The VMMC Experience Project

The VMMC Experience Project is a 501(c)3 nonprofit organisation representing men, women, and children who are adversely affected by “voluntary medical male circumcision” (VMMC) programmes for HIV prevention in sub-Saharan Africa. Developed by native Ugandans and Kenyans, it is the only platform for VMMC-affected men and women to share their experiences without Western interference. Its aim is to empower affected communities to raise awareness of adverse health and human rights consequences of mass circumcision and the African resistance movement at large.

The Project rejects coercive practices for VMMC, and supports male circumcision as an elective procedure for fully informed, consenting adults.

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Disclosure

The VMMC Experience Project discloses the following as potential sources of bias:

Executive Director Prince Hillary Maloba belongs to a male circumcising community that is heavily burdened by HIV/AIDS. He reports being forcibly circumcised in a traditional Bagisu setting, and has campaigned against forced circumcision and child genital cutting practices for more than 25 years. Project Coordinator David Okwalo has experienced forced circumcision attacks among family members in Kenya, and has expressed human rights objections to child circumcision. Assistant Keneth Nuwamanya reported having at least one colleague who remains adversely affected by the VMMC campaign for HIV prevention in Uganda.

Community Mobiliser Mutebi Ramadhan was circumcised in a religious setting and discloses no biases.
Background

The campaigns

“Voluntary medical male circumcision” (VMMC) is among the core strategies of the global AIDS response in sub-Saharan Africa (SSA). VMMC programmes are administered by the Bill & Melinda Gates Foundation and Joint United Nations Programme on HIV/AIDS (UNAIDS), and largely funded through American taxpayers via four US government agencies: the President’s Emergency Plan For AIDS Relief (PEPFAR), the US Agency for International Development (USAID), the Centers for Disease Control (CDC), and the Department of Defense (DOD).

The Israeli government has also provided African circumcision aid, including mass distribution of the Israeli-developed PrePex™ circumcision device [1,2]; and the World Health Organisation (WHO) is reported to have consulted religious circumcision practitioners in Jerusalem prior to recommending mass African circumcision for HIV prevention [3].

Per the most recent (2018) Global AIDS Response Progress Reporting, 18.6 million men and children were circumcised in VMMC programmes between 2008 and 2017 [4].

The VMMC campaign is based on three randomised clinical trials that were conducted in rural South Africa, Uganda, and Kenya. Over the trial periods, medical male circumcision reduced men’s relative risk of contracting HIV by 60%, 51%, and 53%, respectively [5-7]. Combined data from the three trials indicate a 53% relative risk reduction (Table 1).

Upon review of the trials and associated literature in 2007, the WHO recommended male circumcision to reduce female-to-male HIV transmission within 14 high-burden African countries whose majority populations did not traditionally practice genital cutting. The WHO corroborated its recommendation in 2012, estimating that achieving and maintaining 80% male circumcision coverage through 2025 could avert up to 3.4 million new HIV infections [8].

Table 1. Reduction in HIV infections to men from circumcision

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Infected with HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control group</td>
<td>5,497</td>
<td>137</td>
</tr>
<tr>
<td>Circumcised</td>
<td>5,411</td>
<td>64</td>
</tr>
<tr>
<td>Absolute risk reduction: (2.49% - 1.18%)</td>
<td>1.31%</td>
<td></td>
</tr>
<tr>
<td>Relative risk reduction: (2.49% - 1.18%) / 2.49%</td>
<td>52.61%</td>
<td></td>
</tr>
</tbody>
</table>

Combined data from the three female-to-male trials [5-7].

The target age range for VMMC participation is 15–49 years. However, children are also targeted in schools and orphanages—a practice that has drawn criticism from children’s rights groups (see Appendix A). In light of suboptimal voluntary participation from men, a 2017 PLOS Collections progress blog reported that nearly half of all VMMCs were performed on children between 10 and 14 years of age [9].

An “early infant male circumcision” (EIMC) campaign was added to the African circumcision agenda in 2016. EIMC is administered by UNICEF.

The controversy

From the outset, male circumcision for HIV prevention has received mixed opinions within the global public health community. Whereas VMMC and EIMC policy documents take the reported 50–60% relative risk reduction in female-to-male HIV transmission at face value, a Cochrane review adopted a more liberal interpretation of a 38–66% relative risk reduction [10]. Others have questioned the trial methodology itself (up to and including a lack of double-blinding*) [11,12], the possibility of an overriding increase in male-to-female transmission (suggested from the “buried” Rakai trial conducted after the WHO recommendation [14]); the possibility of risk compensation (Section III); and whether the WHO recommendation was premature [15-17].

Christopher Guest, Medical Director for the Children’s Health and Human Rights Partnership in Canada, expressed scepticism on the basis that the trials’ lead authors were not HIV specialists, but longstanding proponents of medical male circumcision [18].

* Critics have proposed a lack of double-blinding as a confounding behavioural incentive within the female-to-male trials. Both the circumcised and control arms were provided intensive behavioural counseling on HIV prevention and access to condoms over the trial periods; however, the circumcised trial cohorts were fully aware they were expected (and paid [5-7]) to achieve a lower HIV incidence, and may have behaved accordingly using the available methods. No placebo was available for the control groups [12].

Other potential sources of bias highlighted in the trials include duration bias (the trials were not long enough to determine whether the positive effect of male circumcision would plateau over time, and were also terminated early), lead-time bias (the control groups had a 6-week “head start” to contract HIV while the intervention groups healed from surgery), and attrition bias (the number of participants reported to be lost to follow-up vastly outnumbered those who contracted HIV) [11,12] (VMMC proponents’ response at [13]).
In the South African Medical Journal, Emeritus Editor-In-Chief Daniel Ncayiyana alleged that the acclaimed female-to-male trials had acquired “considerable interpretation creep,” citing inferences of lifelong HIV protection and benefits to circumcising newborn infants that were not self-evident from the trials. “I remain sceptical,” he concluded, “that VMMC has been sufficiently field-tested to validate a mass VMMC campaign.” African colonial suspicions toward the Western-driven agenda, he added, were “not off the wall” [17].

In a 2011 letter response to a children’s rights group opposed to EIMC, the South African Medical Association (SAMA) described the circumcision of infants for HIV prevention in South Africa as “unethical and illegal,” adding:

The [SAMA Human Rights, Law & Ethics] Committee expressed serious concern that not enough scientifically-based evidence was available to confirm that circumcisions prevented HIV contraction and that the public at large was influenced by incorrect and misrepresented information. The Committee reiterated its view that it did not support circumcision to prevent HIV transmission. [emphasis theirs] (Appendix B)

By 2015, criticism of the campaign had not subsided, and Global Public Health published a special edition on male circumcision to encapsulate the controversy. As proponents addressed the scientific criticism: “Scientists no longer contest whether safety belts or parachutes save lives, or whether vaccines for polio or yellow-fever work” [19].

On the other side, attendants of the hybrid forum on male circumcision for HIV prevention attributed the WHO recommendation to a circumcision-promoting “network” which was dually active in research and policymaking, adding: “There was no mention of the contradictory findings that had been published, nor of a scientific controversy” [20]. Previously, Ugandan researchers found the same 11 author names—including the trials’ lead authors—on 80% of all male circumcision literature in the Global Health Database [21].

Since the WHO’s recommendation in 2007, a range of newer developments have reinvigorated the controversy surrounding male circumcision for HIV prevention:

- The statistical data did not support a real-world correlation between circumcision status and HIV prevalence.
  The first Demographic and Health Survey (DHS) data on circumcision status and HIV prevalence were released by USAID at the start of the VMMC campaign in 2008. They showed “no clear pattern of association” between male circumcision and HIV prevalence. In 8 of the 18 countries where circumcision data was available, HIV prevalence was lower among circumcised men, while in the remaining 10 it was higher [22].

- A male-to-female trial suggested that VMMC may significantly increase women’s HIV risk.
  Following the WHO recommendation in 2007, a male-to-female trial was conducted to determine whether male circumcision could have a protective effect to women. The trial found that even with optimal behavioural counseling, which emphasised the need to abstain from sex during the surgical healing period, male circumcision increased women’s HIV risk by 54%. Whereas the female-to-male trials were performed in triplicate, the single male-to-female trial was terminated early “for futility” [14]. The implications are problematic for the epidemic at large, as male-to-female HIV transmission is more common than female-to-male transmission.

- In vitro findings challenged the scientific basis for male circumcision as an HIV-preventive measure.
  Langerhans cells are a “first line of defense” component of the immune system that is concentrated in the mucous membranes of the mouth, inner foreskin, and vaginal epithelium [23].1 Because HIV targets the immune system, foreskin Langerhans cells are believed to be viral portals in men [25].2 However, studies published after the WHO’s male circumcision recommendation found that Langerhans cells also produce a potent antiviral protein (langerin) that destroys HIV-1 in vitro [26,28,29], and that a high mucosal blocking score is associated with HIV protection [30]. The implications of foreskin immunology to vaccine development and immunotherapy are discussed in the Conclusion and Recommendations. The protective effect of foreskin langerin remains unexplored in the VMMC literature.

1 Although receptive anal intercourse is the riskiest type of sex for HIV transmission [24], Langerhans cells are not present in rectal tissue [23].
2 The WHO reference on foreskin Langerhans cells as HIV viral portals is authored by Robert C. Bailey, a longstanding circumcision proponent and the lead author on the Kenyan female-to-male trial. Its citations document the abundance of Langerhans cells in the foreskin with attendant speculation into HIV infection, but do not actually trace Langerhans cells to HIV infection [25]. A broader histological study into the immunological components of the foreskin is available at [26], with a demonstration of HIV infection of cadaver foreskin cells at [27]; however, prior to study, foreskins were sanitised with phosphate-buffered saline which would have removed antiviral langerin as a mucosal barrier to HIV transmission.
• **Delayed washing in uncircumcised men was found to be significantly more protective than circumcision.**

Findings from a clinical trial in Uganda presented at the Fourth International AIDS Society Conference (Table 2) appeared to corroborate the findings of the in vitro studies on foreskin resistance to HIV-1 via langerin [28-30]: Uncircumcised men who waited more than 10 minutes to bathe after sex had **87% reduced HIV incidence** relative to the majority who bathed immediately after sex [31]. However, study authors did not explore the emerging research into foreskin langerin, instead attributing the anti-viral effect of delayed washing to vaginal fluid acidity.

• **Pre-exposure prophylaxis (PrEP) became standard HIV prevention in the Western world.**

Since 2012, a combination of two antiretroviral drugs (tenofovir and emtricitabine) sold as Truvada® has been approved for more than 90% HIV prevention, and became standard HIV prevention for at-risk men and women in the Western world.

• **Child circumcision became a subject of ethical and legal controversy in Europe.**

The Nordic Ombudsmen for Children issued a Joint Statement against the circumcision of minors in 2012, arguing that the practice is in conflict with Articles 12 and 24 of the UN Convention on the Rights of the Child [32]. The following year, the 63rd session of the Committee on the Rights of the Child classified circumcision as a “harmful practice” [33]. Also in 2013, the Council of Europe Parliamentary Assembly (representing 47 countries) adopted Resolution 1952, which classified religiously motivated circumcisions as a violation of children’s right to physical integrity [34]. Medical policies opposing the nontherapeutic circumcision of children on ethical grounds were adopted by the Royal Dutch Medical Association (KNMG) in 2010 [35] and the Danish Medical Association in 2016 [36]. The ethics council of the Swedish Medical Association opposed the circumcision of non-consenting children and proposed a minimum age of 12 years for consent in 2014 [37]. In 2017, the Belgian Government Committee for Bioethics ruled against infant circumcision, arguing that children’s right to bodily integrity supersedes parents’ right to practice their religion [38]. Child circumcision was briefly criminalised in Cologne, Germany in 2012; and national bans were proposed in Danish and Icelandic Parliaments in 2018 (Section I).

• **A Zimbabwean senator urged government resistance to mass circumcision on children’s rights grounds.**

The late Senator Sithembile Mlotshwa introduced a motion in the Senate of Zimbabwe to prohibit child and infant circumcision and resist related programmes, stating: “[H]istory will judge us for allowing the policy to continue.” Her motion, transcribed in Appendix C, was not made publicly available in the online Hansard, possibly due to sensitivities to international donors and funding interests.

• **A multi-national press conference presented opposition to mass circumcision on human rights grounds.**

The 2017 press conference in Berlin (Fig. 1) was organised by MOGiS e.V., a children’s rights NGO specialising in childhood sexual trauma, and included representatives from the German Paediatric Association (BVKJ), the VMMC Experience Project, Intact Kenya, Aktion Regen, and Terre Des Femmes. Complete speeches and resulting press coverage are presented in Appendix A. Following the conference, the Worldwide Day of Genital Autonomy (7 May) in Cologne took mass African circumcision as its theme for 2017 (Fig. 2).

• **A joint letter to UNICEF condemned EIMC as medically unjustified and ethically unacceptable.**

The letter from the VMMC Experience Project—co-signed by international medical leaders and experts—presented egregious human rights issues documented on the ground, and urged “a plan of action or retraction” from the infant circumcision campaign [39] (UNICEF’s response at [40]).

• **Harvard researchers found higher HIV prevalence among medically circumcised than uncircumcised men in South Africa.**

In the 2018 study among older men in the HAALSI cohort, the authors concluded that the conception of circumcised men as safer sex partners that underscores VMMC policy “may be incorrect” [41]. The finding corroborates innumerous anecdotal reports on the ground, explored in Section III, of a false sense of protection resulting from the circumcision campaign that rapidly accelerates HIV transmission in VMMC-intensive areas.

### Table 2. Reduction in HIV incidence to uncircumcised men from delayed washing in a Ugandan clinical trial

<table>
<thead>
<tr>
<th>Duration from sex to penile washing (minutes)</th>
<th>Follow-up</th>
<th>Incident cases per 100 person-years</th>
<th>Adjusted IRR (95% CI)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3</td>
<td>1,787 (49%)</td>
<td>2.32</td>
<td>1.0</td>
</tr>
<tr>
<td>&gt;3-10</td>
<td>984 (27%)</td>
<td>1.68</td>
<td>0.62</td>
</tr>
<tr>
<td>&gt;10</td>
<td>861 (24%)</td>
<td>0.39</td>
<td>0.13</td>
</tr>
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</table>

Relative risk reduction from >10 minute delay

0.83 (83%) 0.87 (87%)

Adapted from Makumbi et al. (2007) [31].

*Calculated with Huber-White sandwich robust estimator using Poisson regression model.

UN Report: African opposition to mass circumcision
• Ugandan President Yoweri Museveni spoke out against mass circumcision as an HIV transmission accelerator.

Resisting political and economic pressure to endorse a continuation of the multi-billion dollar effort, President Museveni broke his silence on VMMC in October 2018 at the launch of Presidential Fast-Track Initiative to end HIV/AIDS in Uganda by 2030 [42]. Citing widespread rumours of HIV immunity following circumcision for HIV prevention, and a 22% higher national HIV prevalence after a decade of circumcision implementation than before, Museveni’s statement was the first public instance of African opposition to mass circumcision by a national leader.

Within this climate of internal contradictions, there remain no clear answers as to whether the mass circumcision of African boys and men is beneficial or harmful on balance, whether the controversial “60%” female-to-male trials will translate into a positive impact on the HIV epidemic, or whether VMMC and EIMC participants will come to value or resent their circumcisions. For these reasons, the following report defaults to the reported experiences of those affected by the programmes.

Economic barriers

In settings marred by poverty and chronic unemployment, VMMC and EIMC provide a wealth of economic opportunities that confound African resistance efforts. A 2013 operational guide by PEPFAR suggested 18 VMMC staffing roles in both clinical and administrative capacities [43].

Reporting a severe circumcision botch and sexual deformity from UNICEF’s infant circumcision campaign in Arua, Uganda, concerned neighbour Jackline Mugisha reached out to the VMMC Experience Project to explain confounding financial motives: “We [live] in a country where everyone tells you they can do everything as long as you are going to pay.” The email was forwarded to UNICEF on 9 August 2017, and did not receive a response.

In rural Uganda and Kenya, some medical practitioners have reported that they were unable to claim satisfactory salaries independently of the VMMC campaign, and will continue to mass-circumcise children—sometimes against personal beliefs—for financial reasons. Also in Kenya, a 2018 US government report uncovered evidence of a decade of falsified “ghost circumcisions” reported at donors’ expense [44].

African resistance efforts are frequently offset by financial incentives at all levels of VMMC policymaking and implementation (see Section I). The VMMC Experience Project invites reviewers to consider the concerns of VMMC-affected communities independently of the economic interests of those who are benefiting from the campaign.

African resistance in the news

Public opposition to the mass circumcision campaign remains difficult for political and economic reasons. However, a robust body of local African news headlines identifies egregious problems on the ground. These problems include concerns related to unlawful “forced” circumcisions, schoolwide circumcision programmes conducted without parental consent, medical complications and a lack of follow-up care, buried evidence of risk compensation resulting from a false sense of HIV protection, in-
creased HIV/AIDS rates attributed to the campaign, and associated ethical and human rights concerns. A sample of these headlines is presented in Appendix D.

African viewpoints opposing the circumcision campaign have yet to reach the fore. Western media coverage has echoed positive press releases from VMMC-promoting institutions, with critical omissions regarding the personal and professional biases of policymakers and stakeholders. For example, a *Los Angeles Times* article described Brown University medical professor David Tomlinson as the WHO’s “chief expert on circumcision” [45], but neglected to disclose Tomlinson’s conflict of interest as the patent owner on AccuCirc, for which he receives royalty payments from Clinical Innovations, LLC [46], among other male circumcision devices [47-51].

In light of the dearth of African representation in the Western media, the VMMC Experience Project is committed to presenting the view on the ground. Between December 2016 and August 2018, the Project has published three press releases divulging the findings of its February 2016 investigation into experiences with the mass circumcision campaign in rural Uganda and Kenya. These press releases are available to view at www.vmmcproject.org/press-releases.

In May 2017, the VMMC Experience Project participated in a joint press conference to present the African opposition at the *Bundespressekonferenz* in Berlin (Fig. 1). The conference included speakers from the German Paediatric Society (BVKJ) and multicontinental children’s rights NGOs opposed to VMMC and EIMC on medical and ethical grounds. The full texts of the testimonies and resulting media coverage are presented in Appendix A.

In the hours following the press conference on 4 May, a primetime evening special dedicated to the VMMC Experience Project’s work in rural Kenya by Nano Media aired on Channel 3 News in Germany, with a Saturday morning rerun on 6 May (Fig. 3).

In July 2018, the Project attempted to engage the BBC World Service on the African resistance movement to mass circumcision in Kampala, Uganda (Fig. 4). However, interviews with the Project’s executives and a VMMC participant reporting egregious sexual harm from circumcision did not reach the final story, which limited criticism of the campaign to outside speculation [52].

From December 2016 through August 2018, Intact Kenya, a Luo-run organisation representing traditionally non-circumcising minority groups in Kenya, made a series of guest...
appearances on radio programmes in rural Migori and Siaya Counties (Fig. 5). On these programmes, Intact Kenya executives Kennedy Owino Odhiambo and Job Kajwang shared education on foreskin functions and frequently reported problems from VMMC programmes targeting Luos. In turn, callers reported a range of negative experiences with VMMC. Men reported adverse sexual changes and feelings of regret, betrayal, and depression. Parents reported child abductions from schools and circumcisions performed against their wishes. Unable to secure broader media coverage, Odhiambo began summarising these radio programmes as a guest-blogger on the VMMC Experience Project’s website at www.vmmcpjject.org/guest-blogs.

Other locally organised resistance activities, including live music events (Fig. 6) and rally demonstrations (Fig. 7), have yet to receive media attention. However, Ugandan Parliamentary member Namulanda Oundo’s attendance of a VMMC Experience Project rally and football tournament in Namayingo District in January 2019 (Fig. 8) received coverage on Mengo Radio Kampala, and is expected to facilitate further local media coverage of Ugandan resistance to mass circumcision. Photos of locally organised resistance activities by Prince Hillary Maloba and the VMMC Experience Project from 2016 through 2019 are presented on Pages 11-13.

The present report includes the African circumcision controversy and opposition in lieu of Western media representation.

The Scope of This Report

The present Report is designed to catalogue what is currently known about the African resistance movement to mass male circumcision. It covers the testimonies of men and women adversely affected by VMMC as presented to Ugandan and Kenyan interviewers without Western interference. Research is presented qualitatively, not quantitatively; and is grouped into three categories: involuntary circumcisions (Section I), adverse sexual complications (Section II), and HIV infections attributed to the campaign (Section III).

The Report is focused on medical male circumcision programmes that are financed through the Bill & Melinda Gates Foundation, PEPFAR, USAID, CDC, DOD, UNAIDS, UNICEF, and various NGOs engaged in the global AIDS response. To that end, research into traditional African genital cutting practices is omitted. For the Project’s research into traditional male circumcision and the high HIV burden among the Bagisu tribe in Mbale, Uganda, please visit Project Bagisu at www.vmmcpjject.org/project-bagisu.
The VMMC Experience Project limits its scope to African experiences with VMMC and EIMC. The Project does not make medical or legal claims about circumcision. References to circumcision literature and policy are added to explain the motives for this research and provide context for participant testimonies throughout.

The following report does not address the Western public health discourse around VMMC. For official VMMC documentation, please visit the Clearinghouse on Male Circumcision’s website at www.malecircumcision.org.

Source material

Material in the following report is sourced from the VMMC Experience Project’s February 2016 investigation into VMMC experiences within traditionally non-circumcising communities: Soroti District, Kenya; and Busia, Kumi, Pallisa, and Tororo Districts, Uganda. The investigation includes content from 98 interviews conducted with VMMC-affected men, women, and adolescents. Full unabridged interviews are available to view at www.vmmcproject.org.

All aspects of the investigation, including coordination of travel and human resources; planning and decision-making into target regions, communities, and focus areas; determination of topics and questions; and conducting of the interviews themselves, were handled exclusively by Executive Director Prince Hillary Maloba with his local team in Uganda and Kenya.

The rise of social media in SSA provides new opportunities to hear from African men and women without researcher interference. Supplementing the VMMC Experience Project’s investigative material are testimonies from multinational VMMC-affected men and women that have appeared on the Project’s Facebook page between February 2017 and April 2019 (Appendix F). Public Facebook posts are printed on a Fair Use basis.

All image material is original with the exception of VMMC advertisements in Section II, and news headlines in Sections I and III and Appendices A and D, which are printed on a Fair Use basis, and where photo credit is explicitly provided to other sources which have granted permission for inclusion in this Report.

Concluding Remarks

The VMMC Experience Project’s February 2016 investigation in rural Uganda and Kenya uncovered an emerging vanguard of VMMC-affected men and women who are reporting human rights violations attributed to the campaign.

In light of egregious health and human rights complications presented in this Report, the VMMC Experience Project calls for the immediate termination of quota-based incentives and programmes targeting minors below the legal age of consent. VMMC services should remain available for men who choose to be circumcised as a possible supplementary measure for HIV prevention, with safeguards added to ensure informed consent. However, in light of present human rights concerns, a burgeoning African resistance movement, and the newer advent of more efficacious alternatives including 90% efficacy PrEP, VMMC should no longer be viewed as a primary HIV-preventive strategy.

The VMMC Experience Project proposes a Three Tier System (TTS) as a comprehensive HIV solution until a vaccine becomes available. An elaborated TTS model is included in the Conclusion and Recommendations. The Project welcomes an ongoing dialogue on the role of male circumcision in light of improved HIV preventive technologies.

Above all, the Project wishes to honour the brave men and women who provided testimony for this Report by making their experiences with mass circumcision efforts available to policymakers and stakeholders on an urgent basis.
References


16: Green LW, McAllister RG, Peterson KW, et al. (2008). Male circumcision is not the ‘vaccine’ we have been waiting for! Fut HIV Ther 2(3):193-199. DOI: 10.2217/17469600.2.3.193


