PUBLIC HEALTH ETHICS VOLUME 14 • ISSUE 1 • 2021 • 79–89

The Ethics of Stigma in Medical Male Circumcision Initiatives Involving Adolescents in Sub-Saharan Africa

Stuart Rennie, University of North Carolina, Chapel Hill

Adam Gilbertson *, Pacific Institute of Research and Evaluation (PIRE)

Denise Hallfors, Pacific Institute of Research and Evaluation (PIRE)

Winnie K. Luseno, Pacific Institute of Research and Evaluation (PIRE)

*Corresponding author: Adam Gilbertson, Pacific Institute for Research and Evaluation, 101 Conner Drive, Suite 200, Chapel Hill, NC 27514, USA. Tel.: 919 260 7513; Fax: 919 265 2659; Email: adamgilbertson@outlook.com

Ongoing global efforts to circumcise adolescent and adult males to reduce their risk of acquiring HIV constitute the largest public health prevention initiative, using surgical means, in human history. Voluntary medical male circumcision (VMMC) programs in Africa have significantly altered social norms related to male circumcision among previously non-circumcising groups and groups that have practiced traditional (non-medical) circumcision. One consequence of this change is the stigmatization of males who, for whatever reason, remain uncircumcised. This paper discusses the ethics of stigma with regard to uncircumcised adolescent males in global VMMC programs, particularly in certain recruitment, demand creation and social norm interventions. Grounded in our own experiences gained while conducting HIV-related ethics research with adolescents in Kenya, we argue that use of explicit or implicit stigma to increase the number of VMMC volunteers is unethical from a public health ethics perspective, particularly in campaigns that leverage social norms of masculinity. Ongoing global efforts to circumcise adolescent and adult males to reduce their risk of acquiring HIV constitute the largest public health prevention initiative, using surgical means, in human history. VMMC programs in Africa have significantly altered social norms related to male circumcision among previously non-circumcising groups and groups that have practiced traditional (non-medical) circumcision. One consequence of this change is the stigmatization of males who, for whatever reason, remain uncircumcised. This paper discusses the ethics of stigma with regard to uncircumcised adolescent males in global VMMC programs, particularly in certain recruitment, demand creation and social norm interventions. Grounded in our own experiences gained while conducting HIV-related ethics research with adolescents in Kenya, we argue that use of explicit or implicit stigma to increase the number of VMMC volunteers is unethical from a public health ethics perspective, particularly in campaigns that leverage social norms of masculinity.

Introduction

The World Health Organization's Ottawa Charter (World Health Organization, 1986) conceived health promotion in terms of actions involving a wide array of stakeholders engaging with the political, social and economic determinants of daily life, with the goal of empowering people to gain control over and improve their health (Awofeso, 2004). More than 30 years later, it seems indisputable that individual and population health can and should be improved through broad interventions informed by sound scientific research. Further, it is commonly assumed in public health circles that such interventions should be welcome, in principle, wherever population health needs the greatest improvement. For this reason, health promotion lies at the core of global health, i.e., trans-national efforts to improve population health in low and middle-income countries.

Stigma—defined as the process whereby people and groups become socially stained and discredited because

doi:10.1093/phe/phab004
Advance Access publication on 13 February 2021
© The Author(s) 2021. Published by Oxford University Press. Available online at www.phe.oxfordjournals.org

they possess a characteristic or behavior that is classified as unacceptable or undesirable (Brewis and Wutich, 2019)—has long been a major concern in health promotion. Importantly, according to this definition, stigma is not necessarily direct or intentional. For example, health campaigns aiming to associate early breastfeeding with ideal motherhood ('Breast is best') can indirectly and implicitly stigmatize women who are not (for whatever reason) breastfeeding their infant (Kukla, 2006; Bresnahan *et al.*, 2020).

Whether it is ethically justified to use stigma intentionally as a tool to promote public health remains a controversial topic. Some argue there are legitimate uses, justified by their overall outcomes, such as the stigmatization of smokers (Bayer, 2008; Callahan, 2013; Kim *et al.*, 2018). Others contend that stigma ought never to be used instrumentally in public health because it disrespects persons and communities, can be counterproductive and may worsen health inequalities (Burris, 2008). A less discussed topic in the public health literature is the ethics of implicit stigma, or stigma as an unintended (but perhaps foreseeable) consequence of health promotion efforts.

In this paper, we focus on the ethics of intentionally employing or unintentionally causing stigma in campaigns to promote medical male circumcision for HIV prevention among adolescent males in Sub-Saharan Africa (SSA). Reflecting on our experiences conducting qualitative and quantitative research with adolescents in Kenya, as well as the scientific literature and a repository of VMMC campaign materials, this paper describes how stigma occurs in VMMC campaigns. Additionally, we explore two questions. First, is it ethically acceptable for genitally intact adolescents to be stigmatized during VMMC campaigns to reduce HIV infection in SSA?[1] Second, is it ethically legitimate to change or exploit social norms to increase the number of circumcised males for HIV prevention purposes?

Background

Three randomized controlled studies in Africa have indicated that adult male circumcision in the context of clinical trials conducted in settings of high HIV prevalence and low baseline prevalence of male circumcision reduces the relative risk of HIV acquisition by men from women during sexual intercourse by roughly 60% (Auvert *et al.*, 2005; Bailey *et al.*, 2007; Gray *et al.*, 2007).[2,3] These findings were an important input for the development of policies on male circumcision and HIV prevention among leading global health agencies, and to the creation of VMMC programs in regions of high HIV incidence and low male circumcision prevalence, though the inclusiveness and impartiality of those deliberations has been called into question (Giami *et al.*, 2015). The US President's Emergency Plan for AIDS Relief (PEPFAR) is one of the most prominent funders of VMMC programs. Between 2007 and 2018, almost 19 million PEPFAR-supported circumcisions were performed in 14 priority World Health Organization (WHO) designated countries in eastern and southern Africa (U.S. President's Emergency Plan for AIDS Relief (PEPFAR), 2019). More recently, a WHO article stated that approximately 25 million males in the East and Southern Africa had undergone medical male circumcision through 2019 (World Health Organization, 2020). Ten percent (more than 1.9 million) of these medical male circumcisions took place in Kenya, a country that is now considered a success story in regard to number of circumcisions performed (Mwandi *et al.*, 2011). According to the 2016 UNAIDS Prevention Gaps report, the greatest uptake of VMMC up to 2015 in Kenya was among 10–14-year old adolescents, as was the case in eight other VMMC-priority countries (Joint United Nations Programme on HIV/AIDS, 2016).

However, to assess the genuine success of a public health initiative, it is necessary to look, not only at the positive or intended outcomes, but also the costs, including unintended, negative outcomes. While our team was conducting a study in Kenya on the responsible inclusion of youth in HIV-related research (Rennie *et al.*, 2017; Groves *et al.*, 2018), reports of irregularities in local VMMC programs involving children and adolescents were brought to our attention. Curious to learn more, we conducted quantitative and qualitative research on VMMC program implementation. The methods and results of these studies have been previously published elsewhere (Gilbertson *et al.*, 2019), including a study indicating greater depressive symptoms among genitally intact Kenyan adolescents exposed to VMMC initiatives compared to their circumcised counterparts (Luseno *et al.*, 2019). Our qualitative data (acquired through in-depth interviews and field observations) showed how the pursuit of targets (i.e., number of male adolescents circumcised within a certain period) by VMMC programs in Kenya led to unintended and ethically problematic outcomes (Gilbertson *et al.*, 2019). Here we focus on one such outcome: stigmatization of genitally intact male adolescents.

In our study, stigmatization of the genitally intact occurred during VMMC recruitment efforts and interpersonally among adolescent males and their peers. For instance, during some public mobilization activities

(such as informative theatrical skits) led by VMMC client recruiters or 'mobilizers' the messages conveyed included that women strongly prefer circumcised men as sexual/marital partners and/or that a genitally intact penis is an unclean object of disgust. In other recruitment efforts we observed, the foreskin was depicted in disparaging terms such as 'the sleeve of a sweater' or 'boiled goat intestines'. During one VMMC recruitment 'health talk' held among pupils in a local school, adolescents were told that keeping their foreskins would compromise their future happiness and make them more vulnerable to HIV infection and responsible for HIV transmission. Our interview data also suggested mobilizers knew that if they depicted being genitally intact in a negative light, some young adolescents might re-enact the stigmatization among themselves, potentially resulting in more volunteers for circumcision through peer pressure mechanisms. In short, during the VMMC promotion activities we witnessed and documented, genitally intact males were regularly (and intentionally) cast as unacceptable and/or undesirable perpetrators of the ongoing HIV epidemic. This is a particularly powerful form of stigma, that targets an intimate body part deeply related to self-esteem and sexuality, potently combines social undesirability and blame with implied moral failing, and is clearly intended to motivate intact male youth to undergo circumcision.

Stigma in VMMC Program Demand Creation Initiatives

Initiatives to promote male circumcision as a HIV prevention strategy have been swept up by a growing trend in public health, namely the adoption of commercial strategies originally designed to sell products to consumers. What are 'sold,' however, are interventions intended to improve population health. One of the most prominent of these strategies is 'demand creation', whereby instead of supplying products or services to meet a preexisting community demand, the demand for those products and services is generated through various means. According to the United States Agency for International Development (USAID), in the context of VMMC programs, demand creation consists of:

> ... outreach and communication activities spreading information on the benefits of VMMC and the availability of VMMC services. Demand creation is aimed at increasing general awareness and uptake of VMMC among target populations. Platforms employed for VMMC demand generation include advocacy (e.g., with community leaders, school teachers); communication with target audiences through different communication channels (e.g., television, radio, print media, interpersonal communication, road shows, social media, SMS reminders, household visits); and community engagement and mobilization (USAID Assist Project, 2020).

For our purposes here, we will mention a few cases below where the boundary between VMMC demand creation and stigmatization starts to blur, i.e., where stigmatization is mobilized in an effort to create VMMC demand. These examples come from the current scientific literature and the Clearinghouse on male circumcision for HIV prevention which collects material used in VMMC demand creation initiatives worldwide (FHI 360 in collaboration with WHO, 2019).

- Rudrum *et al.* (2017) describe how the Ugandan 'Stand Proud, Get Circumcised' campaign used posters of women seemingly looking down at a partner's penis with displeasure, with the caption: 'Forget size, you mean you're not circumcised?' (Rudrum *et al.*, 2017)
- In 2013, the 'Stylish man' demand creation campaign was launched in Rakai, Uganda. The key message of this initiative was that a stylish man conducts his life in an admirable way: he knows what he stands for, provides for his family, and takes care of his own health. Essential to being stylish is being circumcised medically because that makes him modern and strong. (FHI 360 in collaboration with WHO, 2014).
- In Zambia, the 'A man who cares' campaign associated medical male circumcision with caring attitudes: care for one's own life, care for one's family and care about personal hygiene. A man who cares will also encourage his sons, cousins, brothers, nephews and neighbors to get circumcised (FHI 360 in collaboration with WHO, 2011).
- In Swaziland, an organization implementing VMMC launched a 'guerilla marketing' campaign to create demand by distributing posters of two men in turtlenecks, with one of the men's turtleneck rolled up over his face to symbolize the foreskin. The image was accompanied by the phrase: 'Don't give HIV a place to hide.' They then hired an acting troop to stand in various public venues with green turtlenecks pulled up over their faces, and instructed to talk to no one. This spectacle caused a public uproar, subsequently leading to the troop's arrest. However, the campaign received national exposure in the process (RTI International, 2014).
- The 'Be the pride of your tribe' campaign in Uganda focused on traditionally circumcising communities, and attempted to alter important elements of traditional circumcision rites to fit with medical protocols and public health goals. The key message was for men and youth to demonstrate discipline and pride in their culture by practicing ABC (abstinence, being faithful and using condoms) and by undergoing medical circumcision during the traditional circumcision (*imbalu*) season (RTI International, 2014).
- According to an editorial in *Nature*, VMMC demand creators in Tanzania transformed the 60% relative risk reduction of HIV transmission found in clinical trials into a message that those who

become medically circumcised would become '60% more men' (Precautionary measures: Major African campaigns targeting malaria and HIV could help millions, 2013).

- In testing different ways to create demand among adult males for VMMC in Soweto, South Africa, Wilson et al. (2016) compared four interventions: postcards with basic information about the HIV risk reduction benefits of circumcision; postcards with basic HIV information and a conditional cash transfer; postcards with basic HIV information including an alleged advantage of VMMC (i.e., that women supposedly prefer circumcised men); and a postcard with basic HIV information and a challenge message ('Are you tough enough?') (Wilson et al., 2016; Kaufman *et al.*, 2018).
- Kaufman *et al.* (2018) present qualitative data on attitudes of adolescent females towards VMMC in three African countries and how they may influence the decisions of genitally intact partners. For purposes of demand creation, the authors recommend that VMMC programs combat views about male circumcision leading to promiscuity (citing lack of evidence) and suggest capitalizing on (some) women's views about circumcised men as being more attractive, confident, brave, worthy of respect, cleaner and preferred as sexual partners. This despite their recognition that '. . . adolescent females could be contributing to shaping social norms that encourage adolescent VMMC and heighten stigma against those not seeking VMMC services.'

Many VMMC demand creation programs have explicitly incorporated strategies from commercial marketing. These strategies rest on the assumption that accurate information about VMMC and HIV prevention by itself is insufficient motivation and therefore, VMMC campaigns must also appeal on an emotional level to the values, perceived needs and aspirations of male adolescents and adults. 'Selling' VMMC to the genitally intact requires positioning and messaging it in ways that go beyond just the prevention of HIV and should incorporate appeals to hygiene, appearance, attractiveness to partners, peer group norms and modernity (Sgaier *et al.*, 2014; Sgaier *et al.*, 2015). Similarly, as Moyo *et al.* (2015) put it, 'To provide outreach and education, one recommendation would be to implement a form of social engineering where new meanings of masculinity are created, resting on norms that are most valued by men'. The VMMC Demand Creation Toolkit developed by Research Triangle Institute (RTI) International, Population Services International (PSI) and Center for Disease Control and Prevention (CDC) uses fictional profiles to explain how to promote VMMC among particular audiences. It describes the profile of 'Jubani', a young Zambian male, and states: 'Audience insights often have very little to do with public health. The insights above provide a window into Jubani's most prominent emotional concerns: gaining acceptance from friends, demonstrating that he is masculine, and focusing on the needs of his sexual partner. Demand creation messages that are positioned to address these needs may be more appealing to the target group than those focused on a functional benefit of VMMC, such as HIV prevention' (RTI International, 2014).

However, as indicated above, some of these emotional appeals appear to be stigmatizing, directly or implicitly. To a greater or lesser degree, as we also witnessed among adolescents in Kenya, males who remain genitally intact are cast as potential objects of female disapproval; lacking in style or modernity; uncaring about others; not someone to be proud of; insufficiently tough or sexy; cowardly about surgery; or disturbing, unattractive and dirty. The further implication is that genital surgery is the only way to avoid being regarded in these ways, and accepted by peers, because unlike other forms of stigma, the stigmatization of the genitally intact is not about behavior, but the possession of a naturally occurring body part. And, as others have noted, not just any body part: the foreskin is an integral, functional component of a particular organ with special psychosocial significance, with properties such as heightened sensitivity (Bossio *et al.*, 2016; Earp, 2016) that make its loss through surgical removal a potential matter of serious existential and moral concern, in addition to its impacts on cultural identity.

VMMC Initiatives as Social Norms Interventions

Those promoting VMMC for HIV prevention often view the social reality of affected communities from a 'barriers and facilitators' perspective (George *et al.*, 2014; Carrasco *et al.*, 2019). Barriers are whatever inhibits genitally intact men from undergoing circumcision; facilitators are whatever factors make (or would make) them more likely to opt for the procedure. The goal is to reduce barriers and leverage facilitators in order to increase voluntary uptake. For instance, misinformation about VMMC (e.g., length of time for recovery) can be a barrier. However, a community's social norms can also be barriers, and when VMMC programs tackle those, their demand creation activities become social norms interventions.

Social norms can be defined as the informal rules that dictate what is acceptable in a given social context (Brennan *et al.*, 2013). Social norms interventions can be defined as actions that seek to purposively alter these informal rules in order to change the behavior they govern (Cislaghi and Heise, 2018). In development circles, child marriage, intimate partner violence and female genital mutilation have been prominent foci of social norms interventions (Shell-Duncan et al., 2011; Clark

et al., 2018; Cislaghi *et al.*, 2020). Social norms interventions also are being increasingly designed and used in global public health (Cislaghi and Heise, 2019).

As indicated above, some VMMC demand creation initiatives mobilize social norms related to masculinity. Their key message is that becoming circumcised is essential to be a good or 'real' man. Different initiatives conceive what a good or real man is in different ways, but in any case, they implicitly convey the message that genitally intact men are falling short of (new, public health motivated) norms of masculinity. According to Rudrum *et al.* (2017), Uganda's 'Stand Proud, Get Circumcised' campaign aimed precisely at increasing recruitment for VMMC by targeting men's anxieties over sexual performance, genital appearance and perceived (un)cleanliness. Interestingly, the narrative of VMMC as the modern gateway to manhood appropriates the traditional conception of male circumcision as a rite of passage. The stigma of genitally intact males in VMMC programs may also echo the typically explicit stigma traditionally circumcising communities reserve for those who remain uncut (Mavundla *et al.*, 2010).

Qualitative research studies suggest that VMMC social norm interventions are having an impact. Kabare (2019) conducted surveys and focus group discussions with adult men and women (aged 18 and older) in three ethnic communities in western Kenya, one traditionally non-circumcising (Luo) and two traditionally circumcising (Kisii and Maragoli). In the case of the Luo, the group with the highest HIV prevalence and the most intensely targeted by VMMC programs in Kenya, the data indicated that circumcision decisions were strongly influenced by non-biomedical considerations, many having to do with masculine norms. These included anticipation for greater sexual pleasure, attractiveness to women (especially from circumcising groups), libido enhancement, and being part of 'modern' Kenya. Among adolescents, these decisions were also driven by desires to avoid being bullied for having a foreskin, being viewed as less than a real man or as a '*kihii*' (boy) by other ethnic groups, as backward or unmarriageable by non-Luo women and/or as incapable of sexually satisfying women.

Other studies indicate similar effects. The study by Fleming *et al.* (2017) in the Dominican Republic revealed how tightly VMMC can be linked to norms of masculinity among men and how easily VMMC initiatives can promote or slide into stigmatization. Many men interviewed said they 'felt more like men' after medical circumcision, citing enhanced sexual performance, pleasure and even (for some) a perceived increase in penis size. Fleming *et al.* explicitly warns against using this kind of information (itself likely an artifact of demand creation initiatives) for future VMMC recruitment purposes because of the potentially 'emasculating' message it can send to those who remain genitally intact. Similarly, Humphries *et al.* (2015) reveal how men in KwaZulu-Natal who have been medically circumcised for HIV prevention describe themselves in terms of increases in libido, virility, attractiveness and sexual opportunities.

Discussion: Is Stigmatization of the Genitally Intact within VMMC Initiatives Ethically Justified?

Across SSA, millions of men and boys have been circumcised through VMMC initiatives. Whether the stigmatization of the genitally intact may be ethically justifiable relies, at least in part, on the relationship between stigmatization and reduction of HIV incidence. If stigmatization measurably increases the number of males circumcised, and the number of HIV infections averted by these circumcisions could be reliably quantified, this would be one consideration in favor on consequentialist grounds, similar to arguments in defense of stigmatizing smokers. However, to date there has been no attempt to measure a 'stigma effect' associated with VMMC campaigns. In fact, the evidence base for the effectiveness of demand creation activities of any sort is thin (Sgaier *et al.*, 2015), and much the same is true of social norm interventions in low-income settings (Cislaghi and Heise, 2019). Furthermore, while there is a widespread assumption that VMMC initiatives are appropriate and ethically justifiable because of their potentially substantial contribution to HIV prevention, it is no easy task to tease out the specific effect VMMC has had or will have on HIV incidence, independent of other HIV prevention factors. Examples of these other factors include the increased availability and use of anti-retroviral therapy and pre-exposure prophylaxis. In addition, a robust consequentialist position would need to take into account all effects of the initiative: direct and indirect, intended and unintended, social and more immediately health-related, and negative as well as positive. In short, it is less easy to justify stigma in VMMC initiatives on consequentialist grounds than it may at first appear.

In fact, there are two strong consequentialist reasons to avoid explicit stigmatization of the genitally intact, and to anticipate and minimize implicit stigma. The first is that there are alternative ways of conducting demand creation that do not seem to involve interventions on

social norms around masculinity and the concomitant stigma. Sport-based and cash transfer models do not appear to be stigmatizing (DeCelles *et al*., 2016), and they have at least demonstrated some evidence of effectiveness (Ensor *et al*., 2019). As Kass (2001) writes, if public health programs can be modified in ways that minimize harms and burdens without greatly reducing the program's effectiveness, doing so is an ethical requirement.

The second reason concerns the potential impacts of unanticipated consequences. Our own recent research in Kenya with 1939 males aged 15–19, in a region targeted for VMMC recruitment, found that boys who had not undergone circumcision reported worse quality of life outcomes and greater likelihood of depressive symptoms compared to their circumcised peers (Luseno *et al*., 2019). These quantitative findings support qualitative data suggesting bullying and shaming of boys who remained genitally intact (Gilbertson *et al*., 2019). We also found that boys who reported circumcision without parent or guardian permission were more likely to report symptoms of depression and lower quality of life compared to boys who had been circumcised with parent consent (Luseno *et al*., 2019). These findings suggest that VMMC recruitment strategies that use stigma and bypass parental permission for minors may have contributed to the psychosocial distress reported by some adolescents in our study. Experts in social norm intervention theory recognize that social norms are embedded in a larger ecological networks including material conditions, institutions, family structures and so on (Cislaghi and Heise, 2019). Changing a given behavior will therefore involve more than just changing an isolated social norm related to it.

One implication of this model is less often drawn: that intervening into social norms may have unintended and undesirable impacts on other norms, practices and institutions. For example, according to Kabare (2019) while stigmatization of the Luo by neighboring (circumcising) ethnic groups predates VMMC initiatives, these programs tapped into established stigma narratives about circumcision status and masculinity. In her view, this approach helped expedite medical male circumcision among the Luo, but also accelerated a process of identity loss among this traditionally non-circumcising ethnic group. Others have raised the concern that VMMC initiatives have leveraged and exacerbated political conflicts between non-circumcising and circumcising groups in Kenya, fueling the idea that the 'cultural deficiency' of the Luo has a medical basis, most radically expressing itself in cases where Luo men are forcibly circumcised by members of opposing tribes and political parties (Auchter, 2017; Lamont, 2018). The longer-term social impacts of VMMC initiatives on both traditionally non-circumcising and traditionally circumcising communities are under-studied, but will need to be considered in understanding the ethics of conducting VMMC initiatives in low- and middle-income countries in sub-Saharan Africa such as Kenya.

Stigmatization of the genitally intact, involving interventions into masculine norms, may have other unintended consequences, including those related to gender/power dynamics. For example, what will be the impact on women when men are being circumcised in VMMC marketing campaigns that emphasize attainment of 'real' masculinity while relatively downplaying HIV prevention information? While there are data indicating that VMMC does not significantly increase sexual risk behavior (Shi et al., 2017), the question is not closed. Findings in some recent studies point in the other direction, including behaviors among medically circumcised fishermen in western Kenya (Ombere *et al*., 2015), casual sex post-VMMC among Ugandan men for 'sexual cleansing' (Kibira *et al*., 2017) and beliefs among South African women that medical male circumcision reduces the need for men to worry about HIV and to use condoms (Kalichman *et al*., 2018). There are standing reasons for concern. Many Sub-Saharan countries (including Kenya) are highly patriarchal, where women often have less power and consequently more difficulty negotiating within sexual relationships. Demand creation strategies, especially ones that suggest circumcised males will be superior to their genitally intact counterparts in attractiveness and sexual prowess, may further empower men at the increased expense of women (Rudrum, 2020). Fleming *et al*. (2014) write that public health programs that emphasize masculinity related to sexual conquest can serve to reinforce the norms that encourage men to take multiple partners. In Kenya, Kabare (2019) raises concerns about 'hypermasculinity' norms in VMMC programs, and questions what strongly associating circumcision status and manhood with virility, potency and superior sexual performance among Luo male youths might mean for women and girls. Similarly, Lamont (2018) argues that male circumcision in Kenya strongly symbolizes masculine authority and power, and that VMMC programs for HIV prevention in Kenya have co-opted (and been co-opted by) longstanding ethnic and political discourses in which genitally intact Kenyan males fall short of being 'total men'. In this way, VMMC programs in Kenya benefit from pre-existing negative attitudes towards genitally intact males among some ethnic groups, while

inadvertently giving a local culture of 'foreskin chauvinism' a scientific and medical boost.

Lastly, there is a non-consequentialist argument against stigmatization in VMMC programs, especially those that target male adolescents. Approaches to VMMC uptake that stigmatize or encourage stigmatization of genitally intact adolescents (or adult men, for that matter) are in conflict with an ethical principle central to bioethics and human rights discourse: respect for persons. In this context, disrespect for persons can be reasonably interpreted in terms of diminishing a person's worth on account of their circumcision status. In 2007, an influential consultative workshop led by the WHO and the United Nations Programme of HIV/AIDS (UNAIDS) concluded that the conduct of VMMC programs should be informed by human rights considerations, and '. . .a human rights-based approach to the development and expansion of male circumcision services requires measures that require that the procedure can be carried out safely, under conditions of informed consent, and without coercion or discrimination' (World Health Organization, 2007). In keeping with this approach, the WHO/UNAIDS consultation recommended that countries and institutions should ensure that VMMC is promoted and delivered in '. . .a culturally appropriate manner that minimizes stigma associated with circumcision status' (World Health Organization, 2007). It is telling that influential global health agencies that strongly promote VMMC for HIV prevention publicly regard, on human rights grounds, circumcision status-related stigma as something to be minimized rather than to be deployed to increase VMMC uptake.

Is It Ethically Legitimate to Change or Exploit Social Norms to Increase the Number of Circumcised Males for HIV Prevention Purposes?

As the medical historian Randall Packard notes (2016), global health can be usefully framed as interventions into the lives of other peoples, from a perspective in which 'other peoples' denotes those from non-Western countries. VMMC programs in SSA are clearly interventions into the intimate lives of other peoples as well as interventions into their social fabric. When it comes to changing the norms of others related to forced child marriage or intimate partner violence, the justification for normative change may appear stronger because these practices are seriously harmful and indefensible from a health and human rights standpoint. Health and wellbeing considerations could arguably override cultural norms, though even here the ethics of norm change are often less than clear-cut (Monahan, 2007; Imoh, 2011). In the case of VMMC, do demand creation and social norm interventions have a strong justificatory basis? Is possession of a foreskin in certain sub-Saharan regions an 'intrinsically harmful practice' that must be corrected in the name of global public health? In this context, the weaker the justificatory basis, the more vulnerable to accusations of (neo-) colonialism these global health initiatives become.

To date, there has been surprisingly little discussion about the ethics of demand creation and social norm interventions in VMMC programs in SSA. Instead, more attention has been devoted to program cost and efficiency than to the conditions under which program activities can be considered ethically legitimate. This paper describes the presence of stigma, both implicit and explicit, in campaigns to increase uptake of VMMC for HIV prevention. More specifically, it focuses on demand creation programs and social norm interventions that mobilize social norms of masculinity to increase numbers of circumcisions, and argues that the ethical reasons against such strategies are stronger than those in favor. On this basis, VMMC programs should abstain from these approaches on ethical grounds, seek to de-stigmatize their activities and reflect critically on the social norms they are promoting.

Greater attention should also be paid to the consequences of these interventions, such as impacts on gender relations, psychosocial wellbeing and cultural identities. VMMC demand creation programs should be more robustly informed by social science research led by local investigators in affected countries in order to counteract the dominance of Western biomedical and public health perspectives. Voluntary medical male circumcision providers should be knowledgeable about local beliefs (or fantasies) about the benefits medical male circumcision can provide and make efforts to manage expectations. Those involved in the funding and planning of VMMC programs should recognize that the ethical justification of VMMC initiatives is closely tied to their epidemiological impact and the diverse effects of VMMC implementation on communities. Finally, the ethical issues we have identified cannot be reasonably laid at the feet of errant mobilizers: the potential for stigma is also top-down and structural, starting with how VMMC targets/quotas are set and the unreflective promotion of demand creation approaches.

Conclusion

The use and presence of stigma in VMMC initiatives is not ethically justified (and should be minimized)

because (1) it is unclear the extent to which it decreases HIV incidence; (2) there are less burdensome ways to increase VMMC uptake; (3) social norm interventions that stigmatize those who fall short of the new norms can have serious unanticipated and undesirable consequences; and (4) stigma-involving VMMC approaches traffic in disrespect for persons, which in this case are vulnerable adolescents. From an ethical perspective, what may appear like an obvious public health triumph may look differently over time and under closer inspection.

Funding

This work was supported by the U.S. National Institute of Mental Health [3R01MH102125-03S1 to W.K.L.]; and the Center for AIDS Research, University of North Carolina at Chapel Hill [P30 AI050410 to S.R.]. S.R.'s work was also supported by a visiting residency at the Brocher Foundation.

Notes

1. We are using 'genitally intact' rather than 'uncircumcised' as the latter can itself be potentially stigmatizing by implying that being genitally intact—as one was born—is a deviation from the norm of circumcision. In this use of terminology, we follow authors concerned about cultural bias towards circumcision in medical contexts (Earp and Shaw, 2017; Wallace, 2015).
2. To put the relative risk reduction in context, in the three randomized trials, 1.1% of circumcised men became HIV infected after voluntary medical male circumcision and 2.5% of genitally intact men became infected. The relative risk reduction was 56%. However, the absolute risk reduction was 1.4 percentage points (2.5% minus 1.1%), i.e., the risk of a man getting HIV from a woman is reduced by less than two percentage points through medical male circumcision. Observers have noted that only relative risk reduction is typically mentioned in medical male circumcision recruitment and consent processes, likely because it sounds much more protective.
3. The three trials, converging on similar results, are often regarded as an incontrovertible evidence-base for the implementation of medical male circumcision as a HIV prevention strategy. However, a fourth and less reported clinical trial (Wawer, 2009) indicated that women whose male partners were medically circumcised acquired HIV transmission at a 55% higher rate. This 'inconvenient' trial raises questions about the impact on medical male circumcision initiatives on female partners (Berer, 2009), including the vulnerability of women when some men in the Waver et al. clinical trial failed to abstain from sex during wound healing and condoms were used very inconsistently (Fish, 2020).

References

Auchter, J. (2017). Forced Male Circumcision: Gender-Based Violence in Kenya. *International Affairs*, **93**, 1339–1356.

Auvert, B., Taljaard, D., Lagarde, E., Sobngwi-Tambekou, J., Sitta, R., and Puren, A. (2005). Randomized, Controlled Intervention Trial of Male Circumcision for Reduction of HIV Infection Risk: The ANRS 1265 Trial. *PLoS Medicine*, **2**, e298.

Awofeso, N. (2004). What's New about the 'New Public Health'? *Am J Public Health*, **94**, 705–709.

Bailey, R. C., Moses, S., Parker, C. B., Agot, K., Maclean, I., Krieger, J. N., Williams, C. F., Campbell, R. T., and Ndinya-Achola, J. O. (2007). Male Circumcision for HIV Prevention in Young Men in Kisumu, Kenya: A Randomised Controlled Trial. *The Lancet*, **369**, 643–656.

Bayer, R. (2008). Stigma and the Ethics of Public Health: Not Can we but Should we. *Social Science & Medicine*, **67**, 463–472.

Berer, M. (2009). Male Circumcision and Risk of HIV in Women. *The Lancet*, **374**, 1497–1498.

Bossio, J. A., Pukall, C. F., and Steele, S. S. (2016). Examining Penile Sensitivity in Neonatally Circumcised and Intact Men Using Quantitative Sensory Testing. *The Journal of Urology*, **195**, 1848–1853.

Brennan, G., Eriksson, L., Goodin, R. E., and Southwood, N. (2013). *Explaining Norms*. Oxford: University Press.

Bresnahan, M., Zhuang, J., Goldbort, J., Bogdan-Lovis, E., Park, S.-Y., and Hitt, R. (2020). Made to Feel like Less of a Woman: The Experience of Stigma for Mothers Who Do Not Breastfeed. *Breastfeeding Medicine*, **15**, 35–40.

Brewis, A., and Wutich, A. (2019). *Lazy, Crazy, and Disgusting: Stigma and the Undoing of Global Health.* Baltimore: Johns Hopkins University Press.

Burris, S. (2008). Stigma, Ethics and Policy: A Response to Bayer. *Social Science & Medicine*, **67**, 473.

Callahan, D. (2013). Obesity: Chasing an Elusive Epidemic. *Hastings Center Report*, **43**, 34–40.

Carrasco, M. A., Wilkinson, J., Kasdan, B., and Fleming, P. (2019). Systematic Review of Barriers and Facilitators to Voluntary Medical Male

Circumcision in Priority Countries and Programmatic Implications for Service Uptake. *Global Public Health*, **14**, 91–111.

Cislaghi, B., and Heise, L. (2018). Theory and Practice of Social Norms Interventions: Eight Common Pitfalls. *Globalization and Health*, **14**, 1–10.

Cislaghi, B., and Heise, L. (2019). Using Social Norms Theory for Health Promotion in Low-Income Countries. *Health Promotion International*, **34**, 616–623.

Cislaghi, B., Nkwi, P., Mackie, G., and Shakya, H. (2020). Why Context Matters for Social Norms Interventions: The Case of Child Marriage in Cameroon. *Global Public Health*, **15**, 532–543.

Clark, C. J., Ferguson, G., Shrestha, B., Shrestha, P. N., Oakes, J. M., Gupta, J., Mcghee, S., Cheong, Y. F., and Yount, K. M. (2018). Social Norms and Women's Risk of Intimate Partner Violence in Nepal. *Social Science & Medicine*, **202**, 162–169.

Decelles, J., Hershow, R. B., Kaufman, Z. A., Gannett, K. R., Kombandeya, T., Chaibva, C., Ross, D. A., and Harrison, A. (2016). Process Evaluation of a Sport-Based Voluntary Medical Male Circumcision Demand-Creation Intervention in Bulawayo, Zimbabwe. *Journal of Acquired Immune Deficiency Syndromes (1999)*, **72**, S304–S308.

Earp, B. D. (2016). Infant Circumcision and Adult Penile Sensitivity: Implications for Sexual Experience. *Trends in Urology & Men's Health*, **7**, 17–21.

Earp, B. D., and Shaw, D. M. (2017). Cultural Bias in American Medicine: The Case of Infant Male Circumcision. *Journal of Pediatric Ethics*, **1**, 8–26.

Ensor, S., Davies, B., Rai, T., and Ward, H. (2019). The Effectiveness of Demand Creation Interventions for Voluntary Male Medical Circumcision for HIV Prevention in Sub-Saharan Africa: A Mixed Methods Systematic Review. *Journal of the International AIDS Society*, **22**, N.PAG–N.PAG.

FHI 360 in Collaboration with Who, U. A. (2011). *Male Circumcision: Are You a Man Who Cares?* [Online]. Clearinghouse on Male Circumcision for HIV Prevention, available from: https://www.malecircumcision.org/resource/male-circumcision-are-you-man-who-cares [last accessed 7 February 2021].

FHI 360 in Collaboration with Who, U. A. (2014). *Rakai Stylish Man Campaign* [Online]. Clearinghouse on Male Circumcision for HIV Prevention, available from: https://www.malecircumcision.org/resource/rakai-stylish-man-campaign [last accessed 7 February 2021].

FHI 360 in Collaboration with Who, U. A. (2019). *Clearinghouse on Male Circumcision for HIV Prevention* [Online], available from: https://www.malecircumcision.org [last accessed 7 February 2021].

Fish, M., Shahvisi, A., Gwaambuka, T., Tangwa, G. B., Ncayiyana, D., and Earp, B. D. (2020). A New Tuskegee? Unethical Human Experimentation and Western Neocolonialism in the Mass Circumcision of African Men. *Developing World Bioethics*, 1– 16. 10.1111/dewb.12285.

Fleming, P. J., Barrington, C., Pearce, L. D., Lerebours, L., Donastorg, Y., and Brito, M. O. (2017). 'I Feel like More of a Man': A Mixed Methods Study of Masculinity, Sexual Performance, and Circumcision for HIV Prevention. *Journal of Sex Research*, **54**, 42–54.

Fleming, P. J., Barrington, C., Perez, M., Donastorg, Y., and Kerrigan, D. (2014). Amigos and Amistades: The Role of Men's Social Network Ties in Shaping HIV Vulnerability in the Dominican Republic. *Culture, Health & Sexuality*, **16**, 883–897.

George, G., Strauss, M., Chirawu, P., Rhodes, B., Frohlich, J., Montague, C., and Govender, K. (2014). Barriers and Facilitators to the Uptake of Voluntary Medical Male Circumcision (VMMC) among Adolescent Boys in KwaZulu–Natal, South Africa. *African Journal of Aids Research*, **13**, 179–187.

Giami, A., Perrey, C., De Oliveira Mendonça, A. L., and De Camargo, K. R. (2015). Hybrid Forum or Network? The Social and Political Construction of an International 'Technical Consultation': Male Circumcision and HIV Prevention. *Global Public Health*, **10**, 589–606.

Gilbertson, A., Ongili, B., Odongo, F. S., Hallfors, D. D., Rennie, S., Kwaro, D., and 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**, e0224548.

Gray, R. H., Kigozi, G., Serwadda, D., Makumbi, F., Watya, S., Nalugoda, F., Kiwanuka, N., Moulton, L. H., Chaudhary, M. A., Chen, M. Z., Sewankambo, N. K., Wabwire-Mangen, F., Bacon, M. C., Williams, C. F., Opendi, P., Reynolds, S. J., Laeyendecker, O., Quinn, T. C., and Wawer, M. J. (2007). Male Circumcision for HIV Prevention in Men in Rakai, Uganda: A Randomised Trial. *The Lancet*, **369**, 657–666.

Groves, A. K., Hallfors, D. D., Iritani, B. J., Rennie, S., Odongo, F. S., Kwaro, D., Amek, N., and Luseno, W. K. (2018). 'I Think the Parent Should Be There Because No One Was Born Alone': Kenyan Adolescents' Perspectives on Parental Involvement

in HIV Research. *African Journal of AIDS Research*, **17**, 227–239.

Humphries, H., Van Rooyen, H., Knight, L., Barnabas, R., and 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. *Culture, Health & Sexuality*, **17**, 920–931.

Imoh, A. T.D. (2011). Searching for a Middle Ground in Children's Rights in Ghana. *Journal of Human Rights*, **10**, 376–392.

Joint United Nations Programme on Hiv/Aids (2016). *Prevention Gap Report*. Geneva: UNAIDS.

Kabare, M. (2019). *Negotiating change: Studying the impacts of medical male circumcision on traditional beliefs in Western Kenya*. PhD, Murdoch University.

Kalichman, S., Mathews, C., Kalichman, M., Eaton, L. A., and Nkoko, K. (2018). Male Circumcision for HIV Prevention: Awareness, Risk Compensation, and Risk Perceptions among South African Women. *Global Public Health*, **13**, 1682–1690.

Kass, N. E. (2001). An Ethics Framework for Public Health. *American Journal of Public Health*, **91**, 1776–1782.

Kaufman, M. R., Dam, K. H., Sharma, K., Van Lith, L. M., Hatzold, K., Marcell, A. V., Mavhu, W., Kahabuka, C., Mahlasela, L., Patel, E. U., Njeuhmeli, E., Seifert Ahanda, K., Ncube, G., Lija, G., Bonnecwe, C., and Tobian, A. a R. (2018). Females' Peer Influence and Support for Adolescent Males Receiving Voluntary Medical Male Circumcision Services. *Clinical Infectious Diseases*, **66**, S183–S188.

Kibira, S. P. S., Atuyambe, L. M., Sandøy, I. F., Makumbi, F. E., and Daniel, M. (2017). 'Now That You Are Circumcised, You Cannot Have First Sex with Your Wife': Post Circumcision Sexual Behaviours and Beliefs among Men in Wakiso District, Uganda. *Journal of the International AIDS Society*, **20**, 21498–21498.

Kim, J., Cao, X., and Meczkowski, E. (2018). Does Stigmatization Motivate People to Quit Smoking? Examining the Effect of Stigmatizing anti-Smoking Campaigns on Cessation Intention. *Health Communication*, **33**, 681–689.

Kukla, R. (2006). Ethics and Ideology in Breastfeeding Advocacy Campaigns. *Hypatia*, **21**, 157–180.

Lamont, M. (2018). Forced Male Circumcision and the Politics of Foreskin in Kenya. *African Studies*, **77**, 293–311.

Luseno, W. K., Field, S. H., Iritani, B. J., Rennie, S., Gilbertson, A., Odongo, F. S., Kwaro, D., Ongili, B., and Hallfors, D. D. (2019). Consent Challenges and Psychosocial Distress in the Scale-up of Voluntary Medical Male Circumcision among Adolescents in Western kenya. *AIDS and Behavior*, **23**, 3460–3470.

Mavundla, T. R., Netswera, F. G., Toth, F., Bottoman, B., and Tenge, S. (2010). How Boys Become Dogs: Stigmatization and Marginalization of Uninitiated Xhosa Males in East London, South Africa. *Qualitative Health Research*, **20**, 931–941.

Monahan, K. (2007). Cultural Beliefs, Human Rights Violations, and Female Genital Cutting: Complication at the Crossroad of Progress. *Journal of Immigrant & Refugee Studies*, **5**, 21–35.

Moyo, S., Mhloyi, M., Chevo, T., and Rusinga, O. (2015). Men's Attitudes: A Hindrance to the Demand for Voluntary Medical Male Circumcision – A Qualitative Study in Rural Mhondoro-Ngezi, Zimbabwe. *Global Public Health*, **10**, 708–720.

Mwandi, Z., Murphy, A., Reed, J., Chesang, K., Njeuhmeli, E., Agot, K., Llewellyn, E., Kirui, C., Serrem, K., Abuya, I., Loolpapit, M., Mbayaki, R., Kiriro, N., Cherutich, P., Muraguri, N., Motoku, J., Kioko, J., Knight, N., & Bock, N. (2011). Voluntary Medical Male Circumcision: Translating Research into the Rapid Expansion of Services in Kenya, 2008-2011. *Plos Medicine*, **8**, e1001130.

Ombere, S. O., Nyambedha, E. O., and Bukachi, S. A. (2015). Wimbo: Implications for Risk of HIV Infection among Circumcised Fishermen in Western Kenya. *Culture, Health & Sexuality*, **17**, 1147–1154.

Packard, R. M. (2016). *A History of Global Health: Interventions into the Lives of Other Peoples*. Baltimore: Johns Hopkins University Press.

Precautionary Measures: Major African Campaigns Targeting Malaria and HIV Could Help Millions, But Key Concerns Over Their Long-Term Effects Should Not Be Forgotten. (2013). *Nature*, 503, 165.

Rennie, S., Groves, A. K., Hallfors, D. D., Iritani, B. J., Odongo, F. S., and Luseno, W. K. (2017). The Significance of Benefit Perceptions for the Ethics of HIV Research Involving Adolescents in Kenya. *Journal of Empirical Research on Human Research Ethics: JERHRE*, **12**, 269–279.

RTI International, P. S. I., and the Centers. (2014). Voluntary Medical Male Circumcision (VMMC): Demand Creation Toolkit.

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*, 1–15.

Rudrum, S., Oliffe, J. L., and Benoit, C. (2017). Discourses of Masculinity, Femininity and Sexuality

in Uganda's Stand Proud, Get Circumcised Campaign. *Culture, Health & Sexuality*, **19**, 225–239.

Sgaier, S. K., Baer, J., Rutz, D. C., Njeuhmeli, E., Seifert-Ahanda, K., Basinga, P., Parkyn, R., and Laube, C. (2015). Toward a Systematic Approach to Generating Demand for Voluntary Medical Male Circumcision: Insights and Results from Field Studies. *Global Health. Science and Practice*, **3**, 209–229.

Sgaier, S. K., Reed, J. B., Thomas, A., and Njeuhmeli, E. (2014). Achieving the HIV Prevention Impact of Voluntary Medical Male Circumcision: Lessons and Challenges for Managing Programs. *Plos Medicine*, **11**, e1001641.

Shell-Duncan, B., Wander, K., Hernlund, Y., and Moreau, A. (2011). Dynamics of Change in the Practice of Female Genital Cutting in Senegambia: Testing Predictions of Social Convention Theory. *Social Science & Medicine*, **73**, 1275–1283.

Shi, C. F., Li, M., and Dushoff, J. (2017). Evidence That Promotion of Male Circumcision Did Not Lead to Sexual Risk Compensation in Prioritized Sub-Saharan Countries. *PLoS One*, **12**, e0175928.

U.S. President's Emergency Plan for Aids Relief (Pepfar). (2019). *PEPFAR Panorama Spotlight* [Online]. Washington, D.C.: PEPFAR, available from: https://data.pepfar.gov/ [last accessed 7 February 2021].

Usaid Assist Project. (2020). *Demand Creation* [Online]. University Research Co, available from: https://www.usaidassist.org/toolkits/vmmc-cqi-and-eqa-toolkit/demand-creation [last accessed 7 February 2021].

Wallace, W. G. (2015). An Undeniable Need for Change: The Case for Redefining Human Penis Types: Intact, Circumcised, and Uncircumcised (All Three Forms Exist and All Are Different). *Clinical Anatomy*, **28**, 563–564.

Wawer, M. J., Makumbi, F., Kigozi, G., Serwadda, D., Watya, S., Nalugoda, F., Buwembo, D., Ssempijja, V., Kiwanuka, N., Moulton, L. H., Sewankambo, N. K., Reynolds, S. J., Quinn, T. C., Opendi, P., Iga, B., Ridzon, R., Laeyendecker, O., and Gray, R. H. (2009). Circumcision in HIV-Infected Men and Its Effect on HIV Transmission to Female Partners in Rakai, Uganda: A Randomised Controlled Trial. *Lancet*, **374**, 229–237.

Wilson, N., Frade, S., Rech, D., and Friedman, W. (2016). Advertising for Demand Creation for Voluntary Medical Male Circumcision. *Journal of Acquired Immune Deficiency Syndromes (1999)*, **72**, S288–S291.

World Health Organization. (1986). Ottawa Charter for Health Promotion, 1986.

World Health Organization. (2007). *New Data on Male Circumcision and HIV Prevention: Policy and Programme Implications: WHO/UNAIDS Technical Consultation Male Circumcision and HIV Prevention: Research Implications for Policy and Programming, Montreux, 6–8 March 2007: Conclusions and Recommendations.*

World Health Organization. (2020). *Preventing HIV in High HIV Burden Settings through Voluntary Medical Male Circumcision [Online]*. Geneva: World Health Organization, available from: https://www.who.int/news/item/21-08-2020-preventing-hiv-in-high-hiv-burden-settings-through-voluntary-medical-male-circumcision [last accessed 7 February 2021].