



MALE CIRCUMCISION ROLL-OUT CERTAIN – NOW FOR ‘THE HOW’



Deputy chairperson of the South African National AIDS Council (SANAC), Mark Heywood.

Picture: Chris Bateman

The deputy chairperson of the South African National AIDS Council (SANAC), Mark Heywood, believes oft-cited legal barriers to universal, voluntary neonatal circumcision are over-rated and can be overcome to bolster HIV prevention.

The HIV treatment activist lawyer was responding to *Izindaba* questions at the 5th Social Aspects of HIV/AIDS

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Research Alliance (SAHARA) conference at Midrand early last December about barriers to the proven and potent infection control efficacy of large-scale male circumcision (MC).

After 2 years of consultation and scientific briefings of stakeholders SANAC has prepared MC guidelines, while the health department is busy with a feasibility study and cost analysis. MC will be part of a comprehensive new HIV prevention package due out later this year, officials have confirmed.

Head of the National Health Insurance (NHI) task team, Dr Olive Shisana, has additionally said that MC will almost certainly be part of the benefit package her 28-member expert team is preparing for legislation this June.

A modelling exercise by Johns Hopkins University academics suggests that scale-up of MC coverage to 80% of men and neonates in South Africa over the next 5 years will avert more than 1 million new HIV infections by 2025.

MC trials in Uganda, Kenya and South Africa have shown a 60% reduction in HIV infection among heterosexual men, prompting aggressive World Health Organization (WHO) guidelines for high HIV, low MC prevalence countries 2 years ago. South Africa lags behind several of her neighbours in MC policy development and implementation, with Kenya and Zambia already accelerating roll-outs.

Wherever MC is widespread, HIV infections are down – and vice versa. Research has also shown that for every 5 circumcisions conducted, 1 infection is averted, an excellent return for high HIV prevalence countries. In spite of start-up difficulties, the financial payoff is huge. Modelling exercises suggest the cost of averting an estimated 4 million new HIV infections in South Africa, Namibia, Botswana, Swaziland, Lesotho, Malawi, Zambia, Zimbabwe, Mozambique, Tanzania, Kenya (Nyanza Province only), Uganda and Rwanda over 5 years to be around R7.5 billion – saving R150 billion in treatment costs.

Neonatal circumcision would form a vital part of such a long-term strategy.

Legal obstacles to neonatal MC outlined

Heywood was asked about a clause in the Children’s Act, aimed at protecting young men and infants from botched circumcisions (i.e. preventing circumcision for anyone under 12, ‘unless for medical or religious reasons’).

‘That would have to be looked into, but I’d qualify it by saying that offering universal voluntary circumcision is definitely for medical reasons, is in the best interests of the child and constitutes basic health care.’



Professor Helen Rees, head of the Reproductive Health Unit at Witwatersrand University and co-chair of SANAC's programme implementation committee.

Picture: Chris Bateman

Asked about critics who argued that MC violates the rights of an infant because they are unable to participate in the decision making and that it therefore cannot meet the legal (and medical) test of 'non-malificence', he cited the Constitution. 'The Constitution says that a decision must always be in the best interests of the child and we would argue that this is,' he said.

One constitutional and medico-legal expert told *Izindaba* of a 'movement' arguing that circumcision was a violation of a child's section 12 constitutional rights (to freedom and security of the body) and that they should instead make such a decision when they were 12 years old (in terms of the new Children's Act).

'The question is, from an age and consent perspective, whether circumcision is regarded as a "surgical operation", or as "medical treatment", and as we know with modern medicine these lines are already blurred.'

She added that circumcision as national health policy would have to be accompanied by a 'massive and very explicit' educational campaign, something she had doubts about given the 'failure' of the State's TB education campaigns.

MC messaging would have to address the reduction of women's power to demand condom use, as men's refusal to change their sexual behaviour would 'inevitably' be strengthened by MC.

Professor Helen Rees, co-chairperson of SANAC's programme implementation committee and executive director of the Reproductive Health and HIV Research Unit at Wits University, said the current MC emphasis was on adolescents and men.

Rees said the biggest barriers to a universal MC roll-out were human resources and money, 'all in the face of our already struggling health services'.

'That's where we'll get the quickest return in HIV (infections averted),' she said. However, there were strongly motivated proposals that infant circumcision be part of the prevention of mother-to-child transmission (PMTCT) package and offered at all maternity facilities where it would be 'less traumatic and far safer'. 'That certainly should be looked at,' she added.

Beware of premature MC campaigns

Shisana, Rees and Heywood concurred in warning that wholesale unfocused public promotion of MC could prove counter-productive unless capacity was first created.

Although research had shown that there was no statistically significant sexual disinhibition among newly circumcised men, members of the House of Traditional Leaders had expressed reservations, claiming it was happening.

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Rees said HIV testing should be offered before MC, but not as a prerequisite. She emphasised that MC programmes should be gender sensitive, with messaging targeting women 'as partners and mothers of sons'. Messaging should explain

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to women the advantages of MC, but programmes should not pull funding away from existing programmes targeting women (PMTCT, female condoms).

A crucial component of any MC programme would be to avoid further stigmatising of HIV-positive women by blaming them should a circumcised male become infected.

Rees said there were more than 3 million uncircumcised young men in South Africa.

Shisana emphasised that in terms of efficacy, condoms and PMTCT outperformed MC but added that a follow-up of Kenyan men for 42 months after voluntary medical circumcision showed efficacy to have increased to 65%.

On achieving the Millennium Development Goal of slashing new HIV infections by half by 2011, she said it was 'a delicate balance of ensuring you consult and the minister of health pushing to reduce infections to achieve this. There's a constant tension between how quickly you move and getting everybody on board,' she observed.

Rees said the biggest barriers to a universal MC roll-out were human resources and money, 'all in the face of our already struggling health services'. SANAC was costing dedicated MC operating facilities and training hundreds of practitioners, most of whom would be nurses.

What local MC models predict

A modelling of public sector MC services in Hillbrow had shown that only 19% of the local population needed to be interested to operate 1 theatre at full capacity for 5 years. (A survey measured the actual interest at 80%.)

With 5 theatres, 54 704 surgical procedures could be performed in those 5 years, resulting in 81% coverage.

Performing operations for 10 hours per day instead of 5 would boost coverage from 19% to 37%. Using professional nurses instead of doctors would reduce the costs of the procedure by 12%.

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Rees shared a South African 'scorecard' on MC. It shows ticks for situational analysis, leadership and partnership, advocacy, exploring enabling policy and a regulatory environment, a strategy and an operational plan, but Xs for quality assurance and improvement, human resource development, commodity security, social change communication, and monitoring and evaluation. It provides a snapshot unnervingly similar to the overall public health care system.

Rees summed up local scientific sentiment about how under-rated MC was by hypothesising: 'if it was a pretty drug in nice packaging ...'.

Chris Bateman

Errata

In a comprehensive report on male circumcision in the *Izindaba* section of the December 2009 edition of the *SAMJ*, the period of abstinence from sexual activity following male circumcision is cited as 'about 3 weeks'. This is incorrect. The recommended period of abstinence is a minimum of 6 weeks, the main criterion being full healing of the circumcision wound.

Kelly Curran, Technical Director of the HIV/AIDS and Infectious Diseases Department at Jhpiego, a not-for-profit international health organisation *affiliated* with Johns Hopkins University, was also incorrectly depicted as having this title 'at Johns Hopkins University'.

The author regrets the errors.