

Targeting mothers and selling men what they do not want: A response to 'Missed opportunities for circumcision of boys'

To the Editor: Millard *et al.*^[1] state in their editorial in the *SAMJ* January issue that medical male circumcision (MC) in South Africa (SA) peaked in 2013, only to decline in subsequent years despite improved surgical infrastructure and 'high-level marketing'. They attach great hope to 'demand creation', which they state is supported by the Bill and Melinda Gates Foundation and the Clearinghouse on Male Circumcision. 'Demand creation is trying to sell something that many men don't want', they state.

Elucidating MC statistics, the authors report that '45% of all 2014 circumcisions were among boys <15 years of age.' According to them, 'it is time for SA to change gears and orient marketing and programmes to males of all ages', but particularly to boys of this age range. In addition, they compare MC of boys to successful 'immunisation' and suggest that 'mothers are an influential but neglected target of circumcision promotion', since they will presumably motivate their boys to be circumcised and spread the word about MC to their friends. Their conclusion is that 'the time to change course is now'.

Adult MC as a form of partial prophylaxis against female-to-male, heterosexually transmitted HIV, where valid, informed consent has been acquired, has its supporters and there are legitimate arguments to be made in its defence. Even then, the scope of information required for consent to be valid is a matter of serious concern. For example, have the functions, sensitivity and other anatomical properties of the foreskin been fully communicated and understood?^[2,3] Are the ongoing ethical and medical controversies regarding MC at least mentioned in the process of obtaining consent?^[4] Such matters are not mere technicalities; for consent to be ethically valid, it must be fully informed – not solicited by emphasising only the benefits of a procedure, as in the case of a 'marketing' campaign.

There has been repeated criticism of the idea that MC of boys can be compared with immunisation.^[5] Immunisation involves a needle-prick to the skin and can prevent serious conditions that pose a current risk to the child, and which are easily transmittable to other children through incidental contact. MC, by contrast, involves the irreversible excision of healthy genital tissue, to reduce the risk of potential diseases to which the child may one day be exposed. Vaccination is uniformly supported by mainstream medical associations; MC is, however, a source of sustained controversy among qualified experts.

The creation of an artificial 'demand' through 'high-level marketing' and 'targeting mothers' – for a surgical procedure that removes healthy tissue from a minor individual in the absence of actual pathology – raises serious ethical questions. To 'target' mothers as a means to an end smacks of manipulation, undermines parental autonomy, and may be a misuse of medical authority and the power differential between doctor and patient. The authors' admission of medical interference with cultural rituals also raises serious concerns regarding medical patronising.

It is also problematic that no reference is made to the Children's Act (Act No. 38 of 2005), which stipulates that a boy to be circumcised must be 16 years of age and must provide his own informed consent. It may only be performed after counselling and in accordance with the regulations to the Act (s 12(9)(a) - (c)). Circumcision of any male child under the age of 16 is prohibited except when it is performed for religious purposes in accordance with the practices of the religion

concerned, or for medical reasons on the recommendation of a medical practitioner (s 12(8)). Contravention of s 12(8) is rendered a criminal offence by s 305(1)(a)).

Given a situation as controversial and complex as MC of minors for intended risk-reduction of HIV transmission, an attitude of caution is surely warranted. Medical programmes implemented without due ethical regard for the decision-making autonomy of boys and their parents run the risk of accumulating 'so much power, that they become immune to their own mistakes'.^[6] If MC is something 'many men don't want', we should listen to them and take seriously their perspectives. This could be attained via community engagement and community consultation initiatives. Simply bypassing them and pressing the procedure onto more vulnerable commodified 'targets' represents a 'missed opportunity' to learn from its intended beneficiaries.

More importantly, the missed opportunities to educate patients on matters of genital hygiene, safe sex and other HIV preventive measures are blatant in many HIV clinics in public hospitals where patients sit in waiting rooms for hours with minimal educational or motivational input from healthcare workers. High school education in SA is yet another missed opportunity, with life orientation classes often spending minimal time on education around sexually transmitted diseases, including HIV. Simply applying a biomedical fix to a complex multifactorial sociobehavioural medical crisis in the context of extreme poverty, marginalisation and disenfranchisement has not worked and will not work.

D Sidler

Division of Paediatric Surgery, Department of Surgical Sciences, Faculty of Medicine and Health Sciences, Stellenbosch University and Tygerberg Children's Hospital, Cape Town, South Africa
ds2@sun.ac.za

B D Earp

Yale-Hastings Program in Ethics and Health Policy, Yale University, USA; and Research Fellow, Oxford Uehiro Centre for Practical Ethics, University of Oxford, UK

A A van Niekerk

Centre for Applied Ethics, Stellenbosch University, Cape Town, South Africa

K Moodley

Centre for Medical Ethics and Law, World Health Organization Collaborating Centre in Bioethics; and Department of Medicine, Faculty of Medicine and Health Sciences, Stellenbosch University, Cape Town, South Africa

S Kling

Department of Paediatrics and Child Health, Faculty of Medicine and Health Sciences, Stellenbosch University and Tygerberg Children's Hospital, Cape Town, South Africa

1. Millard P, Goldstick N. Missed opportunities for circumcising boys. *S Afr Med J* 2017;107(1):19. <https://doi.org/10.7196/SAMJ.2017.v107i1.12177>
2. Earp BD. Infant circumcision and adult penile sensitivity: Implications for sexual experience. *Trends Urol Mens Health* 2016;7(4):17-21. <https://doi.org/10.1002/ure.531>
3. Cold CJ, Taylor JR. The prepuce. *BJU Int* 1999;83(S1):34-44.
4. Parker R, Aggleton P, de Camargo, KR Jr. Circumcision and HIV prevention: Emerging debates in science policies and programmes. *Global Public Health* 2015;10(5-6):549-551. <https://doi.org/10.1080/17441692.2015.1015705>
5. Lyons B. Male infant circumcision as a 'HIV vaccine'. *Public Health Ethics* 2013;6(1):90-103. <https://doi.org/10.1093/phe/pps039>
6. Harari YN. *Homo Deus, A Brief History of Tomorrow*. London: Harvill Secker, 2016:167.

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