

**Meeting Report:  
Civil Society Dialogue on  
Male Circumcision for HIV Prevention:  
Implications for Women**

**Mombasa, Kenya**

**22-23 June 2008**

Sponsored by:  
*AVAC: Global Advocacy for HIV Prevention*



*"My mother was a kitchen girl, my father was a garden boy,  
that's why I'm a feminist"*

-South African women's song, taught to and sung by participants at the Civil Society Dialogue on Male Circumcision for HIV Prevention: Implications for Women

## EXECUTIVE SUMMARY

On 22-23 June 2008, over 35 civil society representatives – the majority of whom were women living with HIV in sub-Saharan Africa – gathered in Mombasa, Kenya, to discuss the implications for women of male circumcision for HIV prevention. The two-day dialogue was organized by AVAC and directly preceded a WHO Expert Consultation on the same topic which was held from 24-25 June at the same location. WHO sponsored the civil society participants from its meeting to attend the civil society dialogue, and AVAC invited and sponsored an additional group of women activists and advocates from sub-Saharan Africa to attend the civil society dialogue.

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

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

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

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### Day 1: JUNE 22, 2008

#### 1. Opening

*Facilitator: Milly Katana, Health Rights Action Group, Uganda*

*Organizer: Emily Bass, AVAC, USA*

Milly Katana reviewed the goals of the meeting:

- 1) To develop a civil society presentation on perspectives to be delivered at the WHO Expert Consultation on Male Circumcision

- 2) Develop collective next steps and distinctive, regional and overarching steps to influence public health policy around male circumcision.
- 3) Expand and inform awareness of research on and issues related to male circumcision for HIV prevention and its specific implications for women through exchanges between researchers and community, and between women from different countries, contexts and backgrounds.

## **2. Researchers' Panel**

*The goal of this session was to provide researchers and community members with the opportunity to interact, ask questions and receive introductions and/or updates on the clinical trial data on adult male circumcision for HIV prevention, as well as information on what might be happening next in terms of roll-out.*

### ***Dr. George Schmid, member of the Male Circumcision Task Force at the World Health Organization, Switzerland***

Dr. Schmid reviewed the history of interest in male circumcision for HIV prevention. He noted that observational data (studies which looked at population characteristics but did not include an active experimental intervention) over 15-20 years showed lower rates of HIV prevalence in areas where there were higher levels of male circumcision. These kinds of observations are complicated by the other factors like religion, culture, age, etc. that might also be affecting the observations. (As many women in the meeting noted, there are also instances of traditionally circumcising communities where HIV prevalence is quite high. Here, too, additional factors may come into play: rates of risk behavior, culture, and the mode of circumcision – how much of the foreskin is removed, whether the same knife is used for several surgeries, etc.)

Dr. Schmid explained that the observational data had led to the decision to conduct randomized controlled trials (sometimes called RCTs) that looked at male circumcision in a clinical trial setting to measure its safety and efficacy for HIV prevention.

Three trials took place, one each in Kenya, South Africa and Uganda. In each of these trials, there was evidence that male circumcision reduced men's risk of getting HIV from female partners by 60% compared to uncircumcised men enrolled in the trials.

Dr. Schmid said that in March 2007 the UNAIDS family concluded the data are persuasive and effective, and so formulated a series of recommendations for countries to consider if they wish to adopt male circumcision as one of a number of prevention modalities. So far, three countries have developed policies and others are working on them.

*Dr. Kawongo Agot, UNIM Project Lumumba Health Center, Kisumu, Kenya*

Dr. Kawongo Agot helped to lead the Kenyan trial of male circumcision for HIV infection and is now working on introducing male circumcision in the Western Nyanza province of the country, where Kisumu is located. She reviewed some of the key findings from the Kisumu study.

In the Kenyan study, men who were circumcised were more than over 53% less likely to get HIV from female partners than men in the trial's "control arm" who were uncircumcised. (Randomized controlled trials have two or more "arms" or groups that volunteers are randomly assigned to. Volunteers in the "intervention" arm receive the experimental intervention. In the case of male circumcision, men in the intervention arm underwent the surgery. Volunteers in the "control arm" are comparable in all respects to men in the intervention arm, but they do not receive the intervention. In the case of the male circumcision study, men in the control arm were asked to delay male circumcision until the end of the two-year study period.) All of the men in the trial received STI treatment, condoms, counseling on risk reduction at every study visit.

This counseling may have influenced participants' sexual risk behaviors. At the first study visit (also called "baseline") men were asked a range of questions about condom use, number of sexual partners, number of unprotected sex acts, et cetera. They were asked the same questions throughout the trial. In Kisumu, men in the control arm and the intervention arm decreased their risk behaviors from baseline. The men in the control arm had more of a decrease than the men in the intervention arm – but both groups had lower rates of reported risk behavior at the end of the trial than they did at the beginning.

The Kisumu site also asked questions to the broader community about how "acceptable" male circumcision was. In their survey (which was separate from the clinical trial) they found that 65% of men were willing to get circumcised, and that 69% of women wanted or were interested in having their partners circumcised.

Dr. Agot went on to note that many questions remain about the intervention's protection to women:

- How long does it take for full wound healing to occur?
- How much is protection attributable to its effects against genital ulcers?
- What is the impact of male circumcision programs at the population level?
- Will there be behavioral disinhibition/risk compensation now that the results are out?

Operations research looking at impact on sexual risk behaviors and length of follow-up after surgery is needed.

She said that, moving forward, communities must be educated, the mechanism of protection must be better understood, the intervention must be delinked from religion and culture and seen as a health issue, women must be engaged, male circumcision must be effectively integrated with other services, i.e., VCT and STI treatment, and acceptability of infant circumcision must be addressed.

*Update on the data from the trial of HIV-positive men conducted by the Rakai Health Sciences Program, Uganda*

Unfortunately, representatives from the Rakai Health Sciences Program (RHSP) that conducted the trial experienced travel complications and were not able to attend the meeting. RHSP conducted two trials of male circumcision for HIV prevention. One enrolled HIV-negative men and the other enrolled HIV-positive men to look at the impact of male circumcision on male-to-female sexual transmission. Prior to the discussion, there was a review of available background material summarizing the data from the RHSP's trial in HIV positive men that asked: What is the safety of male circumcision for HIV positive men; What is its impact on rates of other sexually transmitted infections; and what is its impact on transmission from men to women?

This trial enrolled HIV positive men and, where possible, their female partners. It was stopped early after a scheduled review by an independent data monitoring board that found that the rate at which the trial was enrolling men and women, and the rate of new infections in this group, meant that the trial could not answer its study question.

The committee also noted that there were more infections in women partners of circumcised men than uncircumcised. These infections were seen particularly in women whose partners reported sex before wound healing. It is therefore possible that men who resume sex prior to wound healing are more likely to transmit, and that HIV positive men who wait until full wound healing before resuming sex are less likely to transmit. But these are very small numbers and it is hard to draw any firm conclusions from them. All that is known at this point is that there are no conclusive data supporting any direct benefit to women from male circumcision for HIV prevention (in terms women's risk of getting HIV from a circumcised partner.) There is also the possibility that women's vulnerability will increase if men insist on resuming sex before wound healing.

*Discussion*

Following the researchers' presentations, there was a discussion with questions focused on clarification and observations about the research finding. While there were many specific questions (see below), there were some key themes. These included:

- Community involvement and women's involvement to date in male circumcision research. Women were concerned that broader consultations about the acceptability and relevance of trials of male circumcision for HIV prevention had not been held. Researchers from the Kisumu team shared that there had been extensive community outreach and education projects, as well as work with local leaders, national policy makers, traditional tribal leaders and other stakeholders before during and after the trials. This gap between trial-related community consultations and information going to broader communities – who may be geographically removed from the location of the trial – is an ongoing challenge for all research, and for HIV prevention research in particular.
- Potential adverse effects of male circumcision: what is known, what is not known, what needs to be looked at. In this discussion and throughout the two

days, there was a strong emphasis from the women on the need to minimize the harm of this intervention, which could lead men to feel more protected and therefore entitled to take more sexual partners, refuse condoms, and demand sex. Widespread roll out of male circumcision could also increase blame and stigma directed at HIV positive women as vectors of disease.

- The need to better understand roll-out: how will voluntary counseling and testing be linked to male circumcision, especially when men have, traditionally, been reluctant to get tested in many settings. What are the implications around infant or child circumcision – will women have the right to inform these decisions for their children? How will the rights of the child be protected? Another critical concern in this area is: how will the direction of new resources to male circumcision affect the resources directed to HIV prevention for women?

*Key questions and comments from civil society:*

- Was there planned community involvement in the Kisumu study?
- What community strategies are being planned for leaders?
- It's important to talk with religious leaders, and strategize how to make traditional circumcision safer.
- Counseling is critical for the young men who get circumcision to prevent its attendant uptake of sexual behavior.
- How did the WHO look at policies affecting women? Do these protect women?
- There's a great fear of HIV testing among men. Won't this affect uptake of male circumcision?
- How can women negotiate safer sex after wound healing?
- The communication around male circumcision can perpetuate more stigma against women as vectors of HIV.
- What are the human rights issues relevant to parents making the choice of circumcision for their children?

### **3. Civil Society Perspectives Panel**

*In this panel, three women shared their perspectives on and concerns around male circumcision for HIV prevention.*

*Jeni Gatsi, Namibia Women's Health Network, Namibia*

Beyond the 60% efficacy finding, what are the further implications of male circumcision for men and particularly women? It will work only if most men are circumcised and educated to engage in other prevention measures such as use of condoms, delaying the onset of sex, penetrative sex, and know their status. It's essential that information be given to both men and women so they know it is not a magic bullet for HIV prevention. It's worrisome because men are now asking, "Does it mean I can have five mistresses?"

We must ensure that the introduction to male circumcision is an entry point for transforming gender norms, and integrating men into sexual health services. We must also ensure that resources for rollout do not displace microbicide research and other

women-initiated prevention technologies. At the same time, we need to make female condoms accessible and affordable.

*Siphiwe Hlopwe, Swaziland*

Prevention has been biased toward men. Female condoms are very difficult to get. The way male circumcision has been promoted compared to the female condom is evidence that men are a priority. Furthermore, we have been trying to put the issue of cervical cancer on the agenda, which is hitting our women hard while hospital facilities don't even have any resources for pap smears. Now that male circumcision has funding, every government and NGO will say yes, because they want the funding. This puts our countries at risk.

There will be an impact on the women's already difficult negotiation for safe sex. The man will say, "I am circumcised, why should I have safe sex?" What will rural women do who cannot understand the science we are talking about? How are they prepared to deal with this 'outbreak' of male circumcision in the communities? We may need authority or a mandate to stop this decision, unless we are prepared to stop the impacts. Let me urge the drivers of this program that the burden of this outbreak of wound in the community is going to be on women.

*Marion Stevens, Health Systems Trust, South Africa*

There's a tendency to promote male circumcision as a magic bullet as evidenced by the money and support it receives. However, there are both biomedical and social issues to be considered. The biomedical approach (including the randomized clinical trial model) does not provide all the data needed to understand the social implications of introducing a new strategy. There are a number of questions in many communities, both about what a randomized clinical trial is and about what else needs to be understood and done to craft techniques for testing male circumcision as a population intervention.

In South Africa, with its history of delayed access to life-saving antiretrovirals and drugs for opportunistic infections, there has been great enthusiasm around male circumcision for HIV prevention and limited opportunities to discuss this intervention that's "60% effective." However, it's important to have time to interrogate.

There are great and valid concerns that male circumcision will add additional credence to the notion that women bring HIV into the relationship and/or that they are vectors of disease, since if male circumcision is perceived as a "badge" of HIV negative status, blame will be directed even more towards the woman if HIV comes into an HIV-negative, seroconcordant couple.

*Discussion*

The conversation following the civil society presentation added additional layers to some of the key themes identified in the earlier part of the discussion. These included concerns about how women-focused HIV prevention programs, which have been

historically under-resourced and/or absent in many settings, will fare in the context of increased resources for male circumcision for HIV prevention. There are also concerns about the burden that will be placed on women around post-operative care and assistance with wound healing. Other issues included the large challenges involved in communicating what male circumcision does and does not do (challenges shared by any partially-effective prevention strategy) and as a continued theme, the concern that women will be less able to negotiate if, when and how sex happens, and will be blamed for bringing HIV into relationships.

*Key questions and comments from civil society:*

- What are the implications for women-controlled strategies? In the context of male circumcision it behooves us to ensure that there is a place for all HIV prevention.
- How will we as civil society communicate messages? How do we make sure people in a rural village understand the words “60% protection for men?”
- Could male circumcision be misconstrued to continue with female genital mutilation?
- How will male circumcision affect intergenerational sex given that mature men are more averse to male circumcision?
- We must provide targeted counseling around gender relations and men’s roles in protecting their families against HIV and gender violence.
- There is a fear that women, whose male partners get circumcised and then seroconvert, will be blamed for bringing HIV home.
- With the possibility of condom migration, male circumcision may take away the power that women have worked so hard to gain. How do we forge forward with male circumcision while increasing women’s power to negotiate condom use? At the same time, how do we advocate for access to the female condom?
- How do we deal with cultural issues: respectfully addressing communities who don’t traditionally circumcise and how do we work with those who do to carry out the practice more safely?
- We’re getting a lot of conflicting policy from the UN around male circumcision. Why is there no policy convener for male circumcision as there is for other interventions?

**4. Working Group Report Backs**

*In the afternoon of Day 1, participants broke into small working groups organized around four thematic areas:*

- 1) Process, policies and politics – what is underway and/or should be underway on the part of normative agencies, national governments, research teams and other key stakeholders in terms of developing approaches to male circumcision for HIV prevention that minimize harm and maximize benefit for women and men.

- 2) Program and service delivery – what needs to be in place in programs offering male circumcision to ensure that women’s concerns are addressed and that the intervention minimizes harm and maximizes benefit for women and men?
- 3) Communications and messaging – what are some of the key messaging and communications challenges around explaining various concepts related to male circumcision for HIV prevention that must be addressed in order to anticipate and minimize any negative outcomes for women?
- 4) Operations research – what else needs to be learned; what are the key questions for women?

Each of these groups was asked to consider three questions:

- 1) Where are we now?
- 2) Where do we want to get to?
- 3) What needs to happen to make this possible – and what are the potential obstacles?

#### ***Report back: Process, policies and politics***

Respondents from this session voiced the concern that male circumcision for HIV prevention has been introduced and discussed as a solution to the epidemic without fully engaging in the ways that the epidemic is feminized and, therefore, the possible implications of the intervention for women. As participants in the group stated, dialogues like this civil society forum are an important step towards bridging the gap between researchers and implementers on the one hand, and communities that were not directly involved in the research, but who are concerned about and may be affected by its implementation on the other – especially HIV-positive women. The conversation we are having here is an important step in attempting to bridge. As this group stated, women, especially HIV positive women, are key stakeholders who must be engaged and consulted with in research, policy setting and program implementation at all levels. Resource allocation is a key concern, as is ensuring that male circumcision is implemented as one strategy in a comprehensive approach to HIV prevention. Participants in this groups also noted that male circumcision must be delivered as part of a comprehensive package that also focuses on scaling up female-initiated prevention, such as access to the female condom, and addresses broader issues of health systems strengthening.

#### ***Report back: Program and service delivery***

There is more engagement with male circumcision in countries where research took place: Kenya, South Africa, and Uganda. Paradoxically, there’s lower uptake of male circumcision as an HIV precaution where it’s been practiced traditionally.

Across all countries engaging in the new intervention, VCT is still needed, along with couples counseling. There's also a need for strong community involvement in implementation with a focus on women's participation. Male circumcision's scale-up should be used as an opportunity to strengthen HIV prevention and sexual reproductive health services.

***Report back: Communications and messaging***

Key messages should convey the following:

- Male circumcision is only 60% protective for men. This means only partial protection only for men.
- Women having sex with men who are circumcised are not directly protected from HIV.
- It takes 30 days to six weeks for wound healing. During this period HIV is more readily transmitted from the male to his partner.
- Male circumcision does not diminish manhood.
- There is no proof that male circumcision protects men who engage in anal sex with men or women.
- Male circumcision is a medical, not only cultural, intervention.

***Report back: Operations research/key questions for women***

There is a need to understand:

- The impact of male circumcision on women (i.e. incidence, population level impact and wound healing or immediate risk)
- Impact on prevention behavior (uptake or reduction of use of counseling, condom use, couples' counseling, risk compensation in traditionally circumcising communities)
- Early versus late circumcision (age/time of circumcision)
- Opinions and experience of circumcision (sexual pleasure, stigma, changing attitudes, or opinions about it).

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**June 23<sup>rd</sup>, 2008**

**1. Women's feedback on day one**

*At the start of the second day of the meeting, women participants shared a draft civil society statement that they developed to summarize a range of concerns which remained at the end of day 1. This statement, which emphasized that there were risks for women related to male circumcision for HIV prevention, that there were major concerns among women's groups about the intervention, and that there was an over-arching need to broaden engagement with women and HIV positive women in particular, helped to frame the activities for the remainder of the day and was also an essential starting point for the presentation and statement eventually delivered*

*at the WHO Expert Consultation on male circumcision for HIV prevention: implications for women.*

As participants reviewed the previous day's proceedings, they made the following points:

- The question of what exactly is adequate "community input" was raised when the women articulated not knowing about the WHO community consultation in 2006, at which the recommendations for male circumcision guidelines were drafted. Even with the consent of 13-14 country representatives to go ahead with male circumcision, civil society was not adequately consulted.
- Another concern is the drain on existing health services, such as condom distribution and STI treatment. To avoid this "money creep" other monies must come in to support male circumcision.
- Is VCT going to be mandatory before male circumcision is allowed? How will this be enforced? As one participant said, "Male circumcision and not knowing your status does not go well together."
- There is a concern that there will be a rise in gender-based violence if women refuse a male circumcised partner. This sentiment is very strong even with no evidence that men who get circumcised change their behaviors in negative ways. "The core problem is gender relations; male circumcision doesn't alter relations, it helps the patriarchy to flourish." Conversely, it could be an opportunity to bring men into the healthcare system to adopt safer sex behavior. One participant noted, "If there are fewer men infected, even if he's a pig, that's a benefit for women."
- We don't have the hard first-level evidence that women will directly benefit from male circumcision, but we have years of evidence of protection afforded to Jewish and Muslim women who are partnered with circumcised men. And we have anecdotal evidence that childhood male circumcision protects women from HPV and other infections.
- If the intervention reduces HIV infection rates in men, it will benefit women – that's the public health model. But studies say, yes, in 10, 20, or 30 years we'll see a positive effect on women because fewer men will have HIV. They all take positive views, and we don't really know. There's a push before the effects are known. It's dangerous to rely on modeling without further investigation of effects on women.

After discussing these issues, the question was posed: Is there a space for women to support this while saying, “This isn’t our intervention”? Even if this doesn’t have a benefit for women, how do people feel about going forward?

The clear and emphatic answer from women was that there was no direct benefit for women in terms of HIV risk reduction related to male circumcision. (This is supported by the data at this time.) Having stressed that there was no benefit, women nonetheless emphasized that it was important to engage with the strategy – as the train was already moving on rolling out male circumcision – and that there were a range of activities that could and must be implemented to maximize benefits and minimize harm for women. Cautious support for and engagement with male circumcision for HIV prevention was thus clearly and directly linked to women’s desire for honest communications about the lack of immediate-term, individual-level benefits to women of male circumcision for HIV prevention.

## **2. Examining and engaging with existing documents**

Tyler Crone (USA) and Jeni Gatsi (Namibia) led the group through a discussion/introduction to some of the existing language on gender and women in WHO/UNAIDS documents on male circumcision for HIV prevention. The 2007 document titled *New Data on Male Circumcision and HIV Prevention: Policy and Programme Implications* contains specific recommendations on the need for gender analyses and considerations of impact on women as part of any roll out strategy, and also specifies a minimum package of male circumcision services including male and female condoms, STI testing and treatment and counseling. This language was explored by participants as a possible starting point for developing specific recommendations for the WHO Expert Consultation on implications for women. It is important and useful to note that many participants were unfamiliar with the normative guidance documents that contained this language, and that more community-level work by both community-based organization and public health policy makers and implementers is needed to ensure that communities understand, are familiar and engage with these guidance documents as tools for advocacy.

## **3. Developing a civil society statement**

In the final session, Emily Bass (USA) and Milly Katana (Uganda) led the group through a collaborative process of drafting a civil society statement and a set of specific recommendations related to existing WHO/UNAIDS language on male circumcision for HIV prevention. This activity took, as its starting point, an updated version of the civil society statement presented at the start of Day 2 (see above). Each sentence of the statement was considered and edited by the full group, with careful attention to wording and to the implications of the language. The statement had two parts: an open letter/preamble/declaration that summarized women’s over-arching concerns and approaches to male circumcision, as well as the context for these remarks; and a set of specific observations and additions to relevant WHO/UNAIDS recommendations. The slide set of this presentation is attached as an appendix to this meeting report. The open

letter/declaration did not have official signatories at the time that it was delivered to the WHO Expert Consultation; it was developed by the participants of the Mombasa civil society dialogue with the understanding that it could be further developed and distributed as such, and that it was, in the short-term, a clear statement of the concerns and expertise of civil society that emerged at the meeting.

#### **4. Discussion on next steps and future work**

Meeting participants individually shared their plans and ideas on how to move forward together as a civil society advocacy group and in their own communities to educate and advocate for gender-sensitive rollout of male circumcision while increasing prevention options for women. Below is a summary of meeting participants' strategies and next steps.

There is a commitment from a number of the groups involved in the meeting to work with a variety of existing networks and community-based groups, including ASOs involved in prevention work, women's groups, male-dominated organizations, and young people, to educate and train them to advocate for scale-up of responsible male circumcision. Some of the priorities identified include integrating male circumcision into existing sexual and reproductive health services and ensuring that, as money is invested in male circumcision, additional, comparable levels of funding are also directed to women-focused HIV prevention services. Other groups committed to supporting this work by developing and disseminating educational and advocacy materials to help raise awareness of the key issues related to male circumcision for HIV prevention and its specific implications for women. These documents can be used for a range of advocacy strategies including community education, and advocacy with policy makers, donors, normative agencies and research teams.

EngenderHealth in South Africa will advocate specifically to get public health clinics to refer men who access circumcision to its MAP program, which confronts traditional issues of gender roles and can incorporate messages of responsible male circumcision.

There's an agreement to monitor the effect of male circumcision's rollout on health services and services for women to ensure that resources for women are not appropriated for the new intervention. The launching of a listserv will serve as an evaluation tool, as well as a virtual forum to continue dialogue, information sharing around communicating infractions, research updates, and resource allocations for women's prevention. Additionally, Athena and the International Women's Health Coalition will help facilitate the global and community dialogues in multiple countries.

Some civil society participants will reconvene in August in Mexico City at the International AIDS Conference to recruit, engage and inform activists/advocates to ensure the rollout of the male circumcision from a feminist perspective. Mexico City

may also be a fertile opportunity to request a meeting with donors involved in funding male circumcision.

AVAC, WHO and Family Health International are currently preparing to launch a web-based portal solely dedicated to male circumcision. AVAC is responsible for the advocacy component and welcomes civil society to use this as an open space for communication as well as the aforementioned listserv.

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### Appendix

## **Civil Society Report-back on Dialogue on Male Circumcision: Implications for Women**

Lydia Mungherera

International Community of Women Living with HIV/AIDS

Background

- 22-23 June – 35+ civil society representatives, predominantly women living with HIV in sub-Saharan Africa, met to discuss the implications for women in male circumcision for HIV prevention programs

#### **ENSURING PREVENTION STRATEGIES WORK FOR WOMEN**

#### **Statement on Medical Male Circumcision for HIV Prevention by women's health activists**

- We mainly women from sub-Saharan Africa, the epicentre of the HIV/AIDS epidemic gathered in Mombasa, Kenya note that of all HIV infections in sub-Saharan Africa, 60% affect women. As such, any response should have women as central to any prevention, care and treatment response to HIV & AIDS
- We need prevention and treatment programmes that work for women and thus accept male circumcision as part of a comprehensive package of prevention, care and treatment. We ask that resources not be diverted from prevention and treatment efforts that work

(condoms, female condoms, diagnosis and treatment of sexually transmitted infections and HAART and OI treatment) and that these be continued to scale up.

- There is also a need to continue resource allocation in the integration of HIV/AIDS and sexual and reproductive health and rights programming, as well as around women's empowerment (or gender equality). We also note that there is a need to craft meaningful participation of women and positive women in research; policy development; and, programme planning and implementation efforts.
- Having reviewed the research and evidence from the three RCT's we note that there is an estimated 60% prevention of transmission to heterosexual men. There is no conclusive evidence exists to demonstrate any direct benefit for women. Modeling studies suggest indirect protection will eventually accrue to women but that in the short term increased feminization of the epidemic is likely.

Proven prevention methods like the female condom for women continue to be under resourced. Expanded resources are also needed for research to identify additional biomedical prevention strategies like microbicides, pre-exposure prophylaxis and vaccines, as well as structural and behavioral interventions that will reduce women's risk.

The experience of African women and particularly HIV positive women has shown that the perception of them as vectors or transmitters of disease may lead to increased gender-based violence. We are concerned that once men have yet another prevention strategy in their hands that can allow them to question who is to blame for bringing HIV in, that this will increase gender-based violence.

- Women's health and rights advocates also note the potential harmful effect of male circumcision because men may have a false sense of protection and this can in turn compromise women's ability to negotiate conditions of sex (if and when sex happens, condom use, etc) and increased gender-based violence.
- These are our over-arching concerns. In addition, we have specific comments and recommendations related to existing guidance documents, specifically the March 2007, *New data on male circumcision and HIV prevention: Policy and Programme Implications*

***From: New data on male circumcision and HIV prevention: Policy and Programme Implications***

“5.3 Before policy makers and programme developers promote male circumcision for specific population groups, they should justify the reasons after conducting an analysis of the ethical and gender implications; this analysis should be conducted in consultation with members of such population groups, stakeholders and other critical decision makers.”

**Civil society recommendations (1)**

- Recommendation 5.3 must be implemented. Women and HIV positive women in particular are key stakeholders.
- This type of consultation should be coordinated by individuals and organizations with experience and capacity in conducting gender analyses.

**Conclusion 6: The gender implications of male circumcision as an HIV prevention method must be addressed**

“In all male circumcision programmes, policy makers and programme developers have to obligation to monitor and minimize potential harmful outcomes of promoting male circumcision as an HIV prevention method such as unsafe sex, sexual violence or conflation of male circumcision with female genital mutilation.”

**Civil society recommendations (2)**

- As part of implementing 6.1, 6.2, 6.3 (see original document) – increase funding for groups that are working to change the environment in which women are making choices about their sexuality, their bodies, their lives – including groups working on socioeconomic empowerment, and those actively working on gender transformation – trainings, educational materials, advocacy for women’s rights

**Civil society recommendation on gender-related implementation**

As recommendation 6.1 notes, male circumcision programmes should “maximize the opportunity [afforded] for education and behavior change communication, promoting shared sexual decision making, gender equality and improved health of women and men.”

To put this into practice, it means developing MC programmes and related communications/education campaigns that address issues that have social value in sexual relationships – substance abuse, domestic abuse, shared responsibility around fatherhood, definitions of masculinity

**Civil society recommendations (3)**

- Develop a approach to MC introduction that incorporates research, monitoring and program adaptation that directly seeks to address potential harmful effects including, specifically, gender-based violence, increased stigma of HIV positive women who maybe blamed for bringing HIV into the relationship. Specific resources must be allocated to these activities.
- Monitor resource allocation and flow for HIV prevention, ensuring that, where there is spending on MC there are also additional resources for proven prevention interventions for women

**Civil society recommendations (4)**

- Look specifically at rates of domestic violence, coercive sex during the period of wound healing/recommended abstinence post surgery.
- The unacceptable context of criminalization of HIV transmission must be taken into account when looking at introduction of male circumcision. In addition to being blamed for bringing HIV into the relationship women may face legal repercussions for HIV infection – especially if, after circumcision, men are perceived to be protected.
- There is a need to understand more about the outcomes associated with early (infant) versus adult male circumcision for both women and men

**Civil society recommendations (5-7) on HIV testing and program design**

Current language: “HIV testing should be recommended for all men seeking male circumcision, but should not be mandatory.”

- Women’s civil society recommendation: A rights-based approach to deliberation on this issue is needed in every country and every project. These deliberations should balance issues of coercion (around learning HIV status) with public health interests. Possibly prioritize couple counseling.

**Civil society recommendations (6) on testing and programs**

Male circumcision programs should be designed to increase uptake of (V)CT and partner disclosure, as well as counseling to minimize MC in HIV positive men; priority should be

placed on pairing MC with successful/innovative approaches (such as home-based testing, integration of (V)CT with family planning clinics, male-targeted/ -friendly approaches) should be paired with MC roll out.

#### **Civil society recommendations (7)**

Counseling messages should emphasize partial protection, continued use of condoms, abstinence for recommended duration (6 weeks), and the lack of conclusive evidence of any direct benefit for women.

In over-burdened health systems, this means allocating resources and training for staff, including existing counselors, so that they can incorporate these additional messages effectively into their work.

#### **Current language:**

- “Communities and particularly men opting for the procedure and their partners require careful and balanced information and education materials that underline that male circumcision is not a ‘magic bullet’ for HIV prevention but is complementary to other ways of reducing risk of HIV infection.”

#### **Civil Society Recommendations on messaging**

- As far as women are concerned, there must be messages that having sex with a circumcised man does not have a protective effect to the women.
- We need communications strategies that address the change in power balance (to the extent that male circumcision may reduce women’s ability to negotiate condom use), the ability to negotiate if/when/how sex happens, and the allocation of responsibility for HIV prevention in general and as these factors are affected by the introduction of male circumcision at local and national levels ☺ ☺
- We need clear messages about the time period to wait before resuming sex – even if the wound appears healed -- and the need to continue using condoms. Both women and men need clear messages, however the burden of ‘enforcing’ abstinence until wound healing should not fall on women – the *primary responsibility is on the man*

#### **Civil society recommendation on resources**

- Matching of resources / budget line for prevention and services for women in conjunction with any MC roll out
- Answer the question: *Where is the funding going to come from to ensure that support for other prevention strategies are increased to counteract shifts in power balances?*
- *New and sustained allocation of resources for male and female condoms from existing and potential funders; responsibility on governments, other donors to counterbalance MC funding with funds to ensure that other prevention strategies and primary health care activities are not weakened as MC rolls out – and that the programmes are introduced in the context of funded efforts integrate MC into existing services and to strengthen health systems more broadly*

#### **What will success mean to women?**

- Answers to questions about impact of MC on sexual risk behavior, power imbalances, condom use ...
- Evidence that programmes are influenced by these findings
- Expanded, sustained conversation about gender roles and sexuality
- Increased access and uptake of sexual and reproductive health services for men and women
- Lower HIV incidence in both men and women

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- MC programmes that effectively link HIV positive men and women with HIV treatment (OIs and ARVs) and care and services
- No increased stigma in uncircumcised men, HIV positive men, marginalized populations (LGBTI, sex workers)
- Healthier families

**Thank You!**  
**Asante Sana!**