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Tackling HIV/AIDS as a Contemporary Social Problem in Sub-Saharan Africa: 'A Sociological Critique of Voluntary Medical Male Circumcision (VMMC) as a Preventive Measure'

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Abstract: Background: In view of all the recorded devastation it is causing to society and human life, HIV/AIDS appears to be in possession of all the characteristics of a contemporary social problem facing the world today, particularly Sub-Saharan Africa. Voluntary Medical Male circumcision (VMMC) in Africa and in many other parts of the world is being heralded as the new "fix" to HIV/AIDS pandemic – which has been termed as "prevention technology." The aim of this paper is to critique the widely held belief and argument that male circumcision is or can be used as a preventive measure against HIV infection in Sub-Saharan Africa and other parts of the world. Methods: This article uses the available and abundant empirical data from various epidemiological studies on the subject of male circumcision status and HIV prevention, and national demographic health surveys from a few Sub-Saharan African Countries. Outcome: Empirical evidence from Africa and other parts of the world has clearly indicated that male circumcision has never been and cannot be a preventive measure against heterosexually HIV infection. In fact, empirical data have pointed to the contrary. The relation between male circumcision status and HIV infection has not been in the expected direction, that- male circumcision reduces the risk of HIV infection. Conclusion: The paper concludes that abundant empirical data on male circumcision status and HIV infection do not support the widely held view and argument that male circumcision reduces heterosexual HIV infection.

Keywords: Contemporary Social Problems, Voluntary Medical Male Circumcision (VMMC), HIV/AIDS, Randomised Controlled Clinical Trials (RCCTS), Epidemiology, Politics, Sociology

1. Introduction and Background

This paper presents HIV/AIDS as a contemporary social problem in the world today. It is argued that HIV/AIDS can no longer be regarded as a medical problem only but also as a social problem. In sociology, social problems are perceived as social phenomena that emerge in society as a form of threat to the values and interests dominant in that society and that evoke certain methods of intervention designed to attenuate, control or solve such problems. In the sociological literature concerned with social problems, there has been a division between studies that focus on identification and explanation of social problems, and studies that focus on methods of intervention (the latter studies being more frequent in literature emanating from the other grounded professions, especially social work).

In this regard, the aim of this paper is to make a contribution to the debate on "male circumcision as a preventive mechanism again HIV infection." Male circumcision is defined as the surgical removal of some or the entire foreskin (prepuce) from the penis [1]. This writer is of the view that lack of debate on critical issues in society can result in flawed policies. As a sociologist, I have always been a sceptic of circumcision as a preventive measure against HIV infection even though there is so much fuss and frenzy about male circumcision in my country, Zambia and

Africa as whole. The word on everybody's lips is that "male circumcision reduces HIV transmission by approximately 60%."

Campaigns in support of male circumcision by circumcision advocates have intensified in many countries in Africa aimed at persuading as many male citizens as possible, old and young, to present themselves at health centres for the so called "simple and painless surgical procedure" to remove the foreskin. Wherever these campaigns are taking place, male circumcision advocates have even gone a step further to engage politicians and traditional leaders to publicly announce their intentions to undergo this procedure as a way of portraying it as a very important undertaking worth trying by every right thinking citizen.

The source of this excitement about male circumcision originated from the three Randomised Controlled Clinical Trials (RCCTs) that were conducted in South Africa, Kenya and Uganda between 2002 and 2006 [2]. Although, the World Health Organisation (WHO), and UNAIDS have supported medical male circumcision as an HIV preventive measure in Sub-Saharan Africa and other regions with high rates of heterosexually transmitted HIV, the scientific community has never unanimously endorsed it as a preventive measure against HIV. There is so much contradictory information from many subsequent research studies that have been undertaken on male circumcision as a preventive strategy against HIV infection. A number of recent studies have shown that the male circumcision solution has several fundamental flaws and confounding factors that have been glossed over by its proponents within these organisations and their followers.

1.1. Defining a Social Problem

Social problems are an integral part of society. The term "social problem" applies to social conditions, processes, societal arrangements or attitudes that are commonly perceived to be undesirable, negative and threatening certain values or interests of society such as social cohesion maintenance of law and order, moral standards, stability of social institutions, economic prosperity or individual freedoms. A social problem in similar terms is a social condition that is regarded in some ways as "undesirable" by society or by some sections of society in that it represents a 'threat' of some kind – explicit, latent or potential [3].

1.2. Why HIV/AIDS is a Social Problem

According to the Population Division of the United Nations (UN) Secretariat, Department of Economic and Social Affairs [4], households are the first units affected by the HIV/AIDS epidemic. The death of a breadwinner may lead to the impoverishment of the household. Children are being taken out of school to care for ill parents or for financial reasons, whereas grandparents are acting as surrogate parents to care for their orphaned grandchildren.

HIV/AIDS is also having a sizeable impact on the labour force, costs and productivity of business firms in the areas with high HIV prevalence. The impact of HIV/AIDS on agriculture is also considerable in the most affected countries. Indeed, the impact in agriculture will be far-reaching and threatens the future food security of certain areas within a particular country or entire countries in Sub-Saharan Africa [5].

The health sector is another area which has been heavily adversely affected by HIV/AIDS. The increases in the number of persons seeking medical services and the higher costs of health care for AIDS patients are crippling the already inadequate health systems of the most affected countries in Sub-Saharan Africa. The sector is also losing its personnel to the disease in addition to the stressful job of caring for AIDS patients [6]. In the education sector, the pool of qualified teachers is also shrinking in countries or areas with high HIV prevalence [7].

In the same vein [7], it is stated that overall the impact of HIV/AIDS on the economy and development is likely to intensify in the near future. Some studies found that the impact of HIV/AIDS on the growth of GDP is marginal, although most found that there would be a substantial negative effect on the economies of countries where HIV prevalence is high. Other studies point out the shortcomings of GDP for assessing impact of HIV/AIDS on economic welfare and development [8].

Equally important are the long incubation period of the disease and the different waves of the epidemic, from HIV infection to AIDS mortality. Many countries are still experiencing a rapidly rising prevalence of the HIV and the effects will play out over many years.

In the most affected countries, the HIV/AIDS epidemic exacerbates existing problems and dysfunctions of the socio-economic system of a region or a country. These countries are already faced with many obstacles on their road to development, including famine, war and inefficient governance and illiteracy to name a few. Poverty, illiteracy and other health programs are also demanding attention whilst the HIV/AIDS epidemic is causing unforeseen ravages [8]. Mitigating policies and programmes need to be devised and implemented in order to ease the suffering of entire population and future generations. Only prevention, treatment and increased support will allow the countries affected and the international community to reverse or at least reduce the dire predictions of the implications of the HIV/AIDS epidemic.

2. Methods: Data Collection

The data in this article were derived from secondary sources including a number of epidemiological studies on male circumcision, HIV prevention and treatment, as well as some data from national demographic health surveys from several countries in Sub-Saharan Africa. The paper also reviewed the methodology which was used in the randomised controlled clinical trials (RCCTs) on male circumcision which were carried out in South Africa, Kenya and Uganda between 2002 and 2006 [9].

3. Outcome and Discussion

In a nutshell, empirical evidence from Africa and other parts of the world has clearly indicated that circumcision has never been and cannot be a preventive measure against heterosexually HIV infection. In fact, studies have pointed to the contrary. The relation between male circumcision status and HIV infection has not been in the expected direction - male circumcision reduces the risk of HIV infection. Actually it aids the infection. A number of scientists and scholars have raised serious questions about the randomised controlled clinical trials (RCCTs) that were conducted in Africa in terms of methodology, statistical results, confounding factors, ethics and many other issues. All these questions and concerns make it very difficult to translate the results of these fundamentally flawed studies to the general public.

3.1. HIV/AIDS in Sub-Saharan Africa

Nearly 63 percent of all people with HIV worldwide live in sub-Saharan Africa—25 million people. While southern Africa has been hardest hit, other regions also face serious AIDS epidemics. The number of people infected and the effects on families, communities, and countries are staggering [10].

Just to emphasise, HIV/AIDS is most prevalent in Africa, particularly sub-Saharan Africa. About 1 in 12 African adults has HIV/AIDS, and as many as 9 of 10 HIV-infected people in sub-Saharan Africa do not know that they are infected [11]. The high rates of HIV in developing countries, particularly sub-Saharan Africa, are having alarming and devastating effects on societies. HIV/AIDS has reversed the gains in life expectancy made in sub-Saharan Africa, which peaked at 49 years in the late 1980s and fell to 46 years in 2005, but since then, it has been rising again in a number of countries in the same region [11]. The HIV/AIDS epidemic creates an enormous burden for the limited health care resources of poor countries. Economic development is threatened by the HIV epidemic, which diverts national funds to health-related needs and reduces the size of a nation's workforce. AIDS deaths have left millions of orphans in the world; it was estimated that by the year 2010, 25 million children would be orphaned due to HIV/AIDS [11]. Some scholars fear that AIDS affected countries could become vulnerable to political instability as the growing number of orphans exacerbates poverty, and produces masses of poor, young adults who are vulnerable to involvement in criminal activity and recruitment for insurgencies [12].

Therefore, in an effort to bring this social problem under control, the World Health Organisation (WHO), and UNAIDS have supported surgical male circumcision as an HIV infection preventive measure in Sub-Saharan Africa and other regions with high rates of heterosexually transmitted HIV. Indeed, male circumcision in African countries and in many other parts of the world is being heralded as the new "fix" to HIV/AIDS pandemic – termed as "prevention technology."

3.2. History of Surgical Male Circumcision

The theory that male circumcision may be protective against HIV infection was invented and developed in North America. Professor Valiere Alcena originated the theory that removing the foreskin can prevent HIV infection in an article he published in 1986 titled "AIDS in Third World Countries." Later, a Medical Doctor by the name of Aaron J. Fink, a noted North American advocate of male circumcision began to promote Alcena's theory in letters he wrote to medical journals [13]. This was followed by Gerald N. Weiss, MD, who used to operate a website to promote circumcision, joined in and others to contribute to the development of the theory through a paper which was published in Israel in which they identified the prepuce as a possible entry point for HIV [15]. This publication generated a lot of interest among other North American circumcision enthusiasts such as Stephen Moses, Daniel T. Harperin, and Robert C. Bailey. They carried out numerous observational studies in Africa to establish the relationship between circumcision status and the level of HIV infection. They found insufficient evidence to advocate a circumcision intervention to prevent HIV infection [15].

3.3. Randomised Controlled Clinical Trials (RCCTs)

After the failure of observational studies to show a clear protective effect, the male circumcision advocates obtained funding from the National Institute of Allergy and Infectious Diseases, which is part of the United States National Institutes of Health to conduct randomised controlled clinical trials (RCCTs) in Africa in 2006. Additional support for the Kenyan trial came from the Canadian Institutes of Health Research. The studies were intended to find out if male circumcision is an effective intervention to prevent female-to-male HIV infection.

One randomised controlled clinical trial was undertaken in South Africa at Orange Farm and it was supervised by Bertran Auvert, a French male circumcision proponent; and the other one was carried out in Kenya under the supervision of North American circumcision proponents namely Robert C. Bailey, of the University of Illinois, and Stephen Moses, MD, of the University of Manitoba in Canada; and the third trial was conducted in Uganda under the supervision of another North American male circumcision proponent by the name of Ronald H. Gray, MD, of Johns Hopkins University [16]. The results of these studies (RCCTs) were published in the World's leading independent general Medical Journal called "The Lancet" in February 2007.

Following this publication the World Health Organisation (WHO) and UNAIDS recommended expanding programmes of male circumcision in Sub-Saharan Africa where HIV rates are highest. After the report appeared in "The Lancet," a number of scholars and scientists began to question the studies' methodology and statistical relevance. Scientists and many other scholars have pointed to, among many other concerns, the lack of scientific evidence or the quality of evidence in these studies, the lack of biological plausibility of

male circumcision and the lack of epidemiological evidence (confounding factors) of the male circumcision solution. Let us consider each of these concerns in detail.

The common hypothesis for these trials was that male circumcision would decrease the rate of heterosexually transmitted HIV infection. A basic assumption adopted by the investigators was that all HIV infections resulted from heterosexual transmission. So no effort was made to determine the source of the infections during the trials. There is strong evidence that this assumption was not valid.

To begin the analysis, the trials were nearly identical in their methodology and in the number of men in each arm of the trial who became infected [17]. The trials shared the same biases, which led to nearly identical results. All the three trails had expectation bias (both among researchers and participants); selection and sampling bias; inadequate double blinding; lead-time bias; experimental mortality; and early termination. Let us consider and analyse each one of the biases:

(i) Researcher expectation bias

First, the RCCTs lead investigators, Gray, Bailey, Moses and Auvert were all documented male circumcision advocates who collaborated closely and concurred in recommending the mass male circumcision of millions of African men. These principal investigators, in the Kenya-Uganda study, had a history of co-authoring papers promoting male circumcision suggesting that probably the two trials were not independent. Male circumcision practices are largely culturally determined and as a result there are strong beliefs and opinions surrounding its practice. It is important to acknowledge that investigators' personal biases and the dominant male circumcision practices of their respective countries may have influenced their interpretation of findings. The point here is that the lead investigators of the three studies were known male circumcision advocates. They had previously published work that proposed male circumcision to reduce HIV infection.

Second, there was lack of what in clinical research is referred to as "equipoise" [18]. Equipoise is essential in order to avoid biased findings. Under the principle of equipoise, a participant should be enrolled in a randomised controlled trial only if there is substantial uncertainty about which intervention will likely benefit the participant. It is incumbent upon researchers to start from the position of neutrality and balance [19]. This was not done in these studies, meaning that there was an omission of contradictory evidence which prevented a more balanced consideration of the issues. The trials lacked equipoise right from the outset.

(ii) Participant expectation bias

Participants were informed that previous studies suggested a potential benefit of male circumcision. Presumably the trial authors would argue that this was a requirement of disclosure. But why did they not also inform participants that other observational studies had shown no benefit of male circumcision? Why was this contradictory evidence withheld from the prospective participants? There was also a problem of asking "leading questions" which may have influenced the men's decisions to participate. Indeed Auvert et al (2006) remarked that "59% of uncircumcised men said they would be willing to get circumcised if it reduced their chances of acquiring HIV [20]. Did the researchers create a demand for circumcision by implying that it would help to protect men against HIV and STIS?

(iii) Inadequate double-blinding

It is very easy for a researcher, even subconsciously, to influence experimental observations. Although double blinding reduces observer bias and 'placebo effects,' this was not possible in these trials, since male circumcision cannot be concealed. In line with the principal investigators concession, "in view of the surgical nature of the intervention, neither participants nor study clinicians could be masked to the assignment group." It is not possible to conduct such trials to the same standards as a double-blind placebo-controlled trial taking place in a highly controlled laboratory environment. Nevertheless, the subjects in these trials should have been blinded from knowing which group was being experimented on. They should not have been given an idea of whether it was the foreskin that reduces HIV infection or it was actually the surgical removal of the foreskin (circumcision) which did.

(iv) Lead-time bias

Men in the intervention group had less time to become HIV-infected since effectively they were out of the trial for up to two months while their circumcision wounds (portals for HIV transmission) healed. This occurred early in the trials, thereby amplifying lead-time bias. Although, the rate ratios (RRs) were adjusted for lead-time bias of two months, the 60% protective effect of male circumcision could have been an overstatement as a result [21].

(v) Selection and sampling bias

Pre-screening and participant self-selection may have produced non-equivalent comparison groups and undermined internal validity. Volunteers were not a population-based random sample since religious or ethnic groups already circumcised were excluded. Presumably, the trials were located in areas where male circumcision was uncommon in order to recruit adequate sample sizes. Characteristically, mostly it was unemployed men who were recruited and financially rewarded for participating; it is likely that the samples were skewed towards men from lower socio-economic backgrounds. As most participants were unemployed, the fact that they were paid and provided with two years of free medical care amounted to a substantial inducement.

(vi) Experimental Mortality

It was argued that approximately equal numbers of non-circumcised control-group members dropped out. Participant loss was considerably greater than the number of new HIV infections. The loss of subjects particularly from the comparison groups could have greatly affected comparisons because of the unique characteristics of the lost subjects. Groups to be compared need to be the same before and after the study (experiment).

(vii) Early termination

All three trials were terminated early by their monitoring

boards on ethical grounds. This was done before the incidence of infection in circumcised men caught up with the incidence of infection in the non-circumcised men. It is argued that if the studies had continued for their scheduled time, it is probable that there would have been little or insignificant difference between the circumcised group and uncircumcised group. In view of this, some scholars have pointed out that the early termination of such studies caused the benefits to be exaggerated.

3.4. Lack of Biological Plausibility

Robert S. van Howe asks this question [17], how does the surgical removal of the foreskin prevent the transmission of HIV? This question remains unanswered by the proponents of male circumcision. Proponents of the male circumcision solution have speculated that the interior mucosa of the prepuce (foreskin) is thinner and more prone to tearing and becomes highly receptive to the HIV virus. But mucosa of the inner and outer prepuce has been shown to be of the same thickness [17]. Proponents also speculate that HIV is more likely to be transmitted through the foreskin because it has a high concentration of Langerhans cells, which they believe are the entry point for HIV. However, research has shown that Langerhans cells are very efficient in repelling HIV and explains why the transmission rate of HIV is one per 1000 unprotected coital acts [22]. Many research studies have shown that Langerhans cells are the first line of defence against infections (immunological protection). The inner foreskin secretes Langerin, which kills viruses. For instance, on March 4, 2007 the online Natural Medicine magazine published a letter "Langerin is a natural barrier to HIV-1 transmission by Langerhans cells." One of the authors of the study, Teunis Geijtenbeek [23], said that "Langerin is able to scavenge viruses from the surrounding environment, thereby preventing infection" and "since generally all tissues on the outside of our bodies have Langerhans cells, we think that the human body is equipped with an antiviral defence mechanism, destroying incoming viruses. Langerhans cells also protect against other sexually transmitted infections (STIs), which may explain why circumcised men are at a greater risk of getting an STI. In general, mucosa immunity provides a stronger barrier to infection than the skin.

Unfortunately, distorted presentations and speculations have been repeated so often in the medical literature that many physicians and public health officials consider them factual. Otherwise, there is no direct scientific evidence to support the hypothesis that the foreskin is a predisposing factor for infection [23]. Having said this, one would be prompted to ask a question; how rational is it to tell men that they must be circumcised to protect themselves from HIV, but after circumcision they still need to use a condom to be protected from heterosexually transmitted HIV? Condoms provide near complete protection, so why additional protection would be needed? It is not hard to see that male circumcision is either inadequate (otherwise there would be no need for the continued use of condoms) or redundant (as condoms provide nearly complete protection).

3.5. Lack of Consistent Epidemiological Evidence

If the Randomised Controlled Clinical Trials (RCCTs) are to be believed and male circumcision provides 50% to 60% protection from sexually transmitted HIV infection, then the impact of male circumcision should be readily available in the general population. But this is not the case. In Africa, there are several countries where circumcised men are more likely to be HIV infected than intact men (uncircumcised men). Here are examples from empirical evidence; real world data from countries where male circumcision is already a widespread practice.

According to the demographic health surveys performed in the following countries in Africa, HIV transmission was more prevalent in circumcised men than in intact men (uncircumcised men). Let us look at some of the empirical examples:

Swaziland:

The Demographic and Health Survey report of Swaziland (p. 235) begins by stating that the relationship between HIV prevalence and male circumcision status is not in the expected direction. "Circumcised men have a slightly higher HIV infection rate than men who are not circumcised (22% compared to 20%)" [24].

Rwanda:

The HIV prevalence and associated factors Report of 2005 of Rwanda (p. 239); the report indicates a higher prevalence of HIV among circumcised men (3.5%) than among uncircumcised men (2.1%) [25].

Lesotho:

Empirical studies in Lesotho have pointed out that "the relationship between male circumcision and HIV levels in Lesotho does not conform to the expected pattern of higher rates among uncircumcised men than circumcised men. The HIV rate is in fact substantially higher among circumcised men (23%) than among men who are not circumcised (15%). Moreover, the pattern of higher infection rates is among circumcised men compared with uncircumcised men is virtually uniform across the various subgroups for the results are shown in the report" [25].

Malawi:

In Malawi, 20% of the male population is circumcised. "The relationship between HIV prevalence and male circumcision is not in the expected direction. In Malawi, circumcised men have a slightly higher HIV infection rate than men who were not circumcised (13% compared with 10%) [25].

Other regions

Even in South Africa, where one RCCT was undertaken, 12.3% of circumcised men were HIV-positive, while 12.0% of intact men were HIV-positive. In addition, among developed countries, the United States of America has the highest rate of male circumcision and the highest rate of sexually transmitted HIV. Within the United States, blacks have the highest rate of male circumcision and the highest rate of sexually transmitted HIV. Obviously one would expect the United States to have lower transmission rates and

Europe where most men are intact to have higher transmission rates, but actually it is the opposite [25].

4. Bio-Power, Politics and Profit

The HIV/AIDS epidemic is very severe in many African countries. Public health organisations and Governments are under intense pressure to solve the problem. The understandable haste to find a solution to the HIV pandemic means that the promise offered by RCCTs studies can be overstated and off course have been overstated. Most likely the male circumcision is being proposed for political reasons though it is likely to have little effect on the overall incidence of HIV infection.

One cannot avoid asking why an increasing number of people in western countries contest male circumcision in their countries at a time when international organisations – the WHO and UNAIDS – are striving to promote this practice in order to curb the HIV epidemic in Sub-Saharan Africa. Drawing on a long tradition of racist and eugenic discourses, a common explanation of HIV/AIDS dissemination throughout Africa considers that the disease is the consequence of an over-abundant, uncontrolled, primitive sexuality, compounded by disintegrating social structures and ensuing de-culturation [26]. Such assertions are so widely shared in the western world that they do not need to be proven.

African countries are increasingly being used as operational fields for medical and pharmaceutical research, public health actions, and mass therapies. Scientific Policy actions designed in Western countries and exerted on Africans is emblematic of bio-power.

Many HIV/AIDS opponents contend that, rather than encouraging widespread male circumcision, Governments in Africa and their cooperating partners should be directing their funds on intensive, on-going, continent-wide, and culturally sensitive educational push involving proven methods of HIV risk reduction, especially condoms. For instance, Dr. Robert S. Van Howe (College of Human Medicine, Michigan State University, USA) notes that the cost of one male circumcision ($70) is enough to buy several hundreds of condoms – enough condoms for one man for everyday for a number of years. Condoms are 99% effective (unanimously proven in the scientific and public health community), less invasive and cheap. Unlike male circumcision, condoms also have the advantage of protecting women from heterosexually transmitted infections.

Concern about widespread male circumcision is particularly strong when it is misunderstood or misinterpreted as "virtual medicine," as it has been done and continue being so in some publications and many anti-HIV/AIDS campaign messages. It is important to conduct further research. Its absence has led to a premature promotion of male circumcision as a reliable strategy for combating HIV. We believe that we need to know much about male circumcision for HIV prevention before adopting it as a population health measure [27].

Since male circumcision advocates are already on the ground spreading the false information, scientific researchers should think carefully about their conclusions which can easily and wrongly be translated by both public health policy makers and the general public. While nobody likes to think of scientists as dishonest, there is often pressure, from billion dollar research agencies and governments and the fight for research grants, to generate positive results. HIV is a dreadful pandemic, to be sure, but that does not mean we should lose sight of the fact that care, judgement, experience and knowledge are required before action.

Moreover, both international and local HIV/AIDS experts and profiteers have vested interests in this huge problem of HIV/AIDS in Africa. HIV/AIDS is no longer simply a disease; it has become a multi-billion dollar industry. It is more lucrative in Sub-Saharan Africa where HIV/AIDS is the highest. Profiteers are not interested in eradicating it but in just managing it so that they keep it going.

The fear is that, among newly circumcised African men and boys, an unfounded belief in lifelong protection from infection could cause some to abandon measures that have been proven to provide substantial protection, such as condoms, limiting sexual partners and abstinence.

5. A Sociological View of Male Circumcision

In cultures that practice male circumcision, to be "circumcised" is the norm or the standard or normal whereas to be uncircumcised is to be deviant (violation of a standard norm). However, from a global perspective, to be "uncircumcised" is to be normal or the standard, meaning the males are born, and the way males remain. But as the world debate about male circumcision develops, the words "intact" or "natural" are now being used in place of "uncircumcised" to reflect this global view. This paper is using these three words interchangeably. "Intact" means "not altered, complete, or whole." "Natural" means "formed by nature, inborn, in its original state" [28].

In societies where male circumcision is the norm, culture has reconciled people to the practice; and so because it has been around in such societies for centuries, people have become accustomed to seeing men with circumcised penises and regard them as a perfectly normal practice. According to the social reactionary theory in sociology, as more and more people get circumcised, as a result of the World Health (WHO) and UNAIDS supported mass male circumcision in Africa, the esteem-based and signalling incentives will continue to grow because non-circumcision will be seen as deviant or being different. Already some men are describing the desire to resemble their peers who have been circumcised as one of the primary motivation for circumcision.

It should be noted that in societies where male circumcision is a norm, researches have explained that a stigma is associated with the foreskin. In addition, sociologists maintain that people are social by nature. This

means that humans seek fellowship with other humans, interact with each other, and influence and are influenced by the behaviours of one another. The central point here is that we become who we are as humans because we are social beings [29]. Sociologically speaking, societies where male circumcision is not a norm will drift and move in that direction of labelling uncircumcised men as "deviants" or "social misfits," and it is a label everyone would not want to carry. The consequence will be mass HIV infections.

5.1. Unintended Consequences

In sociology, unintended consequences are outcomes that are not the outcomes intended by a particular action. The unintended outcomes may be positive or negative. The concept has long existed but was named and popularised in the 20th century by the American sociologist, Robert K. Merton [30].

The law of unintended consequences is an adage or idiomatic warning that an intervention in a complex system always creates unanticipated and often undesirable outcomes. Akin to Murphy's law, it is commonly used as a wry or humorous warning against the hubristic belief that humans can fully control the world around them. Many fields of study in the sciences and humanities embrace this concept, including economics, history, philosophy, political science, and psychology [31].

Unintended consequences can be roughly grouped into three types [31]: a) A positive, unexpected benefit (usually referred to as serendipity or a windfall). b) A negative, unexpected detriment occurring in addition to the desired effect of the policy (e.g., male circumcision strategy provide people with a protection from sexually transmitted infections, they can increase risky sexual behaviours that have devastating health effects, i.e. more HIV/AIDS infection). c) A perverse effect contrary to what was originally intended (when an intended solution makes a problem worse), such as when a policy has a perverse incentive that causes actions opposite to what was intended.

5.2. Women Have Been Ignored

What about women, the population at greatest risk for HIV infection in Africa? [25]. There are currently no known direct benefits of male circumcision for women. In 2007 a major research investigation in Uganda and Zimbabwe involving 4,417 women sought to determine whether male circumcision had any effect on the risk to heterosexual African women of acquiring HIV from their male partners. The researchers were able to conclude from their findings that "male circumcision status" was not significantly associated with women's risk of HIV acquisition in any group, and they did not observe a significant protective effect of male circumcision overall or for any subgroup [32]. Women are more likely to suffer the blunt of potential harms that will come with male circumcision. Such potential harms include reduced condom use, increased coercive sex, increased number of sex partners, and difficulties for women to negotiate safe sex or insist on condom use with a circumcised man. These harms may be most likely to emerge in the context of community or individual beliefs that male circumcision is completely protective against HIV, and eliminates the need for other risk reduction strategies. This is one reason why male circumcision for HIV prevention has to be handled with maximum precaution.

6. Conclusion

One very important sociological perspective, the conflict perspective, attempts to explain how wealth, status, power, and the profit motives influence illness and health care. Worldwide, populations living in poverty, with little power and status, experience more health problems and have less access to quality medical care [33].

The perspective criticises the pharmaceutical and health care industry for placing profits above people. In her book, Money-Driven Medicine, Maggie Mahar [34], explains that power in our health care system has shifted from physicians, who are committed to putting their patients' interests ahead of their own financial interests, to corporations that are legally bound to put their shareholders' interests first. "Thus, many decisions about how to allocate health care dollars have become marketing decisions. Drug makers, device makers, and insurers decide which products to develop based not on what patients need, but on what their marketers tell them will sell—and produce the highest profit" [35]. For example, pharmaceutical companies' research and development budgets are spent not according to public health needs but rather according to calculations about maximizing profits. Because the masses of people in developing countries lack the resources to pay high prices for medication, pharmaceutical companies do not see the development of drugs for diseases of poor countries as a profitable investment. This explains why 90 percent of the $70 billion invested annually in health research and development by pharmaceutical companies and Western governments focuses on the health problems of the 10 percent of the global population living in developed industrialized countries [35].

Profits also compromise drug safety. Most pharmaceutical companies outsource their clinical drug trials (which assess drug effectiveness and safety) to Contract Research Organizations (CROs) in developing countries where trial-subjects are plentiful, operating costs are low, and regulations are lax [36]. Because CROs can complete a clinical trial in less time and with less expense than a pharmaceutical company can, they offer millions of dollars in increased revenue per drug. The validity of the clinical trial results from CROs is questionable; however, CROs can earn more money when the clinical trial results are favourable.

The conflict perspective points to ways in which powerful groups and wealthy corporations influence health-related policies and laws through financial contributions to politicians and political candidates and other means.

Finally, conflict theorists also point to the ways in which

health care and research are influenced by male domination and bias. The surgical male circumcision is a clear example; women across the Sub-Saharan continent are omitted from the equation, even though women are at the receiving end of HIV infections. The male-dominated medical research community has also been criticised for neglecting women's health issues and excluding women from major health research studies [37].

The "randomised controlled clinical trials" upon which these recommendations are based represent bad science at its most dangerous. Andrew Sullivan [38] once said "we are talking about poorly conducted experiments with dubious results presented in an outrageously misleading fashion, toward public health recommendations on a massive scale whose implementation would have the opposite of the claimed effect, with fatal consequences." Several studies have shown that circumcision does not prevent HIV [39]. The Auvert study in South Africa reported 20 infections in circumcised men. The R.C. Bailey and S. Moses study in Kenya reported 22 infections in circumcised men. Many professionals have questioned the reliability and validity of these three studies because they were not consistent with empirical evidence. Like it has been stated earlier in this paper, a number of African national population surveys have shown a higher rate of HIV infection among circumcised men than among men who are not circumcised. In the industrialised world, the United States has the highest rate of HIV infection and the highest rate of male circumcision. According to Doctors opposing circumcision [40], they caution both public and the medical community that they must guard against being overwhelmed by the hyperbolic promotion of male circumcision and must receive these new studies with extreme caution. It is important that, while male circumcision interventions are being planned, several points must be considered carefully. In fact, when the experiment fails miserably, Africans are likely to feel abused and exploited by scientists who have been recommending the circumcision solution [41].

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