Mass male circumcision is implemented for HIV prevention in priority countries on the basis of three clinical trials finding 50–60% reduced HIV transmission to men from the intervention [1-3]. Associated controversies, including critical interpretations of the trials themselves and newer contrary developments, were discussed previously (see Background).

With respect to the present controversy around male circumcision for HIV prevention, this Section is to address the behavioural and HIV impact of circumcision programmes as reported in the VMMC Experience Project’s investigation within VMMC-affected communities.

A surgical “vaccine”?

In the introduction to the first (2005) female-to-male HIV transmission trial in South Africa, Auvert et al. concluded that the 60% relative risk reduction conferred to men by circumcision was “equivalent to what a vaccine of high efficacy would have achieved” [1].

A 2008 commentary added that male circumcision is “at least as good as the HIV vaccine we have been waiting for, praying for and hoping to see in our lifetimes” [4].

In a 2014 news article highlighting higher HIV prevalence among circumcised than uncircumcised men following VMMC roll-out in Zimbabwe, proponents continued to defend mass circumcision efforts on the basis of exaggerated claims. Botswanan paediatric HIV expert Gabriel Anabwani—who serves on technical expert panels for the WHO and UNICEF—was quoted:

“All the three research projects showed that male circumcision on its own is more effective than most vaccines. Even if a vaccine for HIV was found today it won’t be as effective as male circumcision.” [5]

In turn, critics have expressed concerns over “circumcision euphoria” [6] and exaggerated claims. One early critical editorial asked: “How can the actual findings be separated from the global chatter that is happening and avoid significant distortions and claims being made?” [7]. PLoS Medicine editors went further in cautioning against a mass circumcision campaign on the basis of the “increased risk taking that may result from expectations of protection following circumcision” [8]. Another commentary proposed that “[o]ffering less effective alternatives can only lead to higher rates of infection” [9]; while others suggested that VMMC “will not complement condom use, as proponents hope, but, in reality, it will compete with condom use” [10].
One critical commentary likened the partially protective intervention to suboptimal “folk methods” of birth control (i.e. the rhythm method among religious groups), and asked: “Is there a rationale for promoting the idea of circumcision when better choices are available?” [11]

Highlighting encouraging condom use trends from a recent survey in Cape Town, South Africa, another critical commentary expressed concerns over risk compensation:

*It is difficult to imagine a convincing public health message that effectively influences men to undergo circumcision and continue to consistently use condoms.* [12]

Other analyses, including early modeling studies by VMMC proponents, predicted that the 50–60% protective effect of male circumcision would be sufficient to overshadow the possibility of increased HIV incidence from risky sexual behaviour that could result from a mass circumcision campaign [13-15].

Similar to the body of research showing a lack of adverse sexual consequences from VMMC (contrary participant experiences in Section II), study findings into increased risky behaviour following circumcision are widely varied and frequently at odds with what is reported on the ground. Studies into post-circumcision risk compensation are explored in Box A.

Local suspicions

In a 2015 investigative article published in the German magazine GEO, a Zambian former Ministry of Health worker recalled not only becoming infected with HIV following participation in VMMC, but discovering how common the problem really is: “‘Thousands share my fate,’ he learned [in an HIV support group]. ‘The circumcision campaign is a deadly deception’” [16].

African news headlines have also presented a more complex view of VMMC’s real-world effects on HIV transmission: “Push for male circumcision in Nyanza fails to reduce infections”; “Circumcision Does Not Prevent HIV/AIDS, Migori Youth Warned”; “Circumcision Promoting Risky Behaviour – Report”; “Circumcised Men Abandoning Condoms”; “Is Voluntary Male Medical Circumcision De-Campaigning Condom Use?”; “Zomba HIV Prevalence Rate at 15 Percent Despite Intensive [VMMC] Campaigns”; “Malawian circumcised men most likely to be infected by HIV, research shows”; “Circumcision disaster: Malawi HIV infection rate doubles”; “Medical male circumcision: is the HIV prevention claim wrong?”; “The benefits of circumcision are exaggerated, we should end it”; and “Malawians blasts [sic] the US: ‘We don’t need aid for circumcision’” among other local news headlines included in Appendix D.

Box A. Risk compensation studies

Risk compensation, or increased risky sexual behaviour resulting from expectations of HIV protection, is a frequently cited concern from the campaign. As one HIV-positive man who had been circumcised explained to the VMMC Experience Project: “People are being told this is a preventive measure. Why use a condom if you are already prevented?” [25]. However, study findings on risk compensation are inconsistent.

Evidence reported from the female-to-male trials found no risk compensation effect of male circumcision for HIV prevention over the trial periods [1-3,26,27]. However, participants received intensive behavioural counseling about risky sexual behaviours throughout the trials, and the protective effect of male circumcision—the impetus for risk compensation—had not yet been established.

A 2012 acceptability study conducted prior to scaling up VMMC in Kisumu, Kenya found that 19% of (uncircumcised) men and 26% of women reported that condom use is less necessary now that circumcision is available, with similar proportions endorsing perceptions of HIV as a less serious or worrisome threat due to VMMC availability [28].

Studies by VMMC advocate authors and stakeholders, including those on the original female-to-male trials, have consistently found a lack of evidence for risk compensation following local VMMC initiatives [29-36]. Following the release of the VMMC Experience Project’s investigation documenting risk compensation on World AIDS Day (1 December) 2016 and attempted media dissemination throughout 2017, VMMC advocate researchers published two new studies showing no association between male circumcision and risk compensation [35,36].*

*The Male Circumcision Consortium (MCC) has conducted its own studies finding no evidence of risk compensation or associated beliefs. MCC research briefs are available at FHI 360’s website at www.fhi360.
Box A. Risk compensation studies, Cont’d

Externally conducted studies into post-circumcision risk compensation are inconsistent. The following list comprises all previously uncited studies that emerged using the search terms “circumcision” and “risk compensation” on PubMed (accessed 6 February 2019):

- A data analysis of the 2004 and 2011 Uganda AIDS Indicator Surveys found risky sex factors to be significantly higher among circumcised than uncircumcised men in both surveys. However, self-reported condom use among circumcised men dropped from 54.4% in 2004 to 41.6% in 2011, which was attributed to the local introduction of VMMC messaging in 2007 [37].

- A study among 981 young school-going men over a one-year period found that risk compensation was not associated with the decision to undergo VMMC. However, at the end of the study, only 39% of young men in both cohorts reported using condoms consistently in the previous month [38].

- Analysis of data from the Cape Area Panel Study (CAPS) found diminished or abandoned condom use after male circumcision to be prevalent in women but not men [39].

- A study using cross-sectional data from the Botswana AIDS Impact Survey III found that male circumcision did not impede condom use in men [40].

- A study among women throughout Zambia (n=934) found that misconceptions associated with risk compensation were significant, and only increased with subsequent sensitisation exercises. In Round 1, 30% of women falsely believed that HIV is fully protective to men against HIV infection, and 50% falsely believed that male circumcision confers HIV protection to women; in Round 2, 41% believed that HIV is fully protective to men against HIV infection, and 70% believed that male circumcision confers HIV protection to women. Women also greatly overestimated the protective effect of male circumcision against other STIs [18].

- A large-cohort cross-sectional study (n = 7,464) among young men and women in representative cluster samples in Botswana, Namibia, and Swaziland found beliefs consistent with risk compensation to be considerable, with significant variance between countries. 9–15% of respondents believed a circumcised man is fully protected against HIV; 14–26% believed an HIV-positive man cannot transmit the virus to a woman if he is circumcised; and 9–34% believed it was “okay for a circumcised man to expect sex without a condom.” Incidentally, the study also found that circumcised men were as likely as uncircumcised men to test HIV-positive after controlling for other variables [41].

- A survey of 279 women receiving health services in an impoverished township in Cape Town found that awareness of male circumcision for HIV reduction was associated with false beliefs of a reduced need for men to worry about HIV, a reduced need for men to use condoms, and reduced HIV transmission to women from circumcised men [42].

- Six small in-depth qualitative studies among men were conducted in Uganda, Kenya, South Africa, and Swaziland. Half of the studies found significant direct evidence of risk compensation associated with VMMC [43-45]; while one study found evidence in a minority of participants, typically during a brief period of sexual experimentation shortly after circumcision [46]; another found indirect evidence (i.e. widespread beliefs that “others” engage in risky sex after circumcision) [47]; and one study did not find any reported evidence of risk compensation [48].

- A small in-depth qualitative study (n=32) among wives of VMMC participants in Iringa, Tanzania found that early resumption of sexual activity after circumcision (i.e. increasing HIV risk from bloodborne exposure) was common and a minority of women reported emotional abuse or risk compensation following their husbands’ circumcisions [49].

- A small randomised trial (n=150) among men in South Africa found that a brief HIV counseling session at the time of circumcision sustained self-reported safe sex practices for three months [50].

- A survey of 304 traditionally (non-medically) circumcised men in Cape Town found strong evidence of risk compensation related to VMMC messaging [51].

The wide variation in results on post-circumcision risk compensation may be due to the limitations of self-reported evidence. Self-reported data are likely to be confounded by socioeconomic barriers, and by perceived pressure to conform to researcher expectations. Financial motives to sustain VMMC programming present an additional confounding factor, particularly in low-income areas. The VMMC Experience Project is committed to authentic representation of African men and women affected by VMMC.
African viewpoints on social media are mixed (Box B; Appendix F). Suspicions of increased HIV incidence from VMMC appear to be more prevalent in Uganda, where political opposition is growing, than in Kenya, a circumcision-normative country where Luos face both high HIV prevalence and longstanding sociopolitical pressure to accept the practice.

**Ugandan political opposition**

The scope of the risk compensation problem is beginning to reach Ugandan politicians. In launching the Presidential Fast-Track Initiative to end HIV/AIDS in Uganda by 2030 in October 2018, President Yoweri Museveni pointed to the circumcision campaign as a dangerous distraction from proven HIV preventive measures:

*I have always heard people and partners saying that when you are circumcised you don’t contract the virus. … That’s nonsense. … I think the message should [be to] avoid sex which is not protected.*

Resisting political and economic pressure to support a continuation of the multi-billion dollar effort, the President went on to allege that VMMC had actually reversed progress from Uganda’s famously successful ABC (“Abstain, Be faithful, use a Condom”) campaign:

*Before we started [ABC], [Uganda’s] HIV prevalence was at 18%. Then it dropped to 6%. But when they started this talk of circumcision it confused the masses. Then it went up to 7.3% [a 22% relative increase]. There is much laxity among members of the public and that’s why we need to fast-track the awareness.* [17]

Reactions to President Museveni’s statement on social media are included in Appendix F.

Attending a VMMC Experience Project rally from Parliament in January 2019, Namulanda Oundo encouraged affected communities to make their voices heard (Fig. 1).

**Damage control**

Strategies to control hyperbolic claims surrounding the protective effect of male circumcision are proposed in research but not in practice.

Finding alarmingly high incidence of misconceptions surrounding circumcision for HIV prevention among women in 2016—with false beliefs of male-to-female HIV prevention increasing from 50% to 70% with subsequent VMMC sensitisation exercises—Population Council researchers concluded that VMMC messaging “should address women’s informational needs,” emphasising that condom use remains critical for women regardless of their partners’ circumcision status [18].

Finding higher HIV prevalence among medically circumcised than uncircumcised older men in the HAALSI cohort in South Africa in 2018, Harvard researchers concluded:

*The impression given from circumcision policy and dissemination of prior trial findings that those who are circumcised are safer sex partners may be incorrect … and needs to be countered by interventions, such as educational campaigns.* [19]

An analysis of the 2013–2014 Zambia DHS data by native Zambian researchers concluded with a heated 1,100-word discussion purporting risk compensation as a well-documented inevitability of circumcision for HIV prevention that is not always apparent from raw data:

*While there is no strong evidence from the ZDHS 2013-2014 data on circumcision and risky sex, adjusting this relationship by socio- and [sic] demographic characteristics shows there is. … [R]eults in this paper are not encouraging for any advocate or supporter of circumcision and the strong, well-intended messages around it. … [M]essages in communities seem to [have reached] the extent of making VMMC a “risky factor” by itself … Clearly, circumcision does have negative effects on risky sexual behaviour.*

With respect to damage control, the authors proposed:

*Proponents of VMMC [should] up their messages to ensure complete adherence to safe sexual [sic] messages, behaviour and practice if transmission of HIV and other STIs is to be halted and reversed.* [20]

The present Section presents VMMC-affected men and women in their own words.
**VMMC Experiences**

In light of the present controversy surrounding reported behavioural consequences of circumcision for HIV prevention, the VMMC Experience Project’s February 2016 investigation in rural Uganda and Kenya sought to assess the view on the ground from affected individuals.

Overwhelmingly, respondents in the investigation reported risk compensation from VMMC at the personal and community levels, including diminished safe sex practices and increased sexual violence against women following circumcision for HIV prevention. Within all communities included in the investigation, risk compensation factors were reported to be increasing HIV transmission locally.

**Unsafe sex**

Reported risk compensation factors following male circumcision for HIV prevention included decreased condom use and increased number of sexual partners.

Due to space limitations, the following testimonies prioritise first- and second-hand reports of HIV infections attributed to risk compensation following participation in VMMC. More testimonies, which include self-reported risk compensation factors and more general concerns of increased HIV transmission from VMMC, are available at [www.vmmcproject.org](http://www.vmmcproject.org).

**Agnes Namkendi, age 28:**

*Where I’m working, [VMMC mobilisers] came to our school, they convinced all boys, they went. Then they started messing up, knowing that they will not be affected [by HIV]. By the end of the term, we got some three [who] were HIV-positive after circumcision.*

**Alfos Walega, early 30s:**

*Before I was circumcised I tested negative for HIV. But they said if I circumcise it will reduce my chances of getting HIV. Then they circumcised me. But after that I came to contract HIV. ... For me it didn’t fulfill what I expected. ... Once you are circumcised you are drawn to sleeping with a woman without a condom. You see what I’m saying? So this circumcision thing, I see it like it’s increasing HIV.*

**“Samson,” mid 30s:**

*Personally I’ve been using sex workers a long time and I’m circumcised. But along the way I stopped using condoms because I thought being circumcised would protect me from HIV. I later tested and was found HIV-positive. ... The funds [for VMMC] come under the assumption that circumcision will reduce HIV but instead HIV is on the rise.*

**Ralphich Mutasi, age 18:**

*[We] heard information from radios, also from TVs, that circumcision can decrease the chances of getting HIV. ... I go open [unprotected] because they say that when you are like that [circumcised] you don’t get infected. After the first time I went for a test, they told my girlfriend she’s infected now. ... They told me that I’m not, but I’m going back in March, next month, to go and see the final count.*

**Daniel Moita, age 21,** admitted engaging in frequent unprotected sex following circumcision for HIV prevention. He recalled the following experience as a “complication” from his circumcision:

*I remember one day I went for sex with my girlfriend. After that, I saw something like pimples on my penis. And then I was tested that I have gonorrhea. ... I have never gone for HIV testing and I’m even scared to go. ... Some of my friends have also been circumcised and have gone for HIV testing and they were positive. So I also fear.*

This respondent refused the investigators’ attempts to take him to HIV testing.

**Vincente Endegna, late 40s:**

*I got circumcised so I wouldn’t get AIDS. Before that I had no disease at all. I was told that if I get circumcised I would be safe from the disease. But now I have it. ... The information I got is that if you have sex with a woman after circumcision you won’t get HIV.*

*His voice cracked as he added: “I am now saying circumcision must stop!”*

**Paolo Otieno, mid 40s:**

*My friends lied to me. They told me when you have sex with a girl [after circumcision] you will not feel any pain and she will feel very nice. Even if she meets other men*
she will always praise you to have given the best sex. It’s after that lie that I decided to get circumcised. And also my friends told me with circumcision you will not get HIV. It’s been a year since I got circumcised. Recently I went to get tested and I have HIV. Now I don’t know why they brought this circumcision programme. ... As I had been circumcised, when I tested HIV-positive I was shocked. You can even see how I’ve lost weight, because in my heart I know I have HIV. ... It should be banned following my experience.

When asked about other cases of HIV infections following participation in the VMMC campaign, this respondent stated: “Very many! Just the other week there was a guy [VMMC participant] who died of AIDS, leaving behind a wife and two children.”

“Patrick,” late 20s, reported that he began using condoms after circumcision following advice from colleagues who learned the hard way:

We got some advice from other people that circumcision does not control HIV spread. ... Most of the people now go for sex knowing that when you are circumcised you don’t get HIV, so it has caused very many to be affected. ... Others who got advice, they are now using condoms. Then others who are ignorant about it, they stopped using condoms [after circumcision] and they are the ones dying now.

Pian Gratib, age 18, also began using condoms after witnessing the shortcomings of male circumcision for HIV prevention:

My friend experienced that HIV/AIDS. ... He was circumcised, but at first when he was not circumcised he was safe. But when the time came for testing, they told him that when you are circumcised you do not get HIV/AIDS. But this time [after circumcision] he’s sick.

When asked whether he had received education on HIV transmission and prevention, this respondent stated that he had not, and that he would be interested in such an education: “I’m interested because I love my life.”

To Kwere Kejunas, age 18, the investigation itself became a means of HIV education. As this respondent initially stated:

Just after circumcision with my colleagues, we were all most greatly excited with getting surgery. Because we the youth, when we have a little discussion with our friends, we were told that when you’re circumcised and when you meet your girlfriend, you will physically fit with her. And of course we took that chance of seeing before we get healed, maybe let’s have a sample and we’ll see how it works for us.

Weldon Kwach, an investigator working with the VMMC Experience Project, took the opportunity to explain bloodborne HIV transmission to this respondent during his interview, particularly the high risk of viral transmission through the circumcision wound. The respondent’s reception to this education was reflected in his final statement:

Me, I would feel that if there is any chance of really helping my community—because right now people are getting infected at a high rate of getting HIV—it would have been better that the government and other organisations ... set up some organisation at least to our villages and really educate people about HIV.

John Bosco Beressa, late 20s, expressed similar views:

I think rather than supporting male circumcision, the funders—if they are faithful enough—I think what they would do is ... invest to bring in more condoms [and] employ more personnels [sic] to go and educate the communities about the misconception that male circumcision prevents HIV. ... People misquote this information that circumcision prevents HIV, and they end up not caring. And thus AIDS is increasing. Men are being circumcised but AIDS is not reducing. So I strongly support the people who are trying to pass out this information.

Sex workers

Female sex workers consistently reported difficulty around condom negotiation with newly circumcised clients.

Barbara Asimi, late teens/early 20s:

I encounter many challenges in this work. I may get a customer who doesn’t want to use a condom, and since I need the money, I’m compelled to serve him. He may say that since he’s circumcised he can’t get HIV, which is not true. ... Some use condoms, others don’t use condoms. One may refuse because he’s circumcised and thus believes he can’t be infected by the virus. ... If he was recently circumcised and has yet to heal, it becomes a problem if he wants sex. He can continue bleeding and leave his blood on your private parts. ... Circumcision should be banned.

Jamira Namatovi, age 28: “They don’t want [condoms]. They say they cannot acquire HIV. ... The uncircumcised one is better for me because he usually asks for a condom.”

Kati Ishana, age 22: “A circumcised client will tell you that he is HIV-free, only to learn later from your colleagues that he is indeed infected. His excuse for not using a condom is that he’s circumcised.”
However, this respondent stated that she prefers circumcised clients and believes that male circumcision reduces the risk of HIV infection by “a little bit.” Her preference may be confounded by financial motives:

A circumcised client will offer to pay 30,000 shillings [$9 USD] on condition that you have unprotected sex with him, or he’ll go to the competition. ... It is even more profitable since I don’t have to incur the cost of buying condoms. Clients who insist on condom use usually want to pay 5,000 shillings [$1.50 USD].

Clea Odhiambo, age 28:

Those who are circumcised go without [condoms]. ... Better for them to stop [VMMC] and bring condoms and medicines as usual. ... I wish they could ban it today because it doesn’t help. ... It’s finishing us like nothing! It increases [HIV] very much. ... It’s just killing us more. You are lied to that if you get circumcised you won’t get HIV, but we got it. Even I got HIV this way from a circumcised man. So it’s useless.

When asked whether she was aware of circumcised men dying from HIV/AIDS, this respondent stated: “So, so many! There’s even a burial for one tomorrow.”

**Sexual violence**

The VMMC Experience Project’s investigation did not explore VMMC’s effect on sexual violence. However, the following responses emerged incidentally.

John Bosco Berressa, late 20s: “When somebody is circumcised, there’s a way you tend to go rough ... when you’re [having sex].”

Edith Nakawe, age 18: “My brother at first was never jumpy, but when this programme of circumcision came he thought now he’s safe. So he started becoming so jumpy, and at last he also acquired it [HIV]. And he’s a rapist.”

Apollo Otieno, age 19, was asked about general complications from the VMMC campaign. He reported: “Rape cases.”

Kareem Amza, age 19: “[VMMC] is making Africans suffer because their high sexual appetite is increased and that makes them suffer. Others even end up raping girls which will make them end up in prison.”

Patrick Ocol, age 29, appeared to confuse a question about forced circumcisions with one of forced sex: “I have an experience. You know when you are circumcised, you don’t want to sleep without fucking a lady. You might even fuck more than three at a go.”

Sharon Mohammed, age 27, relayed her challenges with circumcised clients as a commercial sex worker:

[S]omeone can come when he is circumcised and force you, tell you he is going to give you a certain amount of money, do this and that, we’ll do it without a condom. You understand? Which complicates things for me sometimes. Sometimes he says he doesn’t have AIDS. Such are our challenges. ... [I]f that [a circumcised] person comes, he can force me. He can do sex forced because he is circumcised.

When asked if she would support a ban on VMMC, this respondent stated: “I support it with all my life and with all my blood.”

To date, the VMMC campaign has focused on a possible 50–60% reduction in female-to-male HIV transmission without quantifying its effects on women. However, the reality that women are more susceptible to HIV infection as receptive partners, and also face significant challenges around sexual violence in much of SSA, can no longer be ignored.

Male-to-female HIV transmission is more common than female-to-male transmission, making women’s risk factors more impactful to the epidemic at large. The only clinical trial into VMMC’s effect on male-to-female transmission found that even with optimal behavioural counseling, male circumcision increased women’s risk of infection by 54%. The trial was terminated early “for futility” [21]; an even more alarming figure could have resulted if brought to full term.

The VMMC Experience Project’s investigation uncovered a spectrum of violent sexual behaviours attributed to VMMC that may further increase women’s risk. Sexual violence against women deserves attention as a facet of risk compensation following male circumcision for HIV prevention.
Box B. Social media

Evidence of circumcision hyperbole and risk compensation, with attendant concerns of increased HIV transmission from VMMC, appear on social media. Limited examples below:

For more social media testimonies, including cases of HIV infections attributed to the VMMC campaign, see Appendix F.
Conclusion and Recommendations

The World Health Organisation recommends medical male circumcision for HIV reduction in 14 priority countries in SSA—with considerable controversy (Background; Appendix A). In clinical trial settings, with condom accessibility and optimal behavioural counseling, male circumcision reduced the risk of HIV transmission to men by 50–60% [1-3], but increased the risk of transmission to women partners by a minimum of 54% [21]. Sexual abstinence during the wound healing period and consistent condom use thereafter remain essential for HIV prevention.

Risky sexual behaviours following circumcision for HIV prevention make for suboptimal results on the ground. Post-circumcision risk compensation—with subsequent increased HIV incidence—has reached news headlines in most VMMC target countries (Appendix D), is increasingly affirmed by Ugandan politicians, and is now well documented in the VMMC Experience Project’s investigation. Reported risk compensation factors following circumcision for HIV prevention include decreased condom use, increased number of sexual partners, and increased sexual violence against women resulting from a false sense of protection. The VMMC Experience Project’s investigation has put names, faces, and personal testimonies to the widely reported subset of men and women whose health and lives are adversely affected by circumcision for HIV prevention.

Researcher recommendations to address risk compensation from the circumcision campaign have yet to manifest on the ground. A messaging campaign is urgently needed to diffuse the circumcision hyperbole that is putting women and men at higher risk of infection, even if such information may result in lower VMMC uptake and support. The preliminary evidence suggesting an increased HIV risk to women from male circumcision should also be explored and addressed, as this would increase the overall HIV burden in SSA.

A thorough policy review is indicated to assess the continued relevance of VMMC in the global AIDS response as confounded by adverse behavioural consequences, by newer research developments into foreskin langerin as a barrier to HIV transmission [22] (possible clinical implications at [23]; implications for immunotherapy at [24]), and by the advent of pre- and post-exposure prophylaxis (PrEP and PEP) as more efficacious alternatives. The VMMC Experience Project welcomes an ongoing dialogue on the role of male circumcision in light of improved HIV-preventive technologies.

African resistance to the VMMC campaign as an HIV accelerator is not unfounded, and affected communities deserve representation within the larger public health sphere.

Box C. Inferior condoms? Preliminary evidence from Kenya

African scepticism toward condoms for HIV prevention is well known; the possibility of inferior condoms in SSA remains unexplored. The following responses emerged incidentally in the VMMC Experience Project’s investigation.

Samson Dambroka, age 29: “They should do condom testing. ... Those regular condoms at the store are no good. The friction when having sex, you hear the girl say, “Stop, it broke!” I’m surprised. How can something made by white people burst like that? You know? Those are my thoughts. The strong condoms should come.”

At the Kimiliili Pastors Fellowship in rural Kenya, Dr. Kisembre stated: “HIV could be prevented by condoms on a small scale, but nowadays it doesn’t, because those who are manufacturing condoms, they are manufacturing sub-standard condoms. You put on, then it gets [a] tear.”

Pastor Eric Sifu Wamalwa added: “When I was in college, one of the lecturers, we did an experiment. We bought a new condom, then we poured water inside it. Then he said, ‘If this water will not reduce, then we know that condom is 100% [effective].’ But eventually we saw water dropping down. It was a new condom. Water dropped down.”

In a live demonstration by Kennedy Owino Odhiambo following the Berlin press conference (Appendix A), Lifestyle™ brand condoms purchased at a convenience store near Jomo Kenyatta International Airport (Nairobi, Kenya) produced water leakage on contact. However, a later attempted replication using Lifestyle™ condoms purchased at a trading post in rural Nyanza Province did not produce water leakage.

It remains unclear whether fluid leakage is due to inferior condom production or improper storage temperatures. Further research is urgently needed to understand the causes and scope of the problem, as well as the impacted regions.
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Respondents

The following respondents provided testimonies for the present Section. Their complete interviews are available to view at www.vmmcproject.org.

Agnes Namkendi
Age: 28
Tribe: Bagwere
District: Pallisa

Alfos Walega
Age: Unknown
Tribe: Unknown
District: Busia

“Samson”
Age: Unknown
Tribe: Unknown
District: Busia

Ralilich Mutasi
Age: 18
Tribe: Bagwere
District: Pallisa

Daniel Moita
Age: 21
Tribe: Bagwere
District: Pallisa

Vincente Endegna
Age: Unknown
Tribe: Unknown
District: Namayingo

Paolo Otieno
Age: Unknown
Tribe: Unknown
District: Namayingo

“Patrick”
Age: Unknown
Tribe: Iteso
District: Soroti

Pian Gratib
Age: 18
Tribe: Bagwere
District: Pallisa

Kwere Kejunas
Age: 18
Tribe: Bagwere
District: Pallisa

John Bosco Beressa
Age: Unknown
Tribe: Unknown
District: Busia

Barbara Asimi
Age: Unknown
Tribe: Unknown
District: Busia
Jamira Namatovi
Age: 28
Tribe: Unknown
District: Busia

Kati Ishana
Age: 22
Tribe: Unknown
District: Busia

Clea Odhiambo
Age: 28
Tribe: Unknown
District: Busia

Edith Nakawe
Age: 18
Tribe: Bagwere
District: Pallisa

Apollo Otieno
Age: 19
Tribe: Luo
County: Siaya

Kareem Amza
Age: 19
Tribe: Unknown
District: Busia

Patrick Ocol
Age: 29
Tribe: Iteso
District: Soroti

Sharon Mohammed
Age: 27
Tribe: Unknown
District: Busia

Samson Dambroka
Age: 29
Tribe: Samia
District: Busia

Dr. Kisembre
Age: Unknown
Tribe: Luo
County: Bungoma

Eric Sifu Wamalwa
Age: Unknown
Tribe: Kikuyu
County: Bungoma