

EDITORIAL

Doesn't the public have the right to know that male circumcision protects against HIV?

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In 2007, the ethical landscape surrounding medical male circumcision (MC) suddenly lurched and shifted when the World Health Organization and UNAIDS declared unequivocally that the "efficacy of male circumcision in reducing female to male transmission of HIV has been proven beyond reasonable doubt." (1) With that declaration, the Government of India and healthcare providers were suddenly faced with a new ethical question: Don't people have the right to know that male circumcision protects against HIV?

Interestingly, evidence that MC had medical benefits has been mounting for more than 20 years. Not only does the procedure reduce the risk of HIV infection, it also has been shown to prevent urinary tract infections (2), sexually transmitted diseases (3), and penile and prostate cancers (4-6). Researchers have even found that MC reduces the risk of cervical cancer in current female partners (7). In spite of that growing list of medical benefits, the issue has hovered just below the radar screen until several large randomised controlled studies from Africa showed that circumcision offered a 60% to 70% protective effect against the heterosexual acquisition of HIV (8-10). The evidence was so compelling that three of the studies were stopped early, on the recommendation of Data Safety and Monitoring Boards (1).

Evidence that MC offered protection against HIV was not limited to Africa. In a large study of patients attending sexually transmitted infection clinics in India, the National AIDS Research Institute (NARI) found that circumcised men had a lower risk of HIV-1 infection than uncircumcised men (11). Their findings suggested that the reasons were biological rather than behavioral since the male foreskin has been shown to have a high number of cells that were targeted by the HIV virus. Based on those findings researchers suggested that "where culturally acceptable, clinical trials should be a public health priority to assess the safety and effectiveness of medical male circumcision for the prevention of HIV transmission."

Not surprisingly, the Government of India has been reluctant to approach an issue that promises to be controversial among conservative Hindus. MC is considered a marker of religious identity since Muslims routinely circumcise their male children, and Hindus do not. It has been suggested that at times, circumcision status may even have been used to identify people's religious affiliation during communal riots (12). Popular wisdom holds that even the mention of MC in some communities will trigger sectarian violence. Predictably, some opponents have argued that the greater good of society must be protected by withholding information about MC from the population.

If there was one government agency that might be expected to champion what is one of only two proven methods (along with ART prophylaxis for prevention of mother to child transmission of HIV) to slow the HIV epidemic, it would be the National AIDS Control Organisation (NACO). Perhaps predictably, the organisation charged with addressing India's HIV/AIDS epidemic has flatly refused to consider MC trials. Director General K Sujatha Rao was uncharacteristically terse in describing her reasons. "It's a sensitive matter," she explained (13). Nomita Chandhiok, the Deputy Director General of the Indian Council of Medical Research (ICMR), and RR Gangakhedkar, Deputy Director of NARI, on the other hand, took a more courageous stand on what is undeniably a controversial issue in a roundtable in *Reproductive Health Matters* (12):

The voluntary demand for medical 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 sensitized to this new indication for circumcision, so that the demand can be met through provision of quality counseling 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.

How much should we worry that the simple mention of MC will incite people to riot? The research on acceptability of MC in India is sparse, but there are data to suggest that this is an unlikely scenario. One study in Mysore among 795 women with male children showed that after women were informed about the risks and benefits of medical male circumcision, an overwhelming majority of non-Muslim women (n = 534, 82%) said they would definitely circumcise their child if the procedure were offered in a safe hospital setting free of charge, and a smaller number (n = 45, 7%) said they would probably consider MC for their son.

Only three non-Muslim women (0.5%) said that they would definitely not consider circumcision, and 49 (8%) were unsure (14). Interestingly, authors suggested that most mothers, including Hindus, were intensely interested in the intervention because it offered protection against HIV for their children. Another study among doctors in South India found that while many physicians were guarded about recommending preventive circumcision to the general public, most were willing to suggest it to patients with sexually transmitted infections (15). Obviously, limited inferences can be drawn from just these two studies, but the data do suggest that ignorance may be a greater danger than well executed research into the acceptability of MC in a broad range of communities in India.

Will the government accept the prognostications of the nay sayers or conduct serious research to answer the compelling cultural questions around acceptance of MC? The ICMR has announced a collaboration with NARI to conduct future studies in Lucknow, Karnataka, Maharashtra and West Bengal (16) but has not been forthcoming about how they intend to carry out such studies. While they should be congratulated for courage in moving forward, more transparency would go a long way to making the results of such studies credible when they are reported.

While the government dithers, do we as physicians have an ethical responsibility to inform our patients about MC if we know it has substantial medical benefits and could prevent conditions like renal failure, cancer, and HIV? In many ways, MC is similar to a vaccine that prevents life-threatening diseases like diphtheria, whooping cough, and measles. How many of us would shy away from promoting immunisation because our patients might have misconceptions about vaccines? We as doctors are often in possession of information and training not available to our patients. As Milind Deogaonkar has argued persuasively, "the doctor-patient relationship is inherently unequal, placing added responsibilities on those providing care" (17) As he notes, this responsibility is even more important in India where patients often have only the most rudimentary understanding of the issues facing themselves and their families.

The relationship between a doctor and a patient is governed by the principle of autonomy. Patients have a fundamental right to make informed decisions about their health. Of course, the biggest challenge to this autonomy is the asymmetry of information between the care provider and their client. To paraphrase Mclean, autonomy is only meaningful if the doctor provides all the information necessary for the patient to make an un-coerced and informed choice between alternative therapies (18). In this case, while there is no obligation to promote MC, we do, as physicians, have a responsibility to share a balanced picture of the risks and benefits of the procedure. The decision on whether to opt for circumcision rests with our patients.

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