Dear Editor,

Two recent editorials disparaging voluntary medical male circumcision in your online newsletter this week are replete with uninformed conclusions that could undermine efforts to scale-up one of Malawi's most protective and cost-effective HIV prevention strategies.

In his article ***"Malawian circumcised men most likely to be infected by HIV, research shows",*** the author, Mr. Mike .J. Kangwele, expressed his concern over allocation of US$ 15,000,000 towards VMMC (voluntary medical male circumcision) campaigns. He asserts research findings show that circumcision of men does not reduce their HIV risk, but rather increases their chances of contracting HIV. Unfortunately Kangwele conflates the protective potential of voluntary medical male circumcision with that of traditional male circumcision, which often is less protective.

There is a significant difference between traditional male circumcision and VMMC. VMMC is the surgical removal of the foreskin, which is the thin layer of skin that extends over the tip of the penis (performed by trained medical personnel who are trained in internationally accepted standard surgical methods). On the other hand, traditional male circumcision usually involves incomplete removal of the foreskin. As a result, the HIV protective benefits of traditional circumcision are less.

The Malawi Health and Demographic Survey from 2010 quoted in the article states that the HIV prevalence rate was higher among circumcised men compared to their uncircumcised counterparts ages 15-49yrs. However, it is important to note that 85% of those men who reported to have been circumcised were traditionally circumcised. This means that they did not get the full protection of medical male circumcision and hence they were at higher risk of HIV infection. Malawi's VMMC program was in its infancy during the time of the survey, so little protective benefit would have been measurable at the time.

The same government report, quoted by Mr. Kangwele, states that HIV prevalence rates for both circumcised and uncircumcised men varied with age: HIV rates were higher among younger uncircumcised men as compared to circumcised men within the same age groups. Mr Kangwele's conclusion that circumcision is associated with higher HIV numbers conveniently disregards these findings.

It is important to underscore VMMC's proven effectiveness in preventing HIV and its potential as a key component in the goal to end AIDS. Undisputable research has shown that medical male circumcision reduces HIV risk by 60% and even more so over time. This means that men who undergo medical male circumcision are 60% less likely to contract HIV as compared to those who are not circumcised. Consequently as men's risk of HIV drops, women are less likely to encounter an HIV positive partner. This indirect protection for women eventually extends to the population as a whole. VMMC is an inexpensive, once in a lifetime procedure that keeps on protecting.

Malawi was supposed to perform 1.3 million male circumcisions in 14 priority districts over a period of 5 years in order to reach 80% of uncircumcised men. However, due to a reduction in VMMC resources the target number has dropped to 60%. Globally VMMC is one of the HIV prevention interventions

experiencing a reduction in resource allocation, a development that could have negative effects on HIV prevention efforts. Mr. Kangwele is correct, procurement of drugs to treat sick people, including HIV positive people, is imperative. But HIV prevention is equally important. As such, the two complement each other. Now is not the time to be stirring false controversy around medical male circumcision, one of Malawi's best HIV prevention strategies.

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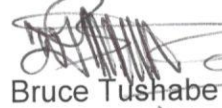

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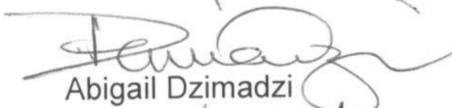

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