A CALL TO ACTION ON VOLUNTARY MEDICAL MALE CIRCUMCISION

IMPLEMENTING A KEY COMPONENT OF COMBINATION HIV PREVENTION

A JOINT REPORT FROM
AVAC, NATIONAL EMPOWERMENT NETWORK OF PEOPLE LIVING WITH HIV/AIDS IN KENYA,
SONKE GENDER JUSTICE NETWORK AND UGANDA NETWORK OF AIDS SERVICE ORGANIZATIONS

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The global HIV epidemic, unprecedented in its scope and impact, has galvanized extraordinary action worldwide. It is now more than three decades since the first cases of AIDS were diagnosed. With a growing array of proven strategies and promising research on HIV prevention, it is now agreed that we have the means to begin to end HIV through strategic combinations of well-defined HIV prevention strategies—often referred to as combination prevention—and continued research for improved tools.

The precise components included in combination prevention vary by context, but core interventions recognized as high-impact and critical to an effective response include: antiretroviral therapy for people with HIV, which preserves health and reduces risk of transmission; expanded HIV testing and effective linkage to prevention and treatment services; prevention of pediatric HIV infection; and voluntary medical male circumcision (VMMC)*, a relatively inexpensive prevention strategy that offers lifelong partial protection from HIV. As a result of slow action on each of these strategies, the potential benefits of combination prevention have not been realized. The countries most heavily affected by the epidemic continue to suffer needless numbers of new infections.

To begin to end the epidemic, and as research for new and improved tools continues, all components of combination prevention need to be expanded based on the context of each country's epidemic. One of the greatest and most feasible short-term victories in the African context involves rapid scale-up of VMMC. This strategy alone will not end the epidemic, but it could dramatically slow the spread of the virus in countries most heavily affected by HIV. Delays in implementing VMMC will prolong the epidemic needlessly. Now is the time for action to bring this high-impact, high-value strategy to scale.

Nearly five years after UNAIDS and WHO issued recommendations for VMMC in countries with high HIV prevalence and low levels of VMMC, there has been limited progress in bringing this prevention intervention to scale. As of March 2012, the world was only about

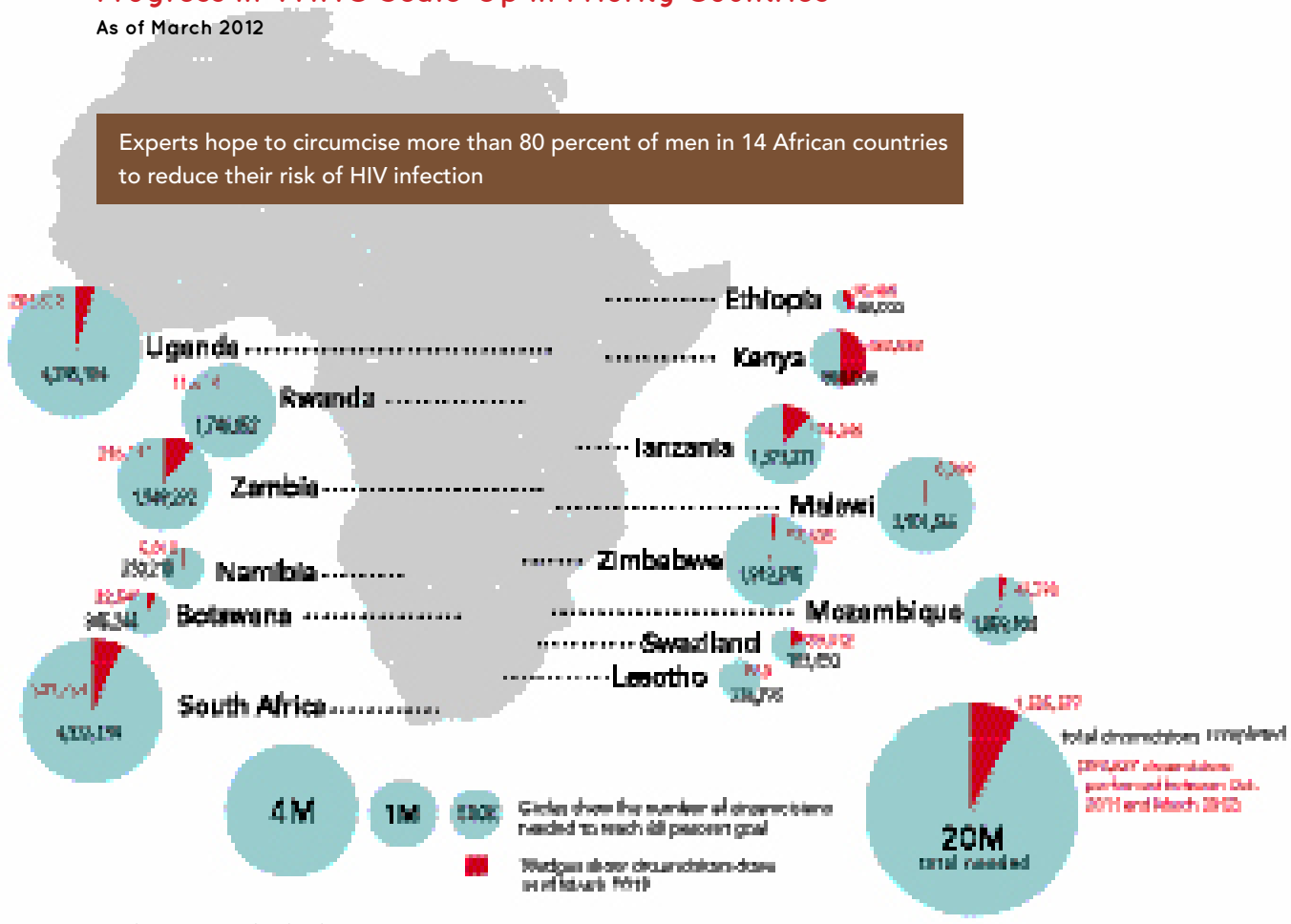
* A note on terminology: throughout this document the term "voluntary medical male circumcision" or VMMC is used to denote the specific procedure, including counseling and supportive services, that has been evaluated and is being implemented as an HIV prevention tool. Various countries use slightly different terminology. VMMC is used here for the sake of consistency.

8 percent of the way to reaching the target of circumcising at least 80 percent of adult males between ages 15 and 49 in fourteen priority countries. The authors note that, given slow progress to date, meeting this by 2015 may not be possible, representing a major missed opportunity. As advocates, we call on governments in priority countries to set national timelines and targets that can be monitored going forward.

Countries, donors and communities must move with speed to realize the opportunity to alter the epidemic's trajectory in the most heavily affected countries. Modelling based on a timeline where 80 percent coverage is achieved by 2015 suggests that more than 20 percent of new HIV infections would be averted by 2025, with a savings of an estimated US$16.6 billion in future medical costs. Even if this timeline shifts, there is still much to be gained. When used in combination with other proven prevention strategies, VMMC has the potential to dramatically cut rates of new HIV infections, AIDS deaths and the overall price tag for the AIDS response in sub-Saharan Africa.

Progress in VMMC Scale-Up in Priority Countries

As of March 2012



Source: PEPFAR Male Circumcision Technical Working Group

Priority Recommendations to Accelerate Scale-Up

Now is the time to redouble efforts and apply lessons learned to achieve the goal of 80 percent coverage of VMMC in men (ages 15-49) in fourteen priority countries. This goal should be linked to milestone-driven implementation plans in each country—and should receive full support from civil society, donors and implementers. There is no time to waste.

AVAC, The National Empowerment Network of People Living with HIV/AIDS in Kenya, Sonke Gender Justice Network and Uganda Network of AIDS Service Organizations make the following priority recommendations to achieve this ambitious target:

Leadership and Commitment

- National political leaders should provide vocal, visible and consistent support for expedited VMMC scale-up, actively exhorting their countrymen to get circumcised and positioning VMMC as a national social norm.
- Regional bodies should actively embrace the goal of 80 percent coverage in priority countries as soon as possible and promote accountability and South-South collaboration on VMMC scale-up. Key regional bodies that have potentially important roles to play in scale-up include the Southern Africa Development Community, the East African Community and the African Union.
- VMMC scale-up should become a visible, high-priority item on the global political agenda, with visibility comparable to the global push to eliminate mother-to-child HIV transmission. In particular, VMMC should be highlighted and promoted through such global forums as the 2012 International AIDS Conference, periodic reviews of progress by the United Nations (i.e., UNGASS process) and the annual World Health Assembly.
- Civil society in priority countries should actively endorse and promote VMMC scale-up. Donors and international agencies should provide support for civil society advocacy on VMMC, and global civil society networks should also embrace the goal of achieving 80 percent VMMC in priority countries.

Country Implementation

- All countries should have in place by the end of 2012 a detailed, costed, timeline-driven operational plan for VMMC scale-up. Country ownership and leadership is critical, and such plans can be used to align and mobilize resources and coordinate activities among national stakeholders, donors, international technical agencies and international NGOs.

- Countries should establish and publicize annual scale-up targets for VMMC. Ambitious annual gains should build toward the ultimate goal of 80 percent coverage.

- Diverse, adaptable delivery strategies should be pursued toward the goal of 80 percent coverage in priority countries. Based on national circumstances, countries should consider a combination of delivery strategies, including stand-alone, dedicated sites; mobile services; time-limited campaigns; and integration of VMMC into mainstream health care delivery sites.

- Priority countries should adopt a comprehensive policy framework to accelerate progress toward 80 percent coverage. Formal policies should provide for task shifting and task sharing, infection control and waste management, and strategic configuration of clinical sites and surgical teams to promote efficiency. Policies should also mandate and guide needed education and counseling for VMMC clients.

Community Engagement

- Communities should embrace VMMC as an advocacy issue, and request donors, national governments and VMMC delivery sites to allocate substantial resources to these activities. Civil society partners have a key role to play in education about VMMC and related issues, such as gender equality, domestic violence, the need to continue risk reduction via partner reduction and condom use, and the importance of abstaining from sex until wound healing. In the context of resource-constrained service delivery, it is critical to work with community partners to create and share comprehensive messages that optimize the benefit of VMMC.

- National and local governments should work with community gatekeepers, including traditional and religious leaders, to implement inclusive community dialogues on VMMC for HIV prevention. It is critical to ensure that social, cultural and community leaders—including those engaged in traditional male circumcision rituals—are engaged as active partners in designing VMMC programs.

Demand Creation

- National governments, clinical sites, community leaders, international agencies and donors should collaborate in the formulation and implementation of operational research to inform demand-creation activities. Such research should investigate the reasons men do or do not access services, optimal messages and communications channels, and key message carriers to motivate VMMC uptake.

- Demand-creation activities should be adequately budgeted and regarded as an essential component of VMMC services.

- Demand-creation activities should focus particular efforts on reaching key stakeholder groups, including men in their 20s and 30s; women and girls; and traditional and religious leaders. These groups should be engaged as partners in communication and education.

Coordination

- National governments should take steps to strengthen the functioning, visibility and capacity of national VMMC task forces. These task forces should be ultimately responsible for overseeing the coordination, adaptation, implementation, monitoring and evaluation of national strategies for VMMC scale-up. Donors and international technical agencies should, where indicated and requested, provide support to build the capacity of national task forces.

- Donors, international agencies, international NGOs and sub-national units should coordinate and align their activities with national operational plans. Activities should be regularly reported to, and coordinated with, national VMMC task forces.

Resources

- All priority countries should make meaningful domestic budget allocations for VMMC services.

- National governments should use their costed VMMC plans to determine national budget allocations and to mobilize resources from in-country donors to ensure that funding gaps are met. National governments quantifying their resource gap should urge PEPFAR, the leading funder for VMMC scale-up, to ensure that needs are met. Where the resource needs have not been quantified, civil society should advocate for government to show leadership and donors to provide technical and financial assistance.

- Countries should prioritize VMMC scale-up in proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Countries should analyze needs and priorities to ensure that existing funds are aligned with the GFATM's new strategy for iterative support to maximize the public health impact of grant funding. The Global Fund Secretariat should provide technical support to countries to assist with rational reprogramming.

Monitoring and Evaluation

- Countries, donors, international agencies and other stakeholders should develop a set of core, standardized indicators to guide monitoring and evaluation efforts for VMMC scale-up. Countries should have the leeway to adapt indicators to national conditions and reporting structures, preserving in all instances the ability to provide regionally comparable reporting on core indicators.

- Donors, international agencies and international NGOs should take steps to synchronize and align their programs, reporting protocols and systems based on standardized indicators and streamlined national reporting structures.

- Individual countries, regional bodies and the global community (with leadership from WHO and UNAIDS) should issue annual reports on progress toward the goal of 80 percent coverage in priority countries. These reports should identify lessons learned, including best practices and implementation bottlenecks.

- All countries should implement routine, standardized, comprehensive reporting of adverse events relating to VMMC services. Donors, international agencies and international NGOs should provide countries with financial and technical support to build adverse-event surveillance systems.

Innovative Devices

- Data from completed and ongoing clinical studies on non-surgical devices for VMMC (the Shang Ring and PrePex are two such devices under evaluation) should be analyzed without delay and used to guide normative agency recommendations with broad applicability by mid-2013. Gaps left by current research, including operations research and additional confirmatory studies should be clearly defined and filled in a strategic, coordinated manner. Donors and international agencies should provide appropriate technical and financial support to ensure timely implementation, completion and analysis of these studies.

- Decision-making tools should be developed to help priority countries evaluate suitability and relevance of new devices. These tools should be in place by mid-2013. WHO should ensure that regional and national consultations are held to implement these tools and analyze results.

- All countries seeking program efficiencies should investigate the feasibility of implementing new devices and make ambitious implementation plans accordingly. WHO and UNAIDS should provide technical support for the development of national rollout plans.

Number of VMMC Procedures Needed to Avert a Single Case of HIV Infection, 2011–2025*	
Botswana	8
Lesotho	5
Malawi	13
Mozambique	7
Namibia	26
Kenya (Nyanza)	8
Rwanda	44
South Africa	5
Swaziland	5
Tanzania	10
Uganda	19
Zambia	8
Zimbabwe	4

Source: Njeuhmeli et al., 2011

*A 14th country, Ethiopia, has been added to this list by PEPFAR, which is the primary funding source of VMMC worldwide.

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