



Medical male circumcision campaigns face cultural challenges in southern Africa

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Campaigns to circumcise tens of thousands of men in southern Africa are falling victim to lingering acceptability issues six years after the procedure was first recommended to help prevent HIV infection, according to speakers at the 2nd International Conference for the Social Sciences and Humanities in HIV in Paris last week.

The World Health Organization (WHO) and UNAIDS began recommending medical male circumcision as an HIV prevention tool in 2007, following three large-scale randomised clinical trials. Conducted in Kenya, South Africa and Uganda, these trials found that medical male circumcision reduced a man's risk of contracting HIV by about 60%. Following international recommendations, high HIV-prevalence countries in both east and southern Africa announced plans for large-scale circumcision campaigns.

Now researchers say campaigns in Swaziland, Botswana and Malawi are failing owing to concerns from men, communities and countries about whether medical male circumcision is appropriate for them.

Social scientists at the Paris meeting argued that those implementing medical male circumcision had paid insufficient attention to the social meaning of circumcision in different settings (it is often a marker of ethnic or religious differences, or associated

with a particular form of masculinity). While there is evidence that the intervention has efficacy (in ideal conditions), it will only be effective (in real-world settings) in certain circumstances when contextual factors including social networks, political debates and cultural values are favourable.

Biomedical researchers had 'divorced any sort of understanding of the efficacy of these tools from how they operate in real people's lives', said Richard Parker of Columbia University. 'That's what's missing from the evidence,' he said, arguing for more social science research to shed light on the issue.

Threats to masculinity, tradition and sovereignty

In Swaziland, about one-quarter of all people between the ages of 15 and 49 are estimated to be living with HIV. With the world's highest HIV-prevalence rate, Swaziland was an early adopter of the WHO recommendations. In 2009, the country developed plans to circumcise 150 000 males within two years. However, by 2011, the country had only met about 12% of this target, according to Alfred Khehla Adams of the University of Amsterdam.

To find out why circumcision had been so unpopular among Swazi men, Adams interviewed men in the Kwaluseni district of Manzini, Swaziland, through a mix of focus group discussions and interviews. He found that because men feared reduced sexual pleasure and possible adverse effects, Swazi men felt the procedure threatened their notions of manhood.

'A real Swazi man is defined as someone who has a wife and children, and is able to take care of family,' Adams told the conference. 'In order to have a wife and children, a man has to be sexually functional – the issue of circumcision introduced a threat to this.'

Nonetheless, the three large randomised clinical trials found that only a small percentage of circumcisions (1.5 - 3.8%) resulted in complications such as wounds or swelling.

Men also reported that they did not see the value in medical male circumcision when continued condom use was still advised following the procedure.

'They tell you to circumcise and also use condoms, why?,' said one uncircumcised man during a focus group. 'This thing is not 100% effective so why don't you just leave the circumcision thing and condomise?'

Research from Botswana also points to lingering acceptability issues in the country, which in 2009 committed to medically circumcising 100 000 men each year. In 2012, the country was able to circumcise about 40 000 men, falling short of the targets of the WHO, according to Masego Thamuku of the University of Bergen.

Conducting research in Mochudi, Botswana, Thamuku found that national circumcision campaigns that were initially well received by traditional leaders and communities had fallen out of favour. This was largely owing to the way campaigns have been publicised and carried out among Tswana communities that already practise circumcision via traditional initiation schools.

'In 2009, three cohorts of initiation schools were brought into the clinic to be circumcised,' said Thamuku during her presentation at the Paris conference. 'In 2011, everything turned all around – the public campaigns had breached traditional privacy.'

Not only had campaigns using radio and public events, as well as female nurses, breached notions of privacy and secrecy attached to traditional circumcision, but they were also seen to have eroded the kind of kinship fostered by traditional schools in which men learned the rules of manhood as part of a rite of passage. Following from this, Thamuku's interviews with men and implementers of circumcision revealed that there were doubts in the community as to whether medically circumcised men could be seen as 'real men' alongside those who had been traditionally cut.

Justin Parkhurst of the London School of Hygiene and Tropical Medicine suggested that the government of Malawi had actively resisted international pressure to implement a prevention method imposed on it by donors.

While medical male circumcision is usually framed as a technical issue, Parkhurst

said that it could be deeply political. In Malawi, information about circumcision was understood in the context of tensions between Christians and Muslims. Local knowledge – such as higher HIV prevalence in regions with high traditional circumcision rates – was privileged and the findings of international researchers questioned. Resistance to circumcision became part of a broader challenge to the country's dependence on Western aid.

AIDS experts' ambivalence

While most speakers suggested that public health experts and international organisations had been unquestioningly enthusiastic about medical male circumcision, a very different analysis came from Ann Swidler of the University of California.

In her view, the attitude was much more awkward and ambivalent. Examining a key WHO and UNAIDS document from 2007, she found the authors reluctant to accept

the overwhelming scientific evidence, with the document full of caveats. The document insists that circumcision should be provided alongside a comprehensive package of HIV prevention interventions. Swidler argued that this obscures the fact that male circumcision has a proven efficacy, whereas existing interventions such as voluntary counselling and testing or programmes to promote and distribute condoms do not.

One reason for the reluctance around circumcision, she said, is that it touches on cultural sensitivities and anxieties, including those around neo-colonial relationships between Europeans and North Americans on the one hand, and Africans on the other.

However, it goes beyond this. The empowerment struggles of women and gay men, as well as a broader aspiration to individual autonomy and self-determination in many contemporary societies, have powerfully shaped the 'moral imagination'

of people working on the response to HIV and AIDS, she argued.

'The lack of enthusiasm for male circumcision has to do with the fact that it doesn't push any of our buttons,' she said. The intervention does not require sustained behaviour change or a transformation of gender relations. 'We don't have to train people; we don't have to teach them to be different kinds of human beings,' she said.

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Article courtesy of www.aidsmap.com

SINGLE SUTURE

Sensor knows when you're lying through your teeth

A sensor embedded in a tooth could one day tell doctors when people have defied medical advice to give up smoking or eat less. Built into a tiny circuit board that fits in a tooth cavity, the sensor includes an accelerometer that sends data on mouth motion to a smartphone. Machine-learning software is taught to recognise each telltale jaw motion pattern, then works out how much of the time the patient is chewing, drinking, speaking, coughing or smoking.

The inventors – Hao-hua Chu and colleagues at National Taiwan University in Taipei – want to use the mouth as a window on a variety of health issues. The device can be fitted into dentures or a dental brace, and the team plan to miniaturise the device to fit in a cavity or crown.

The researchers say the sensor shows great promise: in tests on eight people with a prototype implant installed in their dentures, the system recognised oral activities correctly 94% of the time. The prototype was attached to a power source by an external wire, so the team still needs a way to include a microbattery.

Once they manage this, the researchers want to add a bluetooth radio to the device. However, as that is a microwave energy source – albeit a very low-power one – Chu says medical experts are advising the team on how to ensure the implant would be safe.

If miniaturised and made wireless, the device has potential, says Trevor Johnson, vice-chair of research at the Faculty of General Dental Practice in the UK. 'This could have a number of uses in dentistry, for example as a research tool, for monitoring patients who clench or grind their teeth, and for assessing the impact of various dental interventions,' he says. The work is due to be presented at the International Symposium on Wearable Computers in Zurich, Switzerland, in September.

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