VOLUNTARY MEDICAL MALE CIRCUMCISION

Considerations for Policy and Practice

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Introduction

Voluntary medical male circumcision (VMMC) is currently being rolled out as an HIV prevention strategy in southern and eastern Africa. Studies have found a significant association between VMMC and reductions in HIV infection in men [1, 2, 3]. Evidence from three randomised controlled trials in Africa showed VMMC reduced HIV incidence in heterosexual men by up to 60% [4]. Consequently, in 2007 the WHO and UNAIDS issued recommendations that VMMC be implemented in countries with a generalised HIV epidemic and low circumcision prevalence [5, 6]. A total of 13 countries were identified in southern and eastern Africa as high priority countries for rapid VMMC scale-up [6].

VMMC interventions focus predominantly on men, but it also has important implications for women [7, 8, 9]. Currently, there are no known direct or short term benefits of VMMC for women [7]. Over the next 10-20 years however wide-scale roll-out of VMMC has the potential to lead to decreasing HIV prevalence in both men and women, by averting new infections in men and onward transmission to their female partners [10]. However concerns remain around sexual disinhibition where the protective effect of the circumcision may be negated by risk related behavioural changes [11, 12]. In view of the on-going scale up of VMMC, the following policy brief provides policy guidelines for including VMMC as a safe and sustainable HIV prevention strategy.

Recommendations

- *Respect for human rights*. Adherence to medical ethics and human rights principles in the delivery of VMMC is essential. Health services offering male circumcision should ensure that the procedure is voluntary, based on informed consent and confidential. Policies and programmes for HIV reduction through VMMC should be designed with the best interests of men and women in mind. These should also respect individual's rights to participate in decision-making.
- *Gender equity*. One of the key concerns relating to male circumcision is the potential for sexual disinhibition. Circumcision may provide a false sense of protection resulting in the adoption of unsafe sexual practices such as decreased condom use and multiple

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sexual partnerships by men. These behaviours may ultimately place women at greater risk for HIV infection [11, 12]. At a broader level it may also have implications for sexual decision making. Gender-based violence and stigma for women could also result due to the misperception of men that circumcision implies a permanently negative HIV status and that they cannot transmit the virus [13].

- *Integrated package of HIV prevention services*. There is need to integrate VMMC with other services to ensure that it has a long-term effect in reducing HIV infection. These programmes need to take into account the potential impact of VMMC on women and other vulnerable groups and include this dimension as part of a comprehensive HIV prevention programme. VMMC provides men only partial protection from HIV acquisition and should be understood as only one element of HIV prevention [6]. Essentially VMMC needs to be situated within a package of sexual and reproductive services including comprehensive gender transformation interventions, sexuality education and condom promotion as a complementary HIV prevention methods. These comprehensive services should also empower women to be involved in sexual decision-making including contraceptive use and encourage communication between partners.
- *Provision of safe male circumcision services*. Governments should ensure that health facilities are equipped to provide safe medical male circumcision according to the WHO's minimum health standards. VMMC requires trained staff, clean medical facilities, equipment and medication. Facilities should comply with infection control and establish systems for follow up post circumcision. The capacity of health systems should be strengthened at national, regional, district and health sub-district to effectively provide safe male circumcision services.
- *Human resources*. At an operational level sufficient financial resources in addition to a supportive health system with trained and available medical staff are required. Countries should utilise existing human resources to support VMMC scale-up such as retired nurses and medical students. Scale-up of services may also require task-shifting to accelerate the scale-up of VMMC services [6].
- *Information and communication*. Factual information around VMMC including its advantages, disadvantages and risks for both men and women should be clearly communicated through policies, plans and media. The benefits of VMMC are relative and the challenge will be to formulate communication strategies to reinforce this point. A comprehensive communication strategy on VMMC should be developed in collaboration with public institutions and NGOs.
- *Cultural sensitivity and collaboration*. Male circumcision has longstanding religious

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and traditional associations. In many African communities (and globally), circumcision is indicative of the transition to manhood and practiced by many ethnic groups. However some traditional male circumcision practices - such as using only one knife to circumcise several boys or encouraging sexual intercourse soon after circumcision and before complete wound healing (WHO recommends no sexual intercourse for six weeks) - may actually increase exposure to HIV [14, 15]. As such, governments must clearly distinguish between traditional and medical male circumcision in regions where traditional male circumcision is practiced. VMMC policies and programmes should integrate medical training and procedures with traditional practices. This can include training of traditional surgeons on issues such as infection control; regulating the activities of traditional male circumcisers; and providing safer medical equipment and circumcision kits [16].

- *Strategic partnerships for VMMC delivery.* In light of the human and financial resource challenges in Africa, strategic partnerships are required at local, national and global levels in order to successfully meet VMMC targets. Partners can provide or facilitate technical assistance to support programme implementation and scale-up.

Conclusion

The development of national strategic plans for voluntary medical male circumcision in countries with high HIV prevalence rates should be encouraged. This discussion should involve various stakeholders including traditional practitioners and religious groups. Public information campaigns should be developed that clearly communicate the risks and benefits of voluntary medical male circumcision in the context of HIV prevention. Specific focus should be directed towards ethical and human rights issues with voluntary medical male circumcision in the context of research and in practice. All research, policy and interventions need to give consideration to the direct impact on women, and ensure that they are not placed at increased risk of HIV infection. Ideally VMMC should include comprehensive sexual and reproductive services that target both men and women and should include counseling, testing and treatment and gender transformative education.

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