

## MALE CIRCUMCISION AND HIV: PLAYING RUSSIAN ROULETTE WITH AFRICAN LIVES

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The connection between HIV rate and circumcision is highly questionable and not the foregone conclusion as is recently supposed. High circumcision rates do not always correspond with low HIV rates and a conclusion based on such data is particularly reductionistic. The presence of the human foreskin is unlikely to be the driving force behind HIV prevalence in Southern Africa. Likewise, surgically removing the foreskin will not reduce HIV rates to a significant degree.

African men are falling prey to a dangerous new belief: ‘I have heard that if you get circumcised, you cannot catch HIV/AIDS. I don’t have to use a condom or worry about all those other ways of keeping safe. I finally get a method that suits me’ [1].

Southern Africa’s military have also been made to tremble before the humble foreskin by the consideration of implementing circumcision in the Armed Forces as a proposed surgical intervention against HIV acquisition. Does Africa really need to fear the foreskin when there is clear evidence showing the foreskin is not the cause of HIV, and its removal will not cure the HIV crisis.

### Nature of male circumcision

Male circumcision is an irreversible amputative operation that permanently excises large amounts of skin and mucosa from the penis [2]. It forever changes the configuration of the human person.

### Where did this un-African belief originate?

This theory gained ground at the AIDS 2005 Conference in Brazil when preliminary and partial results were presented from a trial at Orange Farm and released to the media. Researchers concluded: ‘Male circumcision provides a degree of protection against acquiring HIV infection, equivalent to what a vaccine of high efficacy would have achieved.’[3] However, comparing the results to a vaccine is misleading and dangerous, since the average person understands a vaccine to mean:

1. Life-long near-absolute protection from infectious agents, and
2. Permanent protection not influenced by behaviour modification over time.

This study, and two subsequent studies, hereafter referred to as the three studies [3,4,5], show only a partially protective effect limited to 21-months. Circumcision can only be said to *delay* HIV infection. Subsequently, circumcision has been heavily *marketed* using key figures to promote exaggerated claims. A 55 percent protective effect is a phrase that has been used. Efficacy suggests potential effectiveness in a real world situation, and while *55 percent sounds effective*, the reality is quite different. It means that if it takes an intact man (non-circumcised) 5 sessions of unsafe sex to get infected with HIV, then it will take a circumcised man approximately 10 sessions.

In real world settings the number needed to treat (NNT) is a much more important figure. The NNT, based on cumulative data from all three studies, is eighty circumcisions to prevent one HIV infection. Eighty circumcisions will have a fair number of complications including bleeding and infection. In comparison, vaccines typically have a NNT approaching one, that is, it is effective in nearly all cases.

Relying on circumcision to stop HIV is a fallacy created out of careful manipulation of data implying an exaggerated effect. Without critical analysis it could escalate to a mass experimental program on African men with *grave* consequences, creating a false sense of security and ultimately worsening the epidemic. The likely repercussion amongst newly circumcised men, and more especially amongst already-circumcised men, would be to encourage unsafe sex practices.

### **Clinical experiments unnecessary**

The three studies are essentially clinical experiments on African men and it is highly questionable as to why these studies were passed by ethical boards. Only small numbers actually seroconverted:

- 20 circumcised men and 49 intact men in the Orange Farm trial [3]
- 22 circumcised men and 45 intact men in the Uganda trial, and [4]
- 22 circumcised men and 47 intact men in the Kenya trial [5].

These are unusually similar and small figures. Extrapolation to the general population is problematic and the ultimate conclusion becomes: Circumcision only delays HIV infection and circumcised men still *acquire* HIV, *pass on* HIV and *die from* HIV at an alarming rate.

WHO/UNAIDS notes that there was a high incidence of HIV in circumcised men in the trials, 'In all three randomized controlled trials HIV incidence was considerably lower in the intervention (circumcised men) than in the control group (uncircumcised men), but nevertheless remained high overall (0.7 to 1.0 per 100 person-years in circumcised men). This high incidence persisted in spite of intensive safer sex counselling, condom provision and the management of sexually transmitted infections.' [7]

### **Serious problems of three trials**

- 'Leading questions', such as: 'Would you be circumcised if it offered you protection from HIV?' have confounding effects on these studies. These same questions were included in previous 'acceptability studies' by the same authors confounding previous research also.
- The researchers omitted reference to all studies contradicting their opinions.
- Full informed consent was not given with regard to possible side effects of circumcision.
- The 4-8 week period of wound-healing when the circumcised men were not having sex was not taken into account. In the Orange Farm study this represents a substantial percentage of the total study period that was not even adjusted for.
- The studies were prematurely stopped just as the intact group's rate of infection was about to level off. In the Kenyan study, more intact than circumcised men contracted HIV during months 2-18, however, during months 18-24 there was no significant difference in transmission rates. It was at this point that the study was halted. The apparent protective effect may not have held up under longer surveillance.
- In an experimental environment, subjects get counselling and safe-sex advice that would not be available in a mass circumcision campaign. As a result, the WHO has a number of times expressed concern that the studies' results may not hold up in the real world stating, '... the ideal and well-resourced conditions of a randomized trial are often not replicated in other service delivery settings.' (13 December 2006) [8].

- There was a failure to fully account for behavioral risk compensation, ‘The protection of Male Circumcision (MC) may be partially offset by increased HIV risk behaviors, or “risk compensation,” especially reduction in condom use or increases in numbers of sex partners. Risk compensation occurs when individuals adjust their behavior in response to perceived changes in their vulnerability to a disease’ [9].
- The gold standard of medical testing is the *double blind* randomized control trial (RCT) which these trials were not. Circumcision cannot be concealed from the experimenter or the subject.
- Circumcision itself is a vector in the transmission of HIV. Dowsett notes: ‘Traditional male circumcision is common in some parts of Africa, and is not without its difficulties including being implicated in HIV transmission itself’ [10,12,26].
- High rates of complications occur with circumcision [27].
- The HIV status of the receptive partner is not taken into account putting women at a greater risk.

### **The circumcision experiment has already been tried**

Populations of circumcised men and intact men living with HIV already exist. Simple mathematics could draw comparisons based on real population examples without the unnatural variables at play when studying complex human sexual behaviour.

The USA instituted a mass circumcision campaign on infants since the late 1800s, yet has the highest rate of HIV in the developed world - firm proof that circumcision does not protect against HIV acquisition. In South Africa the Zulus do not practice circumcision. The Xhosas do practice circumcision. Yet the HIV rates are not different, or statistically relevant [13].

The recent Mishra study also shows no important correlation between circumcision and HIV and concludes, ‘We find a protective effect of circumcision in only one of the eight countries for which there are nationally-representative HIV seroprevalence data. The results are important in considering the development of circumcision-focused interventions within AIDS prevention programs’ [11].

### **Selective and biased research**

The researchers of the three trials failed to make mention of any previous research contrary to their opinions, even in pre-trial submissions to ethical boards. The only comprehensive and systematic review by the highly respected Cochrane Institute was not even alluded to in the articles describing the three trials [14]. This leads the reader to believe that there is no other research contradicting these exaggerated claims. However, a multitude of research showing circumcision to have no statistically relevant effect on HIV rates is readily available

The clear bias displayed by the three trials in ignoring opposing research is unethical and calls the results into further question. A circumcision and HIV correlation is far from established fact and can only be concluded once more research is completed, and *all* available research is considered and critically reviewed by a neutral research panel. This has not happened.

### **What were the men promised and what is fueling apparent demand for circumcision?**

A protective effect was offered or implied by researchers in the three trials. The men expected a positive response or would not have volunteered for irreversible surgery. Dowsett notes, ‘Researchers had conducted previous studies to see if population groups would accept circumcision. This creates a demand and expectation that was not there before. There was a significant amount of “crossovers” such as men who sought circumcision elsewhere before the end of the trials. “This indicates that the promise of possible protection suffused these trials

discursively and affected the communities in which the participants lived, even before they produced findings” [10].

The researchers themselves were creating demand for the very thing they were researching - circumcision. The false expectations of the researchers created real expectations of men that circumcision would decrease their risk of HIV acquisition. Not only does this confound results, but it shows that men were somewhat coerced into the experiment and did not freely volunteer, due to some expectation. The resulting influence to ‘desire a circumcision’ makes these trials even less ethical.

### **Why only do this caliber of research in Africa?**

American money funded two of the three trials, so why not perform it in America? Why not experiment on Americans? Aside from the fact that such a trial would have difficulty passing human subjects review boards, it seems unlikely that more educated Americans would allow such experimentation on adult males. On the other hand, are poorer African men more expendable to such research and easier to coerce into needless surgery? This can easily be viewed as a colonial undercurrent.

In 1991, long-time American circumcision proponent, Edgar Schoen, tried and failed to export American infant circumcision to Europe[15]. Europe apparently did not need circumcision, but Africa suddenly does? This sounds even more like colonialism and can easily be interpreted as foreign powers exporting circumcision to cure the dirty, oversexed and irresponsible black men that can’t be trusted to wear a condom.

### **Could this campaign be more about promoting circumcision than about HIV prevention?**

Is America attempting to export the American ‘solution’ of circumcision as *a cure-all* into Africa using HIV as an excuse? History teaches us that this is not an unreasonable assumption.

Victorian crusaders against the foreskin, like the fanatical Peter Charles Remondino, said that circumcising blacks prevents them from raping white women [16]. Remondino attacked enemies of circumcision as prejudiced, backward and unscientific. According to him, dirty black men must be cleansed through circumcision and using this justification, circumcision was forced upon many black men to cure syphilis.

More unusual and published medical claims have been made about circumcision. It has been claimed to prevent all of the following: Epilepsy, penile cancer, masturbation, paralysis, hip-joint disease, digestive disorders, masturbation, black men from raping white women, syphilis, incontinence, constipation, general nervousness, restlessness, irritability, insomnia, night terrors, venereal diseases, hygiene, cervical cancer, and now HIV.

A similar core group of anti-foreskin proponents appear many times in circumcision-related literature with some of them linked to the three trials in question, e.g., Bailey, Halperin, Schoen and Moses. The plan now seems to be to export circumcision to Africa and circumcise all of Africa’s men and even boys. UNAIDS/WHO has also been fooled, and its report astonishingly recommends infant circumcision despite no supporting evidence, and in full knowledge that it has not helped America’s HIV rate. Are Africans easier to coerce? The tactics have been to selectively choose studies that support a prematurely concluded theory and thereby ignore all other research, as well as vital input from sexologists and sociologists.

### **What is driving the research?**

The Cochrane Institute warns, 'It is important to acknowledge that researchers' personal biases and the dominant circumcision practices of their respective countries may influence their interpretation of findings.' Researchers in the three trials did not disclose their own circumcision status. Failure to do so introduces bias into the research due to the importance of circumcision in certain religions and cultures from which some researchers may have come. Men circumcised as infants feel compelled that other infants be circumcised also, while men circumcised as teens or adults feel compelled that other teens or adults be circumcised also. However, there is a marked difference between infant and adult circumcision. When circumcised as an adult, the man is able to provide a cognitive structure that can associate positively with the ritual. This accords consent and removes the violation inherent in early cutting. An infant is unable to consent or rationalise this harmful experience

### **Medical circumcision will remove cultural meaning**

The cultural meaning of tribal circumcision will be removed should circumcision be medicalized. A man is not considered to have successfully being initiated into manhood in some Southern Africa cultures if he is cut in hospital and an initiation consists of more than simply a circumcision.

### **Who is not blinded by these three non-double blind trials?**

Not everyone has got out the scalpel so prematurely. 'Reacting to these findings, the technical advisor for the Brazilian Health Ministry says that her country will not begin practicing circumcisions due to what she considers misleading information: "I find the recommendations of the WHO and U.N. HIV/AIDS program a little surprising and even frightening," Simao told Agencia Brasil [March 2007]...This proposal gives a message of "false protection" because men might think that being circumcised means that they can have sex without condoms without any risk, which "is untrue", she said' [18]. Other countries have outright rejected recommendations of mass circumcision [32].

Ugandan President Yoweri Museveni, 'has condemned a new study showing that male circumcision reduces the risk of HIV infection during sex, saying it sent out a dangerous message. The state-owned New Vision paper on Friday [December 2006] quoted Museveni as saying there were many confusing messages about HIV and AIDS. "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?" the paper quoted him as telling medical students in Kampala' [19].

### **Proper circumcision programs needed prior to proposed implementation**

Even if circumcision is ultimately considered within Southern Africa, effective monitoring devices should already be in place ahead of time to chart success or failure of this intervention and note its effect on the men and society as a whole. National circumcision registers are needed before the first man can be cut, considering the unknown repercussions. Informed consent forms are not available, yet circumcision is being called for. Clinics do not have the proper equipment. Trained surgeons are not available. The objective is clearly to *cut now and ask questions later*. This is an unscientific approach towards a health intervention.

WHO/UNAIDS notes that: 'Taking a human rights-based approach to the development or expansion of male circumcision services requires measures that ensure that the procedure can be carried out safely, under conditions of informed consent, and without coercion or discrimination. Such measures should already be features of good medical care. Communities where male circumcision is introduced have a right to clear and comprehensive information about what is known and not known about male circumcision and HIV prevention. Men opting for male

circumcision have the right to receive full information on the benefits and risks of the procedure. Countries should ensure that male circumcision is provided with full adherence to medical ethics and human rights principles. Informed consent, confidentiality and absence of coercion should be assured' [7]. Any government or armed force's written policy encouraging circumcision will amount to coercion without proper exploration and review of all circumcision-related literature.

### **Infant circumcision unethical and illegal in South Africa**

Prophylactic surgery is highly controversial and often unethical. Cutting off normal healthy human tissue without immediate benefit is not an ethically-sound option in modern medicine. We would similarly not sanction the prophylactic removal of female infant's breast tissue to prevent breast cancer in the future, despite this having a permanent preventive effect on the acquisition of breast cancer. There is also ample time to educate the child about safe sex practices. Thus it is even more remarkable that WHO/UNAIDS is pushing for infant circumcision and the human rights implications are profound.

The South African Children's Act, No. 38 2005, prevents circumcision of minors without clear and immediate medical justification. Prophylactic justification is not the same as medical justification. It would be illegal to circumcise infants and minors in government and military hospitals. The foreskin is important for proper development of the child and its premature removal is harmful to the child [17]. There is a growing body of men who are distressed from negative effects of infant circumcision. A physician is also required to obtain full informed consent from an adult (National Health Act 2003 [6]) or full assent whenever possible from a child (Children's Act 2005 [29]).

### **What are the implications of cutting men for HIV prevention?**

With no guarantee for HIV prevention, a policy on medicalizing circumcision is likely to backfire and cause an increase in HIV rates. The HIV rate in Southern Africa is dropping off and if circumcision is implemented now, it might incorrectly be seen as the intervention responsible. We also run the risk of creating more outraged men who acquire HIV despite losing their foreskin. What compensation and consolation can be given to the circumcised man who acquires HIV after getting circumcised in the false belief that he will be protected? And what of his female partner? Women are likely to be put at more risk.

### **Why is the military not doing its own research?**

The armed forces have the perfect opportunity to test the conclusions of the researchers of the three trials. Detailed records are kept of HIV prevalence. Circumcision status can be easily uncovered. Blindly accepting biased and flawed research is counterproductive. The US Navy has already done its own research into the prevalence of male circumcision and its association with HIV and sexually transmitted infections in a U.S. Navy population and concluded, 'Male circumcision, is not associated with HIV or STI prevention in this U.S. military population' [20].

### **Violation of the Constitution of South Africa**

Mandatory circumcision of military personnel would violate their rights under Article 2, Section 12 of the Constitution of South Africa. This action, therefore, is prohibited to the armed forces [24].

Reliable statistics of male circumcision are currently unavailable, yet estimates suggest 40 percent of South African males to be circumcised. This would exclude South Africa from the WHO/UNAIDS recommendations in any case.

### **The condom**

It is the presence or absence of a condom that is going to have an effect on the HIV epidemic and *not* the presence or absence of a foreskin. Anything that weakens the 'use a condom' message is irresponsible and will cause loss of African lives. Circumcision is not a benign procedure and has been shown to decrease penile sensitivity [21], decrease sexual pleasure [22] and induce circumcised men to engage in riskier sex with few condoms [23].

### **Playing Russian Roulette with African lives**

A previous UNAIDS report noted: 'In one study in South Africa, for example, two out of five circumcised men were infected with HIV, compared with three out of five uncircumcised men. Relying on circumcision for protection is, in these circumstances, a bit like playing Russian Roulette with two bullets in the gun rather than three' [25].

### **Conclusion**

Removing every foreskin will not eliminate HIV and will have complications for men and consequences for women. In an actuarial model, Johnson and Dorrington calculated that even if circumcision were scaled up according to the extent indicated by the acceptability studies, over the next 10 years the overall rate of new HIV infections in South Africa would be reduced by a mere 8.9% [30] while Williams noted that even if 100% of men were circumcised, the reduction would amount to only 11% [31].

Non-circumcising countries such as Brazil, Uganda and Thailand have successfully reduced their overall HIV rates (not only new infections) by significant percentage points without resorting to circumcision. Rather ABC approach was properly implemented [28, 33]. Some countries have spoken out against WHO/UNAIDS recommendations and will not be considering circumcision as part of their policies [18,19,32].

The premature call for mass circumcision policy should not be encouraged for the proposed prevention of HIV without further study, neutral peer review, in depth cost analysis and research into its negative impact on male sexuality, and society as a whole.

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