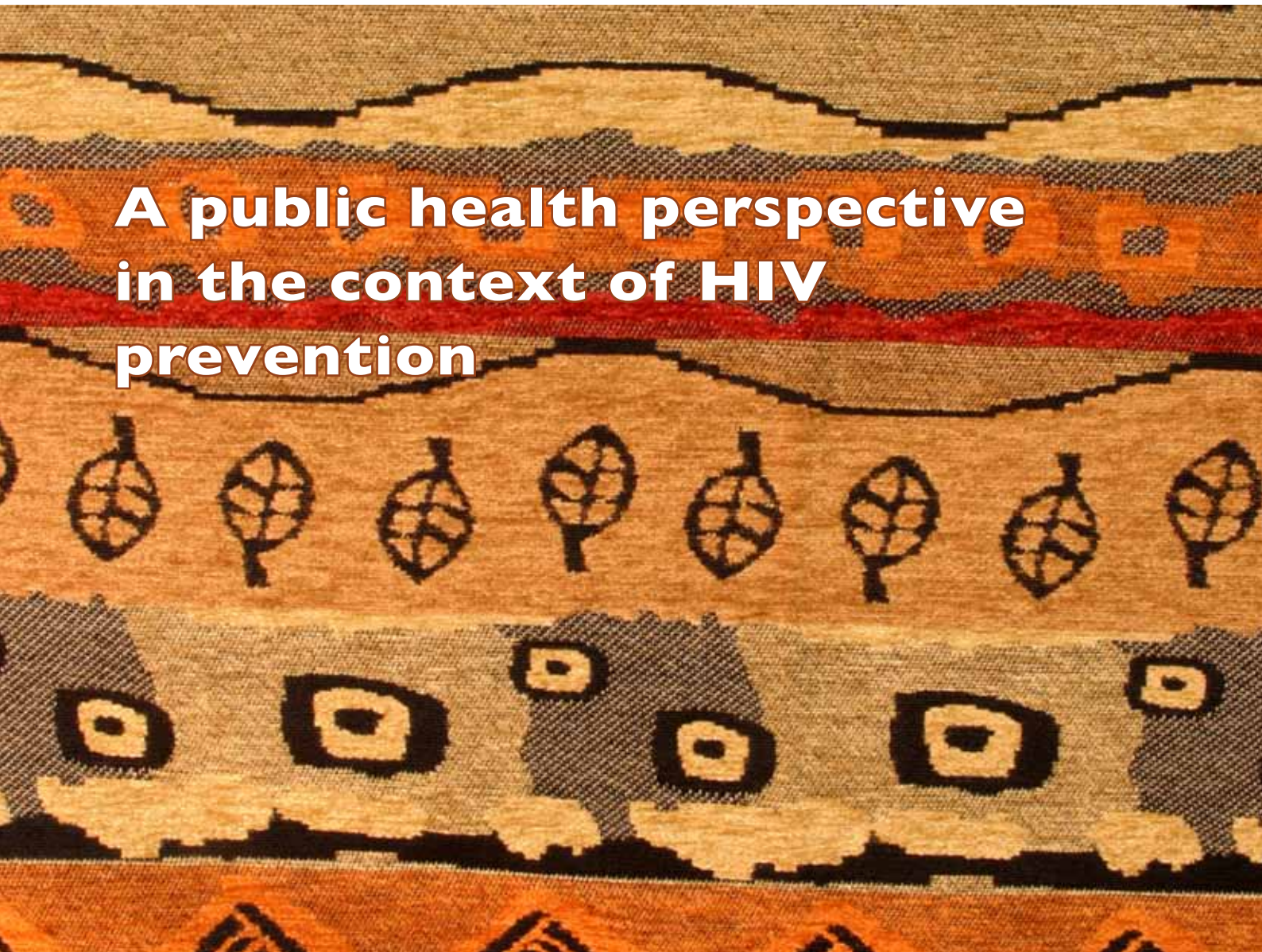
World Health Organization

November 2009

TRADITIONAL MALE CIRCUMCISION AMONG YOUNG PEOPLE



A public health perspective in the context of HIV prevention

WHO Library Cataloguing-in-Publication Data

Traditional male circumcision among young people : a public health perspective in the context of HIV prevention.

1.Circumcision, Male -utilization. 2.Circumcision, Male - psychology. 3.HIV infection - prevention and control. 4.Ceremonial behaviour. 5.Cross-cultural comparison. 6.Decision-making. 7.Medicine, Traditional. 8.Delivery of health care. 9.Adolescent. I.World Health Organization.

ISBN 978 92 4 159891 0 (NLM classification: WC 503.6)

Printed by the WHO Printing Service, Geneva, Switzerland.

Contents

Abbreviations

ABC	Abstain, Be faithful, use a Condom
AIDS	Acute immunodeficiency syndrome
CHAL	Christian Health Association of Lesotho
CHAZ	Christian Health Association of Zambia
DHS	Demographic and health survey
FBO	Faith based organization
FGD	Focus group discussion
HIV	Human immunodeficiency virus
IATT	Interagency task team
ICFEM	Inter-Christian Fellowship Evangelical Mission
MC	Male circumcision
MCK	Methodist Church of Kenya
MMC	Medical male circumcision
NGO	Nongovernmental organization
PCEA	Presbyterian Church of East Africa
PROMETRA	Association for the Promotion of Traditional Medicine
RCT	Randomized controlled trial
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
THP	Traditional health provider
TM	Traditional medicine
TMC	Traditional male circumcision
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1 Acknowledgements

Andrea Wilcken carried out the original research and key informant interviews for this review, and prepared the report in collaboration with Bruce Dick, Department of Child and Adolescent Health, WHO Geneva. Thanks are given to the people who reviewed and made comments on previous drafts of the report, including the staff of the OTS Unit of the HIV Department, WHO Geneva, the members of the WHO/UNAIDS Working Group on Male Circumcision, and members of the East and Southern Africa Interagency Task Team on Male Circumcision. Special thanks are given for the inputs and contributions of Kim Dickson, Cate Hankins, Rick Hughes, Nina Ingenkamp, Thomas Keil, Nicolas Lohse, Sacha Meuter, Helen Weiss and Brian Williams.

2 Executive summary

Introduction

Male circumcision is increasingly being incorporated as a key component of comprehensive HIV prevention strategies in national responses to AIDS. Under the leadership of the World Health Organization (WHO), efforts are being made by UN bodies such as UNFPA, UNICEF, and the UNAIDS Secretariat, along with international NGOS and funding organizations, to assist countries in making evidence-based policy and programme decisions with a view to increasing the availability, accessibility and safety of male circumcision services for HIV prevention. Priority countries for the scale-up of male circumcision for HIV prevention have high HIV prevalence and low levels of male circumcision.

In many African societies, and among certain ethnic groups in other geographical regions, male circumcision is carried out for cultural reasons, as an initiation ritual and a rite of passage into manhood. In general the countries and communities where traditional male circumcision is performed are not those with high HIV prevalence and low levels of male circumcision. However, for a number of reasons, including concerns about the safety of the procedure carried out by providers without any formal training, traditional male circumcision is receiving increasing attention. Since most countries in sub-Saharan Africa practice traditional circumcision to some extent, it will be increasingly important for Ministries of Health to have a clear position on traditional male circumcision when rolling out male circumcision programmes for HIV prevention and developing related national policies, standards and guidelines.

In addition, there is growing interest in the opportunity that male circumcision programmes might provide for making contact with adolescents and young men, in order to move beyond HIV prevention and to include broader sexual and reproductive health and gender issues. Traditionally, an educational component is included in the cultural practices surrounding male circumcision as an initiation into manhood. Since they are often knowledgeable about the determinants affecting the lives of the adolescents in their communities, traditional circumcisers and other community members traditionally involved with the ritual of male circumcision may have the potential to contribute not only to HIV prevention but also to improving other aspects of young people's sexual and reproductive health.

Scope of the review

The aim of this review is to assess the available literature on traditional male circumcision among adolescents,[a] defined as male circumcision for cultural (non-religious) reasons by a provider without any formal training. The review focuses mainly on East and Southern Africa. The following topics are addressed.

- The prevalence of traditional male circumcision, and the ages at which it is performed (Section 4.1).
- Traditional male circumcision as part of the larger context of initiation into manhood: how is circumcision performed, how much foreskin is removed, and what takes place before, during and after the male circumcision procedure? (Sections 4.2 and 5.2.3)
- Trends in traditional circumcision: what aspects of the practice are changing, including attitudes of young men and parents, and links with clinical practice? (Section 4.4)
- What are the problems associated with traditional male circumcision, including safety, and what are the consequences of particular practices around traditional male circumcision which may have implications for HIV prevention? (Sections 5 and 6)
- What attempts to work with traditional circumcisers are reported in the literature, including experiences from efforts to train traditional providers of male circumcision? What lessons have been learnt from programmes that have capitalized on traditional male circumcision practices as an entry point for addressing adolescents' sexual and reproductive health? (Section 7)

Results

Data on the prevalence of traditional male circumcision are not generally available in the literature. However, estimates of the prevalence of traditional male circumcision have been made for some countries in sub-Saharan Africa and South-East Asia.

The age at which traditional male circumcision is performed varies by country and ethnicity. It ranges from 6 years in Indonesia and Senegal to 35 years in Zambia. The majority of males in East and Southern Africa are circumcised between the ages of 12 and 22 years, whereas those in West Africa are generally circumcised much earlier.

Three phases have been described for the ritual of male circumcision: preparation leading to the actual procedure, a period of seclusion, and reintegration of the initiates into their society. Male circumcision techniques vary markedly between ethnic groups, ranging from the making of a small incision in the prepuce to the complete removal of the foreskin. The period of seclusion constitutes the most significant part of the ritual in many communities. It is an "incubation period" for new attitudes, practices and behaviours among the initiates, rather than simply being a time of wound-healing.

The transmission of cultural knowledge, skills deemed necessary for the development of the initiates' personality, and education on sexual issues are all sometimes part of the teaching in initiation schools, although an educational component on sexual and reproductive health issues is not included in all cultures. Where they exist, messages on sexual education vary widely: the importance of sexual reserve and the inappropriateness of promiscuity after reintegration into society are emphasized in some cultures, whereas in other contexts boys are encouraged to have sex shortly after male circumcision, even before complete wound-healing, to prove their manhood. During this period spent "in the bush", boys often experience privations, bullying and humiliation.

Community involvement before, during and after traditional male circumcision is strong, different roles being given to a range of players comprising family members, teachers, traditional circumcisers and traditional carers. Traditional circumcisers are not the only people in contact with the initiates while they are in the circumcision school.

a Although this review focuses on *adolescents* (10–19 years), many of the issues raised are likely to be relevant to men in their early twenties, and consequently the terms *youth* (15–24 years) and *young people* (10–24 years) are sometimes used.

Cultural identity and the desire to continue ethnic traditions are the strongest determinants for continuing traditional male circumcision. In some societies, male circumcision as a rite of passage is of major importance to the social status of a man, essential to him becoming a full member of society. In some communities, an uncircumcised man remains a boy forever, whatever his age.

The acceptability of traditional male circumcision and the desire to continue the practice among community members in traditionally circumcising societies depends on a variety of factors, including rural vs. urban life, awareness of complications, cost of traditional vs. medical circumcision, accessibility of medical services, sociocultural norms and values, and perceptions of potentially harmful practices associated with the ritual (such as drug and alcohol consumption). Traditional male circumcision practices continue to be of great cultural importance in many societies, although in some traditionally circumcising communities trends towards a preference for medical male circumcision services[b] have been reported.

In many communities there is a high level of secrecy associated with ritual male circumcision, which is probably an important reason why complications associated with male circumcision practices, including long-term morbidity and death of initiates, have not been systematically assessed in most studies. A recent study carried out in Kenya reported complication rates of 35% after traditional male circumcision; wound infection and delayed wound-healing were the most common adverse events.

With regard to HIV prevention, several aspects of traditional male circumcision should be considered. First, the amount of foreskin removed during the procedure is important, since males who are partially circumcised or initiated through a simple incision in the prepuce are unlikely to benefit from the level of partial protection against HIV seen in the randomised controlled trials, even though culturally they may be considered to be circumcised. Secondly, certain cultural practices are likely to increase the risk of HIV transmission and may reverse the potential benefits of male circumcision in respect of HIV prevention, e.g. using one knife to circumcise several boys or encouraging sexual intercourse shortly after circumcision and before complete wound-healing. In addition, prolonged wound-healing, attributable to traditional ways of cutting the foreskin or complications after traditional male circumcision, has implications for HIV prevention, since vulnerability to contracting and/or transmitting HIV is potentially higher until the circumcision wounds are fully healed.

There appear to be relatively few initiatives to collaborate with traditional circumcisers in terms of training or regulation, with the exception of efforts in Ghana, Kenya, South Africa, and Zambia. Some programmes being implemented in Kenya and Lesotho are trying to combine medical male circumcision with an adapted version of the traditional rites of passage components surrounding the circumcision procedure. In addition, successes have been achieved