Slow and Steady Won't Win the Prevention Race: Why VMMC still isn't a global priority—and how to make it one

The data from trials of voluntary medical male circumcision (VMMC) for HIV prevention remain the biggest prevention news of the 21st century so far. AVAC isn't inclined to pit prevention strategies against one another—and we're also not a fan of hyperbole—but VMMC, which is the single most effective one-off intervention an HIV-negative man can use to reduce his own HIV risk, makes us want to say attention-grabbing things. That's because VMMC continues to fight for its fair share of attention, funding and prioritization in the global response.

The past 12 months have been a notable time for VMMC. UNAIDS included the strategy in its non-ART prevention targets. The new VMMC target is 27 million additional circumcisions by 2021. PEPFAR also released a new target of 11 million cumulative circumcisions by the end of 2016 and 13 million by the end of 2017.

So, are things going well? Not exactly. Annual numbers hover the vicinity of 2.5 to 3 million. There has not been a surge in the rate of scale-up since 2014. In fact, the pace has slowed down. WHO reports that there were roughly 20 percent fewer procedures in 2015 compared with the year before.* Yet the new UNAIDS target requires roughly five million procedures per year between now and 2020. This simply isn't possible based on pace to date.

Additional resources need to be sought and committed by national governments and the GFATM. VMMC needs to be tracked as part of Prevention Data Dashboard (see page 8). The following steps are also key:

Data on and messaging about VMMC needs to get much, much clearer. PEPFAR, national governments and WHO/UNAIDS all track annual numbers of VMMCs performed. PEPFAR tracks its own procedures and reports on national totals; WHO/UNAIDS report on national totals that include PEPFAR. But the numbers come out at different times and sometimes reflect different trends. There isn't a clear sense of where there are problems and where there is progress—and AVAC takes responsibility for working even harder to sort out the figures and identify gaps and areas for action. AVAC also insists that messages to country stakeholders about how to position VMMC remain clear and consistent—in terms of the minimum service delivery package and the rationale for pursuing high-coverage goals. While VMMC can be the foundation for a platform of services, particularly for young men, it is highly impactful as a one-off procedure and the successes to date have hinged on campaigns that saturate specific geographies and then move on. In 2016, we'll be watching closely to ensure that countries get clear messages about the models to invest in to reach the new ambitious targets.

No one should be being turned away from VMMC programs. HIV treatment programming reflects the need to reach people when they ask for services, not ask them to come back when they (the clinic or program) are ready.

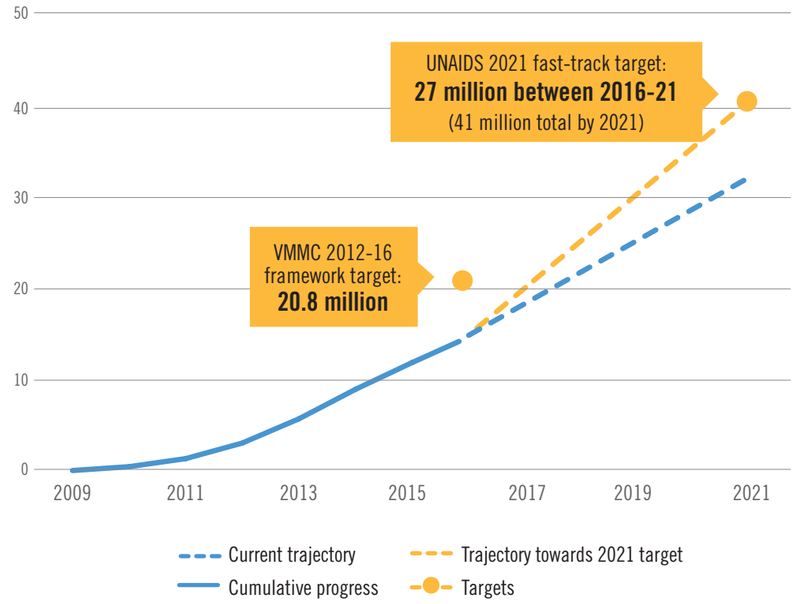
Generate funding estimates and gap analyses. It is much harder than it should be to understand the global price tag and funding shortfall for VMMC. WHO/UNAIDS has in the past released its strategic framework without messaging regarding funding—and as *AVAC Report* went to press was preparing to do so again. PEPFAR doesn't work with countries to quantify funding gaps left by its prioritization of specific geographies and ART coverage goals.

PEPFAR can't pay for all of the VMMC procedures that need to happen in a country. There has to be a clear, coordinated approach to identifying the gaps left by any single program-funding source as matched against ambitious national goals.

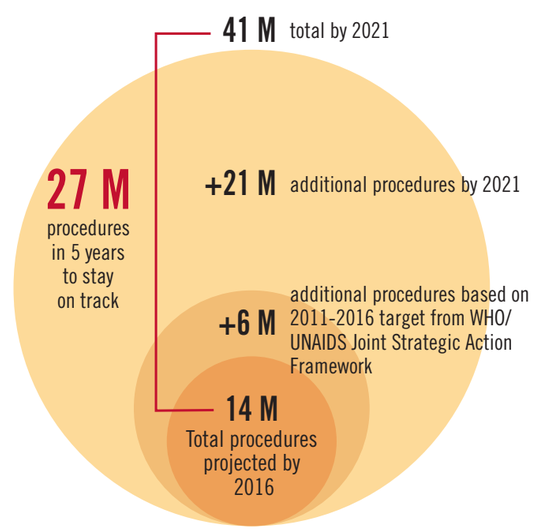
Country-level budgets for VMMC should not be disproportionately reliant on PEPFAR central funding. If you're running a household, a business or a large-scale HIV program, you need to know your budget in order to plan. The budget for PEPFAR programs is determined during the process of finalizing the annual Country Operational Plan (COP). Programs with targets matched to funds in the COP know what they're expected to do and what resources they will have on an ongoing basis. A windfall can make a difference, and can help achieve some great things, but it doesn't support good planning. PEPFAR central funds—which come out of a fund administered in Washington, DC—are, in some ways, a windfall-type resource. Central funds aren't allocated on the COP funding cycle, they aren't predictable, and they aren't guaranteed. Right now this is happening with VMMC and central funds. Since the increase in funding in 2016 is coming solely from central funds, it is essential that PEPFAR find ways to streamline funding disbursal such that identification of new partners, launch of new campaigns and other programmatic activities aren't adversely impacted.

* WHO. 2016. *WHO Progress Brief: Voluntary Medical Male Circumcision for HIV Prevention in 14 Priority Countries in East and Southern Africa. www.who.int/hiv/pub/malecircumcision/brief2016/en/.*

Not on Track: The slow pace of VMMC scale-up



The Global VMMC Gap



Sources: UNAIDS, WHO. 2011. *Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa: 2012-2016. www.pepfar.gov/documents/organization/178294.pdf;*
UNAIDS. 2015. *On the Fast-Track to end AIDS. www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf*
www.malecircumcision.org.

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