Cut to the chase: quickly achieving high coverage male circumcision

David Griffith, Benjamin Bellows and Malcolm Potts

J. Epidemiol. Community Health 2007;61;612-

Updated information and services can be found at:
http://jech.bmj.com/cgi/content/full/61/7/612

These include:

Rapid responses
You can respond to this article at:
http://jech.bmj.com/cgi/eletter-submit/61/7/612

Email alerting service
Receive free email alerts when new articles cite this article - sign up in the box at the top right corner of the article

Notes

To order reprints of this article go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to Journal of Epidemiology and Community Health go to:
http://journals.bmj.com/subscriptions/
**SPEAKER’S CORNER**

Cut to the chase: quickly achieving high coverage male circumcision

Three randomised control trials on male circumcision (MC) in South Africa (November 2005), and in Uganda and Kenya (December 2006), have now confirmed what a growing body of evidence has indicated for more than 15 years: MC reduces human immunodeficiency virus (HIV) infection by around 50%. In 1999, Halperin and Bailey published an article, “Male circumcision and HIV infection: 10 years and counting.” Over the preceding decade, considerable evidence had accumulated that MC reduces the risk of HIV acquisition in previously uninfected men. In the eight years since that article, additional studies have only underscored this relationship. However, no large-scale, systematic effort has yet taken up the challenge to translate this science into preventive strategies.

Are there barriers to roll out MC? MC is cost effective. Kahn et al estimate that, in a South African adult population, MC costs $181 (£90.52; €133.43) per HIV infection averted, which compares favourably with treatment for sexually transmitted infections in Uganda and for safe motherhood and family planning in Kenya. In both these programmes, vouchers for MC could be added, and the appropriate providers contracted and trained within a few months.

Given the results of the randomised control trials, it is now high time to make MC available to the poor in countries with high HIV prevalence. A voucher scheme would be the most efficient way to do this quickly.

David Griffith  
Health Consultant, Heidelberg, Germany

Benjamin Bellows  
School of Public Health, University of California at Berkeley, Berkeley, California, USA

Malcolm Potts  
School of Public Health, University of California at Berkeley, Berkeley, California, USA

Correspondence to: Mr B Bellows, 140 Warren Hall, School of Public Health, University of California at Berkeley, Berkeley, CA 94720, USA; bbellows@berkeley.edu

References


