



## Cut to the chase: quickly achieving high coverage male circumcision

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## 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%.<sup>1-3</sup> In 1999, Halperin and Bailey<sup>4</sup> 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*<sup>5</sup> 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 for HIV prevention, and voluntary counselling and testing services.

Predictably, MC arouses strong emotions. As with condoms to protect against HIV, or oral contraceptives to prevent unwanted pregnancy, the accusation is always made that the introduction of a new method of protection will lead to increased sexual licence. The evidence suggests otherwise. Kawango *et al*<sup>6</sup> conducted a study among 324 recently circumcised men and 324 uncircumcised men in Kenya to determine the effect of circumcision on sexual behaviour. The researchers found that, during the first month after circumcision, men were 63% less likely to report having 0-0.5 risky sexual acts weekly than uncircumcised men. The differences in sexual risk disappeared during the remainder of the follow-up period, and the researchers concluded that, during the first year, circumcised men did not report an increased number of risky sexual acts compared with uncircumcised men.

While the world waits to act, patients from Uganda to Swaziland who can afford the operation are seeking this biological "vaccine".<sup>6,7</sup> The result is that men who can afford it are already protecting themselves, whereas the poor either cannot access MC or are going to unsafe and untrained providers.

We think an efficient and socially equitable way to make this intervention available across large geographical areas, while ensuring that the poorest men could participate, would be to use an output-based aid (OBA) voucher programme.

The OBA approach contracts providers at agreed prices for clearly stipulated outputs, and then sells vouchers to clients for, in this case, MC services. The voucher is marketed at a nominal price, and entitles the client to treatment at no additional cost from approved providers. The provider is paid according to the number of clients served. The payment represents a realistic unit cost for the procedure covering staff fees and the costs of drugs and materials.<sup>8,9</sup>

An independent voucher management agency is appointed to run the system, and its activities include identifying, training and approving service providers, marketing and distributing the vouchers, claims processing and payments, and maintaining

the quality of the service, as well as monitoring and evaluating the system.

An entirely new cadre of MC specialists may not be needed. Given the simple surgical procedures, it is reasonable to assume that a variety of paramedical, and even non-medical, operators may be able to provide safe MC under OBA. In many parts of the world, MCs are not done by highly trained doctors, but by religious and traditional leaders. Serious consideration could be given to including them in a well-controlled OBA scheme.

Voucher schemes are already functioning for treatment of 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.

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