

# Kenya launches a consortium on male circumcision as country heightens war on AIDS

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A five year project, dubbed the Male Circumcision Consortium (MCC) designed to expand and improve safe, voluntary male circumcision (MC) services, with the aim of reducing the number of HIV infections in the country has been launched.

This follows a recent study by Dr. Robert Bailey, an epidemiology professor from the University of Illinois, among nearly 3,000 HIV-negative men in Kisumu the result of which showed that MC reduced the risk of HIV infection by 53 percent. The MCC will work to create a male circumcision research and training centre in Kisumu to train providers, build the capacity of health facilities, and monitor clinical outcomes. They will train the "trainers of MC providers" and establish male-circumcision training teams (MCTT) that will train and monitor MC providers in the public and private sectors of Nyanza. MCTT will train MC providers at 12 health facilities- 3 in Kisumu East, 3 in Kisumu West, and 6 in Nyando. The facilities will be equipped and facilitated to provide MC services through fixed and outreach services. Another MCC goal is identifying and addressing any controversies or misunderstandings about MC. Male circumcision is one of the new potential methods being proposed for use in the fight against HIV and AIDS, that affects sub-Saharan Africa where of the 32.2 million people living with HIV globally, nearly 22.5 million of them are located in Africa's sub-Saharan nations. Kenya has close to 1.5 million people living with HIV and AIDS. Other methods being used are vaginal microbicides, pre-exposure prophylaxis with antiretroviral medication, herpes suppressive therapy, cervical barrier methods and HIV vaccines. The tissue of the internal foreskin absorbs HIV up to nine times more efficiently than female cervical tissue, mainly because it contains Langerhans and other HIV "target cells" in much greater quantities than the cervix or other genital tissue (including other parts of the penis). In addition, the internal foreskin has a mucosal surface, as opposed to the more hardened skin like surface of the external foreskin. This mucosal surface is particularly susceptible to tears and abrasions, and, consequently, infection by STDs and HIV. The AIDS Vaccine Advocacy Coalition (AVAC) states that "male circumcision could also provide a new way to reach men and adolescent boys who are frequently under-represented in health clinics and HIV-prevention programs." MC will be offered as part of a comprehensive HIV prevention strategy. The preventive effect could be offset by high-risk behaviour, where patients assume that circumcision gives full protection against HIV. There is a dire need then to educate people on the benefits and risks of circumcision. The Male Circumcision in Siaya and Bondo Districts, found that "during first year, men did not engage in more risky sexual behaviours than uncircumcised men, suggests that any protective effect of male circumcision on HIV acquisition is unlikely to be offset by an adverse behavioral impact." However, a South African study, conducted by the National Institute for Communicable Diseases, reported that circumcised men engaged in slightly higher rates of high-risk acts than did men in the control group. Clearly, there needs to be more research on this issue to assess the risk in order to counter it. Nevertheless, the emphasis should be on circumcision as part of a preventative package, alongside other methods. The WHO and UNAIDS point out that "communities, and particularly men opting for the procedure and their partners, require careful and balanced information and education materials that underline that male circumcision is not a "magic bullet" for HIV prevention but is complementary to other ways of reducing risk of HIV infection." The cultural practice of circumcision will form a barrier to the implementation of this strategy, where particular tribes are circumcised, while others are not. The WHO and UNAIDS emphasises that "broad community engagement is required to introduce or expand access to safe male circumcision services." They call for the need for "countries and institutions promoting male circumcision for HIV prevention to ensure that it is promoted and delivered in a culturally appropriate manner that minimizes stigma associated with status." Male circumcision serves as a rite of passage, marking the men from the boys. This has dangerous effects when associated with tribal groups, as can be imagined. There is a need then to play down the cultural connotations, as the WHO and UNAIDS point out, but also pander to them, as such ingrained beliefs would be difficult to shift. The WHO and UNAIDS suggest that "countries and international development partners should involve traditional practitioners in places where they perform male circumcision." There is a similar complex dichotomy operating in The Aids Vaccine Advisory Coalition advice, where they promote separating the procedure from its tribal connotations, but also suggest introducing the traditional into the clinical. The AVAC states that "programs offering male circumcision must be sensitive to the different meanings and the procedure, delineating its use as a strategy for HIV risk reduction separate from its uses as marker of religious or tribal affiliation." Yet, it also promotes that there is a need to "consider the roles of traditional male circumcision practitioners as conveying critical messages and potentially adapting the practice to ensure safety and efficacy for HIV prevention." This conflict in separating the traditional from the clinical and introducing the traditional into the clinical creates a concern whether both can be achieved simultaneously in real life. It seems there may be a case of a lack of feasibility in the policies that stand to date. However, some studies suggest that it is not even a barrier. The AVAC states that "in the studies that have taken place, education about the possibility that male circumcision could reduce the risk of HIV infection appears to have been well-received at the community level, regardless of cultural or traditional attitudes in the surrounding area. The trials enrolled rapidly in both Kenya and Uganda." A reproductive health program in central Kenya, where MC is traditionally performed on adolescents, is building upon cultural values and incorporating preventive health education with clinical circumcision. This hospital-based program for adolescent boys is an adaptation of the traditional one- to two-week period of seclusion following MC. Cultural practices can be replaced by medical procedures. These studies suggests that culture is not really a barrier, whereas the AVAC, WHO and UNAIDS emphasis the need to address the cultural tradition that accompanies circumcision. The rite of passage that circumcision culturally signifies means that it is

not performed at birth, which is the best medically. The WHO and UNAIDS advise that “since neonatal circumcision is a less complicated and risky procedure than circumcision performed in young boys, adolescents, or adults, such countries should consider how to promote neonatal circumcision in a safe, culturally acceptable and sustainable manner.” Clearly, there will be a conflict in interests, where the medical stance stands in opposition to the traditional one. The promotion of neonatal circumcision will have to overturn embedded beliefs. The difficulty of promoting it in a “culturally acceptable” manner can be understood. It is also the cultural belief that you should not be going to hospital to get circumcised, but at home. Integrating the traditional into the medical or replacing the traditional with the medical will not be an easy process. Traditional male circumcision runs the risk of infection with HIV through non-sterile surgical procedures where the same knife is used from procedure to procedure. It would also be performed by nonmedical professionals. Similarly, it may be conducted in different ways with differing results from a small cut to complete removal of the foreskin. These all form barriers to the provision of safe male circumcision that reduces the risk of transmission of HIV for men. The cost of service poses a barrier to patients, where the WHO and UNAIDS identifies that “the cost of service at the point of delivery can be a barrier to men seeking safe male circumcision services and needs to be addressed.” One estimate, based on experience in Kenya, puts the cost at approximately US\$25 per procedure (using the forceps-guided method). However, implementation of male circumcision will offer critical data that can pinpoint cost-effectiveness ratio for different settings. Like in most developing countries, access is a major issue that amplifies the necessity that implemented strategies are cost-effective. The WHO and UNAIDS assure that “based on early studies, the cost-effectiveness of male circumcision is comparable to other HIV prevention strategies.” The AVAC emphasises the issue of funding, where “WHO and UNAIDS should be fully funded to provide necessary leadership and technical assistance.” However, they point out “as important as these steps are, they are not sufficient. Neither WHO nor UNAIDS are implementers and the world has already witnessed the failure of funders and implementing groups to meet the “3 by 5” target that these groups set for treatment access, which aimed for 3 million individuals on antiretroviral treatment by 2005.” The Policy on Male Circumcision released by the Ministry of Health, in January 2008, even claimed that the “MOH has been instrumental in provision of safe male circumcision services but on a limited scale. Current resources however cannot meet the anticipated demand.” The common troubling barrier of financing crops up yet again in terms of health services in Kenya, where here groups should collaborate in the effort to provide a safe male circumcision service. The AVAC claims that it “is committed to working with partners to advocate for new resources to support programs that follow WHO/UNAIDS recommendations and address local community concerns.” Kenya’s limited resources quite obviously cause much concern in the introduction of this strategy. The AVAC points out the necessity for “every effort should be made to minimize the diversion of resources from other sectors of the AIDS response and/or sexual and reproductive health programs, to male circumcision.” WHO and UNAIDS suggest that “simpler and safer methods for performing male circumcision in resource-limited settings, including the use of suture-less, blood-free procedure and devices, need to be developed and addressed. This can help tackle the financial strain and health-risks that accompany the procedure, especially in a country where sanitation is not at the highest level.