

Adolescent boys: who cares?

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The paper by Bailey et al.¹ in this issue of the *Bulletin* is the first to systematically investigate adverse events following traditional male circumcision. It highlights the frequency of lingering and permanent sequelae, including sequelae that likely impair sexual functioning. In one of the few other studies that has explored this issue, between 2001 and 2005, the Eastern Cape province of South Africa recorded 1748 hospital admissions, 177 deaths and 107 genital mutilations/amputations following circumcision.²

Despite this significant morbidity among adolescents and young men, it is surprising that so little attention has been paid to the complications of traditional male circumcision by most organizations.

Globally, 30–34% of men are circumcised.³ Most of these circumcisions are performed for cultural or religious reasons during adolescence, outside formal health-care settings, without anaesthesia and in challenging traditional settings. Within sub-Saharan Africa, this is a particularly important issue within the context of current efforts to “scale-up” male circumcision services for HIV prevention.⁴ There, depending on the country, 15% to 80% of men are circumcised.⁵ These circumcisions, when done in adolescence, as in Bungoma, Kenya, are typically practiced as part of “rites of passage” ceremonies, as the adolescent moves from childhood to manhood. The ceremonies, variable from society to society, often last for weeks and are held under secretive circumstances. They may include instructions on how to behave as men and responsible community members and deliberately test the adolescents’ ability “to be men” – their tolerance to pain – but factors sometimes associated with the circumcision, such as cold, hunger or dehydration, are also challenging. Circumcision is performed without anaesthesia, often using a single cutting instrument (of unknown sharpness and sterility) for multiple boys,

without the use of sutures to prevent haemorrhage.

The populations affected seem very aware of the consequences.^{6,7} Of initiates in South Africa, 70% expected complications to occur,⁸ and pain is particularly feared.⁷ Although not wanting to lose the traditional activities that surround circumcision, parents are also aware of the high likelihood of significant complications occurring and many would prefer that their sons be circumcised in the formal health-care system.^{6,7,9}

Male circumcision provides partial protection for men against acquiring HIV infection through heterosexual sex, about 60% effectiveness at two years of follow-up,³ with one study now showing protection over 42 months of 64%.¹⁰ Countries in sub-Saharan Africa are developing strategies to make male circumcision part of a comprehensive strategy for HIV prevention. The critical question is how to increase young men’s access to and use of safe male circumcision services.

Bailey et al. show that the focus of these efforts should not only be on traditional circumcising communities but also on the formal health-care setting, the focus for interventions in countries and communities where there is high HIV prevalence and low male circumcision prevalence. Here, too often, there is currently insufficient training, supervision, hygiene, equipment and supplies. That the adverse event rate of 35.2% in traditional settings was twice the rate of 17.7% in medical settings is scarcely comforting.¹ WHO and UNAIDS recognize that services must be safe and have developed a variety of guidance documents and training tools (available at: www.who.int/hiv/topics/malecircumcision/en/index.html) while international partners are addressing additional needs, including ways of working with the private sector and supplying appropriate surgical commodities.

In those communities where the tradition of male circumcision occurs,

it likely makes an important contribution to HIV prevention. However, working with traditional circumcisers to improve the safety of male circumcision remains a challenge. We must, therefore, explore ways to increase the provision of safe and humane male circumcision services to those who want to be circumcised in these settings. Several examples were discussed during a meeting of faith-based organizations, convened by the Catholic Medical Mission Board, in collaboration with WHO and other UNAIDS cosponsors in 2007.⁹ This meeting indicated that many parents and adolescent boys want a clinical option in the formal health-care setting *as well as* traditional activities. By providing male circumcision in a clinical facility and at the same time supporting traditional activities surrounding the circumcision, it is possible to contribute to adolescent boys’ sexual and reproductive health via counselling and education programmes that are currently lacking or which could be enhanced.

In addition to improving adolescent boys’ access to safe male circumcision services when these are provided within a traditional context, when developing male circumcision programmes in the formal health-care system, we must carefully regulate the providers to ensure that they are adequately trained and have the equipment and supplies to perform male circumcision safely and effectively.

The paper by Bailey et al. is timely, with important messages. By recognizing the need for safe services for adolescent boys, wherever delivered, male circumcision can provide an entry point for promoting safer sex practices, improving sexual and reproductive health and contributing to positive gender attitudes and behaviours. ■

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Available at: <http://www.who.int/bulletin/volumes/86/9/08-057752/en/index.html>

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