

**UNAIDS/CAPRISA Consultation on
Social Science Perspectives on Male Circumcision for HIV Prevention
18-19 January, 2007
Summary Report**

1. Background:

On December 13th, 2006, the US National Institutes of Health announced that two trials assessing the impact of male circumcision on HIV risk would be stopped on the recommendation of the Data Safety and Monitoring Board. The trials being carried out in Kisumu, Kenya, and Rakai District, Uganda revealed an approximate halving of risk of HIV infection in men who became circumcised. These results support findings published in November 2005 from the South Africa Orange Farm Intervention Trial, funded by the French Agence nationale de recherches sur le sida (ANRS), which demonstrated at least a 60% reduction in HIV infection among men who became circumcised.

UNAIDS and WHO are convening a meeting in early March to examine the policy and programming implications of the results of the randomised controlled trials of male circumcision for HIV prevention. In preparation for the policy meeting, UNAIDS and CAPRISA organized a small exploratory meeting on social science perspectives on male circumcision for HIV prevention in Durban on 18 and 19 January 2007.

2. Purpose:

The objectives of the consultation were to:

1. Explore cultural, social and other aspects related to the proposal to scale up the offer of male circumcision services in high HIV prevalence settings; and
2. Develop recommendations for research and action.

3. Participants:

The meeting was attended by about 30 participants including social and biomedical scientists from research and academic institutions (Bennington College, Université Cheikh Anta Diop, Human Sciences Research Council, Indian Council of Medical Research, University of Kwa-Zulu Natal, La Trobe University, Mahidol University, Makerere University, Moi University, University of Pretoria, Progressus); government (Department of Health, South Africa); representatives from the UN

(WHO, UNICEF, UNFPA, UNAIDS); civil society (Sonke Gender Justice, Treatment Action Campaign); and foundations (Ford and Bill and Melinda Gates).

Participant expectations and views of the meeting.

Recognizing that male circumcision is more than a biomedical intervention, the following were participant expectations:

- How to best to support countries to integrate male circumcision into comprehensive HIV prevention and male sexual and reproductive health programming, particularly ensuring that correct and consistent male and female condom use, which is viewed as a gold standard in HIV prevention, is not displaced by the addition of male circumcision to the prevention choices available to people;
- How to contextualize male circumcision within construction of culture, religion, sexuality, young people, individual and group identity;
- Help better understand male circumcision and gender relations: male sexual and reproductive health (SRH), sexuality, "men as partners", and what male circumcision means for females;
- Inform discussions of how the findings on male circumcision can affect trials of other biomedical HIV prevention interventions (e.g. microbicides, vaginal diaphragm, pre-exposure prophylaxis, herpes suppression, vaccines, etc.);
- Inform the debate on the place of male circumcision for HIV prevention within national HIV strategic plans and equitable health systems;
- Challenge the narrow focus of randomized clinical trials and biomedical science in the context of HIV prevention and advocate for a multi-pronged approach to male circumcision for HIV prevention;
- Mechanisms by which the meeting results will inform current and future consultations on male circumcision and HIV prevention about psycho-social and cultural issues which need to be considered in programme planning.

4. Agenda (cf. Annex 1):

The programme for the two-day meeting was structured into plenary sessions with ample open discussion periods. The sessions were as follows:

- Broad biomedical and social overview of the evidence of male circumcision and HIV prevention
- Social perspectives of male circumcision service delivery from different parts of the world.
- Group discussions to identify key social science research questions that need to be considered to move forward with male circumcision for HIV prevention in various contexts.

- Summary session to outline the central issues of a social science research agenda on male circumcision for HIV prevention in order to help countries and international partners advance from research evidence to policy decisions, funding allocations and technical support for service provision within a framework addressing socio-cultural considerations.

5. Session 1: Overview of the evidence and knowledge

Highlights of the four presentations are:

- Drivers of the epidemic in southern Africa
 - Most strategies in Africa look similar although the epidemic is heterogenous with different risk groups, prevalence rates, and transmission dynamics, e.g. concentrated in Ghana but generalized epidemic in Zambia.
 - Multiple concurrent partnerships (highest risk is during period of acute infection at seroconversion), low male circumcision and high mobility of the population seem to be the key determinants of epidemic dynamics in southern Africa- "The Perfect Storm" that started in the 1980s. These have not been adequately addressed and HIV incidence is unaffected.
 - Lifetime partners are not different from the rest of the world. STI treatment interventions have not consistently reduced HIV infection.
- Male circumcision in the context of existing and emerging HIV prevention technologies
 - More evidence has emerged to consider male circumcision as a public health intervention. Randomised controlled trials (RCTs) show the short term effect of male circumcision on infection; we need follow up on impact in the context of real-life implementation.
 - Heterosexual transmission accounts for more than 85% of HIV globally. Multiple approaches are needed for synergistic effect to prevent transmission through increased protected coital acts. Proven interventions are condoms and male circumcision; unproven and under investigation are partner ARV treatment, HSV-2 prevention/treatment, vaginal diaphragm, microbicides, pre-exposure prophylaxis and vaccines. There is evidence at population level that prevention can work e.g. Uganda, Thailand.
 - Male circumcision will influence the coming continuum of interventions. There are opportunities to review current approaches to HIV prevention: gender, culture, equity, adherence issues.

- Overview of current evidence on male circumcision and HIV prevention
 - There is compelling evidence of the partial protective effect of male circumcision on ulcerative sexually transmitted infections such as syphilis and chancroid as well as HIV acquisition. For the latter there are observational data, biological plausibility and the results of three large scale randomised controlled trials for more than 10, 000 men.
 - Acceptability of male circumcision in non-circumcising populations is already high and growing
 - Modelling suggests male circumcision could avert millions of new HIV infections in East and southern Africa, and would be highly cost-effective
 - Data on safety are limited; however, safety is feasible but ensuring it through training, supervision and certification; adequate facilities; appropriate and well maintained equipment; and counselling on post-operative care will require resources
 - Risk compensation must always be a concern; there are communication challenges, especially about the partial protection afforded by male circumcision and the importance of combination prevention (using more than one of the prevention choices available: delayed sexual debut, abstaining from penetrative sex, reduction in the number of sexual partners, correct and consistent male or female condom use and male circumcision).
 - Needs for financial, facility and human resources are widespread.
 - National legal, regulatory and policy frameworks are essential to ensure respect for human rights (see UNAIDS human rights/legal/ethical guidance document).

- Cultural, social, ethical and legal issues of male circumcision scale-up for HIV prevention
 - Current discourse on male circumcision and HIV prevention includes enthusiasm and statements without due consideration for socio-cultural aspects. There are dichotomies in how we think and talk about male circumcision for HIV prevention (public health vs. social and contextual perspectives). Assessment of Medline coverage since 1996 on male circumcision is focused on adverse events (28%) and ethics, ethnology and history (11%).
 - Randomised controlled trials showing partially protective effect of male circumcision on HIV infection are context-specific - real world best

practice examples are needed. The intensive observation in trials carries the potential for *Hawthorne effect* (the very act of participating in a clinical trial leads to reduced sexual risk which can affect the findings, although this should affect all trial arms). More can be learned from the trials, about motivation for participation and nature of the demand; characteristics of those who got infected despite becoming circumcised; the nature of counselling; behavioural monitoring; diagnosis and treatment for sexually transmitted infections; communication circuits and community influence; and longer term impact.

- Social and contextual determinants of male circumcision include gender dimensions (female partners and men who have sex with men), ethical issues and communication challenges. A full assessment of the mediating effects of social and contextual factors is needed to inform any scale-up.

Discussion:

- *How to separate/integrate medical circumcision and traditional initiation practices:*
 - UNAIDS has a Best Practice publication on how to engage traditional healers for HIV prevention and care in sub-Saharan Africa with suggestions applicable to male circumcision research, policy and programming;
 - acceptability studies and anecdotal evidence show preference in a number of settings for low cost, safe medical circumcision services to replace traditional circumcision;
 - religious customs and cultural practices may be conflated in areas where male circumcision is widely practised;
 - better understanding of the cultural meanings of male circumcision of infants and young children is needed.
 - traditional initiation schools throughout East and southern Africa play a significant role in reinforcing existing gender inequalities, and currently provide little in the way of HIV prevention education. Efforts to improve or modernise male circumcision may provide an important entry point for transforming initiation schools into sites for HIV and gender education.
 - Medical circumcision can be combined for adolescents with either traditional socialisation about becoming a man or integrated into sexual reproductive health programming which can be gender-transformative (masculinities, manhood, gender-based violence, good parenting, etc).

- *Different epistemologies (ways of knowing) can complement each other: we can learn from both existing randomised controlled trials and operations research during implementation of male circumcision programmes for HIV prevention;*
 - anthropological/social studies using dynamic contextual analysis should be integrated into male circumcision for HIV prevention programming to monitor any unintended effects;
 - traditionally circumcising regions of the world can inform discussions about rationale, acceptability, programme design, communications, etc.
 - multidisciplinary social science research on male circumcision for HIV prevention, outside a controlled trial environment, should be a priority rather than being sidelined as taking too long

- *Nature of HIV prevention trials: the minimum standard of prevention package in HIV prevention trials, may change now to include an offer of male circumcision in addition to the standard safer sex counselling, male and female condom promotion, sexually transmitted infection treatment*
 - Hawthorne effect applies to both arms in a trial;
 - A randomised controlled trial can be an intervention in itself, e.g. trials of prophylaxis have been stopped because the prevention package given to all trial arms was so effective that the overall incidence was too low
 - Although efficacy (determined through randomised controlled trials) and effectiveness (real life because it combines efficacy and adherence/correct uptake) are different, the goal in implementation programmes is to achieve levels of effectiveness similar to the levels of efficacy attained in trials;

6. Session 2: Social perspectives of male circumcision service delivery

- a. HIV prevention, male circumcision and the construction of masculinity.**
 - There are various perspectives of masculinity on the subject of male circumcision for HIV prevention which are context-bound by determinants such as class, culture, religion, and geography.
 - Constructions of masculinity and HIV affect perceptions of HIV risk: a sole focus on empowerment of women and/or on ABC prevention messages neglects patriarchal constructions of masculinity as 'invulnerable', risk taking and conquest focused which reinforces men's marginalisation in sexual and reproductive health;

- Masculinity and male circumcision- there are variable norms around circumcision (infant, pre-adolescent, adolescent, adult, non-circumcision); it is normative (good parenting, sons like fathers and other boys), sometimes regardless of medical information indicating that socio-cultural factors can play a more important role in decision-making
 - Introduction of male circumcision for HIV prevention should consider masculinity perspectives: on the one hand local anaesthesia removes a public display of pain tolerance but on the other medical male circumcision can be an opportunity for greater involvement of men in sexual and reproductive health refining definitions of manhood.
- **Ethnography of male circumcision in the context of initiation in Southern Africa**
 - Male circumcision is typically done as a rite of passage into manhood. Across societies, initiation (both boys and girls) processes follow the sequence: 1) removal of child from society; 2) period of seclusion (in the bush up to 3 months, male circumcision performed); and 3) reintegration as a changed being (distinguish from child to adult, female from male, marked by celebration). Christianity and colonialism vigorously opposed initiation rites and male circumcision went through periods of decline and resurgence.
 - Cultural meanings of circumcision: a gendering process (shed boy-like and female-like elements- metaphor expressed by cutting of the foreskin, excess skin); imagery of sexuality and 'unclean' elements.
 - Need to think of promotion of medical male circumcision separate from cultural initiation: for example, infant circumcision or cosmetic cut at initiation followed by a safe medical circumcision.
 - many ethnic groups in high prevalence southern African countries once practiced circumcision but abandoned it some 150 years ago during a time of social upheaval (i.e. Zulu, Swazi, Mpondo, Ndebele, Fingo). Promoting or advocating circumcision in these societies may not be as difficult as some assume.
 - **Male circumcision beliefs and preferences among women**
 - Qualitative interview excerpts with female partners of migrant men in Durban: a man wanted to use condoms but the female partner did not want to since he was circumcised ... *"We all know that circumcised men can't give us the disease easily"*. Was this a justification for not wanting to use condoms? A desire for fun? Did she want to get pregnant so she

could get him to marry and support her? Is this a sign of acceptability of male circumcision among female partners (in a non-circumcising Zulu community)?

- There is need to distinguish personal protection from wider public health benefits of male circumcision

b. Potential opportunities and barriers to scale up: experiences and views from countries, regions and organisations:

The Case of Thailand

- In Thailand condoms were introduced among sex workers, and were not used in a family context. If male circumcision is introduced for HIV prevention there may be stigma attached to it; it is better to introduce it for other health benefits, as a gender issue and integrated within sex education in schools.
- Circumcision is practiced among the Muslim population which is mainly found in the south; the government pays for the procedure. HIV prevalence has no direct relation to residence (it is not different in areas where Muslims are less common).
- Acceptability studies in Chiang Mai have shown low acceptability of circumcision among adults; but higher acceptability for infant circumcision. More studies are needed to assess acceptability among parents and male and female adult partners.

- **Circumcision in Peru and Latin America**

- The HIV epidemic is urban, concentrated among men who have sex with men: HIV prevalence is less than 0.6% among the adult population and more than 5% among men who have sex with men. The sexual networks of the latter extend to women partners.
- Male circumcision is rare; it is mainly done pre-adolescent; among urban and Jewish populations; no acceptability or feasibility studies have been conducted.

- **Southern Africa:** social, cultural and religious issues around male circumcision scale up: where to from here?

- Studies based on the Orange Farm results have shown that male circumcision is a cost-effective intervention for HIV prevention in sub-Saharan Africa.

- There seem to be a weakening of cultural links in relation to circumcision: urbanization with peer pressure for youth; increase in information and uptake for health reasons; more statutory regulation of traditional circumcision; acknowledgment by traditionalists of medical circumcision; peer pressure. As well, traditional initiation is time consuming and often conflicts with work or schooling responsibilities. Medical circumcision is viewed as both quicker and safer.
 - Acceptability studies before the randomised controlled trial and elsewhere show wide acceptability of male circumcision for health benefits across cultural groups.
 - Male circumcision should be promoted as a health intervention and health systems will need to be strengthened to meet demand using more cadres of health workers.
- **Male circumcision in India: challenges ahead**
 - India has an estimated 5.2 million HIV infections, with a prevalence of approximately 1%. Women are 40% of those infected (much higher rates among wives of sexually transmitted infection patients and injecting drug users); the transmission is mostly heterosexual (85%); male circumcision is practised only among Muslims (13.4%) and done mainly neonatally.
 - Acceptability will need to address religious and cultural barriers, communication of risks and benefits. Suggest integration of male circumcision into sexual and reproductive health services to avoid HIV-associated stigma.
 - Service delivery: low national public health expenditure; health services are mainly private and unaffordable to many. Many outstanding issues about who, when, how to provide male circumcision. Need to learn from vasectomy programme- coercion, poor communication, ill-prepared providers and facilities lead to low acceptability.
 - **Social aspects of traditional male circumcision in West Africa: the case of Senegal**
 - Male circumcision is universal in Senegal (HIV prevalence 0.7%); performed pre-adolescent; cultural influence is stronger than religion.
 - Male circumcision is part of an initiation process which is not just an individual medical procedure but is a dynamic social construction process of gender, spirituality, health, and sexual control. Women (primarily mothers) are central in the preparation of the initiate to take on the individual challenge; pain is constructed as a sign of self control

strengthened thorough preparation by parents. The initiation institution provides care and follow up (up to 6 years). Education focuses on symbols and codes, emotions that symbolize what the initiate will go through in real life (pain, pride, joy, humility...), abstinence advice; and building of new community (new brotherhood).

- There are opportunities for knowledge and experience sharing between: circumcising and non-circumcising communities and between medical and traditional systems. This may reveal limitations in emotional support within a specific social infrastructure and lead to improved medical systems.
- **Male circumcision and HIV infection in South Africa**
 - The 2002 population-based HIV national survey collected data on national prevalence of male circumcision, its determinants and relationship to HIV infection- by age, race, socioeconomic status, province, home language, religion, and sexual experience.
 - Findings show that timing of circumcision is important; self-reported male circumcision only had a significant effect on HIV infection for those who were circumcised before 12 years (6.8% vs 13.6%). Most of the circumcision was traditionally performed after the men were already sexually active.
- **Bungoma district, Kenya: Assessment of traditional and medicalised male circumcision**
 - There is a shift towards medical male circumcision among the Bukusu, and cost (affordability) is the main factor.
 - The study, which was conducted to establish a pre-training baseline assessing safety of male circumcision in resource-poor settings found high rates of adverse events for both medical (17%) and traditional circumcision (35%). The most common were profuse bleeding, infections, pain, insufficient foreskin removal and torsion. The study findings highlight what could go wrong if providers are not well trained and adequately equipped to perform male circumcision in hygienic settings with good post-surgical follow-up.
- **Lesotho, Swaziland and Zambia: interplay between traditional and public health service providers: prospects and possibilities.**
 - A needs assessment study is underway to determine costs, acceptability and potential impact of male circumcision for HIV prevention.

- Sensitivities exist around having female service providers conducting male circumcision (Lesotho); however, doctors feel that nurses and paramedics can be trained to perform male circumcision.
- Traditionalists are open to medical circumcision as part of the initiation process
- There are safety concerns about use of the Tara Clamp device for adult male circumcision. It is used for newborn male circumcision in some countries,
- Among the strategies being considered are involving the mining sector for worksite programmes as well as engaging with traditionalists, the church and civil society organisations to provide a comprehensive package of male circumcision services, communication and advocacy).

Discussion

- ***Culture change:*** In the face of HIV cultural and social norms can change. For example, there is less traditional circumcision in areas where medical circumcision has been made more available and there are reports of men from non-circumcising communities getting circumcised in order to get a wife or attract sexual partner/partners from a circumcising ethnic group (a reproductive/sexual strategy).
- ***Positioning of male circumcision:*** In areas with high HIV prevalence and low male circumcision, it is unethical to ignore the current evidence. In areas with low HIV prevalence and low male circumcision levels, male circumcision could be introduced as a modern health discovery, for improved penile hygiene or as prophylaxis against sexually transmitted infections to avoid stigma associated with HIV.
- ***Understanding initiation institutions:*** In most parts of Africa initiation is characterised by secrecy with songs which may sound as 'nonsense' to an outsider, yet this is coded language marking unique social construction of an adult. Women also play a crucial role in the initiation of their sons in some cultures.
- ***Social change communication:*** It is important to be clear about what different words mean and how they are interpreted, for example 'partial protection'. Rather than focus solely on the intention or motivation for male circumcision, it is meaningful to focus also on ***who provides*** the service-traditional or medical? The randomised controlled trials were concerned with safe medical circumcision. Some traditional circumcision practices can transmit infections such as herpes.

- ***Programming at country level:*** Thought should be given to supporting debate at country level, similar to that in the meeting, to help countries consider socio-cultural aspects in addition to public health aspects in their decision making. Supported by UNAIDS, five countries have already conducted stakeholder meetings involving traditional providers as well as other key groups, and have participated in a subsequent regional country-to-country learning process attended by four additional countries.
- ***Implications of new prevention strategies:*** There are important lessons to learn from other interventions such as, for example, implementation of single dose Nevirapine for prevention of mother-to-child transmission. There was early adoption, but problems emerged later. Antiretroviral drugs were provided for prevention for the unborn baby but not for treatment for the mother, health systems were weak. Then social science, operations and Phase IV research initiatives were developed to address some of these problems. A further example is the polio programme in India which experienced decreased uptake of polio vaccination leading to increased cases - all as a result of circulating rumours that polio shots affect fertility.
- ***Monitoring of sexual cultures among men who have sex with men:*** The evidence on the protective effect of male circumcision for penile-vaginal intercourse may not apply to penile-anal intercourse. The receptive partner in anal intercourse may not have a reduced risk due to the circumcision status of his or her partner and, if male, will not have reduced risk due to his own circumcision status. It is also not known whether male circumcision reduces the risk of HIV infection for the insertive partner during anal intercourse. Although in Senegal HIV prevalence is less than 1%, it is greater than 10% among men who have sex with men.
- ***Context of male circumcision:*** Although UN global guidelines place the locus for decision making at the country level, they need to be contextualized within countries or across borders (e.g geographical sexual groups)
- ***Safety:*** The Bungoma safety assessment study raises the question of minimum conditions, i.e.: when not to recommend male circumcision for HIV prevention if the conditions are not hygienic, if equipment is inadequate and not well maintained and if providers are not trained and certified. The complication rates for abortion care, for example, can be an indicator of problems with the whole health system and the potential for problems in the provision of safe medical male circumcision services.
- ***Devices:*** it was emphasized that the WHO/UNAIDS/JPIEGO manual for male circumcision under local anaesthesia does not recommend use of devices such

as Tara Clamp for adults. A nested study of this clamp by the Orange Farm team revealed high rates of complications and led to discontinuance of its use.

7. Session 3: Brainstorming on social science research agenda: group work

Participants were divided into three discussion groups to agree on key social science research questions that need to be considered as some countries move forward to consider, pilot and implement male circumcision programming for HIV prevention. The three groups were asked to discuss two specific questions: 1) ecology (socio-ecology) of the randomised controlled trials - what questions should be considered for follow up from the trials; and 2) what social science questions need to be considered to inform decision making and implementation of male circumcision?

1. Socio-ecology of the trials:

It was emphasized that social science research considerations need to be integrated into randomised controlled trials as a fundamental core rather than just an add-on during the trial or post-hoc. Such research includes:

- ***Community contextual analysis*** around meanings and symbols of male circumcision for both sexes and by sexual preference and identity. Examining how these evolved before, during and after the trials.
- Examine more deeply the ***characteristics of those who were infected*** in order to understand why they may have been infected despite becoming circumcised: risk ratios; age analysis.
- Monitor ***effectiveness*** of male circumcision for HIV prevention in real world settings through operations research.
- Studies to better understand the dynamic relationships between ***biomedical health providers*** and ***traditionalists***.

2. Social science questions for implementation:

A broad definition of social science was proposed that includes non-traditional disciplines such as linguistics and language studies (for better understanding of symbolisms and meanings)

- ***Construction of sexuality and bodies:*** in circumcising and non-circumcising communities?
- ***Dynamic contextual analysis:*** identify gaps and reconcile different sources of evidence and knowledge

- **Assess legislative framework and infrastructure** within a wider context of prevention framework.
- **Literature review** of anthropology on masculinity, initiation and safety.
- **Acceptability:** in-depth data to examine the motivation and barriers for medical circumcision; understanding of community context of young people; cultural sensitivity and specificity; informed choice...
- **Reduction of stigma:** especially in non-circumcising communities with low male circumcision prevalence and also in inter-group relations like Muslim vs. Buddhist, Xhosa vs. Zulu.
- **Communication studies:** exploring messaging and monitoring behaviour changes; interpretation of male circumcision in the context of conceptions of masculinity, individual and group identity as well as inter-group relations; how different communities, groups and the media understand messages on male circumcision being put out by UN agencies and by researchers? Will messages clearly distinguish male circumcision from female genital mutilation?
- **Dissemination of information:** testing of the best way to disseminate information on male circumcision in order to facilitate decision making on uptake by individuals, groups and communities? (Who and how? As part HIV prevention and sexual and reproductive health?)
- **Masculinity:** apply a critical masculinity studies conceptual framework to help better understand sexuality and prevention contexts for male circumcision; identify potential facilitators and barriers to male circumcision within different cultures of men who have sex with men
- **Capacity:** Assessment of the receptivity of health systems to providing male circumcision services? (Training needs; what is the need and by whom?).

Conclusion: In order to accomplish the necessary social science research pertinent to the subject of male circumcision for HIV prevention, it will be essential to build research capacity, including supporting local ethnographers who can speak the language and understand the context better.

8. Session 4: Recommendations and Next Steps

The meeting identified five central issues:

1. **Context and meanings:** the meeting highlighted that understanding the meaning of male circumcision involves knowledge of a number of contextual issues which can vary by society:
 - Circumcision can range from a small snip to full removal of the foreskin;

- If conducted in adolescence, male circumcision is characterised by a maturation (coming of age) process that underscores it;
 - Adverse events: more surveillance data are needed in resource-limited settings; but existing evidence suggests these are high when practitioners are untrained, non-certified and/or inadequately equipped;
 - Male circumcision defines individual, group and gender identity. It is important to understand how these identities differ within and between communities/countries;
 - Male circumcision as a practice has complexities and nuances; it is rarely just a one-off surgical intervention.
2. ***Multi-disciplinary approaches:*** A range of scientific disciplines could constructively contribute to the consideration of male circumcision as an HIV prevention choice. For example, the relationship between medical and traditional circumcision and potential positive and negative interactions between them could be explored from a variety of angles. Initial steps were taken in the meeting in the process to define a social science research agenda with three broad areas of interest: 1) meanings; 2) operational research; and 3) evaluation.
3. ***Towards a social science research agenda:*** Social science seems to have been a somewhat neglected area of science in relation to HIV, in contrast to biomedical sciences. Several mechanisms for getting more prominence for social science research endeavours were discussed. For example:
- Identify funding sources such as:
 - USA National Institutes of Health (for research)
 - Global Fund (has a mandate to fund prevention which includes evaluation of programmes)
 - PEPFAR (countries can use PEPFAR funds to conduct situational analyses using the tool kit developed under the first UN Work Plan which is currently being piloted by through CDC)
 - Agence nationale de recherches sur le sida (follow up operations research studies post trial in Orange Farm)
 - Bill and Melinda Gates Foundation (funder first UN work plan; reply pending on submission of second UN work plan)
 - Ford Foundation (could commission a review and fund a meeting to set a social science agenda)

- Address two layers of questions that need to be urgently considered in 2007 (rather than after the fact) to guide resource allocation and prevent further HIV infections, especially in sub-Saharan Africa.
 - *implementation*: needs assessment, cultural context, appropriateness and effectiveness of communication messages concerning male circumcision
 - *strategy development*: for determining programme focus.
- 4. **Leadership**: Although there are passionate researchers, these champions need fertile ground to succeed. Double-vision leaders (biomedical and social science) are needed to mobilize joint initiatives to address all the outstanding questions.
 - **UN is the global leader**:
 - UN can convene an integrated group. There is a potential role for the UNDP/UNFPA/ WHO/World Bank Special Programme of Research, Development, and Research Training in Human Reproduction
 - discussions from this meeting will help decision makers make informed decisions for the coming WHO/UNAIDS-convened meeting to examine implications of the research evidence for policy and programming.
 - In sub-Saharan Africa, **SAHARA** (Social Aspects of HIV/AIDS Research Alliance) can galvanise research. UNAIDS could encourage it to take on a more prominent role in this field through support to a symposium on male circumcision and HIV prevention at the Kisumu meeting in April.
- 5. **Local context and local situation**- requires local colleagues to take leadership, using existing network infrastructures and evaluation frameworks and focusing on ensuring inclusion of qualitative research components as part of assessment tools and guidelines, including the UN Work Plan rapid assessment tool.
 - SAHARA is willing to take on this leadership in the region and regional point persons exist (both the West Africa and southern Africa chairs were in the meeting and committed to further work).
 - The role of women in male circumcision for HIV prevention should not be underestimated and requires more study and reflexion.

Background documents for the consultation: to be added

Annex 1: Meeting agenda

Consultation on Social Science Perspectives on Male Circumcision for HIV Prevention Proposed Agenda 18-19 January, 2007 Chairs: Dr Catherine Hankins and Professor Salim Abdool Karim

Time	Topic	Presenter/Facilitator	Comments
Day 1 18 Jan.07	Male Circumcision: Overview of the evidence for HIV prevention, current practice and service delivery options		
Morning	Introduction and broad overview of evidence of male circumcision and HIV prevention		
8:30-9:00	Welcome, introductions and meeting objectives	Salim Abdool Karim Catherine Hankins	
9:00-9:30	Determinants and drivers of the epidemic	David Alnwick	
9:30-10:00	Male circumcision in the context of emerging HIV prevention technologies	Quarraisha Karim	
10:00-10:30	Overview of current evidence male circumcision and HIV prevention	Cate Hankins	
10:30-11:00	Thematic analysis of cultural, social, ethical and legal issues of male circumcision scale up for HIV prevention.	Gary Dowsett	
11:00-11:30	Tea/coffee break		
11:30-12:30	Discussion		
12:30-13:30	Lunch		
Afternoon	Male circumcision and HIV Prevention Social perspectives of male circumcision service delivery		
14:00-14:30	Masculinity and male circumcision	Graham Lindegger Aphichat Chamratrithirong	
14:30-17:30 (with a 30 min tea break)	Current cultural practices and male circumcision service delivery: potential opportunities and barriers to scale up. Experiences from countries (and regions) such as: India, Kenya, Peru Thailand, Senegal, South Africa, Uganda Experiences and views from organisations: Sonke Gender Justice, Treatment Action Campaign...	Carlos Caceras Nomita Chandhiok Omar Egesah Bafana Khumalo Suzanne Leclerc-Madlala Cheikh Ibrahima Niang Eleanor Preston-Whyte Leickness Simbayi Dirk Taljaard	Informal presentations and open discussion

18:30- Dinner

Day 2

19 Jan 07

Morning

8:30-9:00

Review of Day 1

Salim Abdool Karim

9:00-10:30

Group work to outline the key socio-cultural issues and gaps for Male Circumcision provision in high HIV prevalence settings

All

10:30-11:00

Tea break

11:00-12:30

Feedback from group work and discussion

Group rapporteurs

12:30-13:30

Lunch

13:30-16:00

Recommendations and Next Steps

Key messages for policy makers, programmers and researchers

How to strengthen collaboration around male circumcision

Conclusions

Appendix: Participant List

Participant's Name	Organization	Country	Email address	Tel
Carlos Caceres	Peru, South America	Peru	ccaceres@upch.edu.pe	51 1 241 8334 / 241 6929
Aphichat Chamratrithirong	Institute of Population and Social Research, Mahidol university	Thailand	pracr@mucc.mahidol.ac.th	
Nomita Chandhiok	Division of Reproductive Health & Nutrition, ICMR	India	n_chandhiok@hotmail.com	91 225563290/ 22551993
Mary Crewe	Centre for the Study of AIDS, University of Pretoria	South Africa	mary.crewe@up.ac.za	27 12 420 4391
Gary Dowsett	Australian Research Centre in Sex, Health and Society Faculty of Health Sciences, La Trobe University	Australia	g.dowsett@latrobe.edu.au	61 3 9285 5199 /61 433 504 220
Zweliphakamile Dweba	Eastern Cape Dept of Health	South Africa	sirddweba@telkomsa.net	27 833 780082
Omar Egesah	Department of Anthropology, Moi University, Eldoret	Kenya	oegesah@yahoo.co.uk	254 735824453
Mziwethu Faku	Treatment Action Campaign	South Africa	mziwethu@tac.org.za	27 45 838 1364 / 27 73 467 2827
Quarraisha Abdool Karim	Women and HIV/AIDS Programme, University of KwaZulu Natal	South Africa	abdoolq2@ukzn.ac.za	
Salim Abdool Karim	Centre for the AIDS Programme of Research in South Africa (CAPRISA), Nelson R. Mandela School of Medicine, University of	South Africa	Karims1@ukzn.ac.za	27-31-2604550

Participant's Name	Organization	Country	Email address	Tel
	KwaZulu Natal			
Bafana Khumalo	Sonke Gender Justice	South Africa	bafana@genderjustice.org.za	27 11 544 1900/ 27 829057587
Edward Kirumira	Department of Sociology, Makerere University	Uganda	ekirumira@ss.mak.ac.ug	256 41 545-040 /256 752 767 439
Barbara Klugman	Ford Foundation	USA	b.klugman@fordfound.org	
Suzanne Leclerc-Madlala	School of Anthropology, University of Kwa-Zulu Natal	South Africa	Leclercmadlals@ukzn.ac.za	27 31 260-2387
Graham Lindeggar	Professor of Psychology at the University of KwaZulu-Natal.	South Africa	lindeggar@ukzn.ac.za	27-33-260-5335
Lusanda Mahlasela	Department of Health, National AIDS Programme	South Africa	mahlal@health.gov.za	27 12 312 0942
Eleanor Preston-Whyte	Centre for HIV/AIDS Networking, University of KwaZulu Natal	South Africa	prestonw@ukzn.ac.za	27-31-2602241
Kim Dickson	WHO, HQ	Switzerland	DicksonK@who.int	41 22 791 4548
Lindsay Edouard	UNFPA, HQ	USA	edouard@unfpa.org	263 91393 866
David Alnwick	UNICEF, ESARO	Kenya	dalnwick@unicef.org	254 20 7622771
Cheikh Ibrahima Niang	Institut des Sciences de l'Environnement, Université Cheikh Anta Diop, Dakar	Senegal	ciniang@sentoo.sn	2218251957/ 221 6502950
Amy Welton	HIV, TB & Reproductive Health, Bill & Melinda Gates Foundation	USA	amy.welton@gatesfoundation.org	1 206 709 3100/ 206-660-4130

Participant's Name	Organization	Country	Email address	Tel
Dirk Taljaard	Progressus	South Africa	dirk@progressus.co.za	27 11782 5687 / 82 454 6964
Chiweni Chimbwete	UNAIDS, RST, ESA	South Africa	chimbwetec@unaids.org	27 11 517 1691
Mark Stirling	UNAIDS, RST, ESA	South Africa	stirlingm@unaids.org	27 11 517 1503
Helen Jackson	UNFPA	Zimbabwe	jackson@unfpacst.co.zw	263 91393 866
Catherine Hankins	UNAIDS, HQ	Switzerland	hankinsc@unaids.org	41 22 791 3865
Leickness Simbayi	Human Sciences Research Council	South Africa	lsimbayi@hsrc.ac.za	27214668000 / 7910
Miroslava Prazak	Bennington College, Vermont /Demography and Sociology Program, Research School of Social Sciences, Australian National University	USA /Australia	MPrazak@bennington.edu	61 2 6125 4067
Bunmi Akintola	School of Development Studies	South Africa	203511646@ukzn.ac.za	

Attending only one session

Unable to attend

Ms Bunmi Akintola, Graduate Student, School of Development Studies
University of KwaZulu Natal
Durban
South Africa

Dr Kawango Agot
UNIM
Kisumu
Kenya

Professor Robert C. Bailey
School of Public Health
University of Illinois at Chicago
Chicago, USA

