

# From Scalpel to Scale-up: Shaping Perceptions of Male Circumcision

Conference Proceedings

August 2, 2008  
Mexico City, Mexico

Sponsored by the Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) and the National Institute of Mental Health



## Contents

Contents.....	3
Introduction .....	4
One: Framing Lessons from the Cognitive and Social Sciences: Implications for Communicating Male Circumcision .....	5
The importance of communication .....	5
Frames .....	5
How frames work.....	6
Two: Perceptions of Male Circumcision in Africa .....	9
Three: Perceptions of Male Circumcision for MSM in Latin America.....	14
Four: Perceptions of Male Circumcision in the Caribbean .....	17
Five: Concluding Remarks .....	21

## Introduction

Following the positive results of three male circumcision trials in Africa, which found that the procedure reduced the risk of HIV infection by 60 per cent among heterosexual men engaging in vaginal intercourse, those working in the HIV/AIDS field now face the task of rolling out circumcision programs in areas affected by the virus.

Although already practised in many parts of the world, circumcision prevalence rates are very low in some of the countries hardest hit by AIDS. Cultural norms, concerns over safety and pain, weak health services and a lack of political will are among the barriers to wider coverage, and circumcision's advocates will need to bear these in mind as they frame messages to persuade policy-makers and the public to consider the procedure as an option to help prevent HIV and other sexual and reproductive health problems.

In August 2008 in Mexico City, UCLA's Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) and the National Institute of Mental Health (NIMH) held the second in a series of five conferences looking at the behavioral, social and policy implications of biomedical approaches to HIV prevention. 'From Scalpel to Scale-up: Shaping Perceptions of Male Circumcision' brought together researchers, community advocacy organizations, policy-makers and donor agencies for a day-long discussion about the communications needed for successful implementation of male circumcision programs. As Andrew Forsyth of NIMH explained in his welcoming remarks, understanding the social, behavioral and other factors that may facilitate or impede acceptance and uptake of circumcision is critical. These factors vary widely between and within regions. Presentations to the conference included analysis of the challenges and opportunities for male circumcision implementation in sub-Saharan Africa, Latin America and the Caribbean.

This report on the conference summarizes the presentations and the discussions that followed.

# One: Framing Lessons from the Cognitive and Social Sciences: Implications for Communicating Male Circumcision

## **Franklin D Gilliam Jr., Ph.D.**

*Director, Center for Communications and Community*

*Dean, School of Public Affairs*

*University of California, Los Angeles*

Keynote speaker Frank Gilliam gave a presentation to the conference on communicating social issues. He discussed the challenges of having a conversation with the public on such issues, and suggested ways of overcoming them and shifting public perceptions of a topic.

### ***The importance of communication***

Dr Gilliam explained why communication matters for policy implementation. How issues are communicated, he said, can shape culture and direct the thoughts and actions of influential individuals. Communication can therefore have serious implications for the topics that rise to the top of the public agenda. It can also define whether issues are seen as public or private – if male circumcision is seen as purely a private choice, it will be more difficult to move it onto the public policy agenda. Good communication can also help determine accountability for problems and propel social movements to address them.

Service providers and grassroots activists are often skeptical about the value of communication for influencing policy. Many service providers, Dr Gilliam observed, prefer to get on with offering services. Good communication, however, is vital for supporting these grassroots efforts. By moving issues onto the public agenda, communication influences the allocation of resources, thereby helping determine which services are financed out of the public purse.

For activists, communication matters because it can shape the broader environment within which mobilization efforts take place. The American civil rights movement was successful in large part because activists presented the grassroots movement not simply as one claimant group demanding a particular set of rights, but rather as a question of the fundamental values of society. With school desegregation, for example, activists focused on the American belief in the importance of education and opportunity for all, which ultimately led the Supreme Court to order the provision of education to everybody or nobody. According to Dr Gilliam, the civil rights movement was largely a “communications battle,” which worked because “social justice advocates were able to frame the debate in such a way that opened up political opportunities, that allowed the creation of mobilizing structures, that indeed directed dollars.”

### ***Frames***

Unlike those involved in the public and media relations industries, communicators in the social policy sphere are less concerned with what people think about a problem than how they think about it. “We are interested,” said Dr Gilliam, “in the cognitive tools people on the

street and policy-makers have at their disposal to reason about a problem. And then how does that get expressed in the dialogue in a culture or society, how does it get framed, and how does this framing either constrain or influence the kinds of public preferences, behaviors and choices that are ultimately made?”

Frames are key to this discussion. Frames are “organizing principles that are socially shared and persistent over time,” which structure how people understand the world.<sup>1</sup> The journalist Walter Lippman said that, “the way in which the world is imagined determines at any particular moment what men will do.” As Dr Gilliam noted, the important word here is “imagined”; Lippman is not asserting that people understand the world in a fact-based manner. “For many of you scientists and researchers in the room who adhere to the principle that the facts will set people free,” Dr Gilliam said, “I am here to tell you that that is not true. In fact, this principle can harm you more than it helps you.” Frames are about how the world is imagined to be, not necessarily how it is.

An oral health project Dr Gilliam’s team worked on in the US provides an example of why frames are important, and of how they can be shifted. Advocates wanted fluoridated water in their state, both to reduce dental problems and because dental problems have been shown to stunt the educational progress of affected children by making it harder to study and learn. The oral health community spent \$20 million on a campaign to argue for the fluoridation of water, but despite the strong scientific evidence base it had little success. Dr Gilliam’s team realized that the problem in this case was not so much the message as the messenger. The campaign had used dentists as communicators, but since most people are afraid of dentists they did not listen to the message. Their guiding frames equated dentists with pain, so whatever the latter said was unlikely to get through.

A new campaign was therefore developed which attempted to alter policy-makers’ way of looking at the issue. The campaign removed the dentists from the advertisements and instead focused on the educational benefits of good oral health. “Sometimes,” as Dr Gilliam commented, “you have to walk your issue through another door.” The dominant frame had been that oral health is just about brushing your teeth, which is the responsibility of a child and his or her parents, but when it was shown that public expenditure on education was less effective because of the oral health problem, policy-makers were persuaded of the need to fluoridate water, and did so within six months.

*“For many of you scientists and researchers who adhere to the principle that the facts will set people free, I am here to tell you that it is not true. In fact, this principle can harm you more than it helps you.”*

In the above example, the problem had been moved from the private to the public domain, and accountability from parents to the state. Frames help to explain who is responsible for solving a problem. If the attribution is to an individual, as in the case of teeth-brushing or, in the case of HIV/AIDS, risky sexual behavior, then the solutions all fall to the individual. But if attribution of responsibility is societal or cultural or ecological, the solution is different. The problem is seen through a wider frame and a broader set of actors are needed to address it.

### **How frames work**

Dr Gilliam summarized the social and cognitive science research on how people process information.

Researchers, he said, often treat the public as “empty receptacles” waiting to be given new information. However, people are not blank slates – they configure incoming information to what is already in their minds. They are “veterans of perception” who, according to the researcher Deborah Tannen, “have stored their prior experiences as an organized mass. This prior experience then takes the form of expectations about the world.” Understanding is frame-based rather than fact-based, and people often reject facts that do not conform to their preconceptions. Individuals and societies each have a dominant framework of expectation, which determines the first thing that comes to mind when thinking about an issue. This first thought influences all subsequent thoughts, and can crowd out other understandings. Changing opinion requires changing this dominant frame. As Dr Gilliam advised, “you don’t persuade people that the frame that is most accessible for them is wrong, but rather try to make another one accessible to them – one that may comport to other things they believe equally powerfully, even if they are not yet as invigorated by it.”

Dr Gilliam’s five key lessons of framing are, first, that communication is “fast and frugal.” People look for shortcuts to understand an issue. We use metaphors and other cues to help us organize incoming information. Our frames even allow us to save time by filling in missing information. In a US study on crime, trial participants said they could remember the race of a murderer (usually black) even though they were not shown the suspect’s face – they filled in information based on the cultural models and narratives in their society (in this case models that assume most criminals are black).

“Finding some familiar element,” said the cognitive psychology writer Roger Schank, “causes us to activate the story in our heads, and we understand the story as an exemplar of the old story. Understanding means finding a story you know and saying, ‘Oh yeah, that one.’” Moreover, as Dr Gilliam added, “Once we land on the story that we think is appropriate we stop processing.” Advocates cannot succeed, therefore, merely by repeating a message.

*People are “veterans of perception, who have stored their prior experiences as an organized mass. This prior experience then takes the form of expectations about the world.”*

The second lesson of framing is that we reason within the frame. We assign responsibility to actors within the frame and solve the problems mentally with the tools we already have. The third is that uninterpreted numbers are not frames. Most people have difficulty interpreting large numbers, so advocates should use numbers less frequently. Some may argue that they are just reporting facts, but as Dr Gilliam warned, “If you’re not framing, someone else is. Somebody is going to frame your data and interpret it, and they may not come up with the answer you want them to come up with.” When presenting numbers, the numbers should therefore be given a context – many people can only understand large numbers if they are compared to something else, something that resonates with their experience or knowledge. Linked to this is the need to move away from “professor speak” and to communicate in a language the audience can understand.

The fourth framing lesson is that order is important in communications. Researchers often lay out the opposing views first in their communications, and leave their own reframing of a problem until the end. This risks readers and listeners lodging the opposing frames in their heads, so that by the time the favored frame is presented it is too late to change opinions. Communicators should also avoid juxtaposing myths and facts (audiences will often understand the myths as facts), and presenting statements as “true” and “false” (which gives airtime to the opposing argument and risks the audience taking it as true).

The fifth lesson is that audiences are more likely to take action on an issue if they can see themselves as effective actors in the scenario being promoted. Issues therefore need to be made concrete and simplified so that people can understand how they can act to make a difference. On the other hand, communicators should avoid invoking the crisis frame which has surrounded AIDS for so long – this can result in crisis fatigue and in a tendency to discuss problems rather than solutions.

Dr Gilliam concluded with an analogy. “When you start talking about an issue such as male circumcision,” he said, “the public mind is a swamp - you don’t know what you might get out when you stick your hand in.” Circumcision is one of multiple prevention methods, and there are multiple concerns about it, from fear of pain to religious barriers to cost to the risk of people thinking they are safe from HIV once they are circumcised. There is also a lot of science, a lot of numbers, a lot of facts, and these facts and numbers and concerns vary by country and society. And there are questions about who is responsible for implementing circumcision. All these matters are floating around in the swamp, and when advocates of the procedure address the public, any one of them might be foremost in people’s minds: “What you reach in the swamp to get and what you pull out might be different,” Dr Gilliam argued, “so there has to be some ability to control the swamp.”

To do this, he suggested reframing the issue using common cultural values to elevate an issue and invigorate the message. Advocates must find a compelling narrative that trades in a “common cultural understanding in their society,” such as the importance of education in the civil rights example. They must also aim to ensure that the appropriate actors take responsibility for addressing the issue. Dr Gilliam recommended starting with big ideas and organizing principles before moving down to specifics. These big ideas should involve values that are central to society, and advocates should work down from those to their specific problem (from the importance of education down to fluoridating water, for example). Advocates often live at the level of specifics, he said, so changing the overall frame at the big idea level is difficult for them.



## Two: Perceptions of Male Circumcision in Africa

The remainder of the conference involved panel sessions, where presentations on perceptions of male circumcision in different world regions were followed by plenary discussions.

### **Robert C Bailey, Ph.D.**

*University of Illinois at Chicago*

*Chicago, US*

Robert Bailey reported on perceptions of male circumcision in Kenya, where he led the randomized controlled trial at Kisumu.

Kenya has a generalized HIV/AIDS epidemic, with heterosexual sex the primary means of transmission. High HIV prevalence rates have been found among commercial sex workers, truckers, fishermen, injecting drug users and men who have sex with men.

Many older Kenyans believe the epidemic is driven by an increase in promiscuous behavior among young people, and that morals have declined in recent decades. Although there is little evidence that promiscuity has increased since the 1940s and 1950s, when STI rates were no lower and the average age of sexual debut was similar, the common perception, or frame, is that traditional values have been eroded. There is also a perception that prostitution has contributed significantly to the epidemic, and that there are many “loose women” taking advantage of men’s “natural” promiscuity and infidelity.

Eighty-three per cent of Kenyan men are circumcised. Of over 42 ethnic groups in the country, only three do not traditionally practice circumcision. These are the Luo, whose 3.5 million people constitute 12 per cent of the population, and the much smaller Turkana and Teso groups (in the latter two groups, 44 and 31 per cent respectively are circumcised).

Among the ethnic groups that practice circumcision, the most common method is for a traditional circumciser to perform the surgery on young teenage boys, who spend weeks or months sequestered in a bush camp after being circumcised as part of a rite of passage to manhood and an essential precursor to marriage. No anesthetic is used, as the process is supposed to be painful in order for the participant to become a man. After the surgery, which is sometimes forced on boys, there is a celebration.

However, traditional circumcision is changing. Many boys are now circumcised clinically, due primarily to the huge cost of a traditional ceremony and the ensuing party. Other reasons include the opportunity cost of having to take time out of school to attend bush camps or to recover from complications resulting from traditional circumcision methods. The latter has been found to lead to adverse reactions in 35 per cent of cases, although because safety in itself is not of great concern to parents or boys as circumcision is supposed to be painful and difficult, appealing to people on the grounds of safety may not be the most compelling argument for shifting people towards clinical circumcision.

A map of HIV infection in Kenya shows the highest rates in Nyanza province, home of the non-circumcising Luo, which has over double the HIV prevalence of any other region. The 17 per cent of Luo who are circumcised tend to be the wealthier segments of the population and those living in cities and attending boarding schools, where most of their peers are circumcised.

Dr Bailey and his team have conducted focus group studies and key informant interviews gauging the acceptability of circumcision among the Luo. They found that the main barriers to circumcision are the cost, fear of pain, concern for safety and the absence of a cultural tradition of circumcision. On the other hand, those interviewed also saw several positive aspects of circumcision. The most important was hygiene - there is a strong belief that maintaining cleanliness is easier for circumcised men - followed by the reduced likelihood of contracting sexually transmitted infections. Looking like other Kenyans was another attraction, particularly for young Luo men, who also thought they would be more attractive to women if circumcised. Finally, circumcised men and their partners are seen as experiencing greater sexual pleasure.

Although many non-Luo Kenyans believe the Luo will never change their attitudes to circumcision, in fact the balance between the attractions and deterrents of circumcision among the Luo comes out broadly in favor of the procedure. Sixty per cent of the Luo men interviewed said they would prefer to be circumcised, and 62 per cent of Luo women would prefer their partners to be circumcised. Among people below the age of 21, the proportions climbed above 70 per cent. Over 80 per cent said they would circumcise their infant. Although the common frames of understanding expect the Luo to remain intractable when it comes to circumcising, therefore, the reality is that many are willing to consider the procedure.

Dr Bailey then discussed the policy environment in Kenya. He reported that the media, the Ministry of Health, civil society groups and Luo youth have discussed circumcision, but that political leaders have not made any statements about the procedure in the context of HIV prevention. The government has formed a male circumcision task force but has not launched an implementation policy, even though people on the ground are keen for the services to be delivered. The Luo Council of Elders, meanwhile, has said circumcision should be an individual decision, although the BBC recently mistakenly reported that the council rejected the procedure – a story which received substantial press coverage.

*Nyanza province, home of the non-circumcising Luo people, has over twice the HIV prevalence of any other Kenyan region.*

Dr Bailey argued that in order to encourage the government to take action, the voices of more diverse constituencies must be heard, including youth groups, young women and mothers. Conduits need to be opened up between people on the ground who are keen for circumcision to be delivered and policy-makers who are often distant from grassroots organizations. Educating the media is also important, including dispelling the perception that the Luo are against circumcision.

With regard to the message itself, Dr Bailey believes the focus should be on the broad health benefits of male circumcision, and that advocates should emphasize that it is not just about HIV prevention but has many other positive impacts. Policy-makers and the public, he said, need to move from the frame that says circumcision is about culture and tradition to a new frame that presents it as a health and hygiene benefit. Moreover, the surgery should not be promoted solely among communities that do not circumcise – there are many problems with safety among communities that do circumcise, and singling out one or two communities is likely to stigmatize the procedure.

**Noah Kiwanuka, M.D., Ph.D.**

*Rakai Health Services Program*

*Entebbe, Uganda*

Dr Kiwanuka, who worked on the male circumcision trial at Rakai, discussed perceptions of the procedure in Uganda as it begins to be rolled out.

Circumcision is practiced for three main reasons. The first is religion: among Muslims it is carried out on neonates soon after birth. The second is tradition – among the Gisu people in eastern Uganda male circumcision is seen as a puberty rite that initiates boys into manhood. The third is for medical reasons, for people with phimosis or genital ulcers or, nowadays, to prevent HIV infection.

The male circumcision trial in Uganda had a resounding effect on public acceptance of the procedure. Prior to the Rakai trial, a quantitative survey of 1178 people found that 60 per cent were willing to enroll in the trial and receive circumcision, with willingness highest among 20-29 year olds. In focus groups, women generally said they would prefer their husbands and their male children to be circumcised. After the trial, there was an immediate upsurge in demand for circumcision in Rakai. Eighty per cent of the control participants, for example, requested surgery, and many men came from other parts of Uganda because circumcision is offered free of charge in Rakai.

There are many challenges, however, as circumcision is scaled up in Uganda. The first relates to decisions around who should receive circumcision. Questions remain about whether to circumcise only adolescent and adult males (in whom it is proven to protect against HIV) or to extend the procedure to neonates; and about whether to circumcise HIV-positive as well as negative men – if HIV-positive men are excluded, they may face stigma and discrimination, but the effect on positive men is as yet unproven.

*Big questions remain about how to incorporate HIV-positive men into male circumcision programs.*

Questions over who should provide circumcision should also be addressed. Dr Kiwanuka asked: “Who are we going to recommend as the provider? Physicians? Medical personnel like nurses and midwives? And what about traditional and religious circumcisers?” He fears that if the latter are excluded from promotion campaigns, there is a risk of setting them on a collision course with medical practitioners. Questions also remain on where to offer circumcision, whether in hospitals only or in local clinics, or even by mobile teams.

Perhaps a greater challenge lies in shifting cultural beliefs. Focus groups prior to the Rakai trial revealed that men who were about to face circumcision believed they should have excessive and vigorous sex, because they would have to endure six weeks without sex after surgery. There is also a belief that urine and vaginal fluids can assist healing – a belief which could greatly increase the risk of HIV transmission as well as other adverse clinical events. The belief that the first sex after surgery should not be with a man’s regular partner exacerbates this risk.

To overcome these challenges, Dr Kiwanuka argued, messages have to be very clear. Communicating effectively the meaning of the protective effect of male circumcision and that there is a continued risk of HIV infection after surgery is crucial. The procedure should be presented as part of a broader prevention package, including the traditional ABC message promoting abstinence from sex, fidelity to one partner, and condom use. His team has held workshops for the scientific community, political leaders and the media in order to disseminate these messages. Some popular musicians participated in the media workshop and then wrote a song about circumcision, which has since been played regularly on Ugandan radio (and, as one conference participant reported, even in Los Angeles nightclubs). Dr Kiwanuka concluded from this surprising development that “there are many more frames we can use” than traditional messages and communicators.

## **Discussion**

The discussion following the presentations on Africa centered on the messages that should surround implementation of male circumcision programs, and on human rights issues.

Cindra Feuer from the AIDS Vaccine Advocacy Coalition in New York reported that women at a recent meeting her group organized in Mombasa, Kenya, were concerned that there is no immediate benefit of male circumcision for women, and that in fact there may be negative fallout from programs if women’s issues are not carefully considered during their implementation.

According to Noah Kiwanuka and Robert Bailey, these observations reinforce the need to present male circumcision holistically, and not just as an HIV prevention tool. There are benefits to women in terms of hygiene and a reduction in other sexually transmitted diseases, as well as long-term impacts on HIV prevalence within a community. Circumcision should be presented, they argued, as a medical intervention that promotes overall good health.

Regarding human rights, Dr Kiwanuka told the conference that some men in Uganda are forcibly circumcised if they have avoided surgery in their youth. Sometimes these men are circumcised in the street, although more often they are taken to a traditional circumciser. As Laura Stemple of UCLA School of Law noted, this is “clearly a human rights violation,” but one that sees rights from a narrow perspective. When framing male circumcision, she argued, rights should be considered in a broader way, perhaps through an empowerment approach whereby people are encouraged to see the procedure as a right that they are entitled to if they want it. Such an approach would fit in with concerns about informed consent and ensuring people know that it is a choice rather than an obligation. Tom Coates

of UCLA agreed, saying that “people have a right not to get HIV and they have a right to have everything at their disposal to help them do that, including accurate information and useful devices such as condoms and syringes and in this case surgery. It’s been a constant battle in every mode of prevention to get across that notion.”

## Three: Perceptions of Male Circumcision for MSM in Latin America

The next panel session looked at the potential of male circumcision among men who have sex with men (MSM) in Latin America.

### **Jorge Sanchez, M.D., M.P.H**

*Investigaciones Medicas en Salud-INMENSA*

*Lima, Peru*

Jorge Sanchez's presentation to the conference focused on perceptions of the foreskin, or prepuce, in South America. HIV prevalence among MSM in the Andean region's capital cities is approximately 20 per cent. The number of cases continues to increase. Circumcision prevalence is below 5 per cent, and although some studies have shown a protective effect for mainly insertive partners, it has not yet been established that increased circumcision will help reduce HIV prevalence among MSM.

Some South American researchers are keen to conduct a randomized controlled trial to answer this question. Dr Sanchez and his team therefore conducted focus groups with MSM, transgender individuals, male sex workers and male escorts in Peru, Ecuador and Brazil, in an attempt to understand how they perceive the foreskin and the male circumcision procedure. The research included fifteen focus groups with the target population, as well as 25 in-depth interviews with community leaders, gay rights activists, and representatives from health authorities, community advisory boards and ethics committees.

Focus groups respondents were first asked about the foreskin. Many said they did not talk about their private parts, but that they believe the prepuce's function is to protect the glans and keep it lubricated, and that it helps prevent STIs. Many see male circumcision as important for good hygiene, and believe that it will lead to less painful sex for insertive partners. Others thought it would enlarge the penis.

The perceived potential problems with circumcision included a loss of sensitivity in the penis, exposure to infections since the glans is uncovered, and a lack of lubrication. Other concerns related to fear of surgery and the risk that one's partner might be unfaithful in the month following surgery when the circumcised partner must abstain from sex.

Overall, group participants were in favor of having a new HIV prevention tool, but believed whether to circumcise should be a personal decision. Many thought it would not be popular, however, because it might lead to one's virility being questioned or one's penis being scarred. Those who were more skeptical wondered whether there was any point to being circumcised if one still has to use a condom during sex.

The key informants interviewed by Dr Sanchez's team were worried that implementing a male circumcision program in Latin America would increase the burden on the country's limited resources for health services. They also felt that culture would be a large barrier to a

successful program, and that a major education campaign would therefore be needed to increase acceptance of circumcision.

**Jose Enrique Pilotto, M.D.**

*Instituto de Pesquisa Clinica Evandro Chagas*

*Oswaldo Cruz Foundation*

*Rio de Janeiro, Brazil*

Dr Pilotto presented study findings on circumcision among MSM in Brazil – a study linked to that described by Jorge Sanchez. He also discussed the case for a randomized controlled trial in South America.

Estimated HIV prevalence in Brazil in 2004 was 0.6 per cent. 620,000 Brazilians were living with HIV/AIDS. The vast majority of cases result from sexual transmission, with MSM particularly hard hit. The incidence rate among MSM in 2004 was estimated at 226 per 100,000 population, compared to 19 per 100,000 in the general population.

Estimates put circumcision rates in Brazil below 5 per cent, with most of those who undergo circumcision doing so for religious reasons. There has been little discussion about the procedure even after the African trials, with the few media outlets and health agencies that have commented arguing that it is more useful and cost-effective in a context like Africa's, with very high HIV prevalence, than in Brazil, and that health services lack the resources to implement programs. Even scientific researchers have been quiet on the subject, with the result that circumcision is not seen as part of the HIV prevention package.

Dr Pilotto believes messages around male circumcision should emphasize that it is a low-risk way of preventing HIV infection and a useful addition to the prevention package, and that it has other health benefits such as protecting against STIs, urinary tract infections and penile cancer.

The main challenges with regard to a male circumcision trial in Latin America are its high cost, uncertainty over the willingness of the target

*Messages supporting male circumcision in South America should include the broad health benefits of the procedure, as well as its benefits for HIV prevention.*

population to participate, and weak support for a trial among policy-makers. Formative research is needed to determine the feasibility of a circumcision study. This will help assess whether circumcision can be implemented in the different regions of Brazil, and whether it can be implemented among MSM.

Dr Pilotto's team has already conducted focus groups with MSM aged eighteen or older who are at high risk of acquiring HIV through sexual intercourse, as well as in-depth interviews with public health officials, advocacy groups and policy-makers. They found that 95 per cent of uncircumcised MSM were willing to participate in a circumcision trial. The men's main concerns were the risks and pain of undergoing surgery and possible complications afterwards, including scarring. Most stakeholders interviewed, meanwhile, agree that a circumcision trial for MSM is both feasible and needed.

The focus groups also explored men's knowledge of and attitudes to HIV and circumcision. All the groups had good knowledge of HIV prevention methods, citing condoms as the principal means of preventing infection. Male sex workers were the most knowledgeable about circumcision. Some of the men believed the prepuce is important for masturbation and oral sex, and that circumcision would increase sensitivity and lead to premature ejaculation. Most, however, would undergo circumcision if it was proven to be a safe and effective way of preventing HIV.

Some groups outlined specific needs if they were to participate in a trial. Sex workers, for example, would prefer to be contacted at their places of work, while transvestites want messages that are tailored to them and do not want to be classified as MSM. Male escorts and openly gay individuals would prefer information on circumcision to be disseminated via the internet, gay venues, advertisements in the media, saunas and at DVD rental stores. And male escorts would prefer to take part in a trial targeting bisexuals, as the latter would also benefit from being circumcised. Taking account of the needs of different target groups is important to ensuring a successful trial.

## **Discussion**

Discussions on male circumcision in Latin America focused on whether a trial for men who have sex with men was the best option for moving circumcision forward in the region. As some participants pointed out, when HIV prevalence is only around 0.6 per cent, and only some of those infected are MSM, the case for an expensive and time-consuming trial among the latter group is not clear cut. Finding a sufficiently large sample, particularly if it were to be divided between predominantly insertive and predominantly receptive partners, may be a further problem.

Targeting MSM with a trial raises a further potential problem of stigmatization. In some Latin American societies, MSM are discriminated against and they may therefore be reluctant to participate in research. Moreover, if circumcision began among MSM and policy-makers later decided it should be rolled out among the general population, the stigma surrounding homosexuality and HIV/AIDS might make the surgery harder for others to accept.

Given the current lack of evidence on whether it protects MSM against HIV infection, framing male circumcision in the context of HIV/AIDS may not be the best strategy in South America. Robert Bailey suggested that even if circumcision were rolled out among the whole population, with such low regional prevalence rates that would only prevent a very small number of HIV infections. Several conference participants argued that the procedure should therefore be promoted as a health intervention rather than an HIV prevention tool. Tom Coates of UCLA said: "Maybe there are enough benefits, such as preventing cervical cancer, penile cancer, possibly anal cancer and sexually transmitted infections, to recommend male circumcision among the general population without needing a trial." Kate Hankins of UNAIDS suggested that framing circumcision in terms of its broader health benefits might help move things forward in Latin America.



## Four: Perceptions of Male Circumcision in the Caribbean

The final panel session discussed male circumcision policies and perceptions of the procedure in the Caribbean, one of the regions hardest hit by HIV/AIDS.

### **Peter Figueroa, M.D., M.P.H**

*Chief Medical Officer*

*Ministry of Health*

*Kingston, Jamaica*

Peter Figueroa, Jamaica's Chief Medical Officer, outlined his country's male circumcision policy and presented findings from a government survey on the procedure.

The adult HIV prevalence rate in Jamaica is 1.6 per cent. It is estimated that 27,000 of the country's 2.7 million people are infected. Almost half are thought to be unaware of their status. Infection rates are higher among men than women, and heterosexual sex is the main driver of the epidemic. Surveys have found that multiple sexual contacts are the most common reported risk behavior among those with HIV/AIDS (80 per cent report such behavior), followed by commercial sex (25 per cent) and crack cocaine use (9 per cent). Twenty per cent report no obvious risk behavior.

Eighty-six per cent of Jamaican men infected with HIV who report their sexual orientation are heterosexual, with eight per cent bisexual and six per cent homosexual. Infection rates among men who have sex with men are very high, remaining between 25 and 32 per cent for the last fifteen years.

Jamaica's HIV control program has succeeded in reducing mother-to-child transmission of the virus to below 8 per cent, from 25 per cent at the beginning of the decade. Sixty per cent of those in need receive antiretroviral therapy, and AIDS mortality has declined sharply since 1999. Dr Figueroa also reported increases in condom use and an overall slowing in the spread of the epidemic. On the other hand, he said, prevalence rates remain unacceptably high among those most at risk.

*Knowledge of male circumcision in Jamaica is limited, and policy-makers and health professionals are unenthusiastic about promoting it.*

After hearing of the results of the randomized controlled trials in Africa, Dr Figueroa conducted a survey of 143 men and women, aged 15 or above, who attended sexually transmitted disease (STD) clinics in Kingston. They were asked about their knowledge and attitudes to circumcision.

Two-thirds of those interviewed had heard of circumcision. Nine per cent of the men interviewed reported being circumcised, which roughly tallies with Dr Figueroa's own assessment that 5 per cent of Jamaican men are circumcised. When asked about the benefits of the procedure (using a prompted list), 40 per cent of men said it would be easier to clean the penis. Twenty per cent said it would increase sexual satisfaction, 16 per cent

that it would reduce the risk of an STD, and 8 per cent that it would reduce the risk of HIV infection. Twenty-seven per cent did not know of any benefit, however. When the same question was asked to women, 47 per cent saw hygiene as a benefit, with slightly higher proportions of women than men citing the reduced risk of STDs and HIV infection.

Respondents were also asked about the benefits of *not* being circumcised. Thirty-one per cent of men said the foreskin “offers protection,” and 25 per cent believe the uncircumcised penis looks more attractive. Sixteen per cent said that their being uncircumcised facilitates orgasm in their female partners, while 15 per cent believed it allowed men to enjoy heightened sensitivity. Among women, 46 per cent could not see any disadvantage to being circumcised; 12 per cent thought the penis looks more attractive when uncircumcised, but only 8 per cent thought such a penis facilitates female orgasm.

Interviewees then discussed the negative *effects* of being circumcised. Twenty-five per cent of men said it would make masturbating more difficult, while 13 per cent said it would make it easier to get an infection and 8 per cent that it would reduce sexual satisfaction. Thirty-seven per cent did not know of any negative effects.

When respondents were told about the research findings from the African trials, 34 per cent of men said they would consider circumcision and 31 per cent that they would not. Women were more favorable, with 66 per cent saying they would encourage their partner to be circumcised – as Dr Figueroa observed in response to this finding, “of course, women do not have a penis!” 57 per cent of men and 71 per cent of women said they would recommend their son to be circumcised. Of those few women who were reluctant for their sons to be circumcised, the main deterrent was the pain surgery would cause.

The final topic covered was condom use. According to Dr Figueroa, most of the men coming to the STD clinic would have more than one sexual partner, so they were asked if they used condoms with a sex partner other than their main partners. Eighty per cent of men said they did so most of the time or always. Forty-seven per cent of the women surveyed said they had no other sex partner; among the remainder, over 90 per cent said they used condoms most of the time or always. 84 per cent of men and 88 per cent of the women who admitted to having more than one partner said they would continue to use a condom after circumcision.

In summarizing the research findings, Dr Figueroa commented that, “in a population that did not seem to be clear on what circumcision was, they seem to be quite receptive.” He added, however, that because many of the answers were prompted, results might be somewhat exaggerated. “I would express great caution in applying these results to a program,” he said. “It’s one thing for a man to consider circumcision, it’s another for him to come forward for surgery.”

Dr Figueroa’s team also surveyed a handful of policy-makers and physicians. Among both groups, they found a reluctance to promote male circumcision among adults. Waiting lists for other surgical procedures are already too long and adult circumcision is unlikely to be cost-effective in a context of such low HIV prevalence. On the other hand, policy-makers

were broadly in favor of circumcising male infants (physicians were not asked about this), which they see as a potentially worthwhile investment.

**Brendan C. Bain, M.D., M.P.H**

*Community Health & Psychiatry – UWI HIV/AIDS Response Program*

*University of West Indies*

*Kingston, Jamaica*

The final presentation looked more broadly at male circumcision in the Caribbean.

Only Sub-Saharan Africa has higher HIV prevalence than the Caribbean region. There is wide diversity in the Caribbean, but overall prevalence is approximately 1 per cent. In Bermuda, Cuba and some eastern Caribbean islands, prevalence is below 1 per cent, while in Bahamas, Belize, Guyana, Haiti, Jamaica, and Trinidad rates are between 1.5 and 3 per cent. 230,000 people in the region are living with HIV/AIDS, with 75% of these living in either the Dominican Republic or Haiti.

Brendan Bain reported on a survey he had conducted of National AIDS Program Coordinators in the Caribbean. Respondents came from eighteen Caribbean countries, and they were asked questions on the state of the debate around male circumcision in their countries and public perceptions of the procedure.

Male circumcision has not received much attention in the Caribbean. Thirteen of the eighteen survey respondents said there was no public debate on male circumcision in their countries. Only four said there was some debate. Twelve respondents said there were no discussions about the procedure among policy makers, with four reporting some discussions.

*There is little debate among the Caribbean public or policy-makers about male circumcision, even after the success of the African trials.*

The scant attention paid to male circumcision means that, unlike in some other parts of the world, there are few myths surrounding the procedure. Only three respondents were aware of such myths, and each only gave one example. Only four respondents reported that there were fears among the population regarding male circumcision. These included the fear of pain, of unspecified complications, and of reduced sexual potency and reduced sensitivity of the penis.

Other comments from those surveyed focused on the influence of certain groups on decisions over whether to circumcise. In Jamaica, for example, a leading pediatric surgeon told Dr Bain that fathers and grandparents have most say in whether a child should be circumcised. Mothers, who often do not want to subject their children to pain, submit to the views of their husbands and of grandparents. The surgeon also reported that the pediatric fraternity in Jamaica is almost unanimously against circumcision of newborn males. Many pediatric surgeons were trained in the United Kingdom, where the practice is uncommon

and there is a very conservative attitude to male circumcision. This has influenced their views on returning to the Caribbean. In Anguilla, meanwhile, the National AIDS Program Coordinator reported that many men “place high pride on their penis and testicles.” She believes it will take “a whole lot of persuasion to get the adult male to begin thinking about circumcision and then to actually come forward to be circumcised.”

As in other world regions, therefore, the individual characteristics and beliefs of different Caribbean communities will need to be considered by those rolling out circumcision programs. As Dr Bain summarized, “the Caribbean is often reported on as a region, but one of our realities is that there are 15 or 16 sovereign states that really want to make decisions individually, and so the debate has to be raised in each of those countries.”

## **Discussion**

There was some debate over whether investment in male circumcision would be the most effective means of tackling HIV/AIDS in the Caribbean. Peter Figueroa argued that increasing condom use and reducing concurrent sexual partnerships were more important and likely to be a better use of resources. Kate Hankins of UNAIDS, on the other hand, suggested that male circumcision should be made available at low cost, without necessarily mounting an expensive campaign to support it. “What we’re trying to do,” she said, “is not displace any current prevention methods, but add to the existing set of tools.”

Dr Figueroa believed that making circumcision more widely and cheaply available would require “a lot more work with surgeons, pediatricians, obstetricians and policy-makers,” who are not focused on the procedure as a prevention tool and who need to be persuaded in advance of any public debate on the issue. The results of the African trials had little impact in the Caribbean and health professionals see other health problems than HIV/AIDS as priorities for surgery. There is a long way to go, he said, before male circumcision is seen as part of the region’s HIV prevention toolbox.

## Five: Concluding Remarks

Tom Coates of UCLA summarized the conference proceedings. Looking ahead to the next 25 years of the HIV/AIDS epidemic, he said, it will be important to collect evidence on how promising new technologies like male circumcision work in practice. Those thinking about HIV prevention for future generations, moreover, will have to consider whether infant circumcision, which is a much easier procedure than adult circumcision and will help in fighting HIV/AIDS in the long-term, should be the focus of their efforts.

A further key issue raised at the conference was that what advocates of male circumcision think are the barriers often prove not to be the main obstacles when programs are rolled out on the ground. The same applies to factors that facilitate circumcision uptake. Perceptions of the benefits of male circumcision vary by region, with Africans placing much more emphasis on the procedure because the epidemic there is more widespread than in Latin America and the Caribbean. The same messages and frames, therefore, are unlikely to be applicable in all parts of the world, and program implementers need to bear in mind these different perceptions if they want to increase uptake. In some areas, they may benefit from framing the surgery in terms of its overall sexual and reproductive health benefits, while in others its importance for tackling HIV will be a more persuasive message.

Dr Coates concluded by reiterating the need to see male circumcision as one part of the HIV prevention package, rather than as a replacement for existing methods. “We want to offer people as many options as possible,” he argued, “because people at different points in their lives may take advantage of different options. That’s really the way we need to think about this problem.”

---

<sup>1</sup> Reese, Gandy, Grant (2001): Framing Public Life. New Jersey. Lawrence Erlbaum.