The Deception and Dishonesty

of African HIV/AIDS and Sexuality Statistics

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Rethinking AIDS Conference
November 7, 2009

"Give the people a new word and they think they have a new fact."
Willa Cather

The main work of the historian "is the pursuit of truth through a reduction of ignorance, including untruths."[1] The characteristics of a historian include the trait of curiosity, a willingness to hold up evidence from the past to a variety of angles, an ability to make connections between apparently disconnected events, and being prepared to modify deeply held views. For historians, there are no sacred texts or sacred statistics. Logical coherence, relatedness to experience, and acceptance of sharp controversy are indispensable for advancing historical knowledge.

Historical study "instills ways of thinking [which] include a respect for historical context and evidence, a greater awareness of the historical processes unfolding in our own time, and a deeper understanding of the varied traditions current today."[2] Historians interpret the past with the goal of seeing things as they were, understanding why they were that way, and making their findings accessible to the wider public.

In terms of public health, they suggest that an appropriate weight be given to a number of variables thought to have caused changes in the morbidity and mortality of a population cohort. Historians of medicine recognize "the intricate relationships among biological, ecological, and cultural factors in understanding the origins of a disease" in its historical context.[3]

A disease is a social entity that refers "to a web of practice guidelines, disease protocols, laboratory and imaging results and consensus conferences," that are all seemingly objective.[4] Charles Rosenberg adds that "without an agreed-upon vocabulary of disease, the hospital wards could not contribute to the medical profession's collective task of accumulating valid clinical knowledge."[5]

In the modern era, the bureaucratic need "for numbers that legitimate and trigger a sequence of additional diagnostic, therapeutic and administrative actions [may] obscure the very construction of those numbers. The fact that such numbers are routinely generated by seemingly objective, highly technical tools and procedures works to endorse their plausibility and meaningfulness…[but] creates a reciprocal social rigidity as numbers become the measure and legitimation of presumed things."[6]

This predicament applies precisely to what mainstream HIV/AIDS researchers imagine they are counting when it comes to the morbidity and mortality of HIV/AIDS in Africa.[7] There is one set of standards for public health issues and another set of standards for AIDS.

Their catechism runs as follows: "We must spend more to fight AIDS, otherwise it will kill X number of Africans by 2020 who would still be alive but were denied

life saving AIDS drugs." X varies from "thousands" to "millions." These estimates all have a common source: thin air. They betray a misunderstanding of the epidemiology and statistical basis of African AIDS cases.

As an African historian, I am interested in how knowledge about AIDS has been produced, disseminated and practiced. In seeking the origins of AIDS or HIV in Africa, most researchers assume there were links among recent economic trends, Africa's physical geography, Africans' sexual behavior and a variety of animal species.[8] Conventional statements made about AIDS in Africa use the conditional mood (could or might). They avoid the indicative mood of fact.

The HIV/AIDS orthodoxy in Africa depends on a behavior modification paradigm (or a promiscuity paradigm) that is wedded to obsessions about black people's sexual behavior while downplaying the political economy of poverty, sickness and disease. Their statistical sophistry, data manipulation and voodoo math are frightening. It is not possible to satirize the deception and dishonesty of some HIV/AIDS true-believers, nor can I fabricate the things they so seriously and fervently believe in.

Beginning in October 1985, western AIDS researchers clustered together the widespread clinical symptoms of ill health in many impoverished parts of Africa, renamed them as "AIDS," and then proclaimed they were caused by risky sexual behavior. A variety of social factors were soon mixed together with utter nonsense. Some claimed that truck drivers and prostitutes triggered the rapid spread of the AIDS epidemic via migrations and rapid urbanization. Others cited genital lesions, male demands for "dry sex," soldiers raping women, and unbridled male sexual desire as the causes. A cohort of western feminist scholars used AIDS to aggressively promote their own agenda: that men were the problem and changing them, while empowering women, was the solution.[9]

Critics of the infectious viral theory of AIDS share a scientific realism about how the causal concept of HIV=AIDS was born, sustained and rendered impervious to challenges or second thoughts. Nowhere is that more apparent than in Africa, ironically home to the only major head of state (Thabo Mbeki of South Africa) who ever questioned those fundamental claims, but where ludicrous notions abound about interspecies jumps, whether condomless sex protects against or promotes the acquisition of HIV, and recent claims that male circumcision protects against HIV transmission from heterosexual women.

The HIV/AIDS orthodoxy generally permits only one acceptable ideology among those who study this subject. Their refusal to consider alternative views and open contempt for skepticism makes a mockery of the scientific method and has contributed to its multiple failures; another example of how junk science produces junk results.

Colleagues occasionally ask me, "do you deny there is an AIDS epidemic in Africa?" I answer them with care and precision. If one uses the term "AIDS" to refer in Africa to a patient who presents a series of clinical symptoms (3 major

ones and any 1 of another six minor ones), then I absolutely agree that those "clinical symptoms" - weight loss, chronic diarrhea, prolonged fever, plus persistent cough or history of herpes zoster - have increased in Africa over the past 25 years.

I quickly add that those clinical signs have little to do with sexual behavior, and everything to do with tuberculosis, malaria, protein anemia, improper waste disposal, malnutrition, and a variety of waterborne infections, all of which were widespread in Africa ***before*** 1985. When I ask a questioner if she would like to discuss the scholarly literature on African sexuality, the conversation usually ends abruptly.

HIV/AIDS dissidents who are skeptical of the reductionism of the AIDS orthodoxy pose a major paradigm threat. We may be described as "dot-connectors" who draw lines between the flawed HIV antibody tests, the porous and elastic definition of an AIDS case that various from continent to continent, racist insinuations about African truck drivers, prostitutes or sexuality in general, and a new found obsession with the male foreskin.

Many claims made by the HIV/AIDS orthodoxy cannot be repeated with a straight face. For instance, when a small number of Kenyan prostitutes were found to be resistant to HIV despite frequent acts of unprotected sex with HIV-infected men, Dr. Anthony Fauci (Director of the National Institute of Allergy and Infectious Diseases) offered this explanation:

> "It could be that to maintain protection, people need nearly continual exposure to HIV so that antigens in the virus can constantly boost the immune system. Or perhaps sperm or semen somehow stimulate a relatively short-lived immunologic reaction in the women that protects them."[10]

Edward Hooper inventively traced the origins of AIDS cases to oral polio vaccines that were accidentally contaminated in the Congo, allegedly with tissues from a primate version of HIV. Other HIV/AIDS researchers explain HIV prevalence in Africa as the result of unbridled male predatory sexual prowess and women's subordination and lack of power to negotiate "safe sex."

The HIV/AIDS establishment clings to the dogma that changing sexual behavior is the key to stopping HIV and AIDS. But many of the studies themselves actually demonstrate why they have been such dismal failures. For instance, the Summertown HIV-Prevention Project was an initiative that lasted three years in an impoverished South African township. It was described as a "mixed bag of disappointments and achievements…[as] many proposed activities [were] yet to be implemented, consistent and widespread condom use remains low…and the most damning lack of Project success over the three-year research period is the lack of evidence for any reduction in STI [sexually transmitted infection] levels."[11]

The analysis by its Director, Catherine Campbell, uses such impenetrable prose

that one is not surprised that the Project had no effect on either sexual behavior, HIV rates, or AIDS cases. As Campbell states in her conclusion:

> "In the interests of contributing to the development of a critical social psychology of sexuality, the research has illustrated the way in which sexual behaviour, and the possibility of sexual behaviour change, are determined by an interlocking series of multi-level processes, which are often not under the control of an individual person's rational conscious choice. Sexualities are constructed and reconstructed at the intersection of a kaleidoscopic array of interlocking multi-level processes, ranging from the intra-psychological to the macro-social."[12]

The researchers of the Summertown Project honestly believed that sexual behavior changes would make people healthy and enable them to stay well. They never imagined that their project failed because its core construct was erroneous and incapable of correction. It's unlikely they ever considered that the production of HIV antibodies was environmentally induced and had little or nothing to do with sexuality. Their sincere interventions and complex proposals were wholly inadequate for the task of sexual behavior modification. The Project is a valuable example, however, of how not to proceed with AIDS education and awareness.

I recently skimmed a book by anthropologist Robert Thornton from the University of Witwatersrand (South Africa) entitled ***Unimagined Community: Sex, Networks and AIDS in Uganda and South Africa*** (University of California Press, 2008). Here is a gem buried on page 222:

> "It seems that the more knowledge we have about HIV/AIDS, the more anxious we become. One of my students in Johannesburg, Zodwa Radebe, who has worked in AIDS research and prevention, once remarked to me. 'The more I learn about HIV and the more people I work with who are HIV-positive, the less I seem to know; the more my understanding is shaken.'
>
> "Knowledge of AIDS is like knowledge of sex, then: it is anxious knowledge."

In my opinion, the prize for most absurd and far-fetched speculation goes to biologist Helen Epstein. In reviewing Hooper's book (in the ***New York Review of Books***), Epstein imagined that the historical linkages might have proceeded as follows:

> "***Perhaps*** a hunter or butcher carrying a benign monkey virus gave blood at a blood bank or had an injection. ***Perhaps*** someone was transfused with his blood, or ***perhaps*** the needle used to inject him was used to inject someone else without being sterilized. ***Perhaps***, a few weeks later, the virus was transferred to a third person through another injection or transfusion. This ***might*** have been enough to 'kick-start' the virus. It ***might*** have evolved through such 'passaging' to become able to grow vigorously in human cells.

> It ***might*** have been able to infect new people through means other than needles or blood transfusions. It ***migh***t have become sexually transmitted, and it ***migh***t have become deadly. [***all italics added***]"[13]

For over 25 years, the media has bombarded the public with stories purporting to tally AIDS cases and AIDS deaths in Africa, or to acclaim the benefits from various kinds of interventions, the latest being male circumcision. In this paper, I examine the empirical basis for a few recent studies and the methodology the researchers used to gather data and interpret its meaning, and then used those statistical results to request increased amounts of funds.

The HIV/AIDS industry has peddled numerous theories about what is making Africans sick. While their hypotheses are often inconsistent with one another, most are based on thin evidence and fat speculation.

To know what's behind African mortality and morbidity, one must compare the state of African political economies in the first two decades of post-colonial independence (1957-1980) with what has happened since the early 1980s. In the 1960s, Africa was a net exporter of food. In 2008, the continent imported 24% of its food as hunger and famine became recurrent phenomena with severe emergencies in southern and central Africa, the Sahel and the Horn. The structural adjustment policies of the 1980s (that coincided with the onset of the "age of AIDS") caused decreased agrarian investments, rising unemployment, reduced social spending, diminished agricultural credits, and lower crop yields. Africa was at a crucial point in its post-colonial history when westerners starting working on AIDS and its origins in Africa.

According to Oxfam, the number of sub-Saharan Africans living on less than $1 a day nearly doubled from 160 million to 311 million between 1981 and 2001–5. In Central Africa, 55 percent of the people are undernourished.[14] "By the start of the 1980s, virtually every African country was manifesting signs of acute economic distress, reflected in a mounting and unsustainable debt burden, a permanent trade deficit and an acute fiscal crisis which meant that the state was unable to maintain basic infrastructure or fund essential social services."[15] The effects of structural adjustment policies in creating poverty are undeniable: the human costs were grave, the economic gains were slow in coming, and the decline of quality of life in Africa was palpable. Plainly stated, I reject the conventional HIV/AIDS assumptions and suggest that other things, aside from HIV or AIDS, are what continue to make Africans sick in the first place.

The western HIV/AIDS obsession with African bodies, sexuality and behavior patterns has led researchers to focus on the penis, how semen can kill, why the foreskin must be removed, or the dangers that lurk in mother's milk. They believe that the problems of hunger, poverty and illness in Africa have technical solutions – wear condoms, practice abstinence, circumcise males, ingest pills, don't breastfeed. These same people turn priggish, uptight and edgy the moment one tries to really talk honestly about sexuality. The HIV/AIDS orthodoxy relies on a reactionary set of claims; in the case of African research, it harkens back to the Victorian era with its obsessions about sexual restraint. The abuse of

language by the international AIDS orthodoxy has left it with no words to even consider their own misdeeds and deceptions.

The data used to create the HIV-is-everywhere in Africa bogeyman are either flawed or involve small samples. In this paper, I do not emphasize the massive problems and grotesque delusions with the whole notion of HIV, HIV tests and their unreliability. For my purpose here, I simply use the HIV/AIDS orthodoxy's terms.

HIV/AIDS skeptics are obliged to read entire reports or research results and flag their errors, exaggerations, outright falsehoods and other malignancies. Here is the lead editorial from the October 3, 2009 issue of ***The Lancet***:

> " 'Breakthrough'; 'landmark'; 'an important day for the planet.' Such were some of the reactions to the news released on September 24th that, for the first time, an HIV vaccine has shown a modest degree of efficacy in a phase 3 clinical trial...[In 1984, Margaret] Heckler declared that a vaccine would be available within 2 years. A quarter of a century on, it seems as though the journey is only now just beginning. The development of an effective and practical HIV vaccine will take ***more*** basic research, ***more*** collaboration, ***more*** money, and ***more*** trust and goodwill from ***more*** volunteers. But the latest findings present a tantalising hope that such efforts could one day pay off. [***emphases added***]"[16]

What did this earth-shaking, promising trial actually find? Leave aside all the flaws, inconsistencies and disclaimers about HIV tests, none of which ever crossed the mind of the researchers:

> 1) ***Intervention group*** of Thai volunteers - 8197 ***received vaccines*** over the 3-year period, at the end of which 51 were HIV+ (or 6/10 of 1%)
>
> 2) ***Control group*** of Thai volunteers - 8198 ***received placebos*** over the 3-year period, at the end of which 74 were HIV+ (or 9/10 of 1%)

This is an absolute difference of 3/10 of 1%.

But hold on. Do not divert your glance from these HIV/AIDS magician's numbers. It is the ***relative reduction***, i.e. the difference between 51 and 74, which amounts to a planet-saving 31% reduction!

On October 20, 2009, an Associated Press medical writer, Marilynn Marchione claimed " last month researchers announced that a two-vaccine combination cut the risk of becoming infected with HIV by more than 31% in a trial of more than 16,000 volunteers in Thailand."[17]

Finally, I want to examine briefly the statistics from investigations regarding male circumcision and alleged HIV protection. The first two randomized trials were based in Uganda and Kenya. The research results were reported in the British medical journal *The Lancet* in February 2007. According to the researchers,

their studies showed that the circumcision of heterosexual men could reduce their risk of HIV infection by 50 to 60 percent.[18]

The results of the Ugandan and Kenyan trials were released to the media to coincide with UN World AIDS Day (December 1, 2006), two months ***before*** the studies were published in *The Lancet.* As one journalist wryly observed, "This unusual move produced worldwide publicity that was heavy on eye-catching headlines and light on details, because - in the absence of the published studies themselves - few journalists took the time to dig beyond the press releases made available to them."[19] A related issue that raises scientific concerns is the African trials' short duration, with initial results presented as definitive less than two years into the studies.

It is crucial to look closely at how the HIV/AIDS researchers arrived at their conclusions.

In Uganda, researchers started with 4,996 men and randomly divided them into two groups, medically circumcising one group (2,474 men) and leaving the other group intact (2,522 men). After 24 months, both groups were tested for HIV infection. Of the circumcised men, 22 tested positive, while 45 in the uncircumcised group tested positive. In other words, 67 out of 4996 (or 1.3%) were HIV-positive while the remaining 98.7 percent remained HIV-negative.

Researchers simply derived the 50 percent "risk prevention" figure from the difference in results between the two groups, i.e., the difference between 22 and 45. Hence, male circumcision was said to reduce heterosexual male acquisition of HIV from heterosexual women by 50%.

In a similar fashion, the Kenyan trials began with 2,784 men and randomly divided them, with 1,391 undergoing circumcision and 1,391 left intact. Two years later, testing showed 22 new infections among the circumcised men and 47 among those left intact. Astonishingly, neither group of researchers ever attempted to determine the HIV-status of any of the men's female partners, a glaring omission that effectively negates whatever statistical significance their findings are alleged to show.

After *The Lancet* articles appeared, I examined the studies' methodology and statistical relevance. The extremely small number of new infections in each group raised questions about extrapolating them to larger populations. In the Ugandan trial, a mere 8/10 of one percent of the circumcised men tested positive after two years, while 1.7 percent of the uncircumcised men tested positive.

Likewise, in Kenya, the claim of a 50 to 60 percent rate of risk reduction was based on 1.5 percent of circumcised men becoming infected, compared with 3.3 percent of those left intact. All told in the Kenya study, 2.4% of all men tested HIV-positive, while 97.6% remained HIV-negative.

These were microscopically small studies. But in the research world of AIDS in Africa, such numbers become "mutant statistics" which take on a life of their

own and may have a remarkably long shelf life. The more they're repeated, the longer the shelf life. This is extremely important because policy decisions affecting millions of lives are based on sensational figures that may not reflect the reality on the ground.

Finally, the very latest study from Uganda sought to determine if there was any association between male circumcision and reduced risk of HIV infection among heterosexual female partners.[20] They found none.

The investigators identified 922 uncircumcised HIV-positive males, aged 15-49 who were asymptomatic for AIDS, and had CD4 cell counts above 350.

In the intervention group, 474 men were immediately circumcised. In the control group, 448 men were delayed circumcision for 24 months. The researchers randomly selected 92 HIV-negative women who were sexual partners of men in the intervention group (92 couples). Of those 92 women, after 24 months, 17 (18%) had become HIV positive.

They also randomly select 67 HIV-negative women who were sexual partners of men in the control group (67 couples). Of those 67 women, only 8 (12%) became HIV positive. In other words, among the female sexual partners of the circumcised males, a ***higher*** percentage of those women became HIV-positive!

The researchers conceded that "the trial was stopped early because of futility [since] circumcision of HIV-infected men did not reduce transmission to female partners over 24 months…"[21] The research team found that consistent condom use was actually higher in the intervention group (50%) where there were more sero-conversions to HIV than in the uncircumcised control group (36%).[22] That conundrum aside, the investigators reflexively concluded, "condom use after male circumcision is essential for HIV prevention."[23]

They expressed concern that "circumcised HIV-uninfected men might use their circumcised status to negotiate unsafe sex."[24] One can only imagine what the researchers would say if someone asked them to speculate on what an actual dialogue might sound like in the "negotiation" for sex between the circumcised male and his unwitting female partner. This farce typifies how conventional HIV/AIDS researchers reduce African sexuality to lust and exoticism.[25]

These are some examples of the statistical sophistry, data manipulation and sleight-of-hand hyperbole that are reviewed in my forthcoming book, ***AIDS in Africa: The Plague That Wasn't,*** that critiques the AIDS orthodoxy.

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[1] John Lukacs, *The End of an Age* (New Haven: Yale University Press, 2002), p. 77.

[2] Jonathan Gorman, "Historians and Their Duties," *History and Theory*, Vol. 43, #4 (December 2004), p. 110.

[3] Charles E. Rosenberg, *Our Present Complaint: American Medicine Then and Now* (Baltimore: Johns Hopkins University Press, 2007), p. 154. See also, Alfred S. Evans, *Causation and Disease: A Chronological Journey* (New York: Plenum Medical Book Company, 1993); and Morley C. Sutter, "Assigning Causation in Disease: Beyond Koch's Postulates," *Perspectives in Biology and Medicine*, Vol. 39, #4 (Summer 1996), pp. 581-591.

[4] Rosenberg, *op. cit*., p. 5.

[5] *Ibid*., p. 21.

[6] *Ibid*., p. 26.

[7] The World Health Organization has defined health as "a stage of complete physical, social and mental well being and not merely the absence of disease or infirmity," a definition that psychiatrist Seamus Sweeney termed "a statement of awesome fatuity which renders health unattainable in this world." Seamus Sweeney, "Incredible Promises," *Times Literary Supplement* (June 20, 2008), p. 15.

[8] Edward Hooper, *The River: A Journey to the Source of HIV and AIDS* (Boston: Little, Brown Publishers, 1999).

[9] A valuable but largely ignored exception is Women's Health Interaction, *Uncommon Questions: A Feminist Exploration of AIDS* (Ottawa: Women's Health Interaction, 1999).

[10] Lawrence Altman, "A New AIDS Mystery: Prostitutes Who Have Remained Immune," *New York Times* (February 3, 2000), p. A17.

[11] Catherine Campbell, *'Letting Them Die:' Why HIV/AIDS Prevention Programmes Fail* (Oxford: James Currey, 2003), p. 185.

[12] *Ibid*., p. 183. Despite the stunning failures of the Project, one reviewer, who happened to be the Series Editor for its publisher, called it "the best book yet written on the struggle to control HIV." Alex de Waal, "Sex in Summertown," *Times Literary Supplement* (6 August 2004), p. 5.

[13] Helen Epstein, "Something Happened," *New York Review of Books* (December 2, 1999), p. 18. Eight years later, Epstein barely altered her bizarre and circuitous reasoning in a book, *The Invisible Cure: Africa, the West, and the Fight Against AIDS* (New York: Farrar, Straus and Giroux, 2007), pp. 46-47.

[14] "Causing Hunger: An Overview of the Food Crisis in Africa," Oxfam Briefing Paper 91 (2006), p. 1.

[15] Paul Nugent, *Africa Since Independence: A Comparative History*. (New York: Palgrave Macmillan, 2004), p. 326.

[16] "A (Prime) Boost for HIV Vaccine Research?" *The Lancet* (Vol. 374, October 3, 2009), p. 1119.

[17] Marilynn Marchione, "New Results Show Experimental AIDS Vaccine Only Marginally Effective," *Chico (Calif.) Enterprise-Record* (October 20, 2000).

[18] Ronald H. Gray, et al., "Male Circumcision for HIV Prevention in Men in Rakai, Uganda: A Randomized Trial," *The Lancet* (Vol. 369, February 24, 2007), pp. 657-666; and Robert C. Bailey, et

al., "Male Circumcision for HIV Prevention in Young Men in Kisumu, Kenya: A Randomized Controlled Trial," *The Lancet* (Vol. 369, February 24, 2007), pp. 643-656.

[19] Gussie Fauntleroy, "The Truth About Circumcision and HIV," *Mothering Magazine* (July-August 2008), p. 45.

[20] Maria J. Wawer, et al., "Circumcision in HIV-infected Men and Its Effect on HIV Transmission to Female Partners in Rakai, Uganda: A Randomized Controlled Trial," *The Lancet* (Vol. 374, July 18, 2009), pp. 229-237.

[21] *Ibid*., p. 229.

[22] *Ibid*., p. 236.

[23] *Ibid*., p. 229.

[24] *Ibid*., p. 235.

[25] For a general overview, see Curtis Keim, *Mistaking Africa: Curiosities and Inventions of the American Mind* (Boulder: Westview Press, 1999); for a useful but incomplete critique of the racism of conventional AIDS research in Africa, see Eileen Stillwaggon, *AIDS and the Ecology of Poverty* (New York: Oxford University Press, 2006), especially Chapter 7, "Racial Metaphors: Interpreting Sex and AIDS in Africa."

Male circumcision and HIV claims in ***The Lancet*** (2007-09)

Rakai, Uganda

Took 4996 uncircumcised men, all HIV negative.
2474 were then circumcised.
2522 were left uncircumcised.

After two years:

22 of the 2474 circumcised men were HIV+ (8/10 of 1%)
45 of the 2522 uncircumcised men were HIV+ (1.7%)
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67 out of 4996 = 1.3%

The difference between 22 and 45 is 50%. Hence, male circumcision is said to reduce male acquisition of HIV from women by 50%.

Investigators never determined the HIV status of the heterosexual men's female sexual partners.

Kisumu, Kenya

Took 2784 uncircumcised men, all HIV negative
1391 were then circumcised & 1393 were left uncircumcised.

After two years:

22 of the 1391 circumcised men were HIV+ (1.5%)
47 of the 1393 uncircumcised men were HIV+ (3.3%)

The difference between 22 and 47 is 47%, hence male circumcision is claimed to provide 47% better protection against HIV acquisition.

Male Circumcision in ***The Lancet*** (Vol. 374, July 18, 2009), pp. 229-237.

Rakai, Uganda

922 uncircumcised HIV+ men, asymptomatic, CD4 cell >350, aged 15-49.

Intervention Group – 474 men immediately circumcised
Control Group - 448 men delayed circumcision for 24 months

Randomly select 93 women for intervention group (92 couples) – 17 women (18%) became HIV+
Randomly select 70 women for control group (67 couples) - 8 women (12%) became HIV+

"The trial was stopped early because of futility….circumcision of HIV-infected men did not reduce transmission to female partners over 24 months; longer term effects could not be assessed. Condom use after male circumcision is essential for HIV prevention." (p. 229)

"…circumcised HIV-uninfected men might use their circumcised status to negotiate unsafe sex." (p. 235). One can only imagine the actual dialogue that might ensue as part of that "negotiation" for sex between the circumcised male and an unwitting female partner.

consistent condom use was "still quite low at 24 months (50% in the intervention group and 36% in the control group)…." (p. 236)