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Hybrid forum or network? The social and political construction of an international 'technical consultation': Male circumcision and HIV prevention

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The technical consultation in Montreux, organised by World Health Organization and UNAIDS in 2007, recommended male circumcision as a method for preventing HIV transmission. This consultation came out of a long process of releasing reports and holding international and regional conferences, a process steered by an informal network. This network's relations with other parties is analysed along with its way of working and the exchanges during the technical consultation that led up to the formal adoption of a recommendation. Conducted in relation to the concepts of a 'hybrid forum' and 'network', this article shows that the decision was based on the formation and consolidation of a network of persons. They were active in all phases of this process, ranging from studies of the recommendation's efficacy, feasibility and acceptability to its adoption and implementation. In this sense, this consultation cannot be described as the constitution of a 'hybrid forum', which is characterised by its openness to a debate as well as a plurality of issues formulated by the actors and of resources used by them. On the contrary, little room was allowed for contradictory discussions, as if the decision had already been made before the Montreux consultation.

Keywords: international conferences; science studies; male circumcision; HIV prevention; international public health

Introduction

During the technical consultation organised by the World Health Organization (WHO) and UNAIDS in Montreux, Switzerland, on 6–8 March 2007, male circumcision was officially approved as a method for reducing the risks of HIV transmission from women to men during sexual intercourse. This recommendation targeted 16 countries in Africa, where the epidemic is widespread or hyperendemic, i.e., the virus is mainly transmitted through heterosexual relations, a high proportion (more than 80%) of men are not circumcised, and the epidemic is deemed 'out of control'. The countries targeted were Botswana, Burundi, Central African Republic, Kenya (Nyanza Province), Lesotho, Liberia, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe (WHO/UNAIDS, 2007). This decision temporarily put

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an end to a long scientific controversy about this technique's efficacy, merits and limits (Perrey, Giami, Rochel de Camargo, & de Oliveira Medonça, 2012; Rochel de Camargo, de Oliveira Mendonça, Perrey, & Giami, 2013).

This kind of conference is not a site for the production of scientific knowledge, but rather a place where scientific results are used in order to justify and legitimate the implementation of evidence-based public health policy. It brings together international experts selected for the circumstances, staff persons from international organisations, 'bureaucrats' (Hodžić, 2013) and representatives from major global foundations, sponsors, funding organisations and non-governmental organisations (henceforth NGOs) of activists, patients and other interested persons not to forget officials from the governments and local or regional authorities to be concerned by the measure's adoption. The diversity of participants at that meeting and their characteristics raises the issue of the social and political inequalities and power relations between them according to country of origin, institution of work, discipline and expertise. It is also evidence of the political dimension of this process, even though most advocates of the measure claim a linear relation between the scientific evidence and public health decision (Wamai et al., 2008). Taking into account the importance of that meeting's political dimension neither reduces nor negates the centrality of the science which has been mobilised; instead, it re-situates its importance in a broader social and political environment. The technical consultation culminated a long process of international meetings during which the decision had been prepared for official approval in Montreux.

This article describes the organisational process and the parties involved, as well as the nature and dynamics of relations among them, in an effort to understand how this international decision on public health was made. To this end, it addresses the following questions: Who were the participants? What political balance had to be maintained? How was their work organised? What scientific knowledge was mobilised? What was the framework for discussions and the conditions underlying them? How open were discussions during the technical consultation in Montreux?

From 'laboratory life' to 'conference work'

Since Latour and Woolgar's (1979) pioneering work on 'laboratory life', some Science and Technology Studies have been carried out in the field of academic, technical meetings and conferences, which assemble scientists and researchers with or without other parties, whether lay, policy-makers or professionals from industry.[1] Studies of the activities carried out by WHO (Deveaud & Lemennicier, 1997; Hodžić, 2013; Verdrager, 2005) and the Pan American Health Organization (Cueto, 2007) deserve credit for their analyses of the limitations of these institutions. However, these analyses do not adequately take into account the work performed, the characteristics of the parties involved, the negotiating and decision-making processes, the line-up of forces and power struggles that are at stake in the work performed in these conferences. More central to the focus of the present study, Ford and Harding (2008) have focused on the conditions for 'self-making' during such meetings and demonstrated that these are places for exercising symbolic domination over participants. In her study of the French National Committee on Ethics (CCNE), Memmi (1996) has analysed the relations between, on the one hand, 'places' on the podium and in the room and, on the other hand, the scientific or medical status of participants. By relating these places and statuses to what was said and to forms of self-presentation, she detected evidence of how docile participants were to the proposed staging of the conference. Owing to the diversity of its participants and of the

topics discussed, the technical consultation in Montreux can be considered as an example of a new type of deliberation that mixes participants from various groups. Callon, Lascoumes, and Barthe (2009) have coined the concept 'hybrid forum' to refer to open spaces for discussions between heterogeneous groups (scientists, politicians, ordinary citizens) who debate various aspects (scientific, health, ethical, economic) of a single topic of collective concern, echoing Knorr-Cetina's (1981) definition of 'trans-epistemic arenas'. The controversy expressed during such forums sets at odds participants of various sorts: 'Certain actors are reduced to silence; others restricted to an officious forum that have been carefully separated from the forum attended by the few participants who determine the problems, arguments and legitimate interests' (Callon, 2006, p. 10). Callon goes on to state that the necessary counterpart to the possibility for expressing opinions and conducting action is the exclusion of others, by reducing them to silence (p. 12). According to Callon et al. (2009), three dimensions characterise hybrid forums: INTENSITY, which refers to the early involvement of laypersons and the intensity of the quest for a 'common world'; OPENNESS to the diverse groups consulted and their independence from other stakeholders; and QUALITY, i.e., the seriousness in words and follow-up in deeds.

Our initial hypothesis was that this consultation did not – despite the diversity of participants and a certain, though limited, openness – meet the aforementioned criteria of a 'hybrid forum'. It is worthwhile taking a closer look at the conditions and process that led to the Montreux consultation and identifying the place of the different actors and the role they could play in the construction and the development of the decision: the medical doctors and scientists involved in epidemiological research and public health, representatives from international organisations, financial sponsors and public health officials and representatives from activist organisations. As Callon and his colleagues have clearly shown, the diversity of participants and the participation of 'citizens' and activists in meetings do not necessarily lead to a democratic process of discussion and decision-making. Using a terminology proposed by Collins and Evans, such processes range between two extremes: on the one hand, the complete refusal of the role of technical and scientific expertise in public policy debates, which they denominate 'technological populism'; on the other hand, the technocratic approach in which only technical and scientific expertise should have a say in determining public policies in areas that concern them, what they call 'technological fascism' (Collins & Evans, 2007, p. 8). The spectre of technological fascism cannot be kept at bay simply by having token representatives of stakeholders outside the techno-scientific domain in such meetings.

Given the characteristics of the Montreux consultation, we resorted to the concept of a 'network' in order to better grasp the dynamic forming of groups with influence in international meetings (Riles, 2000). We thus came to see the process leading to the technical consultation as the gradual formation of a network in charge of organising the collection of data, disseminating information and seeing to it that the institutions overseeing the process would approve its recommendations (Riles, 2000). Formed by co-optation, the core of this network shared scientific objectives and had joint practices. It played a key role in the process leading to the decision made in Montreux. Our analysis refers dynamically to the concepts of 'network' and 'hybrid forum'. Was this gathering a genuine example of participatory democracy? Or a mere occasion for exchanges during a meeting organised for the purpose of legitimating decisions that had been made elsewhere?

We shall start by placing the 'WHO/UNAIDS technical consultation on male circumcision and HIV prevention: Research implications for policy and programing' in

the series of international conferences and reports that, leading up to it, sought to prove the political acceptability of male circumcision and establish the conditions for implementing it. We shall then shift attention to the participants at Montreux, the institutions represented and the agenda. Finally, light will be shed on the procedures (programme, themes, points of agreement and disagreement, etc.) for the discussions that produced the text of the recommendation.

Method

Our analysis is a reconstruction of a historical event, a kind of micro-history (Ginzburg & Poni, 1981), based on collecting and analysing documents produced for the conference by its organisers as well as the reports and publications by WHO, UNAIDS and other international, regional and national public health agencies involved in the fight against AIDS and in the promotion of male circumcision as a preventive measure against HIV infection. The list of 80 participants figuring in the final report was used to describe and then analyse professional biographies in terms of: the participant's geographical origins, nationality, affiliations with international institutions, field of expertise, implication in research and in AIDS prevention work and specialisation in research on male circumcision or gender. This enabled us to draw up profiles of the individuals and groups in attendance and understand relations between them. We also carried out 11 semi-directive interviews, using the expert interview technique (Bogner, Littig, & Menz, 2009), 5 of them with participants who attended the consultation in Montreux: 3 members of the WHO task force on male circumcision, an official from the ANRS (Agence Nationale de Recherche sur le SIDA/National Agency for AIDS Research), and a social scientist. The other interviewees were persons from NGOs involved in the fight against AIDS, Africanist anthropologists and a demographer who criticised the epidemiologists' hypotheses about the efficacy of male circumcision for preventing HIV infection. A senior researcher, who advocated male circumcision programmes, and a major scientist, who was involved in one of the randomised controlled trials (RCTs), refused to be interviewed. The persons located outside France were interviewed through Skype (audio and video). All interviews were transcribed in full. Through these interviews, we could detect different, somewhat conflicting, viewpoints that, however, did not cover the full range of positions on this issue.

On the way to Montreux

The question of how effectively male circumcision prevents HIV transmission has long been debated (Aggleton, 2007; Perrey et al., 2012). This controversy started with the publication of clinical observations that the rate of HIV infection was somewhat lower among circumcised than uncircumcised men (Alcena, 1986; Fink, 1986). Studies based on geographical correlations (Bongaarts, 1989; Moses et al., 1990) and epidemiology (case-controls and cohorts) were then carried out, followed by a review of findings (Moses, Nagelkerke, & Blanchard, 1999). Differing interpretations and recommendations came out of this work. For some, circumcision's efficacy had been established as early as 1999, and 'it was time to act' (Halperin & Bailey, 1999). For others, it was hard to draw a conclusion from epidemiological studies (de Vincenzi & Mertens, 1994). The findings of Helen Weiss's meta-analysis tended towards the conclusion of a relative efficacy but without excluding the possibility of biases (Weiss, Quigley, & Hayes, 2000). Moreover Siegfried et al. (2003), who authored a Cochran review, found insufficient evidence to

support an interventional effect of male circumcision on HIV acquisition in heterosexual men.

The publication of these first studies sparked a controversy in scientific circles. Further work on this issue would be done through an informal 'network', of which Halperin and Bailey appear as the first visible members. It is worth pointing out that Halperin has had doctoral training in medical anthropology and later specialised in epidemiology, while Bailey was trained in biological anthropology before specialising in epidemiology and biostatistics. These two names are to be found in most conferences and projects up until 2007.

Launching the randomised controlled trials

The decision to organise RCTs, deemed to be the 'gold standard' for evidence in epidemiology (Timmermans & Berg, 2003), was made in 2000 following an informal meeting organised by WHO in Durban, on the sidelines of the 13th International AIDS Conference. These clinical trials were intended to clear up three nagging doubts about the factors causing confusion, (1) the length of time after circumcision until evidence of a decrease in the incidence of HIV infection emerges, (2) the effectiveness in the case of the recently circumcised and (3) the overall efficacy of this practice. In 2002, the Office of HIV/AIDS at the United States Agency for International Development (USAID) organised the conference 'Male circumcision: Current epidemiological and field evidence' in Washington, DC (USAID/AIDS, 2003). This first big official conference on circumcision as a technique for preventing HIV/AIDS brought together experts from several institutions (USAID, UNAIDS, WHO). The persons who attended formed the network's core and would take part in most of the following events related to this issue. Helen Weiss (London School of Hygiene and Tropical Medicine, henceforth LSHTM) presented the meta-analysis of epidemiological studies; Bailey (University of Illinois at Chicago), Gray (Johns Hopkins Bloomberg School of Public Health) and Auvert (INSERM) reported on the design of the RCTs under way. Halperin (USAID senior technical adviser) moderated the session on the feasibility and acceptability of male circumcision as a means of prevention.

In the wake of this meeting, studies were made on the acceptability of male circumcision, its safety and patient satisfaction (Bailey et al., 2004; Kebaabetswe et al., 2003). Epidemiologists then published a review for sub-Saharan Africa (Westercamp & Bailey, 2007). These studies concluded that the concerned populations had a positive perception of circumcision, with the level of satisfaction sometimes attaining 100% (Bailey et al., 2004). In July 2005, Auvert presented the findings of the Orange Farm trial at the 3rd International AIDS Society Conference on HIV Pathogenesis and Treatment. The results showed, 24 months after circumcision, a reduction in the transmission of HIV from women to men by 59% (Auvert et al., 2005). Studies from the social sciences would be solicited later in 2007.

Accelerating the process: the feasibility of implementation

Given these findings, a new round of work groups and conferences was organised for implementing male circumcision in the 16 target countries. In August 2005, an interagency task force, coordinated by UNAIDS and made up of international officials and regional representatives from WHO, UNICEF, UNFPA and the World Bank, was set up on this issue. Its assignment was to acquire, within a year, the information necessary

for making a decision and implementing the programme. A task force was formed to circulate information and organise discussions through a series of international consultations and conferences. It included the persons who had organised the 2002 Washington conference.

As of 2006, regional consultations with an average of 60 participants were held in Lesotho, Kenya, Swaziland, Zambia and Tanzania. The goals were: to present the findings, preliminary or definitive, of the RCTs; discuss the strategies best adapted given the public health situation and availability of services for performing circumcision safely; evaluate the need in terms of human resources; organise the follow-up; and, above all, create the conditions so that the targeted countries would adopt the recommendation. There was no real debate of the pros and cons of male circumcision as a means of prevention. Since the actual findings from the RCTs were taken for granted, the only point actually open for discussion had to do with the conditions for implementing the programme and its acceptability.

Only in the results from one survey did a problem crop up. The Demographic Health Survey (DHS) in Lesotho found a higher HIV prevalence among circumcised than uncircumcised males. A possible explanation was that men in the sample had not been asked how long they had been circumcised, the implication being that they might have been infected prior to circumcision. Another explanation was that they had been circumcised in a way that did not protect them (WHO, 2006). This survey was criticised as probably being biased, and another study was launched to obtain new data. This situation lets us glimpse the conflicting interpretations of epidemiologists and demographers. According to Michel Garenne, a demographer from the Pasteur Institute in France, comparisons of major demographic surveys in Africa (of the DHS type) did not detect any difference in HIV prevalence between the circumcised and uncircumcised (Garenne, 2006, 2012).

In December 2006, another international conference, 'Strategies and approaches to male circumcision programing', was held in Geneva to review conclusions from the previous regional conferences (WHO, 2007). The points on the agenda were: implementation strategies (intensive campaigns with mobile teams vs. health teams in existing facilities, methods for combining both approaches), the parties to mobilise (medical personnel, traditional practitioners, etc.), the communication kit, funding needs and the research to conduct for the purpose of implementation. Given this agenda, as we can see, and the persons who attended (researchers, officials at the central or regional levels of UNAIDS and WHO and representatives from governments and NGOs), this conference served as the 'dress rehearsal' for Montreux.

The consultation held on 18–19 January 2007 in Durban addressed the eventual recommendation's social aspects, as indicated by its title, 'Consultation on social science perspectives on male circumcision for HIV prevention' (UNAIDS/CAPRISA, 2007). Its agenda is evidence that social scientists were invited to facilitate applying biomedical decisions in the targeted countries. The purpose of their presence was not to help draw up a protocol, since that had already been done. A group named Social Aspects of HIV/AIDS Research Alliance (SAHARA) was in charge of coordinating social science studies on the issue. WHO and UNAIDS officials would not, however, wait for its report before approving the recommendation (Peltzer et al., 2007).

The technical consultation in Montreux was not improvised. The chronology of events from 2000 to 2007 sheds light on the gradual accumulation of evidence-based knowledge, the evaluation of the political and psychological acceptability of the measure parallel to the emergence and construction of the network. During this period, the

spreading epidemic was a cause of concern among officials from major international organisations, who were calling for new measures. The scientific arguments advanced and intensely debated tended towards the conclusion that male circumcision might to some degree – though limited and controversial – prevent the transmission of HIV from women to men. This was the ground for awareness campaigns and the mobilisation, through a round of regional and international conferences, of public health personnel in Africa for the purpose of implementing the recommendation. The technical consultation had been well prepared, along with the work on the feasibility and acceptability of male circumcision, through an international network formed around a core of epidemiologists and public health experts from WHO and UNAIDS. It sought to make the parties that would have a part in applying decisions in their region and country aware of the stakes (Table 1).

The technical consultation in Montreux

The impact of the randomised controlled trials

In February 2007, the results of the two RCTs conducted by North American researchers were published in *The Lancet* (Bailey et al., 2007; Gray et al., 2007). These clinical trials bore out the findings from the Orange Farm study, reporting a decrease by, respectively, 51% and 59% of HIV infection among circumcised men as compared with the uncircumcised. The evidence from the three RCTs seemed sufficient for the members of the WHO/UNAIDS task force to claim scientific and ethical grounds for the recommendation. An official in a European agency funding AIDS research told us, 'It would have now been reprehensible not to act'.

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. A French anthropologist told us that advocates of the recommendation talked to him after a public meeting, saying, 'If you continue opposing circumcision, you will have blood on your hands'. Positions were hardening, as supporters of the measure morally discredited opponents. This process of disqualification, though initially based on scientific arguments, resorted to a rhetoric that borrowed from the realm of values (Rochel de Camargo et al., 2013).

For members of the WHO/UNAIDS task force, it was urgent to release the findings of the RCTs and officially recommend, as part of a 'combined prevention strategy', male circumcision as a new method for reducing the risks of transmitting HIV (Giami & Perrey, 2012; Nguyen, Bajos, Dubois-Arber, O'Malley, & Pirkle, 2011). The technical consultation in Montreux was held barely a month after publication of the results from a single trial. Since little information was available about the findings from the two other RCTs (at the time under review for publication), what was known depended on the permeability assumed to take place between scientific circles, international public health organisations and the network advocating male circumcision.

The idea guiding the organisation of the technical consultation in Montreux was to present arguments for justifying the decision to a broad representation of official organisations and NGOs from various countries and thus obtain their backing before implementing the recommendation. In other words, the recommendation was taken for granted and the conference was not to bring it under question but to convince those still in doubt to adopt it. What remained to be done was to work out the contents of the recommendation and the instructions for implementing it. Questions were still open about, for instance, the usefulness of the recommendation for persons already infected by

Table 1. Meetings and reports leading up to the technical consultation in Montreux.

2000	WHO satellite symposium on male circumcision on the sidelines of the 13th International AIDS Conference in Durban
2002	Conference organised by USAID/PATH/JHU: *Male Circumcision: Current epidemiological and field evidence. Program and policy implications for HIV prevention and reproductive health*
2005	*February*: Publication by USAID/JHPIEGO/AIDSMark: *Strengthening male circumcision in Zambia* *August*: Publication of the UN *Workplan for male circumcision and HIV* *October*: Formation of the WHO/UNAIDS 'Male circumcision steering group' *November*: UNAIDS/WHO/SACEMA meeting: 'Modelling the impact of male circumcision of HIV prevention', Geneva
2006	Publication by Wilson & de Beyer: *Male circumcision: Evidence and implications* (World Bank Global HIV/AIDS Program) Publication by WHO/UNAIDS/JHPIEGO: *Manual for male circumcision under local anaesthesia* (available at: www.who.int/hiv/topics/malecircumcision/en/) *July*: Regional consultation on male circumcision and HIV in Lesotho *September*: Regional consultation on male circumcision and HIV prevention in Kenya, Swaziland, Zambia, and Tanzania *November*: Regional consultation on safe male circumcision for HIV prevention, Nairobi *December*: WHO international conference: 'Strategies and approaches to male circumcision programming', Geneva
2007	*January*: UNAIDS/CAPRISA consultation: 'Perspectives from social science on male circumcision for HIV prevention', Durban *6–8 March*: 'WHO/UNAIDS technical consultation on male circumcision and HIV prevention: Research implications for policy and programming', Montreux, Switzerland, whence the publication *New data on male circumcision and HIV prevention: Policy and programme implications* *28 March*: The recommendation of male circumcision was officially announced during a press conference in Paris *June*: Publication of WHO/UNAIDS report: *Male circumcision: Global trends and determinants of prevalence, safety and acceptability* *June*: WHO international consultation in Nairobi, 'Male circumcision and HIV prevention: Operation research implications' *June*: Publication of *Safe, voluntary, informed male circumcision and comprehensive HIV prevention programming guidance for decision-makers on human rights, ethical and legal considerations* by the UNAIDS Secretariat with assistance from the AIDS Law Project, South Africa *September*: CMMB/WHO meeting: 'Male adolescent circumcision for HIV prevention as an entry point for sexual and reproductive health: The role of faith-based organisations', Limuru, Kenya *September*: Publication of AVAC brochure: 'A new way to protect against HIV? Understanding the results of male circumcision studies for HIV prevention' *November*: UNAIDS/WHO/SACEMA international consultation, Stellenbosch, South Africa: 'Making decisions on male circumcision for HIV risk reduction: Modelling the impact and costs'

the virus, the list of countries to target and the impact on women. A WHO expert involved in organising the consultation said:

> We had a good idea about what themes were important … the things about which we wanted recommendations, but the exact sentences had not been written … The exact words were not on paper, we worked a lot during the conference to find the words.

The participants

Eighty persons, selected by the UNAIDS/WHO task force, attended the meeting. Two major points attracted our attention when examining the list of persons in attendance at Montreux.[2] First of all, there were no 'laypersons', i.e., non-specialists with no direct knowledge bearing on the recommendation. Second, very few opponents attended the meeting, whether scientists with relevant publications to their credit or representatives from NGOs opposed to genital and body mutilations. The diversity and independence of the representations in Montreux were restricted. The members of the network that had taken shape over the years leading up to the technical consultation came from varied backgrounds, but shared a single conviction about the efficacy of circumcision for HIV prevention and the urgency of the need to implement it. The overwhelming majority of participants were medical doctors: 52.5% with diplomas as doctors of medicine or the equivalent, 75% with a biomedical education in the broad sense (medicine, pharmacy, public health, medical and biological anthropology and epidemiology). This contrasts with the small proportion (6.3%, five of the participants) of social scientists (sociologists, social anthropologists, demographers or economists) and jurists (one participant), not to mention the absence of nurses and social workers. In terms of the number of papers presented, epidemiologists stood out owing to their involvement in the RCTs, meta-analyses, observational studies, cost/benefit analyses and assessments of the recommendation's impact. We identified five, sometimes overlapping, groups of participants, each with its own source of legitimacy (Table 2).

Table 2. Groups of participants at the technical consultation in Montreux.

Groups	Number of persons	Status as speakers	Opinion
Academics and researchers Persons involved in the RCTs (epidemiologists and social scientists) Social scientists/public health	20	Speakers and non-speakers	Most in favour, a few opponents
Representatives of international organisations Medical doctors Epidemiologists HIV specialists Persons involved in the RCTs Authors of the recommendation	20	Speakers and non-speakers	All in favour: *WHO/UNAIDS Male Circumcision Working Group*
Sponsors Medical doctors and programme managers World Bank, UN agencies (UNICEF, United Nation Population Fund), Global Fund, ANRS, Bill and Melinda Gates Foundation	15	Non-speakers	All in favour
Public health authorities from targeted countries Programme managers	10	Non-speakers	Observers
NGOs Specialists and activists working on gender issues Representatives of youth or family associations Representatives of persons living with HIV	10	Non-speakers	No common position

In the group of academics and researchers, a distinction can be made between speakers and the other persons invited, whether or not they were involved in studies on circumcision. It should be pointed out that the core of researchers who had conducted the RCTs also carried out the projects for proving the recommendation's value to public health: impact assessment (Gray et al., 2007; Nagelkerke, Moses, de Vlas, & Bailey, 2007), cost-effectiveness analysis (Kahn, Marseille, & Auvert, 2006) and acceptability (Westercamp & Bailey, 2007). Although he did not speak at Montreux, Halperin stood out as a staunch proponent of male circumcision. As of 1999, well before any clinical trials, his article in *The Lancet* (Halperin & Bailey, 1999) exhorted international authorities to implement a programme of circumcision in southern Africa.

Nearly all the academics/researchers attending the meeting were in favour of the recommendation. There was but one avowed opponent in this group: Gary Dowsett, an Australian sociologist who had extensive experience in social science research on AIDS and had served as consultant for WHO and other international organisations. As one of a group of self-identified gay researchers, his activities in this field reached back to the mid-1980s. Nonetheless, the possibility for him to present his critique was limited by both the agenda and the perceived hostility towards him during discussions by, in particular, a major US epidemiologist, one of the recommendation's principal advocates. During our interview, Dowsett cited this person's name, which we have replaced with the pronoun HE in the transcripts:

> I'm standing in the hotel, with a glass of champagne and HE … comes charging over to me, immediately … and just started to attack me, immediately, and … 'How wrong I was! Why I was doing this? I got the argument wrong – Did I not understand how important all this was' … and HE attacked me … every time I spoke in the meeting at Montreux. Every time!

The second group, representing international health institutions and holding positions in WHO or UNAIDS (either at headquarters in Geneva or in regional offices), were part of the core network who had worked on the recommendation. Nearly all of them were medical doctors with training in public health or epidemiology and articles on the HIV in top-ranking international journals to their credit. But they had published very little on circumcision. A third group of sponsors, public and private, was mostly made up of medical doctors by education who were managing programmes with significant budgets. All members of these two groups favoured the recommendation and had the possibility to influence the international decision.

In the fourth group were public health authorities from targeted countries. Not all targeted countries were represented, however. No representatives came from Burundi, the Central African Republic or Rwanda, for instance. On the other hand, a few countries not directly concerned by the recommendation had official representation: Congo, Haiti and Brazil. The members of this group were invited for the purpose of addressing items on the agenda related to the conditions for implementation.

The ten participants from NGOs, who compose the fifth group, had been invited owing to their competence in fields related to the recommendation. They included, among others, were specialists or activists working on gender issues, representatives of youth or family associations, representatives of persons with HIV. It is hard to explain why the representation from NGOs involved in the fight against AIDS was so low.

The interviews conducted in France with leaders of AIDS-related NGOs brought to light the lack of agreement on the issue of male circumcision, both among members

internally and among the NGOs themselves. According to the Secretary-General of the International AIDS Coalition:

> There is no common position against circumcision among the targeted countries. As long as the measure is not coercive and is voluntary, we do not have to mobilise against it.

In fact, persons who were known for their opposition to the recommendation or whose positions were not cut and dried did not attend Montreux. Among them were epidemiologists, demographers, social scientists and representatives from NGOs. The absence of urologists and sexologists is telling. The lively controversy in the field of sexual medicine at the end of the 1990s about the harmful effects of circumcision – increasingly likened to a mutilation, thus in violation of health and sexual pleasure (Wagner et al., 2005) – was no longer current. Though absent at the consultation, urologists from the field of sexual medicine would soon afterwards revisit their views on circumcision and lay claim to an expertise that could be put in the service of mass male circumcision campaigns in southern African countries (Sharlip, 2008).

Participants from Africa or working there accounted for about a third of the attendance. Most of them were policy-makers whose role, during the meeting and the drafting of the recommendation, was advisory, not actual decision-making. Nearly all the papers presented came from researchers or the representatives of institutions in the 'Global North'. This distribution is evidence of an imbalance: participants from research centres tended to come from and work in the USA or Europe, whereas the African participants tended to be involved in public health or policy-making. Although only a third of the participants came from Africa, the meeting proposed to set priorities for the fight against AIDS on that continent and to make decisions about how to pursue them (Table 3).

The 'HIV-male circumcision network'

An examination of the profiles of the scientific and biomedical experts who attended Montreux brings to light a new generation of researchers. The Clearinghouse database (http://http://www.malecircumcision.org/resources/online_resources.html) enabled us to identify the participants

Table 3. Participants at the technical consultation in Montreux by continent of origin and of place of work.

	Continent of origin		Place of work	
	Number	%	Number	%
Africa	29[a]	36.3	25	31.3
Europe	15	18.8	31	38.8
North America	21	26.3	19	23.8
Latin America	5	6.3	2	2.5
Asia	3	3.8	1	1.3
Oceania	2	2.5	2	2.5
No data	5	6.3	0	0.0
Total	80	100	80	100

[a]At least four of these Africans were white persons: Taljaard, Wiulson, Williams and Delate.

whose names were the most cited in scientific publications or the reports of international organisations. Although the previously mentioned experts had a higher score in peer-reviewed publications related to male circumcision, they were not the same as the authors with the most publications when the search term 'HIV' was entered in the database. We thus identified two groups which can be considered as the core of what we have called the 'HIV-male circumcision network':

- Members of the WHO/UNAIDS Male Circumcision Working Group, a more or less formal group of employees from these two organisations. Although no list of its members is available on the Internet, certain names repeatedly crop up in the reports published by the two organisations; Hankins, Schmid, Dickson, Farley and de Zoysa seem to have been key members.
- The principal investigators on the RCT teams at Orange Farm (Auvert), Kisumu (Bailey, Agot, Moses, Ndinya-Achola) and Rakai (Gray, Kigozi, Serwadda, Wawer), as well as Halperin (Harvard) and Weiss (LSHTM).

The agenda

The large majority of the presentations and roundtables focused on the medical, scientific or technical aspects of implementing the recommendation (Table 4). The agenda was weighted towards technical presentations for demonstrating the need for the recommendation: one and a half out of the three days. Speakers were thus placed in the position of experts with an educational role. All the epidemiologists in attendance had, early on, backed the recommendation.

According to some interviewees, the time devoted to the presentations did not allow for a genuine, open debate, in particular about how to extrapolate from the findings in the narrow context of the RCTs to the general population. This question was thought to be settled, given the results from previous observational and epidemiological studies. There was no mention of the contradictory findings that had been published, nor of a scientific controversy. According to Dowsett during our interview, Hankins' speech on the second day barely mentioned the recommendation's social and cultural consequences:

> We were concerned about the cultural consequences of circumcision in terms of shifting ideas of sexuality, sexual cultures and masculinity; and any evaluation of circumcision being rolled out needed to include much broader social and cultural markers than simply medical and behavioural markers of the implementation. That was part of the recommendations for the research agenda, from the social science meeting in Durban. That was simply reported in Montreux, and nothing was either endorsed or done about it. It was just presented as background information.

After the consultation, Dowsett published an article on the difficulty of extrapolating the RCTs results to the general population in 'real life' (Dowsett & Couch, 2007), but there has been no actual follow-up to this debate. Berer, a previous chair of the Gender Advisory Panel at WHO's Department of Reproductive Health and Research (1996–2001), attended Montreux and published a paper afterwards that raised questions about gender relations and the ethical concerns regarding the promotion of a method that could protect only men engaged in heterosexual relations while increasing women's vulnerability (Berer, 2007). The workshops and discussion groups organised during the second

Table 4. Agenda of the Montreux consultation.

Timetable	Activities/presentations	Comments
Day 1	• Results from the RCTs (Orange Farm, 20 minutes; Kisumi & Rakai, 1 hour) presented by Auvert, Gray & Bailey • Discussion	• No mention of contradictory findings • No commentary from NGO representatives
Day 2, morning	• General conclusions from the RCTs • Statistical model for evaluating the efficacy of male circumcision • Cost-effectiveness studies presented by Auvert & Gray • Ethical aspects/human rights • Reports from Nairobi and Durban meetings – social sciences implications (Hankins)	• Scarcely any mention of social and cultural impact aspects
Day 2, afternoon	• Discussion in three smaller groups: (1) Funding (2) Identification of target groups at risk (3) Interaction with other preventive measures: combined prevention	• More possibilities for discussion than during the previous sessions
Day 3	• Feedback from the small group discussions: strategies for implementation • Discussion in groups: human resources, training and certification, campaign messages • Declaration of intent by major sponsors • Presentation and discussion of the first draught of recommendations	• All activities seem derived from an already made decision in favour of the recommendation to implement male circumcision as a preventive measure against HIV/AIDS

half of the consultation placed participants on a more equal footing. Experts who were not affiliated with WHO or UNAIDS and participants who were not scientists could present their opinions about the technical dimensions of the implementation of the decision. The arguments of opponents of the measure were simply ignored or dismissed (Banerjee et al., 2011).

A press conference for announcing the recommendation

After the consultation, on 28 March 2007, the recommendations were officially announced during a press conference held in Paris by three institutional representatives: Kevin de Cock (head of the HIV/AIDS department at WHO), Catherine Hankins (associate director of strategic information and chief scientific adviser at UNAIDS) and Jean-François Delfraissy (director of the ANRS). These recommendations were widely reported in mass media around the world. Nearly all comments in the press were positive. In December 2007, the magazine *Time* claimed that male circumcision as a means for preventing HIV transmission was the 'number one medical breakthrough' during the year.

Discussion and conclusion

Given the 'reconstruction of a historical event' that we have carried out using the concepts of 'hybrid forum' and 'network', we can better understand the sociological and political characteristics of the technical consultation in Montreux. It was certainly multidisciplinary, interprofessional and international. Several themes were discussed having to do with the recommendation's efficacy, its acceptability and the conditions for its implementation and the decision of implementing this method was already taken for granted by most of the participants. Nevertheless, this meeting does not sustain a full comparison with a 'hybrid forum', since its scores are low on the three axes defined by Callon et al. (2009): intensity, openness and quality.

With regard to intensity, there was no effort to establish a common ground for a lasting solution to be approved by a wide range of parties, which could have included non-scientists with a direct or indirect stake in the recommendation, researchers in epidemiology and the social sciences, doctors, surgeons and decision-makers in public health. Instead, researchers/academics in epidemiology and statistics with long experience in HIV/AIDS research and policy formed the core of a network in support of the use of male circumcision for HIV prevention. Members of this network conducted all relevant studies on the eventual recommendation's efficacy, impact, cost-effectiveness and acceptability. This network, as pointed out, included public health specialists, academic researchers, programme managers, employees from WHO and UNAIDS and the representatives of international foundations.

What about the criterion of openness? This network, throughout the process described herein, grew stronger – to the point of organising the choice of speakers and the circulation of ideas at Montreux. Specialists with doubts about the measure were cornered, and few researchers who opposed it outright attended the meeting. Representatives from NGOs, few in number, did not take part in a debate for weighing the pros and cons of the coming decision. Their role was to be onlookers who could ask the experts questions but who had no genuine opportunity for expressing their viewpoints, since the technical discussions on the RCTs monopolised opportunities for taking the floor. Although the workgroup sessions allowed more room for speaking up, they were oriented towards the conditions for implementing the recommendation, not towards debate about its validity. The same role was assigned to the health authorities representing African countries.

As for the criterion of quality, the Montreux consultation did not debate the recommendation's pros and cons. There was no occasion for opponents to bring forth their arguments, formulate their demands or explain their objections. Anything that might resemble a contradictory debate took place outside the consultation, not inside. The relative diversity of the persons invited turned out to be a means for legitimating a measure that, by its very nature, was a wedge issue for both the scientific community and general population: genital surgery with strong religious connotations, the partial protection of men only, the risk of fostering a (fake) feeling of protection.

Our previous experience (in fields other than male circumcision) had made us familiar with WHO work groups and technical consultations. We had observed how these organisations operate and how power struggles are played out. During the opening cocktail at one conference we attended, a WHO official said there were two sorts of conferences: those with results known well ahead of time, the purpose of the meeting being to convince public health actors and experts to give approval; and those from which the WHO staff expected original results in order to formulate new proposals. He added,

of course, that the conference we were attending was one that was expected to produce original results.

The technical consultation in Montreux took place at a time when the fight against AIDS in southern Africa seemed to be stalled and a major shift in strategies was being made towards 'biomedicalization' to the detriment of the then-prevailing social and behavioural paradigm (Giami & Perrey, 2012; Nguyen et al., 2011). It came out of a complex process that included a mixture of controversial studies about the efficacy of male circumcision in preventing HIV transmission from women to men and an organisation in a crescendo of international conferences leading up to the recommendation and its implementation. A core network of biomedical scientists, doctors and employees of international organisations conducted the preliminary studies and followed up on them at the decision-making level. The recommendation had been prepared well ahead of Montreux, during earlier meetings, by members of this network. As a matter of fact, Montreux did not mark a turning point in the decision-making process. Instead, it was an additional step in a process started much earlier by a network of medical doctors, epidemiologists and representatives of funding agencies and international organisations. The technical consultation was an occasion for officially approving the measure for implementation, discussions being limited to technical issues … which is a political choice in itself.

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Notes

1. For some examples of such STS studies in this field with different theoretical focus, see Eggen (2012), Hodžić (2013), Knaapen (2013) and Stirrat (2000).
2. It was not possible to know who was invited, those who were not and those who declined the invitation.

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