Voluntary Medical Male Circumcision 2021

A gateway to adolescent boys’ and young men’s health

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KEY MESSAGES

- HIV remains the single largest cause of years of life lost among men of reproductive age in eastern and southern Africa. In the countries with low male circumcision (MC) and high HIV prevalence in southern Africa, HIV alone accounts for more than half of years of life lost among men aged 15-49 and in eastern Africa still for around a third.

- UNAIDS has set the ambitious global goal to reduce new HIV infections to less than 500,000 by 2020, a 75% reduction compared to 2010. Given the slow progress – with an estimated 1.8 million new adult infections recorded in 2014 – there is need to fast-track the delivery of a core set of interventions including voluntary medical male circumcision (VMMC).

- Scaling up VMMC as part of combination prevention in current priority countries in eastern and southern Africa, alongside treatment is essential to reach the 2020 and 2030 prevention targets.

- By end of 2016, an estimated 14 million adolescent boys and men will have received VMMC for HIV prevention, 67% of the initial goal of 20million circumcisions. The new global target of an additional 27 million men having received VMMC by 2021 requires enhancing the momentum and accelerated scale up of services.

- Adolescent boys and young men face a number of other age-specific health risks in addition to HIV including interpersonal violence, self-harm, alcohol misuse and drug use. In addition, adolescent boys and men have other important sexual and reproductive health needs as partners, husbands and fathers. Other health platforms to reach adolescent boys and men at scale are weak, and VMMC service can provide an important entry point.

- The essence of VMMC 2021 is to build new platforms for adolescent boys’ and men’s health around VMMC, which have the potential to achieve wider sexual, reproductive and other health benefits and enhance gender equality.

- To address the health needs of boys and men of different ages, a person-centred approach to service delivery is needed. Thereby VMMC can become a gateway to the health of adolescent boys and men – and indirectly the health of women and girls.

- VMMC 2021 offers four pragmatic strategic directions and moving towards efficient, effective, sustainable and more integrated VMMC programs 1) synergize, 2) focus & scale-up, 3) innovate, 4) account & commit.
I. A changed global landscape

In countries, where VMMC is currently recommended, HIV is the single largest cause of years of life lost among men of reproductive age accounting for 57% in southern Africa and 31% in eastern Africa. Therefore HIV prevention and treatment programmes including VMMC remain the top priority for public health in these highly affected countries. However, adolescent boys and men also face a range of other health issues and, importantly, these vary by country and other factors such as age, residence and socio-economic factors.

The countries and locations with high HIV prevalence are different from all other countries in the world: They have a uniquely high burden of disease among people of reproductive age. There is need to move from an emergency response to new sustainable and institutionalized approaches to reach adolescents and young adults with optimized packages of services.
Five causes (HIV, TB, violence, self-harm and other injuries): more than 75% of YLL among men 15-49 in Southern Africa and still more than half in Eastern Africa. The five issues relate to underlying gender norms and low health seeking behaviour and also impact on girls and women.

Figure 1: Years of life lost among men in different age groups in Eastern and Southern Africa (2013)


Causes of disease and risk factors for young men’s health such as unprotected sex and alcohol misuse closely relate to life-style choices, concepts of masculinity, risk taking and health seeking behaviors (ref.). Underlying conditions include mental health and psychosocial factors, which contribute to high incidence of self-harm in this age group. Young men’s health and behaviour is also closely interrelated with young women’s health, in particular in relation to their sexual and reproductive health including STI and HIV transmission and male involvement in family planning.

Uptake of health services by adolescent boys and men is commonly low. and VMMC services provide therefore a critical opportunity for reaching them with the mix of information and services they most need.

The Sustainable Development Goals aim to meet the needs of the present without compromising the ability of future generations to meet their own needs. Preventing new HIV infections does both. HIV prevention including VMMC link to several SDGs and other health frameworks developed in line with the SDGs (see below). The need to firmly place the rights, roles and
responsibilities of men and adolescent boys in the HIV and health response on the global agenda is increasingly recognized.

Figure 2: The global landscape for VMMC 2021

Source: Prepared by authors based on various global strategies

Building on VMMC progress so far

Male circumcision reduces the risk of heterosexual transmission of HIV from women to men by around 60% and has additional health benefits. The Joint Strategic Action Framework to

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4 PEPFAR (2014) PEPFAR 3.0 – Controlling the epidemic: Delivering on the promise of an AIDS-free generation
6 Recent studies have also shed new light on the impact of circumcision on the human papillomavirus (HPV) among male and female populations respectively. Circumcised men have been shown to have a higher rate of clearance of high-risk HPV
Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa 2012–2016, has guided Ministries of Health (MOH) and country, regional and global stakeholders in their joint endeavours to expand coverage of this highly effective tool for HIV prevention.

By end of 2016, the target of 20 million men circumcised will likely not be fully reached, but substantial progress will have been made with an estimated 14 million (70% of the target) adolescent boys and men circumcised in priority countries which confirm the feasibility of delivering VMMC at scale. Multitudes of trainings, surgical and infection prevention skills-building, quality improvement methods and supplies have capacitated health workers and systems while monitoring and research capacity to inform implementation expanded.

In generalised epidemics, VMMC has been shown to be cost effective regarding the prevention of new HIV infections. VMMC programmes are cost saving in almost all VMMC priority countries. At between 25 -100 USD depending on service delivery model and country, the total cost of one circumcision is less than half that of one year of ART. The indirect effect of preventing further HIV transmissions to women, their babies and other men adds to the benefit. VMMC in priority countries was identified by the Copenhagen Consensus group as one of the top 19 interventions with best value for money in development over the 2015-30 period.


II. Objectives and targets

Achieving fast-track targets requires a combination of programmes

UNAIDS has set the goal to reduce the number of new HIV infections to under 500,000 in 2020 and under 200,000 in 2030, thus effectively ending the AIDS epidemic as a threat to public health. Compared with a 2010 baseline, these numbers constitute a 75% reduction in new HIV infections by 2020 and a 90% reduction by 2030. Scaling up a combination of interventions and programmes including condom programmes, PreP and VMMC, alongside treatment is required to achieve HIV fast-track targets.

VMMC provides an almost immediate major reduction in risk to men for life soon after a single procedure.

Targets for VMMC 2021

At the centre of the VMMC 2021 strategy, there are two major outcome targets:

- 90% of 10-29 year old males will have undergone VMMC by 2021 in priority settings in sub-Saharan Africa;
- 90% of 10-29 year old men will have accessed age-specific health services tailored to their needs

The first target for VMMC is directly based on the UNAIDS fast-track target, which is “27 million additional men in high-prevalence settings are voluntarily medically circumcised as part of integrated sexual and reproductive health services for men”\(^9\). This is equivalent to approximately 90% of 10-29 year old males by 2021.

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\(^9\) The 14 VMMC priority countries in the 2012-16 global framework were Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe). Estimates for Ethiopia were not available and are not included here. The target of 27 million VMMCs includes South Sudan. For Kenya only Nyanza province is included.
Figure 3: Progress in delivering VMMC and new targets

The rate of progress will have to accelerate from between 2.5 and 3 million VMMCs performed between 2013 and 2015 annually, to more than 4 million VMMCs per year up to 2021. Beyond the 14 priority countries, the integration of VMMC services into adolescent and men's health packages may be required in selected other locations, either because of localized heterosexually driven HIV epidemics or in the context of making traditional MC safer.

The second target refers to tailored age-specific health packages for adolescent boys and men that address their health and well-being more broadly and are defined in subsequent sections.
III. Strategic directions

VMMC for HIV prevention must be positioned to simultaneously achieve HIV incidence reduction by 2020 and build bridges to other health interventions for adolescent boys and men. The new approach will build on the following principles:

A people-centred approach to health services for adolescent boys and men: People-centred health services are defined as an approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants and co-producers as well as beneficiaries of care. In the priority countries for VMMC such people-centred approaches are not consistently in place for adolescent boys and young men. VMMC is the most plausible gateway for creating people-centred health service platforms in these countries.

Service packages specific to sub-populations: The proposed sub-populations for tailored health platforms built around VMMC are adolescent boys 10-14, adolescents 15-19, young men 20-34 and other men at higher risk of HIV (see next chapter).

Integrated service packages: ‘Integrated health services’ are described as ‘health services that are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites of care within the health system, and according to their needs throughout their life course’. Existing VMMC programmes have been designed to provide packages of services, including risk counselling, condom distribution, HIV testing and referral to treatment, and these additional services will now be systematically implemented and their performance monitored, packages made age-specific and new health topics integrated as needed.

Integrated messaging: The conversation on VMMC in the new strategy does not start with VMMC, but with health of adolescent boys and men – and then leads to HIV as the single largest priority in these age groups, SRH and other health priorities (see next chapter for details).

VMMC 2021 as a gateway to health

- From intervention focused to person-centred (adolescent boys & men)
- From single to multiple health outcomes (HIV, STIs, SRH, cervical cancer, ...)
- Common underlying norms (gender, masculinity, risk-taking)
- Interventions with and for adolescent boys and men now recognized for men and women’s good health and well being
- Expanding synergies (TB, SRH, injuries, alcohol, violence...)
- Focus and scale fast-track approaches for delivery & demand generation
- Innovate to shift the paradigm
- Account to achieve the triple return on investing in adolescents:
  1. Good health now
  2. Health benefits in future
  3. Future cost savings

WHO (2015) WHO global strategy on people-centred and integrated health services. Interim report. The WHO global strategy for people-centred and integrated health services has its roots in the UHC and primary health care movements, as well efforts to address non-communicable diseases and the social determinants of health.
Communication will address potential strategies to prevent HIV and STI acquisition and transmission, including condom use, PrEP and VMMC; additional health benefits of VMMC for HPV, genital ulcerative disease, and other population-specific health priorities. Similarly, other health conversations on issues affecting men such as alcohol misuse will touch on HIV and VMMC.

**Enhanced partnerships:** The new VMMC strategy emphasizes building long-term partnerships under national leadership. Linkages with schools, youth programmes, traditional leaders and communities and the formal health sector will be systematized and institutionalized. For example, enhanced partnership will mean a move from single VMMC outreach campaigns to systematic periodic outreach to provide VMMC within a package of age-specific health communications and services for boys 10-14 in school.

**A new image for adolescent boys and young men’s health:** Males seeking relevant health services will be portrayed as taking care of oneself, desirable, dynamic and proactive. This repositioning of VMMC in the context of adolescent and young men’s health will be linked to the promotion of supportive gender norms and concepts of masculinity.

**Synergies with other platforms:** Health platforms for adolescent boys and young men will also be essential to generate benefits for other populations, in particular adolescent girls and young women who will indirectly benefit from reducing HIV and STI incidence among men. Linkages with antenatal care, maternal child and adolescent services will be supported.

The following sections will outline strategic priorities in programming for VMMC as a gateway to adolescent boys’ and men’s health. The VMMC 2021 strategy requires **synergies, focused scale up, continued innovation and expanded accountability** framed around adolescent boys’ and men’s health and involving a broader partnership.
Synergise: Packages, platforms and partnerships

A key priority for VMMC 2021 is to enhance synergies. Health packages for boys and men will need to be expanded with VMMC as a core element, service delivery platforms strengthened and partnerships expanded and institutionalized.

Current VMMC programmes have already integrated elements of combination HIV prevention such as

- Safer sex education
- Condom promotion
- HIV testing and links to treatment for those who test positive, and
- STI management.

Mostly based on their assessments of boys’ and men’s needs specifically related to VMMC, some national programmes have also started providing hygiene education and tetanus vaccinations.

However, progress, added value and impact of these packages of services, for instance in terms of condoms distributed, reduced STI rates, improved vaccination status and infection prevention control in surgical and community settings has not yet been consistently assessed. Neither have indirect benefits for women been studied. Programme evaluation data have shown a sharp increase in HIV case identification and treatment initiation in men due to the introduction of VMMC services in one setting, demonstrating the potential of the VMMC platform beyond primary prevention service. At the same time, insufficient attention has been paid to addressing gender norms and notions of masculinity that can lead to men not using condoms, and avoiding health services such as HIV testing, ART and VMMC.

Service delivery approaches and platforms that have attracted large numbers of adolescent boys and men to undergo VMMC include:

- School-based campaigns that have led to rapid uptake among adolescents when basic conditions such as involvement of school leadership, parents and early provision of information were met.
- Static health clinics that have attracted both men and boys in urban settings where the population size was large enough to receive many clients.
- Mobile services in settings for smaller population sizes that have aimed to attract boys and men in sufficient numbers to be efficient and maintain quality.

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12 Ibid
A significant proportion of VMMCs have been carried during campaigns that have successfully created demand and uptake for this specific procedure but may be less suited to cater for a wider range of health issues. Furthermore, many successful examples of partnerships and collaboration between health and other sectors such as education (ref), sports (ref) and culture (ref), and the private sector (ref) have been documented from different programmes, but have rarely been institutionalized nationally.

VMMC 2021 will build on the lessons learnt from the delivery of existing service packages through different delivery platforms and from successful partnerships, with the aim to strengthen health services for adolescent boys and men. Basic service health packages similar to existing VMMC programmes will continue to be provided, but will be expanded to ensure basic health checks and a review of vaccination status. Dedicated efforts will be made to strengthen the interventions on prevention of alcohol misuse and drug abuse and to address gender norms and notions of masculinity during client provider encounters.

Transitioning services from a VMMC specific focus to boys’ and men’s health perspective will require designing new, integrated service delivery configurations and close collaboration between clinics, schools and work places and other service sites and venues which boys and men attend. Male engagement in family planning and PMTCT will be promoted and conversely, sexual and reproductive health services that are currently overwhelmingly attended by women and young girls will be encouraged to engage adolescent boys and men and promote VMMC and men’s health. Figure 4 provides an overview of service package elements and Table 2 in the Annex breaks these down further by population and sector.

The new focus on synergies and integrated or linked men’s health service packages does not mean that VMMC needs to be provided in all facilities by all providers or that supply should simply respond to demand. Demand creation for VMMC as an integral part of health promotion for adolescent boys’ and men’s health and a continued focus on the practical feasibility of performing large number of VMMCs in an (cost-) effective manner are cornerstones of the new strategy.

Neither will all services and basic package elements be relevant in all settings or for all boys and men. For instance, HIV incidence in 10-14 old boys is usually extremely low, and services need to provide age-appropriate sexuality, gender and alcohol education and the VMMC procedure rather than HIV and STI testing and treatment. National policy-makers will further assess and decide which specific services and packages should be provided for each age group. Lessons from VMMC also clearly show that settings that are convenient for one particular age group may be unsuccessful for another.

The involvement of other relevant health ministry programmes beyond HIV, non-health and non-governmental sector partners, such as education, youth, sports and culture which in the VMMC response has varied, will need to be expanded and formalized. In addition to generating specific demand for VMMC, communities and leaders will need to engage boys and men for their health more broadly including addressing issues related to alcohol misuse, violence and gender norms and masculinity.
The objective of this engagement is to generate adolescent boys’ and men’s awareness of and interest in their own health risks and peer norms and demand access to age-appropriate health services.

VMMC 2021 proposes specific platforms and service packages for four distinct target populations.

**Young adolescent boys (10-14 years) package and platform:** For young adolescents, schools may be an essential primary health promotion platform and the delivery of a basic school health promotion and service package to boys (and girls) needs to be institutionalized. Its delivery will need to be standard practice and a requirement to be repeated every year to reach new cohorts of adolescents of the same age – for example 12-13 year olds. This approach could involve school nurses, outreach by health workers to schools and organized visits of in-school adolescent groups to health facilities. Young adolescents out of school must also be reached. These approaches need to be accompanied by parent meetings providing basic information on adolescent sexual reproductive health, HIV prevention, HIV testing and wound care. In some countries, building on traditional initiation practices and providing VMMC as part of the rituals may well provide an additional strategic option. Safety and quality must be assured regardless of delivery approach.

In addition to the basic services including VMMC, the actual service package for this age group will be embedded in age-appropriate comprehensive sexuality and health education, and also include a tetanus vaccine booster and hygiene counselling. Institutionalizing services for this group will be key to sustainable national VMMC programmes in priority countries. If services coverage is high in this group, the number of young men to be reached at older ages will gradually diminish.

**Older adolescents (15-19 years) package and platforms:** This age group will require health service access and delivery through a mix of different platforms. For 15-19 year olds in school, the school-based approach described above can be applied – with a different package of services. Other platforms for institutionalizing access to the health service package could be vocational training centres, national youth service, existing community-based youth and sports organizations, youth friendly health services and ASRH programmes as well as programmes reaching young key populations. Whatever the modality is, there is need to institutionalize a system to ensure that a majority of adolescents is reached with the package, preferably before age 19. In addition to the basic package including the VMMC procedure, this age group should ideally be provided with more detailed sexual counselling, condom-skills-building, a basic mental health assessment, a brief alcohol misuse prevention intervention and communication on HIV risk, related social and gender norms including concepts of masculinity.

**Young adult men (20-29 years) package and platforms:** This age group will also require to be reached through age-specific health package through a mix of platforms. Large-scale employers such as mines, industry, uniformed services and other public sectors will need to be involved in providing the package through work place health programmes. Health facilities may reach men through male involvement in sexual and reproductive health services including through active invitation of male partners of antenatal care and family planning clients. In addition, community outreach can be an entry point. There is need to institutionalize the
delivery of the package and enhance participation and prevention as a cultural and social norm. In addition to the basic package, this age group will receive condoms, family planning and SRH counselling, STI diagnosis and treatment, alcohol misuse prevention as well as integrated demand generation and communication on related gender, norms and masculinity. HIV testing (including as self-testing and couples’ testing) and linkages to ART are essential in this age group.

**Basic package for men at higher risk:** In specific locations and sectors men are at a particularly high risk of HIV infection (see next section). In these settings, a health package similar to the package for men age 20-29 years described above should be offered to all men age 15-49 years periodically. The basic package would be equivalent to the package for men age 20-29 years, but with intensified condom promotion and – if HIV incidence exceeds 2-3 in 100 person years – an offer of Pre-Exposure prophylaxis (PrEP).

Progress in **early infant male circumcision (EIMC),** shows marked variations between countries. Given the time frame for realizing impact, EIMC remains a long-term investment. Even if EIMC programmes were scaled up very quickly, adolescent programmes will be necessary for at least 15 years. HIV related impact of EIMC programmes will also depend on the state of the HIV epidemic after 2030. Country-specific approaches will continue to be required considering the specific epidemic context, other health benefits and risks, while following available WHO clinical guidance with an emphasis on safety.
The delivery of the different health packages and development of people-centred health platforms will require enhanced collaboration between sectors:

The **health sectors’** primary role is service delivery of the core package of interventions plus referral to other related health services. The health sector also needs to provide outreach services to and share information about existing and any underutilized service delivery capacities with other sectors. The health sector also needs to collaborate closely with other sectors to support the design of school, community and work place health programmes.

The **education sector** has a core role in promoting knowledge of students, enhancing HIV risk perception and comprehensive age-appropriate sexuality and health education. The primary change required is to institutionalize delivery of adolescent boys’ and girls’ health programmes including VMMC through one of the modalities described above (school nurses, outreach from health workers to schools or organized group visits of adolescent boys to health facilities).
**Communities and traditional leaders** have a key role to play in changing norms in relation to health-seeking behaviour and related social norms. Where initiation rites still exist, VMMC and the wider adolescent health package can become integral part. Collaboration with traditional providers is key where these individuals practice in communities. The potential of the large number of civil society organizations working on HIV and health needs in some areas can be utilized to systematically generate demand for age-specific health packages including VMMC.

**Private and public sector employers** will be engaged to develop modalities for providing service packages to workers. This will entail sector specific approaches including work place health services (like in large mines or uniformed services), outreach from health facilities to work places (in medium-sized companies) and a policies to provide leave to access the VMMC health package at a health facility.

Table 1 in the Annex provides further detailed examples on roles of sectors for specific age groups.

**Focus & scale**

Progress in VMMC programmes has been variable across countries, but is becoming a social norm.

VMMC has reached more adolescent males than anticipated and uptake among 10-14 year olds, who were initially not in the focus of programmes, has been high, while it has proven more difficult to reach men aged 24 years and above. Even though males aged 10-14 were not included in the original VMMC scale up targets, they have constituted approximately 35% of clients reached by the end of 2014, and contributed 20% of the projected HIV infections averted. Demand and service preferences differ by age suggesting that differentiated service delivery and demand generation strategies are required.

While the ultimate goal is to reaching 90% of all boys and men aged 10-29 with VMMC and wider health services by 2020, detailed national planning is required to guide the scale up. Three dimensions will be core for focusing the next phase: age, risk, and location.

**Age**

Prioritization by age needs to consider time horizons for impact, rates of uptake and cost. This calls for balanced prioritization by age:

**Target adolescents (10-19)**: Reaching adolescents with VMMC is an investment with medium-term impact contributing to achieving 2020 and 2030 targets to end AIDS as a threat to public health. Recent research has provided further evidence of a high ‘natural demand’ for VMMC services among adolescent boys in several high priority countries, driven largely by

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acceptability of parents, peer pressure, associations with cultural practices such as rites of passage/manhood, and successful adolescent-specific targeting strategies (ref.).

Population pyramids in VMMC priority countries\(^\text{16}\) illustrate that adolescents account for a large proportion of the population and in a majority of countries numbers of adolescents will continue to grow. Reaching these growing adolescent populations early with health education and outreach to schools provides a unique opportunity to build knowledge and demand on a range of health issues.

**Target 20-29 year olds:** Preventing HIV in next five years requires focusing where new infections are highest, which is the 20-29 year age group. VMMCs among 20-25 year olds are also most cost-effective because VMMCs at younger ages take longer to impact on HIV, while VMMCs at older ages impact for a shorter period of time. In this age group HIV prevalence is higher, which requires enhanced links to HTS and ART. However, opportunity cost for men to seek services is higher, which requires enhanced demand generation. Hence,\(^\text{17}\) VMMC services should remain open for men above 30 years of age, but active targeting and demand generation could focus on younger age groups.

**Men at higher risk**

Specific other groups of men at a particularly high risk of acquiring HIV need to be targeted using differentiated approaches (Table 2):

**Table 1: Populations at higher risk**

<table>
<thead>
<tr>
<th>Population</th>
<th>Avenues to uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV negative men in sero-discordant relations</td>
<td>Integration of VMMC in HTS for men and couples’ testing</td>
</tr>
<tr>
<td>Clients of sex workers</td>
<td>Integration of VMMC communication into condom distribution in sex work venues such as bars</td>
</tr>
<tr>
<td>Mobile workers in mines, farms, tourism and transport business</td>
<td>Outreach services at work places</td>
</tr>
<tr>
<td>Uniformed personnel</td>
<td>Outreach services at work places</td>
</tr>
<tr>
<td>STI patients</td>
<td>Enhanced referral from STI diagnosis and treatment to VMMC</td>
</tr>
</tbody>
</table>

Important strides forward have been taken in identifying and targeting male sub-populations in relation to their HIV risk profile and attitudes towards VMMC. For example, In Zambia and Zimbabwe, quantitative work has been undertaken to segment men according to their place on the path to VMMC and the barriers and motivators that are most relevant to them. This may

\(^{16}\) See Annex


http://dx.doi.org/10.1371/journal.pmed.1002012
enable men in each segment to be easily identified by community mobilisers using a simple questionnaire, and thus reached more systematically by interpersonal communication\(^{18}\).

**Key locations**

Modelling exercises undertaken in some countries suggest that the number of HIV infections averted by VMMC programmes can be enhanced by prioritising geographic areas (e.g. districts) whose HIV prevalence exceeds that of the average national HIV prevalence. It is estimated that this strategy could increase the number of infections averted by as much as 33% in Zambia compared to 19% in Zimbabwe by 2025\(^{19}\).

Geographic scale up of VMMC programmes needs to triangulate different types of data on where adolescents live and go to school, where adult men live and work, where HIV incidence rates are high and where most new infections occur. Urban-rural and labour migration patterns will influence targeting due to high mobility of young adult men. Since adolescent boys from different parts of a country might move to higher HIV incidence settings in urban areas or around work places, national scale up in areas with low MC prevalence will often be required for this age group. For men 20-29, additional or initial focus in scale up should be in high HIV incidence locations.

In settings with high HIV prevalence in southern Africa, locations matter in terms of when and how to deliver VMMC, but high coverage is required nationally and wider health services are needed even where HIV risk is lower. Geographical focus is required for VMMC, but platforms for adolescent and men’s health – funded from non-HIV budgets – could be expanded nationally.

**Empower female partners**

Increasing attention has been paid to the role of female partners in delivering VMMC-related messages and encouraging men to access VMMC services. Integrating men’s health messages into women’s health platforms such as MCH and PMTCT will be critical. In some settings, girlfriends advocating for VMMC to her partner seemed to enjoy much greater success as a trigger than a wife doing so\(^{20}\). Greater efforts are needed to empower females to communicate support around the fear of pain and healing, rather than just talking about the benefits of circumcision for HIV and for themselves as female partners, as this can help to build trust and provide support to males through what remains an important barrier to VMMC and other health service uptake.

**Innovation**

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Over the first decade of VMMC programming, the field has seen a tremendous amount of innovation. The VMMC agenda has benefitted from ongoing new research on implementation innovations, method options including devices, demand generation approaches including new methods from marketing and service delivery models suitable for different settings. Continued innovation is required as the next 4 millions of circumcisions per year may require different approaches than those used to reach the first 14 million, as moving from the innovators and early adopters to accelerate progress amongst those less able to adopt new approaches will be more challenging, and widening the scope of adolescent boys’ and men’s health services requires a new approach.

- The proposed roll-out and institutionalized delivery of integrated health packages for adolescent boys and young men, which include VMMC, constitutes a major strategic shift and needs to be accompanied by operational research.
- Factors linked to effective adolescent-focused services have included engagement of parents and the community, an adolescent-friendly service environment and VMMC counseling messages that were easy to understand.  
- Demand generation for VMMC as part of a wider health package was initially necessarily ad-hoc, but can now be based on evidence-based frameworks as well as socio-cultural and market research.
- Efficiency in reaching sufficient numbers and coverage targets through different service delivery models (outreach, mobile, static VMMC sites) should be continuously evaluated and the models best suited to the local context and specific populations prioritized.
- Health care providers’ concerns about adequacy of time allocation, legal scope of practice, difference in payment modalities, service provider burn-out, training and practice of different VMMC techniques and devices for different age groups as well as communication and practice of new elements such as alcohol and gender and masculinity issues need to be addressed based on existing and new evidence.
- Major innovations have been seen in VMMC devices whose use needs to be accelerated while further research is required to continuously improve devices and their application.
- Continued innovation is required in how to optimally use the health work force for VMMC. Different delivery models for high-volume sites, task sharing and task shifting can be introduced in new settings.
- New coalitions can be formed around the adolescent boys and men’s health platforms

Brothers for Life – an existing platform for VMMC as a gateway to men’s health

“Brothers for Life promote positive male norms and encourage the uptake of health services such as Medical Male Circumcision (MMC), Men taking up HIV Testing, Consistent condom use by Men and reduction of sexual partners. The campaign mobilises men to actively engage in activities to address Gender-Based Violence (GBV) in their communities.”

Source: http://www.brothersforlife.org/our-manifesto.html

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including youth, sports, education and community organizations.

- E-learning tools offer opportunities for service providers and everyone involved in demand generation.
- Evaluation of innovative demand generation approaches using mobile phone applications and new media can provide insights into additional demand generation options.
- There is need to forge partnerships with traditional and religious leaders to increase acceptability and ensure safety.

In 2014, the South Africa National Department of Health reached an agreement with the Congress of Traditional Leaders of South Africa (Contralesa) which enabled traditional leaders to choose professional circumcision doctors to help them with pre-circumcision screening, circumcision and after-care. Agreements with private sector providers contributed to a rapid increase in the number of VMMC performed.

Accountability for results

Accountability for VMMC has largely focused around achieving and monitoring targets in line with external funding agreements or national VMMC working group processes, which was a pragmatic approach in a context of initial rapid scale up. However, there now is a need to fully incorporate men’s and boys’ health into national health strategies with VMMC one key component.

There are several specific opportunities for generating renewed commitment and accountability towards VMMC:

- Developing national strategies and operating procedures for adolescent boys and men’s health platforms involving an expanded group of partners;
- Processes of country adaptation of global HIV fast-track targets and setting national targets;
- Continued engagement of traditional, religious and political leaders, but with renewed focus on adolescent boys and young men’s health;
- Integration of VMMC into country performance management mechanisms for HIV and health at national and sub-national level;
- Resource mobilization from domestic public and private sector and sub-national sources for VMMC within the context of wider health platforms and including resources from outside HIV;
- Sustaining and maximising external funding opportunities for VMMC while broader male health platforms are being developed.
- The World Bank's piloting of a Health Financing System Assessment (HFSA) protocol to strengthen country health financing systems to enable them to accelerate and sustain progress towards Universal Health Coverage (UHC).

- Enhanced capacity of national institutions in management, quality assurance, monitoring and evaluation including age-disaggregation.

Figure 5: Accountability framework for VMMC 2021 as a gateway for adolescent boys and young men to health

VMMC 2021 sets out a pathway to sustainability. Only with a joint effort by national sectors, external donors, communities and boys and men taking charge of their own health will indicators improve and ambitious targets are reached. Indicators and operational frameworks will be developed in a next stage to take the VMMC gateway 2021 forward.
<table>
<thead>
<tr>
<th>Sectors</th>
<th>Health</th>
<th>Community</th>
<th>Education</th>
<th>Work place</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dimension</strong></td>
<td>Service delivery &amp; referral</td>
<td>Norms &amp; demand</td>
<td>Knowledge &amp; risk perception</td>
<td>Information &amp; access</td>
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<tr>
<td><strong>Populations</strong></td>
<td>Package elements integrated OR linked</td>
<td></td>
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<tr>
<td>Cross-cutting (all priority groups)</td>
<td>Basic package: - basic health assessment; - behavioural counselling /HIV risk factors and prevention; - VMMC surgical procedure infection control; - HIV testing service and referral for ART; - wound care counselling; - review vaccination status/ offer booster</td>
<td>- traditional leaders engaged and empowered*; - communication on gender norms, masculinity, social norms; - continued communication on HIV risk factors and services; - improve health literacy *</td>
<td>- Sector development to support adolescent/ young people's health (VMMC knowledge and service delivery integrated)</td>
<td>- Sector development to support adolescent/ young people's health (VMMC knowledge integrated) - leave provision of family health information incl. on HIV prevention/ VMMC to parents</td>
</tr>
<tr>
<td>Adolescent boys, 10 – 14</td>
<td>Basic package plus - Tetanus vaccine booster; - Hygiene counselling; - Parent counselling on wound care, - outreach services in schools</td>
<td>- parent ability to talk about sex, wound care, HTS</td>
<td>- age-appropriate comprehensive sexuality and health education (VMMC integrated) - hosting VMMC outreach services</td>
<td>- provision of family health information incl. on HIV prevention/ VMMC to parents</td>
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<tr>
<td>Adolescent boys 15-19</td>
<td>Basic package plus - Tetanus vaccine booster; - Mental health assessment - condom skills-building - alcohol risk counselling - outreach to schools</td>
<td>- integrated demand generation for VMMC, condoms, HTS, ART - communication about age-specific health risks (sexual behaviour/alcohol/ substance use), related social norms including gender &amp; masculinity</td>
<td>- age-appropriate comprehensive sexuality and health education (VMMC integrated) - hosting VMMC outreach services</td>
<td>- access to health check for employed adolescents - host VMMC outreach (large companies) - condom access</td>
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<tr>
<td>Young men 20 – 34</td>
<td>Basic package plus - STI screening/ treatment - Family planning - outreach services in communities and work places</td>
<td></td>
<td>- hosting VMMC outreach services in tertiary institutions</td>
<td>- host VMMC outreach (large companies) - condom access</td>
</tr>
<tr>
<td>High risk men</td>
<td>Basic package plus - HIV testing services - STI screening/ treatment - family planning - PrEP; - outreach services in communities and work places</td>
<td>- integrated demand generation for VMMC, condoms, HTS, ART &amp; PrEP - communication about health risks (sexual behaviour/ alcohol/ substance use), related social norms including gender &amp; masculinity</td>
<td>n.a.</td>
<td>- host VMMC outreach (large companies) - condom access</td>
</tr>
<tr>
<td>Adolescent girls and young women</td>
<td>VMMC and EIMC information integrated into: - comprehensive SRH - HTS including as couples - family planning - HPV vaccine</td>
<td>- integrated demand generation for condoms, HTS, ART &amp; PrEP includes VMMC information</td>
<td>- keep girls in schools - CSE (VMMC knowledge integrated)</td>
<td>- access to health check</td>
</tr>
<tr>
<td>Actors</td>
<td>Ministries of Health; nursing service, city and local health departments; public, private and NGO health service providers. Funding partners, WHO, UNFPA, UNICEF, international NGOs</td>
<td>Traditional, religious, political and administrative leaders, CBOs, NGOs, FBOs</td>
<td>Ministries of Education; primary, secondary and tertiary education institutions. Funding partners, UNAIDS UNFPA, UNICEF, international NGOs</td>
<td>Various Ministries, local authorities, private, public and civil society employers - Funding partners, ILO, business coalitions</td>
</tr>
</tbody>
</table>
References