

place and who performs it. However, data from Nyanza, Kenya suggest that circumcision can be done in medical facilities for about US\$ 25 per procedure. This includes US\$ 8 for medical expendables such as sutures and needle, bandaging and analgesics, US\$ 7 for surgical preparation (preparing the room, cleaning linens, sterilizing instruments, and US\$ 10 in overheads (physician's fee, maintenance of room and equipment). Professor Tom Quinn from Johns Hopkins University told the 2006 Conference on Retroviruses and Opportunistic Infections that he calculated that 16 operations would prevent one incident HIV infection over 10 years. The cost per HIV infection averted could be as low as US\$ 1052, if protection occurs in both sexes, making circumcision extremely cost effective.

The current position of WHO is that safe circumcision should be provided where people want it but that a policy decision on whether to promote it should wait until the results of the Kenya and Uganda trials are available. In the meantime a UN Work Plan on Male Circumcision is being implemented to help countries improve the safety of their circumcision practices. WHO has produced a technical manual, *Male circumcision under local anaesthesia*, which addresses the provision of safe male circumcision services for newborns, adolescents and adults and gives detailed technical information on the different surgical approaches.

### How could male circumcision protect against HIV?

Male circumcision is the surgical removal of all or part of the foreskin of the penis. There are several biological explanations as to why this operation may reduce the risk of HIV infection. Removal of the foreskin reduces the ability of HIV to penetrate the skin of the penis. In addition, on the underside of the foreskin are located many special immunological cells such as Langerhans cells which are prime targets for HIV. Another possible explanation is that small tears in the delicate skin of the inner surface of the foreskin during sexual intercourse could allow a portal of entry for HIV. Men with a foreskin are more prone to have some infections, including sexually transmitted infections, which can enhance HIV transmission. Male circumcision is associated with a much lower risk of penile cancer. Several studies now suggest that female partners of circumcised men have a lower risk of cancer of the cervix. Other benefits include prevention of inflammation of the glans and foreskin (balanitis) and prevention of scar tissue causing an inability to retract the foreskin (phimosis).

If the two ongoing trials are positive then governments in sub-Saharan Africa may want to decide whether to commit funds to train medical staff and provide appropriate equipment and facilities. Dr Puren says: "It will put further stress on a health-care system already straining to roll out an ARV (antiretroviral) programme."

Bailey warns: "People want the services. If they are not provided with the services they will seek unqualified practitioners who will exploit the situation. We have to build the capacity to provide safe and affordable services." Venter adds: "There are already long queues for circumcision in South Africa so there will need to be careful planning. We need to train more people to carry out the operations safely. There is no need for doctors to do it. It is a simple procedure that trained technicians could carry out."

When should circumcision take place? One option would be to promote routine circumcision of infants, possibly as part of the antenatal care package. Botswana, in fact, took a policy decision to offer this some years ago but it has not been implemented. Circumcising at this age would reduce the complications that result from traditional circumcision rites in adolescence. But the major benefits of preventing HIV infections would take more than 20 years to be realised.

The other alternative is to offer circumcision through health facilities, and possibly schools and youth centres to young men before they become sexually active. Dr Venter believes a proactive recruitment programme should be carried out. "We need to incentivize circumcision. For example every man who comes forward should be given 100 rand (US\$ 14.50)." ■

Jacqui Wise, *Cape Town*

## WHO coordinates health provision for quake survivors

Days after a devastating earthquake hit two Indonesian provinces, 6000 health workers from across the country were dispatched to the disaster zone. To help Indonesian Government efforts to provide emergency health care, WHO has been coordinating dozens of international organizations and charities to aid survivors.

Within hours of a 6.2 magnitude earthquake that hit the Indonesian provinces of Yogyakarta and Central Java on May 27, a massive relief effort, comprising both Indonesian and overseas organizations, got under way. A fortnight after the quake, approximately 75 international nongovernmental organizations (NGOs), and more than 10 government teams and UN agencies had sent personnel and supplies to the stricken region to support the Indonesian Government's own relief efforts.

WHO's role was as the lead agency of the Health Cluster, set up in June 2005 as one of the key components of wider humanitarian reforms within the UN. At the country level the Health Cluster's role is to coordinate the health response. The Cluster system proved successful in the South Asia earthquake in 2005. In Indonesia,

this approach helped to involve most of the NGOs engaged in relief efforts in efforts to assist the two provincial health authorities, as they grappled with the aftermath of the quake: over 5700 dead, nearly 38 000 injured, 470 000 dwellings damaged or destroyed and 1.5 million people affected.

"WHO's main role is supporting the Indonesian Government in its work responding to the emergency situation, particularly on human health-related concerns, and WHO has been in close relationship in supporting the work of the Ministry of Health (MoH)," says Dr Arturo Pesigan, Head of the Health Cluster in Yogyakarta.

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Dr Arturo Pesigan, Head of the Health Cluster in Yogyakarta.

Unlike the December 2004 tsunami which devastated the province of Aceh, the area affected by the 27 May earthquake was far more localized. It has been easier to obtain accurate numbers related to its effect on the population and therefore an easier task for government agencies and NGOs to get aid to where it is needed. The rapid government response is also, arguably, related to the region's importance, whereas Aceh is on the periphery, the island of Java represents the heart of Indonesia and Yogyakarta is the spiritual and cultural centre of the island.

"Yogyakarta and Central Java provinces have not been overwhelmed. At the national level the earthquake was not even declared a national disaster. Indonesia didn't call for international assistance, but welcomes it," says Charlie Higgins, the UN's Area Coordinator in Yogyakarta. "The government rapidly moved in 6000 health workers from within Indonesia to reinforce local structures," he adds.

The experience of responding to the aftermath of the tsunami — although on a much larger scale to the disaster caused by the May earthquake — stood WHO in good stead to respond to the current emergency, says Pesigan, who is also the Regional Advisor for Emergency and Humanitarian Action from WHO's Office for the Western Pacific Region.

"Like we did in the tsunami, WHO supported the immediate establishment of the crisis centre for the provincial level health response. It was crucial to establish good coordination mechanisms with the government and all the players in the health sector. WHO mobilized its team within a few hours. Vehicles and essential supplies were immediately dispatched. Preparedness strengthened from the tsunami experience facilitated the establishment of a logistics system that readily provided personnel, transport, equipment, medicines and supplies and support was immediately provided from the country office, the regional office and headquarters," Pesigan explains.

The WHO-coordinated health response is split into several main areas: hospital and medical services; communicable disease surveillance and response; immunization; logistics and health supplies; medical emergency supplies management; mental health,



WHO/SEARO: Mir Gunawan

The local deputy mayor in the village of Banyusocha launches a campaign for vaccination. The village is in the district of Gunungkidul, one of the hilly areas of Yogyakarta struck by the earthquake.

water/sanitation and reproductive health; and maternal and child health. Two weeks after the earthquake struck, the emphasis had already shifted from providing emergency medical care to addressing secondary health problems.

The large number of orthopaedic injuries and the risk of disease are the main medical issues. There has been an increase in the number of tetanus cases reported. "Surveillance for communicable diseases is one of the priority concerns of the WHO, the MoH and the Health Cluster," says Pesigan.

A few days after the earthquake struck, WHO urged donors to make sure their donations were appropriate before shipping them, as sending the wrong items could hamper rather than help the relief effort. Still, donated drugs which are unfamiliar to the

country's medical staff, flooded into the area, presenting a logistical challenge to local health officials.

This has led to a request for donations of only locally procured drugs from now on, and the Indonesian Government has also announced that the only shortfall in terms of personnel is orthopaedic specialists, it is also short of orthopaedic medical supplies and equipment.

As the effort to clear rubble and begin the process of housing reconstruction gets under way, the risk of exposure to tetanus increases. In coordination with the Ministry of Health and UNICEF, WHO is implementing a plan to immunize the entire over-15 population in the affected area — some 1.3 million people — with a booster dose of tetanus-diphtheria.

Children aged six months to five years will be vaccinated against measles. Vitamin A is also being distributed.

Although water supplies and sanitation were affected by the earthquake, there have been no major health problems associated with the lack of water. UNICEF is coordinating efforts to distribute over 320 000 litres of water and set up the estimated 31 000 latrines that are required.

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Higgins. UNICEF is also responsible for education and temporary tent-based schools have been set up in order

to maintain some semblance of continuity in education, pending the government’s reconstruction of the 400 schools affected.

However, with hundreds of thousands of people made homeless, reconstruction of housing will be a mammoth task, as is the provision of temporary shelter in the meantime. According to the UN Office for the Coordination of Humanitarian Affairs (OCHA), there are estimates of emergency shelter coverage for only 12 of the approximately 80 sub-districts in the

two affected provinces and even where coverage is known, it is only 65% on average.

Basic food assistance is being provided by the Indonesian Government in the form of rice rations, supplemented with World Food Programme fortified noodles and biscuits. The quake affected an area of rich farmland that produces a surplus of food, but caused only limited damage to irrigation, says Higgins.

In the medium term, food supplies are expected to recover, but, in the short term, there have been inevitable bottlenecks: “There have been reports in the media about problems of delivery of food. Some gaps in sanitation have been identified. There were also complaints of waiting lists in hospitals,” says Pesigan. “Though there may be problems, the concerted efforts of the national and international agencies have been working hard to address the deficiencies.” ■

Jane Parry, *Hong Kong SAR*

## Clinical trials initiative: patients or patents?

The pharmaceutical industry fears that WHO’s clinical trials initiative may limit companies’ ability to compete and dent profitability, as compliance — which is voluntary — will mean having to apply for patents earlier than they currently do. Some companies have pledged to adhere to the recommendations, nonetheless. Others may resist.

WHO’s newly proposed rules on the disclosure of data when researchers register clinical trials they are planning has drawn a mixed reaction from corporations, academic and other institutions funding pharmaceutical R&D.

The pharmaceutical industry fears that companies may refrain from doing R&D in certain fields, firstly, because they would not want to make sensitive information public too early — as required under the initiative — as it would become available to their competitors, and secondly, if they are unable to protect their innovations with patents.

The International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) stated clearly it does not agree with the final vision WHO presented on 19 May of how the International Clinical Trials Registry Platform (ICTRP) initiative will work (see *Bulletin* Vol. 84, No. 6, June 2006) but that it was prepared to work with WHO to develop a new concept that addresses these industry concerns.

“Whilst the industry shares other stakeholders’ concerns about ensuring adequate transparency,” IFPMA Director Harvey Bale tells the *Bulletin*, “it believes that the WHO position is a reflection of the views of some stakeholders, but it is not a consensus”.

“The IFPMA, in conjunction with its member associations and companies, will work with the WHO, national drug regulatory authorities and other stakeholders to reach a final consensus position on the ICTRP,” Bale says, noting that the Geneva-based industry association had launched its own “transparency platform”, the IFPMA Clinical Trials Portal, in 2005, which

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it would continue to develop in the meantime.

For Dr David Korn, Senior Vice President in the Biomedical and Health Science Research division of the Association of American Medical Colleges, the reaction to what he called a “bold” and “frankly unexpected” move to include early phase trials, comes as no surprise. “In all of my interactions with industry leaders, they have always argued that disclosure of early phase

research, often dubbed ‘hypothesis-generating’, as contrasted with ‘hypothesis-testing’, would be unacceptable to them,” he says.

Guy Willis, IFPMA Director of Communications, cites as daily preoccupations of industry players: fierce competition, shareholder expectations, and, above all, the crucial issue of patentability — a weakening of which could dent profits.

Patents are the life blood of the R&D-driven segment of the industry and a company’s ability to stake a claim with a new product, a key