The Drakensberg Declaration of the Pan African Society of Cardiology (PASCAR) calls on national ministries of health in Africa to adopt the A.S.A.P. Programme for the prevention of RF and RHD. This programme seeks to emulate the Cuban and Costa Rican examples through the application of evidence-based approaches to the prevention of the disease on national and continental levels.\(^1\)\(^2\)\(^3\)\(^4\) The occasion of national Rheumatic Fever Week, which was marked by the Minister of Health on 4 - 8 August 2008, provided us with an opportunity to rededicate ourselves to the fight for the eradication of RF and RHD ... ‘in our own lifetime’\(^5\).

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Rolling out male circumcision as a mass HIV/AIDS intervention seems neither justified nor practicable

Two articles\(^1\) published in this issue address male circumcision (MC).

Connolly et al.\(^1\) show in a national survey that MC, whether pre-pubertal or post-pubertal, has no protective effect on acquisition by males of HIV infection as measured by prevalence.

Sidler et al.\(^2\) state that neonatal MC continues to be promoted without adequate justification as a medicalised ritual, via an HIV prevention rationale. They caution that for MC to be a therapeutic as opposed to a non-therapeutic procedure, it is necessary to gather more corroborative and consistent evidence of its benefit, consider the potential harms (psychological, sexual, surgical and behavioural/disinhibition), examine the ethical implications, and examine effectiveness and efficiency (costs and benefits) at the population and societal levels. They point out that MC is not just a technical surgical intervention – it takes place in a social context that can radically alter the anticipated outcome. At the 2008 International AIDS Conference\(^3\) in Mexico cultural, political and educational issues raised by the intervention, such as decreased condom use and marginalisation of women, were hotly debated. Some cultural interpretations may view MC as a licence to have unprotected sex. A case in point is Swaziland, where men are flocking to be circumcised with the understanding that this means they no longer need to use other preventive methods (e.g. wear condoms or limit the number of sexual partners).\(^4\)

The 2003 Cochrane review\(^5\) of observational studies of MC effectiveness concluded that there was insufficient evidence to support it as an anti-HIV intervention. Three randomised controlled trials (RCTs) from South Africa, Kenya and Uganda in 2006 - 2007 show a protective effect of MC. However, Garenne\(^6\) has subsequently shown from observational data that there is considerable heterogeneity of the effect of MC across 14 African countries. Despite the South African RCT showing a protective effect, he reports for the nine South African provinces that ‘there is no evidence that HIV transmission over the period 1994 - 2004 was slower in those provinces with higher levels of circumcision’. Interestingly, in both Kenya and Uganda, where two of the RCTs were done, a protective effect of MC was observed, but a harmful effect was observed in Cameroon, Lesotho and Malawi. The other eight countries showed no significant effect of MC.

These somewhat discordant findings are difficult to interpret. While RCTs are theoretically strong designs, it is conceivable...
that their findings are not generalisable beyond their settings. Furthermore, there have been no trials of neonatal MC. Study flaws such as inability to obtain double blinding, and loss to follow-up in RCTs, may effectively degrade their quality to that of observational studies. Meanwhile other disturbing findings referred to by Sidler et al. are emerging, including the reported higher risk for women partners of circumcised HIV-positive men, disinhibition, urological complications, relatively small effect sizes of MC at the population level, and relative cost-inefficiency of MC.

Not all objections to MC as an HIV intervention have to do with evidence of effectiveness or cost. Sidler et al. raise ethical objections. Owing to the current climate of desperation with regard to the HIV epidemic, evidence in favour of MC frequently seems overstated. This reduces the scope for informed consent and autonomy for adult men considering the procedure. Further problems arise in the case of neonates whose parents may be considering the procedure. Whereas informed consent is at least possible for adult men, it is clearly not possible for neonates. Parents can only guess what the child’s wishes would be if he were presented with the information they have at their disposal. If it could be shown that circumcision was necessary in the neonatal period, parental consent on behalf of the neonate would be justified. In the absence of compelling indications, a procedure such as circumcision could also be seen as a violation of the child’s right to bodily integrity. Furthermore, the ethical principle of non-maleficence cannot be upheld as there are clear harms attached to this practice, to which Sidler et al. refer in their article. Lastly, at a societal level MC may be unjust insofar as it could compete for resources with more effective and less costly interventions’ and disadvantage women.

Despite a strong pro-circumcision lobby driven by enthusiasts who have been promoting MC as an (HIV) intervention for many years, and impatience expressed by protagonists about the long delay after the 2006 - 2007 RCT results and the UNAIDS/WHO policy recommendations of March 2007, few mass campaigns have been launched in African countries.

Given the epidemiological uncertainties and the economic, cultural, ethical and logistical barriers, it seems neither justified nor practicable to roll out MC as a mass anti-HIV/AIDS intervention.

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