Male Circumcision and the Battle against AIDS in Uganda: Is It a Useful Tool in the Fight or Is It Hindered by Cultural Obstacles?

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Introduction

Uganda was one of the first countries in Sub-Saharan Africa to both be ravaged by the horrible impact of HIV and AIDS and to take action on their own to control the spread of the epidemic. With over 32 million people and approximately 50 percent of the population under the age of 14 (CIA World Fact book, 2010), there was, and continues to be a need to curb the spread of HIV/AIDS. While the rate of HIV/AIDS infections in other parts of Africa continues to rise, Uganda has succeeded in lowering its infection rates. Since 1993, HIV infection rates among pregnant women, often considered a key indicator of progress of the HIV epidemic by researchers, have been cut in half (and sometimes more) in some areas of the country and infection rates among men seeking treatment for sexually transmitted diseases has dropped by over one-third.

Success in reducing the prevalence of HIV and AIDS has been the result of a number of initiatives in Uganda. This paper will briefly trace the history of HIV/AIDS as an issue in Uganda, discuss the initiatives that led to a decrease in infections and then introduce the main topic of the paper, male circumcision. It is the intent to discuss male circumcision as a possible tool in the fight against further HIV/AIDS infection while considering the possible cultural barriers that do exist in Ugandan society to such a practice.

The following research questions guided the preparation of this paper:

- How exactly does circumcision help protect against HIV infection?
- What cultural barriers in Uganda (either tribal, religious, or national) might hinder efforts to circumcise males?
- Are there systemic barriers to using circumcision as a tool in the fight to curb the spread of HIV?

- Does male circumcision have any other effects on Ugandan social structures or culture?

It was expected that other questions might also surface as research progressed but the four questions were selected because of the critical issue that this method could be used in a struggle that determines whether someone would have an additional chance at life over death and the interest in whether culture was hindering that effort in any way.

A Very Brief History of HIV/AIDS in Uganda

When AIDS first appeared in Uganda in 1982, it was locally called slim disease because the people who had it were typically characterized by the symptoms of extreme weight loss and diarrhea. In addition, Kaposi sarcoma, the type of cancer that Western researchers typically associated with AIDS, was already endemic to some of the areas of Uganda where patients with slim disease were being seen so it was not treated as a defining sign of AIDS. Kaposi sarcoma is a tumor caused by Human herpes virus 8 and is sometimes known as KSHV.

When the connection between AIDS and slim disease was made in 1982, however, Uganda was in the middle of a civil war. From 1982 until 1986, some research was completed in rural areas of Uganda where there was little violence. However, even though researchers and doctors knew about HIV/AIDS, there was very little they could do in Uganda because of the state of the country at the time. As a result, the incidence of HIV/AIDS infection rose between 1982 and 1986 when the war ended and the first government-led initiative to curb incidence of HIV/AIDS began.

When the civil war ended and President Yoweri Museveni came to power, the first campaign to help stop the incidence of HIV and AIDS was introduced. By this time, urban centers had an incidence rate of up to 29 percent (AVERT, 2010, para. 2). This campaign used

an approach called ABC (abstain, be faithful, use condoms) and later included another government-endorsed initiative called Zero Grazing. Zero Grazing was a nod to the Ugandan tribal culture of polygamous relationships. The initiative, primarily directed at men, asked them to try to stick to one partner, but also allowed them to keep their additional wives and mistresses, stressing the importance of not casually engaging in additional sexual activity or having intercourse with prostitutes.

At the same time as the government programs, locally-based grassroots initiatives started forming in Uganda. One of the most well-known of these was The AIDS Support Organization (TASO), a group originally comprised of 16 members who had been personally affected by HIV/AIDS. TASO later became and currently is the largest indigenous AIDS service organization providing HIV/AIDS services in Uganda and Africa to those who are HIV positive. From 1992 until around 2000, HIV and AIDS incidence in Uganda fell dramatically and this sharp decline has been attributed to the programs put in place by both the Ugandan government and some of the groups coming into Uganda to combat the HIV/AIDS epidemic. In Uganda's capital, Kampala, the level of HIV infection of pregnant women attending prenatal clinics "fell from 31 percent in 1993 to 14 percent by 1998. Meanwhile, outside Kampala, infection rates among pregnant women under 20 dropped from 21 percent in 1990 to eight percent in 1998" (World Health Organization, p. 20). The effort in Uganda included personal involvement of the country's president but also involved religious and tribal leaders, non-governmental organizations (NGOs), and even the lowest levels of Ugandan society as billboards were put up describing not only the disease and prevention techniques but directions to places where Ugandans could get information, testing, and education. Discussion about HIV/AIDS in

communities and villages was encouraged and there became a consensus in the country about the necessity to provide care and support for those who were affected by the epidemic.

After 2000, the history of HIV/AIDS in Uganda shifted focus from actively engaging in preventative campaigns to trying to stabilize the number of citizens affected by HIV/AIDS. This occurred for a number of reasons. First and foremost, some of the sex education campaigns that had been used to curb the spread of HIV/AIDS such as programs to increase condom use ran against the religious beliefs held by groups funding those programs. In some cases, the polygamous Ugandan culture and Western religious views of fidelity and abstinence-only ran afoul of each other with sex education programs and condom distribution programs getting stuck in the crossfire (Epstein, 2007). Another factor in this focus switch may have had to do with anti-retroviral drug availability. Since 2004, anti-retroviral drugs have been free in Uganda. One theory is that because of the view that AIDS was no longer a death sentence (AVERT, 2010), some Ugandans felt complacent about HIV which then led to a slight increase in cases.

Today in Uganda, the current HIV rate is estimated to be 5.4 percent among adults (UNAIDS, 2009). According to the Uganda HIV and AIDS Sero-Behavioral Survey, "the number of people living with HIV is higher in urban areas (10.1 percent prevalence) than rural areas (5.7 percent); it is also higher among women (7.5 percent) than men (5 percent)" (AVERT, 2010, para. 21). As much of the HIV/AIDS prevention money that goes to Uganda has been American money, specific American values have sometimes clouded the HIV/AIDS prevention programs. The Bush administration's desire to promote and fund abstinence-only programs through the President's Emergency Plan for AIDS Relief (PEPFAR) founded in 2003, pushed Uganda's HIV/AIDS prevention initiative and those who work in the field back to the ABC approach – first, be *abstinent* until marriage, second, *be faithful* to only one partner, and third –

use *condoms* if engaging in sexual activity with more than one partner. The previous inclusion of the Ugandan culture of polygamy is less discussed in HIV and AIDS prevention circles now. It will remain to be seen if these policies continue under the administration of Barack Obama.

Male Circumcision and HIV Prevention

Over the last decade, there have been numerous studies concerning the link between uncircumcised males and the risk for HIV infection. These studies have led to recommendations that male circumcision be added to the list of effective strategies that should be employed in trying to prevent incidence of HIV. Some public health officials argue that circumcision should be a key weapon in the fight against HIV/AIDS in Africa and Uganda is not new to this discussion as one of the most famous set of studies regarding circumcision and HIV transmission was conducted in Rakai District, Uganda, throughout the late 1990s and 2000s (Wawer et al, 2009; Gray et al, 2000; Wawer et al, 1999). Despite this, the topic of male circumcision is not without controversy as the procedure does elicit cultural implications in some parts of Africa and brings up questions regarding transmission of other sexual diseases and infections. In addition, when discussing male circumcision, researchers and those trying to curb the spread of HIV/AIDS often encounter questions concerning appropriate age for circumcision, risks of the procedure itself, religious issues and queries, and issues of genital hygiene (Bailey et al., 2001).

In history, male circumcision has been practiced for thousands of years as part of a religious ceremony shortly after birth (Jews and Muslims), as a traditional ‘coming of age’ event at puberty or some other predetermined time (several African tribes and ethnic groups), or as a medical procedure to prevent urinary tract and sexually transmitted infections or to remedy some defect of the penis which does not allow it to function properly (Titus and Moodley, 2008). In simple terms, male circumcision involves removing all or part of the foreskin. In the past, it has

been practiced for reasons of hygiene in the United States, Canada, and Australia and the practice is rare in Europe and South America (de Vincenzi and Mertens, 1994).

Outside of Africa, S.J. Reynolds conducted a study in 2004 of 2,298 uninfected men in India who were already visiting clinics for treatment of sexually transmitted diseases. His study noted that "circumcision was protective against HIV-1 infection (relative risk (RR)) 0.15; with a 95% confidence interval 0.04-0.62 p=0.0089) but did not protect against other sexually transmitted diseases such as gonorrhea" (Titus and Moodley, 2008, p. 66). His study suggested a biological (via circumcision) rather than a behavioral effect in reducing the risk of HIV/AIDS. In Africa, randomized trials in Uganda and South Africa have kept the debate concerning the use of circumcision as a tool in the fight against AIDS alive.

Studies in Africa have shown that the circumcision procedure reduces infection rates by 50 to 60 percent among heterosexual African men. Given that number, some experts estimate that up to three million lives could be saved in sub-Saharan Africa alone if the procedure were to become widely used. How exactly circumcision prevents HIV transmission, scientists are not sure, but many believe that the foreskin acts "as a reservoir for HIV-containing secretions, increasing the contact time between the virus and target cells lining the foreskin's inner mucosa" (Katz and Wright, 2008, p.2412). Researchers working in Africa and Asia first noticed a link between male circumcision and HIV rates back in the late 1980s, when they noticed that HIV prevalence rates in areas where male circumcision was commonly practiced were generally lower than in areas where circumcision was not the norm. In some scientific circles, "it has been suggested that following circumcision, the surface epithelium of the glans develops a natural keratin layer, a form of a natural condom" (de Vincenzi and Mertens, 1994, p. 153). More than 40 observational studies were done concerning circumcision and HIV prevalence but most

researchers were skeptical about the results. It was not until the first randomized controlled trial was launched at Orange Farm, South Africa in 2002 that researchers began to pay attention to see if male circumcision really did have a connection to lower HIV rates.

When the Orange Farm study was concluded after 12 months, the results were clear – circumcision had reduced the rate of HIV infection in heterosexual men by 60 percent. Two other randomized controlled trials, one in Rakai District, Uganda, and another in Kenya, confirmed the results of the South African study. Nearly 5,000 men participated in the Ugandan study while an additional 2,800 men took part in the Kenyan study. These results gave the research community what it needed – hard data to use to get funding to push for circumcision programs in different regions of Africa. However, having the data was only one part of the issue. In order to get Ugandans and other Africans to allow themselves to be circumcised, researchers, doctors, health professionals, educators, and others have to deal with the religious, cultural, and other barriers to male circumcision, even though it may be a valuable tool in the fight against HIV/AIDS incidence.

Barriers to the Acceptability of Male Circumcision

The first barrier to the acceptability of male circumcision is a rather simple one – pain. Doctors, health professionals, and AIDS educators working in Africa have to deal with a very simple concern of the populace, the idea that the circumcision procedure itself will be painful (Westercamp, 2007; Bailey, 2001) and that fear leads many to reject the idea of male circumcision outright especially if they are older. In addition, those men who belong to non-circumcising ethnic groups are often familiar with the circumcision practices in neighboring circumcising tribes where pain was a key characteristic of the procedure. If circumcision is a rite

of passage to becoming a man, endurance of the pain was often an integral aspect of the ceremony.

Tribal culture can also be a barrier to the acceptance of male circumcision. In Uganda, female circumcision was banned by the legislature in December 2009. Some tribes do not circumcise but for others, like Uganda's Bagisu tribe, it is unacceptable to remain uncircumcised. The tribe, located in eastern Uganda, practices circumcision on boys ages 12-18 as an initiation into manhood and generally circumcises about 3,000 boys each year between July and January in an "Imbalu" ceremony (Kagumire, 2008). July to January is actually considered "circumcision season" in the Bagisu tribe. While the Bagisu do circumcise their young men, in other communities where circumcision is not regularly practiced, circumcision sometimes leads to rejection by local women and is a barrier to marriage.

Furthermore, religion can be a deterrent in regards to male circumcision. Islam is generally associated with male circumcision and in the 1999 Rakai District study, where 98.5 percent of Muslim men were circumcised, "it was found that those circumcised before the age of 12 had a lower risk of HIV compared with uncircumcised men" (Weiss, Quigley and Hayes, 2000, p. 2368). Religion, however, is also tied to some fundamental Christian and animalist sects in Uganda (Westercamp, 2006) and other parts of Africa. In some areas of Uganda, as well as other small pockets of Africa, circumcision is frowned upon by some Christian churches as a pagan tradition. In these cultures, it is very hard to convince these communities of the value of undergoing circumcision procedures, even if it might save their lives.

Another obstacle to persuading Ugandans to circumcise children and men to undergo the procedure is general concerns of safety. Mothers believe that the procedure has high rates of complications and ill effects as do many men. Education is necessary to reverse the negative

perceptions of the procedure in the communities and local villages. One particular concern by mothers is excessive bleeding and this fear is often heightened if the circumcision procedure is going to be performed by a traditional practitioner (Westercamp, 2006; Bailey, 2001) outside of a hospital. The key to dealing with this fear is providing education and support so that rumors and misinformation are not brought back to local communities. This is where health professionals and those working with HIV/AIDS education could be most helpful in advancing the cause of male circumcision in Uganda. Infection and healing were additional concerns. Despite these fears, mothers generally felt comfortable with and trusted the procedures done by medical professionals in hospital settings.

Cost is sometimes viewed as a hurdle to getting communities or families to agree to circumcision. Some members of poorer villages hold the belief that if circumcision is promoted by the government, it should be provided at health clinics and hospitals for free or at reduced cost (Westercamp, 2006). Still, in other areas of Uganda, people recognized the need to pay for circumcision because a free circumcision would be done by a traditional practitioner and may not be hygienic or safe. It may also be of poor quality and this could is thought to perhaps hinder a male's ability to father children later. In reality, traditional circumcision is often more expensive than circumcision at a medical facility as families often have to pay costs of food, drink, clothing and other special items required for a prolonged celebration. Because of aid money, some medical and health facilities in Uganda can offer the procedure at a cost of approximately $3 American or even lower (Westercamp, 2006; Weiss et al, 2000).

One of the most frightening barriers to male circumcision and even an argument against this procedure, is related to male sexual behavior in Uganda. There is a belief that circumcision may lead some men in Uganda to feel less inhibited in their sexual activities and thus this would

lead to riskier behaviors (Westercamp, 2006). This would then thereby mitigate the partial protective effect of male circumcision. The argument here is that if men get circumcised, they will mistakenly feel they are in some way 'protected from all', causing them to engage in risky sexual practices. This is further complicated that at one time President Museveni himself sneered at the notion of male circumcision, saying it could make his countrymen take fewer precautions during sex (Kagumire, 2008). In Ugandan society, men and women are generally polygamous, where it is acceptable for a man to have as many wives as he can afford to support. In addition to wives, a man may often engage in affairs during which they are or are not faithful. In the ABC approach to HIV/AIDS prevention mentioned earlier in this paper, there is little mention or consideration of Uganda's polygamous societal structure. Men often have many encounters with many sexual partners (they need not even be prostitutes) and an HIV-positive man who does not use condoms could be spreading the virus exponentially (Epstein, 2007). This is part of the reason more women than men have HIV/AIDS in Uganda.

Finally, in addition to the barriers discussed in the paragraphs above, there are systemic barriers within Uganda that hamper efforts to constrain the spread of HIV through male circumcision. The World Health Organization recommends circumcision as a prevention strategy for HIV yet the government of Uganda is hindering efforts to push the effort to circumcise males throughout the country because of a shortage of health workers, among other things. Uganda has approximately one physician per 1,000 people. Many people who train as doctors leave the country as soon as their training is completed because of better pay opportunities; many trained doctors go to South Africa and Great Britain. Because circumcision is considered a minor operation and optional, "few people will stand for the inconvenience [or the] long queues that are common in most health care delivery centres," says Dr. Innocent

Nuwagira, a professional officer on HIV at the World Health Organization in Kampala (Kagumire, 2008, p.1120). An additional systemic concern is should a nation-wide circumcision program be pushed in Uganda, other programs including older prevention strategies based on the ABC model (abstinence, be faithful, use condoms) could suffer and Ugandans could lose trust in those who are trying to help them the most. Researchers, aid workers, and government officials are unsure how to incorporate a new initiative without undermining old ones. Education can help but on their own, Uganda is not able to do this on their own and must rely on foreign aid, assistance, and personnel, like PEPFAR and WHO.

In spite of the reasons noted above, there are definitely things that are considered a benefit of male circumcision in addition to the potential for curbing the transmission of HIV/AIDS in Uganda and Africa. Penile hygiene is universally recognized as important and probably one of the main reasons to advocate for male circumcision. In Uganda, both men and women generally agree that it is easier for a circumcised man to maintain cleanliness. Because of the societal structure, it is usually a woman's role to provide clean water, and thus poor hygiene, penile or otherwise, is often seen as a woman's failing (Westercamp, 2006; Bailey, 2001). In addition, women in these communities often link improper hygiene to their own risk of contracting either a sexually transmitted disease (STD) or HIV/AIDS from their partners. As a result of these factors, as well as the evidence that untreated and undiagnosed STDs enhance transmission of HIV (Wawer et al, 1999; Cohen, 1998), male circumcision should definitely be considered as a possible tool in the fight against increased HIV/AIDS incidence.

Conclusions and Further Observations

It seems that the issue of using male circumcision as a tool in the fight against increased HIV/AIDS incidence in Uganda is a complicated one that affects people not only in terms of

whether or not they will live or die but in terms of all of the considerations that must be sorted out when trying to implement a new strategy. Usually when thinking about circumcision in terms of social justice or equity, people tend to look towards female circumcision because of the atrocities sometimes enforced on women in some cultures as a way of control. With regard to male circumcision and AIDS, there are equity issues for the developing world (less doctors available to do the procedure, less education available in rural areas) but there are also ethical issues. Connecting circumcision with HIV testing and education makes this writer ask the following questions:

- What should be done for men who test positive in the process of seeking circumcision procedures?
- Should male circumcision only be offered after a negative HIV test?
- Should men who test positive for HIV be advised to get circumcised anyway, on the possibility that circumcision may directly or indirectly reduce how much they could possibly infect their partners or should these men simply be told to use condoms or practice abstinence?

These are not questions that can be answered at this time, but they are perhaps questions for another research endeavor. Finally, a good, safe circumcision costs money and those in less developed countries may be limited by what is affordable. Anesthesia and hygienic conditions in a hospital by well-trained physicians may be only afforded by those in higher income brackets and those who cannot afford this may be left to more traditional practitioners with less than hygienic conditions, possible with post-operative complications. Economics may also influence a man's ability to be circumcised or a family's ability to circumcise their son.

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