Making Medical Male Circumcision Work for Women

Background

In 2009, AVAC and the ATHENA Network launched the Women's HIV Prevention Tracking Project (WHiPT) to support women's community-based monitoring of concerns around the imminent implementation of medical male circumcision (MMC) for HIV prevention. Teams of women in Namibia, Kenya, South Africa, Swaziland, and Uganda were part of the first, pilot phase of this research, focusing on the implications of MMC for women. In all but one region of focus (Nyanza in Kenya), MMC had not yet been rolled out; therefore, the women documented perceptions and concerns around MMC's pending rollout, not actual or anecdotal experiences of the rollout.

Summary of Findings

- WHiPT participants and informants believe that MMC is protective for men against HIV, would support it and want to be involved in the process.
- WHiPT participants and informants also perceive that MMC might lead to an increase in risk behavior in men with an associated increase in gender-based violence and stigma if the men are not fully informed about partial protection and wound-healing practices.
- Few of the women interviewed were aware of the recommendation, based on clinical trial data, that men abstain from sex for six weeks after circumcision.
- Women reported misconceptions conflating MMC and traditional male circumcision.
- Women reported misconceptions conflating MMC and female genital cutting (FGC):
  - In Uganda, MMC is thought by some to be a *new* justification for FGC, potentially increasing its rates in areas where FGC is practiced.
  - In Kenya, there is an emerging sense among women that MMC fuels female circumcision; with the interpretation that a 'cut' to women is similarly protective against HIV as it is for men.
- Women's perceptions differed depending on whether they came from traditionally circumcising cultures and communities new to MC:
  - Those from traditionally circumcising communities are concerned from a mother's perspective about safety of their sons; those from non-circumcising cutlures look at MMC more from a sexual health perspective.
- Many of the women participating in the project reported that they are currently not able to negotiate condom use. The majority of these women reported that they were not using any form of HIV protection and voiced the need for more female controlled prevention methods.

Methodology

The WHiPT teams, in large part led by women living with HIV, developed a set of three data collection tools to ascertain impressions of MMC from community women. Data collectors from each country team were trained in these instruments for the data collection exercise.

In total, an estimated 500 women were administered the questionnaire across the five countries and almost 40 focus groups were convened. In each country, the research was carried out in diverse locales, selected to reflect a diversity of practices, including traditionally circumcising and non-circumcising communities as well as those practicing female genital cutting.

Women's Perspectives

MMC is a promising intervention for HIV prevention; however, concerns exist among community stakeholders, in particular women, about the impact that the partially effective intervention might have on risk compensation (increased numbers of partners for men and decreased use of condoms by men), sexual negotiation, gender-based violence, stigma, and resource allocation away from comprehensive HIV prevention. Additionally, newly circumcised partners may or may not know their HIV status since testing is not a pre-requisite for surgery. There are data suggesting that HIV-positive men who are circumcised and resume sex prior to complete wound-healing have an increased risk of transmitting HIV to their female partners compared to uncircumcised HIV positive men.[1]

The WHiPT team findings underscore the need to increase women's participation in all aspects of MMC policy and program development. Such policies and programmes should adopt a gendered and rights-based framework for operationalizing MMC for HIV prevention.

Furthermore, the responses gathered by the WHiPT pilot teams point to the need for adequate education campaigns on MMC for HIV prevention, particularly addressing the impact that this intervention could have on women and emphasizing the partial protection from HIV infection for men.

Finally, all five-country chapters express a need for increased access to, and availability of, women-initiated HIV prevention options. The WHiPT findings underscore the importance of monitoring resources to ensure that they are not diverted away from HIV prevention programmes for women. The teams also stress the need for all HIV prevention programmes, including those offering medical male circumcision, to provide services and interventions that directly address women's needs and reduce women's risk of HIV. Such services should be integrated into new medical male circumcision programmes and also developed in their own right.

Scientific Background

In 2007, the WHO and UNAIDS recommended that MMC become a priority HIV prevention intervention in countries with high HIV prevalence rates and low prevalence of male circumcision. This recommendation was based on the results of three randomized controlled trials that took place in Kenya, South Africa and Uganda. Each trial enrolled HIV negative men and together found an approximate 65 percent reduction in men's risk of acquiring HIV from women during vaginal sex.[2] There are no conclusive data on whether circumcision of HIV positive men reduces their risk of transmitting HIV to women. WHO's current safety guidance calls for men to abstain from sex for six weeks post-surgery allowing for full wound-healing. This period of abstinence reduces risk of infections or complications for all men post-surgery. For HIV positive men, resumption of sex before recommended may result in increased risk of transmission to HIV-negative women.

Modeling studies suggest that in countries with high rates of HIV and low rates of male circumcision, widespread uptake of male circumcision for HIV prevention would over time, reduce HIV and rates of other STIs among men at a population level. This would, in turn, reduce women's risk of exposure. Over the long-term, this would be an indirect benefit to women. MMC programmes could also be developed as entry points for reaching men and their partners with information and services on HIV risk reduction, gender equity, contraception, and shared sexual decision-making. Such programmes would also offer indirect benefits to women.

[1] MJ Mawer, et al. Circumcision in HIV-infected men and its effect on HIV transmission to female partners in Rakai, Uganda: a randomised controlled trial, *The Lancet*, July 2009.

[2] Male Circumcision Clearinghouse, *http://www.malecircumcision.org/research/clinical_research.html*, July 15, 2010.

Making MMC Work for Women: Recommendations

Policy makers, implementers and civil society, together must:

- Identify and address myths about MMC in various communities, and provide clear, culturally-appropriate information.
- Distinguish clearly between MMC and traditional male circumcision; and between MMC and female genital cutting in all program literature.
- Implement and monitor efforts to clarify the distinction between MMC and FGC.
- Employ strategies that will engage women in all aspects of MMC to ensure those women's needs, concerns, and HIV risks and vulnerabilities are addressed.
- Implement comprehensive MMC packages that will integrate sexual and reproductive health, gender equity, and empower women to get involved in decision-making especially on condom use.
- Promote voluntary HIV counseling and testing as the entry point for MMC.
- Emphasize MMC as a complementary HIV prevention method rather than as a stand-alone method.
- Include gender indicators in MMC rollout monitoring and evaluation efforts.
- Ensure MMC programs are implemented as part of comprehensive prevention programs that also integrates female condom access.
- Educate women with knowledge and provide skills in decision-making regarding the circumcision of their infants.
- Develop clear and correct messages and train the media on MMC issues relevant to women.

Next Steps for WHiPT Advocacy

Over the next six months, WHiPT teams will develop and execute advocacy plans based on their findings. Actions include:

- Leading national level launches of WHiPT's comprehensive report of findings and key recommendations.
- Linking women's organizations and networks to WHO MMC country delegations.
- Working with MMC implementers on women-sensitive MMC communications materials.
- Ensuring implementers include gender indicators in MMC rollout monitoring and evaluation efforts.
- Developing a collaborative research literacy curriculum aimed at women in affected communities.
- Monitoring resources allocated to MMC.
- Further investigating the conflation of MMC and FGC and how an increase in FGC may be mitigated.
- Documenting the process and lessons learned through WHiPT so that the experience and knowledge gathered may serve as model and reference to bring forward other community led monitoring initiatives by women.

Full-Report Launch

The full report will be launched in parallel with country reports in the coming months. For a listing of these events, go to *http://www.avac.org/ht/d/sp/i/306/pid/306*. For questions or to know how you can become involved in MMC and women's advocacy, please contact us at *avac@avac.org* or *admin@athenanetwork.org*.

About WHiPT

The Women's HIV Prevention Tracking Project (WHiPT) is a collaborative initiative of AVAC and the ATHENA Network launched in 2009 bringing community perspectives, particularly women's voices, to the forefront of the HIV and AIDS response. The specific purpose of WHiPT is to advance and facilitate the monitoring of HIV prevention research, advocacy, and implementation by women who are the most affected by the epidemic.