

## Circumcise

In March 2012, it will be five years since the UNAIDS and the World Health Organization issued its guidance identifying voluntary medical male circumcision (VMMC) as a key prevention tool for countries with high HIV/AIDS prevalence and low rates of VMMC. The guidance is based on dramatic findings: a simple surgical procedure reduced an HIV-negative man's risk of acquiring HIV from a female sexual partner by approximately 60 percent.

The news was big; the reaction, less so. Slow implementation of VMMC is one of the biggest missed HIV prevention opportunities of the past five years. Had there been swifter, more ambitious implementation of large-scale VMMC campaigns, then many countries would be significantly closer to realizing the tremendous benefit of this intervention.

Orange Farm, South Africa is one place where the potential benefits have started to be realized. Home to the first randomized-controlled VMMC trial, Orange Farm has seen massive expansion of VMMC services in recent years. Earlier this year, researchers from the French ANRS, which helped conduct the initial clinical research and subsequent implementation, released long-term prevalence and incidence calculations. They calculated that there had been a 55 percent reduction in incidence among men in Orange Farm who'd been circumcised during the trial or during the implementation, compared to those who'd remained uncircumcised.<sup>2</sup>

Many countries have moved slowly on VMMC implementation. In Zimbabwe, which has one of the lowest rates of VMMC in southern Africa, roughly 42,000 circumcisions have been performed since the country launched its VMMC

strategy in 2009—even though approximately 1.9 million circumcisions are needed to optimize the prevention benefits at a population level (see box).<sup>3</sup>

In South Africa, where Orange Farm has been a notable exception to slow rates of rollout, there is now a national male circumcision policy in place. This document outlining the new policy was launched in 2011 with strong political and cultural leadership including endorsements from the country's president, Jacob Zuma, and the Zulu King Goodwill Zwelithini.

It's hoped that the South African plan will catalyze action on the ambitious goal of

AVAC "PLAYBOOK" 2012				
DELIVER	Testing/Diagnostic	Male Circumcision	Treatment as Prevention	Comprehensive Approach
DEMONSTRATE	DEMONSTRATE	DEMONSTRATE	DEMONSTRATE	DEMONSTRATE
<b>Male circumcision</b>	<b>GLOBAL GOAL</b>		<b>AVAC PRIORITY</b>	
	<ul style="list-style-type: none"> <li>Roll out male circumcision with strategic, long-term plans in countries that meet WHO recommended criteria, with goal of 80 percent circumcision.</li> </ul>		<ul style="list-style-type: none"> <li>Catalyze civil society advocacy for ambitious scale-up of VMMC in slow-implementing countries.</li> </ul>	

circumcising 80 percent of 15- to 49-year-old men by 2015. But the country has yet to launch a mass national campaign. It has no national communications or monitoring and evaluation strategy and there are reports of

### The Kindest Cut: The potential impact of VMMC as an ending AIDS strategy

Achieving 80% VMMC coverage by 2015, and maintaining it thereafter would avert more than 20 percent of projected new HIV infections in Botswana, Lesotho, Malawi, Namibia, Rwanda, Swaziland, Uganda, Zambia, and Zimbabwe.

Hankins C, Forsythe S, Njeuhmeli E (2011) Voluntary Medical Male Circumcision: An Introduction to the Cost, Impact, and Challenges of Accelerated Scaling Up. *PLoS Med* 8(11): e1001127. doi:10.1371/journal.pmed.1001127

<sup>2</sup> P. Lissouba et al., "Adult male circumcision as an intervention against HIV: An operational study of uptake in a South African community (ANRS 12126)," *BMC infectious diseases* 11, no. 1 (2011): 253.

<sup>3</sup> K. Dickson et al. "Voluntary Medical Male Circumcision: A Framework Analysis of Policy and Program Implementation in Eastern and Southern Africa". *PLoS Med* (2011) 8(11): e1001133. doi:10.1371/journal.pmed.1001133.

lagging implementation at the provincial level—even in cases where money has flowed from national coffers to support provincial VMMC programming. The promise of the plan won't be realized without equally ambitious and well thought out programming.

As the title of a recent report from Ugandan civil society advocates states, in too many countries VMMC implementation can be characterized as “Too Little, Too Slow.”<sup>4</sup> In Uganda it took four years to develop VMMC guidelines—and while guidelines are now available, they remain inadequate as they are still not paired with a country-authored strategy setting targets and guiding district-level planning.

On a positive note, some countries, like Tanzania, have increased the numbers of circumcisions performed over the past year. To stay on track for ending AIDS in our lifetimes, 2012 should be

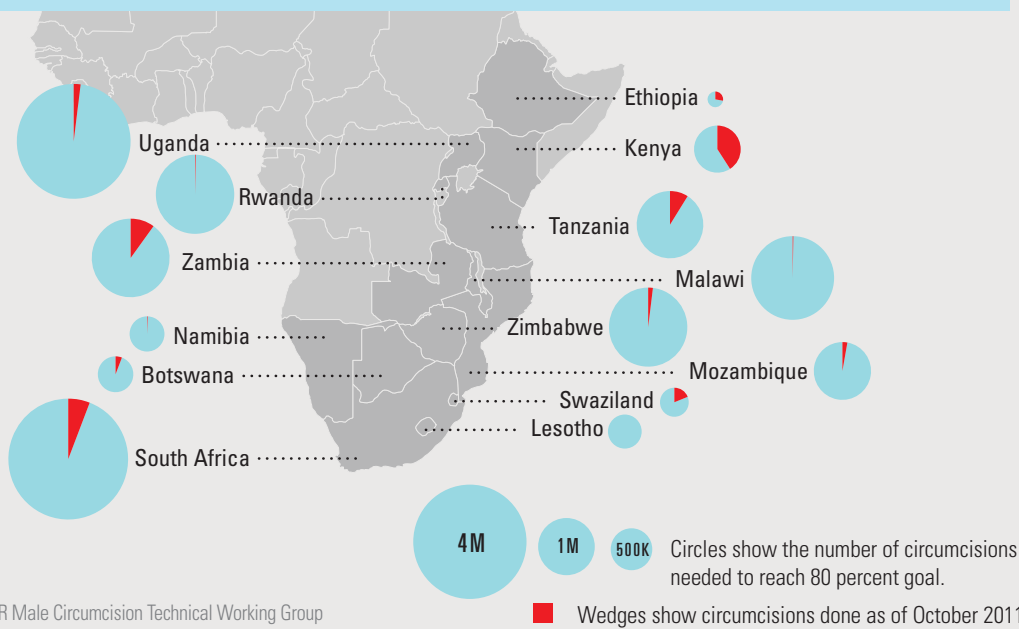
the year that male circumcision truly takes off. In Zimbabwe, as few as four male circumcisions will avert one new HIV infection by 2025. The latest modeling suggests that a US\$1.5 billion investment in rapid VMMC scale-up (circumcision of 80 percent of adult men in 13 priority countries by 2015) would yield US\$16.6 billion in savings on treatment and care services for HIV-positive individuals<sup>5</sup>—and that doesn't include the economic and social benefits of reduced HIV incidence in families and communities.

Four steps stand out for maximizing the prevention benefit of VMMC:

- **Galvanize global and national leadership.** VMMC lacks the passionate advocates and international champions that transformed AIDS treatment access in poor countries from a lofty goal to an achievable reality. With recent

## Progress in VMMC Scale-Up in Priority Countries

Experts hope to circumcise more than 20 million men in 14 African countries by 2015, to reduce their risk of HIV infection



<sup>4</sup> Male Circumcision: Too Little, Too Slow (Uganda: HAG and Mama's Club, 2011), [www.avac.org/toolittletooslow](http://www.avac.org/toolittletooslow).

<sup>5</sup> Catherine Hankins et al. "Voluntary Medical Male Circumcision: An Introduction to the Cost, Impact, and Challenges of Accelerated Scaling Up." *PLoS Med* (2011) 8(11): e1001127. doi:10.1371/journal.pmed.1001127.

remarks from the US Secretary of State Hillary Clinton identifying VMMC as one of three pillars of an effective prevention response, there is hope that this can start to change.<sup>6</sup> Champions at a country level are also absolutely essential. Top political, religious and cultural leaders can be essential to mobilizing demands.

- **Close the funding gap.** PEPFAR funding for VMMC has paid for roughly 75 percent of surgeries performed to date,<sup>7</sup> yet the dollars committed are a surprisingly low percentage of overall PEPFAR prevention spending, according to US advocates tracking allocations. There are places where funds need to be invested in demand mobilization and others where the demand is high and the funds simply aren't there to provide the services. These are glaring missed opportunities. Developing countries should be investing their own resources in VMMC programs. PEPFAR should increase its investment in VMMC, shifting money from less effective prevention efforts. Existing Global Fund grants should be reviewed for possible prevention reprogramming and, in the future, any new proposals from countries with high HIV prevalence and low rates of VMMC should be ranked based on whether it includes VMMC as a cornerstone of combination HIV prevention.
- **Keep up the research.** Clinical research on adult VMMC devices including PrePex and the Shang Ring is underway in several countries, and these devices have the potential to greatly simplify the VMMC procedure, which would be very beneficial in countries with shortages of health workers.
- **Put VMMC in the context of combination prevention.** No strategy—regardless of its effectiveness—should stand on its own. Some of the most innovative VMMC programs today are microcosms of combination prevention.

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Slow implementation of VMMC is one of the biggest missed HIV prevention opportunities of the past five years.

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They offer couples counseling, HIV testing, referrals and linkage to care—as well as the surgery. Nor is it an intervention for men alone. VMMC has myriad implications for women. Some are positive, like the significant secondary prevention benefit and the reduction in risk of acquiring human papillomavirus and therefore cervical cancer. It also is critical to monitor, analyze and act on data on shifts in condom use, prevalence of coerced sex and the blaming of female partners if HIV infection occurs post circumcision.

VMMC is also a test case for the task of implementing evidence-based prevention at a scale that brings the epidemic under control. To be sure, there are many differences between VMMC, a surgical procedure, and use of coitally-dependent gel or daily pill. There may be reasons that a gel or a pill for HIV prevention is more acceptable to users and providers. On the other hand, VMMC is a one-off procedure which sets it clearly apart from user-dependent methods.

The point is not to parse the differences between each emerging strategy but to emphasize that VMMC is one of the most powerful biomedical HIV prevention tools at hand and that success in ending the epidemic depends on how well it is implemented. This holds true for any new emerging strategy. Therefore, the ability to follow through on VMMC roll out is an indicator of readiness for work on PrEP, microbicides and more complex combination prevention.

<sup>6</sup> Hillary Rodham Clinton, "Remarks on 'Creating an AIDS-Free Generation'" (presented at the National Institutes of Health, Bethesda, MD, November 8, 2011), <http://www.state.gov/secretary/rm/2011/11/176810.htm>.

<sup>7</sup> *Ibid*