A new Tuskegee? Unethical human experimentation and Western neocolonialism in the mass circumcision of African men

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Abstract
Campaigns to circumcise millions of boys and men to reduce HIV transmission are being conducted throughout eastern and southern Africa, recommended by the World Health Organization and implemented by the United States government and Western NGOs. In the United States, proposals to mass-circumcise African and African American men are longstanding, and have historically relied on racist beliefs and stereotypes. The present campaigns were started in haste, without adequate contextual research, and the manner in which they have been carried out implies troubling assumptions about culture, health, and sexuality in Africa, as well as a failure to properly consider the economic determinants of HIV prevalence. This critical appraisal examines the history and politics of these circumcision campaigns while highlighting the relevance of race and colonialism. It argues that the “circumcision solution” to African HIV epidemics has more to do with cultural imperialism than with sound health policy, and concludes that African communities need a means of robust representation within the regime.

KEYWORDS
male circumcision, HIV, VMMC, cultural imperialism, racism, colonialism

1 | INTRODUCTION

In 2007, the World Health Organization (WHO) and the Joint United Nations Programme on HIV and AIDS (UNAIDS) approved a campaign to circumcise millions of African boys and men. This policy followed the results of three randomized trials published between 2005 and 2007 reporting a relative risk reduction in female-to-male transmission of HIV of 50%–60% among circumcised men.1 Given the urgency of the HIV crisis in sub-Saharan Africa (SSA), which represents over 70% of the global infection burden,2 it is understandable that public health officials would seize on such an apparent “silver bullet.” Between 2008–2018, 23 million men and boys underwent so-called “voluntary medical male circumcision” (VMMC) in Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe.3


On the surface, VMMC appears to be the straightforward application of a clinically efficacious procedure to address an acknowledged public health emergency. Within the context of Western colonialism and neocolonialism in Africa, however, a different story emerges. As Peter Aggleton has argued, circumcision has its roots in the deep structure of society. Far from being a simple technical act, even when performed in medical settings, it is a practice which carries with it a whole host of social meanings. These meanings may concern rites of passage, gendered social roles, norms surrounding sex and sexuality, fulfillment of perceived religious obligations, modes of ethnic identification, or beliefs about hygiene or aesthetics, with circumcision often standing as “a potent indicator of hierarchy and social difference.” Circumcision is therefore not simply an act of healthcare. Rather, it is “nearly always a strongly political act, enacted upon others by perceived religious obligations, modes of ethnic identification, or beliefs about hygiene or aesthetics, with circumcision often standing as “a potent indicator of hierarchy and social difference.”

The “Clearinghouse on Male Circumcision,” a WHO/UNAIDS collaboration with NGOs engaged in VMMC implementation and policymaking, highlights hundreds of studies and articles divulging clinical and epidemiological evidence, practical considerations, and arguments favoring the scaling up of mass male circumcision within target countries. Within this literature, VMMC’s efficacy and validity as part of the global HIV/AIDS response is largely taken for granted. However, from its inception, researchers from various fields have also questioned the mass circumcision campaign on scientific, ethical, gender equity, and public health policy grounds. The present article adds to the smaller literature focused on race, culture, and geopolitics, examining historical proposals to use circumcision as a means of curbing venereal disease among African and African American men. It further considers racial, political, and ethical aspects of VMMC research and implementation, with particular attention to the fact that these programs are fueling charges of racism and neocolonialism within African communities.

Section 2 begins with a brief history of overtly racist proposals to apply medical male circumcision to African and African American men. Section 3 reviews the development of, and evidence for, mass VMMC as a response to the HIV crisis. Sections 4 and 5 consider the colonial and neocolonial contexts in which the resulting VMMC campaigns operate and the problematic assumptions upon which they rely. Section 6 concludes.

2 | A RACIAL HISTORY OF MALE CIRCUMCISION

While circumcision has long been practiced on parts of the African continent and among Jews and Muslims globally, medicalization of the practice is a relatively new phenomenon. Historically, justifications for medical male circumcision in the Western world have aligned with the latest public health scares: nervous disorders in the late nineteenth and early twentieth centuries, later followed by cancer and a host of sexually transmitted infections (STIs) including syphilis and now HIV. African and African American men, stereotyped in the West as being promiscuous or hypersexual, have long been caught in the crosshairs of the circumcision debate.

Within this climate, the foreskin has been portrayed—often by those with a pre-existing cultural or religious commitment to circumcision—as a vector for disease; it is only the proposed mechanism for disease transmission that has changed. From the mid-nineteenth

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2Ibid.
8Gollaher, op. cit. note 13.
to early twentieth centuries, it was widely believed that maladies ranging from hysteria to neurasthenia (a presumed medical condition involving fatigue, headaches, and irritability) stemmed from "reflex neurosis," a nervous disorder thought to be caused by irritation or overstimulation of the genitals, for example by masturbation. An empirical study of the period revealed that, while in the eighteenth century "medical men endeavored to cure masturbation, in the nineteenth century they were trying to suppress it." This change in tactics, the study found, "is sharply visible [in the] sudden rise of repressive and surgical measures in the treatment of masturbation beginning with 1850. While up to 1849, masturbation was treated mostly with hydrotherapy, diet, etc., between 1850 and 1879 surgical treatment [such as circumcision] was recommended more frequently than any of the other measures." 

Subsequently, such moral hygiene arguments for male circumcision intertwined with turn-of-the-century racism as African and African American men’s "lynching breeding prepuce [foreskin]" became a prominent concern for American circumcision advocates. As editors of the Maryland Medical Journal explained in 1894:

The brutal and uncontrollable passion of the Negro has been traced to a variety of causes, the chief of which has been referred to a perversion of his sexual instincts and ungodned sexual passion. [It is worth considering] that the legal enforcement of circumcision among the negro race would effectually remedy the predisposition to raping inherent in this race.

African and African American men, allegedly "ignorant of the laws of hygiene," were prime targets for Victorian circumcision ideology at the close of the nineteenth century, when medical journals published such titles as "Circumcision for the correction of sexual crimes among the Negro race," "The solution of the Negro rape problem," "Negro rapes and their social problems," "Sexual crimes among the southern Negroes scientifically considered," and "Enforced circumcision of the colored race," and "Circumcision enforced by law—a plea for mass circumcision, especially of the colored people of the South." That was presented at the annual convention of the Colored Physicians Association in 1889. According to Marie Fox and Michael Thomson, such rhetoric casts circumcision "as the medical solution to ignorance, bad hygiene, and low morals in the black population," often premised on a wider understanding of African American men as sexual predators who posed a threat to "White southern womanhood and White male sexual hegemony."

Even as the Victorian preoccupation with masturbation faded, newer claims about the hygienic and purported anti-venereal benefits of circumcision found enduring medical traction. African and African American men were by no means the only group targeted by such claims—medicalized circumcision was advocated in the United States and elsewhere not only across boundaries of race or ethnicity but also of sex, with "female circumcision" claimed to have important health benefits into the latter half of the twentieth century. Nevertheless, pervasive stereotypes about the American "Negro" facilitated a philanthropic interest in providing medical circumcisions to low-income men of color. As the author of a 1914 article published in the Journal of the American Medical Association lamented:

The prophylaxis of syphilis in the Negro race is especially difficult, for it is impossible to persuade the poor variety of Negro that sexual gratification is wrong, especially when he is in the actively infectious stages. It is probable that sex hygiene lectures will not have the slightest effect on this type.

The article went on to advocate the use of male circumcision "both for the purpose of avoiding local irritation which will increase the sexual appetite and for preventing infection."

A climate of disrespect for the agency, intelligence, and sexual integrity of Africans and African Americans is not confined to the issue of circumcision. Rather, Africans and African Americans have been prime subjects of degrading experimentation, often involving their genitals, throughout American medical history.

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13 Ibid.
15 Editors. (1894). Circumcision for the correction of sexual crimes among the Negro race. Maryland Med J, 30(16), 345–346. The proposal which they suggest is "worthy of consideration" is that put forward by Remondino, op. cit. note 20. 
17 Editors, op. cit. note 21.
19 Remondino, op. cit. note 20.

23 Editors. (1894). Circumcision for the correction of sexual crimes among the Negro race. Maryland Med J, 30(16), 345–346. The proposal which they suggest is "worthy of consideration" is that put forward by Remondino, op. cit. note 20. 
25 Editors, op. cit. note 21.
27 Remondino, op. cit. note 20.
Sims, commonly credited as the "father of modern gynecology," is notorious among scholars of medical racism for his use of enslaved women for reproductive surgery experiments without anesthetization. More recently, in the infamous "Tuskegee Study of Untreated Syphilis in the Negro Male," African American syphilis patients were observed without treatment over four decades as they developed complications, infected others, and ultimately died. The HeLa cell scandal, in which Johns Hopkins University cultivated an immortal cell line from the cervix of Henrietta Lacks, an unknowing and i ps o f a c t o unconsenting African American patient, remains a subject of concern among scholars and activists. (The fact that the same university has amassed "possibly the world's largest collection of foreskins" from African boys and men through the VMMC program has yet to be subjected to proper scrutiny.)

The Tuskegee syphilis study was terminated by Congressional order in 1972 upon media publicity and subsequent civil outrage, and was followed by a $1.8 billion class-action lawsuit against the U.S. Centers for Disease Control and Prevention (CDC) and other responsible agencies. Twenty years later, U.S. President Bill Clinton delivered a public apology to survivors at the White House for "a study so clearly racist." But degrading attitudes toward and/or treatment of Africans and African Americans within medical research did not evaporate after Tuskegee. In fact, the very same Johns Hopkins research group behind the Ugandan VMMC trials—discussed in greater detail below—conducted two prior HIV trials in Rakai, Uganda that inspired related ethical criticism. The first trial, led by Maria Wawer, sought to measure the impact of treatment for various STIs on HIV acquisition. To achieve this, Ugandan men and women with treatable STIs were randomized into groups to be either treated or given inert placebos of anthelminth (an antiparasitic drug) and iron-folate vitamins. The latter cohort mirrors that of the Tuskegee syphilis study, in which infected men were provided aspirin for mild pain relief in lieu of penicillin treatment. In the second trial led by Thomas Quinn, the Johns Hopkins group allowed and assessed HIV transmission—from participants who had already tested positive for the virus—to unknowing, seronegative partners, 90 of whom ultimately contracted HIV. The permitted transmission of a lethal infection to unknowing partners was one of the points of ethical criticism and subsequent racial condemnation of the Tuskegee syphilis study. Daniel Reidpath and colleagues agree that the associated ethical review boards for the trial, including institutional and U.S. government agencies, "approved a study that they would have considered inappropriate, unethical, and possibly illegal in their own country." In an editorial preceding the trial’s publication in the New England Journal of Medicine, then editor-in-chief Marcia Angell weighed in on the controversy:

It is important to be clear about what this study meant for the participants. It meant that for up to 30 months, several hundred people with HIV infection were observed but not treated. It was also left up to the seropositive partner in couples discordant for HIV-1 to decide whether the seronegative partner would be informed, even though both were regularly seen by the investigators. In addition, many people who were found to have other sexually transmitted diseases were left to seek their own treatment. ... Such a study could not have been performed in the United States, where it would be expected that patients with HIV and other sexually transmitted diseases would be treated.

How could such research continue to be conducted—and be approved by U.S.-based ethics committees—after the supposed lessons

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Wawer et al., op. cit. note 43.
Washington, op. cit. note 35.
Quinn et al., op. cit. note 43. As Reidpath et al. (op. cit. note 44) state, "Notwithstanding the clear intent to link the records of couples, the researchers report that they chose not to do so until after the completion of the trial. [But if] this is a defense, it means that researchers could conduct otherwise unethical research merely by choosing not to look at the data they collected until after the completion of the study" (pp. 59–60).
Washington, op. cit. note 35.
Reidpath et al., op. cit. note 44, p. 61.
As acknowledged by Angell (ibid., p. 968), those who defend such research could argue that, in light of limited treatment access and poorer health outcomes generally in the developing world, subjects are “no worse off” than they would be if they were not enrolled in the study, and that this, in turn, implies that “ethical standards governing research should vary with the political and economic conditions of the region.” Against this view, Angell maintains that investigators are responsible for the subjects they enlist in their studies and must do their best for them, regardless of the surrounding conditions: “those conditions should not be used to justify a lower standard of care for some subjects [as] any other position could lead to the exploitation of people in developing countries in order to conduct research that could not be performed in the sponsoring countries.”
of Tuskegee? In their 2014 article, "Systemic racism and U.S. healthcare," prominent theorists Joe Feagin and Zenobia Bennefield argue that "medical and public health communities, including their mostly white leadership and leading medical schools, seem unwilling to examine the current impacts of past racial oppression on U.S. medical and public health institutions."52 Individual actors need not consciously harbor racist beliefs for their decisions to be influenced by racist premises or stereotypes: such stereotypes are "largely invisible" within institutions such as medicine that have long been dominated by those who do not suffer from their implications.53

Taken together, these considerations suggest that longstanding, invidious assumptions about certain groups can continue to shape medical research and practice in the present day.54 As such, the historical conviction that surgical intervention is necessary to prevent African and African American men from acquiring STIs, for instance, could, however unwittingly, constitute part of the underlying logic of the present campaigns. Indeed, writing in 2007, the founding editor of Reproductive Health Matters, Marge Berer, alleged that "there was an unstated assumption in the WHO/UNAIDS consultation [on VMMC] that unprotected, unsafe sex on the part of men in sub-Saharan Africa cannot be changed."55

It is against this backdrop that three randomized trials of male circumcision for prevention of female-to-male HIV transmission were conducted on young men in rural South Africa,56 Uganda,57 and Kenya.58 Ethical arguments have been raised from multiple perspectives. Armed with results from the trials, proponents have framed male circumcision for HIV prevention as a moral imperative: "Stressing that circumcision had the potential to save lives [they] urged that to refuse to act was to act unethically."59 As Alain Giami and colleagues explain, "This new rhetoric morally condemned any doubts (deemed a form of opposition) about the efficacy of male circumcision as a means for preventing HIV transmission from women to men."60

Such urgent rhetoric is not unique to circumcision: it has formed a part of many proposals for combating HIV/AIDS in line with what some scholars have called "AIDS exceptionalism,"61 i.e., the tendency to coopt the language of ethics to promote urgent action—and suppress dissent—without fully considering the moral dimensions of the problem or alternative ethical or policy views.62,63 In the case of circumcision, such exceptionalism is especially salient because, as Michael Drash notes, "experiments which cut into and remove [healthy] tissue from their subjects without specific cause, i.e., to see what happens, are the kind which prompted the very first frameworks of the rights of human subjects."64 Moreover, given that the specific tissue in question—the penile foreskin or prepuce (see Box 1)—is a prominent, functional component of a psychosocially significant organ, the irreversibility of circumcision is, according to Drash, a red flag for trial ethics: it comprises a "point of no return" that is at odds with the subject's right to withdraw consent and exit a study after the experiment has begun.65

A subsequent male-to-female trial in Uganda, conducted by the same Johns Hopkins Rakai research team mentioned earlier, sought to establish a protective effect of male circumcision for women by allowing HIV-positive men to infect unknowing seronegative partners.66 We will discuss the results from this trial in the following section. Here, we simply note that the serious criticisms67 of the Rakai group's earlier research—in which they similarly permitted the transmission of a lethal infection to unknowing Ugandan subjects—did not lead to substantive ethical changes.

Although the cohorts were not deliberately singled out by race or class, the "subjects" across the four circumcision trials were virtually all poor African men and women, raising concerns about vulnerabilities that are consistent with a history of medical exploitation. The lesson here is that the VMMC campaigns take place not in a vacuum, nor in a post-racial era, but rather within a particular historical and geopolitical context in which ethical issues associated with racialized power imbalances are apt to continue to arise in the current regime. Whether they are a result of implicit values within public health structures, or whether they are also sometimes the result of explicit opportunism is unclear. What is clear is that the relevant science and policy cannot be secured

56Auvert, et al., op. cit. note 1.
57Gray, et al., op. cit. note 1.
58Bailey, et al., op. cit. note 1.
63Drash, op. cit. note 9, p. 396.
64Drash, op. cit. note 9, p. 397.
66Reidpath, et al., op. cit. note 44; Zion, op. cit. note 44.
against these moral shortcomings until affected communities of color in the Global South can assume a more central role in medical decision-making about their own bodies.


68Bossio, J. A., Pukall, C. F., & Steele, S. S. (2016). Examining penile sensitivity in neonatally circumcised and intact men using quantitative sensory testing. J Urol 195(6), 1848–53. Note: This study has been mischaracterized as having found that the foreskin is not the most sensitive part of the penis, likely due to a misleading statement to that effect in the authors’ abstract. Responding to critics who pointed this out, the authors clarified that their study had in fact “replicated the results reported by Sorrells et al.” (see following reference), namely, that the foreskin is the most sensitive part of the penis to light-touch sensation, specifically, when compared to all other tested sites: Bossio, J. A., Pukall, C. F., & Steele, S. S. (2016). Reply by authors. J Urol 196(6), 1825–1826, p. 1825; see Sorrells, M. L., Snyder, J. L., Reiss, M. D., Eden, C., Milos, M. F., Wilcox, N., & Van Howe, R. S. (2007). Fine-touch pressure thresholds in the adult penis. BJU Int, 99(4), 864–869. For further discussion of the controversy, see Earp, B. D. (2016). Infant circumcision and adult penile sensitivity: implications for sexual experience. Trends Urol Men’s Health, 7(4), 17–21.

69Fahmy, op. cit. note 69.


3 | MASS MALE CIRCUMCISION: AN ANSWER FINDS ITS QUESTION

Within three years of the discovery of HIV, a lack of male circumcision was suggested in the United States as a “possible explanation” for its high burden on the African continent.77 However, the suggestion failed to consider the circumcision practices that were already longstanding among various African tribes. To rectify this, proponents compared regional data and amassed a body of observational studies showing a negative correlation between male circumcision and HIV prevalence rates throughout SSA.78 A Cochrane review accepted this correlation as “a strong epidemiological association,” but concluded that the studies themselves were insufficient as they were “inherently limited by confounding.”79

In a later meta-analysis presenting an inconclusive and largely conflicting association, demographer Michel Garenne explained, “The demographic evidence indicates that the relationship between male circumcision and HIV seroprevalence is complex, and that both positive and negative relations can be found for a variety of reasons.”80 Bertran Auvert, a longstanding male circumcision advocate, admitted that the supporting evidence “was not convincing enough for WHO, UNAIDS, and other organizations…. A randomized trial was really needed in this area to convince people.”81 In turn, an Information Sheet provided to participants in the Auvert et al. trial made this aim explicit upon enrollment, stating that if they achieved a lower HIV and STI incidence following circumcision, they “will have contributed to important progress in the fight against STD’s [sic] and HIV.”82

Men in the Auvert et al. South African trial, and in the supporting Ugandan and Kenyan trials, were randomized into intervention and control groups.83


79Ibid.


82Auvert, et al., op. cit. note 1, Suppl. 3.
control groups who, as the researchers presumed, might engage in risky sexual behavior that would lead to HIV infection. Across the three trials, the intervention groups had an average HIV incidence of 1.18% versus 2.49% in the control groups, with relative risk reductions reported from male circumcision ranging from 50%–60%.

The trial methodology and relative consistency of findings across the female-to-male trials were characterized as "strong evidence" for the protective effect of circumcision in a subsequent Cochrane review. However, critics alleged that the trials shared the same biases, "which led to nearly identical results." Earlier, we mentioned a subsequent male-to-female HIV transmission trial in Uganda, carried out by the Rakai team at Johns Hopkins University. This trial might be characterized as "buried" in the sense that it is much less commonly cited by VMMC proponents.

One potential reason for this relative reticence is that the trial had to be stopped early for "futility" after partners of newly circumcised men became infected at a 55% higher rate. The cumulative probability of HIV infection among these women at 24 months was 21.7% versus 13.4% in the control group, translating to a 62% relative risk increase to women following male circumcision.

A later Cochrane review accepted the three "successful" female-to-male trial findings alone as evidence of a 38%–66% protective effect of male circumcision for men over two years, and both the perceived urgency of the HIV crisis and novelty of a biomedical solution led to the commencement of VMMC roll-out planning before the Ugandan and Kenyan trials had reached publication. Giami and colleagues provide a timeline of the policy research and discussions leading to and resulting from the WHO/UNAIDS recommendation on VMMC, noting, "There was no mention of the contradictory findings that had been published, nor of a scientific controversy." Instead, contrary voices were largely excluded, "as if the decision had already been made."

The involvement of African communities was limited. As Abdullahi Ahmed An-Na’im has pointed out, because of the influence of Western hegemony on elites within the Global South, "it is misleading to assume genuine representation of popular perceptions and attitudes in our countries from the formal participation of our delegates in international fora." At the WHO/UNAIDS technical consultation that resulted in the recommendation to roll out VMMC, African representatives accounted for only one-third of those in attendance, and their role was "advisory, not actual decision-making. Nearly all the papers presented came from researchers or representatives of institutions in the Global North."

The current paradigm has also been criticized for failing to take cultural variance and other contextual variables sufficiently into account. In their introduction to a special double issue of Global Public Health on VMMC, Richard Parker and colleagues argue that "it would be naive to think" that VMMC or other "supposedly simple medical interventions" could be successfully implemented.
... without consideration of the meanings they carry to people and the social context in which they are implemented – a fact that many of their proponents understand and respect, but sometimes choose to downplay in order to highlight how their supposed simplicity makes them superior to seemingly more complex and less efficacious alternatives. This simplification ... carries serious risks, since it tends to silence and even erase a concern with, and understanding of, the wide range of social, cultural, economic and political factors that need to be engaged in order to successfully implement such approaches in the real world.96

Consistent with this concern, VMMC policymakers prioritized the internal validity of the studies in arguing for a protective effect of male circumcision,97 hypothesizing that an unknown biological mechanism would ensure real-world effectiveness, leading to "attempts to generalize the results of the circumcision [trials] to novel contexts via anism would ensure real-world effectiveness, leading to "attempts to generalize the results of the circumcision [trials] to novel contexts via appeals to the foreskin's biomolecular susceptibility."98 That is, VMMC proponents began to argue that simply having a foreskin should be "effectively considered a pre-disease state defined in relation to HIV risk."99 Yet this neglects the more complex social and epidemiological reality that five VMMC target countries had higher HIV prevalence rates among circumcised than uncircumcised men at the start of the campaign; this was the case for 10 of 18 countries surveyed.100 As Kirsten Bell argues, researchers should be on guard against a biomedical mindset in which "culture, meaning and context are irrelevant."101

The upshot of such a mindset is this: rather than adapting a potentially useful intervention to the contexts in which it might offer most benefit, and cautiously adjudicating its real-world suitability, the trials produced a mythology around VMMC which has instead required that the contexts of application be themselves adapted. In other words, the "real-world" setting is constructed and refashioned, rather than encountered and adapted to.102 The environment in which VMMC takes place is accordingly modified, and the overall cultural, epistemic, and infrastructural transformation (which may be considered a form of imperialism) becomes much broader than that of the action of circumcision alone:

98Ibid: 5.
99Giami et al., op. cit.note 60.

The guidelines and tools produced by WHO aim to standardise the action, which requires the standardisation of techniques, tools, organisation, and behaviour, and more generally the standardisation of the environment: laws must be written to provide a legal justification for circumcision, well-known figures must engage in advocacy designed and adapted for specific populations, the entire health system must be restructured, roles and tasks within the health system must be redefined.103

Furthermore, qualitative studies into men’s resistance were designed not to understand the cultural barriers in their own right, but to inform VMMC promotion strategies for getting around them.104 This approach mirrors prior "acceptability" studies in failing to give weight to participants’ reasons for disfavoring circumcision,105 effectively minimizing subjects’ perspectives and input in the regime. Within this literature, African cultural traditions were identified among the "main barriers" to the rolling out of mass circumcision in Zambia.106

103Ibid: 1607.
106Lukobo & Bailey, op. cit. note 105.
Further, policy-motivated studies may "imbue willingness to be circumcised with a sense of ethical obligation," in that men are encouraged to imagine themselves within a new binary risk category by virtue of having a foreskin. Such methodology fails to consider men's voluntariness on their own terms, within the complex personal and sociocultural contexts that underpin their very identity. Botswana's primary acceptability study indicated a favorable local reception to VMMC, but community responses to its actual implementation, including suboptimal uptake and perceived insult to traditional initiation rites and social norms, indicate a lack of acceptability: "Disgusted" and 'Frustrated' were the terms uttered by the traditional leaders.  

The inclusion of African men and women in decision making regarding their own bodies, cultures, and health was—and remains—overshadowed by a Western hegemonic model promising HIV reduction to African men through circumcision.

4 | VMMC THROUGH A COLONIAL LENS

4.1 | Cultural conversion

The first trial publication on male circumcision for HIV prevention in South Africa begins with a paragraph not on the potential medical benefits of the procedure, but on male circumcision's venerability on cultural and religious grounds. "Genesis (17:11) places the origin of the rite among the Jews in the age of Abraham," Auvert and colleagues state. Indeed, medical justifications for male circumcision are relatively recent, and medicalized circumcision accounts for only a minority of instances of the practice globally. It is primarily a cultural practice, and has accordingly become a point of tension where cultures collide. This can be seen in its use within campaigns of cultural imperialism, either as a practice to be enforced or discouraged.

Among various African groups, male and female genital cutting rites were widespread prior to the arrival of colonial-era missionar- ies, who described the practices as barbaric and un-Christian, and spearheaded their abandonment.  

Ironically, some regions in which circumcision was once suppressed fall within modern states in which VMMC programs now operate. Modern Botswana is a priority country for VMMC, but barriers to its uptake include its perceived incompatibility with Christianity and its association with "backward values," which is precisely the line once peddled by colonizers. In the opposite direction, male circumcision has long been imposed by powerful groups onto marginalized ones. In Kenya, a tradition of forcible circumcisions of non-circumcising Luo tribal minorities is longstanding.

Within an African tribal context, a circumcision intervention can never be strictly medical; it requires either cultural compliance or cultural conversion. A payout from the U.S. Agency for International Development (USAID) to the Luo leadership to "accept" VMMC against their deeply held cultural beliefs remains sealed from public record, but a local oral history of its aftermath reports intra-tribal tensions and damage, including the ousting of Riaga Og allo, head of the Council of Elders who had refused the payout, along with centuries of tradition. VMMC’s social impact, too, cannot be divorced from tribal politics. Since the policy was rolled out in Kenya, members of the Kikuyu ruling elite have drafted bills to make male circumcision mandatory at both county and national levels, citing the "cowardly and childish" nature of Luos and perceptions of their foreskins as inherently pathogenic and disgraceful to Kenyan nationalism. Following the 2017 presidential election, a Kikuyu member of Parliament rallied support in threatening to forcibly circumcise losing candidate Raila Odinga and his Luo constituents with scissors. As a Kikuyu bishop alleged: "When the Westernites imposed [VMMC] on us, it is like they empowered the evils, the most separations between the tribes." Conversely, non-circumcising tribal minority parents have reported feelings of cultural erosion and identity loss following the circumcision of their children by U.S. government agencies, a number of which are reported to have occurred through school programs without their knowledge or consent.

Local government opposition, too, has been marginalized. In Lesotho, where Demographic and Health Survey data showed that HIV prevalence was 31% higher in men who were circumcised, state actors

108Kebaabetswe et al., op. cit. note 105.
110Auvert et al., op. cit. note 1.
111Ibid.
112Gollhaier, op. cit. note 13.
114Upton, op. cit. note 113.
115Agleton, op. cit. note 4.
121Fish, op. cit. note 85, p. 30.
positioned their initial resistance to the intervention as an informed response to national population-level data. National resistance in Lesotho was “not in an effort to reassert local or indigenous knowledge, but rather to negotiate for a shared position of authority within current global public health structures.” Subsequently, the dismissal of local government opposition reflects “inherent inequality and the limitations for meaningful involvement of those on the margins of global society.”

Failure to pay due attention to the varied existence and complex meanings and effects of circumcision among different ethnic groups is endemic in Western VMMC policymaking. In response to a study finding higher HIV prevalence among medically circumcised older men in Mpumalanga Province, South Africa, former chief epidemiologist for HIV prevention at the CDC, Peter Kilmarx, defended the intervention by claiming that no apologies were needed “for the many, many thousands of HIV infections we have prevented making safe, voluntary medical male circumcision more widely available in Africa where traditional circumcision is already widely practiced as a local custom.” This statement is concerning for two reasons.

First, there is growing evidence that many circumcisions performed through the VMMC program have been neither safe nor voluntary. The CDC's own reporting has identified safety issues up to and including VMMC-related tetanus infections and deaths, and a growing concern in the literature is that false beliefs surrounding HIV protection from male circumcision (e.g., that one becomes low-risk or even “immune” to the virus) may be associated with increases in HIV burdens in some regions. In early 2020, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) suspended funding for circumcisions on children below the age of 15—who had previously comprised nearly half of all VMMCs—on the basis of unacceptably high rates of reported adverse events among this age group. Although participation is purportedly voluntary, various enticements including money and food vouchers are allocated to pressure impoverished men, and a recent report has documented U.S. government-funded circumcisions of non-consenting minors without even parental permission, estimating >35,000 of these illegal cases between 2013 and 2016 in one region of Kenya alone. Other reports raise concerns of coercion and a lack of informed consent from those who have found themselves on the receiving end of ambitious circumcision quotas, with some involuntary participants endorsing perceptions of the experience as a human rights violation.

Second, so-called “traditional” circumcision is not a generic “local custom” in Africa. In praising the way in which VMMC campaigns make circumcision more “widely available,” Kilmarx falsely implies that Africans, qua Africans, have a general preference for circumcision, thwarted only by its availability. This remark not only homogenizes African cultures; it neglects the fact that VMMC campaigns have targeted particular groups precisely on the basis that they did not traditionally embrace circumcision.

Not only does the public health discourse around VMMC generally fail to acknowledge African cultural heterogeneity and nuance—and the significance of these factors for the associated campaigns—there is little recognition of the extent to which VMMC is itself an instance of cultural imperialism. Among the Global North, it is only the United States that practices routine, non-religious circumcision as a majority custom. VMMC is canvassed by the U.S.-led public health community, and its main target is Africans from traditionally non-circumcising groups. If the significance of power and history are lost on champions of these programs, they are at the forefront of target communities’ objections. As one local leader put it: “[W]e have thought the Ministry of Health was going to help us [but they] insult us. They should respect our culture and not confuse it. Go and tell them to come and talk to our chief.”

4.2 Competing normalities

Rather than promoting a “neutral” HIV prevention measure, VMMC donors may be funding what is in effect a significant cultural
crusade. The intention to overwrite local cultural norms is explicit, and is epitomized by a study examining barriers to VMMC among older men in a setting where circumcision has been taboo for centuries, in which the authors suggest that "messages should focus on the normality of the circumcised penis.” Consider that cultural imperialism is precisely this: the imposition of a more dominant conception of normality. Accordingly, VMMC policymakers have opted in many cases to focus on engineering social norms. International HIV/AIDS relief funding has been allocated to circumcise already HIV-positive men because, in the words of one advocate, "you don’t want to be the only guy on the block who hasn’t been circumcised.” This is an attempt to contrive a new bodily norm which plays on, or produces, anxieties about masculinity and sexual acceptability, factors which have been identified as important for men seeking VMMC.

This strategy is underwritten by a study which concluded that demand creation messages "should emphasize non-HIV prevention benefits, such as improved hygiene and sexual appeal." Subsequently, Brothers for Life, a subsidiary of Johns Hopkins University, released a television advert marketing VMMC to South African women as "an upgrade down there." Sarah Rudrum analyzed 30 VMMC campaign posters from 12 target countries and found "a paucity of HIV-related information," noting an “anything-goes” demand creation approach in which the HIV-preventive purpose was often sidelined by other purported benefits to circumcision including masculine comradery, improved sexual attractiveness and cleanliness, and prevention of cervical cancer in women. She further cautioned that some of the campaigns “tended to reify gender inequality, the objectification of women, and sexual conquest as an expression of masculinity – norms that contribute to the epidemic,” a concern raised elsewhere. Such marketing of VMMC also has been criticized by tribal elders who are respected as custodians of tradition. Katisi and Daniel found that Bakgatla elders viewed the sexualization of male circumcision for demand creation purposes "as disgusting and conflicting with culture.”

Such propagation techniques are consistent with the Global North’s dismissal of traditional African values and social norms, often based on misinformed stereotypes. Efforts to eradicate (all forms of) traditional female genital cutting (FGC), frequently overlapping with VMMC target regions, have occurred at the expense of, and with indifference to, local women who reject the characterization of their bodies as "mutilated" and the intrinsic implications of cultural inferiority. In turn, Western actors seeking to criminalize ritual FGC have invoked imageries of African barbarism in order to prevent the practices from entering Western countries and to distinguish them from culturally palatable female genital "cosmetic" surgeries such as labiaplasty (increasingly performed on white Western minors). Failing to recognize that wherever ritual FGC occurs, so too does ritual male circumcision, usually in a parallel initiation process serving similar social functions and with overlapping consequences for health and sexuality, these same Westerners compare apples to oranges: they tend to think of the most extreme forms of female genital cutting, done in the least sterilized environments, with the most drastic consequences likeliest to follow [while simultaneously thinking of] the least severe forms of male genital cutting, done in the most sterilized environments, with the least drastic consequences likeliest to follow, largely because this is the form with which they are culturally familiar.

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143Macintyre, et al., op. cit. note 104, p. 6.
145Humphries, et al., op. cit. note 104.
148Rudrum, op. cit. note 9, p. 9.
149Ibid. 6.
Challenges we are facing is water crisis and famine, we expect rains in April. Have high hopes that funding for our project will come and stop this western propaganda on circumcision. Africa we are poor we need water, food, education, medicines, employment, not money for butchering Africans. Thank you so much.

FIGURE 1 A personal email from a Kenyan man criticizing VMMC funding in light of a severe drought.

Consequently, Global North responses to male and female genital cutting, respectively, have relied on opposing views of what constitutes bodily integrity and normality, but in both cases, the overpowering of African values and social norms is a precondition to establishing Western cultural dominance. Male circumcision practices are to be medicalized and multiplied, their female analogs to be totally extinguished.

4.3 Concerns from VMMC-targeted communities

For some communities subject to VMMC programs, concerns about cultural imperialism are plainly rooted in the West’s history of colonialism. Those old enough to remember “boots on the ground” exploitation-style colonialism appear to be the most skeptical of VMMC, as captured incidentally in a qualitative study among Zimbabweans who resisted circumcision. The study showed that men perceived circumcision as a threat to their masculinity, but also found that senior participants used terms such as “colonisation,” “re-colonisation,” and “political agenda” to describe the campaign. Even a respondent too young to have known Africa before decolonization was skeptical: “Who does not know that circumcision is a strategy of controlling African men’s sexuality?” Likewise, medical practitioners trained to deliver VMMC programs have expressed reservations. A nurse in Swaziland remarked, “Doesn’t it seem a bit like colonial paternalism for a White American physician to advocate for cutting the foreskin of a Black African man’s penis for his own good?” In Swaziland, Alfred Adams and Eileen Moyer found that “the aggressive nature of the circumcision campaign exacerbated peoples’ suspicions.” One man asked: “[W]ho is funding this whole thing? What are their motives?” This sentiment was echoed rather strongly in a personal email from a Kenyan man during the 2015 drought: “We need water, food, education, medicines, employment, not money for butchering Africans” (see Figure 1).

So far, the involvement of African representatives in VMMC research seems to have only reified the problem of Western cultural imperialism. A locally organized qualitative study in Zimbabwe found that “circumcision is perceived as an alien culture or something for ‘younger’ men,” but then concluded that “there is need to address the misconception that VMMC is for other cultures.” Stanza Moyo and colleagues acknowledged that VMMC in Zimbabwe was equated with “political and ideological agendas of Western countries,” but backpedaled by emphasizing “the need for key political and social leaders to actively dispel such notions.” A paper by a Ugandan epidemiologist working with the aforementioned Johns Hopkins Rakai Program—which conducts not only VMMCs but also wide-ranging circumcision experiments on rural men—went a step further in contemplating how to motivate hard-to-reach men to
“accept” the unwanted intervention. The desire for increased status and visibility in an unequal global health system may create a perverse incentive for some people to perpetuate these very inequalities within their own communities, adding to Africa’s powerlessness against VMMC as a form of cultural domination.

There remains a fundamental disconnect between the ambitions of Western programs in Africa and the sentiments within African communities. In a qualitative study aiming to understand and improve the informed consent process, Population Council researchers identified Zambian and Swazi parents who attempted to refuse the intervention as “gatekeepers” to the circumcision of their own sons. Even after uncovering a slew of regretful testimonies and cultural contraindications surrounding VMMC in Swaziland—a country where HIV was already more prevalent among circumcised than uncircumcised men—researchers concluded that VMMC “remains as one of the most important HIV interventions in Swaziland.”

Rather than include them in decision-making, they suggested that “Swazis should be informed about the funding and why it is so important to promote the [VMMC] intervention” as decided by Western policymakers. This paternalistic approach recognizes significant differences between African and Western interests in relation to circumcision, but reduces Africans’ perspectives to a homogenous inconvenience.

The continued exclusion of Africans from substantive conversations about their own bodies has fomented suspicions about the VMMC campaign’s true intentions. These suspicions have resulted in claims that the campaign is a Western “Trojan Horse” aimed at cultural erosion and control. While numerous local sources including the Ugandan president have implicated VMMC campaigns in rising HIV rates on the continent, little attention has been paid to the resulting colonial suspicions. In Swaziland, the U.S.-funded “cut and conquer” campaign has caused confusion in that it seems to suggest that once cut, a man has “conquered” HIV, or is subsequently free to “conquer” women, leading to beliefs that VMMC is actually a colonial campaign to infect Africans. Interviews carried out by the VMMC Experience Project, an African-led grassroots coalition in rural Kenya and Uganda, confirm that some local men view VMMC as a device deployed by the Global North to recolonize and experiment on Africans. Reverend Casmiel Otieno from Kenya vocalized his suspicions thus: “The people from the West, I think they want to misuse the Africans because [Africans] are not informed, the lack of information in Africa. So they are using other methods to make sure that they use their tools to have a place where they can exercise their power.” Similarly, another clergyman from Kenya, Bishop Cleophas Matete, making reference to the continent’s colonial past, argued, “Africa was targeted, and it is still being targeted. It is used as a continent to experiment. Should they introduce anything that is evil, they want to experiment in Africa. So I believe that the entire process of trying to test in Africa was wrong from the beginning, and I say no to it.”

The distrust of global health systems is rooted in the general distrust of colonial health systems, and seems justifiable given the parallels between the two. Both operate on the same paternalistic framework which casts the Global South as “the White Man’s Burden.” Correspondingly, the Global North, much like the colonial state, acts as the “benevolent dictator,” making decisions in the “best interests” of the Global South with insufficient regard for local or national sovereignty, the multiplicity of different peoples and interests, or the health priorities as conceived and experienced by communities themselves. These similarities evoke traumatic memories of colonial brutality, marginalization, and experimentation.

5 | VMMC AND NEOCOLONIALISM

The Global North’s enthusiasm for VMMC as a response to the HIV crisis in SSA reflects a preference among funders for one-off, permanent, generalizable solutions. VMMC is often praised by public health scholars for the fact that “its effectiveness does not rely on repeated and consistent behaviors.” Its independence from behavioral and structural changes is seen as a point in its favor, from which several related assumptions can be deduced.

First, there is the implicit belief that the behavior of African men with respect to safer sex practices is both irrational and unchangeable. The rise of VMMC was concurrent with many public health scholars and practitioners abandoning behavioral approaches to reducing HIV transmission in SSA, deeming them to be ineffective.

Those adopting this view note that despite aggressive, well-funded campaigns, condom-use remains low and concurrency of partners
high.\textsuperscript{180} Within this literature, references to "risky behaviors" and "promiscuity" appear again and again, yet remain unanalyzed, implying that these behaviors are fixed, which is to say, inherent.\textsuperscript{181} There is the implication of ungratefulness, of an unwillingness to be helped, of savagery. In light of this, the intensive promotion of the irreversible removal of an intimate, functional, culturally significant portion of the genitals in order to bring about a partial reduction of risk for men is deemed to be a reasonable and necessary last resort.

Second, there is the related assumption that interventions can be introduced and appraised independently of systemic, which is to say social, political, and economic considerations. Thus, the poverty of SSA, and of the Global South more generally, is treated as unconnected to the individual decisions of its peoples. Behavioral strategies have typically focused on raising awareness of HIV/AIDS, with the expectation that people should respond "rationally" and make "better" choices. Where this fails to happen, the "irrationality" or "backward-ness" of Africans may be cited, which is seen to mandate a "last resort" surgical solution. This overly-simplistic model neglects the ways in which structural factors (such as the influence of poverty, gender, and social stigma) delimit the options available to individuals, and influence them into behaving in ways which may appear to be irrational to an observer with limited understanding of the socioeconomic context in which such individuals operate. For example, insisting on condom-use during transactional sex is not a rational choice for a woman whose survival is dependent on those earnings, and where greater sums are available for unprotected sex.\textsuperscript{182} In these contexts, the stakes shift so that the risk of contracting HIV may seem less immediate and distressing than the more urgent concern of surviving,\textsuperscript{183} a calculation whose logic is determined by economics rather than culture or essence.

Further, structural adjustment policies (SAPs) imposed by the World Bank and International Monetary Fund exacerbate HIV risk factors. SAPs have required market liberalization across sub-Saharan Africa in order to qualify for new loans or reduce interest rates on existing loans. This has had multiple effects which increase vulnerability to HIV/AIDS: the removal of food subsidies, increased rural-to-urban migration, reduced access to education, wage reduction, and unemployment.\textsuperscript{184} They have also led to the decimation of healthcare systems, which, in conjunction with free trade agreements, have impeded access to HIV treatments for those affected.\textsuperscript{185} SAPs have left Global South states diminished, and reliant on the assistance of a patchwork of rival NGOs in order to provide essential services. This has permitted Global North states to exercise control over the health agendas of Global South states by channeling urgently needed aid through NGOs in accordance with their own interests and priorities.\textsuperscript{186,187}

VMMC, a public health campaign recommended by the WHO and UNAIDS, funded by U.S. government agencies, and implemented through various NGOs can, therefore, be located within the macro-neocolonial environment as another vehicle for Western geopolitical power. While in principle a state may reject recommendations or restrict the operations of a campaign or organization, in reality that power is very limited, not least because doing so endangers more general funding sources that are critical to the health of the population. In this way, VMMC campaigns offer Global North institutions a form of biopower over African subjects. They cement racist stereotypes about African sexuality while maintaining the West’s image as benefactor and savior, and justify enduring forms of soft power in former colonies. The production of the African penis in the image of the ideal, "medically-enhanced" American penis mirrors the expectation that African cultures and economies will fall in line with the system on which the global supremacy of the West depends.

6 | CONCLUSION

Historically, medical male circumcision advocacy in the West has not been limited by culture, ethnicity, or race, although some of the more coercive proposals have indeed targeted poor and otherwise vulnerable "Negros."\textsuperscript{188} And more broadly, poverty and systemic racism have made African and African American communities particularly susceptible to medical exploitation.\textsuperscript{189} This is not the first time that Western circumcision advocates have turned their attention toward the allegedly "uncontrollable" sexuality of African and African American men,\textsuperscript{190} nor is it the first time that they have proposed mass circumcision for this demographic.\textsuperscript{191} A century after the first such proposals, the struggle to respond to HIV has given the "circumcision solution" a new lease on life in sub-Saharan Africa.

\textsuperscript{181}Bemer, op. cit. note 10.
\textsuperscript{187}A live example of this dependency is seen in the restriction of abortion services across the Global South as a result of Trump’s extended “Global Gag Rule,” which restricts U.S. funding to NGOs which do not counsel toward, or provide, abortions. The impact of the policy is substantial because millions of women depend on NGOs for essential care. Shafirisi, A. (2018). “Women’s empowerment,” imperialism, and the global gag rule. Kohl, 4(2), 172–184.
\textsuperscript{188}See for discussion, Editors, op. cit. note 21; McGuire & Lydston, op. cit. note 26; Hazen, op. cit. note 34; Remondino, op. cit. note 20; Shattuck & Edson, op. cit. note 24; Daniel, op. cit. note 22; Vandavel, op. cit. note 28.
\textsuperscript{189}Washington, op. cit. note 35.
\textsuperscript{190}Editors, op. cit. note 21.
\textsuperscript{191}Editors, op. cit. note 21; McGuire & Lydston, op. cit. note 26; Hazen, op. cit. note 34; Remondino, op. cit. note 20; Shattuck & Edson, op. cit. note 24; Daniel, op. cit. note 22; Vandavel, op. cit. note 28.
The most significant issue with VMMC is that it has been viewed myopically as a public health measure rather than adequately appraised in the broader context of Western cultural imperialism. This article offers a contextualized perspective on the regime: a history of medical male circumcision discourse as adapted for African and African American men drawing on sexual stereotypes; the racial problems inherent in VMMC research and policy; the neglected role of poverty and systemic factors; and how these elements are fueling suspicions of neocolonialism and racism among targeted groups.

As elsewhere, the act and fact of being circumcised, or not, is a matter of great importance to African societies and cultural identities; it is not reducible to an act of healthcare. In light of the controversial contexts of both circumcision and Western colonial and neocolonial intervention, the international response to HIV must have African experiences and viewpoints at its core. Affected communities need a means of representation in order for the campaign to break out of the Western hegemonic framework. To that end, an independent platform for men and women to share perspectives without the involvement or influence of campaign-affiliated research parties is indicated. “Barriers” to VMMC uptake should be reframed as reasons for resisting; “misconceptions,” when rooted in experience or local knowledge, should be accepted as alternate views deserving attention in their own right. Only then can Africans be said to have a voice in the campaign.

Compounding communities’ limitations for meaningful involvement in decision-making, HIV treatment and prevention options have progressed considerably since the policy was recommended in 2007. In particular, the newer development of more efficacious biomedical solutions—pre- and post-exposure prophylaxis (PrEP and PEP) and treatment as prevention (TasP)—create a need to rethink the role of male circumcision within the global HIV/AIDS response. The male foreskin, rationally reduced by VMMC proponents to a mere vector for HIV transmission, is now increasingly thought to contain important anti-HIV defenses in the foreskin, see Bomsel, M., & Ganor, Y. (2014). CGRP receptor agonist for HIV treatment or prevention. U.S. Patent No. US20160106813A1.

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CONFLICTS OF INTEREST

None.

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195Fish, op. cit. note 85, Section 3; Garenne & Matthews, op. cit. note 129; Kim et al., op. cit. note 129; Rosenberg, et al., op. cit. note 129.
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