

Circumcision Denialism Unfounded and Unscientific

To the Editor: Although three RCTs¹⁻³ and dozens of observational studies have confirmed that medical male circumcision reduces the risk of HIV acquisition in men by at least 60%,⁴ Green et al.⁵ continue to question its effectiveness and would deny millions of men—and their female partners—a proven, permanent, and inexpensive method to reduce their lifetime risk of HIV infection. Such denialism in the face of the ongoing pandemic are unethical and immoral.

The argument that the clinical trials of medical male circumcision lack external validity because of ideal counseling conditions and condom promotion is nonsensical because both study arms were equally exposed to those noncircumcision interventions. The concern that the effect is not durable is not supported by evidence from the Kenya trial showing that the protective effect of medical male circumcision was sustained—and actually strengthened—at 54 months of follow-up.⁶ Outside of study settings, a wealth of ecologic data shows that countries with widespread male circumcision consistently have low HIV prevalence. In West Africa where nearly all men are circumcised, HIV has been circulating for more than 80 years. Yet, as is true of all countries where male circumcision is nearly universal, no country in that region has an adult HIV prevalence greater than 6%.⁴

Advocates of medical male circumcision are not arguing for—as Green et al.⁵ suggest—a “shift from condom use to reliance on circumcision for HIV prevention.” Medical male circumcision has been integrated into the WHO’s recommended prevention package of HIV testing and counseling, treatment for sexually transmitted infections, and provision and promotion of safer sex practices, including condoms.

Medical male circumcision also benefits women. In addition to protection from *Trichomonas vaginalis*, bacterial vaginosis, herpes simplex virus, and cervical cancer, a recent meta-analysis found that “circumcision may confer a 46% reduction in the rate of HIV transmission from circumcised men to their female partner.”⁷ Further, the population effect, or herd immunity, means that with fewer HIV-infected men, far fewer women would be at risk.

With respect to the concern that men might engage in riskier sexual behavior after circumcision, data from the three RCTs¹⁻³ and a prospective cohort study⁸ found no overall increases in risk behavior following circumcision. Among the Kenya RCT participants, Mattson et al.⁹ found that risk behavior actually decreased over the

course of 12 months. While Green et al.⁵ attempt to stall efforts to scale up medical male circumcision by citing debunked arguments,¹⁰ modeling reveals that in sub-Saharan Africa alone, widespread circumcision could avert up to 2 million new HIV infections and 300,000 deaths over the next 10 years, many of those among women.¹¹ The urgency has never been more apparent or the evidence more clear: Further delay is counter-productive. Deliberate misrepresentation of data, broad generalizations, and poor understanding of research methodology undermine efforts to prevent millions of premature deaths annually. It is time to mobilize sufficient resources to provide safe and widespread medical male circumcision in high-HIV-burden countries.

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