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ORIGINAL ARTICLE

A new Tuskegee? Unethical human experimentation and Western neocolonialism in the mass circumcision of African men

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Abstract
Campaigns to circumcise millions of boys and men to reduce HIV transmission are being conducted throughout eastern and southern Africa, recommended by the World Health Organization and implemented by the United States government and Western NGOs. In the United States, proposals to mass-circumcise African and African American men are longstanding, and have historically relied on racist beliefs and stereotypes. The present campaigns were started in haste, without adequate contextual research, and the manner in which they have been carried out implies troubling assumptions about culture, health, and sexuality in Africa, as well as a failure to properly consider the economic determinants of HIV prevalence. This critical appraisal examines the history and politics of these circumcision campaigns while highlighting the relevance of race and colonialism. It argues that the "circumcision solution" to African HIV epidemics has more to do with cultural imperialism than with sound health policy, and concludes that African communities need a means of robust representation within the regime.

KEYWORDS
male circumcision, HIV, VMMC, cultural imperialism, racism, colonialism

1 | INTRODUCTION

In 2007, the World Health Organization (WHO) and the Joint United Nations Programme on HIV and AIDS (UNAIDS) approved a campaign to circumcise millions of African boys and men. This policy followed the results of three randomized trials published between 2005 and 2007 reporting a relative risk reduction in female-to-male transmission of HIV of 50%–60% among circumcised men.[1] Given the urgency of the HIV crisis in sub-Saharan Africa (SSA), which represents over 70% of the global infection burden,[2] it is understandable that public health officials would seize on such an apparent "silver bullet." Between 2008–2018, 23 million men and boys underwent so-called "voluntary medical male circumcision" (VMMC) in Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe.[3]

[1]Auvert, B., Taljaard, D., Lagarde, E., Sobngwi-Tambekou, J., Sitta, R., & Puren, A. (2005). Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. *PLOS Med*, *2*(11), e298; Gray, R. H., Kigozi, G., Serwadda, D., Makumbi, F., Watya, S., Nalugoda, F., … Chen, M. Z. (2007). Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. *Lancet*, *369*(9562), 657–666; Bailey, R. C., Moses, S., Parker, C. B., Agot, K., Maclean, I., Krieger, J. N., … Ndinya-Achola, J. O. (2007). Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. *Lancet*, *369*(9562), 643–656.

[2]Kharsany, A. B. M., & Karim, Q. A. (2016). HIV Infection and AIDS in Sub-Saharan Africa: current status, challenges and opportunities. *Open AIDS J*, *10*, 34–48.

[3]Samuelson, J. (2019). *Voluntary Medical Male Circumcision in an Evolving HIV Prevention Landscape in East and Southern Africa*. Presented on behalf of the WHO at the 20th International Conference on AIDS and STIs in Africa. Retrieved Jan 3, 2020 from https://www.malecircumcision.org/resource/voluntary-medical-male-circumcision-evolving-hiv-prevention-landscape-east-and-southern.

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On the surface, VMMC appears to be the straightforward application of a clinically efficacious procedure to address an acknowledged public health emergency. Within the context of Western colonialism and neocolonialism in Africa, however, a different story emerges. As Peter Aggleton has argued, circumcision "has its roots in the deep structure of society. Far from being a simple technical act, even when performed in medical settings, it is a practice which carries with it a whole host of social meanings."[4] These meanings may concern rites of passage, gendered social roles, norms surrounding sex and sexuality, fulfilment of perceived religious obligations, modes of ethnic identification, or beliefs about hygiene or aesthetics, with circumcision often standing as "a potent indicator of hierarchy and social difference." Circumcision is therefore not simply an act of healthcare. Rather, it is "nearly always a strongly political act, enacted upon others by those with power."[5] Accordingly, careful ethical evaluation of programs initiated and funded by those with considerable power to circumcise those with less power is needed.[6]

The "Clearinghouse on Male Circumcision," a WHO/UNAIDS collaboration with NGOs engaged in VMMC implementation and policymaking, highlights hundreds of studies and articles divulging clinical and epidemiological evidence, practical considerations, and arguments favoring the scaling up of mass male circumcision within target countries.[7] Within this literature, VMMC's efficacy and validity as part of the global HIV/AIDS response is largely taken for granted. However, from its inception, researchers from various fields have also questioned the mass circumcision campaign on scientific,[8] ethical,[9] gender equity,[10] and public health policy grounds.[11] The present article adds to the smaller literature focused on race, culture, and geopolitics,[12] examining historical proposals to use circumcision as a means of curbing venereal disease among African and African American men. It further considers racial, political, and ethical aspects of VMMC research and implementation, with particular attention to the fact that these programs are fueling charges of racism and neocolonialism within African communities.

Section 2 begins with a brief history of overtly racist proposals to apply medical male circumcision to African and African American men. Section 3 reviews the development of, and evidence for, mass VMMC as a response to the HIV crisis. Sections 4 and 5 consider the colonial and neocolonial contexts in which the resulting VMMC campaigns operate and the problematic assumptions upon which they rely. Section 6 concludes.

2 | A RACIAL HISTORY OF MALE CIRCUMCISION

While circumcision has long been practiced on parts of the African continent and among Jews and Muslims globally, medicalization of the practice is a relatively new phenomenon.[13] Historically, justifications for medical male circumcision in the Western world have aligned with the latest public health scares: nervous disorders in the late nineteenth and early twentieth centuries, later followed by cancer and a host of sexually transmitted infections (STIs) including syphilis and now HIV.[14] African and African American men, stereotyped in the West as being promiscuous or hypersexual,[15] have long been caught in the crosshairs of the circumcision debate.

Within this climate, the foreskin has been portrayed—often by those with a pre-existing cultural or religious commitment to circumcision[16]—as a vector for disease; it is only the proposed mechanism for disease transmission that has changed. From the mid-nineteenth

[4]Aggleton, P. (2007). "Just a snip"? A social history of male circumcision. *Reprod Health Matters*, *15*(29), 15–21, p. 15.

[5]Ibid.

[6]Earp, B. D., & Darby, R. (2019). Circumcision, autonomy and public health. *Public Health Ethics*, *12*(1), 64–81.

[7]Clearinghouse on Male Circumcision. (n.d.) Resource Library. Retrieved July 16, 2020 from https://www.malecircumcision.org/resources/resource-library.

[8]e.g., Garenne, M., Giami, A., & Perrey, C. (2013). Male circumcision and HIV control in Africa: questioning scientific evidence and the decision-making process. In T. Giles-Vernik & J. Webb (Eds.), *Global Health in Africa* (pp. 185–210). Athens, OH: Ohio University Press.

[9]e.g., Drash, M. (2019). Circumcising human subjects: an evaluation of experimental foreskin amputation using the Declaration of Helsinki. *Bioethics*, *33*(3), 383–388; Earp & Darby, op. cit., note 6; Rudrum, S. (2020). Promoting male circumcision as HIV prevention in sub-Saharan Africa: an evaluation of the ethical and pragmatic considerations of adopting a demand creation approach. *Glob Public Health* [epub ahead of print].

[10]e.g., Berer, M. (2007). Male circumcision for HIV prevention: perspectives on gender and sexuality. *Reprod Health Matters*, *15*(29), 45–48; Berer, M. (2008). Male circumcision for HIV prevention: What about protecting men's partners? *Reprod Health Matters*, 16(32), 171-175; Rudrum S., Oliffe J. L., & Benoit C. (2017). Discourses of masculinity, femininity and sexuality in Uganda's Stand Proud, Get Circumcised campaign. *Cult Health Sex*, *19*(2), 225–239.

[11]For a list of prior policy criticisms and other articles questioning the soundness of the VMMC trials and/or campaigning, compiled by the authors, see (n.d.) Further Reading. Retrieved July 16, 2020 from https://www.vmmcproject.org/further-reading.

[12]e.g., Aggleton, "Just a snip?" op. cit., note 4; Bell, K. (2015). HIV prevention: making male circumcision the 'right' tool for the job. *Glob Public Health*, *10*(5–6), 552–572; Bulled, N. L. (2015). Hesitance towards voluntary medical male circumcision in Lesotho: reconfiguring global health governance. *Glob Public Health* 10(5-6),757–752; Fox, M., & Thomson, M. (2016). HIV/AIDS and male circumcision: discourses of race and masculinity. In M. A. Fineman & M. Thomson (Eds.), *Exploring Masculinities* (pp. 97–113), London: Routledge; Katisi, M., & Daniel, M. (2015). Safe male circumcision in Botswana: tension between traditional practices and biomedical marketing. *Glob Public Health*, *10*(5–6), 739–756; Parkhurst, J. O., Chilongozi, D., & Hutchinson, E. (2015). Doubt, defiance, and identity: understanding resistance to male circumcision for HIV prevention in Malawi. *Soc Sci Med*, *135*, 15–22.

[13]Gollaher, D. L. (2000). *Circumcision: A History of the World's Most Controversial Surgery*. New York: Basic Books.

[14]Ibid.; Darby, R. (2013). *A Surgical Temptation: The Demonization of the Foreskin and the Rise of Circumcision in Britain*. Chicago: University of Chicago Press.

[15]In the words of urologist Frank Lydston circa 1919, "The negro's well-known sexual impetuosity may account for more abrasions of the integument [skin] of the sexual organs and therefore more frequent infections than are found in the white race," quoted in Jones, J. H. (1981). *Bad Blood: The Tuskegee Syphilis Experiment*. New York and London: Free Press, p. 25. For a history of the hypersexual African archetype in the Western Christian tradition, see Brakke, D. (2001). Ethiopian demons: male sexuality, the black-skinned other, and the monastic self. *J Hist Sex*, *10*(3/4), 501–535.

[16]Gollaher, op. cit. note 13.

to early twentieth centuries, it was widely believed that maladies ranging from hysteria to neurasthenia (a presumed medical condition involving fatigue, headaches, and irritability) stemmed from "reflex neurosis," a nervous disorder thought to be caused by irritation or overstimulation of the genitals, for example by masturbation.[17] An empirical study of the period revealed that, while in the eighteenth century "medical men endeavored to cure masturbation, in the nineteenth century they were trying to suppress it."[18] This change in tactics, the study found, "is sharply visible [in the] sudden rise of repressive and surgical measures in the treatment of masturbation beginning with 1850. While up to 1849, masturbation was treated mostly with hydrotherapy, diet, etc., between 1850 and 1879 surgical treatment [such as circumcision] was recommended more frequently than any of the other measures."[19]

Subsequently, such moral hygiene arguments for male circumcision intertwined with turn-of-the-century racism as African and African American men's "lynching breeding prepuce [foreskin]"[20] became a prominent concern for American circumcision advocates. As editors of the *Maryland Medical Journal* explained in 1894:

> The brutal and uncontrollable passion of the Negro has been traced to a variety of causes, the chief of which has been referred to a perversion of his sexual instincts and ungoverned sexual passion. [It is worth considering] that the legal enforcement of circumcision among the negro race would effectually remedy the predisposition to raping inherent in this race.[21]

African and African American men, allegedly "ignorant of the laws of hygiene,"[22] were prime targets for Victorian circumcision ideology at the close of the nineteenth century, when medical journals published such titles as "Circumcision for the correction of sexual crimes among the Negro race,"[23] "The solution of the Negro rape problem,"[24] "Negro rapes and their social problems,"[25] "Sexual crimes among the southern Negroes scientifically considered,"[26] "Enforced circumcision of the colored race,"[27] and "Circumcision enforced by law"[28]—a plea for mass circumcision, "especially [of] the colored people of the South,"[29] that was presented at the annual convention of the Colored Physicians Association in 1889. According to Marie Fox and Michael Thomson, such rhetoric casts circumcision "as the medical solution to ignorance, bad hygiene, and low morals in the black population,"[30] often premised on a wider understanding of African American men as sexual predators who posed a threat to "White southern womanhood and White male sexual hegemony."[31]

Even as the Victorian preoccupation with masturbation faded, newer claims about the hygienic and purported anti-venereal benefits of circumcision found enduring medical traction.[32] African and African American men were by no means the only group targeted by such claims—medicalized circumcision was advocated in the United States and elsewhere not only across boundaries of race or ethnicity but also of sex, with "female circumcision" claimed to have important health benefits into the latter half of the twentieth century.[33] Nevertheless, pervasive stereotypes about the American "Negro" facilitated a philanthropic interest in providing medical circumcisions to low-income men of color. As the author of a 1914 article published in the *Journal of the American Medical Association* lamented:

> The prophylaxis of syphilis in the Negro race is especially difficult, for it is impossible to persuade the poor variety of Negro that sexual gratification is wrong, especially when he is in the actively infectious stages. It is probable that sex hygiene lectures will not have the slightest effect on this type.[34]

The article went on to advocate the use of male circumcision "both for the purpose of avoiding local irritation which will increase the sexual appetite and for preventing infection."

A climate of disrespect for the agency, intelligence, and sexual integrity of Africans and African Americans is not confined to the issue of circumcision. Rather, Africans and African Americans have been prime subjects of degrading experimentation, often involving their genitals, throughout American medical history.[35] J. Marion

[17]Bonomi, C. (2015). *The Cut and the Building of Psychoanalysis, Volume I: Sigmund Freud and Emma Eckstein*. New York and London: Routledge; Darby, op. cit., note 14; Gollaher, op. cit. note 13.

[18]Spitz, R. A. (1952). Authority and masturbation: some remarks on a bibliographic investigation. *Psychoanal Q*, *21*, 490–527, p. 499, quoted in Bonomi, C. (2009). The relevance of castration and circumcision to the origins of psychoanalysis: 1. The medical context. *Int J Psychoanal*, *90*(3), 551–580.

[19]Ibid.

[20]Remondino, P. C. (1894). Negro rapes and their social problems. *Nat Pop Rev*, *4*(1), 3–6.

[21]Editors. (1894). Circumcision for the correction of sexual crimes among the Negro race. *Maryland Med J*, *30*(16), 345–346. The proposal which they suggest is "worthy of consideration" is that put forward by Remondino, op. cit. note 20.

[22]Daniel, F. E. (1889). Enforced circumcision of the colored race. *Daniel's Texas Med J*, *5*(1), 28.

[23]Editors, op. cit. note 21.

[24]Shattuck, G. B., Edson, C. E. (1894). The solution of the Negro rape problem. *Boston Med Surg J*, *130*, 126–127.

[25]Remondino, op. cit. note 20.

[26]McGuire, H., & Lydston, G. F. (1893). Sexual crimes among the southern Negroes scientifically considered. *Virginia Med Monthly*, *20*, 105–125.

[27]Daniel, op. cit. note 22.

[28]Vandavel, J. (1889). Circumcision enforced by law. *Daniel's Texas Med J*, *5*(1), 7–11. For a contemporary critique of the proposal, see Waugh, W. F. (1889). Circumcision enforced by law. *Phila Med Times Register*, *20*(570), 349.

[29]Ibid: 10.

[30]Fox & Thomson, op. cit. note 12, p. 103.

[31]Nagel, J. (2008). Sexualizing the sociological: queering and querying the intimate substructure of social life. *Sociol Q*, *41*, 1–17, p. 12.

[32]Gollaher, op. cit. note 13.

[33]Dawson, B. E. (1915). Circumcision in the female: its necessity and how to perform it. *Am J Clin Med*, *22*(6), 520–23; Rathmann, W. G. (1959). Female circumcision: indications and a new technique. *GP*, *20*(3), 115–120; Rodriguez, S. B. (2014). *Female Circumcision and Clitoridectomy in the United States: A History of a Medical Treatment*. Woodbridge, England: Boydell & Brewer.

[34]Hazen, H. H. (1914). Syphilis in the American Negro. *JAMA*, *63*(6), 463–466.

[35]Washington, H. A. (2006). *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. New York: Doubleday Books.

Sims, commonly credited as the "father of modern gynecology," is notorious among scholars of medical racism for his use of enslaved women for reproductive surgery experiments without anesthetization.[36] More recently, in the infamous "Tuskegee Study of Untreated Syphilis in the Negro Male," African American syphilis patients were observed without treatment over four decades as they developed complications, infected others, and ultimately died.[37] The HeLa cell scandal, in which Johns Hopkins University cultivated an immortal cell line from the cervix of Henrietta Lacks, an unknowing and *ipso facto* unconsenting African American patient, remains a subject of concern among scholars and activists.[38] (The fact that the same university has amassed "possibly the world's largest collection of foreskins" from African boys and men through the VMMC program[39] has yet to be subjected to proper scrutiny.)[40]

The Tuskegee syphilis study was terminated by Congressional order in 1972 upon media publicity and subsequent civil outrage, and was followed by a $1.8 billion class-action lawsuit against the U.S. Centers for Disease Control and Prevention (CDC) and other responsible agencies.[41] Twenty years later, U.S. President Bill Clinton delivered a public apology to survivors at the White House for "a study so clearly racist."[42] But degrading attitudes toward and/or treatment of Africans and African Americans within medical research did not evaporate after Tuskegee. In fact, the very same Johns Hopkins research group behind the Ugandan VMMC trials—discussed in greater detail below—conducted two prior HIV trials[43] in Rakai, Uganda that inspired related ethical criticism.[44] The first trial, led by Maria Wawer, sought to measure the impact of treatment for various STIs on HIV acquisition. To achieve this, Ugandan men and women with treatable STIs were randomized into groups to be either treated or given inert placebos of anthelminth (an antiparasitic drug) and iron-folate vitamins.[45] The latter cohort mirrors that of the Tuskegee syphilis study, in which infected men were provided aspirin for mild pain relief in lieu of penicillin treatment.[46] In the second trial led by Thomas Quinn, the Johns Hopkins group allowed and assessed HIV transmission—from participants who had already tested positive for the virus—to unknowing, seronegative partners, 90 of whom ultimately contracted HIV.[47] The permitted transmission of a lethal infection to unknowing partners was one of the points of ethical criticism and subsequent racial condemnation of the Tuskegee syphilis study.[48] Daniel Reidpath and colleagues allege that the associated ethical review boards for the trial, including institutional and U.S. government agencies, "approved a study that they would have considered inappropriate, unethical, and possibly illegal in their own country."[49] In an editorial preceding the trial's publication in the *New England Journal of Medicine*, then editor-in-chief Marcia Angell weighed in on the controversy:

> It is important to be clear about what this study meant for the participants. It meant that for up to 30 months, several hundred people with HIV infection were observed but not treated. It was also left up to the seropositive partner in couples discordant for HIV-1 to decide whether the seronegative partner would be informed, even though both were regularly seen by the investigators. In addition, many people who were found to have other sexually transmitted diseases were left to seek their own treatment. … Such a study could not have been performed in the United States, where it would be expected that patients with HIV and other sexually transmitted diseases would be treated.[50]

How could such research continue to be conducted—and be approved by U.S.-based ethics committees[51]—after the supposed lessons

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[36]Wailoo, K. (2018). Historical aspects of race and medicine: the case of J. Marion Sims. *JAMA*, *320*(15), 1529–1530.

[37]Gamble, V. N. (1997). Under the shadow of Tuskegee: African Americans and health care. *Am J Public Health*, *87*(11), 1773–1778; Jones, op. cit. note 15; Washington, op. cit. note 35.

[38]Washington, op. cit. note 35.

[39]Dusto, A. (2011, Spring). Women benefit from male circumcision, too. *Johns Hopkins Public Health*. Retrieved January 2, 2020 from http://magazine.jhsph.edu/2011/spring/news_briefs/women_benefit_from_male_circumcision_too.

[40]Ironically, these foreskins are used to research the very immune defenses in the mucous membrane their unknowing donors have lost to circumcision (ibid.). Accordingly, the concerns many Africans have expressed about the uses of their tissue are well-founded (Bell, op. cit. note 12, p. 14). Such tissue cultivation is not the only instance of commercial exploitation associated with VMMC campaigns. The WHO's own erstwhile "chief expert on circumcision," David Tomlinson, has personally received $271,908 in royalty payments associated with a WHO-recommended infant circumcision device for which he owns the patent. ProPublica. (n.d.). David Tomlinson. *Dollars for Docs*. Retrieved January 3, 2020 from https://projects.propublica.org/docdollars/doctors/pid/775085. For "chief expert" reference, see Hennessy-Fiske, M. (2011, September 26). Injuries linked to circumcision clamps. *Los Angeles Times*, Retrieved July 17 from https://www.latimes.com/health/la-xpm-2011-sep-26-la-he-circumcision-20110926-story.html.

[41]Washington, op. cit. note 35.

[42]Ibid.

[43]Wawer, M. J., Sewankambo, N. K., Serwadda, D., Quinn, T. C., Paxton, L. A., Kiwanuka, N., … Gray, R. H. (1999). Control of sexually transmitted diseases for AIDS prevention in Uganda: a randomised community trial. *Lancet*, *353*, 525–35; Quinn, T. C., Wawer, M. J., Sewankambo, N., et al. (2000). Viral load and heterosexual transmission of human immunodeficiency virus type 1. Rakai Project Study Group. *N Engl J Med*, *342*(13), 921–929.

[44]Reidpath, D., Allotey, P., & Thomas, J. (2000). Ethics and trials in developing countries: researchers and responsibility. *Monash Bioethics Rev*, *19*(3), S53-S64; Zion, D. (2004). HIV/AIDS clinical research, and the claims of beneficence, justice, and integrity. *Camb Q Healthc Ethics*, *13*(4), 404–413.

[45]Wawer et al., op. cit. note 43.

[46]Washington, op. cit. note 35.

[47]Quinn et al., op. cit. note 43. As Reidpath et al. (op. cit. note 44) state, "Notwithstanding the clear intent to link the records of couples, the researchers report that they chose not to do so until after the completion of the trial. [But if] this is a defense, it means that researchers could conduct otherwise unethical research merely by choosing not to look at the data they collected until after the completion of the study" (pp. 59–60).

[48]Washington, op. cit. note 35.

[49]Reidpath et al., op. cit. note 44, p. 61.

[50]Angell, M. (2000). Investigators' responsibilities for human subjects in developing countries. *New Engl J Med*, *342*(13), 967–969.

[51]As acknowledged by Angell (ibid., p. 968), those who defend such research could argue that, in light of limited treatment access and poorer health outcomes generally in the developing world, subjects are "no worse off" than they would be if they were not enrolled in the study, and that this, in turn, implies that "ethical standards governing research should vary with the political and economic conditions of the region." Against this view, Angell maintains that investigators are responsible for the subjects they enlist in their studies and must do their best for them, regardless of the surrounding conditions: "those conditions should not be used to justify a lower standard of care for some subjects [as] any other position could lead to the exploitation of people in developing countries in order to conduct research that could not be performed in the sponsoring countries."

of Tuskegee? In their 2014 article, "Systemic racism and U.S. healthcare," prominent theorists Joe Feagin and Zenobia Bennefield argue that "medical and public health communities, including their mostly white leadership and leading medical schools, seem unwilling to examine the current impacts of past racial oppression on U.S. medical and public health institutions."[52] Individual actors need not consciously harbor racist beliefs for their decisions to be influenced by racist premises or stereotypes: such stereotypes are "largely invisible" within institutions such as medicine that have long been dominated by those who do not suffer from their implications.[53]

Taken together, these considerations suggest that longstanding, invidious assumptions about certain groups can continue to shape medical research and practice in the present day.[54] As such, the historical conviction that surgical intervention is necessary to prevent African and African American men from acquiring STIs, for instance, could, however unwittingly, constitute part of the underlying logic of the present campaigns. Indeed, writing in 2007, the founding editor of *Reproductive Health Matters*, Marge Berer, alleged that "there was an unstated assumption in the WHO/UNAIDS consultation [on VMMC] that unprotected, unsafe sex on the part of men in sub-Saharan Africa cannot be changed."[55]

It is against this backdrop that three randomized trials of male circumcision for prevention of female-to-male HIV transmission were conducted on young men in rural South Africa,[56] Uganda,[57] and Kenya.[58] Ethical arguments have been raised from multiple perspectives. Armed with results from the trials, proponents have framed male circumcision for HIV prevention as a moral imperative: "Stressing that circumcision had the potential to save lives [they] urged that to refuse to act was to act unethically."[59] As Alain Giami and colleagues explain, "This new rhetoric morally condemned any doubts (deemed a form of opposition) about the efficacy of male circumcision as a means for preventing HIV transmission from women to men."[60]

Such urgent rhetoric is not unique to circumcision: it has formed a part of many proposals for combating HIV/AIDS in line with what some scholars have called "AIDS exceptionalism,"[61] i.e., "the tendency to coopt the language of ethics to promote urgent action—and suppress dissent—without fully considering the moral dimensions of the problem or alternative ethical or policy views."[62,63] In the case of circumcision, such exceptionalism is especially salient because, as Michael Drash notes, "experiments which cut into and remove [healthy] tissue from their subjects without specific cause, i.e., to see what happens, are the kind which prompted the very first frameworks of the rights of human subjects."[64] Moreover, given that the specific tissue in question—the penile foreskin or prepuce (see **Box 1**)—is a prominent, functional component of a psychosexually significant organ, the irreversibility of circumcision is, according to Drash, a red flag for trial ethics: it comprises a "point of no return" that is at odds with the subject's right to withdraw consent and exit a study after the experiment has begun.[65]

A subsequent male-to-female trial in Uganda, conducted by the same Johns Hopkins Rakai research team mentioned earlier, sought to establish a protective effect of male circumcision for women by allowing HIV-positive men to infect unknowing seronegative partners.[66] We will discuss the results from this trial in the following section. Here, we simply note that the serious criticisms[67] of the Rakai group's earlier research—in which they similarly permitted the transmission of a lethal infection to unknowing Ugandan subjects—did not lead to substantive ethical changes.

Although the cohorts were not deliberately singled out by race or class, the "subjects" across the four circumcision trials were virtually all poor African men and women, raising concerns about vulnerabilities that are consistent with a history of medical exploitation. The lesson here is that the VMMC campaigns take place not in a vacuum, nor in a post-racial era, but rather within a particular historical and geopolitical context in which ethical issues associated with racialized power imbalances are apt to continue to arise in the current regime. Whether they are a result of implicit values within public health structures, or whether they are also sometimes the result of explicit opportunism is unclear. What is clear is that the relevant science and policy cannot be secured

[52]Feagin, J., & Bennefield, Z. (2014). Systemic racism and U.S. health care. *Soc Sci Med*, *103*, 7–14, p. 9.

[53]Verschaeve, J. M. (2008). Scientific racism and human rights violations in our time: Tuskegee must never be forgotten. *Mich Sociol Rev*, *22*, 222-226.

[54]Adebowale, V., & Rao, M. (2020). Racism in medicine: why equality matters to everyone. *BMJ*, *368*, m530; Washington, op. cit. note 35.

[55]Berer, 2007, op. cit. note 10, p. 10.

[56]Auvert, et al., op. cit. note 1.

[57]Gray, et al., op. cit. note 1.

[58]Bailey, et al., op. cit. note 1.

[59]Earp & Darby, op. cit. note 6, p. 67. For examples, see Klausner, J. D., Wamai, R. G., Bowa, K., Agot, K., Kagimba, J., & Halperin, D. T. (2008). Is male circumcision as good as the HIV vaccine we've been waiting for?. *Futur HIV Ther 2*(1), 1–7.

[60]Giami, A., Perrey, C., de Oliveira Mendonça, A. L., & de Camargo, K. R. (2015). Hybrid forum or network? The social and political construction of an international 'technical consultation': male circumcision and HIV prevention. *Glob Public Health*, *10*(5–6), 589–606, p. 596.

[61]Smith, J. H., & Whiteside, A. (2010). The history of AIDS exceptionalism. *J Int AIDS Soc*, *13*(1), 1-8.

[62]Earp & Darby, op. cit. note 6, p. 67.

[63]Framing the HIV epidemic in terms of crisis, emergency, and urgency facilitates a state of exception in relation to experiments and treatment programs, within which the normal expectations regarding evidence, accountability, and sensitivity to non-biomedical considerations are at least partially suspended: Mariner, W. K. (1992). AIDS research and the Nuremberg Code. In G. Annas & M. Grodin (Eds.), *The Nazi Doctors and the Nuremberg Code* (pp. 286–303). Oxford: Oxford University Press; Nguyen, V. K. (2009). Government-by-exception: enrolment and experimentality in mass HIV treatment programmes in Africa. *Soc Theor Health*, *7*(3), 196–217; Rottenburg, R. (2009). Social and public experiments and new figurations of science and politics in postcolonial Africa. *Postcolonial Stud*, *12*(4), 423–440). Likewise, Helen Tilley argues that harmful experimental treatment campaigns in colonial Africa have been underpinned by the same principle of urgency, "guided by the logic that doing something was better than doing nothing," Tilley, H. (2016). Medicine, empires, and ethics in colonial Africa. *AMA J Ethics* 18(7), 743–753, p. 747.

[64]Drash, op. cit. note 9, p. 396.

[65]Drash, op. cit. note 9, p. 397.

[66]Wawer, M. J., Makumbi, F., Kigozi, G., et al. (2009). Circumcision in HIV-infected men and its effect on HIV transmission to female partners in Rakai, Uganda: a randomised controlled trial. *Lancet*, *374*(9685), 229–237.

[67]Reidpath, et al., op. cit. note 44; Zion, op. cit. note 44.

Box 1 A brief overview of the male prepuce. Adapted from Frisch and Earp (2018).[68]

The foreskin is a complex, double-layered structure which protects the penile glans from environmental irritation such as rubbing against diapers and clothing.[69] This elastic, motile sleeve of tissue has been shown to be the most light-touch sensitive part of the penis,[70] composed of a moist mucous membrane on the inside and a protective skin layer on the outside.[71] It is rich in specialised nerve endings and sensory structures involved in the normal functionality of the penis,[72] and it comprises up to 100 square centimeters in adult men, with reported mean values between 30 and 50 square centimeters.[73] While the scientific literature on the "average" sexual consequences of circumcision is inconclusive and contradictory[74]—and granting that circumcision is likely to affect different individuals differently, even when it is properly performed[75]—at least two outcomes can be known with certainty due to the inherent nature of the procedure: first, any sensation that would have been experienced in the foreskin itself is necessarily eliminated; and, second, any sexual (e.g. masturbatory) functions that require manipulation of the foreskin are also of necessity precluded.[76]

against these moral shortcomings until affected communities of color in the Global South can assume a more central role in medical decision-making about their own bodies.

3 | MASS MALE CIRCUMCISION: AN ANSWER FINDS ITS QUESTION

Within three years of the discovery of HIV, a lack of male circumcision was suggested in the United States as a "possible explanation" for its high burden on the African continent.[77] However, the suggestion failed to consider the circumcision practices that were already longstanding among various African tribes. To rectify this, proponents compared regional data and amassed a body of observational studies showing a negative correlation between male circumcision and HIV prevalence rates throughout SSA.[78] A Cochrane review accepted this correlation as "a strong epidemiological association," but concluded that the studies themselves were insufficient as they were "inherently limited by confounding."[79]

In a later meta-analysis presenting an inconclusive and largely conflicting association, demographer Michel Garenne explained, "The demographic evidence indicates that the relationship between male circumcision and HIV seroprevalence is complex, and that both positive and negative relations can be found for a variety of reasons."[80] Bertran Auvert, a longstanding male circumcision advocate, admitted that the supporting evidence "was not convincing enough for WHO, UNAIDS, and other organizations.... A randomized trial was really needed in this area to convince people."[81] In turn, an Information Sheet provided to participants in the Auvert et al. trial made this aim explicit upon enrollment, stating that if they achieved a lower HIV and STI incidence following circumcision, they "will have contributed to important progress in the fight against STD's [*sic*] and HIV."[82]

Men in the Auvert et al. South African trial, and in the supporting Ugandan and Kenyan trials, were randomized into intervention and

[68]Frisch, M., & Earp, B. D. (2018). Circumcision of male infants and children as a public health measure in developed countries: a critical assessment of recent evidence. *Glob Public Health*, *13*(5), 626–641.

[69]Berry Jr., C. D., & Cross Jr., R. R. (1956). Urethral meatal caliber in circumcised and uncircumcised males. *AMA J Disease Child*, *92*, 152–156; Fahmy, M. A. B. (2020). *Normal and Abnormal Prepuce*. Cham: Springer International Publishing.

[70]Bossio, J. A., Pukall, C. F., & Steele, S. S. (2016). Examining penile sensitivity in neonatally circumcised and intact men using quantitative sensory testing. *J Urol 195*(6), 1848–53. Note: This study has been mischaracterized as having found that the foreskin is not the most sensitive part of the penis, likely due to a misleading statement to that effect in the authors' abstract. Responding to critics who pointed this out, the authors clarified that their study had in fact "replicated the results reported by Sorrells et al." (see following reference), namely, that the foreskin is the most sensitive part of the penis to light-touch sensation, specifically, when compared to all other tested sites: Bossio, J. A., Pukall, C. F., & Steele, S. S. (2016). Reply by authors. *J Urol*, *196*(6), 1825–1826, p. 1825; see Sorrells, M. L., Snyder, J. L., Reiss, M. D., Eden, C, Milos, M. F., Wilcox, N., & Van Howe, R. S. (2007). Fine-touch pressure thresholds in the adult penis. *BJU Int*, *99*(4), 864–869). For further discussion of the controversy, see Earp, B. D. (2016). Infant circumcision and adult penile sensitivity: implications for sexual experience. *Trends Urol Men's Health*, *7*(4), 17–21.

[71]Fahmy, op. cit. note 69.

[72]Cold, C.J., & Taylor, J. R. (1999). The prepuce. *BJU Int*, *83* (Suppl 1):34–44; Fahmy, op. cit. note 69.

[73]Kigozi, G., Wawer, M., Ssettuba, A., Kagaayi, J., Nalugoda, F., Watya, S., ... & Serwadda, D. (2009). Foreskin surface area and HIV acquisition in Rakai, Uganda (size matters). *AIDS*, *23*(16), 2209; Werker, P. M., Terng, A. S., & Kon, M. (1998). The prepuce free flap: dissection feasibility study and clinical application of a super-thin new flap. *Plastic Reconstruct Surg*, *102*(4), 1075–1082.

[74]Bossio, J. A., Pukall, C. F., & Steele, S. (2014). A review of the current state of the male circumcision literature. *J Sex Med*, *11*(12), 2847–2864; however, see Morris, B. J., & Krieger, J. N. (2013). Does male circumcision affect sexual function, sensitivity, or satisfaction? A systematic review. *J Sex Med*, *10*(11), 2644–2657. For criticisms of the review by Morris and Krieger, see Bossio, J. A., Pukall, C. F., & Steele, S. (2015). Response to: The literature supports policies promoting neonatal male circumcision in N. America. *J Sex Med*, 12(5), 1306-1307; Myers, A., & Earp, B. D. (2020). What is the best age to circumcise? A medical and ethical analysis. *Bioethics*, [epub ahead of print].

[75]Kim, D., & Pang, M. G. (2007). The effect of male circumcision on sexuality. *BJU Int*, 99(3), 619-622; Darby, R., & Cox, L. (2009). Objections of a sentimental character: the subjective dimensions of foreskin loss. *Matatu*, 37, 145–168; Earp, B., & Darby, R. (2017). Circumcision, sexual experience, and harm. *U Penn J Int Law*, *37*(2, online), 1-56; Hammond, T., & Reiss, M. D. (2018) Antecedents of emotional distress and sexual dissatisfaction in circumcised men: previous findings and future directions—comment on Bossio and Pukall (2017). *Arch Sex Behav*, *47*(5), 1319–1320; Johnsdotter, S. (2013). Discourses on sexual pleasure after genital modifications: the fallacy of genital determinism (a response to J. Steven Svoboda). *Global Discourse*, *3*, 256–265. For related discussions, see Earp, "Infant circumcision and adult penile sensitivity," op. cit. note 70; Adams, A., & Moyer, E. (2015). Sex is never the same: men's perspectives on refusing circumcision from an in-depth qualitative study in Kwaluseni, Swaziland. *Glob Public Health*, *10*(5–6), 721–738.

[76]Earp, B. D. (2015). Sex and circumcision. *Am J Bioeth*, *15*(2), 43–45.

[77]Fink, A. J. (1986). A possible explanation for heterosexual male infection with AIDS. *N Engl J Med*, *315*(18), 1167–1167.

[78]Siegfried, N., Muller, M., Volmink, J., et al. (2003). Male circumcision for prevention of heterosexual acquisition of HIV in men. *Cochrane Database of Systematic Reviews*, *3*, CD003362.

[79]Ibid.

[80]Garenne, M. (2008). Long-term population effect of male circumcision in generalised HIV epidemics in sub-Saharan Africa. *Afr J AIDS Res*, *7*(1), 1–8, p. 5.

[81]Auvert, B. (2005). Randomized clinical trial shows male circumcision has great potential to curb HIV infections in Africa. (M. Wainberg, interviewer). *Medscape*. Retrieved July 27, 2015 from http://www.medscape.org/viewarticle/509662.

[82]Auvert, et al., op. cit. note 1, Suppl. 3.

control groups who, as the researchers presumed, might engage in risky sexual behavior that would lead to HIV infection. Across the three trials, the intervention groups had an average HIV incidence of 1.18% versus 2.49% in the control groups, with relative risk reductions reported from male circumcision ranging from 50%–60%.[83] The trial methodology and relative consistency of findings across the female-to-male trials were characterized as "strong evidence" for the protective effect of circumcision in a subsequent Cochrane review.[84] However, critics alleged that the trials shared the same biases,[85] "which led to nearly identical results."[86]

Earlier, we mentioned a subsequent male-to-female HIV transmission trial in Uganda, carried out by the Rakai team at Johns Hopkins University. This trial might be characterized as "buried" in the sense that it is much less commonly cited by VMMC proponents.[87] One potential reason for this relative reticence is that the trial had to be stopped early for "futility" after partners of newly circumcised men became infected at a 55% higher rate.[88] The cumulative probability of HIV infection among these women at 24 months was 21.7% versus 13.4% in the control group,[89] translating to a 62% relative risk *increase* to women following male circumcision.

A later Cochrane review accepted the three "successful" female-to-male trial findings alone as evidence of a 38%–66% protective effect of male circumcision for men over two years,[90] and both the perceived urgency of the HIV crisis and novelty of a biomedical solution led to the commencement of VMMC roll-out planning before the Ugandan and Kenyan trials had reached publication.[91] Giami and colleagues provide a timeline of the policy research and discussions leading to and resulting from the WHO/UNAIDS recommendation on VMMC, noting, "There was no mention of the contradictory findings that had been published, nor of a scientific controversy."[92] Instead, contrary voices were largely excluded, "as if the decision had already been made."[93]

The involvement of African communities was limited. As Abdullahi Ahmed An-Na'im has pointed out, because of the influence of Western hegemony on elites within the Global South, "it is misleading to assume genuine representation of popular perceptions and attitudes [in] our countries from the formal participation of 'our delegates' [in] international fora."[94] At the WHO/UNAIDS technical consultation that resulted in the recommendation to roll out VMMC, African representatives accounted for only one-third of those in attendance, and their role was "advisory, not actual decision-making. Nearly all the papers presented came from researchers or representatives of institutions in the Global North."[95]

The current paradigm has also been criticized for failing to take cultural variance and other contextual variables sufficiently into account. In their introduction to a special double issue of *Global Public Health* on VMMC, Richard Parker and colleagues argue that "it would be naive to think" that VMMC or other "supposedly simple medical interventions" could be successfully implemented

[83]Auvert, et al., Gray, et al., Bailey, et al. op. cit., note 1.

[84]Siegfried, N., Muller, M., Deeks, J. J., & Volmink, J. (2009). Male circumcision for prevention of heterosexual acquisition of HIV in men. *Cochrane Database of Systematic Reviews*, *2*, 1465–1858.

[85]Methodological biases alleged across the female-to-male trials include participant expectation bias (lack of double-blinding and lack of placebo control), selection bias, attrition bias, lead-time bias, duration bias (i.e. early termination), potentially confounding behavioral counseling, and failure to trace sources of infections (Boyle, G. J., & Hill, G. (2011). Sub-Saharan African randomised clinical trials into male circumcision and HIV transmission: Methodological, ethical and legal concerns. *J Law Med*, *19*(2), 316 [for a response, see Wamai, R. G., Morris, B. J., Waskett, J. H., Green, E. C., Banerjee, J., Bailey, R. C., … Hankins, C. A. (2012). Criticisms of African trials fail to withstand scrutiny: Male circumcision does prevent HIV infection. *J Law Med*, *20*(1), 93]; Collier, R. (2012). The studies that launched a thousand snips. *CMAJ 184*(1), E37–E38; Dowsett, G. W., & Couch, M. (2007). Male circumcision and HIV prevention: Is there really enough of the right kind of evidence? *Reprod Health Matters*, *15*(29), 33–44; Green, L. W., McAllister, R. G., Peterson, K. W., & Travis, J. W. (2008). Male circumcision is not the HIV 'vaccine' we have been waiting for! *Future HIV Therapy*, *2*(3), 193–199 [for a response, see Wamai, R. G., Weiss, H. A., Hankins, C., Agot, K., Karim, Q. A., Shisana, O., … & Cash, R. (2008). Male circumcision is an efficacious, lasting and cost-effective strategy for combating HIV in high-prevalence AIDS epidemics. *Future HIV Therapy*, *2*(5), 399-405]; Van Howe, R. S., & Storms, M. R. (2011). How the circumcision solution in Africa will increase HIV infections. *J Public Health Afr*, *2*(1), 11–15, p.11 [for a response, see Morris, B. J., Waskett, J. H., Gray, R. H., Halperin, D. T., Wamai, R., Auvert, B., & Klausner, K. D. (2011). Exposé of misleading claims that male circumcision will increase HIV infections in Africa. *J Public Health Afr 2*(2), e28]). Representing the German Pediatric Society (BVKJ) at a multi-national press conference calling for an end to VMMC policy, Ulrich Fegeler characterized the trials as "scientifically as holey as Swiss cheese" (Fish, M. (2019). Circumcision Campaigns: African opposition and human rights [UN report]. The VMMC Experience Project. Retrieved Jan 3, 2019 from https://vmmcproject.org/un-report, p. 85).

[86]Van Howe & Storms, op. cit. note 85.

[87]Indeed, in a recent press release "doubling down" on VMMC, the WHO prominently cites only the female-to-male trials, with no mention of the male-to-female trial. WHO (2020, 21 August). Preventing HIV in high HIV burden settings through voluntary medical male circumcision. WHO News Room. Retrieved Aug 30, 2020 from https://www.who.int/news-room/detail/21-08-2020-preventing-hiv-in-high-hiv-burden-settings-through-voluntary-medical-male-circumcision. Moreover, a Google Scholar search conducted on August 30, 2020 shows that the male-to-female trial has been cited 351 times in total, compared to 2,933, 2,659, and 2,259 citations for the South African, Ugandan, and Kenyan female-to-male trials, respectively.

[88]Wawer, et al., op. cit. note 66. VMMC proponents typically argue that this surprising result was likely due to early resumption of sex by the circumcised men (i.e., during wound healing), and they urge that men should be counseled to wait until healing is complete. But men in the trial *were* counseled to wait until wound healing was complete, and yet, "consistent condom use was uncommon at enrolment [and] still quite low at 24 months (50% in the intervention group and 36% in the control group), despite repeated health education and the provision of free supplies" (p. 236). If VMMC led to increased transmission of HIV to female partners under relatively ideal trial conditions, with "repeated health education [and] free supplies," it is unclear why VMMC proponents remain sanguine about better prospects for effectiveness under real-world conditions.

[89]Ibid. Risk compensation beliefs and/or behaviors among women are identified in Andersson, N., & Cockcroft, A. (2012). Male circumcision, attitudes to HIV prevention and HIV status: a cross-sectional study in Botswana, Namibia and Swaziland. *AIDS Care 24*(3), 301–309; Haberland, N. A., Kelly, C. A., Mulenga, D. M., Mensch, B. S., & Hewett, P. C. (2016). Women's perceptions and misperceptions of male circumcision: a mixed methods study in Zambia. *PLOS ONE 11*(3), e0149517; Kalichman, S., Mathews, C., Kalichman, M., Eaton, L. A., & Nkoko, K. (2018). Male circumcision for HIV prevention: awareness, risk compensation, and risk perceptions among South African women. *Glob Public Health 13*(11), 1682–1690; Greevy, C., King, R., & Haffejee, F. (2018). Male circumcision for HIV prevention: female risk compensatory behaviour in South Africa. *AIDS Care*, 30(9), 1083-1089; Kapumba, B. M., & King, R. (2019). Perceived HIV-protective benefits of male circumcision: risk compensatory behaviour among women in Malawi. *PLOS ONE*, *14*(2), e0211015; Maughan-Brown, B., & Venkataramani, A. S. (2012). Learning that circumcision is protective against HIV: risk compensation among men and women in Cape Town, South Africa. *PLOS ONE 7*(7), e40753; Ledikwe, J. H., Mawandia, S., Kleinman, N. J., Ntsuape, C., Ramabu, N. M., Semo, B. W., & Wirth, K. E. (2020). Voluntary medical male circumcision and perceived sexual functioning, satisfaction, and risk behavior: a qualitative study in Botswana. *Arch Sex Behav*, [epub ahead of print].

[90]Siegfried, et al., op. cit. note 84.

[91]Giami, et al., op. cit. note 60.

[92]Ibid: 600.

[93]Ibid: 589.

[94]An-Na'im, A. A. (1995). Conclusion. In A. A. An-Na'im (Ed.), *Human Rights in Cross-Cultural Perspectives: A Quest for Consensus* (pp. 427–435). Philadelphia: University of Pennsylvania Press, p. 133.

[95]Giami, et al., op. cit. note 60, p. 600.

> … without consideration of the meanings they carry to people and the social context in which they are implemented – a fact that many of their proponents understand and respect, but sometimes choose to downplay in order to highlight how their supposed simplicity makes them superior to seemingly more complex and less efficacious alternatives. This simplification … carries serious risks, since it tends to silence and even erase a concern with, and understanding of, the wide range of social, cultural, economic and political factors that need to be engaged in order to successfully implement such approaches in the real world.[96]

Consistent with this concern, VMMC policymakers prioritized the internal validity of the studies in arguing for a protective effect of male circumcision,[97] hypothesizing that an unknown biological mechanism would ensure real-world effectiveness, leading to "attempts to generalize the results of the circumcision [trials] to novel contexts via appeals to the foreskin's biomolecular susceptibility."[98] That is, VMMC proponents began to argue that simply having a foreskin should be "effectively considered a pre-disease state defined in relation to HIV risk."[99] Yet this neglects the more complex social and epidemiological reality that five VMMC target countries had higher HIV prevalence rates among circumcised than uncircumcised men at the start of the campaign; this was the case for 10 of 18 countries surveyed.[100] As Kirsten Bell argues, researchers should be on guard against a biomedical mindset in which "culture, meaning and context are irrelevant."[101]

The upshot of such a mindset is this: rather than adapting a potentially useful intervention to the contexts in which it might offer most benefit, and cautiously adjudicating its real-world suitability, the trials produced a mythology around VMMC which has instead required that the contexts of application be themselves adapted. In other words, the "real-world" setting is constructed and refashioned, rather than encountered and adapted to.[102] The environment in which VMMC takes place is accordingly modified, and the overall cultural, epistemic, and infrastructural transformation (which may be considered a form of imperialism) becomes much broader than that of the action of circumcision alone:

> The guidelines and tools produced by WHO aim to standardise the action, which requires the standardisation of techniques, tools, organisation, and behaviour, and more generally the standardisation of the environment: laws must be written to provide a legal justification for circumcision, well-known figures must engage in advocacy designed and adapted for specific populations, the entire health system must be restructured, roles and tasks within the health system must be redefined.[103]

Furthermore, qualitative studies into men's resistance were designed not to understand the cultural barriers in their own right, but to inform VMMC promotion strategies for getting around them.[104] This approach mirrors prior "acceptability" studies in failing to give weight to participants' reasons for disfavoring circumcision,[105] effectively minimizing subjects' perspectives and input in the regime. Within this literature, African cultural traditions were identified among the "main barriers" to the rolling out of mass circumcision in Zambia.[106]

[96]Parker, R., Aggleton, P., & de Camargo Jr, K. R. (2015). Circumcision and HIV prevention: emerging debates in science, policies and programmes. *Glob Public Health*, *10*(5–6), 549.

[97]Giami et al., op. cit.note 60.

[98]Norton, A. T. (2017). Foreskin and the molecular politics of risk. *Soc Stud Sci*, *47*, 655–680, p. 4.

[99]Ibid: 5.

[100]Mishra, V., Medley, A., Hong, R., Gu, Y., & Robey, B. (2009). *Levels and Spread of HIV Seroprevalence and Associated Factors: Evidence from National Household Surveys*. USAID report. Calverton, NY: Macro International, Inc.

[101]Bell, K. (2012). Cochrane reviews and the behavioural turn in evidence-based medicine. *Health Soc Rev*, *21*(3), 313–321, p. 318.

[102]Brives, C. (2018). The myth of a naturalised male circumcision: heuristic context and the production of scientific objects. *Glob Public Health*, *13*(11), 1599–1611.

[103]Ibid: 1607.

[104]Downs, J. A., Fuunay, L. D., Fuunay, M., Mbago, M., Mwakisole, A., Peck, R. N., & Downs, D. J. (2013). 'The body we leave behind': a qualitative study of obstacles and opportunities for increasing uptake of male circumcision among Tanzanian Christians. *BMJ Open*, *3*(5), e002802; Evens, E., Lanham, M., Hart, C., Loolpapit, M., Oguma, I., & Obiero, W. (2014). Identifying and addressing barriers to uptake of voluntary medical male circumcision in Nyanza, Kenya among men 18–35: a qualitative study. *PLOS ONE*, *9*(6), e98221; George, G., Strauss, M., Chirawu, P., Rhodes, B., Frohlich, J., Montague, C., & Govender, K. (2014). Barriers and facilitators to the uptake of voluntary medical male circumcision (VMMC) among adolescent boys in KwaZulu–Natal, South Africa. *Afr J AIDS Res*, *13*(2), 179–187; Humphries, H., van Rooyen, H., Knight, L., Barnabas, R., & Celum, C. (2015). 'If you are circumcised, you are the best': understandings and perceptions of voluntary medical male circumcision among men from KwaZulu-Natal, South Africa. *Cult Health Sex*, *17*(7), 920–931; Macintyre, K., Andrinopoulos, K., Moses, N., Bornstein, M., Ochieng, A., Peacock, E., & Bertrand, J. (2014). Attitudes, perceptions and potential uptake of male circumcision among older men in Turkana County, Kenya using qualitative methods. *PLOS ONE*, *9*(5), e83998; Moyo, S., Mhloyi, M., Chevo, T., & Rusinga, O. (2015). Men's attitudes: a hindrance to the demand for voluntary medical male circumcision–a qualitative study in rural Mhondoro-Ngezi, Zimbabwe. *Glob Public Health*, *10*(5–6), 708–720; Nyaga, E. M., Mbugua, G. G., Muthami, L., & Gikunju, J. K. (2014). Factors influencing voluntary medical male circumcision among men aged 18-50 years in Kibera Division. *East Afr Med J*, *91*(11), 407–413; Osaki, H., Mshana, G., Wambura, M., Grund, J., Neke, N., Kuringe, E., … Weiss, H. (2015). "If you are not circumcised, I cannot say yes": the role of women in promoting the uptake of voluntary medical male circumcision in Tanzania. *PLOS ONE*, *10*(9), e0139009; Price, J. E., Phiri, L., Mulenga, D., Hewett, P. C., Topp, S. M., Shiliya, N., & Hatzold, K. (2014). Behavior change pathways to voluntary medical male circumcision: narrative interviews with circumcision clients in Zambia. *PLOS ONE*, *9*(11), e111602; Rupfutse, M., Tshuma, C., Tshimanga, M., Gombe, N., Bangure, D., & Wellington, M. (2014). Factors associated with uptake of voluntary medical male circumcision, Mazowe District, Zimbabwe, 2014. *Pan Afr Med J*, *19*; Sabone, M., Magowe, M., Busang, L., Moalosi, J., Binagwa, B., & Mwambona, J. (2013). Impediments for the uptake of the Botswana government's male circumcision initiative for HIV prevention. *Sci World J*, *2013*(387508), 1-7.

[105]Bailey, R., Opeya, C., Ayieko, B., Kawango, A., Onyango, M., Moses, S., & Krieger, J. (2004, July). Adult male circumcision in Kenya: safety and patient satisfaction. Paper presented at the International AIDS Conference, Bangkok; Kebaabetswe, P., Lockman, S., Mogwe, S., Mandevu, R., Thior, I., Essex, M., & Shapiro, R. L. (2003). Male circumcision: an acceptable strategy for HIV prevention in Botswana. *Sex Trans Infect*, 79, 214–219; Lukobo, M. D., & Bailey, R. C. (2007). Acceptability of male circumcision for prevention of HIV infection in Zambia. *AIDS Care*, *19*(4), 471–477; Tarimo, E. A., Francis, J. M., Kakoko, D., Munseri, P., Bakari, M., & Sandstrom, E. (2012). The perceptions on male circumcision as a preventive measure against HIV infection and considerations in scaling up of the services: a qualitative study among police officers in Dar es Salaam, Tanzania. *BMC Public Health*, *12*(1), 529; Westercamp, M., Agot, K. E., Ndinya-Achola, J., & Bailey, R. C. (2012). Circumcision preference among women and uncircumcised men prior to scale-up of male circumcision for HIV prevention in Kisumu, Kenya. *AIDS Care*, *24*(2), 157–166.

[106]Lukobo & Bailey, op. cit. note 105.

Further, policy-motivated studies may "imbue willingness to be circumcised with a sense of ethical obligation,"[107] in that men are encouraged to imagine themselves within a new binary risk category by virtue of having a foreskin. Such methodology fails to consider men's voluntariness on their own terms, within the complex personal and sociocultural contexts that underpin their very identity. Botswana's primary acceptability study indicated a favorable local reception to VMMC,[108] but community responses to its actual implementation, including suboptimal uptake and perceived insult to traditional initiation rites and social norms, indicate a lack of acceptability: "'Disgusted' and 'Frustrated' were the terms uttered by the traditional leaders."[109]

The inclusion of African men and women in decision making regarding their own bodies, cultures, and health was—and remains—overshadowed by a Western hegemonic model promising HIV reduction to African men through circumcision.

4 | VMMC THROUGH A COLONIAL LENS

4.1 | Cultural conversion

The first trial publication on male circumcision for HIV prevention in South Africa begins with a paragraph not on the potential medical benefits of the procedure, but on male circumcision's venerability on cultural and religious grounds.[110] "Genesis (17:11) places the origin of the rite among the Jews in the age of Abraham," Auvert and colleagues state.[111] Indeed, medical justifications for male circumcision are relatively recent, and medicalized circumcision accounts for only a minority of instances of the practice globally.[112] It is primarily a cultural practice, and has accordingly become a point of tension where cultures collide. This can be seen in its use within campaigns of cultural imperialism, either as a practice to be enforced or discouraged.

Among various African groups, male and female genital cutting rites were widespread prior to the arrival of colonial-era missionaries, who described the practices as barbaric and un-Christian, and spearheaded their abandonment.[113] Ironically, some regions in which circumcision was once suppressed fall within modern states in which VMMC programs now operate. Modern Botswana is a priority country for VMMC, but barriers to its uptake include its perceived incompatibility with Christianity and its association with "backward values," which is precisely the line once peddled by colonizers.[114] In the opposite direction, male circumcision has long been imposed by powerful groups onto marginalized ones.[115] In Kenya, a tradition of forcible circumcisions of non-circumcising Luo tribal minorities is longstanding.[116]

Within an African tribal context, a circumcision intervention can never be strictly medical; it requires either cultural compliance or cultural conversion. A payout from the U.S. Agency for International Development (USAID) to the Luo leadership to "accept" VMMC against their deeply held cultural beliefs remains sealed from public record, but a local oral history of its aftermath reports intra-tribal tensions and damage, including the ousting of Riaga Ogallo, head of the Council of Elders who had refused the payout, along with centuries of tradition.[117] VMMC's social impact, too, cannot be divorced from tribal politics. Since the policy was rolled out in Kenya, members of the Kikuyu ruling elite have drafted bills to make male circumcision mandatory at both county and national levels, citing the "cowardly and childish" nature of Luos[118] and perceptions of their foreskins as inherently pathogenic and disgraceful to Kenyan nationalism.[119] Following the 2017 presidential election, a Kikuyu member of Parliament rallied support in threatening to forcibly circumcise losing candidate Raila Odinga and his Luo constituents with scissors.[120] As a Kikuyu bishop alleged: "When the Westernites imposed [VMMC] on us, it is like they empowered the evils, the most separations between the tribes."[121] Conversely, non-circumcising tribal minority parents have reported feelings of cultural erosion and identity loss following the circumcision of their children by U.S. government agencies, a number of which are reported to have occurred through school programs without their knowledge or consent.[122]

Local government opposition, too, has been marginalized. In Lesotho, where Demographic and Health Survey data showed that HIV prevalence was 31% higher in men who were circumcised, state actors

[107]Norton, A. T. (2013). Surveying risk subjects: public health surveys as instruments of biomedicalization. *BioSocieties*, *8*(3), 265–288, p. 265.

[108]Kebaabetswe et al., op. cit. note 105.

[109]Katisi & Daniel, op. cit. note 12, p. 752.

[110]Auvert, et al., op. cit. note 1.

[111]Ibid.

[112]Gollaher, op. cit. note 13.

[113]Bulled, op. cit. note 12; Muraya, M. W. (2015). Mau Mau War, female circumcision and social-cultural identity among the Agikuyu of Kiambu, Kenya. *Int J Cult Hist*, *2*(2), 26-45; Upton, R. L. (2018). Illness and healing: Africanist anthropology. In: R. R. Grinker, S. C. Lubkemann, C. B. Steiner, & E. Gonçalves (eds.), *A Companion to the Anthropology of Africa* (pp. 97-117), New York: John Wiley & Sons; Yusuf, C., & Fessha, Y. (2013). Female genital mutilation as a human rights issue: examining the effectiveness of the law against female genital mutilation in Tanzania. *Afr Hum Rts L J*, *13*(2), 356–382.

[114]Upton, op. cit. note 113.

[115]Aggleton, op. cit. note 4.

[116]Glass, M. (2014). Forced circumcision of men (abridged). *J Med Ethics*, *40*(8), 567–571; Lamont, M. (2018). Forced male circumcision and the politics of foreskin in Kenya. *Afr Stud*, *77*(2), 293–311.

[117]Owino, K. (2019, April 15). "Circumcision is not a noble decision": the late Ker Riaga Ogallo recalled the political struggle against VMMC [Blog post]. Retrieved Jan 3, 2019 from https://www.vmmcproject.org/2019/04/15/circumcision-is-not-a-noble-decision.

[118]Kanyotu, J. (2019, October 21). Cate Waruguru proposes bill to make circumcision compulsory. *Kenya Updates*. Retrieved Jan 2, 2020 from https://updates.co.ke/cate-waruguru-proposes-bill-to-make-circumcision-compulsory.

[119]Ibid; Aluru, L. (2013, October 2). Siaya County seeks forced male "cut" law. *The Standard*. Retrieved Jan 2, 2020 from https://www.standardmedia.co.ke/article/2000094743/siaya-county-seeks-forced-male-cut-law.

[120]GHAFLA 254 Blog. (2017, September 8). Moses kuria [*sic*] wants to circumcise Raila Odinga with scissors [Video file]. Retrieved Jan 3, 2020 from https://youtu.be/JKn9gN2M1Os.

[121]Fish, op. cit. note 85, p. 30.

[122]Fish, op. cit. note 85; see also Luseno, W. K., Field, S. H., Iritani, B. J., et al. (2019). Consent challenges and psychosocial distress in the scale-up of voluntary medical male circumcision among adolescents in western Kenya. *AIDS Behav 23*(12), 3460–3470.

positioned their initial resistance to the intervention as an informed response to national population-level data.[123] National resistance in Lesotho was "not in an effort to reassert local or indigenous knowledge, but rather to negotiate for a shared position of authority within current global public health structures."[124] Subsequently, the dismissal of local government opposition reflects "inherent inequality and the limitations for meaningful involvement of those on the margins of global society."[125]

Failure to pay due attention to the varied existence and complex meanings and effects of circumcision among different African ethnic groups is endemic in Western VMMC policymaking. In response to a study finding higher HIV prevalence among medically circumcised older men in Mpumalanga Province, South Africa,[126] former chief epidemiologist for HIV prevention at the CDC, Peter Kilmarx, defended the intervention by claiming that no apologies were needed "for the many, many thousands of HIV infections we have prevented making safe, voluntary medical male circumcision more widely available in Africa where traditional circumcision is already widely practiced as a local custom."[127] This statement is concerning for two reasons.

First, there is growing evidence that many circumcisions performed through the VMMC program have been neither safe nor voluntary. The CDC's own reporting has identified safety issues up to and including VMMC-related tetanus infections and deaths,[128] and a growing concern in the literature is that false beliefs surrounding HIV protection from male circumcision (e.g., that one becomes low-risk or even "immune" to the virus) may be associated with increases in HIV burdens in some regions.[129] In early 2020, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) suspended funding for circumcisions on children below the age of 15—who had previously comprised nearly half of all VMMCs[130]—on the basis of unacceptably high rates of reported adverse events among this age group.[131] Although participation is purportedly voluntary,[132] various enticements including money and food vouchers are allocated to pressure impoverished men,[133] and a recent report has documented U.S. government-funded circumcisions of non-consenting minors without even parental permission, estimating >35,000 of these illegal cases between 2013 and 2016 in one region of Kenya alone.[134] Other reports raise concerns of coercion and a lack of informed consent from those who have found themselves on the receiving end of ambitious circumcision quotas,[135] with some involuntary participants endorsing perceptions of the experience as a human rights violation.[136]

Second, so-called "traditional" circumcision is not a generic "local custom" in Africa. In praising the way in which VMMC campaigns make circumcision more "widely available," Kilmarx falsely implies that Africans, *qua* Africans, have a general preference for circumcision, thwarted only by its availability. This remark not only homogenizes African cultures; it neglects the fact that VMMC campaigns have targeted particular groups precisely on the basis that they did *not* traditionally embrace circumcision.

Not only does the public health discourse around VMMC generally fail to acknowledge African cultural heterogeneity and nuance—and the significance of these factors for the associated campaigns—there is little recognition of the extent to which VMMC is *itself* an instance of cultural imperialism. Among the Global North, it is only the United States that practices routine, non-religious circumcision as a majority custom.[137] VMMC is canvassed by the U.S.-led public health community, and its main target is Africans from traditionally non-circumcising groups. If the significance of power and history are lost on champions of these programs, they are at the forefront of target communities' objections. As one local leader put it: "[W]e have thought the Ministry of Health was going to help us [but they] insult us. They should respect our culture and not confuse it. Go and tell them to come and talk to our chief."[138]

4.2 | Competing normalities

Rather than promoting a "neutral" HIV prevention measure, VMMC donors may be funding what is in effect a significant cultural

[123] Bulled, 2015, op. cit. note 12.

[124] Ibid: 766.

[125] Ibid: 766.

[126] Rosenberg, M. S., Gómez-Olivé, F. X., Rohr, J. K., Kahn, K., & Bärnighausen, T. W. (2018). Are circumcised men safer sex partners? Findings from the HAALSI cohort in rural South Africa. *PLOS ONE*, *13*(8), e0201445.

[127] Kilmarx, P. H. (2019, November 12). No apologies. *Twitter*. https://twitter.com/PeterKilmarx/status/1194237482767912966?s=20.

[128] Grund, J. M., Toledo, C., Davis, S. M., et al. (2016). Tetanus cases after voluntary medical male circumcision for HIV prevention — eastern and southern Africa, 2012-2015. *MMWR Morb Wkly Rep 65*, 36–37.

[129] Garenne, M., & Matthews, A. (2019). Voluntary medical male circumcision and HIV in Zambia: expectations and observations. *J Biosoc Sci*, *14*, 1–13; Kim, H. B., Pop-eleches, C., Jung, J., & Kim, B. (2018, November 10). Male circumcision, peer effects, and risk compensation. Paper presented at the APPAM Fall Research Conference, Washington, D.C.; Rosenberg, M. S., et al., op. cit., note 126. Local community experiences and concerns, including both individual HIV infections and prevalence increases attributed to participation in VMMC programmes, are presented in Fish, op. cit., note 85, Section 3.

[130] Davis, S. M., Hines, J. Z., Habel, M., Grund, J. M., Ridzon, R., Baack, B., ... Toledo, C. (2018). Progress in voluntary medical male circumcision for HIV prevention supported by the US President's Emergency Plan for AIDS Relief through 2017: longitudinal and recent cross-sectional programme data. *BMJ Open 8*(8), e021835.

[131] PEPFAR. (2019). PEPFAR 2020 country operational plan guidance for all PEPFAR countries. PEPFAR. Retrieved July 16, 2020 from https://www.state.gov/wp-content/uploads/2019/11/2019-11-25-COP20-Guidance-Full-Consolidated_Public-2-1.pdf.

[132] Sidler, D., Earp, B. D., Van Niekerk, A. A., Moodley, K., & Kling, S. (2017). Correspondence: Targeting mothers and selling men what they do not want: a response to 'Missed opportunities for circumcision of boys'. *South Afr Med J*, *107*(4), 281.

[133] An overview of the eight economic compensation trials for VMMC, including five randomized trials, is provided in Kennedy, C. E., Yeh. P. T., Atkins, K., Fonner, V. A., Sweat, M. D., O'Reilly, K. R., ... Samuelson, J. (2020). Economic compensation interventions to increase uptake of voluntary medical male circumcision for HIV prevention: a systematic review and meta-analysis. *PLOS ONE*, *15*(1), e0227623.

[134] Luseno, et al., op. cit. note 122.

[135] Gilbertson, A., Ongili, B., Odongo, F. S., Hallfors, D. D., Rennie, S., Kwaro, D., & Luseno, W. K. (2019). Voluntary medical male circumcision for HIV prevention among adolescents in Kenya: unintended consequences of pursuing service-delivery targets. *PLOS ONE*, *14*(11), e0224548.

[136] Fish, op. cit. note 85.

[137] Earp, B. D., & Shaw, D. M. (2017). Cultural bias in American medicine: the case of infant male circumcision. *J Pediatr Ethics*, *1*(1), 8–26; World Health Organization. (2008). *Male Circumcision: Global Trends and Determinants of Prevalence, Safety and Acceptability* (No. UNAIDS/07.29 E/JC1320E). Geneva: World Health Organization.

[138] Katisi & Daniel, op. cit. note 12, p. 748.

crusade. The intention to overwrite local cultural norms is explicit, and is epitomized by a study examining barriers to VMMC among older men in a setting where circumcision has been taboo for centuries, in which the authors suggest that "[m]essaging should focus on the normality of the circumcised penis."[139] Consider that cultural imperialism is precisely this: the imposition of a more dominant conception of normality. Accordingly, VMMC policymakers have opted in many cases to focus on engineering social norms. International HIV/AIDS relief funding has been allocated to circumcise already HIV-positive men because, in the words of one advocate, "[y]ou don't want to be the only guy on the block who hasn't been circumcised."[140] This is an attempt to contrive a new bodily norm which plays on, or produces, anxieties about masculinity and sexual acceptability, factors which have been identified as important for men seeking VMMC.[141]

This strategy is underwritten by a study which concluded that demand creation messages "should emphasize non-HIV prevention benefits, such as improved hygiene and sexual appeal."[142] Subsequently, Brothers for Life, a subsidiary of Johns Hopkins University, released a television advert marketing VMMC to South African women as "an upgrade down there."[143] Sarah Rudrum analyzed 30 VMMC campaign posters from 12 target countries and found "a paucity of HIV-related information,"[144] noting an "anything-goes" demand creation approach in which the HIV-preventive purpose was often sidelined by other purported benefits to circumcision including masculine comradery, improved sexual attractiveness and cleanliness, and prevention of cervical cancer in women. She further cautioned that some of the campaigns "tended to reify gender inequality, the objectification of women, and sexual conquest as an expression of masculinity – norms that contribute to the epidemic,"[145] a concern raised elsewhere.[146] Such marketing of VMMC also has been criticized by tribal elders who are respected as custodians of tradition. Katisi and Daniel found that Bakgatla elders viewed the sexualization of male circumcision for demand creation purposes "as disgusting and conflicting with culture."[147]

Such propagation techniques are consistent with the Global North's dismissal of traditional African values and social norms, often based on misinformed stereotypes. Efforts to eradicate (all forms of) traditional female genital cutting (FGC), frequently overlapping with VMMC target regions,[148] have occurred at the expense of, and with indifference to, local women who reject the characterization of their bodies as "mutilated"[149] and the intrinsic implications[150] of cultural inferiority.[151] In turn, Western actors seeking to criminalize ritual FGC have invoked imageries of African barbarism in order to prevent the practices from entering Western countries and to distinguish them from culturally palatable female genital "cosmetic" surgeries such as labiaplasty (increasingly performed on white Western minors).[152] Failing to recognize that wherever ritual FGC occurs, so too does ritual male circumcision, usually in a parallel initiation process serving similar social functions and with overlapping consequences for health and sexuality,[153] these same Westerners compare apples to oranges:

> they tend to think of the most extreme forms of female genital cutting, done in the least sterilized environments, with the most drastic consequences likeliest to follow [while simultaneously thinking of] the *least* severe forms of male genital cutting, done in the most sterilized environments, with the least drastic consequences likeliest to follow, largely because this is the form with which they are culturally familiar.[154]

[139]Macintyre, et al., op. cit. note 104, p. 6.

[140]Wawer, M. (2008, February 8). CROI: Circumcising HIV-pos men doesn't block transmission (M. Smith, interviewer). *MedPage Today*. Retrieved Jan 2, 2020 from https://youtu.be/MCRh1Q69Ry4.

[141]Humphries, et al., op. cit. note 104.

[142]Hatzold, K., Mavhu, W., Jasi, P., Chatora, K., Cowan, F. M., Taruberekera, N., … Njeuhmeli, E. (2014). Barriers and motivators to voluntary medical male circumcision uptake among different age groups of men in Zimbabwe: results from a mixed methods study. *PLOS ONE*, *9*(5), e85051.

[143]Brothers for Life SA. (2015, February 7). Brothers for Life – "ZING" MMC Campaign [Video file]. Retrieved Jan 3, 2020 from https://youtu.be/8k0wWqtHLyA.

[144]Rudrum, op. cit. note 9, p. 9.

[145]Ibid: 6.

[146]Fleming, P. J., Lee, J. G., & Dworkin, S. L. (2014). "Real men don't": constructions of masculinity and inadvertent harm in public health interventions. *Am J Public Health 104*(6), 1029–1035; Rudrum. et al., "Discourses of masculinity," op. cit. note 10.

[147]Katisi & Daniel, op. cit. note 12, p. 749.

[148]Ahmadu, F., Ahmadu, S., & Finoh, S. (2009, February 21). Statement by African Women Are Free to Choose (AWA-FC), Washington, D.C. Retrieved July 2, 2020 from http://www.thepatrioticvanguard.com/statement-by-african-women-are-free-to-choose-awa-fc-washington-dc-usa.

[149]Ibid; Earp, B. D. (2019). Mutilation or enhancement? What is morally at stake in body alterations? *Practical Ethics*. Retrieved July 17, 2020 from http://blog.practicalethics.ox.ac.uk/2019/12/mutilation-or-enhancement-what-is-morally-at-stake-in-body-alterations.

[150]Earp, B. D. (2016). Between moral relativism and moral hypocrisy: reframing the debate on "FGM." *Kennedy Inst Ethics J*, *26*(2), 105–144; Muthoni, K. (2019, January 4). Why doctor wants FGM ban lifted. *The Standard*. Retrieved July 2, 2020 from https://standardmedia.co.ke/health/article/2001264973/doctor-fight-to-legalize-fgm.

[151]Women from FGC-practicing communities "regularly report believing that modified genitalia—in both males and females—are more hygienic, more civilized/respectable, and more esthetically appealing" (Earp, B. D. & Johnsdotter, S. (2020). Current critiques of the WHO policy on female genital mutilation. *International Journal of Impotence Research*, [epub ahead of print]).

[152]Bader, D. & Mottier, V. (2020). Femonationalism and populist politics: the case of the Swiss ban on female genital mutilation. *Nations and Nationalism*, [epub ahead of print]; Liao, L. M., Taghinejadi, N., & Creighton, S. M. (2012). An analysis of the content and clinical implications of online advertisements for female genital cosmetic surgery. *BMJ Open*, *2*(6), e001908.

[153]Public Policy Advisory Network on Female Genital Surgeries in Africa. (2012). Seven things to know about female genital surgeries in Africa. *Hastings Cent Rep*, *42*(6), 19–27; Leonard, L. (2000). Interpreting female genital cutting: moving beyond the impasse. *Annu Rev Sex Res*, *11*(1), 158–190.

[154]Earp, B. D. (2015). Female genital mutilation and male circumcision: toward an autonomy-based ethical framework. *Medicolegal Bioeth*, *5*, 89–104, p. 94.

From:
Date: Fri, Mar 13, 2015 at 6:22 AM
Subject: Re: Greetings
To: <@vmmcproject.org> wrote:

Challenge we are facing is water crisis and famine.we expect rains in April.
Have high hopes that funding for our project will come and stop this western propaganda on curcumcision.
Africa we are poor we need water,food,education,medicines,employment, not money for butchering Africans.
Thank you so much.

FIGURE 1 A personal email from a Kenyan man criticizing VMMC funding in light of a severe drought.

Consequently, Global North responses to male and female genital cutting, respectively, have relied on opposing views of what constitutes bodily integrity and normality,[155] but in both cases, the overpowering of African values and social norms is a precondition to establishing Western cultural dominance.[156] Male circumcision practices are to be medicalized and multiplied, their female analogs to be totally extinguished.

4.3 | Concerns from VMMC-targeted communities

For some communities subject to VMMC programs, concerns about cultural imperialism are plainly rooted in the West's history of colonialism. Those old enough to remember "boots on the ground" exploitation-style colonialism appear to be the most skeptical of VMMC, as captured incidentally in a qualitative study among Zimbabweans who resisted circumcision.[157] The study showed that men perceived circumcision as a threat to their masculinity, but also found that senior participants used terms such as "colonisation," "re-colonisation," and "political agenda" to describe the campaign. Even a respondent too young to have known Africa before decolonization was skeptical: "Who does not know that circumcision is a strategy of controlling African men's sexuality?"[158] Likewise, medical practitioners trained to deliver VMMC programs have expressed reservations. A nurse in Swaziland remarked, "Doesn't it seem a bit like colonial paternalism for a White American physician to advocate for cutting the foreskin of a Black African man's penis *for his own good?*"[159] In Swaziland, Alfred Adams and Eileen Moyer found that "the aggressive nature of the circumcision campaign exacerbated peoples' suspicions."[160] One man asked: "[W]ho is funding this whole thing? What are their motives?"[161] This sentiment was echoed rather strongly in a personal email from a Kenyan man during the 2015 drought: "We need water, food, education, medicines, employment, not money for butchering Africans" (see **Figure 1**).

So far, the involvement of African representatives in VMMC research seems to have only reified the problem of Western cultural imperialism. A locally organized qualitative study in Zimbabwe found that "circumcision is perceived as an alien culture or something for 'younger' men,"[162] but then concluded that "there is need to address the misconception that VMMC is for other cultures."[163] Stanzia Moyo and colleagues acknowledged that VMMC in Zimbabwe was equated with "political and ideological agendas of Western countries,"[164] but backpedaled by emphasizing "the need for key political and social leaders to actively dispel such notions."[165] A paper by a Ugandan epidemiologist working with the aforementioned Johns Hopkins Rakai Program—which conducts not only VMMCs but also wide-ranging circumcision experiments on rural men—went a step further in contemplating how to motivate hard-to-reach men to

[155]Moller, K. (2019). Male and female genital cutting: between the best interest of the child and genital mutilation. *Ox J Leg Stud*, [epub ahead of print]; Earp, B. D., Hendry, J., & Thomson, M. (2017). Reason and paradox in medical and family law: shaping children's bodies. *Med Law Rev*, *25*(4), 604-627; Earp, B. D. (2020). Why was the US ban on female genital mutilation ruled unconstitutional, and what does this have to do with male circumcision? *Ethics Med Public Health* [epub ahead of print]; Johnsdotter, S. (2018). Girls and boys as victims: asymmetries and dynamics in European public discourses on genital modifications in children. In M. Fusaschi & G. Cavatorta (eds.), *FGM/C: From Medicine to Critical Anthropology* (pp. 31–47), Turin: Meti Edizioni; Lunde, I. B., Hauge, M. I., Johansen, R. E. B., & Sagbakken, M. (2020). 'Why did I circumcise him?' Unexpected comparisons to male circumcision in a qualitative study on female genital cutting among Kurdish–Norwegians. *Ethnicities*, 1468796819896089; Shahvisi, A., & Earp, B. D. (2019). The law and ethics of female genital cutting. In S. Creighton & L.-M. Liao (eds.) *Female Genital Cosmetic Surgery: Solution to What Problem?* (pp. 58–71). Cambridge: Cambridge University Press; Tangwa, G. B. (1999). Circumcision: An African Point of View. In G. C. Denniston et al. (eds.), *Male and Female Circumcision* (pp. 183–193). Springer, Boston, MA; Tangwa, G. B. (2004). Bioethics, biotechnology and culture: a voice from the margins. *Dev World Bioeth*, *4*(2), 125–138; Van den Brink, M., & Tigchelaar, J. (2012). Shaping genitals, shaping perceptions: a frame analysis of male and female circumcision. *Netherlands Q Hum Rts*, *30*(4), 417–445.

[156]Oba, A. (2008). Female circumcision as female genital mutilation: human rights or cultural imperialism? *Global Jurist*, *8*(3), 1–38; Shweder, R. (2000). What about "female genital mutilation"? And why understanding culture matters in the first place. *Daedalus*, *129*(4), 209–232.

[157]Moyo, et al., op. cit. note 104.

[158]Moyo, et al., op. cit. note 104, p. 8.

[159]Mallinson, R. K., & Sibandze, B. T. (2018). HIV and male circumcision in Swaziland. In G. E. Dorman & M. de Chesnay (eds.), *Case Studies in Global Health Policy Nursing* (pp. 121-145). New York: NY, Springer Publications, p. 133.

[160]Adams & Moyer, op. cit. note 75, p. 732.

[161]Ibid.

[162]Chikutsa, A., & Maharaj, P. (2015). Social representations of male circumcision as prophylaxis against HIV/AIDS in Zimbabwe. *BMC Public Health*, *15*(1), 603, p. 1.

[163]Ibid: 8.

[164]Moyo, et al., op. cit. note 104, p. 11.

[165]Ibid.

"accept" the unwanted intervention.[166] The desire for increased status and visibility in an unequal global health system may create a perverse incentive for some people to perpetuate these very inequalities within their own communities, adding to Africa's powerlessness against VMMC as a form of cultural domination.

There remains a fundamental disconnect between the ambitions of Western programs in Africa and the sentiments within African communities. In a qualitative study aiming to understand and improve the informed consent process, Population Council researchers identified Zambian and Swazi parents who attempted to refuse the intervention as "gatekeepers" to the circumcision of their own sons.[167] Even after uncovering a slew of regretful testimonies and cultural contraindications surrounding VMMC in Swaziland—a country where HIV was already more prevalent among circumcised than uncircumcised men[168]—researchers concluded that VMMC "remains as one of the most important HIV interventions in Swaziland."[169] Rather than include them in decision-making, they suggested that "Swazis should be informed about the funding and why it is so important to promote the [VMMC] intervention" as decided by Western policymakers.[170] This paternalistic approach recognizes significant differences between African and Western interests in relation to circumcision, but reduces Africans' perspectives to a homogenous inconvenience.

The continued exclusion of Africans from substantive conversations about their own bodies has fomented suspicions about the VMMC campaign's true intentions. These suspicions have resulted in claims that the campaign is a Western "Trojan Horse" aimed at cultural erosion and control.[171] While numerous local sources including the Ugandan president[172] have implicated VMMC campaigns in rising HIV rates on the continent, little attention has been paid to the resulting colonial suspicions. In Swaziland, the U.S.-funded "cut and conquer" campaign has caused confusion in that it seems to suggest that once cut, a man has "conquered" HIV, or is subsequently free to "conquer" women, leading to beliefs that VMMC is actually a colonial campaign to infect Africans.[173] Interviews carried out by the VMMC Experience Project, an African-led grassroots coalition in rural Kenya and Uganda, confirm that some local men view VMMC as a device deployed by the Global North to recolonize and experiment on Africans. Reverend Casmiel Otieno from Kenya vocalized his suspicions thus: "The people from the West, I think they want to misuse the Africans because [Africans] are not informed, the lack of information in Africa. So they are using other methods to make sure that they use their tools to have a place where they can exercise their power."[174] Similarly, another clergyman from Kenya, Bishop Cleophas Matete, making reference to the continent's colonial past, argued, "Africa was targeted, and it is still being targeted. It is used as a continent to experiment. Should they introduce anything that is evil, they want to experiment in Africa. So I believe that the entire process of trying to test in Africa was wrong from the beginning, and I say no to it."[175]

The distrust of global health systems is rooted in the general distrust of colonial health systems, and seems justifiable given the parallels between the two. Both operate on the same paternalistic framework which casts the Global South as "the White Man's Burden."[176] Correspondingly, the Global North, much like the colonial state, acts as the "benevolent dictator," making decisions in the "best interests" of the Global South with insufficient regard for local or national sovereignty, the multiplicity of different peoples and interests, or the health priorities as conceived and experienced by communities themselves.[177] These similarities evoke traumatic memories of colonial brutality, marginalization, and experimentation.

5 | VMMC AND NEOCOLONIALISM

The Global North's enthusiasm for VMMC as a response to the HIV crisis in SSA reflects a preference among funders for one-off, permanent, generalizable solutions. VMMC is often praised by public health scholars for the fact that "its effectiveness does not rely on repeated and consistent behaviors."[178] Its independence from behavioral and structural changes is seen as a point in its favor, from which several related assumptions can be deduced.

First, there is the implicit belief that the behavior of African men with respect to safer sex practices is both irrational and unchangeable. The rise of VMMC was concurrent with many public health scholars and practitioners abandoning behavioral approaches to reducing HIV transmission in SSA, deeming them to be ineffective.[179] Those adopting this view note that despite aggressive, well-funded campaigns, condom-use remains low and concurrency of partners

[166] Serwadda, D. (2015). How to motivate hard-to-reach men to accept circumcision. *Lancet HIV*, *2*(5), e170–e171.

[167] Schenk, K. D., Friedland, B. A., Sheehy, M., Apicella, L., & Hewett, P. C. (2014). Making the cut: evidence-based lessons for improving the informed consent process for voluntary medical male circumcision in Swaziland and Zambia. *AIDS Edu Prevent*, *26*(2), 170–184.

[168] Mishra, et al., op. cit. note 100.

[169] Adams & Moyer, op. cit. note 75, p. 733.

[170] Ibid: 736.

[171] Katisi & Daniel, op. cit. note 12.

[172] At the 90-90-90 Campaign Launch in 2018, Ugandan President Yoweri Museveni cautioned attendees against a reversal of safe sex practices following circumcision for HIV prevention, and attributed the nation's coinciding 22% increase in HIV prevalence to the campaign itself. Prior to VMMC roll-out, Uganda had registered a 66% reduction in the national HIV prevalence, which the president attributed to safe sex messaging campaigns: Aine, B. (2018, October 20). Museveni castigates circumcision as away [*sic*] to prevent HIV/AIDS. *PML Daily*. Retrieved July 17, 2020 from http://www.pmldaily.com/news/2018/10/ museveni-castigates-circumcision-as-away-to-prevent-hiv-aids.html.

[173] Mallinson & Sibandze, op. cit. note 159.

[174] Fish, op. cit. note 85, p. 32.

[175] Ibid: 30.

[176] Easterly, W. R. (2006). *The White Man's Burden*. New York: Penguin.

[177] Shahvisi, A. (2019). Tropicality and abjection: What do we really mean by "Neglected Tropical Diseases"? *Dev World Bioeth 19*(4), 224–234.

[178] Ortblad, K. F., Bärnighausen, T., Chimbindi, N., Masters, S. H., Salomon, J. A., & Harling, G. (2018). Predictors of male circumcision incidence in a traditionally non-circumcising South African population-based cohort. *PLOS ONE*, *13*(12), e0209172, p. 2.

[179] Potts, M., Halperin, D. T., Kirby, D., Swidler, A., Marseille, E., Klausner, J. D., ... Walsh, J. (2008). Reassessing HIV prevention. *Science*, *320*(5877), 749–750.

high.[180] Within this literature, references to "risky behaviors" and "promiscuity" appear again and again, yet remain unanalyzed, implying that these behaviors are fixed, which is to say, inherent.[181] There is the implication of ungratefulness, of an unwillingness to be helped, of savagery. In light of this, the intensive promotion of the irreversible removal of an intimate, functional, culturally significant portion of the genitals in order to bring about a partial reduction of risk for men is deemed to be a reasonable and necessary last resort.

Second, there is the related assumption that interventions can be introduced and appraised independently of systemic, which is to say social, political, and economic considerations. Thus, the poverty of SSA, and of the Global South more generally, is treated as unconnected to the individual decisions of its peoples. Behavioral strategies have typically focused on raising awareness of HIV/AIDS, with the expectation that people should respond "rationally" and make "better" choices. Where this fails to happen, the "irrationality" or "backwardness" of Africans may be cited, which is seen to mandate a "last resort" surgical solution. This overly-simplistic model neglects the ways in which structural factors (such as the influence of poverty, gender, and social stigma) delimit the options available to individuals, and influence them into behaving in ways which may appear to be irrational to an observer with limited understanding of the socioeconomic context in which such individuals operate. For example, insisting on condom-use during transactional sex is not a rational choice for a woman whose survival is dependent on those earnings, and where greater sums are available for unprotected sex.[182] In these contexts, the stakes shift so that the risk of contracting HIV may seem less immediate and distressing than the more urgent concern of surviving,[183] a calculation whose logic is determined by economics rather than culture or essence.

Further, structural adjustment policies (SAPs) imposed by the World Bank and International Monetary Fund exacerbate HIV risk factors. SAPs have required market liberalization across sub-Saharan Africa in order to qualify for new loans or reduce interest rates on existing loans. This has had multiple effects which increase vulnerability to HIV/AIDS: the removal of food subsidies, increased rural-to-urban migration, reduced access to education, wage reduction, and unemployment.[184] They have also led to the decimation of healthcare systems, which, in conjunction with free trade agreements, have impeded access to HIV treatments for those affected.[185] SAPs have left Global South states diminished, and reliant on the assistance of a patchwork of rival NGOs in order to provide essential services. This has permitted Global North states to exercise control over the health agendas of Global South states by channeling urgently needed aid through NGOs in accordance with their own interests and priorities.[186,187]

VMMC, a public health campaign recommended by the WHO and UNAIDS, funded by U.S. government agencies, and implemented through various NGOs can, therefore, be located within the macro-neocolonial environment as another vehicle for Western geopolitical power. While in principle a state may reject recommendations or restrict the operations of a campaign or organization, in reality that power is very limited, not least because doing so endangers more general funding sources that are critical to the health of the population. In this way, VMMC campaigns offer Global North institutions a form of biopower over African subjects. They cement racist stereotypes about African sexuality while maintaining the West's image as benefactor and savior, and justify enduring forms of soft power in former colonies. The production of the African penis in the image of the ideal, "medically-enhanced" American penis mirrors the expectation that African cultures and economies will fall in line with the system on which the global supremacy of the West depends.

6 | CONCLUSION

Historically, medical male circumcision advocacy in the West has not been limited by culture, ethnicity, or race, although some of the more coercive proposals have indeed targeted poor and otherwise vulnerable "Negros."[188] And more broadly, poverty and systemic racism have made African and African American communities particularly susceptible to medical exploitation.[189] This is not the first time that Western circumcision advocates have turned their attention toward the allegedly "uncontrollable" sexuality of African and African American men,[190] nor is it the first time that they have proposed mass circumcision for this demographic.[191] A century after the first such proposals, the struggle to respond to HIV has given the "circumcision solution" a new lease on life in sub-Saharan Africa.

[180]Ibid.; Wamai, R. G., Morris, B. J., Bailis, S. A., Sokal, D., Klausner, J. D., Appleton, R., … de Bruyn, G. (2011). Male circumcision for HIV prevention: current evidence and implementation in sub-Saharan Africa. *J Int AIDS Soc*, *14*(1), 49.

[181]Berer, op. cit. note 10.

[182]Maganja, R. K., Maman, S., Groves, A., & Mbwambo, J. K. (2007). Skinning the goat and pulling the load: transactional sex among youth in Dar es Salaam, Tanzania. *AIDS Care*, *19*(8), 974–981.

[183]Whiteside, A., Hickey, A., Ngcobo, N., & Tomlinson, J. (2003). What is driving the HIV/AIDS epidemic in Swaziland, and what more can we do about it? *National Emergency Response Committee on HIV/AIDS and United Nations Programme on HIV/AIDS*, 1–58.

[184]De Vogli, R., & Birbeck, G. L. (2005). Potential impact of adjustment policies on vulnerability of women and children to HIV/AIDS in Sub-Saharan Africa. *J Health Pop Nutrition*, *23*(2), 105–120; Poku, N. K. (2002). Poverty, debt and Africa's HIV/AIDS crisis. *Int Affairs*, *78*(3), 531–546.

[185]Hickel, J. (2012). Neoliberal plague: the political economy of HIV transmission in Swaziland. *J South Afr Stud*, *38*(3), 513–529.

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[187]A live example of this dependency is seen in the restriction of abortion services across the Global South as a result of Trump's extended "Global Gag Rule," which restricts U.S. funding to NGOs which do not counsel toward, or provide, abortions. The impact of the policy is substantial because millions of women depend on NGOs for essential care. Shahvisi, A. (2018). "Women's empowerment," imperialism, and the global gag rule. *Kohl*, *4*(2), 173–184.

[188]See for discussion, Editors, op. cit. note 21; McGuire & Lydston, op. cit. note 26; Hazen, op. cit. note 34; Remondino, op. cit. note 20; Shattuck & Edson, op. cit. note 24; Daniel, op. cit. note 22; Vandavel, op. cit. note 28.

[189]Washington, op. cit. note 35.

[190]Editors, op. cit. note 21.

[191]Editors, op. cit. note 21; McGuire & Lydston, op. cit. note 26; Hazen, op. cit. note 34; Remondino, op. cit. note 20; Shattuck & Edson, op. cit. note 24; Daniel, op. cit. note 22; Vandavel, op. cit. note 28.

The most significant issue with VMMC is that it has been viewed myopically as a public health measure rather than adequately appraised in the broader context of Western cultural imperialism. This article offers a contextualized perspective on the regime: a history of medical male circumcision discourse as adapted for African and African American men drawing on sexual stereotypes; the racial problems inherent in VMMC research and policy; the neglected role of poverty and systemic factors; and how these elements are fueling suspicions of neocolonialism and racism among targeted groups.

As elsewhere, the act and fact of being circumcised, or not, is a matter of great importance to African societies and cultural identities; it is not reducible to an act of healthcare. In light of the controversial contexts of both circumcision and Western colonial and neocolonial intervention, the international response to HIV must have African experiences and viewpoints at its core. Affected communities need a means of representation in order for the campaign to break out of the Western hegemonic framework. To that end, an independent platform for men and women to share perspectives without the involvement or influence of campaign-affiliated research parties is indicated. "Barriers" to VMMC uptake should be reframed as *reasons* for resisting; "misconceptions," when rooted in experience or local knowledge, should be accepted as alternate views deserving attention in their own right. Only then can Africans be said to have a voice in the campaign.

Compounding communities' limitations for meaningful involvement in decision-making, HIV treatment and prevention options have progressed considerably since the policy was recommended in 2007. In particular, the newer development of more efficacious biomedical solutions—pre- and post-exposure prophylaxis (PrEP and PEP) and treatment as prevention (TasP)—create a need to rethink the role of male circumcision within the global HIV/AIDS response. The male foreskin, rhetorically reduced by VMMC proponents to a mere vector for HIV transmission,[192] is now increasingly thought to contain important antiviral defenses that could be harnessed in future preventive therapies.[193] As HIV-preventive solutions continue to diversify, and as Global South states continue to rise out of poverty, local communities will need to occupy a more central role in decision-making to ensure the success of future interventions across this evolving landscape. Local perceptions would also provide a worthy anchor for the ongoing debate about VMMC's effectiveness against local HIV burdens, where questions remain as to whether the decade of mass circumcision policy—translating to surgeries performed on more than 23 million Africans—ultimately has been beneficial[194] or harmful[195] to its objective.

In turn, the global HIV/AIDS response must not only accommodate, but centralize the views of its subjects. As with all forms of cultural imperialism, subjects' perspectives have been marginalized in VMMC policymaking; but without extensive input from African communities on their own terms, Western health policy is merely repeating the errors and harms of its colonial past.

CONFLICTS OF INTEREST

None.

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