

Missed opportunities for circumcising boys

The UNAIDS *Fast Track: Ending the Global AIDS epidemic by 2030*^[1] circumcision programme is in trouble. After several years of rapid increases, the annual number of circumcisions performed in 8 of the 14 priority countries stayed level or decreased in 2015, dropping to 2.6 million in 2015 (compared with 3.2 million in 2014).^[2] In South Africa (SA), medical circumcisions reached a peak of 500 000 in 2013 and declined slightly in each subsequent year.^[2] This decrease comes in spite of improved surgical infrastructure and high-level marketing.

The Fast Track plan calls for an additional 25 million medical circumcisions in these high-priority countries by 2020. This is an optimistic, probably unrealistic goal that would require increasing circumcisions to 5 million a year, nearly double the current rate. To reach its goals, UNAIDS is counting on programme changes and technical advances in circumcision devices, but the latest setback with Prepex is likely to further disrupt those plans.

After six cases of tetanus following Prepex circumcision, the World Health Organization (WHO) recently recommended a full series of five tetanus immunisations, or two immunisations at least 4 weeks apart, with the second dose at least 2 weeks before Prepex placement.^[3] This will further impede acceptance and utilisation of an innovation that has shown neither safety, efficiencies, or cost-effectiveness.^[4]

The great hope is 'demand creation.' Funding agencies (primarily the Bill and Melinda Gates Foundation) are squarely behind marketing circumcision to men, and demand creation now plays a central role in the Clearinghouse on Male Circumcision (<http://www.malecircumcision.org>). Marketing materials are exclusively focused toward men. However, many African men see circumcision as a rite of passage into adulthood (and not therefore appropriate for them), and a recent survey in Orange Farm suggests that demand creation is not working.^[5]

Data showing who was actually circumcised in 2015 tell the story. In Swaziland, for example, 73% of all circumcisions performed were among boys <15 years of age; in Lesotho, it was 52%, and Botswana, Ethiopia, Kenya, Zimbabwe and Mozambique all reported rates of more than 40%.^[6] In the most recent data from South Africa, 45% of all 2014 circumcisions were among boys <15 years of age. As these data clearly demonstrate, adult circumcision has consistently lagged behind. Four of the high-priority countries – Malawi, Swaziland, Uganda and Zambia – have revised their operational plans to reflect this reality.^[8]

Demand creation is trying to sell something that many men don't want. As those who are motivated get circumcised, it becomes

increasingly expensive and ineffective to attempt to 'sell' circumcision to the rest.^[5] The resources expended for marketing to adult men could be better spent.

It is time for SA to change gears and orient marketing and programmes to males of all ages, but particularly to boys <15 years of age. Circumcising boys who have not been sexually active does not immediately affect the HIV epidemic, but will have the greatest impact on HIV incidence in the long term.^[1] Let's take a lesson from immunisation programmes and not allow for a lost opportunity at any age.

Mothers are an influential but neglected target of circumcision promotion. Our experience is clear: mothers motivate their boys to get circumcised, come to the clinic with them, and spread the word to their friends about the availability of circumcision. The time to change course is now.

Peter S Millard

University of New England, Portland, Maine, USA

pmillard@mac.com

Norman Goldstuck

Department of Obstetrics and Gynaecology, Faculty of Medicine and Health Sciences, Stellenbosch University and Tygerberg Hospital, Cape Town, South Africa

1. Joint United Nations Programme on HIV/AIDS (UNAIDS). *Fast Track: Ending the Global AIDS Epidemic by 2030*. Geneva: World Health Organization, 2014. http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf (accessed 10 October 2016).
2. Joint United Nations Programme on HIV/AIDS (UNAIDS). *Prevention Gap Report, 2016*. Geneva: UNAIDS, 2016. http://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf (accessed 10 October 2016).
3. World Health Organization (WHO). WHO informal consultation on tetanus and voluntary medical male circumcision. Geneva: WHO, 2016. <http://www.who.int/hiv/pub/malecircumcision/male-circumcision-2016-update/en/> (accessed 10 October 2016).
4. Ridzon R, Reed JB, Sgaier SK, Hankins C. VMMC devices – introducing a new innovation to a public health intervention. *J Acquir Immune Defic Syndr* 2016;72(Suppl 1):S1-4. <http://dx.doi.org/10.1097/qai.0000000000000967>
5. Marshall E, Rain-Taljaard R, Tsepe M, et al. Sequential cross-sectional surveys in Orange Farm, a township of South Africa, revealed a constant low voluntary medical male circumcision uptake among adults despite demand creation campaigns and high acceptability. *PLoS One* 2016;11(7):e0158675. <http://dx.doi.org/10.1371/journal.pone.0158675>
6. AIDSInfoOnline. UNAIDS. 2016. <http://www.aidsinfoonline.org/devinfo/libraries/asp/home.aspx> (accessed 10 October 2016).
7. Kripke K, Chen PA, Vazzano A, et al. Cost and impact of voluntary medical male circumcision in South Africa: Focusing the program on specific age groups and provinces. *PLoS One* 2016;11(7):e0157071. <http://dx.doi.org/10.1371/journal.pone.0157071>
8. Hankins C, Warren M, Njeuhmeli E. Voluntary medical male circumcision for HIV prevention: New mathematical models for strategic demand creation prioritizing subpopulations by age and geography. *PLoS One* 2016;11(10):e0160699. <http://dx.doi.org/10.1371/journal.pone.0160699>

S Afr Med J 2017;107(1):19. DOI:10.7196/SAMJ.2017.v107i1.12177