and women confront and act on their own sexuality and in sexual relationships. Safer sex is a frame of mind, and a way of thinking and relating to others sexually, and it is only safer sex that will defeat the epidemics of HIV and other STIs. Male circumcision will reduce risk for men having vaginal sex with HIV positive women. But structural changes in the way in which patriarchal and other social norms of gender and sexuality operate, accompanied by changes among individuals and in sexual partnerships and partnering, will continue to be needed. What men do (or do not do) with their penises as a whole remains key, with or without their foreskins.

References

1. Ortayli N, Bulut A, Ozugurlu M, et al. Why withdrawal? Why not withdrawal? Men's perspectives. Reproductive Health Matters 2005;13(25):164–73.
2. Richters J. Coitus interruptus: could it reduce the risk of HIV transmission? Reproductive Health Matters 1994;2(3):105–07.
3. Berer M. Condoms, yes! "Abstinence", no. Reproductive Health Matters 2006;14(28):6–16.
4. Cleland J, Ali MM, Shah I. Trends in protective behaviour among single vs. married young women in sub-Saharan Africa: the big picture. Reproductive Health Matters 2006;14(28): 17–22.
5. Working Group on Rights, Gender and Sexuality. Recommendations and what we need to know on rights, gender and sexuality. Male Circumcision and HIV Prevention: Research Implications for Policy and Programming. Consultation convened by WHO and UNAIDS, Montreux, 6–8 March 2007.
6. Imbizo male-only healthcare facilities open in Soweto, S Africa. 1 June 2005. At: <www.medicalnewstoday.com/medicalnews.php?newsid=25450>.
7. South Africa: HIV-positive men come to terms with their status. IRIN Plus News, HIV/AIDS New Service for Africa. 7 June 2005. At: <www.plusnews.org/pnprint.asp?ReportID=4895>.
8. See, for example: Nnko S, Washija R, Urassa M, et al. Dynamics of male circumcision practices in northwest Tanzania. Sexually Transmitted Disease 2001;28(4):214–18.
9. See, for example: Oh SJ, Kim T, Lim DJ et al. Knowledge of and attitude towards circumcision of adult Korean males by age. Acta Paediatrica 2004;93(11): 1530–34.
10. Bonner K. Male circumcision as an HIV control strategy: not a "natural condom". Reproductive Health Matters 2001;9(18): 143–55.
11. O'Farrell N, Morison L, Moodley P, et al. Association between HIV and subpreputial penile wetness in uncircumcised men in South Africa [abstract]. Journal of Acquired Immune Deficiency Syndrome 2006;43(1):69–77.
12. Donovan B. The repertoire of human efforts to avoid sexually transmissible diseases: past and present. Part 1: Strategies used before or instead of sex. Sexually Transmitted Infections 2000;76(1):7–12. Cited in Bonner [10].