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Male circumcision has no role in the Australian HIV epidemic

Key points:

- There is no demonstrated benefit of circumcision in men who have sex with men.
- Correct and consistent condom use, not circumcision, is the most effective means of reducing female-to-male transmission, and vice-versa.
- African data on circumcision is context-specific and cannot be extrapolated to the Australian epidemic in any way.

Background:

Male circumcision is a surgical procedure that involves the removal of all or part of the foreskin from the head of the penis. It is an ancient practice that has been performed in some cultures for millennia – well before the advent of sterile surgery.¹ It has ritual significance in some cultures, and so its practice may be ceremonial, performed with non-surgical instruments by elders rather than doctors, and without anaesthesia.² It is an irreversible procedure. Different cultures have performed the rite at different stages of life: commonly in preadolescence as part of a ritual of becoming a man; sometimes for older adult men as a sign of status; and in more recent history, in infancy. Cultural identity may also be entwined with non-circumcision.³

In the twentieth century in industrialized countries such as Australia and the United States, circumcision became very popular for reasons that are not clear but do not appear to be directly related to religious or specific ethno-cultural affiliation. This trend was reversed in Australia in the 1980s and 90s due to increased acceptance that circumcision provided no medical benefit.

Recent data from three major trials in Africa challenges the notion that it is of no benefit. Adult male circumcision has been found to reduce the risk of acquiring HIV in men by around 55-60% in three randomised controlled studies^{4 5 6}. These trials were conducted in African countries where HIV is endemic – Uganda, South Africa and Kenya. Heterosexual vaginal intercourse is the predominant mode of HIV transmission in these countries. Circumcision did not provide complete protection against HIV, but researchers concluded that circumcision reduced the risk of HIV acquisition in the study groups. While there were high rates of HIV

¹ Aggleton P. (2007) 'Just a snip?': A social history of male circumcision', *Reproductive Health Matters*; 15 (29): 15-21: 15: 20.

² Niang, Cl. & Boiro, H. (2007) 'You can also cut my finger': Social construction of male circumcision in West Africa, a case study of Senegal and Guinea-Bissau'. *Reproductive Health Matters*. 15 (29): 22-32: 31: 32.

³ Ibid.

⁴ Auvert B., Taljaard D., Lagarde E., Sobngwi-Tambekou J., Sitta R., et al (2005) 'Randomized, Controlled Intervention Trial of Male Circumcision for Reduction of HIV Infection Risk: The ANRS 1265 Trial'. *PLoS Medicine*, 2 (11) e298 doi:10.1371/journal.pmed.0020298.

⁵ Gray H., Kigali G., Estrada D., et al. (2007) 'Male circumcision for HIV prevention in young men in Racial, Uganda: a randomised trial', *Lancet*, 369:657-66.

⁶ Bailey C., Moses S., Parker CB., et al. (2007) 'Male circumcision for HIV prevention in young men in Kyushu, Kenya: a randomised controlled trial', *Lancet*; 369: 643-56.

acquisition in both arms of these studies – the circumcised and the uncircumcised – rates were lower in the former group⁷.

Following the release of these trial results UNAIDS and the World Health Organisation held an international consultation to analyse the data and consider policy implications. Mass circumcision programs are being proposed throughout the sub-Saharan region.⁸ While consideration is being given to making such programs culturally sensitive, the proposed implementation of male circumcision raises complex moral problems relating to cultural practice, gender equity, informed consent, and the just allocation of limited resources.

The Australian epidemic

In Australia, receptive anal intercourse is the predominant mode of HIV transmission. There has been some research into whether circumcision status makes a difference in terms of HIV acquired through insertive anal sex, but this research has shown no difference between the two groups.⁹ **Therefore, circumcision is NOT an HIV risk-reduction strategy for men who have sex with men.** (Further research from the Health in Men Study will be reported at the IAS conference in Sydney in July 2007.)

Circumcision to reduce HIV risk for heterosexual men in Australia?

The USA has a growing heterosexual epidemic and very high rates of circumcision¹⁰. Circumcision does not prevent HIV – in high prevalence areas it *reduced the risk* of female-to-male transmission. HIV acquisition rates were nevertheless high in both the circumcised and the non-circumcised groups involved in the trials.

The African epidemic

There is some division of opinion as to whether circumcision programs should be implemented in Africa. UNAIDS and the World Health Organisation have accepted that the data show a population-level benefit of circumcision. However, there are social and ethical arguments against such programs, such as:

- A partially effective technology may adversely affect condom use and negotiation;
- Partial efficacy is a difficult concept to communicate to obtain informed consent;
- Risk behaviour may increase as a result of perceived invulnerability to infection
- Women aged 15-24 are at the greatest risk of HIV acquisition and circumcision and circumcision programs will not reduce infections in women directly for at least 10-20 years;
- Circumcision may reduce women's ability to negotiate condom use;
- Circumcision is a complex cultural practice;
- Circumcision status may become a marker of HIV status, as circumcision of HIV positive men is not being proposed;
- Ritual circumcision itself may be a route of HIV transmission;
- Good penile hygiene (washing under the foreskin) may be as effective in reducing the risk of acquiring HIV and STIs as circumcision in uncircumcised men;^{11 12}
- Circumcision has a 2-10% incidence of complications; and
- If circumcised men have sex before wound-healing their vulnerability to HIV infection increases.

⁷ The incidence in circumcised men was 0.7- 1.0 per hundred person years. 'Male circumcision for HIV prevention: Research implications for policy and programming WHO/UNAIDS technical consultation 6-8 March, conclusions and recommendations' (excerpts). (2007) *Reproductive Health Matters*, 15 (29): 11-14:12.

⁸ 'New data on male circumcision and HIV prevention: policy and programme implications', (2007) WHO/UNAIDS.

http://data.unaids.org/pub/Report/2007/mc_recommendations_en.pdf

⁹ Grulich, A., Hendry, O., Clarke, E., Kippax, S., Kaldor, J. (2001), 'Circumcision and male-to-male transmission of HIV', [Research letter] *AIDS*; 15 (9): 1188-89.

¹⁰ Of the estimated 665 million men worldwide who are circumcised, 13% are men living in the USA who are neither Muslim or Jewish, see Hankins, C. (2007) 'Male circumcision: Implications for women as sexual partners and parents', *Reproductive Health Matters*; 15 (29): 62-67: :63.

¹¹ O'Farrell, N., Morison, L., Moodley, P., Pillay, K., Vanmali, T., Quigley, M., *et al.* (2006) 'Association Between HIV and Subpreputial Penile Wetness in Uncircumcised Men in South Africa', *JAIDS Journal of Acquired Immune Deficiency Syndromes*, September; 43(1): 69-77. HIV prevalence among uncircumcised men without penile wetness was close to that of circumcised men (42.9%).

¹² Hankins, Op Cit: 62.