

Voluntary male medical circumcision – Dan Ncayiyana responds

I thank the above authors, all acknowledged HIV/AIDS experts, for their robust responses. South Africa and the SA HIV/AIDS research community have indeed been at the forefront of the global effort to better understand and to contain the HIV/AIDS epidemic, and there is no gainsaying the motive of the VMMA proponents to control and ultimately to eradicate the disease. That said, the envisaged mass roll-out of a surgically invasive prophylactic intervention is without historical parallel, and it is only appropriate that the VMMC project is deliberated within the medical profession beyond the immediate circles of the panels and committees driving the initiative.

The significance of the evidence from the three African randomised controlled trials (RCTs) is not at issue. However, this evidence seems to have acquired considerable interpretation creep along the way, with inferences of 'lifelong protection', and of benefits of neonatal circumcision that are not self-evident from the RCTs. Clark *et al.* boldly assert in respect of sub-Saharan Africa that '*Mandating*

Professor Dan Ncayiyana is Editor of the SAMJ. profdjn@gmail.com

[my emphasis] neonatal male circumcision is an effective therapy that has minimal risks, is cost efficient and will save human lives. Neonatal male circumcision is medically necessary and ethically imperative.¹ There is no good evidence to back this up. Based on their interpretation of the Children's Act 38 of 2005, paediatric surgeon and ethicist Sidler and colleagues² hold the view that 'infant non-therapeutic circumcision in South Africa (is) illegal, making the discussion of forced infant circumcision moot'.

The debate is about what the evidence means and what its role should be in the greater HIV prevention strategy. UCT's Myers and Myers have cautioned that 'given the epidemiological uncertainties, and the cultural, ethical and logistical barriers, it seems neither justified nor practicable to roll out male circumcision as a mass anti-HIV/AIDS intervention.'³ Pointing to the long history of circumcision as an intervention in search of a malady, they remind us that 'Superficially convincing justifications for this surgery have abounded since the mid-19th century'⁴ to prevent masturbation, insanity, idiocy, epilepsy, TB, STIs, cervical cancer, and penile cancer. Certainly, circumcision should be readily accessible to individuals who, forearmed with full information on the potential benefits, the caveats and the unknowns, make a personal choice to be circumcised.

To argue that 'despite the long presence of the ABCs, HIV

prevention has been slow' is not fair comment. It is counterintuitive to believe that VMMC will fare any better, or that men will be any more amenable to having their foreskin excised than they are to wearing a condom. On the contrary, VMMC is likely to meet with ever-increasing resistance, not least because of deeply rooted cultural attitudes,⁵ much as this dimension has tended to be underplayed in the VMMC euphoria. More importantly, it is worth recalling that until fairly recently, the ABC message has struggled to be heard in the face of AIDS denialism, with the TAC fighting running battles with the political establishment, doctors in the public service getting punished for promoting orthodox HIV practices, and Dr Matthias Rath peddling miracle AIDS cures under the protection of top government officials. That the HIV incidence has shown signs of abatement at all is evidence of the staying power of the ABC strategy.

My concern about offshore funding (and much of the advocacy) driving VMMC is not off the wall. Venter was quoted in the *NEJM*⁶ as expressing similar sentiments that 'Currently all of the funding is

coming from Western nations ... and this makes people suspicious.' This remains the case in most southern African countries beyond our borders. I remain sceptical that VMMC has been sufficiently field-tested to validate a mass VMMC campaign, or that the goal to circumcise millions of men in our region in 5 years is even achievable. Without detracting from the imperative to pursue a multi-pronged prevention strategy, I believe that the proven, simpler and more affordable approaches of the ABCs, VCT and ARTs should remain the primary prevention strategy in our region.

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3. Myers A, Myers J. Rolling out male circumcision as a mass HIV/AIDS intervention seems neither justified nor practicable. *S Afr Med J* 2008;98:781-782.
4. Myers A, Myers J. Male circumcision – the new hope? *S Afr Med J* 2007;97:338-341.
5. Sithole B, Mbhele L, Van Rooyen H, Khumalo-Sakutukwa G, Richter L. Only skin deep: Limitations of public health understanding of male circumcision in South Africa. *S Afr Med J* 2009;99:647.
6. Katz IT, Wright, AA. Circumcision – a surgical strategy for HIV prevention in Africa, 2008. *N Engl J Med* 2008;359(23):2412-2415. [doi: 10.1056/NEJMp0805791]