

The new politics of male circumcision: HIV/AIDS, health law and social justice

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This paper engages with a changing politics of male circumcision. It suggests that various shifts which have occurred in how the issue is debated challenge legal constructions of the practice as a private familial issue. Although circumcision rates have declined in those Western nations which have traditionally practised it, the procedure is now being promoted as a medicalised response to the HIV/AIDS pandemic in sub-Saharan Africa. Such initiatives propose a new biomedical rationale for the practice and have been difficult to confine to the African context or to adult bodies, prompting a resurgence of enthusiasm for neonatal male circumcision on the part of professional bodies in the USA and elsewhere. Although we have reservations about such public health policies, which we suggest downplay risks inherent in the procedure both for the individual and for the advancement of public health, we argue that such strategies have the potential to move debates about circumcision beyond the parameters of traditional 'medical law', with its focus on the doctor–patient nexus and the issue of who can validly consent to medical procedures. We suggest that, as with female genital cutting, male circumcision ought to be debated within a paradigm of social justice which gives adequate weighting to the interests of all affected parties (including women whose health may actually be compromised by the procedure) and which renders visible the socio-economic dimensions of the issue. In line with a social justice approach, we argue that public health initiatives must comply with international ethico-legal standards and be attentive to the emergence of an international human right to health. The shift in analytical frame that we propose has the potential not only to make us re-think our approach to the ethics and legality of male circumcision by challenging its construction as a familial decision but also to impact on the need for a broader conceptualisation of health law as rooted in social justice.

INTRODUCTION

In 2010, in a country devastated by HIV/AIDS, South Africa's President Jacob Zuma began an extraordinarily open conversation about sex and HIV/AIDS. This national dialogue was prompted, in part, by his admission that he had had unprotected sex during an extramarital affair, and saw Zuma state that he had been circumcised and had encouraged his sons to have the surgery.¹ Simultaneously he announced a

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1. 'In South Africa, an unlikely leader on AIDS' *New York Times* 10 May 2010, available at <http://www.nytimes.com/2010/05/15/world/africa/15zuma.html>.

significant increase in the funding of HIV testing and AIDS services. In August 2011 it was revealed that following the lobbying of Deputy Prime Minister Thokozani Khupe, male members of the Zimbabwean cabinet were also considering circumcision.² Members of Parliament and Councillors were to be targeted in a second wave of action. This follows an initiative started in 2009 to circumcise 1.2 million Zimbabwean men in response to HIV/AIDS.³ Similar public health initiatives are taking place across southern Africa and further afield, with the actions of national figures, such as Zuma, making the refusal of such measures seem akin to a dereliction of citizenship.⁴ In this paper, and recognising marked global differences in medical, ethical and legal responses to the procedure, we seek to address the complex new politics of male circumcision being generated by global responses to HIV/AIDS and to consider the implications for the framework within which the procedure should be debated and regulated.

As we have argued elsewhere, in Anglo-American jurisprudence male circumcision has typically been constructed as a 'non-issue' which has, until recently, attracted little ethico-legal commentary, due, in part, to its portrayal as radically different from 'female genital mutilation'.⁵ It is clear from the very limited body of case-law to have addressed the legality of the practice that, where there is no conflict between parental wishes, male circumcision is regarded as a legitimate and private parental choice rather than a body modification implicating a child's fundamental human rights.⁶ In order to problematise this common-sense notion of the procedure as a trivial issue – an understanding implicit in the new public politics of circumcision – our key argument in this paper is that it is necessary to shift current debates about male circumcision away from the moral paradigm of consent and autonomy which typifies traditional medical law.⁷ Instead, and locating the debate within a broader public health context, we argue for the adoption of a social justice paradigm that can

2. SAfAIDS 'Zimbabwe: Circumcision drive targets cabinet ministers' available at <http://www.safaid.net/content/zimbabwe-circumcision-drive-targets-cabinet-ministers>.

3. Ibid.

4. We are indebted to Thérèse Murphy for this insight.

5. M Fox and M Thomson 'Short changed?: The law and ethics of male circumcision' (2005) 13 *International Journal of Children's Rights* 161 at 167.

6. *Re J* (Specific Issue Orders: Muslim Upbringing and Circumcision) (1999) 2 FLR 678 (Fam Div); *Re J* (Child's Religious Upbringing and Circumcision) [2000] 1 FLR 571 (CA); *Re S* (Children) (Specific Issue: Religion: Circumcision) [2005] 1 FLR 236.

7. We would therefore locate this paper within a recent trend of challenging the traditional parameters of the discipline of medical law. As Dickenson has observed, 'the individualistic slant of medical law, which tends to focus narrowly on a doctor-patient dyad' is ill-equipped to deal with the broader implications of many forms of research and interventions on the human body, given the multiple interests involved. D Dickenson *Body Shopping: Converting Body Parts to Profit* (Oxford: Oneworld, 2008) p 36. See also E Fee and N Krieger 'Understanding AIDS: historical interpretations and the limits of biomedical individualism' (1993) 10 *American Journal of Public Health* 1477; O O'Neill 'Public health or clinical ethics: thinking beyond borders' (2002) 16 *Ethics and International Affairs* 35. As we have detailed elsewhere, in our view the discipline should be more broadly conceptualised as Health Law or Healthcare Law – see S Sheldon and M Thomson 'Introduction' in Sheldon and Thomson (eds) *Feminist Perspectives on Health Care Law* (London: Cavendish, 1998); R Fletcher, M Fox and J McCandless 'Legal embodiment: analysing the body of healthcare law' (2008) 16 *Med LR* 321.

encompass the political and economic dimensions of the issue and show how the circumcision debate re-inscribes the cultural, racial and economic divisions which have characterised the HIV pandemic. Shifting the terms of the debate, as public health discourse allows by highlighting the multiple interests at stake,⁸ can serve to politicise a debate which has been privatised and depoliticised in Anglo-American law. Locating male circumcision in a broader global context, where the procedure has been actively promoted and funded as a public health response to HIV/AIDS by various stake-holders, including NGOs, private philanthropic organisations, pro-circumcision activists and national governments, the political stakes become more readily discernible. It then becomes more difficult to construe the decision to circumcise as a purely private matter beyond the legitimate reach of law. Furthermore, we would suggest that casting circumcision as a public health measure makes it problematic to discount a role for the state in regulating how and why the procedure is performed, particularly in the case of neonatal circumcision.

The appeal of circumcision as a public health response to HIV/AIDS in sub-Saharan Africa – the region at the centre of the resurgence of public health interest in the procedure – is clear. Clinical trials conducted here which suggest that circumcision may inhibit the spread of the virus have garnered significant attention, particularly as the procedure does not require the heavy investment of time and money entailed by a search for vaccines or therapeutics. Furthermore, circumcision can be portrayed by its advocates as a well-established and cost effective intervention, routinely performed in the West. In this paper we seek to highlight the various hidden costs of mass circumcision programmes given increasingly enthusiastic and simplified claims about its effectiveness. We also suggest that there is a danger that pro-circumcision policies may undermine the dominance of the human rights paradigm in the field of HIV/AIDS policy, as individual interests or rights are trumped by the promise of group or population benefits. For those concerned to protect the human rights to autonomy or bodily integrity that we discuss below, there are clearly risks once the debate is played out on the terrain of public health. Yet, while mindful of these risks, in this paper we argue that it is important that public debate is initiated about the procedure and that for this reason the growing politicisation of the topic in the USA and elsewhere is to be welcomed. In order to avoid the danger of human rights being overridden where circumcision is promoted as a ‘solution’ or public health imperative,⁹ we contend that

8. As Freedman argues, ‘public health allows us to go beyond isolated anecdotes or incidents and to see social patterns and configurations associated with what is experienced as individual phenomena of death, disability or disease’. L Freedman ‘Reflections on emerging frameworks of health and human rights’ in JM Mann et al (eds), *Health and Human Rights: A Reader* (New York: Routledge, 1999) p 246. See also J Coggon ‘Public health, responsibility and English law: are there such things as no smoke without fire or needless clean needles’ (2009) 17 *Med LR* 127 at 133. As recently as 1996 Brazier and Harris noted that ‘public health barely features as an issue in “medical law” texts or literature in the United Kingdom’. M Brazier and J Harris ‘Public health and private lives’ (1996) 4 *Med LR* 171 at 173.

9. R Martin ‘Implementing public health policy and practice within a legal framework: constraints of culture, faith and belief’ (2009) 9 *Medical Law International* 311; T Murphy and N Whitty ‘Is human rights prepared? risk, rights and public health emergencies’ (2009) 17 *Med LR* 219; L Gostin ‘Legal foundations of public health law and its role in meeting future challenges’ (2006) *Public Health* 1; JA Harrington ‘Commentary on “Legal foundations of public health law and its role in meeting future challenges”’ (2006) *Public Health* 9.

sound public health policy must be formulated on a very clear evidence base, and that clinical trials which purport to offer such an evidence base must conform to international standards which recognise fundamental human rights and the importance of social justice.¹⁰ Consequently, while the new advocacy of circumcision can appear compelling, we suggest that its claims merit careful scrutiny. Recognising the existence of a 'clamour for circumcision',¹¹ in some quarters, we believe it is crucial to delineate the specifics of the evidence currently available from clinical trials. As we shall demonstrate, findings are often exaggerated or simplified, and there is a risk of these inflated claims informing public debate and policy both domestically and internationally. Of course, inaccurate scientific reporting is not peculiar to the issue of circumcision,¹² but we argue that accurate reporting is particularly crucial to an informed debate about public health interventions in this newly controversial field.¹³

We also contend that ethico-legal norms applicable in the West must also govern the conduct of research trials in the Global South,¹⁴ and the translation of research findings into policy and practice there and beyond. For reasons we outline below, if a meaningful notion of social justice and respect for human rights is to be at the core of public health policy and provide a foundation for governance in the field,¹⁵ it is necessary to embark on these programmes with great caution. In this regard we are mindful that the global nature of public health initiatives may militate against the level of care required. In particular, given that most funding in this field originates from the USA, it should be noted that these controversial programmes are being promoted largely by organisations from a jurisdiction that remains significantly invested in male genital cutting.¹⁶ Moreover this promotion occurs as professional and governmental agencies around the world increasingly question the ethics and legality of the procedure where it is performed on infants. Thus, across a range of jurisdictions,

10. See Nuffield Council on Bioethics *The Ethics of Clinical Research in Developing Countries* (1999); *The Ethics of Research Related to Healthcare in Developing Countries* (2002); *The Ethics of Research Related to Healthcare in Developing Countries: a Follow Up Discussion Paper* (2005).

11. GW Dowsett and M Couch 'Male circumcision and HIV prevention: is there really enough of the right kind of evidence?' (2007) 15 (29) *Reproductive Health Matters* 33 at 40.

12. As the MMR saga demonstrates vividly, see B Goldacre *Bad Science* (London: Fourth Estate, 2008) chs 11 and 15.

13. C Paton *Inventing AIDS* (New York: Routledge, 1990) ch 2.

14. M Angell 'The ethics of clinical research in the third world' (1997) 337 (12) *New England Journal of Medicine* 847; E Jackson *Medical Law: Text, Case and Materials* (Oxford: OUP, 2nd edn, 2010) pp 486–493.

15. See J Coggan 'Does public health have a personality (and if so, does it matter if you don't like it)?' (2010) 19 *Cambridge Quarterly of Healthcare Ethics* 235.

16. Yet even in the USA the popularity of the procedure is declining. In the mid-1980s 84–89% of men in the USA were estimated to be circumcised – American Academy of Paediatrics Task Force on Circumcision *Circumcision Policy Statement* (1999) (103) (3) 686–693. Later estimates suggested that for some years circumcision rates remained relatively stable at around 60–65% in the white population but with a growth in popularity in black communities to similar levels – CP Nelson et al 'The increasing incidence of newborn circumcision: data from the nationwide inpatient sample' (2005) 173 (3) *Journal of Urology* 978–981. It has, however, been claimed that the rate has fallen precipitously in the years 2006–2009, so that fewer than half of boys born in US hospitals are now circumcised – see R Caryn Rabin 'Steep drop seen in circumcisions in US' *New York Times* 16 August 2010.

professional guidance has moved from recommending the procedure to a more neutral stance which acknowledges its medical risks.¹⁷ The Royal Dutch Medical Association has recently gone further in a viewpoint document which states explicitly that circumcision is a violation of the rights of the child, and recommends that 'a powerful policy of deterrence should be established'.¹⁸ At the time of writing we would suggest that there is a discernible 'blowback' effect in the USA,¹⁹ as the Center for Disease Control and Prevention (CDC), the American Association of Pediatricians (AAP) and the American Association of Family Physicians (AAFP) are considering recommending the routine circumcision of infant boys in the USA on the basis of the African trials showing that the procedure may reduce the risk of HIV infection for adult men. Dr Susan Blank, chair of an AAP task force on circumcision, has described arguments in favour of the procedure based on three studies carried out in sub-Saharan Africa as 'very compelling'.²⁰ Should the AAP propose universal circumcision this would be the first instance since the 1970s of the procedure being promoted by a Western professional medical body, and would stand in stark contrast to the Dutch position. Thus, we acknowledge the risk that the African studies may revitalise support for the procedure in the West, notwithstanding the significantly different cultural and epidemiological conditions that obtain and the different issues raised by performing surgical interventions on the bodies of adults and children. Nevertheless we argue that by framing circumcision as a public health intervention these studies have the potential to change how we think about the practice, rendering it less private and more politicised, in Western jurisdictions as well as in Africa.

17. In 1999 the American Academy of Pediatrics (AAP) stated that available data were not sufficient to recommend routine neonatal circumcision (AAP 'Circumcision policy statement' (1999) 103 *Pediatrics* 686). This was reaffirmed in 2005 after publication of the results of the South African trial (AAP 'AAP publications retired and reaffirmed' (2005) 116 *Pediatrics* 796). The Paediatrics and Child Health Division of the Royal Australasian College of Physicians' *Policy Statement on Circumcision* (Sydney: RACP, 2004) states that 'there is no medical indication for routine male circumcision', available at www.racp.edu.au/hpu/paed/circumcision/print.htm.

18. Royal Dutch Medical Association *Non-Therapeutic Circumcision on Male Minors* (2010) available at <http://knmg.artsenet.nl/Diensten/knmgpublicaties/KNMGpublicatie/Nontherapeutic-circumcision-of-male-minors-2010.htm>. The Royal Australian College of Physicians released a new position paper in September 2010. This paper takes a far less critical stance on the procedure, restating parental rights in this matter. RACP 'Circumcision of infant males', available at <http://www.racp.edu.au/index.cfm?objectid=D7FAA93E-E091-4209-15657544BA419672>.

19. As Harrington has pointed out to us, Africa, with its AIDS pandemic and history of colonial and post-colonial governance is an ideal site for public health policies to be pioneered and then transferred back – see J Harrington 'Law and the commodification of healthcare in Tanzania' (2003) *Law, Social Justice & Global Development*, available at http://www2.warwick.ac.uk/fac/soc/law/elj/lgd/2003_2/harrington. In the current context, Darby and Svoboda have argued that part of the drive for circumcision in Africa can be explained by a desire to reverse the decline in the practice in the USA – see R Darby and S Svoboda 'A rose by any other name: symmetry and asymmetry in male and female genital cutting' in C Zabus (ed) *Fearful Symmetries: Essays and Testimonies around Excision and Circumcision* (Amsterdam and New York: Rodopi, 2008) pp 251–297.

20. P Shishkin 'Circumcision decreases the risk of contracting STDs, study says' *Wall Street Journal* New York, 26 March 2009, available at http://online.wsj.com/article/NA_WSJ_PUB:SB123802256715541879.html.

THE NEW ADVOCACY OF MALE CIRCUMCISION IN AFRICA

Montgomery has charted how coverage of the HIV/AIDS pandemic has a 'strong racial overtone . . . AIDS is no longer represented as a gay plague but an African one',²¹ thus illustrating how social marginalisation contributes to our understanding of the pandemic. In addressing contemporary public health initiatives in the HIV/AIDS field we argue that it is essential to recognise this ongoing history of targeting particular, stigmatised, groups for intervention.²² As we shall demonstrate, this history entails not only that certain groups are constructed as sources of infection, but that other interests are downplayed in formulating public health policy. In Africa, male genital cutting was posited early on in the health crisis as a possible response.²³ Indeed, it was promoted by some as a 'natural condom'.²⁴ Over the past decade the relationship between circumcision status and HIV status has become a focus of scientific study and public health policy discussions, particularly following the results of three trials in South Africa, Kenya and Uganda between 2005 and 2007. These trials demonstrated a partial protective effect against HIV infection for circumcised men who engaged in heterosexual intercourse.

This long and complex history of medically justified male genital cutting is tied, in part, to concerns about male sexuality, hygiene and race.²⁵ It is a procedure that has prompted a lengthy and contested search for a bio-medical justification.²⁶ Given the repeated turn to circumcision in the context of sexually transmitted disease it is scarcely surprising that it was mooted as a response at an early stage in the HIV/AIDS crisis, although it is worth stressing that any relationship between circumcision and sexually transmitted diseases is itself contested,²⁷ as indeed is the construction of HIV as a purely sexually transmitted infection.²⁸ As Bonner notes, 'The belief that circumcision is protective against STI is persistent in the circumcision literature, although studies of the effect of circumcision on STI rates give mixed results'.²⁹

21. J Montgomery 'Medicalizing crime – criminalizing health? The role of law' in C Erin and S Ost (eds) *The Criminal Justice System and Health Care* (Oxford: OUP, 2007) pp 257 and 267.

22. K Bonner 'Male circumcision as an HIV control strategy: not a "natural condom"' (2001) 9 *Reproductive Health Matters* 143 at 150. Bonner cites an Australian Report on HIV/AIDS which recommended 'routine neonatal circumcision at least in Aborigines and Torres Strait Islander communities'. D Kault 'Assessing the national HIV/AIDS strategy evaluation' (1996) 20 *Australia New Zealand Journal of Public Health* 347.

23. AJ Fink 'Newborn circumcision: a long-term strategy for AIDS prevention' (1989) 82 *Journal of the Royal Society of Medicine* 695; S Moses et al 'The association between lack of male circumcision and the risk of HIV infection. A review of the epidemiological data' (1994) 21(4) *Sexually Transmitted Disease* 201; J Cardwell and P Cardwell 'The African AIDS epidemic' (1996) 274(3) *Science America* 62.

24. Fink, above n 23.

25. See DL Gollaher 'From ritual to science: the medical transformation of circumcision in American' (1994) 28 *Journal of Social History* 5; R Darby *A Surgical Temptation: The Demonization of the Foreskin in Britain* (Chicago: University of Chicago Press, 2005).

26. Gollaher, above n 25; Darby, above n 25.

27. HA Weiss et al 'Male circumcision and risk of syphilis, chancroid, and genital herpes: a systematic review and meta-analysis' (2006) 82 *Sex Transm Infect* 101.

28. S Gilman 'AIDS and syphilis: the iconography of disease' in D Crimp (ed) *AIDS: Cultural Analysis/Cultural Activism* (Cambridge, Massachusetts: MIT Press, 1988).

29. Bonner, above n 22, at 148.

In advance of credible scientific studies, articles were published which short-circuited the need for credible and consistent scientific evidence.³⁰ Gostin notes that this is always a temptation in the public health field where, in order to ‘achieve . . . beneficent objectives, public health professionals may exaggerate risks or benefits, or may make claims that are insufficiently grounded in the science’.³¹ It was also clear to some that there was a hunger on the international stage to find a correlation between circumcision status and HIV status. As Dowsett and Couch observed, reflecting on the XVI International Conference on AIDS in 2006:

‘[T]he rhetoric coming from the Toronto conference in August 2006 suggested that it was simply a procedural nicety to have to wait for the evidence from these trials . . . the clamour for circumcision silenced many questions, overrode any misgivings and swept sceptics to the sidelines. Silenced, too, was any call for the kind of ongoing evidenced-based decision making on male circumcision as a preventative technology that acknowledges that what causes something to happen has nothing to do with the number of times we observe it happening.’³²

A randomised controlled trial in Orange Farm, South Africa, in 2005 was the first to establish a connection between circumcision status and the rate of HIV transmission.³³ The results were subsequently duplicated in Uganda³⁴ and Kenya.³⁵ These trials, in countries where the virus is endemic and where penile-vaginal intercourse is the predominant mode of virus transmission, found that over a 24-month period circumcision reduced the risk for men of acquiring HIV by around 51–61%.³⁶ In each trial, those men assigned to an intervention group who were then circumcised had a lower incidence of HIV infection in up to two years of follow-up study compared to men assigned to a control group who were not circumcised. All three trials were halted by their safety and monitoring boards when interim results prompted the conclusion that it would be unethical to withhold circumcision from the control groups any longer.

In March 2007, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) held a technical consultation on male circumcision and issued a summary document offering conclusions and recommendations relating to policy and programme development. It hailed the results of the three African studies as ‘an important landmark in the history of HIV prevention’. The organisations concluded that the three trials demonstrated a population-level benefit and proposed the introduction of mass circumcision programmes throughout

30. Fink, above n 23; T Szabo and RV Short ‘How does male circumcision protect against HIV infection?’ (2000) 85(1) *BMJ* 19.

31. L Gostin *Public Health Law and Ethics: A Reader* (Berkeley: University of California Press, 2nd edn, 2010) p 14.

32. Dowsett and Couch, above n 11, p 34 (references omitted).

33. BD Auvert et al ‘Randomised, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 trial’ (2005) 11 *PLoS Medicine* 2, e298 doi:10.1371/journal.pmed.002098.

34. H Gray et al ‘Male circumcision for HIV prevention in young men in Rakai, Uganda: a randomised trial’ (2007) 369 *Lancet* 657.

35. C Bailey et al, ‘Male circumcision for HIV prevention in young men in Kyushu, Kenya: a randomised controlled trial’ (2007) 369 *Lancet* 643.

36. South Africa 61%, Uganda 53%, Kenya 51%. This averages at 55% although it is notable that it is usually the South African figure that is standardised and typically cited.

sub-Saharan Africa.³⁷ These proposals have attracted high level international support, including philanthropic endorsement and funding, notably from the Bill and Melinda Gates and Clinton Foundations.³⁸

In April 2009 a Cochrane Review – a systematic assessment of healthcare interventions which purports to provide the most comprehensive, reliable and relevant source of evidence – was established to assess the effectiveness of male circumcision in preventing acquisition of HIV.³⁹ It concluded that there was strong evidence that male circumcision, performed in a medical setting, reduces the acquisition of HIV by men engaging in heterosexual sex by a rate of between 38% and 66% over a 24-month period. Crucially, however, the Review noted that further research was required to assess the feasibility, desirability and cost-effectiveness of implementation within local contexts. We suggest that advocacy of a ‘circumcision solution’⁴⁰ in Africa and elsewhere on the basis of the three studies to date is ethically problematic in the absence of such further research.⁴¹ In the following two sections we outline some of these concerns, focusing on the parameters and limitations of the trials. In particular, we highlight the problems of moving from clinical trials to effective health policy (feasibility) and the problems that exist in terms of the possible impact on other prevention strategies (desirability).

37. WHO/UNAIDS ‘New data on male circumcision and HIV prevention: policy and programme implications’ (2007), available at http://data.unaids.org/pub/Report/2007/mc_recommendations_en.pdf.

38. We would suggest that, while space precludes a full consideration here, the role of such private philanthropic organisations in this arena merits further scrutiny. For all the plaudits it has attracted, the Gates Foundation has been criticised for its lack of transparency or accountability, while its commitment to peer review of grant making has been questioned – see L White ‘Tipping the balance’ *Sunday Times* 3 July 2005; A Beckett ‘Inside the Bill and Melinda Gates Foundation’ *Guardian* 12 July 2010. Furthermore, as Booth has argued, homogenising constructions of Africa as ‘desperate’, ‘needy’ and dependent on intervention by international bodies, omits any ‘acknowledgement of US and Western European participation in creating and worsening the various disasters faced by many of the countries hosting [various HIV related] trials’ – see K Booth ‘Magic bullet for the “African” mother? Neo-imperial reproductive futurism and the pharmaceutical “solution” to the HIV/AIDS crisis’ (2010) 17 *Social Politics* 349 at 365.

39. *Cochrane Database of Systematic Reviews* 2009; (2):CD003362, doi: 10.1002/14651858.CD003362.pub2.

40. RS Van Howe and MR Storms ‘How the “circumcision solution” in Africa will increase HIV infections’ (paper on file with authors).

41. The absence of an adequate information base for public health interventions is a pervasive problem in the field. For instance, in the UK the Wanless Report noted that: ‘Although there is often evidence on the scientific justification for action and for some specific interventions, there is generally little evidence about the cost-effectiveness of public health and preventative policies or their practical implementation. Research in this area can be technically difficult and there is a lack of depth and expertise in the core disciplines. This, coupled with a lack of funding of public health intervention research and slower acceptance of economic perspectives within public health, all contribute to the dearth of evidence of cost-effectiveness. This has led to the introduction of a very wide range of initiatives, often with unclear objectives and little quantification of outcomes and it has meant it is difficult to sustain support for initiatives, even those which are successful’. D Wanless *Securing Good Health for the Whole Population* (London: Department of Health, 2004) Summary ch 5. The report also deplored the ‘very poor information base’ and noted the ‘lack of conclusive evidence for action’. See also J McHale ‘Law, regulation and public health research: a case for fundamental reform?’ *Current Legal Problems* (2010) 63 475.

PARAMETERS AND LIMITATIONS

Epstein has noted that, notwithstanding how they are '[w]idely considered the pathway to objectivity in modern biomedical research, clinical trial results in practice can be subject to enormous amounts of interpretive flexibility' so that 'deciphering clinical trial findings can prove not only a contentious process, but also a highly public one'.⁴² Further, the valorisation of the clinical trial as the gold standard for conducting research can mean that difficulties in then translating clinical trials into effective policy outcomes and law are glossed over. As Imrie and colleagues observed in the year that the African trials were halted:

'It is important to remember that efficacy is not the same as effectiveness. All trials of biomedical interventions to prevent HIV have biological markers or reduced HIV as their primary end point. Their aim is to show efficacy (health improvement under ideal circumstances, in expert hands), rather than effectiveness (impact on health, under real-world conditions, for entire populations).'⁴³

Similarly, Bertozzi et al have noted, 'One of our challenges is confronting the chasm that exists between the academic world, in which optimisation is normally based on controlled trials that report with 95% certainty, and the real world, where uncertainty reigns.'⁴⁴

While the internal validity of the randomised controlled clinical trial has been generally (although not universally) accepted, the external validity – that is the generalisability of the scientific results from the specific contexts of the trials – remains unproven.⁴⁵ The African trials have been recognised as context-specific for a number of reasons, principally relating to transmission dynamics. In the regions where the trials were conducted, penile-vaginal transmission is the predominant means of sexual infection. Further, there exists a high level of HIV infection in the partner 'pool'⁴⁶ and a low incidence of male circumcision. The correlation between high levels of male circumcision and low HIV prevalence in some other African countries and other developing regions has been challenged.⁴⁷ Two further studies have found protective effects in only some countries and no consistent relationship elsewhere.⁴⁸ Moreover, as Van Howe and Storms observe, the results of the three trials to date do not seem to correlate with meta-analysis of population survey results from 19

42. S Epstein *Impure Science: AIDS, Activism and the Politics of Knowledge* (Berkeley: University of California Press, 1998) p 32.

43. J Imrie et al 'Biomedical HIV prevention – and social science' (2007) 370 *Lancet* 10.

44. SM Bertozzi et al 'Making HIV prevention programmes work, HIV Prevention 5' (2008) 372 *Lancet* 831 at 831.

45. LW Green et al 'Male circumcision and HIV prevention: insufficient evidence and neglected external validity' (2010) *Am J Prev Med* 39(5) 479.

46. A US study has illustrated the impact of partner prevalence of HIV on the association of circumcision and AIDS infection status. Analysis of the data concluded that it was difficult to detect a protective effect from HIV in a setting where there was a lower prevalence of HIV in the partner 'pool' – L Warner et al 'Male circumcision and risk of HIV infection among heterosexual men attending Baltimore STD clinics: An evaluation of clinic-based data' Society of Epidemiological Research Meeting 21–24 June 2006, Seattle, Washington, available at <http://cdc.confex.com/cdc/std2006/techprogram/P11223.HTM>.

47. Van Howe and Storms, above n 40.

48. Dowsett and Couch, above n 11, at 36.

countries which sought to compare HIV prevalence based on circumcision status. This raises questions about whether, on a population level, circumcision is effective in halting or reducing the spread of HIV.⁴⁹

Following the three African trials, other researchers have sought to test their parameters and limitations. A study by Wawer et al in 2009 found that circumcision does not offer the same protection to women.⁵⁰ Research by Miller et al concluded that circumcision had no protective effects for men who have sex with men (MSM).⁵¹ While the CDC and AAP deliberate on whether to recommend circumcision of male children in the USA in the light of the African studies, it should be noted that most sexual transmission of HIV in the USA, UK and Australia occurs through male-male sex, most often infecting the receptive partner in penile-anal intercourse.⁵² Although male-to-female transmission is much more prevalent in Africa, a 2009 study from Oxford University, the Population Council of Ghana, and the Kenyan Medical Research Council concluded that infection via MSM was a major blind spot in HIV/AIDS research and policy development in Africa. The research blamed social and institutional homophobia for this omission.⁵³ Significantly, it also noted evidence of behavioural links between MSM and heterosexual networks.⁵⁴ Aside from this single study, however, little attention has been paid to the realities of sexual practice and regional variation in the African context.⁵⁵ This raises concerns about how far the findings of the trials are generalisable in Africa, and supports Esacove's contention that a 'heterosexual imaginary' is translated into HIV prevention efforts in sub-Saharan Africa.⁵⁶ Such an imaginary may blind public health policy makers to important features of the transmission dynamics of HIV.

While it is clearly impossible to foresee every eventuality, in formulating public health policy it is crucial to anticipate the probable consequences of implementing any mass intervention programme. In this regard, international organisations are unequivocal that circumcision must be seen as complementary to other ways of reducing HIV transmission. For instance, the UNAIDS report *Safe, Voluntary and Informed Male Circumcision and Comprehensive HIV Prevention Planning: Guidance for Decision Makers on Human Rights, Ethical and Legal Considerations* supports circumcision as a response to HIV only 'in combination with other methods to reduce the risk of sexual transmission of HIV', including: correct and consistent

49. Van Howe and Storms, above n 40.

50. MJ Wawer et al 'Circumcision in HIV-infected men and its effect on HIV transmission to female partners in Rakai, Uganda: a randomised controlled trial' (2009) 374 *Lancet* 229.

51. JA Miller et al 'Circumcision status and risk of HIV and Sexually Transmitted Infections among men who have sex with men: a meta-analysis' (2008) 300(14) *JAMA* 1674.

52. B Varghese et al 'Reducing the risk of sexual HIV transmission: Quantifying the per-act risk for HIV on the basis of choice of partner, sex act, and condom use' (2002) 29 *Sexually Transmitted Disease* 38. A presentation at the 2010 International AIDS Conference in Vienna by a team from the University of Pittsburgh Graduate School of Public Health, which focused on gay male sex, questioned whether circumcision would significantly reduce the spread of HIV in the USA. K Melly 'Adult circumcision minimally effective at controlling US HIV transmission' *Edge Boston* 22 July 2010.

53. AD Smith et al 'Men who have sex with men and HIV/AIDS in Sub-Saharan Africa' www.thelancet.com published online 20 July 2009 doi:10.1016/S0140-6736(09)61118-1.

54. *Ibid.*

55. AE Esacove 'Heteronormativity, modernity, and AIDS prevention in Malawi' (2010) 24 *Gender & Society* 83.

56. *Ibid.*, at 86.

condom use, delayed sexual debut, reduced numbers of sexual partners, avoiding penetrative sex, and voluntary HIV testing and counselling.⁵⁷ However, this message is often lost in public policy formulation. Additionally, as Van Howe and Storm point out, in a context of scarce resources condoms are not only more effective at reducing disease transmission but also cheaper. Yet 'public health workers in Africa are finding that resources that previously paid for condoms are now being redirected to circumcision'. They calculate that '[w]ith every circumcision performed, 3000 condoms will not be available'.⁵⁸ In similar vein, Annas and Grodin have argued that even though:

'we already know that effectively treating sexually transmitted diseases such as syphilis, gonorrhoea, and chancroid with the simple and effective treatments that are now available can drastically lower the incidence of HIV infection . . . these inexpensive and effective treatments are not delivered to poor Africans'.⁵⁹

Thus, although circumcision can be presented as a relatively cheap preventative measure this does come at the cost of diverting resources from other, arguably cheaper and more effective measures.

A related problem with mass circumcision policies is that risk compensation behaviour may follow the procedure due to misunderstandings about the partial nature of the protective benefits, which potentially diminishes the impact of safer sex campaigns. The AIDS Vaccine Advocacy Coalition (AVAC) is clear that any 'benefits of male circumcision could be offset by an increase in high-risk acts like unprotected sex or an increase in the number of partners'.⁶⁰ It is foreseeable that the partial protective effects of circumcision will be misunderstood, not least when experts in the field compound this by providing oversimplified and misleading accounts of the results of the trials. In this regard two examples are worth noting. First, in 2008, the year that Peter Piot stood down as head of UNAIDS, the BMJ published an open letter by Epstein to Piot's successor. In the letter she made the exaggerated and unqualified statement that: 'Recent randomised trials have shown that circumcised men are 60–70% less susceptible to HIV than uncircumcised men'.⁶¹ Second, in a *Lancet* paper co-authored by Piot the following year, entitled 'AIDS: lessons learnt and myths dispelled', the authors offer a useful assessment of the progress made in treatment of HIV/AIDS over the last three decades. Their account is generally detailed, specific and contextual, yet the three African studies are summarised as follows: 'Encouragingly, in the past 2 years, studies have shown that male circumcision reduces HIV infection in men by about 60%, although it does not reduce transmission from men to women or between men'.⁶² No reference is made to the contexts of the trials (in terms of the clinical setting or the high prevalence of HIV infection and low prevalence of circumcision) or of the imperative to maintain or adopt other preventive methods in conjunction with circumcision (particularly using condoms and limiting multiple and

57. UNAIDS *Safe, Voluntary and Informed Male Circumcision and Comprehensive HIV Prevention Planning: Guidance for Decision Makers on Human Rights, Ethical and Legal Considerations* (Geneva: UNAIDS, 2007) at 7.

58. Van Howe and Storm, above n 40.

59. GJ Annas and MA Grodin 'Human rights and maternal-fetal HIV transmission prevention trials in Africa' (1998) 88 *American Journal of Public Health* 561 at 561.

60. AVAC 'A new way to protect against HIV? Understanding the results of male circumcision studies for HIV prevention' AIDS Vaccine Advocacy Coalition report (New York: AVAC, 2007) at 9.

61. H Epstein 'AIDS and the irrational' (2008) 337 *BMJ* 1265 at 1266.

62. P Piot et al 'AIDS: lessons learnt and myths dispelled' (2009) 374 *Lancet* 260.

concurrent partners). Further, and in common with the overwhelming majority of reporting in this field, the paper makes no reference to the risk of complications. In such accounts the scientific specifics of the trials are erased and the necessary caution in providing clear and accurate information about the parameters of the trials is absent.

In terms of risk compensation, unprotected sex is particularly dangerous should it occur before the wound has properly healed. Men who have sex in this period are more vulnerable to HIV infection, while those already infected may increase the risk of their sexual partners acquiring HIV.⁶³ The Wawer study, which was funded by the Bill and Melinda Gates Foundation in Uganda and halted early, suggested that women were particularly vulnerable to infection in this period since sexual intercourse could cause small tears in the circumcision wound, transmitting HIV infected blood into the vagina.⁶⁴ Analogously, tears in the circumcision wound would also increase the risk of transmission to receptive partners in anal sex between men. The Wawer study demonstrated that the HIV acquisition rate in female partners of circumcised men who resumed sexual activity before wound healing was 27.8%. This compared with 9.5% in partners of men who had undergone circumcision but delayed sex until healing and 7.9% in the partners of uncircumcised men. Regarding the likelihood of risky behaviour, a 2006 prospective study from Kenya traced a shift from high levels of risk behaviour prior to surgery, to an excellent level of immediate post-operative compliance, but then a reversion to the same levels of pre-circumcision risk behaviour within a year.⁶⁵ As commentators at the XVI International Conference on AIDS in Toronto noted, 'Activists and practitioners . . . were concerned with a potential undercutting of their hard-won shifts in sexual cultures, in many places, towards safe sex practices'.⁶⁶ Such studies also raise serious questions about the ethics of trials which appear to increase the risk of HIV transmission to partners who were HIV-free when the trials commenced,⁶⁷ and speak to feminist concerns that public health initiatives often fail to make connections between gender, disadvantage and health, thereby compromising women's health.⁶⁸ In order to facilitate a more joined up approach which addresses structural factors that impact on health and wellbeing, we argue that a new approach, grounded in social justice is needed, and that such arguments have relevance beyond the African context.

63. Joint United Nations Programme on HIV/AIDS *New Data on Male Circumcision and HIV: Policy and Programme Implications* (2007), available at http://www.who.int/hiv/mediacentre/MCrecommendations_en.pdf.

64. 'HIV-positive men who have sex before circumcision wounds are healed could increase female partners' infection risk, study says' *Kaiser Daily HIV/AIDS Report* 7 March 2007. Kevin de Cock, Director of the WHO HIV/AIDS Department, was reported as stating that the data do not 'derail [the potential usefulness of circumcision] by any means', but 'what it does do is to provide a little more insight into the complexities that face us'. See also Bonner, above n 22, at 147; DD Brewer et al 'Male and female circumcision associated with prevalent HIV infections in virgins and adolescents in Kenya, Lesotho, and Tanzania' (2007) 17 *Annals of Epidemiology* 217.

65. KE Agot et al 'Male circumcision in Siaya and Bondo districts, Kenya: prospective study to assess behavioural disinhibition following circumcision' (2006) 41 *Journal of Acquired Immune Deficiency Syndrome* 66.

66. Dowsett and Couch, above n 11, p 34.

67. TM Okwusoa, V Guopa, and A Goel 'Male circumcision for prevention of HIV transmission' (2009) 374 *Lancet* 1497; M Berer 'Male circumcision for HIV prevention: what about protecting men's partners?' (2008) 16 *Reproductive Health Matters* 171.

68. WA Rogers 'Feminism and public health ethics' (2005) 31 *J Med Ethics* 351.

RE-FRAMING LEGAL DEBATES

A new jurisprudential lens: the case for social justice

As we noted in the introduction, in Anglo-American jurisprudence a common-sense view of circumcision, which conceptualises it as a trivial familial matter, obscures the ethical issues that the procedure raises. While studies show that all circumcisions, however competently or hygienically performed, have a 2–10% incidence of complications,⁶⁹ these risks tend to be erased or downplayed when infant circumcision is discussed in the West. Similarly, we have suggested that the pain experienced by neonates is disregarded and that inadequate attention has been paid to the ethics of parents consenting to an irreversible bodily intervention on behalf of children too young to participate in decision making.⁷⁰ Given how these questions about the ethics and legality of the practice are glossed over in the West, it is no surprise that the issue of pain, risks and complications have not figured prominently in discussions of circumcision in the African context, even though the risks and complications of surgery there are dramatically increased, for reasons we explore below. Understandably, in sub-Saharan Africa the emphasis has been overwhelmingly on the importance of finding a solution to the epidemic. Yet it is precisely this imperative which, we suggest, makes the ethico-legal questions even more acute.

In addressing pain, Powers and Faden have called attention to the many ways in which pain is incompatible with health.⁷¹ They contend, however, that not all public health policy decisions do or should rest on the single moral foundation of health, but rather are grounded in a broader concept of social justice.⁷² Thus, for instance, in examining the analogous cutting practice which they term ‘female genital mutilation’, Powers and Faden suggest that arguments opposing that practice should be grounded not purely in concerns for health, but in ‘the physical and psychological inviolability encompassed by the dimension [of social justice that] we label as personal security, and self-determination’.⁷³ We argue here that comparable questions of social justice are raised by the forms of genital cutting advocated by proponents of mass circumcision programmes. As DeLaet observes, they ‘are not sufficiently divergent practices to warrant a differential response from the international community’.⁷⁴ We follow Powers and Faden in suggesting that well-formulated public health policies must be grounded in a commitment to social justice. This understanding of social justice

69. Fox and Thomson, above n 5.

70. See, for example, M Benatar and D Benatar ‘Between prophylaxis and child abuse: the ethics of neonatal male circumcision’ (2003) 3 *American Journal of Bioethics* 35 and our critique of their position in Fox and Thomson, above n 5.

71. M Powers and R Faden *Social Justice: The Moral Foundations of Public Health and Health Policy* (Oxford: OUP, 2006) p 17.

72. *Ibid.*, ch 2.

73. *Ibid.* Commentators persist in drawing a clear distinction between genital cutting of boys and girls – see for instance CL Annas ‘Irreversible error: the power and prejudice of female genital mutilation’ in Mann et al, above n 8, p 337. However, as Berer notes, ‘the concept of genital integrity is one of the most potent reasons put forward for opposition to female genital mutilation which begs the question of why it does not apply with equal force to male genitalia even if there would be public health benefits from removing men’s foreskins en masse’. M Berer ‘Male circumcision for HIV transmission: perspectives on gender and sexuality’ (2007) 15 *Reproductive Health Matters* 45 at 47.

74. DL DeLaet ‘Framing male circumcision as a human rights issue? Contributions over the universality of human rights’ (2009) 8 *Journal of Human Rights* 405 at 406.

encompasses – but is broader than – a right to health, and entails the application of human rights to public health and health policy.⁷⁵ Within the Powers and Faden model, health is posited as only one of six core dimensions of social justice – the others being personal security, reasoning, respect, attachment and self-determination. These dimensions of well-being provide ‘an account of those things *characteristically* present within a decent life . . . [and] are of special moral urgency because they matter centrally to everyone’⁷⁶ thus giving us criteria for evaluating the extent to which requirements of social justice are met in the context of public health. Each dimension provides a separate lens through which existing forms and patterns of social organisation must be evaluated. Social justice demands that policy makers must seek – as far as possible – to secure a sufficient level of each dimension for each individual. Powers and Faden observe that ‘inequalities of one kind beget and reinforce other inequalities’ and the cumulative effect of different inequalities on human well-being will depend on their causal interaction.⁷⁷ Within this theoretical framing, public health should be committed to identifying and addressing patterns of systematic disadvantage which, as we have seen above, have structured understandings of HIV.

Building on the work of Powers and Faden, Baylis, Kenny and Sherwin have offered a relational account of public health ethics which recognises the social nature of persons and the moral significance of social patterns of discrimination and privilege.⁷⁸ They argue that because inequality is (at least partially) socially constructed, and the unequal distribution of health is inextricable from other social inequalities, a focus on social justice demands that public health ethics addresses the structural causes of inequality:

‘Social justice directs us to explore the context in which certain political and social structures are created and maintained, and in which certain policy decisions are made and implemented. It asks us to look beyond effects on individuals and to see how members of different social groups may be collectively affected by private and public practices that create inequalities in access and opportunity . . . Social justice further enjoins us to correct *patterns* of systemic injustice among different groups, seeking to correct rather than worsen systemic disadvantages in society.’⁷⁹

Consequently we argue that attempts to frame a global right to health must be rooted in a commitment to social justice which recognises that structural matters of poverty, gender inequality and power, for instance, will impact on health. Over recent years attempts have been made to develop the right to health which is enshrined in Art 12 of the UN International Covenant on Economic, Social and Cultural Rights (ICESCR,

75. Powers and Faden, above n 71, ch 2. Their approach has similarities with Nussbaum’s conception of justice which entails that citizens should be supported in ways that enable them to realise their basic human capacities. M Nussbaum *Sex and Social Justice* (New York: OUP, 1999). These theorists have been criticised for ‘lack[ing] adequate recognition of power relations and the political’ by downplaying the empowering role of struggles by social movements for human rights – see S Correa, R Petchesky and R Parker *Sexuality, Health and Human Rights* (Abingdon: Routledge, 2008) p 152. However, we maintain that approaches grounded in a commitment to social justice can also avoid the exclusionary and oppositional tendencies of rights discourses.

76. Powers and Faden, above n 71, p 15.

77. *Ibid*, p 31.

78. F Baylis, NP Kenny and S Sherwin ‘a relational account of public health ethics’ (2008) 1 *Public Health Ethics* 196.

79. *Ibid*, at 203.

1966) and we suggest that these developments have the potential to take account of structural factors and to be applicable to the African debates on circumcision. Art 12 recognises ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’.⁸⁰ In 2000 the UN Committee on Economic Social and Cultural Rights (CESCR) produced General Comment 14 which sought to elaborate on Art 12. It is explicit that the right is an:

‘inclusive right extending not only to timely and appropriate healthcare but also to the underlying determinants of health, such as access to safe and portable water and adequate sanitation . . . and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision making at the community, national and international levels’ (para 11).⁸¹ In relation to HIV and other STIs, the comment requires: ‘the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity’ (para 16).

We would suggest that these developments in the field of international human rights law have the merit of opening up space to address issues of social disadvantage and vulnerability. They thus offer a new lens for addressing practices of male circumcision not only in Africa but in the West. Indeed, we argue that grounding public health discourse in a social justice paradigm renders visible the political, social and cultural dimensions of debates around male circumcision which have been obscured within traditional medical law discourses. Not only does this mean that in the circumcision context, issues of power, vulnerability and discrimination become prominent, but viewing practices through the lens of public health and social justice poses a fundamental challenge to the dominance of a biomedical model, which as Harrington and Stuttford argue, ‘privileges clinical care over more wide-ranging interventions’.⁸² Thus, in another version of the ‘blowback effect’, we suggest that adoption of a public health focus rooted in social justice also has the potential to broaden the parameters of health law by moving far beyond its traditional focus on the doctor–patient relationship.⁸³ Of course, within such debates the meanings of social justice and human rights remain indeterminate. Thus, while it is hard to dissent from Gostin’s view that understandings of social justice ‘require the preservation of human dignity and the showing of equal respect for the interests of all members of the community’,⁸⁴ or from Gearty’s similar vision of human rights grounded in compassion and committed to equality of esteem and dignity,⁸⁵ what this might entail in practice is very contested.

80. For the historical backdrop to this provision see J Harrington and M Stuttford ‘Introduction’ in *Global Health and Human Rights: Legal and Philosophical Perspectives* (London: Routledge, 2010).

81. In 2008 the UN General Assembly adopted an Optional Protocol of the ICESCR allowing individuals or groups to take actions against states for violation of their rights, including the right to health, though this is has yet to come into force – *ibid*, p 2.

82. *Ibid*, p 4.

83. See above n 7.

84. Gostin, above n 31, pp 16–17.

85. C Gearty *Can Human Rights Survive?* (Cambridge: CUP 2005) ch 2.

In this paper, while acknowledging the commonalities between conceptions of human rights and social justice, we employ the language of social justice. As Gearty notes, it has been largely superseded by the colonising discourse of human rights, which increasingly 'is being called upon to do all the moral work'.⁸⁶ We see social justice as more apposite for our argument since it is less concerned with individual claims, less closely tied to an elusive sense of human dignity, and potentially affords more space for those groups and individuals most directly affected by the HIV/AIDS epidemic in Africa to frame arguments that work for them and in their context. Nevertheless we recognise that it is almost impossible to avoid human rights discourse, which as Corea et al have noted, is both indispensable and insufficient.⁸⁷ In any event, and regardless of whether social justice or human rights is the preferred terminology, as Baxi has recently argued, it is necessary to translate such meta-theoretical approaches 'into specifically human rights *regional* approaches to justice as providing a versatile range of conceptual frameworks and normative tools of immense help towards the realisation of social and economic rights'.⁸⁸ As Baxi observes, framing a human right to health raises important questions of the 'scope (what obligations do rights cast and upon whom) and of the *justice* of rights (justification for prioritisation, hierarchies, and distribution of rights)'.⁸⁹ He suggests that a meaningful right to health, such as that being developed under Art 12 of CESCR, requires that obligations imposed must extend beyond the state to encompass 'medical education and research establishments, institutions and networks, and especially increasingly to global pharmaceutical industries'.⁹⁰ We would add that this formulation must also include those multilateral bodies shaping pro-circumcision policies, such as UNAIDS, and private philanthropic foundations (such as the Gates Foundation) which are increasingly prominent and influential in the field. Building on Pogge's responsibility based theory,⁹¹ Baxi argues for attention to be diverted from those who experience justice and injustice towards those who produce injustice, through practices such as contemporary unfair trade measures or historic extraction of resources. His account offers an important backdrop against which to begin to frame the ethico-legal obligations of researchers, funders and public health strategists in developing countries.

When considering how an approach rooted in notions of social justice and an emerging right to health might be deployed to assess the ethics and efficacy of promoting circumcision in the African AIDS context, we suggest that community interests can usefully be broken down into three categories. The first comprises the

86. Ibid, p 9.

87. Corea, Petchesky and Parker, above n 75.

88. U Baxi 'The place of the human right to health and contemporary approaches to global justice: Some impertinent interrogations' in Harrington and Stuttford, above n 80, p 17. See further U Baxi *The Future of Human Rights* (New Delhi: OUP, 2002). See also Gearty, above n 85, p 68. He argues that the emancipatory power of human rights ideals are most likely to be realised and maintained where 'the rhetoric of human rights is translated into precise and carefully constructed positive rights'. For a discussion of such rights in an international environmental context see C Gearty, 'Do human rights help or hinder environmental protection?' (2010) 1 *Journal of Human Rights and the Environment* 7.

89. Baxi, above n 88, p 12.

90. Ibid.

91. T Pogge 'Responsibility for poverty-related ill health' (2002) 16 *Ethics & International Affairs* 72; 'Human rights and global health: a research programme' (2005) 36 *Metaphilosophy* 182.

adult men and adolescent boys who are the main targets of these public health interventions, the second are male neonates who are also now suggested as subjects of the policy, and the third are the partners of men who have been circumcised. Disaggregating the groups affected in this way would, we argue, enable the framing of public health policies which are more attentive to the needs and vulnerabilities of those on whom the policies impact in different ways. We contend that adopting this more nuanced approach is better aligned with an underlying vision of social justice, as it can serve to flag up and ‘redress the imbalance between society’s privileged and unempowered members’⁹² by highlighting tensions that may exist, not only between public health objectives and human rights, but also between the potentially competing interests of these three groups. Furthermore, as well as focusing on the differential impact on various groups affected by these policies we believe it is also important to address the question Baxi poses of who benefits from promoting such policies.

The ethics of cutting adults

In general we believe that competent adults have the right to make autonomous decisions about bodily interventions. Such a right is clearly enshrined in Anglo-American law⁹³ and the issue of adults choosing to modify their genitalia has been relatively uncontroversial.⁹⁴ However, we suggest that it is problematic simply to presume the presence of autonomy and consent where circumcision forms part of a clinical research programme and subsequent mass public health policy which is sponsored and heavily promoted by international organisations motivated by an urgent search for an effective response to the pandemic. In such a context, scant attention has been devoted to the bodily risks of the procedure, the autonomy interests of men subject to it, and the social justice implications of targeting procedures solely at men.⁹⁵ Of course, good arguments support targeted interventions. Yet one problem with this strategy, as we discuss below, is the risk that women are marginalised, while another is that targeted interventions can gloss over the importance of ensuring valid consent in that group. Gostin and Mann have noted that this is a key social justice issue in public health:

‘The concept of informed consent is critically important to maintaining sound public health practice. Consent should be viewed as more of a process of communication and interaction with the patient than a stark legal requirement. The process of consent provides the opportunity to counsel and educate while it preserves the integrity of health professionals and the dignity of the patient.’⁹⁶

92. R Cook ‘Gender, health and human rights’ in Mann et al, above n 8, p 259.

93. *Schloendorff v Society of New York Hospital* (1914) 211 NY 124; *Collins v Wilcock* [1984] 3 All ER 374; *Malette v Shulman* (1990) 67 DLR (4th) 321.

94. Although in the UK and some Australian states law prohibits even competent adult women from consenting to this procedure. For a discussion of the Australian position see N Sullivan ‘“The price to pay for our common good”: genital modification and the somatechnologies of cultural (in)difference’ (2007) 13 *Social Semiotics* 395.

95. Or, indeed, to the fact that the targets are African bodies. See M Fox and M Thomson ‘HIV/AIDS: Male genital cutting and the new discourses of race and masculinity’ in M Fineman and M Thomson (eds) *Feminism, Masculinity and Law* (Dartmouth: Ashgate, forthcoming, 2012).

96. L Gostin and JM Mann ‘Toward the development of a human rights impact assessment for the formulation of and evaluation of public health policies’ in Mann et al, above n 8, p 65.

The issue of what constitutes valid consent to participation in research trials has generated considerable debate, given problems about comprehending information and weighing risk.⁹⁷ These issues are compounded when such trials form part of a heavily promoted and high profile public health strategy, where obtaining individual consent in each case may be difficult or impractical.⁹⁸ The matter is complicated still further when this occurs in a developing country in sub-Saharan Africa. Indeed these intractable problems have led some commentators to propose that consent requirements should be dispensed with. One strand of this argument questions whether it is culturally appropriate to import 'Western' notions of informed consent rooted in liberal individualism to Africa, representing this as a form of medico-ethical imperialism.⁹⁹ In our view these claims have been refuted convincingly by Ijsselmuiden and Faden's demonstration that such accounts misrepresent African cultures as static and essentialist, and fail to reflect rapid cultural changes attributable to independence, globalisation, urbanisation, warfare and so forth, which have undermined the significance of tribal or familial authority.¹⁰⁰ Nevertheless, it must be recognised, as Annas and Grodin point out, that in most African settings lack of adequate healthcare provision means that 'informed consent will be problematic and difficult . . . because . . . virtually any offer of medical assistance . . . will be accepted as "better than nothing" and research will almost inevitably be confused with treatment, making informed consent difficult.'¹⁰¹

A second strand of the argument for dispensing with the usual consent requirements is that the need to promote research in the developing world, and in particular the urgency of formulating a response to the HIV epidemic, serves to obviate Western standards of informed consent.¹⁰² For us, however, it is this very urgency which makes adherence to standard consent requirements a vital element of a social justice framework, especially since in many African jurisdictions research subjects are denied legislative protection. Moster Meir attributes this absence to reluctance by African governments to regulate clinical research for fear that it would act as a disincentive to investment by pharmaceutical corporations.¹⁰³ Given this economic backdrop, we share McHale's view that:

'Public health should not be used as an excuse to avoid research regulation, nor should it be used to avoid a participatory dialogue between researcher and

97. See NC Manson and O'Neill *Re-thinking Informed Consent in Bioethics* (Cambridge: CUP, 2007); McHale, above n 41.

98. A Dawson and M Verweij 'Public health research ethics: a research agenda' (2009) 2 *Public Health Ethics* 1.

99. NA Christakis 'The ethical design of an AIDS vaccine trial in Africa' (1988) *Hastings Center Report* 31.

100. C Ijsselmuiden and R Faden 'Research and informed consent in Africa – another look' in Mann et al, above n 8.

101. Annas and Grodin, above n 59, p 156.

102. Ijsselmuiden and Faden suggest such a position underpins the CIOMS Guidelines on Medical Research, above n 100, p 368. (The Council for International Organizations of Medical Sciences (CIOMS) is an international NGO established jointly by the WHO and UNESCO. It published international guidance on the ethical principles to govern human experiments in 1993 which were updated in 2002, available at http://www.cioms.ch/publications/layout_guide2002.pdf).

103. B Mason Meir 'International protection of persons undergoing medical experimentation: protecting the right of informed consent' (2001) 20 *Berkeley Journal of International Law* 513.

research participants. Instead we need a new form of research dialogue with research participants rooted in fundamental respect for their human rights.’¹⁰⁴

Yet, as Montgomery has argued, rather than enhancing autonomy, legal stipulations governing consent to participate in clinical research have often circumscribed decision making by producing forms ‘so long and detailed that they are as likely to confuse people as to assist them making choices. The purpose of these forms is not so much to enhance the quality of decision making as to transfer the risks involved in trials to the research subjects’.¹⁰⁵ Policy makers therefore need to be attentive to the spirit of international obligations and the importance of ensuring real consent through appropriate communication and dialogue.

In the context of circumcision advocacy there has been little consideration of the barriers to effective communication posed by a procedure which is not only heavily promoted as a public health measure, but which also entails the dissemination of complex information given the partial protective effect. At a minimum, valid consent would entail that participants have understood this partial protection and the importance of maintaining or commencing other risk avoidance measures. As Sawires et al note: ‘The benefit from male circumcision is relative, not absolute, and the challenge will be to devise communication strategies to reinforce this point clearly’.¹⁰⁶ Communication strategies must also convey the risks of the procedure; yet typically these are downplayed in relevant policy documents. Thus, in a 2007 guide to *Legal Aspects of HIV/AIDS* published by the World Bank, the opening paragraph of a section on male circumcision notes of the African research that ‘All three trials confirm that male circumcision, performed by well-trained medical professionals, is safe and reduces the risk of HIV infection by between 50 and 60%’.¹⁰⁷ Evidence that public health narratives advocating circumcision have become embedded in prevailing myths about circumcision and processes of disease transmission further complicates the process of obtaining consent. Thus, Berer cites a doctor in Swaziland who reported that ‘Many of the men I speak with think circumcision is like an AIDS vaccine’.¹⁰⁸ Indeed, the belief that circumcision offers immunity from HIV/AIDS is prevalent. Consequently, for consent to be valid, such myths would have to be addressed and corrected. In summary, the difficulties in ensuring consent are such that Berer questions:

‘[W]ould a man who will not use condoms to protect himself and his partner(s) from HIV and who does not practice safer sex in some other way agree to be circumcised? If so, why? Does he really understand the nature of the partial protection circumcision will give him and the lack of protection it will give his partner(s), whether they be female or male?’¹⁰⁹

104. McHale, above n 41, pp 509–510.

105. J Montgomery ‘Law and the demoralisation of medicine’ (2006) 26 LS 185 at 188.

106. SR Sawires and others ‘Male circumcision and HIV/AIDS: challenges and opportunities’ (2007) 369, 9562 *Lancet* 708.

107. L Gable et al *Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform* (Washington, DC: Global HIV/AIDS Program and Legal Vice Presidency The World Bank, 2007) p 38 (emphasis added).

108. Berer, above n 67, at 171.

109. Berer, above n 73, at 46.

Clearly, these complexities in devising adequate processes for obtaining consent even on a one-to-one basis between the doctor and the patient, or the researcher and participant, are multiplied in mass circumcision programmes. This is particularly true if they are rolled out in such a way that surgery is performed in far from optimal conditions, which may well alter the balance of risks to benefits. Indeed, the sheer scale of some programmes poses serious obstacles to risk assessments, as highlighted by recent press reports that KwaZulu Natal – the South African province most affected by the AIDS crisis – has begun a drive to circumcise 2.5 million men.¹¹⁰ Moreover, even where the procedure is carried out in hygienic clinical conditions, it is crucial, given the inherent risks, that adequate provision is made for the follow-up care of men or boys who volunteer for circumcision and suffer health complications as a result. Little attention seems to have been paid in the literature or policy proposals to this point; yet if provision of adequate monitoring¹¹¹ and properly resourced follow-up care is not in place this poses clear threats to health or even life. Follow-up care is arguably particularly important with adults and adolescents since the surgical procedure is more complicated, requiring complex stitching and a healing process lasting for at least 6 weeks.¹¹² A further ethical concern stems from how circumcision status may be seen as indicative of infection status.¹¹³ Indeed, the Wawer study in the *Lancet* even argued that HIV infected men should be offered circumcision because of the potential discrimination faced by those who have not been circumcised.¹¹⁴ Significantly, the authors did not question the ethics of performing a far from risk-free procedure for no demonstrable medical benefit.¹¹⁵

In our view the questions we have posed about the consent process have yet to be addressed, and consequently the ethics and legality of policies advocating mass circumcision are questionable. While acknowledging the difficulties in securing valid consent, the Nuffield Report *Public Health: Ethical Issues* is clear that procedures involving considerable health and safety risks require explicit justification if normal consent measures are to be overridden.¹¹⁶ We would argue that the surgical excision of healthy genital tissue does entail such health and safety risks, and that it is difficult to see how the public or state interest would legitimise dispensing with standard consent requirements where this procedure is concerned.

The cutting of young children

These ethical difficulties in ensuring that adults give valid consent to surgical interventions are compounded where the procedure is performed on children who are too young to consent. Although public health programmes to date have concentrated on

110. C Dugger ‘South Africa redoubles efforts against AIDS’ *New York Times* 25 April 2010.

111. Berer, above n 67, at 174. As she points out, this needs to include much more information than merely crude figures of how many men have been circumcised.

112. These factors of course also heighten the risk that circumcision surgery performed in unhygienic conditions could itself act as a vehicle for HIV transmission.

113. JM Baeten, C Clum and TJ Coates ‘Male circumcision and HIV benefits and risk for women’ (2009) 374 *Lancet* 182.

114. Wawer, above n 50.

115. Berer, above n 73, argues that this proposal is ethically indefensible.

116. Nuffield Council on Bioethics *Public Health: Ethical Issues* (Cambridge: Cambridge Publishers Limited, 2007) para 2.24.

men and adolescents, it has been argued that for maximum effectiveness (particularly cost-effectiveness) any mass circumcision programme should encompass children.¹¹⁷ Of course the enrolment of children in research or public health programmes is contentious, and, as Powers and Faden contend, the duty of justice owed to children is particularly stringent given that poor health and other disadvantages imposed during childhood may be inescapable.¹¹⁸ In our view it follows that we should be cautious before sanctioning irreversible and potentially risky procedures on children, especially when they are performed outside a clinical environment and with inadequate follow-up. Given the concerns we have raised about the current state of the research and the questionable efficacy of mass circumcision programmes, we remain unconvinced that the medical benefits of the procedure are sufficiently compelling to outweigh the risks to the individual infant. It is also worth noting that the practice of removing healthy tissue from a very young child is being promoted for a potential beneficial effect many years in the future, rather than in the immediate 'best interests' of the child. Yet this important issue has received scant consideration.¹¹⁹

A further ethical issue is the violation of bodily integrity which the removal of healthy tissue entails. This concern is frequently raised in the context of genital cutting of females in Africa, and it is striking how female cutting is decried in policy documents which simultaneously promote male genital cutting.¹²⁰ While bodily integrity is clearly at stake in programmes to cut adults, we have outlined our view that provided adults are competent and give valid consent in the absence of any kind of duress then no ethical or legal issues arise if they elect to modify their bodies for any reason. For us, the issue is clearly different where that decision cannot be made by the individual affected, as is the case with neonates. While space precludes any attempt here to unpack claims about bodily integrity (and we acknowledge that notions of integrity, wholeness and intactness need to be problematised in these debates),¹²¹ we wish merely to suggest that we should pay some heed to claims of bodily integrity, particularly in relation to children, given their salience in debates about female genital cutting. In this regard, and as Powers and Faden note, even where invasions of personal security do not result in bodily injury or pain, they nevertheless violate the notion of respect for persons as moral equals and 'beyond this they treat persons as having no morally significant standing and violate human interests everyone has in maintaining physical and bodily integrity and psychological inviolability'.¹²² Such an

117. For example, SC Kalichman 'Neonatal circumcision for HIV prevention: cost, culture and behavioural considerations' (2010) *PLoS Med* 7(1): e1000219.doi:10.1371/journal.pmed.1000219. For a contrary view, see D Sidler, J Smith and H Rode 'Neonatal circumcision does not reduce HIV/AIDS infection rates' (2008) 98 1(0) *South African Medical Journal* 762.

118. Powers and Faden, above n 71, p 165. See also A Nolan 'The child's right to health and the courts' in Harrington and Stuttaford, above n 80.

119. Although see 'Leading edge, circumcision and circumspection' (2007) 7 *Lancet Infectious Diseases* 303.

120. Gable et al, above n 107.

121. See Fox and Thomson 'Interrogating bodily integrity' (forthcoming).

122. Powers and Faden, above n 71, at 19. In this context the authors are referring to criminal actions, such as rape, battery and FGM, but as we have argued elsewhere (M Fox and M Thomson 'Older minors and circumcision: questioning the limits of religious actions' (2008) 9 *Medical Law International* 283), it is the reluctance of Anglo-American law to conceptualise male circumcision as a criminal action which precludes it being regarded in the same light as female genital cutting or other bodily interventions which attract criminal sanctions.

analysis is clearly applicable to male circumcision and, given all these concerns, we believe that a public health policy advocating mass circumcision of infants is deeply ethically flawed.

The invisibility of women in circumcision debates

Michel Sidibé, Executive Director of UNAIDS, at the opening session of the XVIII International AIDS conference in Vienna, stated that full equality for women and girls was one of the four pillars essential to campaigns to eradicate AIDS.¹²³ Sidibé has also highlighted the role of social injustice in the spread of the disease.¹²⁴ His observations provide a pertinent backdrop to a consideration of the potential for mass circumcision policies to compromise women's interests. Although the bodies of women are not directly impacted by policies advocating male circumcision, their interests are clearly implicated. As Gostin and Mann note, 'providing health services to, or running clinical trials for men but not women may reflect society's neglect of women rather than legitimate public health priorities'.¹²⁵ Indeed, in HIV/AIDS policy it frequently appears as though women and their interests and health are paid inadequate attention. One illustration of this is a recent systematic review and meta-analysis of HIV status in discordant couples in the sub-Saharan region by Eyawo et al, which noted that in such discordant relationships men are generally assumed to be the index case and most awareness campaigns are focused on them.¹²⁶ The study showed that women are as likely as men to be the index partner in a serodiscordant couple. The researchers concluded that their study evidenced the need to focus on both sexes in prevention strategies.¹²⁷

In the context of male circumcision, we suggest that issues of gender equity are raised by the potential for this intervention to severely compromise women's health. Thus, while the procedure may offer protective effects to men, it simultaneously serves to increase the risk of viral transmission to women.¹²⁸ Commentators have noted how women's lower cultural and economic status and their lack of power to influence sexual relations are key factors in facilitating the heterosexual spread of the epidemic.¹²⁹ Although at a global level men may be the 'core group' in terms of HIV/AIDS, in the context of sub-Saharan Africa women represent approximately 60% of all people living with the infection.¹³⁰ The majority of new infections in high

123. http://www.sld.cu/galerias/pdf/servicios/sida/discurso_de_iniauguracion_de_conferencia_mundial_2010.pdf last accessed. In March 2010 UNAIDS also launched its Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV.

124. http://data.unaids.org/pub/SpeechEXD/2010/20100322_sp_sidibe_faith_en.pdf.

125. Gostin and Mann, above n 96, p 60.

126. O Eyawo et al 'HIV status in status discordant couples in sub-Saharan Africa: a systematic review and meta-analysis' (2010) 10 *Lancet Infectious Diseases* 770.

127. A further example of unwarranted assumptions about women's behaviour colouring HIV research is addressed in L Sawyer and E Stillwaggon 'Concurrent sexual partnerships do not explain the HIV epidemics in Africa: a systematic review of the evidence' (2010) 13 *Journal of the International AIDS Society* 34.

128. Wawer, above n 50. And of course there are also risks to male sexual partners.

129. J du Guerny and E Sjoberg 'Interrelationship between gender relations and the HIV/AIDS epidemic: some possible consideration for policies and programs' in Mann et al, above n 8.

130. Joint UN Programme on HIV/AIDS and WHO. AIDS epidemic update (December 2009).

prevalence areas are in females,¹³¹ and those aged between fifteen and twenty-four are at the greatest risk of HIV acquisition. In some areas the prevalence of infection for women in this age group is nearly four times that of young men.¹³² Indeed, in 1998, Peter Piot, then executive director of UNAIDS, characterised AIDS as a 'women's epidemic',¹³³ although cynics have noted how 'HIV infection in women worldwide became important to medical personnel only after they learned that HIV infection could affect foetuses and babies'.¹³⁴ Certainly it is indisputable that, as a virus transmitted largely through sexual intercourse, HIV inevitably poses questions about the dynamics of gender relations.¹³⁵

Crucially, it is entirely possible that a pro-circumcision policy will actually increase harm to women as the protection offered by surgery is misunderstood, the ability to negotiate condom use is compromised, and risk compensation behaviour increases. The Wawer study, which found an increase in the exposure of women to HIV during the course of the study, concluded that women would come into contact with fewer HIV infected men as a result of circumcision programmes and that this would offer a net gain for women.¹³⁶ However, a successful circumcision programme would not reduce infections to women directly for at least 10–20 years and this would require an uptake of 70% among the male population in a challengingly short time frame. This target is unlikely to be achieved.¹³⁷ Additionally, a focus on men (and female-to-male transmission) not only leaves women vulnerable and unprotected, but also echoes past constructions of women as vectors for infection.¹³⁸ Historically, in the West, men have been constructed as the victims of female carriers (often figured as racially other), as discourses concerning sexually transmitted disease have replayed nationalistic or racial concerns.¹³⁹ In public health programmes the focus on female-to-male transmission echoes these constructions of women, and particularly black women,¹⁴⁰ as vectors for contagion and men as the victims, while disregarding the

131. RK Jewkes et al 'Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study' (2010) 376 *Lancet* 41 at 41.

132. The report of the South African HIV Prevalence, HIV Incidence, Behaviour and Communication Survey in 2008 showed that in the age group 20–24, HIV prevalence among males was 5.1% as against 21.1% for females. In the age group 25–29 male prevalence was 15.7% compared with 32.7% for females. <http://avert.org/safricasts.htm>.

133. P Piot 'Address to the VIIth Conference on Woman and AIDS' Dakar Senegal 14–17 December 1998.

134. Booth, above n 38, p 358.

135. J Bujra and SN Mlake 'AIDS activism in Dar es Salaam: Many struggles; a single goal' in C Baylies and J Bujra (eds) *AIDS, Sexuality and Gender in Africa: Collective Strategies and Struggles in Tanzania and Zambia* (London: Routledge, 2000) p 154.

136. Wawer, above n 50, p 236.

137. Berer, above n 73.

138. G Seidel 'The competing discourses of HIV/AIDS in Sub-Saharan Africa: discourses of rights and empowerment v. discourses of control and exclusion' (1993) 36 *Social Science and Medicine* 175.

139. S Sontag *Illness as Metaphor* (London: Penguin, 1978); R Faden, N Kass and D McGraw 'Women as vessels and vectors: lessons from the HIV epidemic' in S Wolf (ed) *Feminism and Bioethics: Beyond Reproduction* (Oxford: OUP, 1996).

140. As P Treichler has noted, the 'exotic bodies, sexual practices, or who knows what [of African women] are seen to be so radically different from those of women in the US that anything can happen to them'. 'AIDS, homophobia, and biomedical discourse: an epidemic of signification' in Crimp, above n 28, pp 45–46.

negative impact on women of circumcision advocacy.¹⁴¹ The irony, as Gabel et al observe, is that ‘UNAIDS and OHCHR have urged countries to enact antidiscrimination laws that prohibit gender-based discrimination and reduce the vulnerability of women to HIV infection and the impact of HIV and AIDS’.¹⁴²

Challenging public health policy

These various question-marks concerning how adequately ethico-legal issues have been addressed in relation to earlier clinical trials and the current public health initiatives being operationalised in various African jurisdictions, pose serious obstacles to the ethical implementation of mass circumcision programmes. As we argued above, considerations of risk and justice are frequently erased or downplayed when public health concerns are invoked, and we suggest that too little attention has been devoted to the interests of the groups variously affected, and the potential for conflict between them. We argue that this omission is important not only for the individuals concerned but also because experience in the field of HIV/AIDS prevention demonstrates that ‘taking human rights seriously is a necessary component of an effective public health strategy’.¹⁴³

Finally, as Baxi reminds us, it is not enough to focus simply on those groups unjustly treated by public health policies. A political programme committed to social justice must also be attentive to whose interests are promoted by public health policies advocating circumcision. Hence, an important question is why policy statements by UNAIDS and the World Bank promote overly simplistic narratives about the benefits of male circumcision and why private philanthropic organisations invest so heavily in the procedure. We tentatively suggest that a partial answer can be found in the normalisation and medicalisation of male circumcision in the USA. Investment in the procedure in the USA has contributed to the international adoption of the ‘circumcision solution’, notwithstanding the current uncertain status of the evidence. We would suggest that this mirrors the standard developmental trajectory for (scientific) facts, as Leigh Pigg and Adams write, relying on Latour:

[T]he key point is that facts acquire their facticity (i.e. their quality as context-independent truths) by being inserted into networks. A fact stabilizes as indisputable and self-evident to the degree that it becomes “blackboxed” (i.e., becomes the accepted basis for a wide range of other actions and purposes). Much research in science studies has been concerned with tracing the transition from experimental uncertainty to knowledge claim, and from knowledge claim to universal fact.¹⁴⁴

While acknowledging the complexity of the factors involved, we would argue that a contributing factor in the adoption of circumcision as a public health response to

141. This is comparable to the erasure of women as individuals with interests in their own right in programmes to prevent maternal transmission of HIV to babies. See Annas and Grodin, above n 59; Booth, above n 38. It also, of course, erases non-heterosexual sex.

142. Gable et al, above n 107, p 133.

143. GJ Annas ‘The impact of health policies on human rights: AIDS and TB control’ in Mann et al, above n 8, p 37.

144. S Leigh Pigg and V Adams ‘Introduction: the moral object of sex’ in S Leigh Pigg and V Adams (eds) *Sex in Development: Science, Sexuality, and Morality in Global Perspective* (Durham: Duke University Press, 2005) pp 25–26.

HIV/AIDS has been the insertion of early hypotheses and clinical study results into (predominantly US) pro-circumcision networks. Further, the adoption of the 'fact' or policy has been aided by the diverse range of pro-circumcision interests that the policy supports, as Leigh Pigg writes:

'Numerous detailed empirical case studies of scientific innovations shows that scientific claims stick when they are taken up by others – not just fellow scientists who judge the findings to be sound but people for whom the insight solves a problem, bolsters a case, or furthers an aim. The finding becomes indispensable to the extent that it is melded with a wide range of interests and actions.'¹⁴⁵

This forms a backdrop to the process by which, as we have seen, the African trials have generated a discernible 'blowback' effect with tangible effects on professional policy in the USA. Thus, Daniel Halperin from Harvard School of Public Health – a pioneer of the 'circumcision as prevention' strategy¹⁴⁶ – has been quoted in the British media as predicting that within a decade circumcision could be the norm for infants in North America and perhaps Australia.¹⁴⁷ Similarly, DeLaet has observed that the:

'medical community's movement towards the position of relative neutrality . . . may again shift back more strongly in favour of routine medical male circumcision due to the recent scientific studies finding a strong correlation between circumcision and lower rates of HIV infection'.¹⁴⁸

CONCLUDING THOUGHTS

'Part of the problem for male circumcision as a preventative strategy is going to involve containing it. There is a politics of male circumcision, and anyone with experience in the field of HIV/AIDS internationally should have foreseen this.'¹⁴⁹

Brazier and Harris have pointed to the many ways in which the HIV/AIDS pandemic has obscured rather than clarified debates about public health interventions.¹⁵⁰ Their contention is borne out by Esacove's analysis of HIV/AIDS discourses in Malawi, where she demonstrates how public discourse 'is replete with oversimplifications, inconsistencies and illogical claims'.¹⁵¹ We argue that the pro-circumcision advocacy we have been examining is replete with similar simplifications and inconsistencies. Furthermore, in the prevailing public health narratives which promote circumcision as a common-sense solution to the pandemic, without questioning what it adds to existing strategies or what risks it carries, we suggest that the social justice implications for those most at risk of HIV/AIDS are largely absent from the debate. We hope that this paper has illustrated that, just as has been the case in the more extensive debates over the ethics and legality of female genital cutting in Africa and elsewhere, it is important to unpack the interests of those affected by public

145. S Leigh Pigg 'Globalizing the facts of life' in Leigh Pigg and Adams, above n 144, p 59.

146. See for instance DT Halperin and RC Bailey 'Male circumcision and HIV infection: 10 years and counting' (1999) 354 *Lancet* 1813.

147. A Renton 'So, would you have your son circumcised?' *Observer* 5 July 2009.

148. DeLaet, above n 74, at 405.

149. Dowsett and Couch, above n 11, p 40.

150. Brazier and Harris, above n 8, p 173.

151. Esacove, above n 55, p 84.

health policy if a meaningful concept of social justice is to inform public health interventions.

Crucially, the 'circumcision solution' appears more straightforward than attempts to change sexual behaviour, while also allowing the role of broader structural factors to be downplayed. Such policies do nothing to disrupt the prevalence of what Baxi terms the 'trade-friendly, market-related human rights of global capital' in which 'all this policy talk about "participation" "transparency" "accountability" and "monitoring" comes to possess a hollow ring'.¹⁵² Indeed, as Harrington has noted, this blind spot about structural factors is also replicated in common law scholarship on Africa which 'often ignore[s] the historic causes of world impoverishment, especially the impact of colonial and imperial common law practices and performances'.¹⁵³ Across a range of societies, as Mann has observed, 'those people who before HIV/AIDS arrived were marginalized, stigmatized, and discriminated against became over time those at highest risk of HIV infection'.¹⁵⁴ In our view, placing social justice at the core of health law requires that the role played by poverty and inadequate education in facilitating HIV transmission be recognised. Adopting such a perspective would entail, for instance, a recognition that '[s]trategies for raising the status of women, changing attitudes among men, and adding other means of income for women, could have an important impact on reducing the spread of HIV/AIDS'.¹⁵⁵ Yet these issues are obscured in the search for a biomedical solution to the crisis, and wholly disregarded in the circumcision debates. Relatedly, there is a scientific failure to recognise 'the quite specific contribution of places, times, social networks, populations and cultures to all successful prevention programmes',¹⁵⁶ and how receptivity to circumcision will vary with cultural attitudes to the practice among diverse African peoples and regions.¹⁵⁷ Moreover, and as the quotation from Dowsett and Couch (above) suggests, public health policies on HIV prevention and the role that circumcision may have to play within them cannot be contained within the African context where they originated, but have a broader resonance and global implications.

As we noted at the outset, the urgent search for a solution to the crisis in Africa means that we may see the emergence of a public discourse that is even less sympathetic to the interests of children, or other groups, affected by pro-circumcision policies. However, whatever the dangers in so doing, it seems to us that debating circumcision as a public health issue has the important advantage of shifting the terms of the debate by highlighting the multiple interests that play out, particularly on the infant body. Importantly, locating the issue within a public health and social justice paradigm provides a counterweight to the prevailing political view of health decision making as primarily a private matter,¹⁵⁸ with decisions reached between patient and doctor or parent and health professional. In this way it also, as we have noted, helps broaden the intellectual terrain of health law as a discipline. Certainly it makes it harder for proponents of circumcision to rule out a role for state intervention.

152. Baxi, above n 88, p 19.

153. Harrington, above n 9, citing U Baxi 'Global development and impoverishment' in P Cane and M Tushnet (eds) *Oxford Handbook of Legal Studies* (Oxford: OUP, 2003).

154. JM Mann 'Human rights and AIDS: the future of the pandemic' in Mann et al, above n 8, p 221.

155. du Guerny and Sjoberg, above n 129, p 204.

156. Dowsett and Couch, above n 11, at 35.

157. M Fox and M Thomson 'Foreskin is a feminist issue' (2009) 24 *Australian Feminist Studies* 195.

158. Gostin, above n 31, ch 1.

Although the precise form that legal regulation might take is debatable,¹⁵⁹ we argue that law has a crucial role to play in unpacking and weighing the multiple interests which circumcision raises on a global level. Yet, as Martin has observed, to date law has been relatively neglected as a public health tool due to the belief that science is able to supply the answers.¹⁶⁰ In this paper we have sought to demonstrate the limits of such a view, particularly in this field, where, as Epstein has contended, '[t]he construction of facts in AIDS controversies has . . . been . . . complicated and the routes to closure . . . convoluted'.¹⁶¹ As far as law is concerned, we believe that, at a minimum, health professionals and policy makers should be alert to the possible legal (and other) consequences of a failure to obtain adequate consent or initiate adequate follow-up care. More importantly, we would argue that such challenges could be pre-empted if any roll-out of circumcision awaits the necessary further research and the formulation of policy which allows adequate consultation with the individuals targeted by these programmes and the communities of which they form part. This need for an evidence-based, thoughtful and negotiated process supports Freedman's assertion that health and human rights collaborations cannot take place in a political vacuum.¹⁶² Rather, as she contends and as our social justice analysis supports, there is a need for very concrete and contextualised inquiry that has at its centre the experience of those groups whose health and human rights are most at stake.

159. Some of those who challenge the construction of male circumcision as a private familial matter argue in favour of criminalising the practice, but for reasons outlined elsewhere, we believe this would be counter-productive; see Fox and Thomson, above n 122.

160. Martin, above n 9.

161. Epstein, above n 42, p 3.

162. Freedman, above n. 8.