

introduction that is based on the input of an array of community members: men and women, religious leaders, traditional medical providers, researchers, policy makers and others. With these

perspectives as guiding principles, there is reason to hope that male circumcision can be an important addition to the existing range of options for preventing the spread of HIV. **NU**

Civil Society Report-back on dialogue on Male Circumcision: Implications for Women

Between 22 and 23 June over 35 civil society representatives, predominantly women living with HIV in sub-Saharan Africa, met to discuss the implications for women in male circumcision for HIV prevention programmes. Marion Stevens reports.

ENSURING PREVENTION STRATEGIES WORK FOR WOMEN

Statement on medical male circumcision for HIV prevention by women's health activists

We, mainly women from sub-Saharan Africa, the epicentre of the HIV/Aids epidemic gathered in Mombasa, Kenya note that of all HIV infections in sub-Saharan Africa, 60% affect women. As such, any response should have women as central to any prevention, care and treatment response to HIV and Aids.

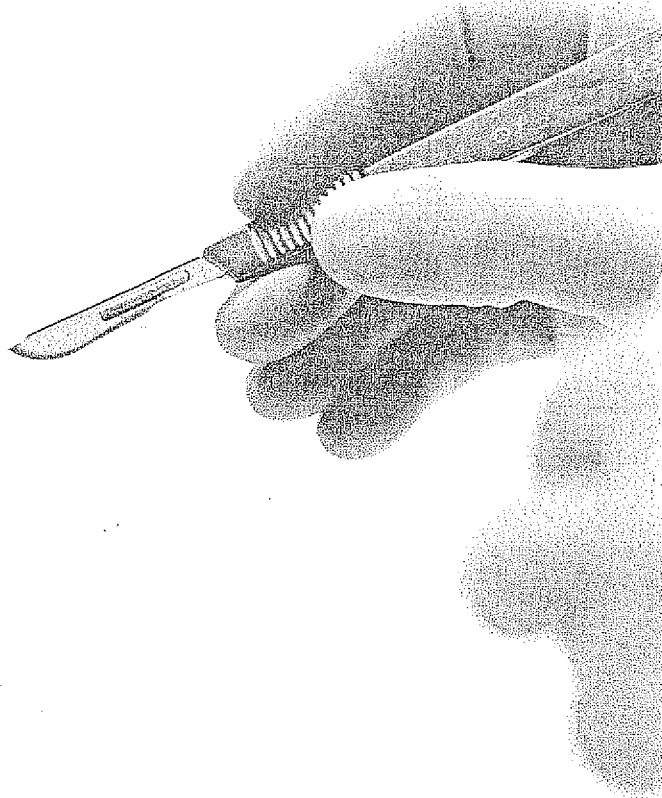
We need prevention and treatment programmes that work for women and thus accept male circumcision as part of a comprehensive package of prevention, care and treatment. We ask that resources not be diverted from prevention and treatment efforts that work (condoms, female condoms, diagnosis and treatment of sexually transmitted infections and HAART and OI treatment) and that these be continued to scale up.

There is also a need to continue resource allocation in the integration of HIV/Aids and sexual and reproductive health and rights programming, as well as around women's empowerment (or gender equality). We also note that there is a need to craft meaningful participation of women and positive women in research, policy development, and programme planning and implementation efforts.

Having reviewed the research and evidence from the three RCTs we note that there is an estimated 60% prevention of transmission to heterosexual men. There is no conclusive evidence to demonstrate any direct benefit for women. Modelling studies suggest indirect protection will eventually accrue to women but that in the short term increased feminisation of the epidemic is likely.

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

The experience of African women and particularly HIV-positive



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

Women's health and rights advocates also note the potential harmful effect of male circumcision because men may have a false sense of protection and this can in turn compromise women's ability to negotiate conditions of sex (if and when sex happens, condom use, etc) as well as increased gender-based violence.



These are our over-arching concerns. In addition, we have specific comments and recommendations related to existing guidance documents, specifically the March 2007, *New data on male circumcision and HIV prevention: Policy and Programme Implications*.

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

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

Civil society recommendations (1)

Recommendation 5.3 must be implemented. Women and HIV-positive women in particular are key stakeholders.

This type of consultation should be coordinated by individuals and organisations with experience and capacity in conducting gender analyses.

Conclusion 6: The gender implications of male circumcision as an

HIV prevention method must be addressed

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

Civil society recommendations (2)

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

Civil society recommendation on gender-related implementation

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

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

Civil society recommendations (3)

Develop an approach to MC introduction that incorporates research, monitoring and programme adaptation that directly seeks to address potential harmful effects including, specifically, gender-based violence, increased stigma of HIV-positive women who may be blamed for bringing HIV into the relationship. Specific resources must be allocated to these activities.

Monitor resource allocation and flow for HIV prevention, ensuring that, where there is spending on MC there are also additional resources for proven prevention interventions for women.

Civil society recommendations (4)

Look specifically at rates of domestic violence, coercive sex during the period of wound healing/recommended abstinence post-surgery.

The unacceptable context of criminalisation of HIV transmission must be taken into account when looking at introduction of male circumcision. In addition to being blamed for bringing HIV into the relationship women may face legal repercussions for HIV infection – especially if, after circumcision, men are perceived to be protected.

There is a need to understand more about the outcomes associated with early (infant) versus adult male circumcision for both women and men.

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

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

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

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

Civil society recommendations (6) on testing and programmes

Male circumcision programmes should be designed to increase uptake of (V)CT and partner disclosure, as well as counselling to minimise MC in HIV-positive men; priority should be placed on pairing MC with successful/innovative approaches (such as home-based testing, integration of (V)CT with family planning clinics, male-targeted/-friendly approaches) should be paired with MC roll out.

Civil society recommendations (7)

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

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

Current language

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

Civil society recommendations on messaging

As far as women are concerned, there must be messages that having sex with a circumcised man does not have a protective effect for the women.

We need communications strategies that address the change in power balance (to the extent that male circumcision may reduce women's ability to negotiate condom use), the ability to negotiate if/when/how sex happens, and the allocation of responsibility for HIV prevention in general and as these factors are affected by the introduction of male circumcision at local and national levels.

We need clear messages about the time period to wait before

resuming sex – even if the wound appears healed – and the need to continue using condoms. Both women and men need clear messages, however the burden of 'enforcing' abstinence until wound healing should not fall on women – the primary responsibility is on the man.

Civil society recommendation on resources

Matching of resources/budget line for prevention and services for women in conjunction with any MC roll out.

Answer the question: Where is the funding going to come from to ensure that support for other prevention strategies is increased to counteract shifts in power balances?

New and sustained allocation of resources for male and female condoms from existing and potential funders; responsibility on governments, other donors to counterbalance MC funding with funds to ensure that other prevention strategies and primary healthcare activities are not weakened as MC rolls out – and that the programmes are introduced in the context of funded efforts integrate MC into existing services and to strengthen health systems more broadly.

What will success mean to women?

Answers to questions about impact of MC on sexual risk behaviour, power imbalances, condom use.

Evidence that programmes are influenced by these findings.

Expanded, sustained conversation about gender roles and sexuality.

Increased access and uptake of sexual and reproductive health services for men and women.

Lower HIV incidence in both men and women.

MC programmes that effectively link HIV-positive men and women with HIV treatment (OIs and ARVs) and care and services

No increased stigma in uncircumcised men, HIV-positive men, marginalised populations (LGBTI, sex workers).

Healthier families. **NU**

