

## SCALING UP VOLUNTARY MEDICAL MALE CIRCUMCISION

It is projected that circumcising 80% of all uncircumcised adult men in the countries with high HIV prevalence and low prevalence of male circumcision by 2015 would avert one in five new HIV infections by 2025, with long-term prevention benefits for women as well as men.<sup>24</sup> At the same time that priority countries scale-up voluntary medical male circumcision for adults, they are advised to roll out the routine offer of medical circumcision for newborn males.

### UNAIDS priority countries for voluntary medical male circumcision:

1. Botswana
2. Ethiopia
3. Central African Republic
4. Kenya
5. Lesotho
6. Malawi
7. Mozambique
8. Namibia
9. Rwanda
10. South Africa
11. South Sudan
12. Swaziland
13. Uganda
14. United Republic of Tanzania
15. Zambia
16. Zimbabwe

Immediately following issuance of the recommendation for scale-up in 2007, progress in implementing voluntary medical adult male circumcision was initially slow, although there are encouraging signs that the pace of uptake may be increasing. However, scale-up of voluntary medical adult male circumcision varies considerably among priority countries (see Figures 1.3, 1.4).

As of December 2012, 3.2 million African men had been circumcised through specific services for voluntary medical male circumcision. The cumulative number of men circumcised almost doubled in 2012, rising from 1.5 million as of December 2011. Still, it is clear that reaching the estimated target number of 20 million in 2015<sup>25</sup> will require a dramatic acceleration.

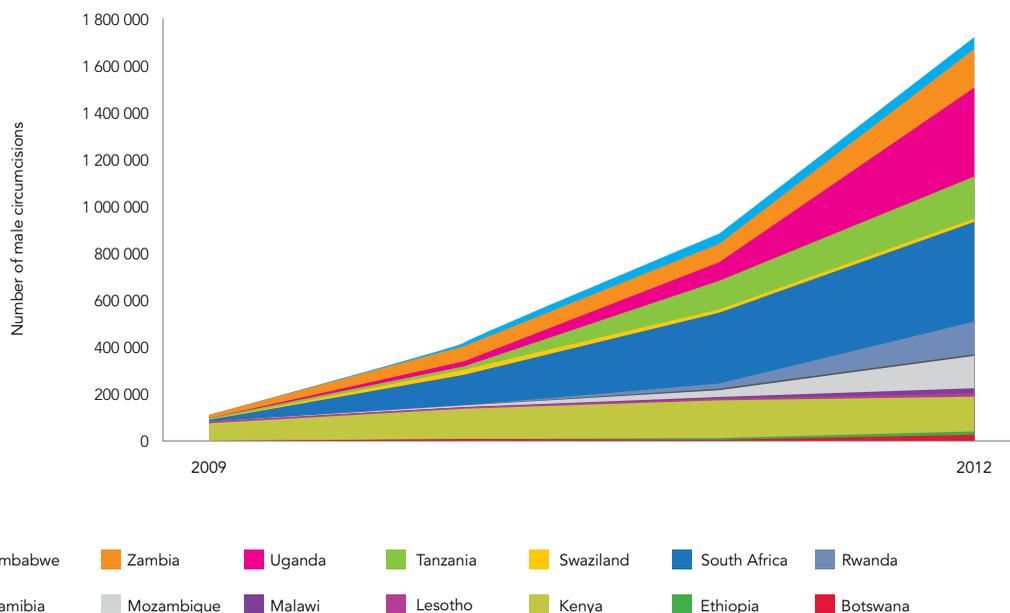
Progress has been most pronounced in the provinces prioritized for scale-up in Ethiopia (reaching 57% of the coverage target) and Kenya (63%). In five countries where voluntary medical male circumcision is stated to be a priority (Lesotho, Malawi, Namibia, Rwanda and Zimbabwe), coverage of voluntary medical male circumcision for adults is less than 10%.

Twelve countries submitted national mid-term reports that identified voluntary medical male circumcision as a priority. Five countries (Botswana, Malawi, Namibia, the United Republic of Tanzania and Zimbabwe) cited low male circumcision uptake as a challenge in their national response. Mid-term reports identified a variety of impediments to expedited scale-up, including financial constraints (Namibia), stock-outs of essential circumcision commodities (Uganda) and human resource limitations (Zimbabwe). Swaziland's mid-term report makes no mention of voluntary medical male circumcision, even though the country has been identified as a key priority for scale-up. Moving forward, Lesotho has committed to increase resources for adult and neonatal medical male circumcision; Zimbabwe aims to provide improved circumcision training for nurses; and Uganda has pledged to intensify circumcision scale-up in the formal health sector and among district health systems.

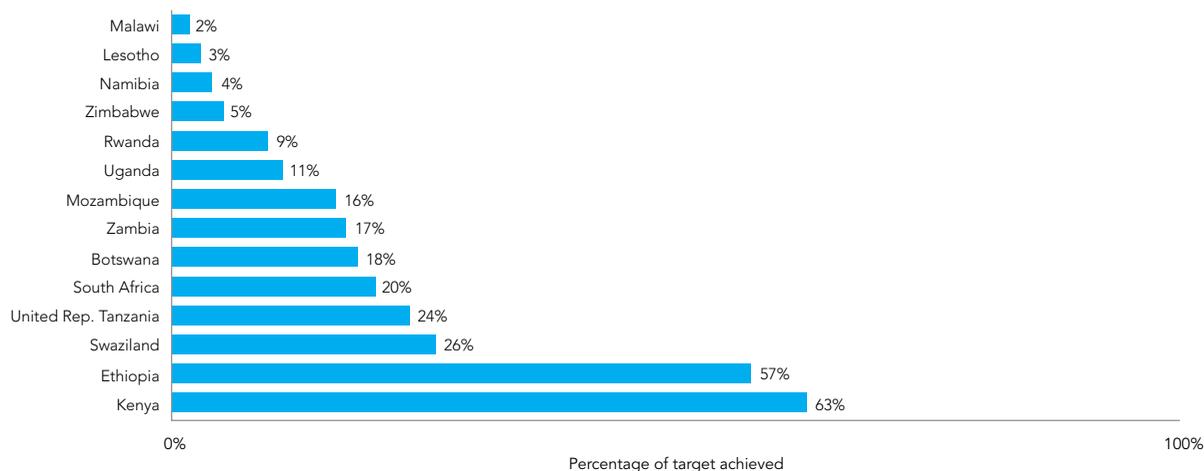
There is evidence that programmes have had much greater success in reaching males younger than 25 years.<sup>26</sup> As men in sub-Saharan Africa are at highest risk for acquiring HIV when they are in their twenties and thirties, men in these age groups are the top priority for scale-up. While voluntary medical circumcision confers a clear HIV prevention benefit on young men and should be continued, it has less immediate impact on new HIV infections than circumcision for men at greater risk. In an effort to reach men aged 25–29 years whose circumcisions would be more likely to result in immediate HIV prevention benefits, studies are currently underway to evaluate various innovative strategies to build demand for circumcision.

In 2013, WHO prequalified the first adult circumcision device for use in low-resource settings. The device, PrePex, requires no sutures or injected local anaesthetic and may be placed and removed by trained mid-level health providers including nurses. It is hoped that the device will accelerate scale-up by providing men with an alternative and by relieving demands on the limited number of surgeons available in priority countries.

**FIGURE 1.3**  
Annual number of voluntary medical male circumcisions, selected countries, 2009–2012



**FIGURE 1.4**  
Voluntary medical male circumcision: countries' progress towards 2015 targets, by December 2012



Sources: GARPR 2013; WHO (2012). Progress in Scaling up Voluntary Medical Male Circumcision for HIV Prevention in East and Southern Africa, January–December 2012.

Notes:

1. Implementation of voluntary male medical circumcisions (VMMCs) is done at different rates in the priority countries.
2. At the end of December 2012 just over 3 million VMMCs were reported in these countries, which amounts to the achievement of 15% of the estimated number needed to reach the 80% prevalence rate overall.