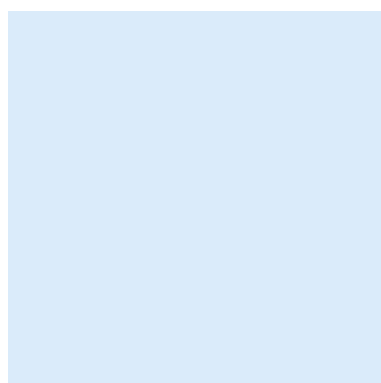
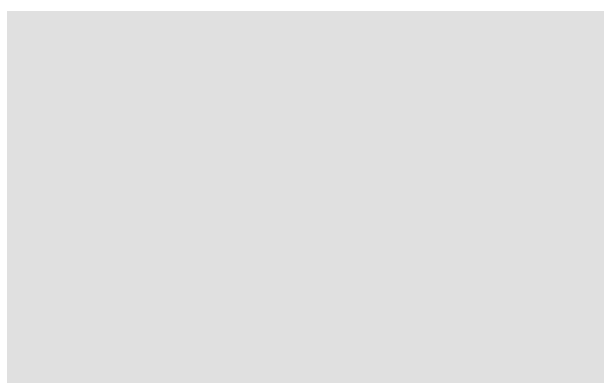


Safe, Voluntary, Informed Male Circumcision and Comprehensive HIV Prevention Programming

Guidance for decision-makers on human rights, ethical and legal considerations



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Introduction

Safe, Voluntary, Informed Male Circumcision—an Opportunity for HIV Risk Reduction

Throughout the world, HIV prevalence is generally lower in populations that practise male circumcision than in populations where most men are uncircumcised. This has been observed over the years of the HIV epidemic and has now been confirmed through three randomized controlled trials concluded in 2005–2006 (see Box 1). The trials showed that male circumcision reduces by 60% the transmission of HIV from women to circumcised men. The results have led to the conclusion that male circumcision is an effective risk-reduction measure for men, and should be used in addition to other known strategies for the prevention of heterosexually acquired HIV infection in men.

Box 1 Randomized controlled trials to examine the impact of male circumcision on HIV transmission

Three randomized controlled trials conducted in South Africa, Kenya, and Uganda examined the impact of male circumcision on the transmission of HIV from women to men.

The trial in Orange Farm, South Africa enrolled 3274 uncircumcised, HIV-negative men aged 18–24 years, and showed a 61% protective effect against HIV acquisition (Auvert et al., 2005). The trial in Kisumu, Kenya involved 2784 HIV-negative men, and showed a 53% reduction in HIV acquisition in men who became circumcised, compared with those who remained uncircumcised. The trial in Rakai District, Uganda involved 4996 HIV-negative men, and showed that HIV acquisition was reduced by 51% in men who became circumcised compared with men who remained uncircumcised (National Institutes of Health, 2006).

The trials involved adult, HIV-negative heterosexual male volunteers assigned at random to either undergo circumcision by trained medical professionals in a clinic setting, or wait until after the end of the trial to be circumcised. All participants were extensively counselled in HIV prevention and risk-reduction techniques, and were provided with condoms. A fourth trial, begun in the Rakai District of Uganda to assess whether there is a direct effect of male circumcision in reducing HIV transmission from HIV-positive men to women, was stopped in December 2006 because the slow speed of recruitment meant that the trial would not have concluded within a reasonable length of time.

Although the results of these trials are highly significant, it is essential to emphasize that male circumcision *does not provide complete protection against HIV*. Furthermore, HIV-infected circumcised men can still transmit HIV to female and male sexual partners. There is no strong evidence that male circumcision reduces the risk of HIV transmission to a female partner, or that male circumcision reduces the risk of HIV transmission during anal sex to the receptive partner, whether male or female.

Because the protective effect of male circumcision is only partial, male circumcision must be promoted *in combination* with other methods to reduce the risk of sexual transmission of HIV, including:

- **correct and consistent condom use**
- **delayed sexual debut**
- **reduced numbers of sexual partners**
- **avoidance of penetrative sex**
- **voluntary HIV testing and counselling.**

In March 2007, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) convened a consultation in Montreux, Switzerland, to examine the results of these trials and other scientific evidence. The aim was to consider the implications for countries, particularly those in sub-Saharan Africa and elsewhere, that currently have high HIV prevalence and low levels of male circumcision. The consultation concluded that the research evidence is compelling—male circumcision reduces HIV transmission from women to men. The participants also confirmed that “a human rights-based approach to the development or expansion of male circumcision services requires measures that ensure that the procedure can be carried out safely, under conditions of informed consent, and without coercion or discrimination” (WHO & UNAIDS, 2007).

When reviewing national HIV prevention policies and programmes in light of the evidence, governments and health-service providers will need to consider the important human rights, legal and ethical issues that arise in the context of male circumcision. These are elaborated in this paper, to assist those involved in introducing or expanding male circumcision services for HIV risk reduction. The paper is divided into two sections:

- (i) guidance for decision-makers and programme planners on the human rights, legal and ethical duties of the State;
- (ii) guidance for health-service providers on their ethical and legal duties when offering or conducting male circumcision.

1. Providing Services for Male Circumcision: Duties of the State

Protection and Promotion of Human Rights

States have made important commitments to increasing the availability of HIV-related goods, services and information to their populations, as outlined, for example, in the Declaration of Commitment on HIV/AIDS (2001) and the Political Declaration on HIV/AIDS (2006) (United Nations, 2001; United Nations, 2006). These commitments and their fulfilment can be seen as part of the human rights obligations of States, particularly those relating to the rights to health, non-discrimination, and the benefits of scientific progress.¹

Given that it reduces a man's risk of acquisition of HIV through penile–vaginal intercourse, male circumcision provides an opportunity to reinforce HIV prevention efforts and thereby promote human rights. A human rights-based approach to introducing or expanding male circumcision services requires measures to ensure that the procedure can be carried out safely, under conditions of informed consent, and without discrimination. From a public health and human rights perspective, it also requires that governments implement male-circumcision programmes in the context of a comprehensive HIV prevention framework. This will ensure that “risk compensation” (i.e. increases in risky behaviour sparked by decreases in perceived risk) (Cassell et al., 2006) does not undermine the partially protective effects of male circumcision for men.

The confirmation of the beneficial effects of male circumcision for HIV risk reduction in men is likely to lead to many more males seeking, or being offered, circumcision. For the best protection of men and their sexual partners, States that introduce or expand male circumcision services should ensure that:

- accurate information is accessible for everyone (men, women and adolescents) on the partial protective effect for men of male circumcision, and the risks and benefits associated with the procedure;
- male circumcision services are accessible to *all of the male population*, starting in areas with high HIV prevalence and progressively expanding outward;
- access to male circumcision services is non-discriminatory;
- male circumcision is integrated *within comprehensive HIV prevention* programming;
- male circumcision services are safe;
- a legal, regulatory and policy framework is in place to guide all of the above.

¹ The duties related to HIV prevention, treatment, care and support have been elaborated, among other places, in the *International guidelines on HIV/AIDS and human rights, 2006 consolidated version*, Guideline 6: “States should also take the measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventative, curative and palliative care of HIV and related opportunistic infections and conditions”. See Office of the United Nations High Commissioner for Human Rights & UNAIDS (2006). *International guidelines on HIV/AIDS and human rights, 2006 consolidated version*.

Developing a Legal, Regulatory and Policy Framework that Ensures Accessibility, Acceptability, Quality and Safety

In countries that are considering the introduction or expansion of male circumcision services, it is recommended that law, regulation and policy be developed to ensure that male circumcision services are accessible, acceptable, and provided safely and without discrimination. The development of such a framework requires the engagement of Parliament; legal, health and regulatory authorities; and the communities where male circumcision services will be implemented.

General laws that regulate the medical profession and the provision of medical services should govern the practice of male circumcision in medical settings by health professionals. In some countries, professional medical associations have developed ethical guidelines to assist health workers to understand their duties in relation to male circumcision.² However, in many other countries, male circumcision is primarily carried out by traditional and religious practitioners, often outside legal or regulatory frameworks. With the exception of South Africa, where the *Children's Act 2005* prohibits male circumcision for males under 16 years, unless there are medical or religious reasons,³ most countries do not have laws dealing specifically with male circumcision.

To ensure that male circumcision services are acceptable, accessible, safe and non-discriminatory, governments should first assess existing laws, policies and practices and identify possible barriers to accessing services. They should also convene community consultations with a broad range of relevant stakeholders, including technical experts from any national AIDS programmes, traditional providers of male circumcision (where male circumcision is an existing practice), representatives of the national human rights institution, women's groups, human rights and legal groups, groups of men working towards gender equality, youth groups and other civil society groups. Findings and recommendations from such consultations should inform the development or revision of specific policies and laws relating to male circumcision.

Health services must be acceptable⁴

The committee that oversees the implementation by States of the International Covenant on Economic, Social and Cultural Rights has stated that "acceptability" is one of the essential characteristics of facilities, goods and services necessary for the realization of the right to health.

All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.⁵

² See, for example, British Medical Association Committee on Medical Ethics (2003). *The law and ethics of male circumcision: guidance for doctors*. March 2003.

³ The text of the South Africa *Children's Act 2005* reads,

- (8) Circumcision of male children under the age of 16 is prohibited, except when -
 - (a) Circumcision is performed for religious purposes in accordance with the practices of the religion concerned and in the manner prescribed; or
 - (b) Circumcision is performed for medical reasons on the recommendation of a medical practitioner.
- (9) Circumcision of male children older than 16 may only be performed -
 - (a) If the child has given consent to the circumcision in the prescribed manner;
 - (b) After proper counselling of the child; and
 - (c) In the manner prescribed.

(10) Taking into consideration the child's age, maturity and stage of development, every male child has the right to refuse circumcision.

⁴ Committee on Economic, Social and Cultural Rights, General comment 14 (2000) on the right to the highest attainable standard of health, adopted on 11 May 2000 (E/C.12/2000/4), paragraph 12.

⁵ *Ibid.*, paragraph 12(c).

Assessing the acceptability of male circumcision is an important part of taking steps to introduce or expand the availability of services. The assessment step should be integrated into a process of community dialogue and public education for two important reasons.

- (i) Addressing male circumcision as a possible health intervention will be an unfamiliar concept to many people. New and accurate evidence in the context of HIV prevention needs to be communicated clearly.
- (ii) In many countries the practice (or non-practice) of male circumcision is deeply embedded in the culture. Where it is practised, it is often associated with a “rite of passage” into manhood and is sometimes celebrated in a community context.

Broad community engagement provides an opportunity to address complex medical and cultural issues together. Complexity—sometimes including a long-standing opposition to the practice of male circumcision on cultural grounds—should not be a barrier to the initiation of dialogue. Even where male circumcision is not currently practised, there is evidence that there will be a demand if it is made available.⁶ People need to be informed about new evidence on the connection between male circumcision and the reduced risk of acquiring HIV in men, to make assessments about the acceptability of the practice in their communities.

Acceptability will be influenced by a range of factors, including how services are delivered. For example, in many places where male circumcision is currently practised, it is primarily performed by traditional or religious practitioners. Depending on local circumstances, this may influence acceptability positively or negatively. International human rights law allows for flexibility in how programmes and services are provided. However, it requires that the enjoyment of certain human rights (e.g. cultural rights) are not inconsistent with respect for other human rights, including the individual’s right to security of the person and bodily integrity. If States decide to support or expand access to male circumcision in the context of HIV prevention through traditional providers and practices, then laws, regulations, policies and programmes will need to be in place to ensure that the procedure is carried out safely, voluntarily or with informed consent, and with access to appropriate follow-up care. Religious and traditional leaders should be engaged in the development of law, policy and programmes in places where they are currently providers of male circumcision (UNAIDS, 2006).

Health services must be scientifically and medically appropriate and of good quality⁷

There is a positive duty on the State to ensure that male circumcision is carried out safely. This requires the use of appropriate and sterile surgical equipment by trained practitioners operating in a hygienic environment, and providing adequate postoperative care—with a system of referral in place for serious complications.

⁶ Thirteen studies conducted in nine countries in sub-Saharan Africa reported that the majority of men interviewed would choose circumcision were it offered to them, and that the majority of women preferred a circumcised sexual partner. The majority of people surveyed in these studies have also reported that they would circumcise their sons. See Westercamp & Bailey, 2007; Kebaabetswe et al., 2003; Lagarde et al., 2003; Mattson et al., 2004; Scott, Weiss & Viljoen, 2005; Mattson et al., 2005).

⁷ Committee on Economic, Social and Cultural Rights, General comment 14 (2000) on the right to the highest attainable standard of health, paragraph 12.

In countries where male circumcision is offered as part of government health services, safety will already be required by laws and regulations governing medical practice. Health workers performing the procedure will be required to adhere to the same standards that exist in relation to all medical and surgical practice.

However, the challenge facing many States will be to ensure that practitioners of customary, ritual or religious circumcision—if they are to continue practising male circumcision—comply with the same standards of safety. The reform of law and regulation can play an important supporting role here. In a province of one southern African country, for example, complications arising from traditional circumcision caused more than 40 deaths, 40 mutilations and more than 1000 hospital admissions in 1995. These data prompted several neighbouring jurisdictions to pass laws to make traditional circumcision safer (see Box 4). Despite legal reforms, however, deaths related to male circumcision continue to be reported (Sidley, 2006). This underlines the need for strong support for implementation and enforcement following a law reform process.

Health services have to be accessible without discrimination⁸

Equality and non-discrimination, including in regard to access to health-care services, is a human right. It is recommended that national policy and laws on male circumcision explicitly include respect for equality and guarantees of non-discrimination in access to male circumcision services.

Members of vulnerable populations (e.g. the poor, ethnic minorities, migrants and refugees) need access to comprehensive HIV prevention services. This includes access to male circumcision services under conditions of voluntariness, informed consent and safety. People in prison, men who have sex with men, male sex workers, and people who inject drugs also have the right to access male circumcision under conditions of voluntariness, informed consent and safety. A person's social or legal status should not be a barrier or the basis for discrimination.

The offer of male circumcision should neither depend on a person undergoing an HIV test, nor on a person being (found to be) HIV-negative. That is, HIV-positive men, as well as men who do not know their status, should be provided with male circumcision if they request it and they are in good health. Following WHO/UNAIDS guidance for provider-initiated HIV testing and counselling, HIV testing should be recommended for all men seeking male circumcision, but should not be mandatory. Male circumcision should only be withheld if it is medically contraindicated.

All men undergoing male circumcision should be clearly instructed and supported to abstain from sexual intercourse until certified that their wound has healed, normally taking up to six weeks, to avoid increasing the risk of both acquiring and transmitting HIV.

⁸ Ibid.

Protecting and Promoting the Rights of the Child

The conclusions and recommendations of the Montreux consultation state that

Countries with hyperendemic and generalized HIV epidemics and low prevalence of male circumcision should consider scaling up access to male circumcision services as a priority for adolescents, young men, and, as indicated by the local epidemiology and other considerations, older men at particularly high risk of HIV. Since neonate circumcision is a less complicated and risky procedure than circumcision performed in young boys, adolescents or adults, such countries should consider how to promote neonate circumcision in a safe, culturally acceptable and sustainable manner.

(WHO & UNAIDS, 2007)

The initiation or expansion of male circumcision services raises different legal and ethical issues according to the age of the recipient and his corresponding capacity to give informed consent (discussed in more detail in Section 2 of this paper). In formulating law and policy, and mechanisms for their implementation, each age group needs to be considered separately.

Box 2 Guidance from the Convention on the Rights of the Child

The Convention on the Rights of the Child includes provisions that can help guide decision-makers when formulating laws and policies related to male circumcision in the context of HIV risk reduction.

- The best interests of the child should be a primary consideration.
- The child should have the protection and care necessary for his well-being, taking into account the rights and duties of his parents.
- The child has the right to express his own views freely in all matters affecting him, these views being given due weight in accordance with the age and maturity of the child.
- The child has the right of access to health services.
- The child has the right to privacy.

Under international human rights law, a child is defined as anyone under the age of 18.⁹ Thus, adolescent boys considering circumcision may qualify as children under international law or under national law, depending on the age of majority in the country. The starting point of children's rights is that decisions that affect children must be **in the best interests of the child** (Convention

⁹ According to the Convention on the Rights of the Child, a child means "every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier"

on the Rights of the Child, article 3). Furthermore, in determining the best interests of the child, children who are capable of doing so have the right to be involved and have a say in decisions that affect them (see Box 2). Article 12 of the Convention on the Rights of the Child provides that

States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Policies and programmes for HIV reduction through male circumcision should be designed with the best interests of male children in mind, as well as respect for children's rights to participate in decision-making. Given that young people between the ages of 15 and 24 years¹⁰ account for more than 40% of new HIV infections each year, it is particularly urgent to ensure a special focus on the needs of young people so as to facilitate their access to health services, including male circumcision where appropriate (Box 3).

Box 3 Responding to the health needs of children

"The Committee is concerned that health services are generally still insufficiently responsive to the needs of children under 18 years of age, in particular adolescents. As the Committee has noted on numerous occasions, children are more likely to use services that are friendly and supportive, provide a wide range of services and information, are geared to their needs, give them the opportunity to participate in decisions affecting their health, are accessible, affordable, confidential and non-judgemental, do not require parental consent and are not discriminatory. In the context of HIV/AIDS and taking into account the evolving capacities of the child, States parties are encouraged to ensure that health services employ trained personnel who fully respect the rights of children to privacy (art. 16) and non-discrimination in offering them access to HIV-related information, voluntary counselling and testing, knowledge of their HIV status, confidential sexual and reproductive health services, and free or low-cost contraceptive methods and services, as well as HIV-related care and treatment if and when needed, including for the prevention and treatment of health problems related to HIV/AIDS, e.g. tuberculosis and opportunistic infections."

Committee on the Rights of the Child, general comment 3 on *HIV/AIDS and the Rights of the Child*, adopted 17 March 2003 (CRC/GC/2003/3), paragraph 20.

¹⁰ Under international human rights law, every person under the age of 18 years is defined as a child. However, many States do not keep statistics based on 18 years as a cut-off point. The United Nations estimates HIV prevalence for "young people", which it defines as those between 15 and 24 years.

Should the law fix an age of consent for male circumcision?

Consideration of the age of consent is important in the context of policy on male circumcision for HIV risk reduction. This is particularly so, given the expected potential benefits of male circumcision for adolescents and the likelihood that, in some places, male adolescents may wish to opt for circumcision privately, without the knowledge of their parents or guardians. Countries will need to have laws and guidance in place that protect the interests of children and the appropriate responsibilities of parents, but do not stand as barriers to accessing health-care services—a situation that has often been the case in the context of the protection of adolescents from HIV.¹¹

Decision-makers also need to consider issues related to age of consent in the context of existing legislation and regulations regarding consent to health care and potential barriers to accessing services. In some countries, national or subnational law identifies an age at which minors can give their own consent to medical procedures—sometimes differentiated by the type of procedure and the degree of risk associated with it.¹² In other countries, laws direct health-care providers to assess the capacity of adolescents to appreciate risks and benefits associated with a procedure, and to give informed consent independent of parents or the legal guardian.

Given the importance of male circumcision in terms of HIV risk reduction, consideration should be given to allowing adolescents who have the capacity to appreciate risks and benefits, access to male circumcision independently of parental consent.

Infant male circumcision: ethical, legal and human rights considerations

Studies have shown that the circumcision of infants is simpler and carries fewer medical risks than circumcision of older people. Parents considering circumcision of an infant boy should be provided with all the facts so they can determine the best interest of the child. In these cases, determining the best interests of the child should include diverse factors—the positive and negative health, religious, cultural and social benefits. Because the HIV-related benefits of circumcision only arise in the context of sexual activity, and because male circumcision is an irreversible procedure, parents may consider that the child should be given the option to decide for himself when he has the capacity to do so.

¹¹ See WHO (2004). *Global consultation on the health services response to the prevention and care of HIV/AIDS among young people: achieving the global goals: access to services: technical report of a WHO consultation, Montreux, Switzerland, 17–21 March 2003*. This consultation was convened in collaboration with UNAIDS, United Nations Population Fund and YouthNet; it identified legal barriers related to consent and confidentiality as one of the challenges in expanding access to HIV prevention and care for minors.

¹² For example, an adolescent may be able to consent to be tested for HIV at a younger age than that at which he could consent to circumcision.

Box 4 Regulating traditional circumcision—an example from South Africa

In 2001, the Eastern Cape Provincial Government in South Africa passed the Application of Health Standards in Traditional Circumcision Act. This law sets standards for the safe practice of traditional circumcision, and sets the rules for giving permission to carry out circumcisions and run circumcision schools.

Under the provisions of the law, the provincial Minister of Health can appoint at least one medical officer whose job is to grant permission to circumcise or treat adolescent men (known as “initiates” in the culture of the Xhosa), and to keep records about circumcisions. The medical officer is allowed access to any occasion where circumcisions are carried out or where initiates are treated. Among other things, the law says that:

- nobody may run a circumcision school without the written permission of the medical officer;
- nobody, including the parents or guardians of initiates, may interfere with the medical officer or prevent the job being done;
- the medical officer grants permission to experienced traditional surgeons to conduct circumcisions;
- nobody may circumcise an initiate without the written permission of the medical officer in that area;
- traditional surgeons who do not have the necessary experience must act under the supervision of an experienced traditional surgeon;
- the medical officer must approve the type of instrument that will be used to carry out the circumcision.

The initiates may not be treated by anyone except a traditional nurse, a medical practitioner, the medical officer or anyone else authorized by the medical officer.

Initiates must be at least 18 years old. If an initiate is younger than 21 years, his parent or guardian must sign a consent form agreeing to allow him to be circumcised.

At the circumcision, the instruments used must be sterilized and the same instrument may not be used for more than one initiate. Traditional surgeons and traditional nurses must cooperate with the medical officers.

At circumcision schools, the medical officer can inspect the school and the initiates whenever deemed necessary.

Anyone who breaks this law can be charged with an offence, required to pay a fine or serve time in jail for up to six months. Anyone who runs a circumcision school or circumcises an initiate without permission can be fined or jailed for up to 10 years.

In this example, the law prescribes an age below which circumcision is not permitted (18 years), as well as an age of consent (over 21 years). These are arguably limitations on the human right to bodily autonomy and to choose (give informed consent) to undergo medical treatment. But, it is important to remember that the context for this law is one where circumcision is part of a cultural ritual marking coming of age—and, in addition to its focus on the safety of the surgical procedure, the law is intended to protect adolescents and young men from being coerced into male circumcision for customary (or non-therapeutic) reasons.

Ensuring Access to Accurate Information

The confirmation that men who are circumcised have a lower risk of becoming infected with HIV is a major opportunity for HIV prevention, but misunderstandings could undermine existing effective HIV prevention strategies. For example, if men or women believe that male circumcision gives complete protection against HIV infection, it could lead to an increase in unsafe sex, undermining other vital prevention efforts, including partner reduction and consistent and correct condom use.

The International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child, among other international legal instruments, identify the positive duty of States to promote and ensure access to health-care services, including health education. In this respect, access to *accurate information* about male circumcision is a human right.¹³ This means that governments and health services must aim to provide information on male circumcision to all people, men and women, and in particular, young people, in a manner that can be understood.

Governments that introduce or expand services for male circumcision will have a responsibility to launch public health campaigns that:

- (i) educate men and women, and adolescents (male and female) about the benefits of male circumcision for HIV risk reduction, and provide comprehensive messages about HIV prevention—correct and consistent condom use, delayed sexual debut, reduction in the number of sexual partners, and abstinence from penetrative sex;
- (ii) explain the benefits and risks of male circumcision in terms of prevention of HIV and other diseases (e.g. human papillomavirus infection, penile cancer, cervical cancer);
- (iii) emphasize the voluntariness of male circumcision;
- (iv) clearly distinguish male circumcision from female genital mutilation, which is a violation of the human rights of women and girls, is illegal in most countries where it still takes place, has no health benefits and carries considerable physical and psychosocial risks for girls and women;
- (v) provide information to women and men emphasizing the importance of abstaining from sex until certified wound healing, countering any belief that it is not necessary to use condoms with circumcised men after healing is complete, and reinforcing the need for combination prevention, as in (i).
- (vi) provide information on the location of recognized health services where the procedure can be undertaken safely.

Protecting Women in the Context of Male Circumcision

It is critical to address the gender implications of male circumcision as an HIV risk reduction method. In all male circumcision programmes, policy-makers and programme developers have an obligation to monitor and minimize potentially harmful outcomes of promoting male circumcision as an HIV risk reduction method (e.g. unsafe sex, sexual violence, or conflation of male circumcision with female genital mutilation) (Hankins, 2007).

¹³ For example, the Committee on Economic, Social and Cultural Rights has stated that it interprets the right to health, as defined in article 12.1, as “an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health” (emphasis added). See general comment 14 on the right to the highest attainable standard of health, paragraph 11.

The expansion of safe male circumcision services provides an opportunity to strengthen and expand HIV prevention and sexual health programmes for men; it is also a means to reach a population that is not normally reached by existing services. Policy-makers and programme managers should maximize the opportunity that male circumcision programmes afford for education and behaviour-change communication, the promotion of shared sexual decision-making, gender equality, and improvements in the health of both women and men. Male circumcision service provision should be used as an opportunity to address the sexual health needs of men. Such services should actively counsel and promote safer and responsible sexual behaviour. Programme managers should monitor and minimize potential negative gender-related impacts of male circumcision programmes.¹⁴

Progressively Expanding Access to Voluntary Male Circumcision Services

In the light of the evidence on the benefits of male circumcision for HIV risk reduction in men, States may wish to consider initiating or expanding access to male circumcision as part of the promotion of the right to “the highest attainable standard of physical and mental health” and as part of their duty to take steps to prevent epidemics. As a first step, a needs assessment should describe and map out the anticipated scope of male circumcision scale-up, human resource and training needs, infrastructure, commodity and logistic requirements, cost and funding, and systems for monitoring, evaluation and follow-up.

Integrated approaches to deliver male circumcision services with other essential HIV and sexual health services are more likely to be sustainable in the longer term. However, vertical, stand-alone programmes that provide the recommended minimum packages of services may be useful in the short term to expand access to safe male circumcision services and to train providers in standardized procedures, especially where demand is high and health systems are weak.¹⁵ The development and expansion of male circumcision services should not disrupt health systems and the implementation of other health programmes.¹⁶

Efforts to expand access to male circumcision have to be made in full partnership with the community. Before policy-makers and programme developers begin to promote male circumcision for specific population groups, they should justify their reasons. First, an analysis of the ethical and gender implications should be conducted; this should be in consultation with members of the population groups, stakeholders and other critical decision-makers.¹⁷ Assessing acceptability is particularly important in regions where no tradition of male circumcision exists. The community dialogue process provides an important opportunity to educate people about HIV prevention, explain how male circumcision offers only partial protection from infection, and clarify possible misconceptions about the procedure. Such engagement may also positively influence acceptability. Services are more likely to be deemed acceptable by people when they have had an opportunity to learn about associated risks and benefits, and have a say about how they are delivered. Policy-makers and programme developers should adopt approaches to the scale-up of male circumcision services that include the goals of changing gender norms and roles and promoting gender equality.¹⁸ Any initial prioritization criteria, if deemed necessary, should be relaxed over time as services are expanded so that all males of all ages have access (see Box 5).

¹⁴ WHO & UNAIDS (2007). Conclusion 6 and Recommendations 6.1–6.3.

¹⁵ *Ibid.*, Conclusion 8.

¹⁶ *Ibid.*

¹⁷ *Ibid.*, Conclusion 5.

¹⁸ *Ibid.*, Conclusion 6 and Recommendations 6.1–6.3.

Box 5 Expanding access—human rights and “progressive realization”

The human rights principle of “progressive realization” requires States to take steps, to the maximum of available resources, towards the full realization of all human rights, including the right to health and other social and economic rights. This duty is also referred to in the *International guidelines on HIV/AIDS and human rights, 2006 consolidated version*, which note that “States should develop and implement plans to progressively realize universal access to ... a full range of goods, services and information for HIV prevention”.

The progressive realization of rights must be based on equality and non-discrimination, ensuring that people do not face barriers to accessing services on account of non-medical criteria (e.g. race, colour, ethnicity, language, religion, political or other opinion, national or social origin, disability, property, birth or other status).

2. Providing Services for Male Circumcision: Duties of Health Providers

So far, the current document has set out the human rights duties that fall on States. This section discusses the duties and responsibilities that fall on those who, as health professionals, provide male circumcision services, including:

- ensuring safety
- ensuring non-discrimination in access to services
- ensuring voluntary and informed consent
- respecting confidentiality.

Ensuring Safety

People have a human right to good-quality health-care services that are provided under conditions of adequate sanitation. Where health professionals have been trained and equipped to perform safe male circumcision, the rate of postoperative complications is less than 5% and almost all these complications resolve with appropriate postoperative care. However small the risk, the damage that can result from male circumcision can be lifelong and, in the most extreme cases, even lead to death. Managers of health facilities have an ethical and legal duty to ensure that facilities for male circumcision are adequately equipped, hygienic and comply with prescribed legal standards. Providers of male circumcision have a legal and ethical duty to ensure that they possess the necessary skills and training to perform the procedure safely. Training and certification of providers should be implemented rapidly to increase the safety and quality of services in the public and private sectors. Supervision systems for quality assurance should be established along with referral systems for the management of adverse events and complications.¹⁹

¹⁹ Ibid., Conclusion 8 and Recommendations 8.2–8.3.

Ensuring Non-discrimination in Access to Services

Health-care workers have an ethical and legal responsibility to offer services to people without discrimination. It is a violation of international human rights standards to deny male circumcision on non-medical grounds, including grounds of race, religion, ethnic origin, health status or sexual orientation, or to members of key populations such as prisoners, men who have sex with men or male sex workers. Training of health-care workers in non-discrimination should be standard practice. The development of codes of conduct that can be monitored and enforced should be part of the provision of male circumcision.

Ensuring Voluntary and Informed Consent

Local health authorities and health-care providers have a critical role to play in ensuring that adult men and adolescents are not forced or coerced to undergo circumcision, or stigmatized or discriminated against if they choose not to.

Some of the reported initial responses to promising scientific findings concerning male circumcision illustrate the potential risks. In one country, a Member of Parliament reportedly stated that, “in order to stop the spread of HIV, male circumcision should be made mandatory by the government”. Similarly, in another country, a mother is reported to have scheduled circumcisions for her four sons aged 6–15 years and her husband. When her 15-year-old son resisted she reportedly told him, “My boy, when you’re 18 you’ll really thank me for this” (Timberg, 2005).

Mandatory or coerced male circumcision is a violation of a range of human rights, including rights to dignity, bodily integrity and personal autonomy. Target numbers of procedures, incentives to men and incentives to providers for reaching targets should be avoided. Furthermore, mandatory male circumcision would have a negative impact on HIV prevention if it fostered misconceptions that male circumcision alone could eliminate the risk of HIV infection. Government policies must make clear that male circumcision should always be voluntary, and only carried out after informed consent for the procedure has been obtained by the provider or health-care worker.

It is recognized that in some settings male circumcision is a rite of passage into adulthood. In such settings, male circumcision is usually conducted as a group activity. In such cases, it is unlikely that individual informed consent is obtained. This is in accord with cultural or religious practices and part of freedom of expression and freedom of religion. In such circumstances, local authorities should take steps to work with traditional practitioners and parents to ensure that participation in such rites is voluntary and without coercion, and that there are means by which boys can decline participation.

Box 6 Principles of Informed Consent

The principle of informed consent is recognized both in ethics and human rights. It is based upon respect for the dignity and autonomy of each person. In a medical setting, it requires that a person is fully informed about both the benefits and possible risks of a medical procedure or treatment. In relation to male circumcision, this can only be achieved through preoperative counselling of the patient. Experts on informed consent say that the principle creates the following four duties for health professionals:

1. the provision of accurate and understandable information to the patient;
2. an assessment of a patient's understanding of the information that is conveyed;
3. an assessment of the capacity of the patient to make the necessary decision;
4. assurance that the patient has the freedom to choose without coercion or manipulation.

Berg JW et al. (1987). *Informed consent: legal theory and clinical practice*.

The process for obtaining informed consent differs for the three age groups for which male circumcision may be recommended (infants and children, adolescents, and adults). It is essential that governments create clear laws and policies, and ensure that health professionals are aware of them.

Male infants and children

Male circumcision performed on infants involves the least physical risk. In counselling parents who are offered, or who request, male circumcision, health providers have a responsibility to explain all of the pros and cons, including that male circumcision is an irreversible procedure, and that it provides a child with no benefits in relation to HIV until the child becomes sexually active. However, there are possible immediate benefits, such as reduced likelihood of urinary tract infections in infancy (see Annex 1 for examples of other possible benefits). Parents considering infant male circumcision may wish to leave the decision to their child, waiting until he has the capacity to consider the risks and benefits on his own. However, some parents, in the context of the best interests of the child, may wish to have their male child circumcised as an infant after considering evidence that there are fewer medical complications associated with the procedure when performed at an early age.

In the case of infants, informed consent must be obtained from parents, the child's legal guardians or, in the absence of both, the primary caregiver.²⁰ All decisions must be based on the best interests of the child. Parents should be provided with clear and understandable information on the benefits and risks of male circumcision in infancy compared with older ages, including when the child is mature enough to decide for himself.

In the case of children who have some capacity to appreciate the risks and benefits associated with the procedure, their assent should also be sought. Before seeking their assent, they should be counselled about the risks and benefits in language that they can understand.

²⁰ In addition to primary caregivers, national or local laws may name other possible substitute decision-makers. As is the case with parents and guardians, all decisions must be based on the best interests of the child.

Male adolescents

“Adolescents” are young people—usually between the ages of 10 and 19 years—who are between childhood and adulthood. Adolescents undergo physical and psychological changes as they grow into maturity and have an increasing capacity to understand issues and make decisions. One fifth of the world’s population are adolescents in low- and middle-income countries—an estimated 1.3 billion people.²¹

One important characteristic of adolescence is discovering and beginning to explore sexuality. Epidemiological studies demonstrate conclusively that this age group is most vulnerable to HIV infection, as well as to other sexually transmitted infections, and to early or unplanned pregnancies. Globally, more than 40% of all new HIV infections every year are among young people 15–24 years of age (UNAIDS & WHO, 2006).

Introducing or expanding male circumcision services may provide an important opportunity to make contact with adolescent males and provide them with information and counselling²² about their sexual and reproductive health, including HIV prevention, testing, counselling and treatment. It is important that health workers know how to respond to a male adolescent’s request for circumcision in ways that respect local laws, as well as the human rights of the adolescent.

In general, no adolescent should be subjected to a medical procedure, such as circumcision, unless he has assented (agreed to the procedure), or given independent informed consent as provided by law. This means that in any case involving the circumcision of an adolescent male, every effort should be made to fully involve him in the decision according to his evolving capabilities, informing him of the short-term and long-term risks and benefits of the procedure in language that he understands. The adolescent should be assisted to take the decision that is in his best interests in light of all relevant circumstances.

With regard to some national or local laws, children and adolescents under the age of legal majority may be prevented from giving independent informed consent—that is, their consent is not legally recognized as valid. Under such circumstances, until the age of legal majority, a parent or legal guardian should accompany an adolescent and provide informed consent for the operation. At the same time, health-care workers should make every effort to obtain the “assent” of the adolescent, as explained above.

All health services provided to adolescents should be kept confidential.

Some adolescents may not live with their parents or legal guardians, or they may not want their parents or guardians to be involved in the decision. In such circumstances, the health-care worker will have to assess whether it is legal to provide male circumcision, based on local laws and regulations, and should also assess the capacity of the adolescent to appreciate the risks and benefits associated with the procedure. In order to do this, health workers need to know what the law says about consent for minors: at what age and under what circumstances minors can make independent

²¹ UNICEF. *Adolescence: the big picture*. UNICEF notes that, for analytical purposes, adolescence can be segmented into three stages: early (10–13 years), middle (14–16 years) and late (17–19 years) adolescents.

²² Counselling should take place both before and after the operation. The adolescent should be advised to return postoperatively for check-ups and further counselling, including information on condom use and other aspects of sexual and reproductive health.

decisions to seek clinical or medical services without the involvement, knowledge and agreement of their parent or guardian.²³

While primary responsibility for the protection and promotion of human rights falls on governments, professional associations and other groups can also play important roles in clarifying the responsibilities of health-care providers in the context of the law, and in educating them on how to fulfil their responsibilities. For example, the Committee on Bioethics of the American Academy of Paediatrics recognizes that “adolescents, especially those aged 14 and older, may have as well developed decisional skills as adults for making informed health care decisions.” They also point to exceptional circumstances related to consent for procedures involving “serious public and/or individual health problems that might not otherwise receive appropriate attention (e.g. sexually transmitted disease)”. They advise that health providers:

have legal and ethical duties to their child patients to render competent medical care based on what the patient needs, not what someone else expresses. Although impasses regarding the interests of minors and the expressed wishes of their guardians are rare, the paediatrician’s responsibilities to his or her patient exist independent of parental desires or proxy consent.

(Anon., 1999)

Male adults

With regard to males who have reached the legal age of majority, obtaining informed consent for male circumcision is more straightforward (see Box 6). In relation to both adult and adolescent males who are already sexually active, it is important to anticipate that their decision as to whether or not to undergo the procedure may be linked to their knowledge of their HIV status. Some men may choose not to undergo male circumcision if they discover they are already HIV positive, whereas others in the same situation may decide to proceed. Male circumcision counselling and patient education is best accompanied by the offer of HIV testing and counselling. However, the provision of male circumcision services should not be conditional on agreeing to undergo an HIV test.

For men who are HIV-negative and choose male circumcision, counselling must stress the need to abstain completely from sexual intercourse until they are certified as healed, which may take up to six weeks. Following certification they should continue to practice safer sex. There are concerns that men who are circumcised may believe that they are less vulnerable to HIV and respond by becoming more sexually active and engaging in unprotected sexual activity.

Some HIV-positive men may choose to undergo male circumcision. It is not known whether male circumcision reduces the risk of transmitting (rather than acquiring) HIV infection (see Box 1). Early resumption of sexual activity before certified wound healing may increase the risk of HIV transmission if a man is already HIV-positive, or of acquisition if he is HIV-negative. This is another reason why it remains vital to emphasize, regardless of serostatus, the importance of abstaining until certified healing and, following this, of safer sex practices, particularly correct and consistent condom use.

²³ Some jurisdictions recognize the greater independence of an “emancipated” adolescent, i.e. one who is supporting him/herself financially, married, and/or no longer under the supervision of his or her parents.

Respecting Confidentiality

All medical procedures and treatment should be performed under conditions of confidentiality. No information regarding such procedures and treatment should be released without the express consent of the individual or patient involved. Male circumcision should be accorded this same protection in the case of its provision in health-care settings. Where male circumcision is a part of a rite of passage in a community setting, it can be assumed that confidentiality has been waived to the degree that families and the boys involved will want the new status of the boy to be known.

CONCLUSIONS

This discussion paper has provided an overview of human rights, and legal and ethical issues that decision-makers may need to consider when deciding whether or not to initiate or expand male circumcision services in the context of comprehensive HIV programming. Taking a human rights-based approach to the initiation or expansion of male circumcision services requires measures that ensure that the procedure can be carried out safely, under conditions of informed consent, and without discrimination. Now that male circumcision has been proven effective in providing partial protection against HIV transmission, this guidance will help ensure that the initiation or expansion of male circumcision services will advance the promotion and protection of human rights in the context of the HIV epidemic.

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ANNEX 1 Questions and Answers on Male Circumcision

What is male circumcision?

Male circumcision is an ancient medical and cultural procedure involving the surgical removal of the foreskin of the penis. It is usually performed either soon after birth or during adolescence as a coming-of-age rite. Currently, an estimated 665 million men, or 30% of men worldwide, are estimated to be circumcised for religious, cultural, medical or other reasons (WHO, London School of Hygiene & Tropical Medicine, and UNAIDS, 2007).

Are there medical benefits to male circumcision beyond the HIV context?

There have been lengthy debates in the medical profession about the therapeutic merits (or lack of them) of male circumcision. Some early claims, such as those claiming that male circumcision would prevent masturbation and cure mental illnesses, are now known to lack scientific basis. Research shows that male circumcision is associated with a lower risk for acquiring some sexually transmitted infections and a lower risk of penile cancer. In addition, two studies suggest that female partners of circumcised men have a lower risk of cancer of the cervix, which is caused by persistent infection with high-risk cancer-inducing types of human papillomavirus. Human papillomavirus infection is the most common sexually transmitted infection worldwide. Studies have also found lower rates of urinary tract infections in male infants who are circumcised. In addition, men who are circumcised have lower rates of infection of the glans (the “head”) of the penis (*balanitis*), do not have infections of the foreskin, and will not encounter difficulties with *phimosis* (an inability to retract the foreskin) or *paraphimosis* (an inability to return the foreskin to its original location). Circumcision is also an effective procedure for males who suffer repeated infections under the foreskin. Decisions about whether males undergo circumcision have been governed by medical necessity, personal or parental choice, culture and religion.

What risks are associated with the procedure?

Male circumcision is an irreversible surgical procedure and, as with all types of surgery, it is not without risk. Circumcision by unqualified individuals under unsanitary conditions with inadequate equipment can lead to serious, immediate and long-term complications, or even death. Where health professionals have been trained and equipped to perform safe male circumcisions, the rate of postoperative complications is less than 5% and almost all these complications resolve with appropriate postoperative care. In low-income countries, the risks of medical male circumcision can be greater than in industrialized countries due to weak or non-existent infection control procedures, shortages of health workers, and limited health infrastructure generally. If male circumcision is not carried out safely, it can have a significant impact on a person’s sexual and mental health. These are reasons why it is suggested that its practice be regulated by law. At the moment, this is not the case even in many countries where male circumcision is widely practised.

What implications might this have for women?

The incidence of HIV infection among sexually active young men is generally lower than among girls and young women. Male circumcision could further reduce infection rates of males, as well as HIV prevalence among men. If offered and accepted widely enough, male circumcision is projected to have an indirect effect on women's risk as a result of reduced HIV prevalence among male sexual partners. Research that was being conducted to better understand whether men living with HIV who are circumcised are less likely to transmit HIV to their female sexual partners was stopped early for reasons of futility (i.e. the slow speed of recruitment meant that the trial would not conclude in a reasonable length of time). As a result, women may never know whether HIV-positive circumcised men are less likely to transmit the virus to them. While the extent of the benefit at the population level is unknown, introducing or expanding male circumcision services—in the context of appropriate counselling and communication strategies about abstaining from sex until certified healing and reinforcing the need for combination prevention²⁴—could hold the promise of improving the sexual and reproductive health of women.

What do the results of the trials mean for policy?

WHO and UNAIDS convened a consultation in March 2007 to examine the findings of the male circumcision trials and their implications for countries. The randomized controlled trials in Uganda and Kenya, with a combined total of nearly 8000 participants, provided additional information beyond that of the Orange Farm Intervention Trial on the impact of male circumcision on the risk of HIV acquisition in men in differing epidemiological, social and cultural contexts. The consultation concluded that the research evidence is compelling, and that male circumcision should be recognized as an efficacious intervention for HIV risk reduction. Governments will now need to make decisions about the inclusion of male circumcision services in their HIV prevention programming and develop policies that are based on international best practice and respectful of human rights. More specifically, governments should:

- ensure that men and women understand that male circumcision will not provide complete protection against HIV infection and that special care must be taken to avoid sex during the period leading up to certified healing. Circumcised men can still contract HIV and pass it to their partners. Male circumcision must be considered as just one element of a comprehensive HIV prevention package that includes correct and consistent use of condoms, reductions in the number of sexual partners, delaying onset of sexual relations, avoidance of penetrative sex, and voluntary and confidential counselling and HIV testing to know one's HIV serostatus;²⁴
- ensure the voluntariness and confidentiality of male circumcision;
- state that men and boys have a right to make informed decisions about male circumcision;
- provide continuing monitoring of the safety, service uptake and prevention outcomes of male circumcision, including behaviour change.

²⁴ Just as combination treatment is more effective than single drug therapy for people with HIV, combination prevention is more effective than reliance on a single HIV prevention method.

What about introducing male circumcision where it is not currently practised? Will there be a demand for services?

Research has shown that, even in areas where male circumcision is not widely practised, there would be a high level of acceptability for the intervention. A comprehensive review of 13 studies carried out between 1991 and 2003 summarized the acceptability of offering male circumcision services among traditionally non-circumcising groups in Botswana, Kenya, Malawi, South Africa, Uganda, United Republic of Tanzania, Zambia and Zimbabwe (Westercamp & Bailey, 2007). Of these studies, 10 included female participants as well as male. The belief that male circumcision improves penile hygiene was nearly universal across all the studies and was a major determinant of acceptability for women. Another primary incentive consistently reported was belief in protection against sexually transmitted infections, including HIV. Sexual function was discussed but was not consistently found to be either a facilitator or barrier to acceptability of male circumcision. The three most important barriers were fear of pain, concerns for safety, and cost. In addition, in areas where traditional circumcision is uncommon, the preference was overwhelmingly for a medical practitioner to be the provider, as this was perceived to be safer. Fear of infection, bleeding, excessive pain, and possible mutilation at the hands of traditional circumcisers was common across all studies.

The determinants of male circumcision in traditionally circumcising populations include cultural identity and this is also likely to affect uptake in traditionally non-circumcising groups. However, sanctions against male circumcision in traditionally non-circumcising communities tend to be less severe than the converse: not being circumcised in a traditionally circumcising community can be an impediment to marriage, particularly in ethnically homogenous areas. In general, culture and religion tended to be more of a concern of older study participants; several studies concluded that circumcision was increasingly an issue of personal choice rather than ethnic identity.

How is male circumcision different from female genital mutilation?

While both male circumcision and female genital mutilation are steeped in culture and tradition, the health consequences of each are drastically different. Female genital cutting or mutilation comprises all surgical procedures involving partial or total removal of the external genitalia (type I) or other injuries to the female genital organs. It frequently involves complete removal of the clitoris (type II), as well additional cutting and stitching of the labia resulting in a constricted vaginal opening (type III). These procedures put the woman at risk in the short and long term, and pose risks to the mother and infant during childbirth: increased death rates among infants during and shortly after birth and increased rates of obstetrical complications when mothers have undergone previous genital cutting or mutilation (WHO, 2006). There are no known health benefits associated with female genital cutting or mutilation. This practice should not be medicalized and should not be allowed to continue. WHO supports communities in their efforts to abandon the practice and to improve care for those who have undergone the procedure.²⁵

²⁵ For further information on female genital mutilation, see <http://www.who.int/reproductive-health/fgm/index.html>

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The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.



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