

women, because these could be related to stigma issues. ■

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Contributors

All authors took part in the construction and writing of the letter.

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WOLFE ET AL. RESPOND

Gamper et al. raise an important concern regarding our sample. As we noted in our limitations section, although individuals were randomly selected from the 5 districts of Botswana with the highest number of HIV infected individuals, we did not sample from the more remote districts of Botswana, limiting the generalizability of our results. It is important to note, however, that the outcome of greatest interest in our study is the one showing an association between HIV stigma and perceived access to antiretroviral therapy; if, as the letter writers suggest, HIV stigma is greater among people who live further from health services and therefore have reduced access to antiretroviral therapy, we would expect data from these remote areas to support, rather than diminish, this outcome.

The cultural context, highlighted by Gamper et al., is an important consideration when

evaluating responses to questions about stigmatizing attitudes. Interestingly, in a population-based study conducted across Botswana in 2001, a majority of respondents readily admitted that they held stigmatizing attitudes toward people living with HIV/AIDS.¹ This finding suggests that existing cultural barriers were inadequate to prevent the expression of stigmatizing attitudes prior to the introduction of the national treatment program. Our concern was that norms might have shifted during the rollout of the national program, increasing the risk of social desirability bias in our results. It was for this reason that we used a measure of anticipated stigma, which allowed respondents to focus explicitly on attitudes in their community rather than to put forward their own personal beliefs.

We agree with Gamper et al. that it would have been interesting to assess awareness of, and attitudes toward, the national treatment program in the general population. Nevertheless, our measure of perceived access to treatment subsumes multiple related factors, including awareness of the treatment program, its geographic penetration, and its perceived effectiveness in reducing barriers to treatment among the general population. Similarly, although qualitative methods to identify barriers to treatment access among vulnerable groups were beyond the scope of this population-based study, we did obtain qualitative data from structured interviews with a convenience sample drawn from support groups for people living with HIV/AIDS from Gaborone, Serowe, and the surrounding villages and rural areas. In these interviews, key barriers to treatment access cited by respondents included inadequate access to food and gender inequality in relationships.²

We welcome the comments from Gamper et al., which highlight the importance of further exploring the etiology and repercussions of HIV stigma in the ever-evolving African context. ■

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At the time of the study, William R. Wolfe, Sheri D. Weiser, Vincent Iacopino, and Michele Heisler were with

Physicians for Human Rights, Cambridge, MA. William R. Wolfe was with the Department of Psychiatry, University of California, San Francisco. Sheri D. Weiser and Wayne T. Steward were with the Center for AIDS Prevention Studies, University of California, San Francisco. Vincent Iacopino was also with the Department of Medicine, University of Minnesota, Minneapolis. Michele Heisler was also with the Department of Internal Medicine, University of Michigan School of Medicine and Ann Arbor Veterans Affairs Health System, Ann Arbor, MI.

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Contributors

W. R. Wolfe, S. D. Weiser, and W. T. Steward contributed substantially to drafting and editing of the letter. V. Iacopino and M. Heisler contributed substantially to the editing of the letter.

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Human Participant Protection

The study to which this letter refers was approved by the Research and Development Committee, Botswana Ministry of Health, and the Human Subjects Committee, University of California, San Francisco.

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MEDICAID COVERAGE OF NEWBORN CIRCUMCISION: A HEALTH PARITY RIGHT OF THE POOR

We applaud Leibowitz et al. for describing the adverse impact on public health of the withdrawal by 16 states of Medicaid coverage for male circumcision.¹ However, we are alarmed by a subsequent letter by anticircumcision lobbyists, in which the evidence regarding circumcision is thoroughly misrepresented.²

Their claims flatly contradict the bulk of the legitimate medical literature demonstrating

that male circumcision protects against urinary tract infections, HIV, HSV-2, syphilis, chancroid, thrush, bacterial accumulation, human papillomavirus, penile (and possibly prostate) cancer, local inflammation (balanitis), phimosis, paraphimosis, sexual problems with age, and, in female partners, human papillomavirus, cervical cancer, HSV-2, chlamydia, and bacterial vaginosis.³ The evidence for several of these conditions now includes data from randomized controlled trials and rigorous meta-analyses. Two recent randomized controlled trials also show no adverse effect on sensitivity, sexual function, or satisfaction.⁴

Risks associated with medical circumcision of infants are extremely low (0.3%–0.6%) and the majority of complications are minor and easily treated.³ Moreover, this procedure remains as popular as ever in the United States, with the majority of male infants being circumcised.

Green et al. display a disturbing lack of understanding of basic epidemiology. A valid test of whether circumcision protects against HIV infection or penile cancer is not by comparing rates between different countries! Moreover, the flaws in their arguments denying circumcision's protection against HIV infection have been exposed previously in a detailed 48-author commentary.⁵ In contrast to their claim about applicability of data from Africa to the United States, the degree of protection that circumcision affords against heterosexual HIV infection confirmed in 3 large randomized controlled trials is now observed in heterosexual men in the United States.⁶ This protection probably extends, moreover, to insertive anal intercourse.⁷

Circumcision also protects against urinary tract infections throughout life.⁸ The accumulated lifetime prevalence in US men is up to 14%.⁹ But the highest rate (1%–4%) is during infancy, where circumcision affords a 10-fold protective effect.³ This is observed consistently in the literature.

Properly conducted cost-benefit analyses have indicated that, over a man's lifetime, infant circumcision provides a positive cost benefit, especially when diseases and medical problems in female partners are also considered.¹⁰

In this new political era in the United States, with its hope for better health care generally, Medicaid coverage for circumcision is a health care parity right of the poor. It must be retained

by the majority of states, and must be reinstated by those states that have previously withdrawn it. ■

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