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ROUNDTABLE

The New Evidence on Male Circumcision: An Indian Perspective

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THE detection of the first cluster of sex workers with HIV in India was in 1986, and Phase I of the National AIDS Control Programme of India was launched in 1992. Although the estimated number of those infected is second only to South Africa, the adult HIV prevalence in India is still low (0.9%).¹ India's success in prevention and control of HIV infection can best be attributed to coverage by comprehensive, targeted interventions among all "at risk" sub-populations, such as sex workers, injecting drug users and to some extent men who have sex with men and migrant workers; strengthening sexually transmitted infection (STI) clinics; and implementation of strategies to enhance blood safety and community involvement.

The HIV epidemic in India is heterogeneous and varies by geographical areas and sub-populations. Of its 35 states and union territories, six states are designated as high HIV prevalence, based on HIV prevalence amongst antenatal (>1%) and STI (>5%) clinic attendees. These include the peninsular states of Maharashtra, Andhra Pradesh, Karnantaka and Tamil Nadu and the north-eastern states of Nagaland and Manipur. However, isolated pockets of high prevalence are present even in other parts of the country. Excepting the northeastern states, where HIV largely spreads through injecting drug use, 85% of HIV transmission is through sexual contact, with heterosexual transmission the predominant route of transmission. Though a recent study has reported a decline in the HIV prevalence rate in South India,² a small increase in

prevalence translates into very large numbers because of the total population size. This is easily compounded by an environment of stigma, which keeps HIV and AIDS under cover and is a barrier to effective prevention and treatment efforts. The epidemic in India is yet to mature, which means an increased investment in prevention today could avert a potential socio-economic and public health crisis in future. The focus of prevention both on the part of the public health system and NGO partners, up to the present time, has been on behaviour change communication, condom promotion and treatment of STIs.

Now, the compelling evidence of the role of male circumcision in reducing the acquisition by circumcised men of HIV³⁻⁵ has introduced a new dimension to the prevention armamentarium. Its advantage over other prevention options, such as condom promotion and behaviour change, is that it is a one-time intervention that does not have issues of adherence or sustaining change that constrain other strategies. However, it would be wrong to consider it as a "magic bullet". Male circumcision should be provided as part of a comprehensive HIV prevention package which includes correct and consistent use of male and female condoms, reduction in the number of sexual partners, delaying the onset of sexual debut, STI management and HIV testing and counselling. International health organisations and some donor agencies are now encouraging countries with high HIV prevalence and low male circumcision

rates to provide male circumcision through public health programmes.⁶

Nevertheless, the promotion of a procedure that has profound cultural implications, risks of biological and social complications, and benefits that are realised only one or two decades later and only when a high population coverage has been achieved, and is only partially protective, presents a formidable public health and political challenge. Consideration by countries of local sensitivities and practices before embarking on such a programme is warranted.

Could male circumcision be introduced successfully in India?

The important question that arises in relation to India is this: given the evidence and need, can male circumcision be introduced in India as a prevention option? Male circumcision is strongly identified with religion in India. It is only practised among Muslims, who constitute over 13% of the population, which amounts to a large number in a country of over one billion people.⁷ Male circumcision is considered a marker of religious identity and proof of belonging to a religion. The significance of this is compounded by stories of men (albeit anecdotal) being identified as Muslim or Hindu during communal strife according to whether or not they were circumcised, with their lives hanging in the balance. The potential negative response due to this religious connotation will need to be responded to with great sensitivity.

Despite the efficacy of male circumcision, protection would depend upon its uptake by most communities. Cultural and religious beliefs, attitudes and perceptions will have a major impact on its acceptability. Typically, in India, the burden of sexual and reproductive health has been borne by women, with male participation being very low. Current condom use is 5% and vasectomy rates are 1%.⁸ Worse still, vasectomy is more likely to be accepted if at all by older men⁹ and those whose wives are more literate.¹⁰ Whether younger men who have not revealed their risk behaviours will now come forth to adopt a procedure that would help to protect them would perhaps require a sea-change in thinking.

Research on male circumcision in India, whether social or bio-medical, has been non-existent. The only study carried out amongst a

cohort of men attending STI clinics suggested a biological rather than a behavioural explanation for the protective effect of male circumcision against HIV.¹¹ Interestingly, it revealed that male circumcision can protect against HIV but not against classical STIs, emphasising the importance of behaviour change strategies among circumcised men. There are no data available on current practices, facilities available or complications of the procedure. In the rural and also perhaps in the urban areas, circumcision is carried out largely by unskilled traditional providers, who could be the local religious priest or barber. Further, given the size and scale of India, there may be regional differences in practices. Most of what is known about circumcision practices is through hearsay and in the first instance, there is a need to mount multi-site studies to get a clearer understanding of what is happening on the ground.

Besides research on social, cultural and religious practices and beliefs, attitudes towards and understanding of the benefits of this intervention will need to be studied in both circumcising and non-circumcising communities in India to guide introduction of this intervention. Qualitative data on barriers to acceptance would guide development of communication messages and help in sensitising communities. Modeling of data for States reporting a generalised HIV epidemic and cost-effectiveness studies will help in undertaking advocacy with policymakers.

The WHO/UNAIDS recommendation for countries like India, where HIV is largely concentrated in specific population groups, is that there would be a limited public health benefit of promoting male circumcision in the general population.⁶ Nonetheless, men at higher risk for acquiring infection, especially those living in states reporting a generalised HIV epidemic, would benefit from it and there is a need to provide them with correct and context-specific information, that should include the risks and benefits of male circumcision. For this, non-governmental organisations, community-based organisations, professional organisations and Ministries of Health could be involved in developing and disseminating communication messages providing this information. Initially, this information could be given in the high prevalence states, to those with multiple sexual

partners and STI clinic attendees, so that a voluntary demand for the procedure is generated. Based on this experience, information dissemination can be widened to other groups and communities.

The voluntary demand for male circumcision may be small to begin with, considering the cultural and religious sensitivity and corresponding issues of acceptability. The Indian public health delivery system will need to be sensitised to this new indication for circumcision, so that the demand can be met through provision of quality counselling and surgical services. Male circumcision services should be integrated into the District Health System and can easily be made available up to the first referral unit level, which covers a population of 100,000. Provision of safe male circumcision services in primary health care would also enhance access to quality services for the circumcising Muslim community. Systems would need to be developed and put in place for monitoring quality of care, safety and complications, not only in the public sector, but also in the private health sector, which addresses 80% of the health care needs of the population.¹² Given the stigma attached to HIV and AIDS, a major concern is whether those accepting this intervention stand a risk of being labelled as at higher risk for HIV exposure. A major challenge then would be the positioning of this intervention so as to avoid this stigma.

Analogy to the vasectomy programme in India

The only surgical intervention analogous to male circumcision for public health benefit in India was the vasectomy programme, carried out in the late 1960s and early 1970s. It is critical that countries embarking on a male circumcision programme benefit from the lessons

learnt from this vasectomy programme. Vasectomy was supposed to become the main method of family planning in India and was promoted and implemented aggressively. A range of means was used to encourage men to be sterilised, which included outreach to men at their workplaces, in rural communities using mobile units, vasectomy “camps” and “festivals”, special clinic hours, settings that were considered more appealing to men, and incentive payments. Additionally, there were incentives and disincentives that could potentially have an impact on acceptance.¹³ Men were not adequately counselled on the risks and benefits of the procedure and any concerns regarding the procedure and its safety were not addressed. The public health system was not sufficiently strengthened in terms of provider training and necessary infrastructure development. In some places, the procedure was reportedly carried out under unhygienic conditions, and deaths were reported due to tetanus and infection.¹⁴ Reports of compulsory vasectomy and low quality operations started making the rounds, leading to protests and uproar. This resulted in a dramatic drop in the number of vasectomies performed. Even today, more than 30 years later, the programme has not been able to recover. The vasectomy rate in India continues to be abysmal.

To conclude, male circumcision as an HIV prevention intervention is likely to pose major challenges in its promotion, acceptance and programmatic implementation in India. However, to begin with, information about male circumcision as one of the range of HIV prevention tools, may potentially be more acceptable to STI clinic attendees and those with “at risk” sexual behaviour. Using the experience gained from the vasectomy programme in planning the strategic implementation of male circumcision in primary health care may enhance its acceptability.

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