

IPPF Medical Bulletin

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IMAP Statement on male circumcision and HIV

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Introduction

An estimated 39.5 million people are living with HIV/AIDS in the world. 70% of these people live in Sub-Saharan Africa. Worldwide in 2006, 4.3 million were newly infected. Among young men, 70% of infections are acquired through vaginal intercourse. Three randomised controlled trials have now shown that the risk of HIV acquisition in heterosexual men is substantially reduced by male circumcision in adult life. This procedure therefore offers a potentially important public-health intervention for HIV prevention.

The randomised trials, conducted in South Africa, Kenya, and Uganda, were begun after observational studies in Sub-Saharan Africa and South-East Asia revealed strong inverse relations between national HIV prevalence rates and the prevalence of male circumcision. Such inverse relations were not seen universally, being absent in countries where male HIV infection was primarily associated with injecting drug use and/or anal intercourse among men having sex with men.

The trials showed that circumcision, performed by well-trained medical professionals, reduced the risk of HIV infection by about 60% in men engaging in vaginal sex. The degree of protection was remarkably consistent not only across these trials but also with the observational data reported from diverse settings. Already the World Health Organization and UNAIDS have responded by issuing policy and programme recommendations. Technical guidelines and rapid assessment toolkits for countries considering instituting male circumcision programmes are under development.

It is important to note that male circumcision does not protect completely against HIV; it should be considered as a strategy additional to existing interventions. Research continues on other aspects of circumcision – for example, a study in Uganda on its effect on male-to-female transmission of HIV and other sexually transmitted infections (STIs) and its safety and acceptability in HIV-infected men. Other potential HIV prevention methods, such as vaginal microbicides, pre-exposure prophylaxis with antiretroviral medications, herpes suppressive therapy, cervical barrier methods, and HIV vaccines, are under development.

Male circumcision – prevalence and procedure

Male circumcision (removal of the foreskin from the head of the penis) is one of the most common surgical procedures in the world: about 30% of males undergo the procedure at some point in their lives, for reasons including religion, tradition, and hygiene. HIV apart,

medical benefits claimed for the procedure include lower rates of urinary tract infection in infancy, of sexually transmitted genital ulcer disease, and of penile cancer and decreased transmission of the human papillomavirus. In global terms the major determinant is religion, but substantial numbers are circumcised for cultural reasons. In a neonate or infant, superficial wound healing occurs within a week, but in an adolescent or adult it may take as long as six weeks. Detailed information on the procedures for male circumcision can be found in the Manual on Male Circumcision under Local Anaesthesia prepared jointly by WHO and UNAIDS (2007).

Adverse outcomes

Short-term complications of male circumcision include excessive bleeding, haematoma formation, meatitis (inflammation of the opening of the urethra), and adverse reactions to anaesthetic agents. Some men report increased sensitivity of the glans penis for the initial months. Complication rates depend on the setting (medical or non-medical/traditional), person operating (medical or traditional), age of the client (infant or adult), surgical technique or instrument used, and availability and quality of follow-up.

Also to be considered is the possibility that, until healing of the epithelium, the wound site offers a portal for HIV entry and heightens the risk of HIV transmission.

Long-term adverse effects – decreased sensitivity during intercourse, erectile dysfunction – have been reported but little evidence exists to substantiate these.

Mechanism of protection

Several biological mechanisms have been proposed to explain the protective effect of male circumcision against HIV acquisition. The foreskin's inner mucosal surface may be more susceptible to HIV because close to the surface it has immunological cells (Langerhans cells) that are targets for HIV. The higher susceptibility of the uncircumcised may also be due to the presence of small mucosal tears (possibly occurring during sexual intercourse) that allow entry of HIV during intercourse. Also, the foreskin traps HIV next to the mucosal surface of the glans, providing a moist environment conducive to viral survival and possibly thus increasing the likelihood of infection.

Implementation challenges

The protective effect of male circumcision against HIV acquisition must now be translated into practice, and this presents special challenges in low-resource settings. Those who contemplate adding it to prevention strategies in regions of high HIV prevalence (where it has greatest potential to reduce the number of new HIV infections) must first consider the human-rights, sociocultural, and legal implications.

Human rights

Communities where male circumcision is introduced have a right to reliable information about its role in HIV prevention. Men requesting circumcision should receive comprehensive information about the risks and potential benefits of the procedure, including the fact

that protection is only partial and that they will have to abstain from sexual intercourse until the wound has healed completely. Additional information on HIV prevention must be provided, to ensure that consent is truly informed (informed consent being a prerequisite for this as for other services). The client must also be assured of confidentiality, there must be no coercion, and quality of care must be maintained at all times.

Neonatal or adult circumcision?

Neonatal circumcision is considerably safer and less expensive than adolescent or adult circumcision. Since the baby cannot make an informed choice, a decision must be made by the parents in his best interests; and, for this purpose, they should be given comprehensive information on the risks and benefits of the procedure. When circumcision is contemplated in a young boy or in an adolescent below the legal age of consent, that person should be supported in making the decision together with his parents.

Legal considerations

Service providers should be aware of the legal age of consent, and of the specific requirements relating to which services can be independently sought by a young person. Where the laws and policies are unclear, an adolescent who is mature enough to understand the risks and benefits of the male circumcision procedure should be encouraged to seek parental or adult support, failing which the service should be provided.

Sociocultural considerations

When male circumcision services are to be introduced or expanded, the sociocultural issues to be considered will depend on the existing prevalence of circumcision. Strong cultural values concerning the practice will affect client perceptions. Community engagement will be helpful in gaining acceptance; and, in regions where male circumcision is performed for cultural or religious reasons by traditional practitioners, ways must be found to ensure the safety of these procedures (which if done without proper hygiene can themselves carry a hazard of HIV transmission).

Messages about male circumcision should be culturally appropriate, to make sure that the procedure carries no stigma. Circumcised men themselves need to be quite clear that the operation has provided only partial protection against HIV acquisition; and, for the same reason, a woman should never accept that male circumcision eliminates the need for a condom.

Human resources and infrastructure needs

A service for male circumcision may exceed the financial and human resources of a Member Association. The associated costs include those for training of service providers, the supply of commodities, and safety monitoring; service providers should actively collect data on complications to ensure that the procedure continues to be performed safely and well.

Communication

An important general message is that, for the individual HIV-negative man, the benefit from circumcision will be modest unless at the same time he reduces the number of his sexual partners and uses condoms correctly and consistently.

One communication issue that needs highlighting is the difference between male circumcision and female genital mutilation. Female genital mutilation, which has serious effects on women's sexual and reproductive health, dignity, and autonomy, has no known medical benefits.

Male-to-female transmission of HIV

Whether male circumcision reduces the sexual transmission of HIV from men to women is not yet known. Preliminary results from a randomised controlled trial among HIV serodiscordant

couples in Uganda showed no significant difference in the rates of transmission from circumcised and uncircumcised men. However, data from the same trial suggest that circumcised HIV-positive men who resumed sexual activity before certified wound healing were more likely to transmit HIV than those who abstained until healing was complete. The safety and acceptability of circumcision in HIV-infected men are under continuing study. On existing evidence, the procedure can be justified if there are medical indications, though the likelihood of postoperative complications is increased by the presence of severe immunodeficiency.

Public-health benefit of male circumcision

The population-level impact of a male circumcision programme is potentially greatest in regions with a high prevalence of heterosexually transmitted HIV, a low prevalence of male circumcision, and a large population at risk of HIV. Substantial population benefit is unlikely without circumcision of a large proportion of the men.

Integration of male circumcision with other sexual and reproductive health services for men

If a male circumcision service is to be provided, it should be added to the existing package of proven methods for HIV prevention, which includes: promotion of delay in the onset of sexual relations, abstinence from penetrative sex, reduction in the number of sexual partners, and correct and consistent use of male or female condoms; provision of HIV testing and counselling; and treatment services for sexually transmitted and opportunistic infections (see Figure 1). Efforts to encourage correct and consistent use of condoms should be continuous, to lessen the potential for further exposure to HIV.

For many men, consultation with a circumcision service will be their first contact with a health service provider. The encounter is thus an opportunity to strengthen and expand HIV prevention and sexual health programmes for men. It also provides a means to reach a population that is not normally served. Male circumcision programmes could also provide a channel between men and the health concerns of their partners and families, including counselling for safer and responsible sexual behaviour, STI/HIV prevention and management, and also family planning. Male circumcision programmes should emphasise education and behaviour-change communication, promoting shared sexual decision-making, changes in gender norms and roles, and gender equality. It also provides a platform to inform men about malignancies of the male reproductive system, with a view to early detection and more effective treatment.

Information on male circumcision can be integrated into existing programmes for outreach, peer education, and behaviour change communication. It is not only clinical facilities that should give information on the risks and benefits; such information should be available also in non-clinical settings such as community-based services.

It is important to maintain broader commitments in the response to HIV, especially with regard to addressing social inequalities that fuel the epidemic, such as gender inequality and HIV-related stigma.

Future research

Further randomised controlled trials of male circumcision cannot be justified ethically, because the protective effect is now certain. However, additional research is required to inform the further development of circumcision programmes. Such projects might include:

- Research into the resources needed for, and the most

effective ways to expand, male circumcision services of good quality

- Follow-up and acceptability studies post-circumcision, to address the issue of disinhibition (increase in HIV risk behaviour)
- Research to determine the longer term effects on perceptions of HIV risk in men who are circumcised for HIV prevention, and in their communities.

What can Member Associations do?

Key considerations

Member Associations who contemplate introducing a male circumcision service should take into account the following:

- The interest of the community in such a service, and its likely acceptability
- Current HIV prevalence and principal mode of transmission
- The capacity of the Member Association to provide other surgical services: where male and female sterilisation are already offered, male circumcision will be easy to introduce in terms of infrastructure and supplies
- The possibility of finding operational partners for provision of sustainable male circumcision services.

Information, education, and communication

Information about male circumcision should address men, women, and young people receiving sexual and reproductive health services. Again, stress should be placed on the continuing need for safe sex practices in those who undergo the procedure.

Member Associations should assess current male circumcision

practice in their region and devise culturally appropriate and acceptable communication strategies.

Counselling

In both preoperative and postoperative counselling, the client should be advised not to resume sexual activity until the wound has healed. An unhealed wound may increase the risk of HIV acquisition; moreover, if the client is already HIV-positive, his sexual partner may be at greater risk of infection during this phase.

Services

Member Associations should provide integrated and comprehensive sexual and reproductive health and HIV related services in which voluntary HIV counselling and testing, prevention and management of HIV infection, prevention of mother-to-child transmission of HIV, promotion of safe sex options (including correct and consistent use of condoms, and limiting the number of sexual partners), and STI diagnosis and treatment are the mainstays of prevention efforts. Male circumcision can be included as an additional component.

Advocacy

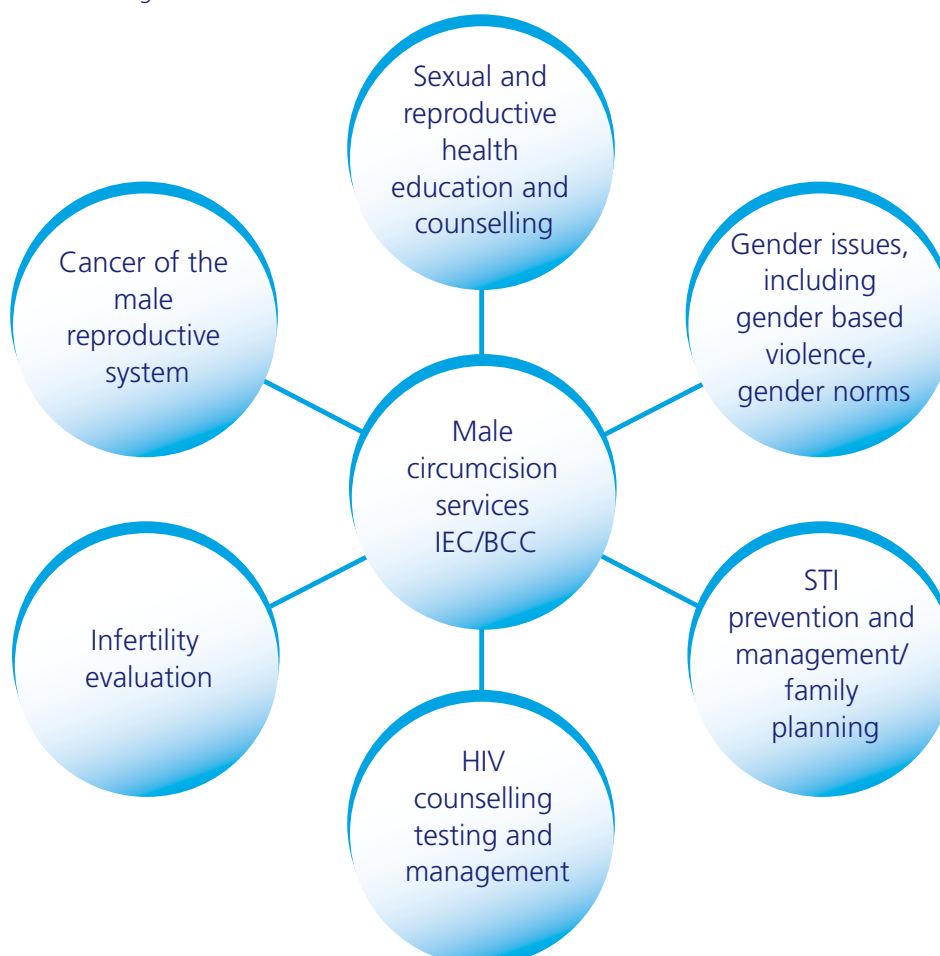
Member Associations considering the introduction or expansion of male circumcision services for HIV prevention need to be aware of, and respect, national laws, regulations, and policies.

Partnerships are a key element in strengthening programme implementation and delivery. Member Associations should build and strengthen their partnerships with other organisations at global, regional, and local levels.

Figure 1: Integration of male circumcision with male sexual and reproductive health services

IEC=Information, education, communication

BCC=Behavioural change communication



Access to emergency contraception

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The introduction of emergency contraception (EC) has been a difficult and long process in many countries and a matter of public debate almost everywhere. Nevertheless, through the efforts of numerous agencies, researchers, women's health activists, and government authorities, the availability of this method has increased substantially and specific products are now registered in 112 countries.¹

Barriers to access

An important social and cultural barrier has been the erroneous perception that the method is an abortifacient; this led to strong opposition from the Catholic Church and "prolife" groups. Others are: conservative attitudes to sexuality; a fear (unfounded) that EC would encourage promiscuity; poor sexual education and lack of information about EC; failure to acknowledge sexual and reproductive rights; and gender conflicts.

Access to EC is affected by scarcity of information about the method, by fears among some health providers and pharmacists of potential "misuse", and by unsatisfactory service conditions, particularly in developing countries. Many countries require a medical prescription that delays timely use of EC and increases its costs, pharmacies may not stock EC dedicated products or boycott their sale, and the high prices of dedicated products jeopardise access, particularly for adolescents.

Lawsuits against the regulatory bodies or the health ministries have been initiated by "prolife" groups in most Latin American countries, where the opponents of EC have argued that national constitutions protect human life from fertilisation onwards.²

Factors that facilitate access to EC

Committed professionals and women health activists have disseminated information about EC among professional groups and the general public, and have lobbied health authorities to include EC in national guidelines and to deregulate dedicated products. Dissemination of information to the general public has been achieved by distribution of educational materials in health centres or through non-governmental organisations (NGOs), by involvement of mass media, and via internet websites. The media were especially influential in countries where there was strong opposition to EC, helping to disseminate information that otherwise might not have reached the public.

Coordination between stakeholders has been essential. For example, in Latin American countries the introduction of EC has involved health authorities, NGOs, medical associations, scientific societies, women's health advocates, opinion leaders, and mass media. Such efforts undoubtedly helped counteract the opposition of the Catholic Church. Measures that have improved access to EC include: registration of dedicated products by pharmaceutical companies or NGOs; over-the-counter sales; social marketing strategies that reduce costs for poorer women; a non-prescription hospital-based programme; advanced provision of EC pills; and the inclusion of EC in national guidelines.

Training of healthcare workers and pharmacists, an essential step to guarantee access to EC, has been conducted through topic-specific workshops, by inclusion of EC in regular contraceptive courses, and in other training activities related to sexual and reproductive health and rights.

Current availability

Registered products

By last year, dedicated products for EC had been registered in 112 countries – 83% of the countries in Europe, compared with 14% in Australasia and the Pacific Islands. Of the 59 dedicated products, 44 are pills containing 0.75 mg levonorgestrel, 11 are pills containing 0.5 mg levonorgestrel, and 4 are combined pills containing 0.25 mg levonorgestrel and 50 µg ethinylestradiol. In around 50 of the 112 countries EC products are available only by medical prescription, but in the other half they are sold in pharmacies without such requirement or by a collaborative drug therapy agreement – that is, behind the counter or over the counter.

National guidelines for family planning and/or sexual violence and provision of EC in public health services

According to information available from the Consortia for Emergency Contraception, differences exist between regions in these matters. Of 53 African countries, 11 have included EC in their national guidelines, although dedicated products are available in another 25. Of 46 Asian countries, 11 have included EC in their national guidelines or other types of governmental health documents and in another 23 countries dedicated products are on the market. Out of 35 American and Caribbean countries, 19 include EC in their national guidelines and 23 have dedicated products. EC is provided exclusively in the public services in 4 countries in Africa, 8 in Asia, 8 in America, and just 1 in Europe. However, in the majority of countries EC is provided through IPPF affiliates, NGOs, and private clinics or sold in pharmacies.

Conclusions

Despite the controversy, the majority of countries have registered EC dedicated products, have included EC in national guidelines for family planning or sexual violence or both, and have made it available in public services, in NGOs clinics, through social marketing, or in pharmacies. However, important obstacles still remain. Efforts in the future should be focused on implementing laws, policies, programmes, and guidelines that ensure easier access to EC, especially for adolescents, poor women, and women who have suffered rape. Advocacy for non-prescription sales, and for availability of a dedicated product free of charge or at low cost in public health services, should continue. Priorities are information to policymakers and training of healthcare providers, pharmacists, and teachers.

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