MALE CIRCUMCISION FOR HIV PREVENTION

MEETING REPORT

IMPLEMENTING THE 2017–2021 FRAMEWORK FOR VOLUNTARY MEDICAL MALE CIRCUMCISION

27 FEBRUARY–1 MARCH 2017

World Health Organization

MALE CIRCUMCISION FOR HIV PREVENTION — IMPLEMENTING THE 2017–2021 FRAMEWORK FOR VOLUNTARY MEDICAL MALE CIRCUMCISION 27 FEBRUARY–1 MARCH 2017, MEETING REPORT

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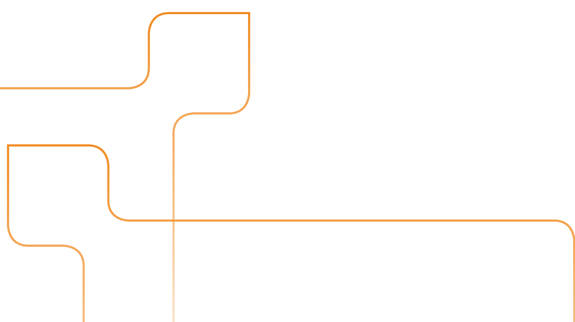
This report was prepared by Raymond Yekeye, Buhle Ncube, HIV Prevention Focal Point, WHO AFRO, and Julia Samuelson, Department of HIV and Global Hepatitis Programme, WHO, Geneva.

LIST OF ACRONYMS

AA-HA!	Global Accelerated Action for the Health of Adolescents
AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ASRH	adolescent sexual and reproductive health
DMPPT	Decision-Makers' Program Planning Tool
HIV	human immunodeficiency virus
HPV	human papilloma virus
MC	male circumcision
MoH	ministry of health
NGO	nongovernmental organization
NSP	national strategic plan
SDGs	Sustainable Development Goals
SRH	sexual and reproductive health
STI	sexually transmitted infection
VMMC	voluntary medical male circumcision

LIST OF ACRONYMS OF ORGANIZATIONS

AFRIYAN	African Youth and Adolescent Network on Population and Development
AFRO	WHO Regional Office for Africa
BMGF	Bill and Melinda Gates Foundation
CAPRISA	Centre for the AIDS Programme of Research in South Africa
CDC	Centers for Disease Control and Prevention
CHAPS	Centre for HIV and AIDS Prevention Studies
COSECSA	College of Surgeons of East, Central and Southern Africa
ICAN	Infection Control Africa Network
ICAZ	Infection Control Association of Zimbabwe
ILO	International Labour Organization
JHCCP	Johns Hopkins Center for Communication Programs
Jhpiego	[This is no longer a formal acronym. Jhpiego is an international non-profit health organization affiliated with Johns Hopkins University.]
OGAC	Office of the US Global Aids Coordinator
PEPFAR	United States President's Emergency Plan for AIDS Relief
PSI	Population Services International
SafAIDS	Southern Africa HIV and AIDS Information Dissemination Service
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization



INTRODUCTION

This report provides an overview of proceedings of a meeting held 27 February–1 March 2017 in Durban, South Africa attended by 135 participants from different levels of various organizations, including from 14 voluntary medical male circumcision (VMMC) priority countries in eastern and southern Africa[1]. The meeting sought to share information on progress, successes, impact and lessons learnt in scaling up national VMMC programmes. It also provided a platform for updates on strategy and technical aspects of VMMC interventions, including the 2017–2021 framework, new guidance and key initiatives for adolescent boys' and men's health. The meeting sought to identify strategic actions, gaps, challenges and possible solutions for continued VMMC programme scale-up and sustainability. A further key objective was to agree on priority directions and key country-specific actions for national leadership of programmes.

Participants included government officials, communication experts, implementation researchers, adolescent and young men, women, traditional leaders, and representatives from nongovernmental organizations (NGOs), community-based organizations, implementing agencies and development partners (see Annex 3 for a full list of participants).

1 Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe.

BACKGROUND

By end 2016 over 14 million[2] men had been circumcised for HIV prevention in eastern and southern Africa.

It is estimated that these male circumcisions (MCs) will avert around 500 000 HIV infections through 2030. Efforts to scale up national VMMC programmes have been enabled through the development of national policies on MC, investments in service delivery, widespread communication and demand generation along with the engagement of many partners and communities. Experience from VMMC programmes in 14 priority countries in eastern and southern Africa has shown high uptake among adolescent boys in particular. The men and boys reached through VMMC programmes have also been provided with a minimum level of safer sex education, offered condoms and HIV testing, and been assisted with the management of sexually transmitted infections.

As a follow-on to the **Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa 2012–2016** UNAIDS and WHO put forward new strategic directions with a focus on adolescent boys and young men in the **Framework for Voluntary Medical Male Circumcision: Effective HIV Prevention and a Gateway to Improved Adolescent Boys' and Men's Health in Eastern and Southern Africa by 2021**, the targets of which are aligned with the UNAIDS Fast-Track goals, namely:

i) 90% of males aged 10–29 years will have been circumcised in priority settings in sub-Saharan Africa as part of integrated sexual and reproductive health services for males;

ii) 90% of males aged 10–29 years will have accessed age-specific health services tailored to their needs.

Modelling done in 2014–15 showed that an intensified focus on younger men aged 15–29 years was required for VMMC programme efficiency and to achieve the most immediate impact on the HIV epidemic. Efforts have been underway to expand the evidence on how to operationalize VMMC services for adolescents while simultaneously accelerating scale and reach to higher-risk and young men. Thus, the need was expressed by many stakeholders to reflect on progress, challenges, lessons learnt and opportunities to inform future VMMC programmes.

With this intention two meetings were held 27 February–3 March 2017 in Durban, South Africa. The first meeting (27 February–1 March 2017) was attended by all participants (see Annex 3) and the proceedings and main outcomes are summarized in this report. The second meeting (2–3 March 2017) was attended by 33 participants (out of the 135 who took part in the first meeting), including VMMC focal points from the ministries of health in the 14 priority countries and from the WHO country offices, as well as representatives from WHO headquarters, the WHO Regional Office for Africa and the Intercountry Support Team for Eastern and Southern Africa. This second meeting was held to provide a forum for further discussion of key issues emerging from the first three-day meeting, including technical support needs and the way forwards in scaling up VMMC.

Meeting objectives

The objectives of the 27 February–1 March 2017 meeting were to:

i. Share progress, successes, impact and lessons learnt in scaling up VMMC.

ii. Provide updates on strategy and technical aspects of VMMC, including the framework, new guidance and key initiatives for adolescent males and other men.

iii. Identify strategic actions, gaps, challenges and possible solutions for continued scale-up and sustainability of VMMC.

iv. Agree on priority directions and country-specific key actions for national programme leadership.

2 The finalized figure for 2016 is a total of 14.5 million VMMCs performed, of which 2.8 million in 2016.

PRESENTATIONS, SUMMARIES AND PRIORITY ACTIONS

DAY 1

OPENING SESSION

The official opening ceremony was presided over by the WHO Country Representative for South Africa, Dr R. Chatora, along with Mr C. Bonnecwe and Dr R. Ndaba from the South African Department of Health, who work at the national and provincial levels respectively.

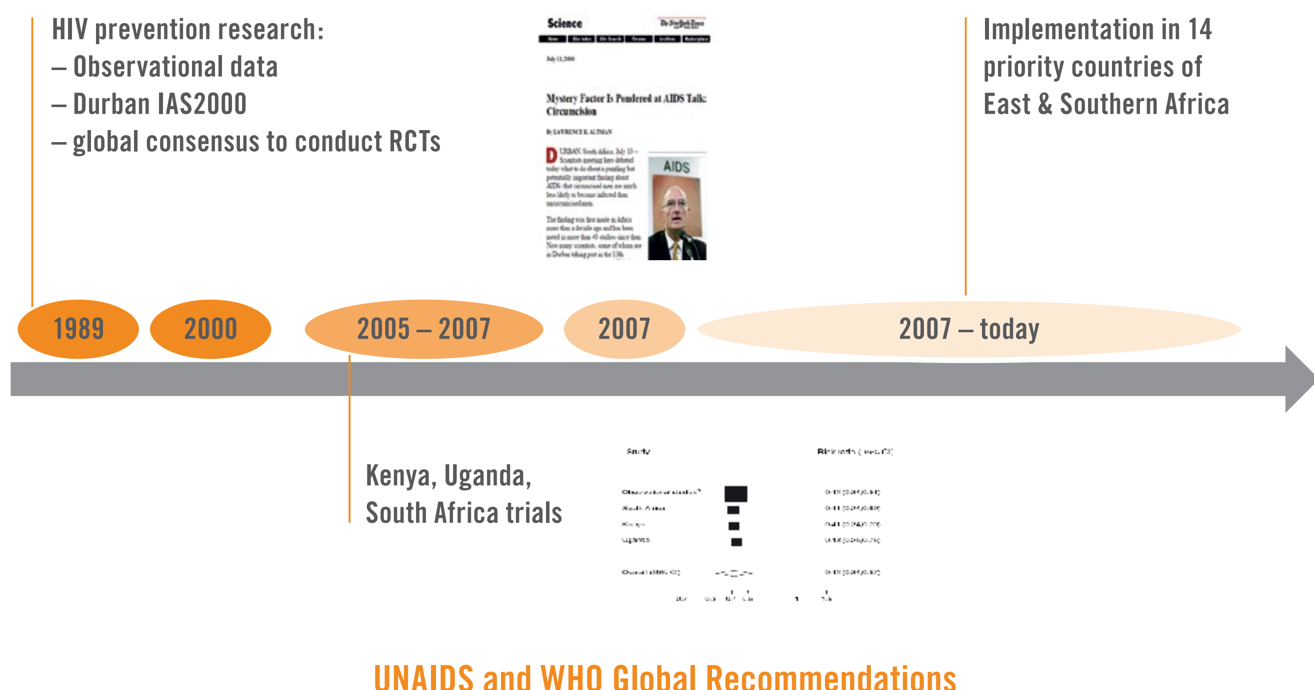
The speakers highlighted the main successes achieved to date by the VMMC programme in South Africa, which not only provides men with access to MC services but also links them to other relevant health services. The programme has leveraged existing partnerships, particularly with the private sector and other health programmes, to facilitate the achievement of results. Challenges around data collection and data quality, low VMMC uptake by older men and the quality of services provided by traditional circumcision providers need to be further addressed.

Share progress, successes, impact and lessons learnt in scaling up VMMC

Setting the scene (B. Ncube, WHO)

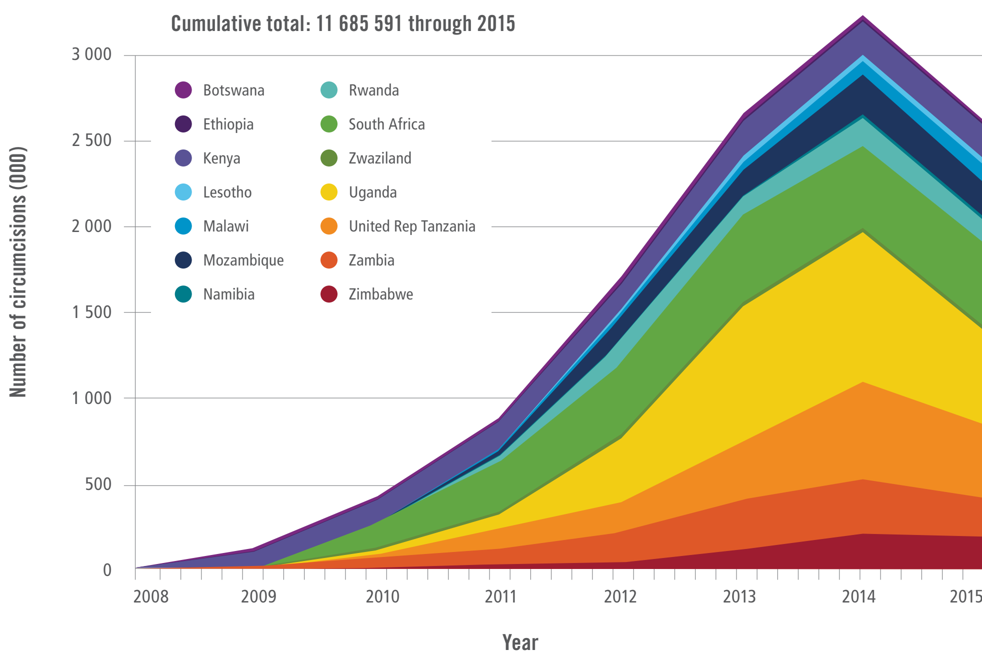
WHO presented the context for the meeting and made reference to some of the key VMMC milestones that have been achieved to date (see Fig. 1).

Figure 1 Key milestones in VMMC for HIV prevention



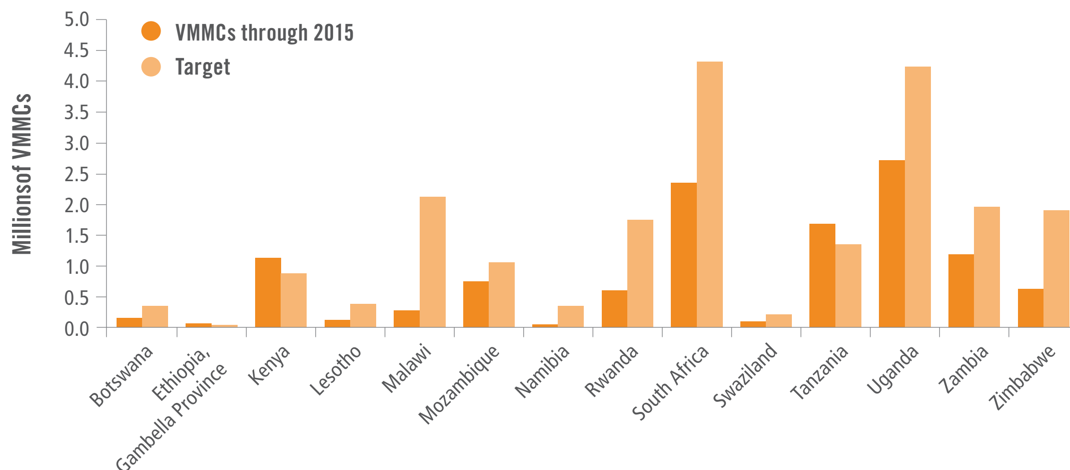
Almost 12 million VMMC procedures were performed in eastern and southern Africa by end 2015. This figure increased to more than 14 million[3] in 2016, which is almost two thirds of the target of 20.8 million MCs set within the initial VMMC framework in 2011. The more than 12 million MCs performed by end 2015 will avert an estimated 452 000 HIV infections by 2030, and the median cost per HIV infection averted of US$ 3800 demonstrates the cost-effectiveness of VMMC. Figure 2 provides an overview of the number of VMMCs performed in the 14 priority countries in eastern and southern African in the period 2008–2015.

Figure 2 Overview of VMMC implementation progress in 14 countries in eastern and southern Africa



Most countries did not meet the 80% VMMC coverage target set within the Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa 2012–2016. South Africa, Kenya, Uganda and Tanzania contributed the highest number of MC procedures in 2015 (see Fig. 3).

Figure 3 Number of VMMCs conducted through 2015 in 14 priority African countries, with estimated target number required to reach 80% male circumcision



3 The finalized number for 2016 is a total of 14.5 million VMMCs performed, of which 2.8 million in 2016.

In the 14 priority African countries, through 2015, 32% of VMMCs were performed in the 10–14-year age group. These circumcisions alone will contribute to a 16% reduction in the number of new HIV infections which would have occurred through 2030.

34% of VMMCs through 2015 were performed among adolescents aged 15-19 years; these will avert an estimated 35% of new HIV infections through 2030.

Lessons learned

Lessons learnt from implementing the Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa 2012–2016 include the importance of working within country-specific contexts and investing in innovation to increase the scope of success. The centrality of sustained national leadership for programme success was also recognized. Key lessons further illustrated that different demographic groups are influenced in varying ways, requiring age-specific communication tools and messaging. Strategic information was critical in supporting programme implementation and scale-up; thus, strong monitoring and evaluation (including collecting and analysing disaggregated data) was important for facilitating informed decision-making. Another lesson was that programme success is dependent on strong multi-stakeholder efforts and coordination, including partnerships with civil society organizations and at all levels of the national health system.

Challenges

Key challenges faced in implementing the 2012–2016 joint strategic action framework were primarily around generating demand for VMMC services among men aged 24 years and above. Insufficient research has been conducted on the barriers to service uptake among this population. In addition, leadership at the subnational level has been limited – or when available was unsustainable – which has affected progress, especially as leadership at all levels is fundamental for programme success. Further, human resource shortages affected progress, especially where programmes were predominantly physician-led, compared to those settings where task-sharing efforts resulted in the inclusion of other cadres.

Perspectives and experiences of young people (L. Mosooane, AVAC; J. Kayombo, AFRIYAN)

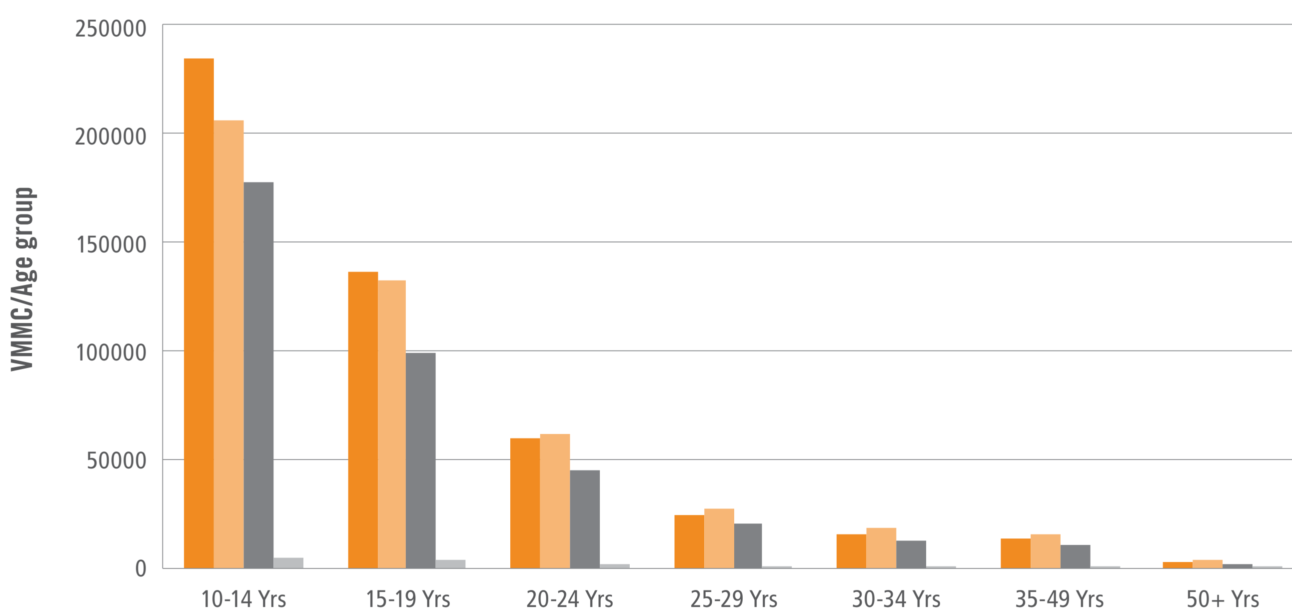
This session provided the floor for young people – who are key for the success of VMMC programmes – to share their perspectives. AVAC and AFRIYAN highlighted the importance of ensuring young people are fully involved in consultations as well as in programming/implementation so that VMMC programmes are relevant. In addition, reference was made to the critical role played by women and girls in decision-making around VMMC for adolescent boys/young men. Moreover, during the design and implementation of programmes careful consideration needs to be given to social norms and structures. Experience has shown that adolescent boys and young men have been left out of programmes on sexual and reproductive health (SRH) or gender-based violence and gender equality, despite the fact that they exert a tremendous influence over girls. Interaction between boys and girls is a fundamental requirement if there is to be better understanding of gender equality and sexual violence at the societal level. Therefore, it is essential to involve boys and young men in programmes on gender equality and gender-based violence. SRH interventions also need to be designed for and targeted at both adolescent boys and girls, bearing in mind their similarities and differences. Furthermore, efforts should be made to provide timely and correct information about SRH to young people. Finally, it was highlighted that programme design and implementation approaches should be built on the understanding that VMMC is a gateway to other services, for example HIV testing services.

KEY PROGRESS, SUCCESSES AND LESSONS LEARNT TOWARDS THE 2016 TARGETS

Country presentations (K. Serrem, Kenya Ministry of Health (MoH); Zambia MoH; G. Lija, Tanzania MoH; Malawi MoH)

This session provided perspectives from the VMMC programmes in Kenya, Tanzania, Malawi and Zambia. One common observation was that uptake of VMMC decreases with age, as evidenced in Tanzania (see Fig. 4), Malawi and Zambia.

Figure 4 Decrease in VMMC uptake by age in Tanzania



	10-14 Yrs	15-19 Yrs	20-24 Yrs	25-29 Yrs	30-34 Yrs	35-49 Yrs	50+ Yrs
FY 2014	234699	135887	59581	24360	15581	13747	2834
FY 2015	205410	131983	61871	27648	18049	15926	3402
FY 2016	177207	99054	45395	20655	12429	10839	2026
FY 2017	4954	3534	1640	737	448	358	72

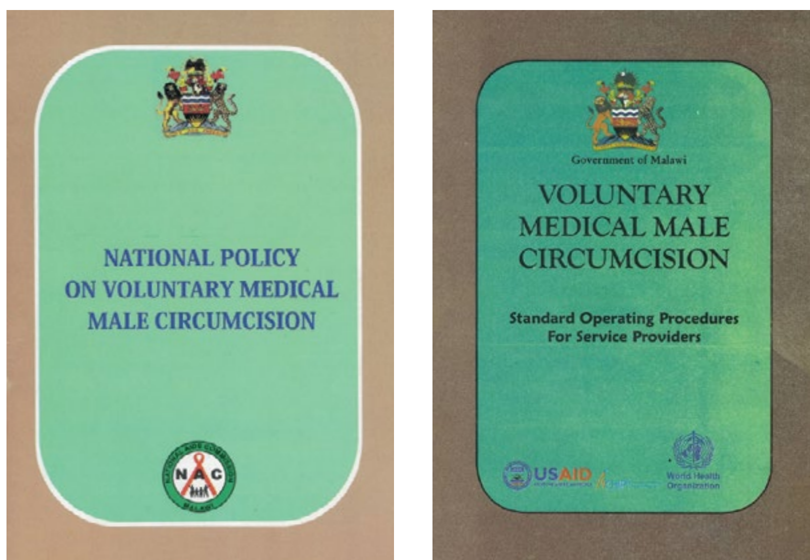
In all four countries: discrepancies were experienced between partner data and data from district-level health information systems; there are plans for the introduction of tetanus mitigation measures; and consideration is being given to providing early infant male circumcision services.

In summary, the following country-specific progress has been made:

- Kenya: although a phased approach to implementation of the national VMMC programme has been adopted, there has already been an impact on HIV incidence as reported in Kenya's VMMC impact evaluation. This success has been attributed to: political engagement and MoH leadership (technical working groups) at all levels; stakeholder engagement, especially cultural and traditional leaders in non-circumcising communities; the availability of a national strategy with subnational targets; and innovative demand creation. Data issues – discrepancies between partner data and data from district-level health information systems – have not yet been resolved; and the community VMMC coverage survey planned for 2016 is still to be undertaken.
- Zambia: 75% VMMC coverage has been achieved. Success is attributable to good partner coordination and resource leveraging through regular technical working group meetings and planning; task shifting; robust community demand generation; involvement of traditional and community leaders and women; harmonization between partner reporting and data from the national health information system. However, there have been challenges with competing health priorities, the lack of data disaggregated by age group or data on adverse events, and inadequate infrastructure.

- **Tanzania:** Successes are attributable to: task shifting, which has permitted nurses to perform VMMC; large-scale public awareness campaigns; MoH ownership – with an operational plan through 2017; and partner support for implementation. Challenges have included: inadequate capacity for waste management, especially disposable instruments; implementation in 2015 was only in the PEPFAR-supported Scale-Up Districts, which resulted in lower numbers of MCs performed; discrepancies between data issued by the national health information system and that used by implementing partners.
- **Malawi:** Successes were attributed to the availability of a national policy on VMMC, an operational plan, guidelines and standard operating procedures (see Fig. 5). Challenges included an inadequate number of trained providers to routinely offer VMMC services, few implementing partners to cover all priority districts, seasonality of demand as well as inadequate infrastructure (limited spaces in facilities and some geographical areas being hard to reach) and data management (limited submission of data by partners to MoH).

Figure 5 Malawi national policy documents



Partners panel (C. Toledo, PEPFAR; M. Sundaram, BMGF; A. Kaggwa, AVAC; C. Laube, Jhpiego)

This session provided opportunities for reflection by partners on progress made in the implementation of VMMC programmes in the 14 priority countries and discussion on the implications of current results on future programming. The presenters stressed that even though the 80% target set out in the Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa 2012–2016 had not been reached in most countries, major milestones had still been achieved in mainly difficult operating environments with competing health priorities. A key theme that has emerged is that demand creation is fundamental to programme success. Formative work and strong partnerships are needed for improved demand creation. Experience has shown that VMMC is a fast-moving programme, hence there is a need for flexibility to put in place learning and sharing mechanisms that facilitate rapid scale-up of approaches that are effective. Appropriate target setting, sustained resource mobilization and a consistent commitment to implementation are key factors for success. The panel recommended ambitious VMMC targets be tied to funding, which is necessary to provide motivation for intervention success. Challenges around financial and technical sustainability were flagged, highlighting the need to further strengthen the capacities of national VMMC programmes. Sustainability is more probable if there is a diversification of the resource base; thus, there is a need to strengthen linkages between VMMC programmes and other services and sectors as well as geographic coordination between implementing partners to avoid competition.

GLOBAL AND REGIONAL LANDSCAPE

UNAIDS targets and strategies in the context of the Sustainable Development Goals (SDGs) and engaging adolescents and men (P. Somse, UNAIDS)

VMMC is included in the fourth pillar (Reduce inequality in access to services and commodities) of the UNAIDS 2016–2021 Strategy (On the Fast-Track to End AIDS), where it is recognized as a game changer. The pillar and related target (90% of women and men, especially young people and those in high prevalence settings, have access to HIV combination prevention and SRH services) provide the basis for pursuing sustainability. Technical aspects of programme implementation need to be distinguished from nontechnical components. There is no such thing as a single issue struggle because we do not live single issue lives.

Three Frees: Start Free, Stay Free, AIDS Free (P. Nary, UNICEF)

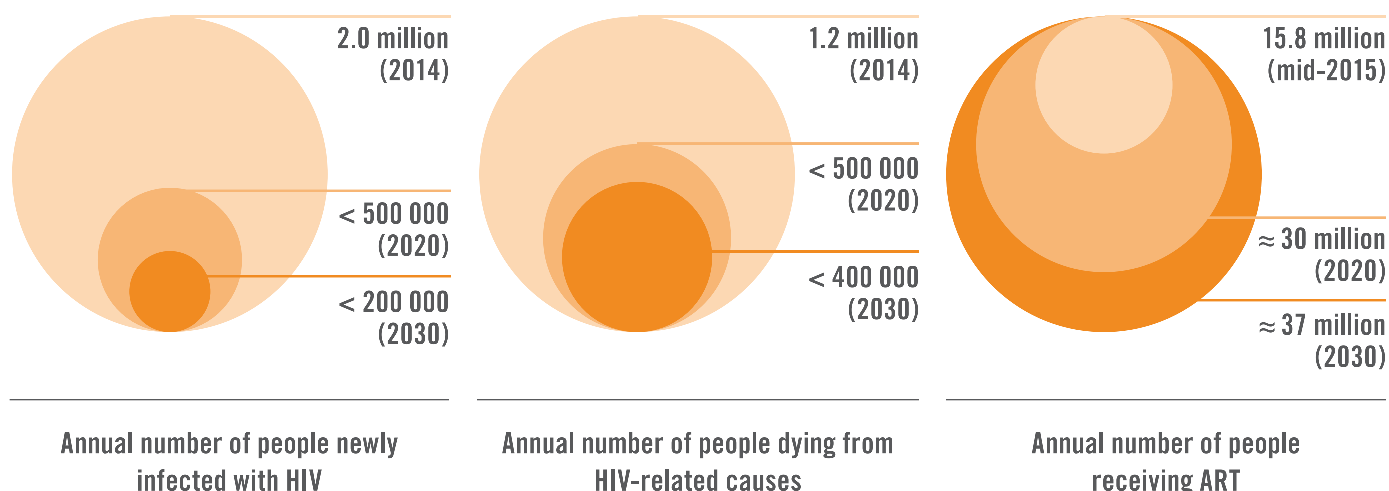
It is important that the different United Nations HIV prevention frameworks work together to avoid duplication and to collectively advance towards the goal of zero HIV infections and an AIDS-free generation. The Three Frees is a collaborative agenda between UNAIDS and PEPFAR. It is a fast-track policy and delivery framework for ending AIDS among children, adolescents and young women by 2020. VMMC is part of the Stay Free component. The key next steps are to encourage ministers of health and stakeholders to adopt this framework, align existing resources and develop implementation plans.

HIV and AIDS: Framework for Action in the WHO African Region 2016–2020 (F. Lule, WHO/AFRO)

This framework for action includes five strategic directions: i) country ownership, ii) effective partnerships, iii) universal health coverage, iv) integration of HIV and AIDS in national health systems and strategies, v) a public health and people-centred approach. It further includes guidance on prioritization – especially high-impact prevention interventions, eliminating HIV in infants, expanding ational HIV testing services, accelerating the scale-up of antiretroviral medicines for treatment and prevention, and early detection and treatment of coinfections.

Figure 6 Global HIV targets – Towards the global HIV targets for 2020 and 2030

Reaching the 2020 targets requires accelerating the integrated public health approach that enabled the achievements of the past 15 years. The proposed WHO Global Health Sector Strategy on HIV 2016-2021 charts such a response.



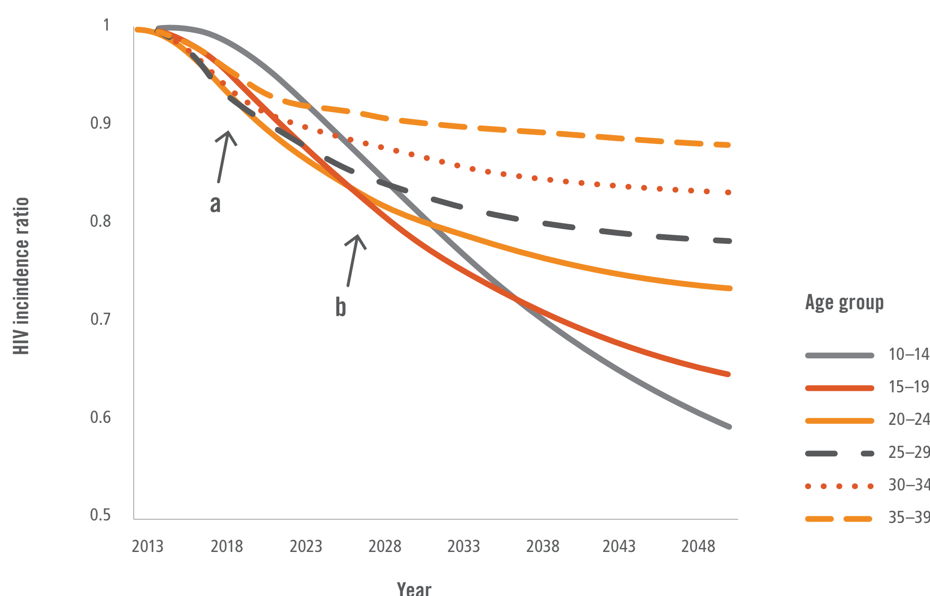
EVIDENCE FOR FOCUSED STRATEGIC ACTION

Age, risk and geography modelling to inform VMMC strategy and targets (T. Farley, consultant for WHO)

Models used earlier to estimate the impact and cost of VMMC programmes have been updated and new models developed. These models use more precise age groups, updated HIV incidence estimates and lower HIV treatment costs. In 2016 WHO and UNAIDS held a meeting to consolidate the findings from the diverse models.

The models consistently showed that VMMC programmes that reach males aged 15–29 years and males at higher sexual risk of HIV infection (such as those with multiple partners) will have **the most immediate impact** on the AIDS epidemic, followed by boys aged 10–14 years.

Figure 7 Relative impact of scaling up VMMC – based on modelling



Reduction in HIV incidence by age group, 2014–2050. Each line represents HIV incidence ratio under scenario in which only indicated 5-year age group circumcised. Marker ***a*** represents 5-yr period from 2014. Marker ***b*** represents a 15-yr period from 2014.

VMMC coverage, modelling and translation of results to inform national strategies (P. Stegman, Avenir Health)

The Decision-Makers' Program Planning Tool (DMPPT), developed in 2009 for advocacy purposes, was used to generate initial estimates on HIV infections averted by MC at diverse coverage levels. A second version of the DMPPT, developed in 2011, was used for strategic planning in nine African countries with national VMMC programmes and by the Government of the United States of America (PEPFAR) in the formulation of country operational plans and for monitoring purposes. Achieving the Fast-Track 90–90–90 HIV prevention goals requires 90% VMMC coverage among males aged 10–29 years (see Fig. 8) and health services that are tailored to the needs of specific age brackets.

Figure 8 UNAIDS Fast-Track MC targets

Estimated number of circumcisions required by country to achieve 80% or 90% coverage in 10-29 yr age group by 2020

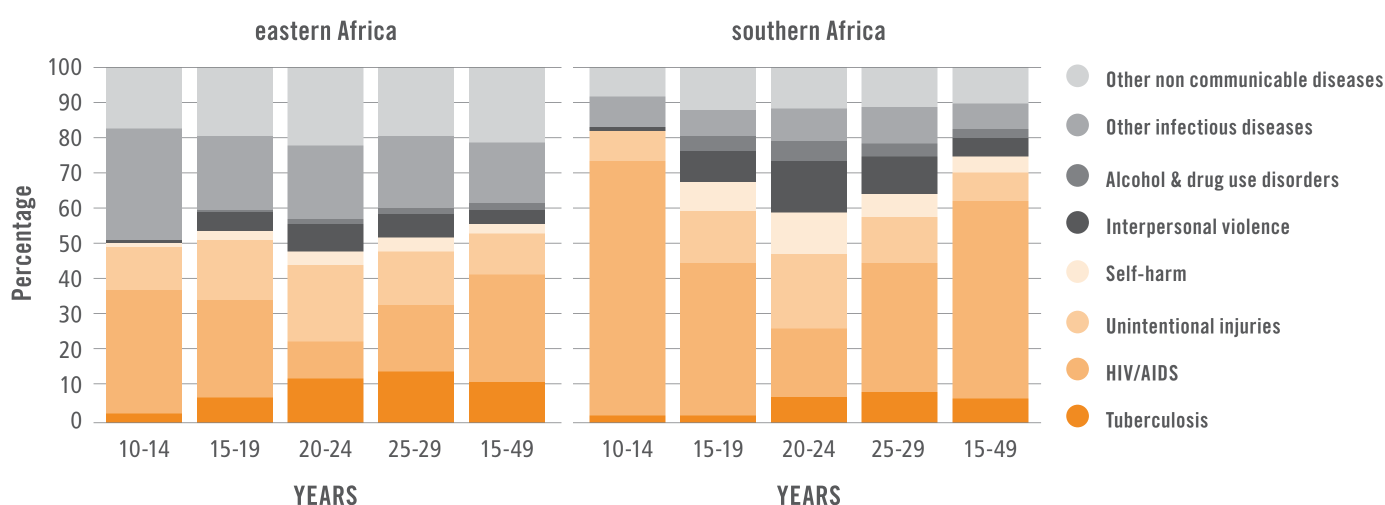
Country	% in 2015	Target 80%	Target 90%
Botswana	31%	240,000	280,000
Ethiopia (Gambela)	75%	10,000	19,000
Kenya (Nyanza)	72%	290,000	505,000
Lesotho	69%	55,000	100,000
Malawi	26%	2.5 million	3.0 million
Mozambique	57%	2.2 million	2.9 million
Namibia	27%	310,000	370,000
Rwanda	35%	1.3 million	1.6 million
South Africa	56%	2.7 million	3.9 million
South Sudan	26%	1.8 million	2.1 million
Swaziland	32%	150,000	180,000
Uganda	53%	3.6 million	4.6 million
Tanzania	84%	1.1 million	2.4 million
Zambia	37%	2.0 million	2.4 million
Zimbabwe	22%	2.2 million	2.6 million
Total		20.4 million	26.8 million

Source: UNAIDS

Framework on VMMC: effective HIV prevention and a gateway to improving adolescent boys' and men's health (J. Samuelson, WHO)

WHO presented on the new landscape in which VMMC implementation is situated and how the new Framework on VMMC is aligned with the SDGs and other global health strategies. It builds on the two Fast-Track targets of 90% circumcision coverage among males aged 10–29 years and broadening the range of age-specific health services offered to this same age group. How to integrate VMMC services into broader health and development aspirations and systems needs to be determined to ensure sustainability. The Framework is based on three principles: a people-centred approach, gender-based perspective and enhancing partnerships.

Figure 9 Years of life lost among men in eastern and southern Africa, according to age group and cause (2013)



Six causes (HIV, tuberculosis, violence, self-harm, injuries and alcohol or drug misuse) contribute more than 80% of years of life lost among men aged 15-49 years in southern Africa, and more than 60% in eastern Africa.

Source: Prepared by the authors, based on the Global Burden of Disease Study 2013 (3).

The Framework has four strategic directions:

1. **Focused action for scale-up.** Using strategic information to determine among which population groups and geographic areas to focus and tailor VMMC interventions is essential for impact, as noted in the modelling results. Age groups should be prioritized, especially the age bracket 10–29 years. Priority should also be given to males at higher sexual risk of HIV infection.

2. **Policies and services for greatest impact.** Male-friendly health service delivery approaches must be enhanced along with relevant age- and risk-specific packages of services.

3. **Innovations for accelerations and the future.** Health policies need to be established that better address the needs of men and boys, including supportive policies from other sectors such as sports and gender. Investing in new coalitions and partnerships is essential for programme success. Research on implementation and operations can inform improvements in service delivery. Creating a culture of health care seeking behaviour will require learning about and changing demand generation approaches, including the effective use of relevant media.

4. **Accountability for quality and results.** Results must be evaluated across programmes and sectors, including the effectiveness of partnerships. Countries need to put strong national monitoring and quality assurance systems in place within the next five years and expand their financial resource portfolios.

BRIEF TECHNICAL UPDATES (PARALLEL SESSIONS)

Manual for male circumcision under local anaesthesia, second edition (M. Mahomed, Jhpiego)

Jhpiego provided a brief overview of the revisions that will be made in the second edition of the Manual for male circumcision under local anaesthesia. These revisions are based on the last 10 years of experience with over 14 million MCs performed in eastern and southern Africa. It includes revised and rearranged chapters geared towards improving quality and safety. WHO recommendations have been incorporated from guidance on infection prevention and control, including hand hygiene and safe injection practices, as well as new surgical recommendations.

VMMC methods, tetanus risk and mitigation through tetanus-toxoid-containing vaccination (J. Samuelson, WHO)

WHO has monitored the safety of MC methods, including new device-based methods. The PrePex (elastic collar compression) and the Shang Ring (collar clamp) have been prequalified by WHO for use among males aged 13 years and over. Less than 4% of the more than 14 million VMMCs performed to date were done using devices; the majority were performed with conventional surgical methods. Between 2012 and mid-year 2016, 16 cases of tetanus were reported. A difference in risk was noted by circumcision method. For example, there was a 30-fold increased risk of tetanus with the use of the elastic collar compression method. Mitigation of this tetanus risk is possible. The WHO position, issued after two advisory group consultations, is that a tetanus-toxoid-containing vaccine (two doses sufficiently timed for protection) should be administered before the elastic collar compression method (PrePex) is used. WHO also recommends vaccination programmes add tetanus-toxoid-containing vaccines (boosters) for adolescent boys[4]. The WHO schedule for provision of both tetanus-toxoid-containing vaccines for adolescent boys and girls and human papilloma virus vaccinations for girls is now aligned to during the ages 9–15 years. Also, awareness should be raised among individuals and communities about clean wound care so that substances such as dung, which may contain spores, are not used. VMMC in general remains a safe procedure with a low rate of adverse events.

Youth advocacy workshop

Fourteen youth advocates, selected through a nomination process carried out by AFRIYAN, attended the meeting as part of their country teams. Their role was to contribute the perspectives of adolescent boys and young men and advocate for responsive VMMC programming. In collaboration with AVAC and AFRIYAN, the youth advocates developed key advocacy messages to encourage policy-makers and programme implementers to give further attention to adolescent boys and young men in the HIV response and make full use of the opportunity that VMMC provides to address their broader health needs. The young participants used these messages for advocacy throughout the three-day meeting. The messages were further developed into an advocacy note for youth organizations to use at the country and international levels. (See Annex 1 for a full report on the youth advocacy workshop.)

4 WHO Weekly Epidemiological Record,10 February 2017, vol. 92, 6 (pp.53–76).

DAY 2

Evidence, lessons and promising practices to actions

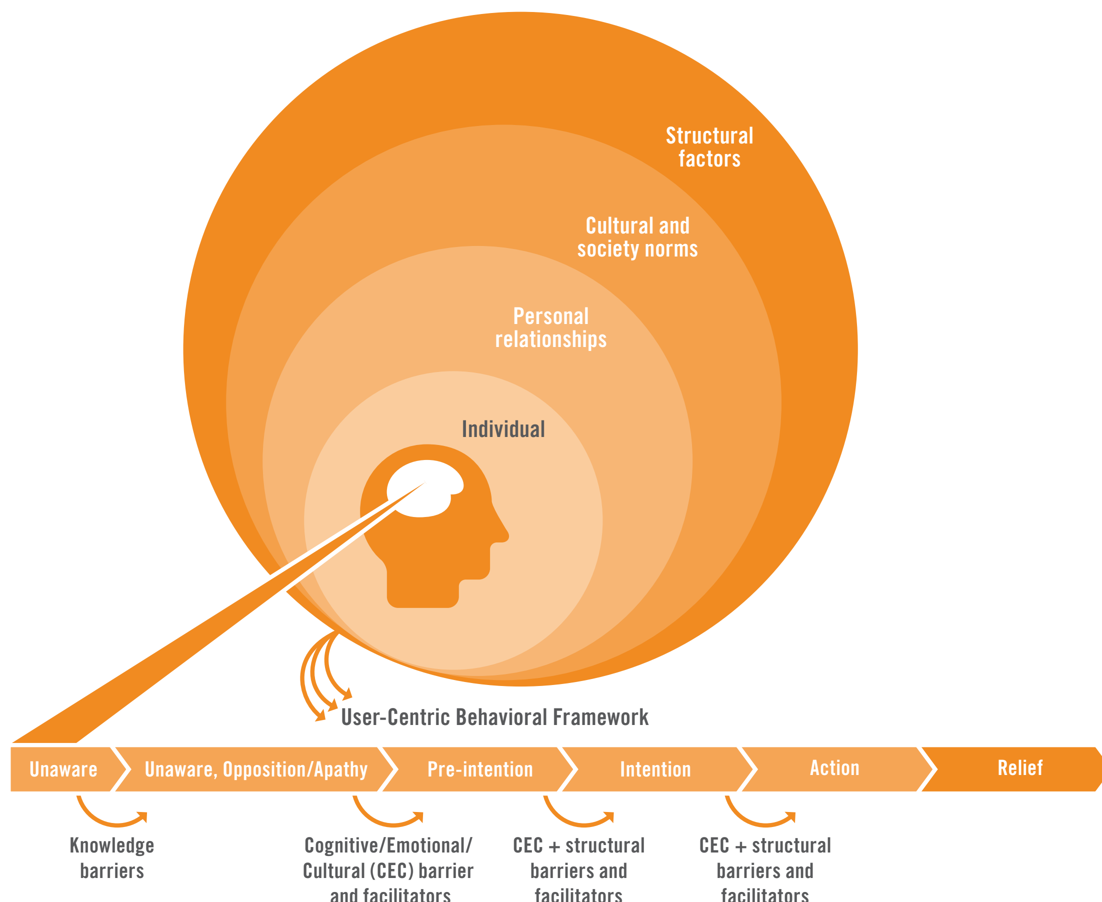
FOCUSED ACTION FOR MALES 20–29 YEARS AND MOST AT RISK MEN

Demand creation (L. Van Lith, JHCCP; C. Laube, Jhpiego; D. Taljaard, CHAPS; C. Toledo, CDC; A. Machinda, PSI Zambia)

This session provided an overview of demand creation strategies, including specific strategies for older men.

Two key approaches to accelerating VMMC uptake among men were outlined: interpersonal communication and community mobilization. The presentation focused on strategies used for VMMC uptake among males aged 20–29 years in South Africa. These strategies have included: focusing on high schools, providing group-based support, encouraging implementing partners to focus on age pivots (ages of highest priority for HIV incidence reduction) through differential reimbursements. Typically, there are multiple steps in a person's progression to changed behaviour, thus numerous interactions with a client may be required to advance him from baseline to action. At each step, internal (cognitive and emotional) and environmental (cultural and ethical factors, or issues around service delivery) factors can influence an individual's immediate VMMC needs and wants, which will govern his subsequent actions (see Fig. 10). Therefore, different strategies, messages and sets of tactics might be employed at each interaction.

Figure 10 Influences and stages of the journey to VMMC



The session also focused on the need to invest in implementation science research. CDC shared information from studies conducted in Tanzania, Kenya and South Africa (see Fig. 11). One key issue that has emerged is that males aged 20 years and over are not accessing VMMC services as much as younger males. Older men are more likely to take part in riskier sexual behaviours, therefore, circumcising men aged 20–34 years would provide the most immediate impact on HIV incidence. The CDC-supported studies addressed demand and service delivery (setting). They showed the need to vary demand creation approaches, including messaging, according to the context, maturity of the VMMC programme and/or target group. Some approaches showed modest increases in VMMC uptake among adults.

Figure 11 Overview of implementation science studies in Tanzania, Kenya and South Africa

TANZANIA	KENYA	SOUTH AFRICA
Research Question		
Does VMMC uptake increase among men aged 20-34 years when exposed to communications and service delivery tailored to older men?	**Does VMMC uptake increase among men 25-39 years when exposed to interventions addressing barriers?**	**Does VMMC uptake increase among men aged 25-49 years when an 'Exclusive Intervention Package' is offered to older men?**
Objectives		
• Increase the total number of VMMC clients and the proportion of men aged 20-34 years • Assess relationship between client age and reported rick of HIV acquisitions	• Increase the proportion of men aged 25-39 years who accept VMMC compared to men randomized to routine service delivery and demand creation activities (including enhanced interpersonal communication and dedicated service outlets).	• Develop tailored VMMC messages addressing barriers for men aged 25-49 years. • Evaluate the effectiveness of an 'Exclusive Intervention Package' to men aged 25-49 years.

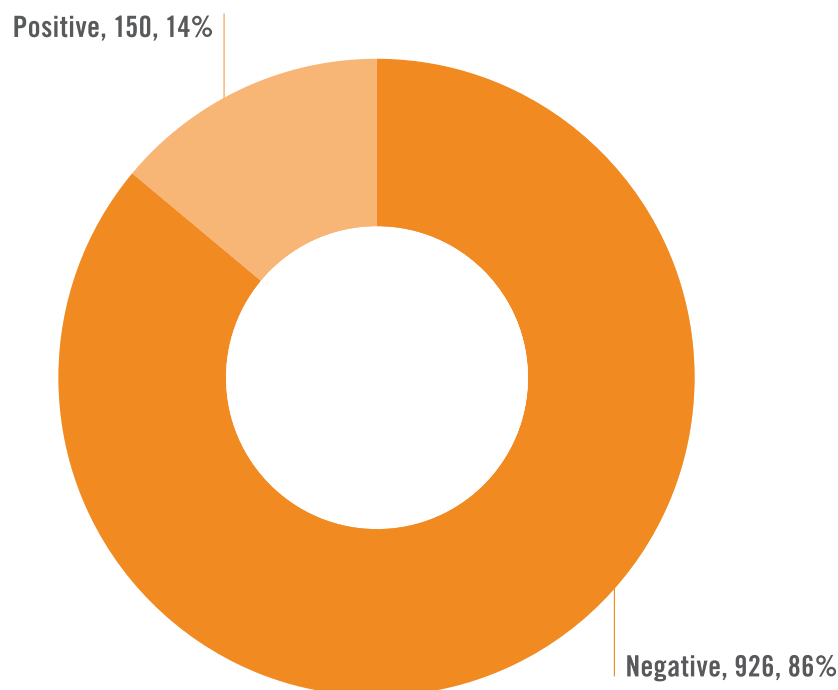
Market research combined with behavioural economics was shared by PSI as a method used in Zambia to increase VMMC uptake. The method includes journey path mapping of a man from awareness of VMMC to uptake of the service and quantitative market segmentation. This approach allows target client archetypes to be developed.

Accessing services (C. Toledo, CDC; V. Kikaya, Jhpiego; K. Hatzold, PSI Zimbabwe; S. Mabhele, ILO; T. Teka Amero, PEPFAR Ethiopia)

This session offered examples of channels through which adult men may be reached with HIV prevention services, including VMMC.

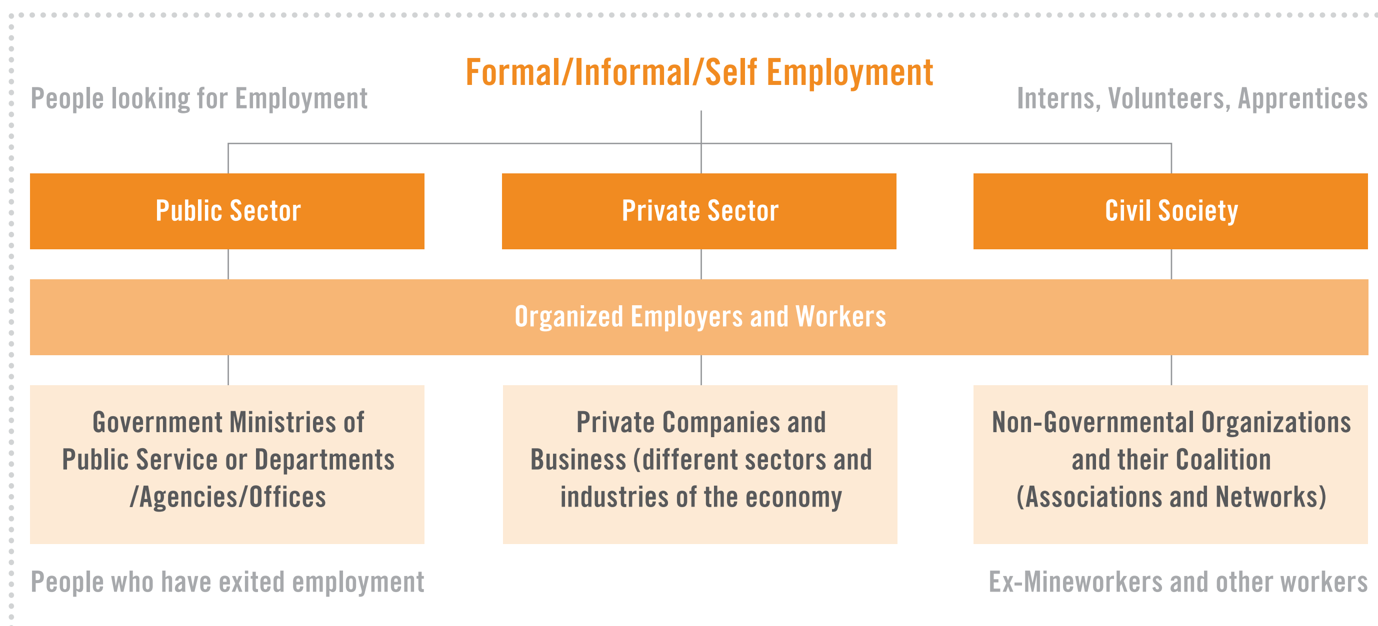
Jhpiego presented on the VMMC/male clinic in the Scott Hospital in Lesotho, which is a stand-alone facility located away from the main hospital. It is the only male clinic in South Africa to be part of a public hospital. The clinic was set up based on demographic and health survey evidence showing that in general Basotho men [men from Lesotho] have suboptimal health seeking behaviours. Within the clinic there is evidence that VMMC is serving as a gateway to other health services (offered at the clinic), including HIV testing, counselling and testing/treatment of other sexually transmitted infections. All VMMC clients at the clinic were tested for HIV between July 2016 and January 2017 (see Fig. 12).

Figure 12 HIV testing results for VMMC clients at male clinic in Scott Hospital, Lesotho



The ILO presentation on reaching adult men with VMMC services through occupational settings highlighted that workplace responses to HIV have an impact on the AIDS epidemic and can, therefore, contribute to national AIDS responses. The commitment of workplace senior managers and workers' leaders are driving forces. Engaging worker representatives (trade unions) facilitates the mobilization of workers (particularly men) to access HIV prevention/treatment services and other health services. The example provided was that of the South African Clothing and Textile Workers' Union: Worker Health Programme, which provides quality HIV- and tuberculosis-related services to blue collar workers and engages with representatives of employers and workers through tripartite consultation forums (labour advisory councils). It was noted that the public sector often employs a larger number of men than the private sector.

Figure 13 Defining and locating the world of work

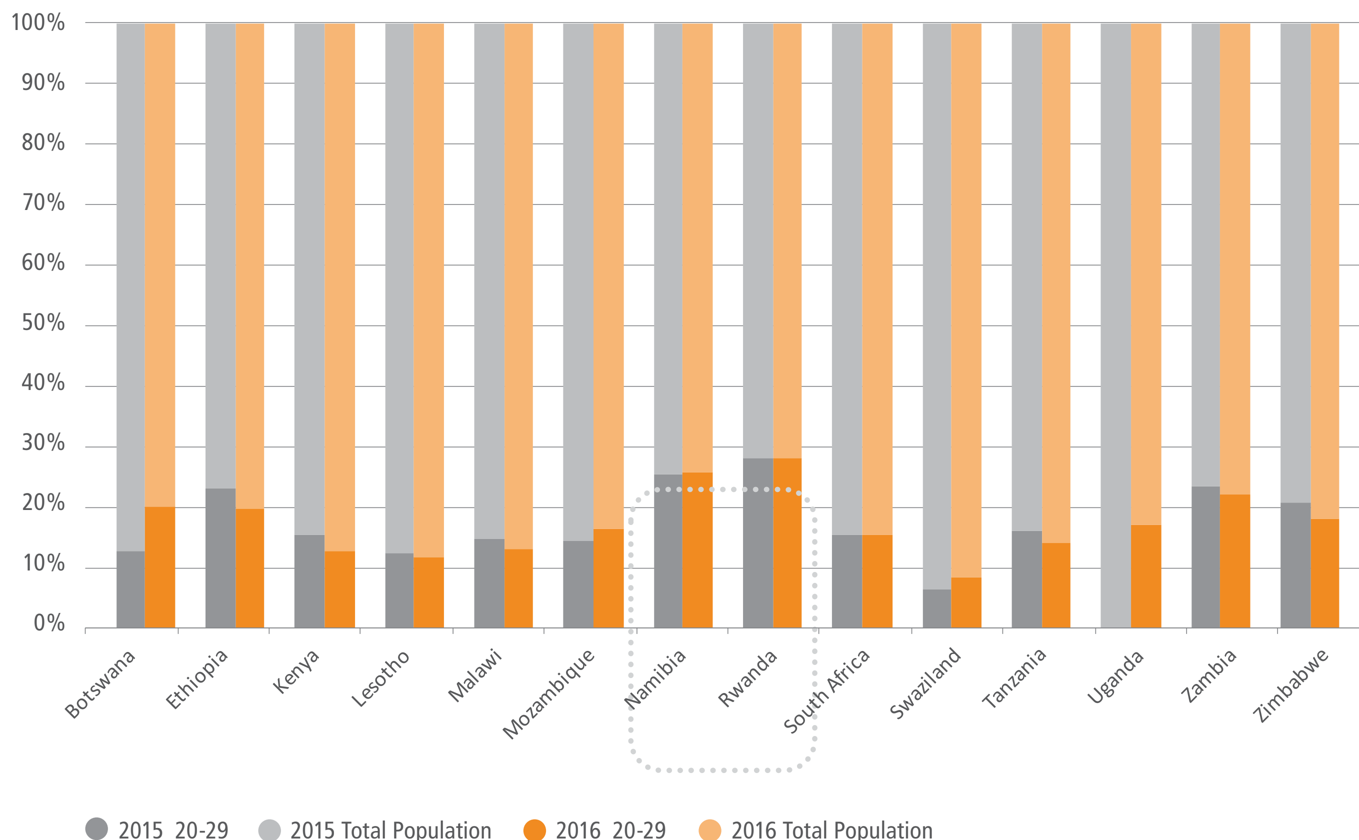


PEPFAR/Ethiopian Department of Defence gave a presentation on reaching adult males with VMMC services through the military in Ethiopia, where VMMC is being offered to new recruits during their training period. Approximately 10–15% of new recruits are uncircumcised, of which around 90–95% accept circumcision. Some active soldiers also accept circumcision. Because of the integration of the VMMC programme in the training centres for new recruits, the Ethiopian National Defence Force is able to achieve its annual VMMC target and there is also an opportunity to address the stigma that some men who are uncircumcised sometimes face. The Ethiopian National Defence Force has shared its experience of integrating VMMC services with the militaries in other African countries, some of which are now working towards this model.

HIV testing is not mandatory for men who undergo VMMC. The PSI/Zimbabwe presentation on HIV self-testing showed that fear of HIV testing, in particular getting a HIV-positive result, is a barrier to the uptake of VMMC among sexually active men. Since HIV self-testing was introduced in Zimbabwe, there has been high uptake among men, young people and key populations. Among these groups, 20–30% are first-time testers. Evidence shows that HIV self-testing may help address fears of taking up provider-delivered HIV testing services. HIV self-testing will help to link HIV-negative people to appropriate prevention services and identify people living with HIV by providing testing to populations that would otherwise not test due to access or privacy barriers.

The CDC presentation highlighted that in the period 2015–2016 males aged 20–29 years constituted less than 30% of all VMMC clients in the 14 priority countries (see Fig. 14). VMMC is one of few preventative health services that caters specifically to males and also provides health screening opportunities, including for noncommunicable diseases. Evidence from Namibia showed that some men were newly diagnosed with hypertension as a result of the screening they received as part of their VMMC service.

Figure 14 VMMC among men aged 20–29 years in 2015 and 2016, by priority country in Africa



Policies that affect men's health and address masculinity (D. Peacock, Sonke Gender Justice)

The results of policy scans by Sonke Gender Justice (see Fig. 15) show that although most national strategic plans acknowledge the importance of gender mainstreaming in HIV-related interventions, very few refer to the need to engage men; almost all the national strategic plans reviewed have a very limited conceptualization of gender – seeing it as referring to women only. National strategic plans are more likely to mention men in relation to efforts to prevent mother-to-child transmission of HIV and medical MC. They rarely mention men in terms of policies to affect their attitudes towards condom use, involving them in home-based care or targeting them to increase their uptake of HIV testing and treatment services. Sonke Gender Justice emphasized the following points:

- Men's health requires urgent attention – for everybody's sake.
- Improving men's and boys' health should enhance – not detract from – women's health and Health for All.
- Women too often blame men for their [men's] ill health and absolve themselves of responsibility.
- The low use of health services among men reflects prevailing gender norms, structural drivers, poor access to health services, lack of policies and weak political will.
- A growing number of policies and programmes are improving men's health – in the few countries where they exist.
- It is necessary to develop and implement policies and programmes that shift gender norms, improve men's access to services and address structural drivers of men's ill health.

Figure 15 Results of policy scans by Sonke Gender Justice

3. HIV NSP Gaps	HIV and Gender	Attempts to challenge or transform gender norms	Engaging men for prevention of GBV	Men's support of PMTCT	Male circumcision	Condoms	Men's use of VCT	Marginalized men & boys	Treatment	Home Based Care
Burundi										
Cote D'Ivoire 2006-2010	Adequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Ethiopia 2009 – 2010/11	Room for improvement	Inadequate	Inadequate	Inadequate	Room for improvement	Inadequate	Inadequate	Room for improvement	Inadequate	Inadequate
Kenya 2009/10 – 2012/13	Adequate	Room for improvement	Inadequate	Adequate	Room for improvement	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Mozambique										
Namibia 2011 – 2016	Room for improvement	Room for improvement	Inadequate	Room for improvement	Room for improvement	Inadequate	Inadequate	Room for improvement	Inadequate	Inadequate
Rwanda 2009 – 2012	Adequate	Room for improvement	Inadequate	Adequate	Room for improvement	Inadequate	Inadequate	Room for improvement	Inadequate	Inadequate
Sierra Leone										
South Africa 2007 – 2011	Adequate	Room for improvement	Room for improvement	Adequate	Room for improvement	Room for improvement	Room for improvement	Room for improvement	Inadequate	Adequate
Tanzania 2008 – 2012	Adequate	Adequate	Inadequate	Adequate	Room for improvement	Room for improvement	Room for improvement	Room for improvement	Room for improvement	Room for improvement
Uganda 2007/8 – 20011/12	Room for improvement	Inadequate	Inadequate	Adequate	Room for improvement	Inadequate	Inadequate	Room for improvement	Room for improvement	Inadequate
Zambia 2011 – 2015	Adequate	Room for improvement	Inadequate	Adequate	Room for improvement	Room for improvement	Adequate	Room for improvement	Room for improvement	Room for improvement
Zimbabwe 2011 – 2014	Adequate	Room for improvement	Inadequate	Adequate	Inadequate	Inadequate	Inadequate	Room for improvement	Inadequate	Room for improvement

Key Adequate · Room for improvement · Inadequate

BREAKOUT GROUP WORK SESSION

Implementation considerations for young men and high-risk men

These group work sessions aimed to provide an opportunity for countries to share their experiences and further explore the requirements for VMMC reprogramming and key implementation considerations. The main feedback from the working groups was as follows:

Young men

- Since young men are an economically viable group, concerted efforts are needed to engage employers, trade unions and medical health insurance companies and facilitate their understanding of the benefits of VMMC in order to encourage uptake of VMMC services among this population group. There is a need to: include VMMC within labour policies; create incentives for employers; strengthen private–public funding partnerships; coordinate scheduling of VMMC services with/between workplaces.
- Peers, champions and traditional/community influencers have been successful in generating demand for VMMC services. This approach should be strengthened, while ensuring links to VMMC services, especially in rural areas, in order to minimize the time between mobilization and the provision of VMMC. In addition, it is necessary to ensure that sites where VMMC services are offered are ready for increased uptake (staffing, infrastructure and supplies).

- More use should be made of up-to-date channels of communication, including mass media, interpersonal communication, mid-media and social media. Additionally, messages should be targeted also at women as key influencers over men's health.
- More engagement with tertiary institutions is necessary to further leverage opportunities for demand creation.
- In order to better understand what works for young men, both in terms of service delivery and demand creation, a review of the data collected over the last five years is needed to compare VMMC programme experiences in different countries, including the outcomes of pilot initiatives and end-user participation rates.
- VMMC should be used as a gateway to address other aspects of young men's health (the same is true for all age groups). Providing VMMC services through men's health clinics, which offer screening for and treatment of noncommunicable diseases, including mental health and substance misuse, might be less stigmatizing and improve VMMC uptake.

High-risk men

- It is important for countries to define which men are 'at high risk' or 'most at risk' and to understand that while men in this population will have some common characteristics there will also be some differences, which has implications for programming. Some countries considered the term 'most at risk' to apply to: men in serodiscordant relationships, those with sexually transmitted infections, clients of sex workers, migrants, miners, long distance truckers and prisoners.
- Prevention messaging alone is insufficient to increase VMMC uptake among men who are most at risk given that other concerns and issues drive their risk behaviour. Therefore, it is important for VMMC services to provide an entry point not only to other HIV prevention services but also to additional priority health services, especially for men who have limited access to these services. The VMMC service package could be broadened to include access to pre-exposure prophylaxis for HIV prevention, information on family planning, guidance on addressing attributes of masculinity that affect health seeking behaviours, and screening for conditions such as hypertension or substance misuse.
- Increasing VMMC coverage among men most at risk will have both programmatic and policy implications and will, therefore, require further significant political and resource commitments.
- Innovation is required to generate demand and improve access to VMMC services among most at risk populations. Suggestions included: providing incentives, flexible services outside of working hours, venue-based outreach, couples services and workplace-based strategies. For men on the move, suggested reprogramming considerations included: health passports, cross-border health service access and referrals as well as shared financial and political responsibilities between countries.
- Countries will need to make concerted efforts to obtain strategic information on most at risk men since data on this group is often not routinely captured or disaggregated in health information systems and it is important for planning and monitoring of VMMC and other services.

FOCUSED ACTION FOR ADOLESCENTS

AA-HA! Adolescent implementation framework – synergies with VMMC2021 (T. Desta, WHO)

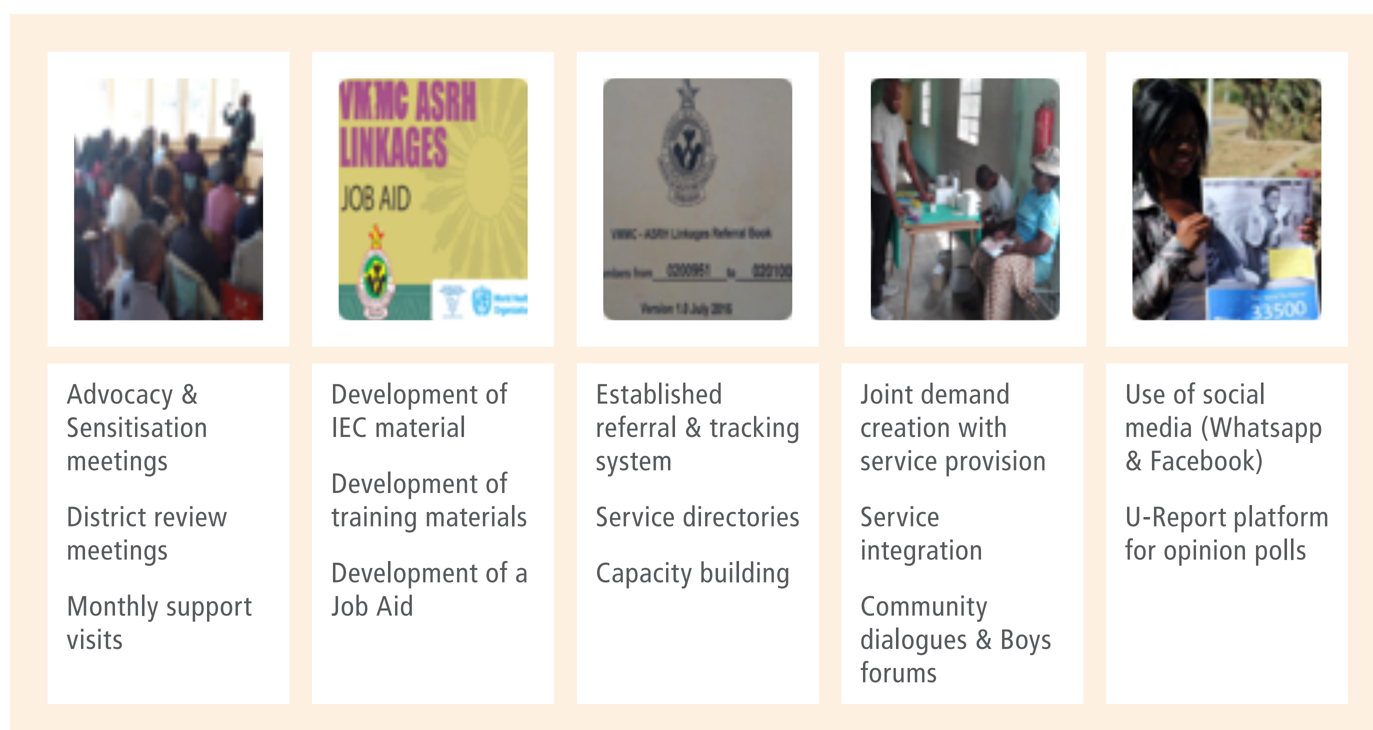
WHO presented the AA-HA! guidance, which aims to provide technical advice to countries to enable them to decide what to do and how to do it as they respond to the health needs of adolescents. Primary target audiences for the guidance include national-level adolescent health policy-makers and programme managers in all relevant sectors. Secondary-level audiences include subnational adolescent health policy-makers and programme managers, international advisors, funders and others.

In the same way as the Framework for Voluntary Medical Male Circumcision: Effective HIV Prevention and a Gateway to Improved Adolescent Boys' and Men's Health in Eastern and Southern Africa by 2021, AA-HA! identifies VMMC as one of a number of priority interventions for countries with generalized HIV epidemics. The AA-HA! implementation guidance also provides advice to Member States on financing adolescent health interventions through existing opportunities such as the Global Fund and the Global Financing Facility investment case. In addition, the AA-HA! guidance can be used to guide countries in prioritizing high-impact national interventions and developing coherent national plans for adolescent health in the period 2017–2030.

Spotlight presentations (S. Mabaya, WHO Zimbabwe; E. Njeuhmeli, USAID; P. Devos, JHCCP)

WHO Zimbabwe, on behalf of the Zimbabwe MoH, presented the Adolescent Sexual and Reproductive Health (ASRH) and VMMC Linkages pilot project, which is being implemented to assess the feasibility of creating and sustaining linkages between ASRH and VMMC services in Zimbabwe, including related capacity needs. The results of the pilot will contribute to guidance on how to effectively deliver the two programmes in order to provide sustainable adolescent services and maintain high VMMC coverage while offering or linking clients to other needed health services. The pilot started in 2014 and has three phases. The first phase (2014) focused on preparatory assessments and stakeholder inputs. The second phase (2014–2015) focused on implementation by identifying linkages, feasible approaches and lessons for scale-up. The third phase (2015–2016) is focused on ongoing implementation (see Fig. 16) with monitoring embedded in the two programmes and research conducted to assess effectiveness and costs in order to inform scale-up by optimizing strategic actions and the delivery of interventions.

Figure 16 Current activities in the ASRH–VMMC Linkages pilot project, Zimbabwe



JHCCP presented on promising practices for reaching adolescent and young men in Mozambique based on communication activities aimed at increasing the uptake of VMMC services among males aged 15–29 years. The project approach was two-pronged: i) identifying appropriate venues to reach different demographic groups (older adolescent boys and young men); ii) utilizing strong and appropriate demand creation strategies. In order to reach adolescents, the project targeted secondary schools and worked closely with the school management, in particular trained mobilizers and a mobilization teacher. The coordination of transport logistics to take boys to circumcision facilities was also an important component of the project. A second approach adopted to reach adolescents with VMMC services was to focus on prisons, mobilizing young detainees and advocating for prison management to provide them with soap for wound care. A third approach to increasing the uptake of VMMC services was to focus on workplaces, targeting small numbers of young men and collaborating with workplace management and existing focal persons. In addition, there was a focus on large social events, including concerts and parties. Strategies for demand creation included personal invitations to attend VMMC services, individual follow-up after MC procedures, telephone hotlines and WhatsApp group messages providing information on where to access VMMC services.

Age-specific essential services for adolescents (Jhpiego; S. Xaba, Zimbabwe MoH; E. Odoyo-June, PEPFAR Kenya; Uganda MoH; L. Van Lith, JHCCP)

Jhpiego shared key points on a study that used quantitative and qualitative methods to assess the quality of in-service communication and counselling and the age-appropriateness of VMMC services provided to younger adolescents. The results of the study showed that, although satisfied with the procedure, adolescents felt the information they received as part of the VMMC service package was limited, suggesting that awareness about ASRH issues among adolescents may not increase with the current level of information disbursed. VMMC providers acknowledged that they need further training in working with adolescents.

Considerations on essential services provided to adolescents in Kenya, with lessons learnt, were shared by PEPFAR. A framework was outlined for exploring how the minimum package of services may change as the VMMC programme evolves from catch-up, through transition to medium-term and finally long-term sustainability (see Table 1). Justifications for redefining the package include new developments in HIV prevention, availability of other tools such as pre-exposure prophylaxis and HIV self-testing, and new strategic directions that better tailor services to age and need such as the limited requirement for routine HIV testing among young adolescents. Services included in the package should be informed by parents and communities.

Table 1 Framework for exploring minimum service package in Kenya[5]

	Catch-up	Transition to sustainability	Long-term sustainability
Priority age group	15-49 years	10-14 and 15-29 years	0-60 days and 10-14 years
Timeframe	2008-2014	2016-2019	2020 and beyond
Service package	HIV testing services, condoms, screening for sexually transmitted infections, MC and follow up.	10-14 years: vaccination, sexuality and health education, screening for sexually transmitted infections. 15-19 years: more detailed education/ counselling (HIV, sexuality, condoms) alcohol/mental health assessment, education on gender equality. 20-29 years: counselling for family planning, testing for tuberculosis/HIV, counselling on alcohol/drug misuse/prevention, education on gender equality, screening for noncommunicable diseases.	0-60 days: neonatal, congenital and postnatal services. 10-14 years: services for adolescents.

5 Adapted from table and slides shown in the PEPFAR presentation.

MoH Zimbabwe provided information on the national comprehensive sexuality education strategy – the plan for roll-out, training of teachers and the new curriculum that includes life skills. Information on genital hygiene is provided within this curriculum and as part of VMMC services. Trained health workers will provide information on ASRH, including VMMC, to adolescents as guest speakers in communities and schools.

MoH Uganda presented on the integration of tetanus-toxoid-containing vaccination in the national Safe Male Circumcision Programme. Between 2012–2014, four cases of tetanus that occurred after MC (two with the elastic collar compression method, two with conventional surgery) unmasked the broader issue of the low coverage of tetanus-toxoid-containing vaccination among adolescent boys and male infants. The Safe Male Circumcision Programme has provided a channel through which to vaccinate males. It was assumed that all potential clients had never received a dose of tetanus-toxoid-containing vaccine, therefore, two doses were recommended for all clients, with one dose at least 28 days prior to MC and one dose the day of the MC intervention. During 2015 and 2016, the numbers of MCs performed dropped. The Ugandan MoH is currently reviewing new evidence, including from a tetanus serosurvey, after which the recommendation on tetanus-toxoid-containing vaccination may be revised.

Integration and linkages: a broader set of interventions for adolescent health (D. Peacock, Sonke Gender Justice; V. Maziya, Swaziland MoH; C. Coakley, Grassroots Soccer; R. Mophosho, Aurum Institute)

This session outlined the importance of systematically streamlining VMMC with other services in order to offer and link adolescents to health services tailored to their needs.

The Aurum Institute shared its experience of implementing the Youth Psychosocial Support Programme in South Africa, which is successfully providing opportunities for collaboration with traditional and cultural sectors in order to enhance understanding of the correct messaging on VMMC that should be relayed to adolescents and to address topics such as manhood and masculinity, gender norms, sexual consent, readiness for sex. Recruitment of participants for the Youth Psychosocial Support Programme is done concurrently with VMMC recruitment. With a view to getting parental buy-in, parents are informed that the Youth Psychosocial Support Programme is a package of services, including VMMC, offered to boys aged 14–17 years. The programme also provides tools for dialogue between adolescent boys and older men in the community. Dialogues cover topics such as defining manhood and masculinity, addressing gender norms and how these can lead to gender-based violence, consent versus coercion in sexual intercourse, defining rape, exploring readiness for sex, how peer pressure influences decisions, and correct, consistent condom usage. The Youth Psychosocial Support Programme is also being used as an entry point into schools, with which good relationships have already been built. Figure 17 shows key successes that have been recorded by the programme. Streamlining of VMMC with clinical and psychosocial services is planned for the future.

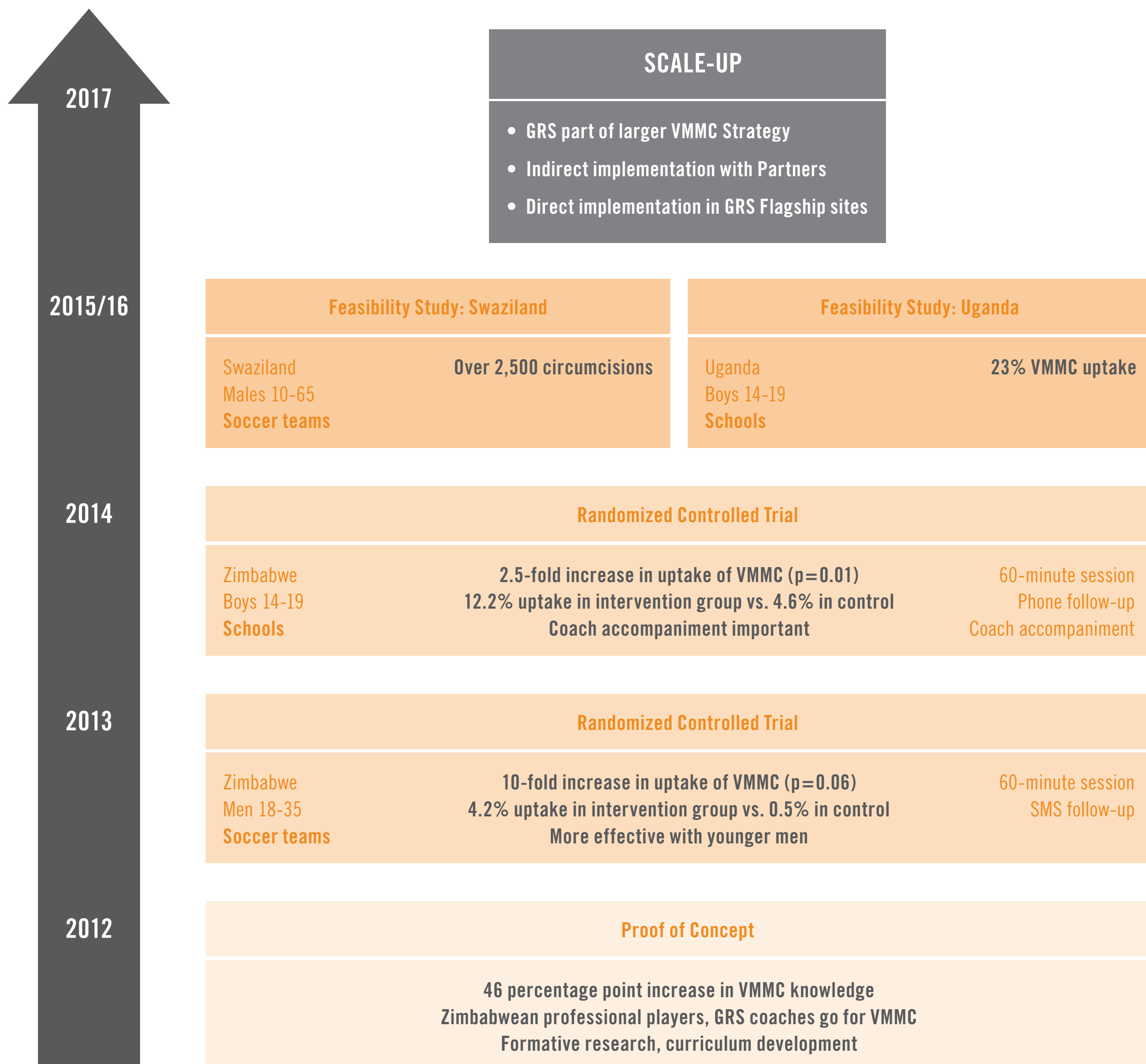
Figure 17 Successes of the Youth Psychosocial Support Programme in South Africa

Successes

- Over 9,000 adolescents have been through the YPS programme since inception in 2012 (23%
- More than 60% of these adolescents are males that have been reached through the MMC clinics in 2 provinces (NW and GP) in South Africa and 40% have been reached through school programme
- Fully fledged schools programme developed from YPS activities (sessions in schools, team invited to participate in interschool cultural and sporting activities)
- Well established relationship with DOE as a result of YPS in schools.

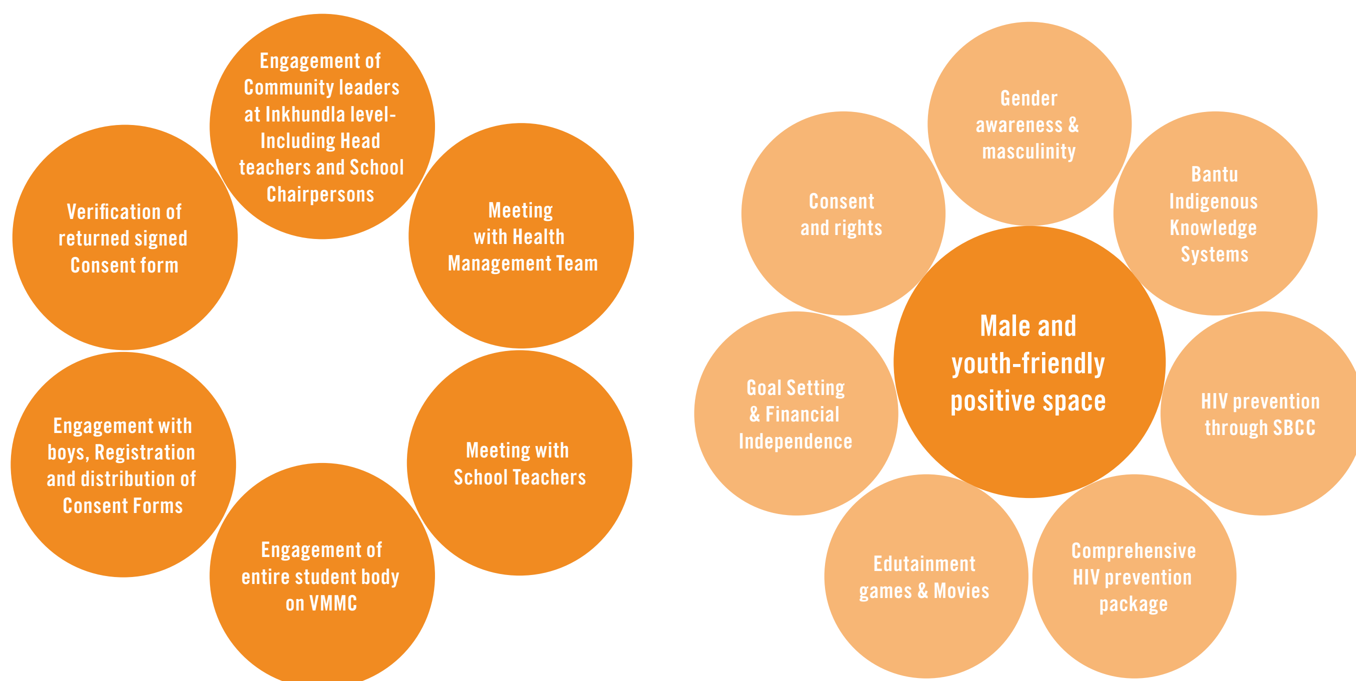
The Grassroots Soccer presentation showed that short, sports-based HIV prevention interventions have the potential to contribute to improved uptake of VMMC by connecting young people with mentors and the information and health services they need. Strong communication with parents is also important. Figure 18 shows the scalability and sustainability of using soccer to increase uptake of VMMC and the studies that have been undertaken that evidence the higher uptake of VMMC in interventions groups.

Figure 18 Scale and sustainability of using soccer to increase uptake of VMMC



The Swaziland MoH presentation focused on how VMMC programmes offer opportunities to implement interventions with young men aimed at shifting harmful gender norms and improving their health. In countries where there are traditional structures that provide mentoring networks for adolescent males, these structures should be documented and leveraged to support VMMC. Figure 19 gives an overview of two approaches that can be adopted to reach community, vocational and out-of-school young people; while effective in building knowledge and skills among a small number of participants, the costs of both these approaches are currently high, however.

Figure 19 Community entry model and elements of Lihawu Camps



Sonke Gender Justice presented on interventions and studies that have provided evidence of positive changes in gender norms leading to greater uptake of HIV prevention methods. These include:

- **Stepping Stones workshop series, South Africa:** where participating men reported fewer sexual partners, higher condom use, less transactional sex, less substance abuse and less perpetration of intimate partner violence.
- **Promundo's Program H:** where participating men were four to eight times less likely to acquire a sexually transmitted infection and 2.4 times more likely to use condoms.
- **Sonke's One Man Can workshop, South Africa:** where 27% of participants tested for HIV soon after the workshop and two thirds increased their use of condoms.
- **Study on male partners involvement in prevention of mother-to-child transmission of HIV, Ethiopia:** in which there was a 46% increase among male study participants testing for HIV with their partners and a 87.6% increase among those joining their female partners in accessing services to prevent mother-to-child transmission of HIV infection.
- **2007 WHO and Promundo assessment of 57 male involvement programmes in the African Region:** in which 53% of the programmes classified as gender transformative were assessed as being either promising or effective.

BREAKOUT GROUP WORK SESSION

Implementation considerations for adolescent boys

Day 2 group work sessions aimed to provide further opportunity for countries to share their experiences and explore the requirements for reprogramming and key implementation considerations. Participants self-selected focus population groups among young and older adolescents and were allocated one of the following five topics for discussion:

1. Minimum VMMC service package for adolescent boys
2. Approaches to sustain adolescent VMMC services
3. Broader package of services for adolescent health
4. Routine demand creation approaches
5. Capacity to deliver adolescent-oriented services

The main points of feedback from the working groups were as follows:

10–14 years

- Demand creation messages, communication and counselling within VMMC services for this age group need to be strengthened and differentiated from older adolescents, with more focused attention on healthy lifestyles and wellness. Age-specific tools and provider capacity require further development.
- Issues around consent, including assent, remain a barrier and require the strengthening of policies, protocols and provider training.
- The VMMC service package is an opportunity to offer additional key health services to adolescent boys, for example testing for human papilloma virus, tetanus-toxoid-containing vaccination and education on issues around masculinity.
- The education sector remains critical in ensuring the health and wellness of this age group. Further efforts are required to develop school health policies and to integrate key components of comprehensive sexuality education specific to boys (for example VMMC) into these policies.
- Stronger partnerships with traditional circumcision providers is required to ensure MC safety and maximize entry points for VMMC.
- Policy and plans for the sustainability of VMMC services as part of a broader health package for adolescent boys requires ownership by various health departments and social sectors.
- Leadership and coordination between government ministries for mutual accountability and resource sharing is needed to steward the broader health agenda forward for this age group.

15–19 years

- Targeted demand creation will remain important. Countries need to understand the range of pressures and motivations for adolescent boys to access VMMC – many of which are broader than HIV and should be leveraged to create demand for ASRH and other services.
- Participatory and multisectoral consultative processes are required to define and implement an appropriate and relevant VMMC demand creation and communication package. Further exploration of the role of technology and social media in targeting this age group is recommended.
- As countries move to the next phase of their VMMC programming response it will be important for them to review the minimum package of services and provide these in an integrated way, strengthening referral/linkages with a range of service providers.
- VMMC should be a component of the universal health care package for adolescent boys. VMMC can provide an important entry point to additional care and is an opportunity to increase adolescent boys' access to ASRH services, including those related to masculinity and healthy behaviours.
- Although the list of challenges to increasing the access of adolescent boys to services and interventions is often long, the real challenge lies in identifying and investing in the solutions. Mobile services, peer-based interventions, camps and the removal of user fees were identified as possible approaches. Additional attention to cost-effective strategies to reach those out of school and in rural areas is required.
- Improving the quality of VMMC services for adolescents requires the integration of these services in overall quality systems, including adolescent components within preservice training, ongoing mentorship of VMMC providers and age disaggregated data in monitoring systems.

DAY 3

Evidence, lessons and promising practices to actions

PROGRAMMING TO SUSTAIN DELIVERY

Experience of transitioning to sustainable services, South Africa (H. Humphries, CAPRISA)

CAPRISA presented on the experience of transitioning to sustainable VMMC services in KwaZulu-Natal (South Africa) based on a pilot that was implemented with the aim of developing a sustainable, adolescent-friendly model for VMMC provision that would be feasible, replicable and easily sustained with minimal effort. The pilot engaged secondary schools with a view to increasing VMMC coverage in KwaZulu-Natal to a population that traditionally does not circumcise. For sustainability, it was important for the pilot to access a population at high risk of HIV infection that was in need of services and to normalize VMMC among the population in order to obtain peer buy-in and increase the acceptability of VMMC.

The pilot included three phases and involved community and school engagement as well as partnerships with local NGOs. The first phase focused on community consultation. The second phase prioritized in-school VMMC awareness-raising sessions and centralized access to HIV testing and VMMC services. VMMC coordinators provided information at school assemblies, and HIV testing services and postsurgical (VMMC) visits were provided in schools. The third phase focused on mobilizing early VMMC adopters for peer recruitment and provided decentralized HIV counselling and testing. The project looked at optimizing service provision, linking to other services including through peers, rethinking consent through teacher-facilitated sessions, and using the strengths of private–public partnerships.

Key lessons learnt included:

- **Peers can sustain demand:**
  - Information disseminated through trendsetting early adopters can diffuse innovation and create demand among peers until VMMC becomes a social norm.
- **Rethinking around VMMC services for adolescents is important:**
  - VMMC for adolescents can be facilitated through Friday and Saturday clinics with follow-up in schools.
  - Interpersonal communication from a variety of sources is required.
- **SRH services in adolescent venues can be optimized by:**
  - Close cooperation between the Department of Health, Department of Education and other service providers.
  - Using schools to provide SRH services, including VMMC.
  - Making health care more mobile and accessible.
  - Engaging pre-existing community organizations to aid implementation.
  - Integrating and fast-tracking pre-exposure prophylaxis for HIV for adolescents.
  - Addressing structural issues related to gender, health prioritization, risk perception and ‘HIV fatigue’.
- **Locally responsive programmes need to be developed.**

Conclusions on sustaining VMMC services included:

- **Speed of coverage** is as important as thinking about sustainability.
- **Private-public partnerships** are necessary to facilitate capacity development, operationalization of innovation and optimization of resources in constrained times.
- **Diffusion of innovation drives sustainability:**
  - Peers can be utilized as a low-cost method for diffusing innovation.
  - The system needs to be sustained so as to normalize behaviour until it becomes self-sustaining.
- **Ease of access to VMMC services outside the primary health care system** is important and can be ensured through:
  - Male-friendly services and hours that accommodate adolescent males;
  - Postsurgical (VMMC) follow-up in schools;
  - Training schools to become information providers and referral mechanisms, educating parents on VMMC, and linking VMMC services with other health care services.
- **The complexity of the local culture needs to be understood** when providing VMMC services:
  - Active engagement with communities is needed.
  - Peers/parents can be instrumental in diffusing the importance of VMMC.
  - VMMC needs to be included in the community of practice and community discourse.
- **The provision of SRH should be diversified and linked to pre-exposure prophylaxis for HIV,** with a view to building the health system architecture.

Maintaining MC services for sustained coverage (Mozambique MoH; M. Galukande, Surgical Association of Uganda; V. Robertson, ICAZ/ICAN; G. Avorti, WHO; R. Delate, UNFPA; J Samuelson, WHO; C. Ntsuape, Botswana MoH)

A panel discussed considerations for sustained VMMC services, with a focus on essential safe surgery, infection prevention and control, condom distribution and other SRH services, vaccine delivery synergies and health promotion. Mozambique MoH highlighted that the steps needed for programme sustainability include increased numbers of trained staff certified to perform VMMC, more integration of VMMC activities with other health services, greater distribution of consumables through the MoH, more coordination with subnational health offices and other programmes and sectors (communities, religious groups, young people, sports, etc.) (see Fig. 20) and permanent monitoring of the quality of services.

Figure 20 Key actors for sustainability of VMMC programmes

Potential departments to engage, coordinate and align activities

Botswana MoH provided information on the Health Information Units that have been set up to oversee health promotion activities in the country. The Units have links with all departments in the MoH and can, therefore, assist in the design and integration of health messaging diffused by different health services. The Units support demand creation and the generation of information materials, and work with traditional leaders.

UNFPA presented on condoms and VMMC. Few countries distribute more than a total of 30 condoms per sexually active male. There are large variations in need, actual distribution and gaps according to country and/or population group. Most countries in which there is a wide distribution of condoms report high condom use. One study showed no significant difference in condom use between circumcised and uncircumcised men, suggesting risk compensation is not occurring. Another study showed a strong positive correlation between being circumcised, getting tested for HIV and condom use. Condoms must continue to be promoted as part of VMMC services because together they can provide effective HIV prevention (see Fig. 21).

Figure 21 Conclusions on condoms and VMMC

Conclusion

- Condoms should be promoted as part of VMMC – added protection against HIV, STIs and prevents unintended pregnancy.
- Only male controlled method of family planning.
- Still insufficient condoms to meet the needs of people that want to use them Behavioural disinhibition needs to be monitored on a regular basis – and measured through both male and female perspectives.
- Male circumcision does not replace condoms; it should be in addition to condoms so that people can reduce their risk of HIV infection. Prevention has not failed – we have failed prevention by not taking interventions to scale through ensuring continued investments.

WHO presented on key lessons around decision-making and implications for action in the introduction of the human papilloma virus vaccination, which is a key component – as is VMMC – of a comprehensive approach to cervical cancer prevention and control (see Fig. 22). Aligning VMMC with vaccination programmes could lead to a rationale for the sequencing of services provided to adolescents. The human papilloma virus vaccination for girls and tetanus-toxoid-containing vaccination for adolescent girls and boys are now recommended for the same age group (9–15 years). Lessons from efforts to introduce the human papilloma virus vaccine may assist countries when they consider the introduction of VMMC for adolescent boys. One lesson has been that integration is key to ensuring that when donor funding ends programmes continue, rather than coming to a stop because no regular budget has been assigned to them and healthcare workers see VMMC services as extra activities.

Figure 22 Decision-making around the introduction of the human papilloma virus vaccination

Decision-making: Implications for Action

- Gaining the support of high-level advocates, such as First Ladies, can have a major impact on the decision to introduce HPV vaccine.
- Prepare evidence: Investigating and reporting on the cervical cancer burden; cost-effectiveness, feasibility and acceptability provides important information for decision-makers.
- Coordination with the right stakeholders from the beginning will ensure all the players are at the table when it's time to make decisions and implement. The Health, Education and Finance Ministries are particularly important.
- Prepare for a process involving the policy committees, regulatory bodies, political and financial processes to ensure the decision is anchored in country policies and budget.
- Consider sustainable funding. Donations and external support can help a country introduce HPV vaccine in the short-term, but countries will need to contribute a portion of funding, and advocates should have a plan to secure funding for longer-term sustainability.

The Surgical Association of Uganda presented on the role it plays in supporting and ensuring the sustainability of the Safe Male Circumcision Programme through:
i) competence building, by supporting pre- and in-service training;
ii) compliance, through monitoring and quality assurance;
iii) coordination, including for patient follow-up.

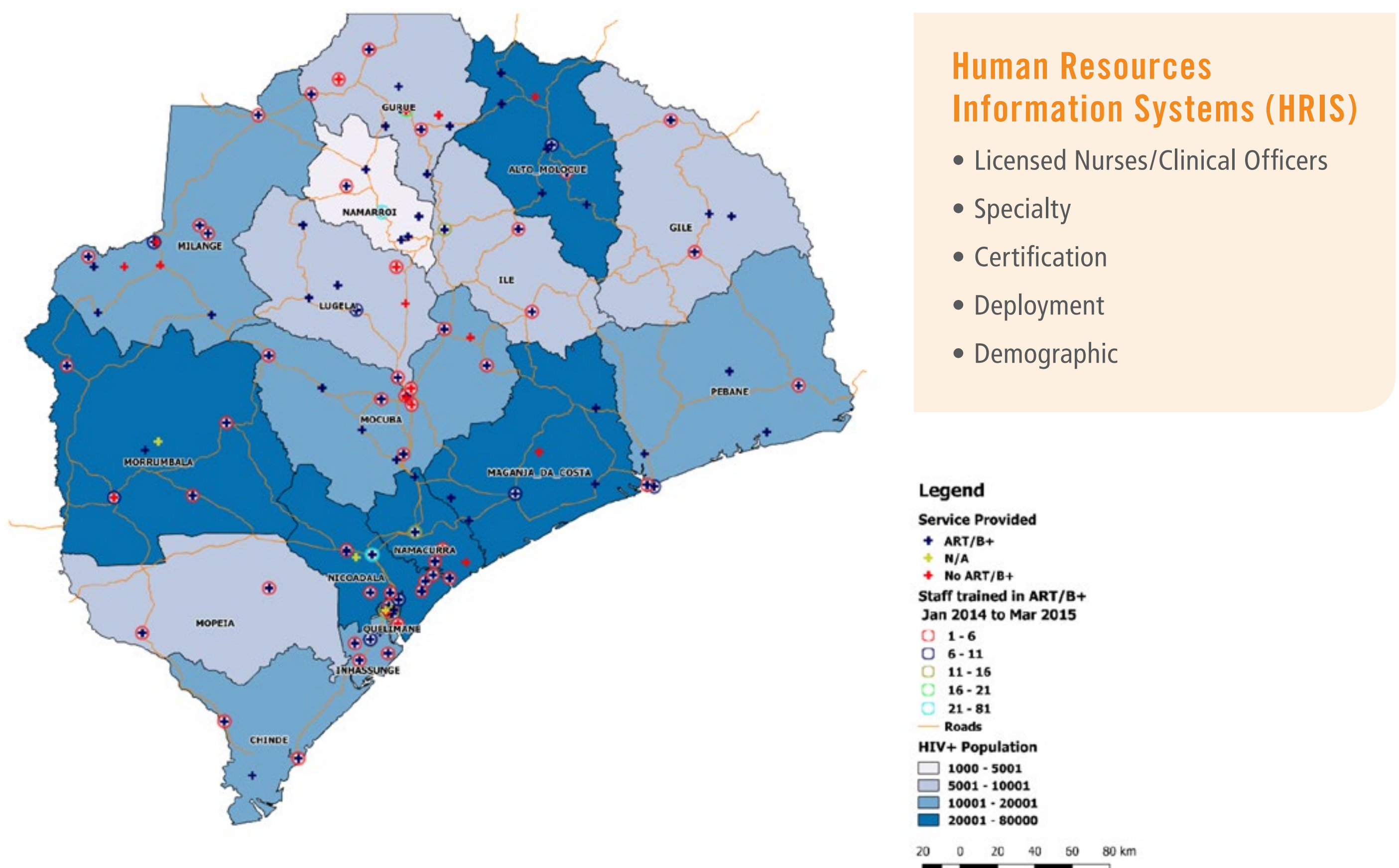
ICAN presented on the way it is structured as a network, highlighting that it has 23 member countries and offers training modules and an accredited training programme on infection prevention and control, in which VMMC could be integrated. ICAZ referred to the new WHO core programme components for infection prevention and control that are now available. ICAZ is delivering training and mentoring for VMMC providers as part of its infection prevention and control work at subnational levels. This includes hand hygiene, safe biomedical waste disposal and recycling of instruments – topics that are of relevance to the health system as a whole, not solely to VMMC. VMMC and infection control programmes could integrate certain resources, for example in relation to surveillance and fundraising for infection prevention and control. Structures for infection prevention and control and quality improvement have been institutionalized; VMMC can be embedded within those structures.

Policies and services for greatest impact (J. Gross, CDC; A. Verani, African Regulatory Collaborative; F. Mtshali, WHO Collaborating Centre for Nurses and Midwives; C. Samkange, University of Zimbabwe College of Health Sciences and COSECSA)

CDC and the African Regulatory Collaborative briefed on the policies needed to authorize nurses to perform VMMC. They outlined lessons learnt from authorizing and building the competencies of nurses and midwives to perform antiretroviral therapy (ART). Regulatory levers were examined that could be utilized to integrate authorization and competency for VMMC services into national regulatory frameworks for nurses and midwives, or other cadres. The presentation further considered how human resource information systems, which are health system workforce databases or surveillance systems operated by regulatory boards and councils or the MoH, can be utilized to increase the availability and accessibility of VMMC services.

The African Regulatory Collaborative is working to facilitate authorization and build competencies for nurse- and midwife-initiated ART in eastern, central and southern Africa. This involves seven regulatory functions: legislation and scope of practice for authorization and registration, licensing, continuing professional development, accreditation and discipline for competency. In many African countries, there is a gap between policy (task-shifting policy or scope of practice explicitly including MC) and practice, meaning a health worker may be authorized but still lack the competency required to perform a specific intervention such as VMMC. The African Regulatory Collaborative has utilized a combination of competitive grants, targeted technical assistance and collaborative learning sessions to advance authorization and build competencies for nurse-initiated ART. In Mozambique, data from human resource information systems was used to map nurses and midwives trained in providing ART and health facilities that offer this HIV treatment. They found that over 30% of nurses trained in ART Option B+ had been deployed to facilities that did not offer ART services. This data was used to discuss more efficient deployment strategies with the MoH. It brought attention to discrepancies along the policy and practice continuum, including the fact that although nurses may be authorized to perform a specific task they might not have received adequate training. Human resource information systems can also catalogue demographic information related to health workers, such as gender. For example, if trainers want to prioritize the certification of male nurses to improve the acceptability of VMMC services for a priority population, they could utilize human resource information systems to identify potential trainees.

Figure 23 **Availability and accessibility of VMMC services based on data from human resource information systems in Mozambique**



Source: Waters et al. (2016). eSIP-Saúde: Mozambique's novel approach for a sustainable human resources for health information system. *Human Resources for Health:* 14:66. DOI: 10.1186/s12960-016-0159-y

WHO Collaborating Centre for Educating Nurses and Midwives in Community Problem-solving (in KwaZulu-Natal) and the University of Zimbabwe's College of Health Sciences presented on institutionalizing training and innovative training approaches. The process of institutionalizing VMMC will require ministries of health to lead and assume ownership of VMMC service delivery and integrate VMMC into the education and training programmes for health professionals. This will require putting in place a framework for VMMC training, certification and quality assurance as well as funding. Planning at a strategic level is needed to move from the population health needs of the country to the introduction of task-shifting policies, changes in scopes of practice, competency frameworks, protocols and guidelines as well as champions to monitor VMMC integration in the curricula for health professionals. Educational institutions need to conduct a content analysis of their current programmes for health professionals and propose to the MoH how to close gaps and integrate the advanced skills needed for VMMC services (for example, surgical skills).

Human resources for VMMC need to be carefully managed, focusing especially on task-sharing, partnerships and preservice training in public health and infection prevention and control for work with adolescents. There is a need to establish steering committees supported by technical working groups. Horizontal integration of VMMC, reimbursement models and sustainable funding models can help achieve the targets in the Framework for Voluntary Medical Male Circumcision: Effective HIV Prevention and a Gateway to Improved Adolescent Boys' and Men's Health in Eastern and Southern Africa by 2021. In addition, quality assurance, supervision and mentoring of personnel responsible for VMMC services is needed.

Determine roles and responsibilities of key stakeholders

Accountability for quality and results (continued) (F. Ndenzako, WHO; S. Xaba, Zimbabwe MoH; Namibia MoH; South Africa MoH; O. Onyekwena, Global Fund; N. Fraser-Hurt, World Bank; E. Njeuhmeli, PEPFAR; M. Sundaram, BMGF; J. Cutler, WHO; R. Ridzon, OGAC; M. Galukande, Uganda MoH; V. Maziya, Swaziland MoH)

The presenters highlighted that accountability entails alignment of strategic directions and results, and involves individual as well as collective commitments. Accountability calls for the highest standards of personal integrity and transparency. While pursuing accountability, it is critical to balance expectations and capacity. It is also important to invest in continuous monitoring, quality and learning.

WHO presented on the components of a sound national VMMC accountability framework that includes: estimating the number of men and boys needing VMMC and other services (disaggregated by age and mapped by geographic location), defining costs for various service packages and formulating well developed scale-up plans with clear milestones and annual targets at the national and subnational levels. Implementing a national accountability framework also requires mapping of service delivery capacity linked to referral systems in communities and establishing the roles of sectors, facilities and outreach services. It further involves establishing and using a rigorous safety and progress monitoring and evaluation framework, integrating VMMC monitoring into broader national and subnational performance management for HIV and health as well as ensuring consistency and harmonization of monitoring and reporting through one national monitoring system. The three principles that underpin the framework are: accountability everywhere and for everyone, performance monitoring, and responsive feedback processes.

The PEPFAR presentation on global adverse event reporting and responses emphasized that safety and continued vigilance are crucial as VMMC services are sustained. Adverse events are a reality in the context of MC. They can emanate from provider error, screening error or client/parent misinformation/behaviour. Identification and reporting of adverse events is crucial to enable VMMC programmes to learn and improve. Figure 24 provides examples of lessons from VMMC programme implementation and mitigating measures that can be considered.

Figure 24 Lessons learnt on VMMC quality and safety for implementation and possible mitigating actions[6]

Finding	Actions
Single use kit quality	• Quality improvement • Encourage use of reusable kits
Inadequate pain control	• Standardized anaesthetic dosing
Undiagnosed bleeding disorders	• Enhanced screening • Earlier referral
Necrotising infections	• Broad spectrum antibiotics • Need for debridement
Tetanus	• Better coverage for males • Assure protection with PrePex • Enhanced wound care counselling
Glans injury with FG in < 15 years	• Mandate DS for < 15 years
No emergency equipment or training	• Equipment and training added
No parental consent for minors	• Policy RE consent for minors
Poor/inconsistent documentation	• Standard forms and training

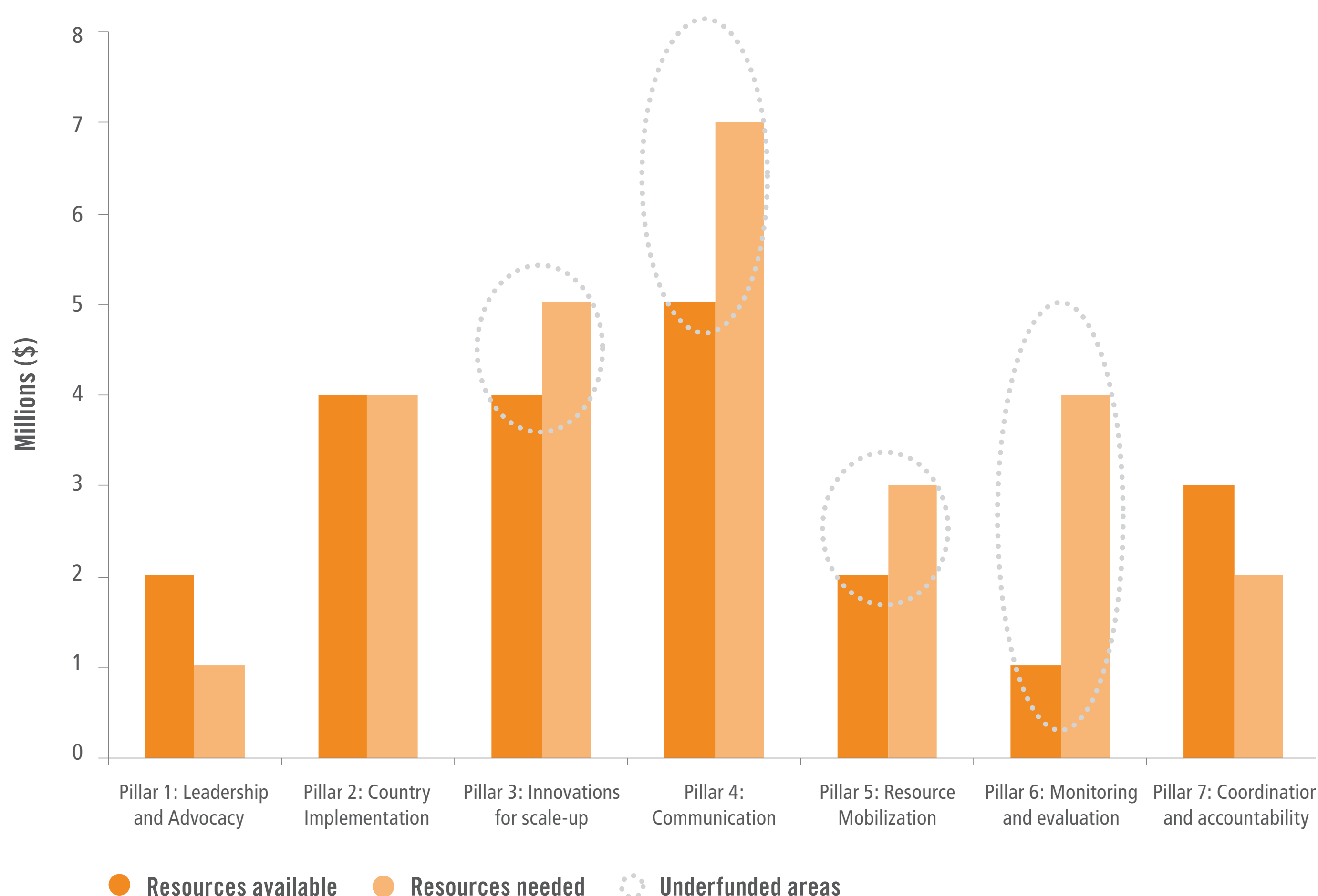
Uganda MoH and Swaziland MoH presented on quality improvement. Resources are required for safety assurance, including informative tools, external quality assessment, quality assurance and continuous quality improvement along with surveillance of adverse events.

Zimbabwe MoH shared a financial resource mapping process, which was a systematic collection of activity-based data on expenditure and budgeting from a VMMC-specific perspective. All organizations involved in the national VMMC programme in Zimbabwe, from the MoH to partners, were engaged in the process, which was led by the Ministry using a tool developed by CHAI.

A district funding gap analysis was also undertaken in 2016 building on a process conducted in 2014 for operational planning. Each step in the process yields outputs that inform the next step. Mapping was also done by strategic pillar. Figure 25 shows the budgetary needs and available resources, enabling the gaps to be visualized. Lessons included the fact that MoH leadership is critical alongside technical support from partners. Harmonization of the planning process was helpful in the funding process. Data transparency is important and frequent follow-up is required for complete, granular data.

6 In Figure 24, FG refers to forceps guided and DS stands for dorsal slit.

Figure 25 Sample data analysis outputs on resource needs and availability by strategic pillar, Zimbabwe



Namibia MoH shared their investment envelope and sources of funding, which were predominantly from the Government of the United States of America (PEPFAR) and the Global Fund. However, given the declining external funding over recent years, it was recognized that there is a need to build a sustainable system for VMMC services, including preservice training and insurance coverage.

A panel composed of representatives from the Global Fund, World Bank, PEPFAR and BMGF spoke on financing issues. Commitment to efficiency on the part of government ministries is critical. There is a need to reposition responses in light of the evidence shared in the working group sessions. The panel gave an overview of the opportunities available for funding from their institutions and the role that each organization plays.

New and enhanced coalitions and partnerships (D. Taljiaard, CHAPS; P. Mwesigye, AFRIYAN; L. Halimani, UNESCO; J. Salliet, AIDS Free; N. Chibukire, SafAIDS; Chief Mumena, Zambia)

CHAPS introduced the session by highlighting that the Framework for Voluntary Medical Male Circumcision: Effective HIV Prevention and a Gateway to Improved Adolescent Boys' and Men's Health in Eastern and Southern Africa by 2021 emphasizes building long-term partnerships and adopting a multisectoral approach by engaging with:

i. Schools, civil society organizations, the private sector, etc.
ii. Youth programmes and networks
iii. Traditional leadership structures
iv. Sports and entertainment sectors
v. Communities and the formal health sector.

Some factors for improved health outcomes lie outside the formal health sector. Sixteen out of the 17 SDGs have some health-related elements, suggesting the need for a stronger health focus in all sector polices.

A panel representing youth coalitions (AFRIYAN), education (UNESCO), public–private partnerships (AIDS Free), community coalitions (SafAIDS) and traditional medicine (Zambia Chief) spoke on partnerships. Enhanced partnerships between the health and education sectors will allow for the provision of VMMC as part of a package of age-specific health and sexuality education services for boys in schools. Where traditional rites of passage are practiced, community and traditional leaders will have an important role in promoting adolescent health in ways that include HIV prevention and safe MC. Each partner brings a set of skills and expertise that is useful to the VMMC programme. These need to be coordinated to maximise efficiency and impact.

Important factors for effective and fruitful collaboration include:

- Common vision, purpose, interests
- Clearly understood roles and responsibilities
- Agreement on contributions/capacity and geographic location
- Transparency
- Active maintenance of partnerships
- Quality participation
- Follow-up on agreed obligations
- Legal and regulatory framework and enabling political environment.

Future priority directions

COUNTRY GROUP WORK

Priority programmatic and policy strategies and interventions

Using a set template, countries were asked to prioritize the age groups that will be most important in their national context for the next five years. Through discussion of current programming and what is working for the priority age groups selected, countries indicated three main challenges and identified programmatic and policy interventions to address these. Countries reported back to the plenary two priority interventions for accelerated action. Interventions were broad-ranging and included:

10–14 years

- Review policy and practice consent procedures with a view to lowering the age of consent.
- Build capacity of providers on dorsal slit MC technique, adolescent-appropriate messaging and counselling.
- Commence discussions and planning for sustainable services.

15–19 years

- Use social media and peer champions.
- Increase service delivery points, including programming for those out of school and in rural areas.
- Broaden the minimal package to include health and wellness information and skills.
- Forge stronger partnerships with other sectors, including education and gender programmes.
- Conduct a situational analysis for advocacy and awareness raising (countries with limited provision of VMMC).

20–29 years

- Choose innovative service delivery models to reach this age group, including outreach and mobile services at tertiary institutions, workplaces and for uniformed services.
- Integrate broader aspects of men's health into VMMC services and vice versa (substance misuse, noncommunicable diseases, etc.).
- Involve partners, including community and traditional leaders, the labour sector and tertiary institutions.
- Use targeted messages and multiple media channels.

Men most at risk

- Review policy to ensure stronger inclusion of considerations for men who are most at risk of HIV infection.

SUMMARY OF KEY POINTS AND PRIORITY ACTIONS

In summary, the key issues raised in presentations, discussions and working group sessions over the three-day meeting include:

1. There has been good progress in thinking around how to transition from an urgent catch-up programme to a sustained programme that institutionalizes training, quality assurance, safety monitoring and service provision; however, this thinking now needs to be implemented.
2. Strategies and policies on how to sustain VMMC programmes have to be developed locally and adapted to local conditions and resources.
3. All countries face challenges in generating demand for the uptake of VMMC among adult men. There is room for innovation, for example: running intensive campaigns in selected areas of the country; focusing on men who have recently migrated to big cities from rural areas; ensuring that all men who are treated for a sexually transmitted infection who are not circumcised are referred to VMMC services; exploring workplace campaigns.
4. There is much work to be done in mapping out the best locally applicable models for the sustainability phase of VMMC programmes among adolescents. Several models can be considered, for example, continuous low volume services integrated with general health services or intensive campaign-style services offered during a circumcision season. The different models need to be costed, the minimum and desirable services that accompany the circumcision procedure defined, and the resource and training needs for long-term sustainability mapped out.

Recommended priority actions included:

- Invest in strengthening the engagement of young people and traditional leaders.
- Ensure geographical coordination, especially in contexts where there are multiple implementing partners.
- Improve the effectiveness of adverse event surveillance.
- Conduct relevant research that informs approaches required to reach the VMMC targets for the 10–29-year age group.
- Improve accessibility of VMMC services and other health services for men using innovative and dynamic service provision models.
- Incorporate lessons learnt from the Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa 2012–2016 in the implementation of the current Framework for Voluntary Medical Male Circumcision: Effective HIV Prevention and a Gateway to Improved Adolescent Boys' and Men's Health in Eastern and Southern Africa by 2021.
- Invest in systems that facilitate sustainability (governance, finance, linkages).
- Prioritize advocacy with governments using evidence that shows that VMMC remains an effective intervention for the prevention of HIV, which requires strong domestic investments for sustainability.
- Expand the role of governments in VMMC programmes, especially in the provision of human resources and infrastructure.
- Consider other possible methods of mobilizing domestic resources, for example the AIDS levy used in Zimbabwe.
- Development partners need to continue supporting VMMC programmes, especially as countries are yet to get to levels where they can sustain their responses without external investment.
- There is a need to clarify whether HIV testing and linkages to other services, for example pre-exposure prophylaxis for HIV, should be made mandatory in VMMC service provision.

Next steps and concluding remarks (R. Yekeye, B. Ncube, F. Lule, WHO; South African Department of Health)

At the close of the meeting, the South African Department of Health and WHO presented on next steps based on a synthesis of the presentations[7], discussions and priorities raised over the three-day period. The following next steps were formulated with the understanding that although countries were completing the catch-up phase of VMMC programmes, the transition to a sustainability phase had started:

- **Build and renew partnerships and dialogue:**
  - VMMC focal points from ministries of health and WHO to immediately continue discussions on key issues in their 2–3 March 2017 meeting.
  - National VMMC programmes to further engage young people, drawing on the ideas and experiences shared by speakers and other meeting participants.
  - All participants to follow up on an informal basis with contacts made at the meeting.
  - All meeting participants to share good examples of partnerships.
- **Diversify funds, including strengthening messaging around the need for funding diversification:**
  - PEPFAR to continue funding VMMC programmes.
  - National governments to advocate for funding from the Global Fund at the country dialogues for applicants held this year.
- **Provide VMMC information for 2017 Global AIDS Monitoring:**
  - National VMMC programmes to ensure their data goes through a data quality and verification process at the national level and that this data is harmonized at global levels.
- **Consolidate information on demand creation approaches to accelerate reach to young men:**
  - National VMMC programmes to formulate systematic approaches for identifying locally relevant demand creation interventions.
- **Start to align thinking and planning:**
  - National VMMC programmes to begin aligning interventions with the new Framework for Voluntary Medical Male Circumcision: Effective HIV Prevention and a Gateway to Improved Adolescent Boys' and Men's Health in Eastern and Southern Africa by 2021.
  - Working groups to continue to advance key areas.

7 All presentations were made available to participants on USB sticks.

MEETING CONCLUSIONS

This report has provided an overview of key issues discussed during the meeting held 27 February–1 March 2017 in Durban, South Africa attended by 135 participants from various organizations including 14 VMMC priority countries in eastern and southern Africa. Key conclusions included the need for:

- country leadership to facilitate programme coordination;
- mechanisms to ensure VMMC programme sustainability;
- prioritizing inclusion of VMMC in costed national HIV strategic plans;
- developing policies that specifically address adolescent boys' and men's health;
- strengthening the engagement of adolescent and young men aged 10–29 years and other sectors;
- fostering multilevel partnerships;
- clarifying the role of traditional circumcisers and strengthening their capacities to conduct safe MC procedures;
- providing policy guidance on HIV testing for MC clients;
- exploring innovations to address human resource challenges;
- reviewing age-specific service packages and service delivery models;
- integrating VMMC into other programmes such as ASRH;
- strengthening data management from all service providers in all sectors;
- strengthening service quality through infection prevention and control as well as health promotion;
- monitoring adverse events; managing logistics; and
- ensuring there is routine use of health information systems.

ANNEX 1. YOUTH ADVOCACY BRIEF

Empowering boys and young men to lead healthy lives

Seizing the opportunity of voluntary medical male circumcision

In 2015, approximately 350 000 new HIV infections occurred among young people aged 15–24 years in eastern and southern Africa. Two thirds of these (68%) occurred among young women. Over the past few years, the increasing HIV incidence among young women in the eastern and southern African region has led to the development of new programmes aimed at preventing the spread of HIV in this group. These prevention efforts are urgent, however, they cannot be targeted at girls and young women alone. Involving adolescent boys and young men in sexual and reproductive health (SRH) interventions is critical for HIV prevention and for the wellbeing *of all adolescents.*

In eastern and southern Africa, health services have traditionally been oriented towards women and children, with SRH viewed as a women's issue. As a result, adolescent boys and young men typically have minimal contact with health services or SRH education – often leaving them in the dark about their responsibility for healthy sexual behaviour or their role in creating positive sexual and romantic relationships. This plays a part in the perpetuation of harmful gender norms, and is damaging to both young women and men. Adolescent boys and young men are a diverse group with different needs and vulnerabilities. In addition to poor access to medical care, this group may experience harsh or abusive punishment, sexual assault, bullying, peer pressure to use violence, depression, substance use and hazardous work conditions.

Voluntary medical male circumcision (VMMC) is one of the most powerful and cost-effective HIV prevention options currently available, and offers an opportunity to integrate boys and young men back into the healthcare system. VMMC reduces the risk of heterosexually acquired HIV infection in boys and men by approximately 60%. Since the rollout of VMMC programmes in 2008, more than 14 million adolescent boys and men have been circumcised, half of whom were aged 10–19 years.

Boys who engage with VMMC programmes can also be linked with and integrated into other HIV and SRH services and provided with relevant information.

VMMC has become highly accepted by many communities in the eastern and southern African region, especially among parents, who view it as a safe and easy way to protect a boy's health and also associate it with a rite of passage to adulthood. Boys who engage with VMMC programmes can also be linked with and integrated into other HIV and SRH services and provided with relevant information. Adolescence is a stage of life when young people form opinions and ideas that they carry into adulthood; research indicates that health behaviours developed during adolescence impact a person's health throughout his/her life. Therefore, adolescence is the right time to positively influence the health seeking behaviours of boys and young men, and to transform gender roles and promote gender-equitable relationships.

The 2016 WHO/UNAIDS Framework for VMMC, Effective HIV Prevention and a Gateway to Improved Adolescent Boys' & Men's Health in Eastern and Southern Africa by 2021 sets out a people-centred approach to VMMC service delivery that tailors services to individuals in different age groups and risk profiles. Reaching adolescent and young men is a main focus of the new framework, which outlines essential service packages for young adolescent boys (10–14 years), older adolescents (15–19 years) and young adult men (20–29 years). In March 2017, key stakeholders from 15 (as South Sudan has been added) priority countries for the scale-up of VMMC in eastern and southern Africa met to discuss the implementation of this new framework. Fourteen youth advocates from across the region attended. In addition to contributing their perspectives throughout the meeting, they also developed key advocacy messages aimed at encouraging policy-makers and implementers to pay more attention to adolescent boys within the HIV response, including in the context of VMMC and SRH programmes.

Involving adolescent boys and young men in sexual and reproductive health (SRH) interventions is critical for HIV prevention and for the wellbeing of all adolescents.

Adolescence is the right time to positively influence the health seeking behaviours of boys and young men, and to transform gender roles and promote gender-equitable relationships.

AfriYAN

The following advocacy messages are intended for youth organizations, activists and allies to use at the country and international levels to inform conversations with policy-makers, healthcare providers and other advocacy targets.

Overall messages

- Adolescent boys and young men are a diverse group, with different needs and vulnerabilities.
- Reaching boys during adolescence is crucial in order to challenge harmful concepts of masculinity that perpetuate gender inequalities and gender-based violence.
- It is urgent to increase HIV prevention efforts to address gender disparities; however, programmes cannot be targeted at girls and young women alone. Boys and young men have an equal role to play in preventing HIV transmission, yet currently few programmes involve or target them.
- Programmes that aim to lower HIV incidence among girls and young women must include specific components aimed at boys and young men, including (but not limited to): testing and treatment services for HIV and other sexually transmitted infections; the promotion of safer sex practices; the provision of male and female condoms and the promotion of their correct and consistent use; accurate sexuality education; VMMC; and activities to transform gender norms.
- Boys and young men can be advocates for expanding access to VMMC and other SRH services and raise awareness about these issues among their peers.
- Adolescent boys have a right to participate in decision-making about whether or not to get circumcised. ***"Involve us from Day 1!"***
- Girls and young women can be mobilizers who engage their brothers, friends, boyfriends and sexual partners in VMMC and SRH services.
- VMMC is a critical entry point for opening up dialogue around SRH, gender dynamics and other critical issues. ***"Let's get the conversation started!"***

Messages or the service provision

- Healthcare providers need skills and support to implement VMMC and SRH programmes that have different components depending on a client's age and development.
- VMMC and SRH programmes require collaboration between communities, young people, parents and healthcare workers. ***"Everyone should be involved in the discussion!"***
- Depending on the local context, VMMC can draw on community traditions and become an integrated part of a symbolic transition from adolescence to adulthood.
- Youth-friendly health services place young people's agency and leadership at the centre of VMMC and SRH efforts, providing young people with opportunities to educate their peers, create demand and serve as community liaisons.
- All VMMC and SRH services should be provided in the context of quality youth-friendly health services that are tailored to age and development. Youth-friendly health services include providers who are open and welcoming. These services also give young people choices, including the ability to select their service provider.
- Health services should be flexible and seek to reach young people, including boys and young men, in convenient locations and at appropriate times, for example through mobile services, schools and youth centres.
- VMMC can never be a stand-alone intervention. It should always be accompanied by linkage and integration with other services, including: testing and treatment for HIV and other sexually transmitted infections; and the provision of behaviour change information, skills and counselling. VMMC reduces a male adolescent's risk of HIV, but it is only one step on a continuum of providing ongoing health services, information and skills for leading healthy lives.

Tips on getting the message out there

- Share the messages with fellow HIV and SRH youth advocates.
- Map out upcoming opportunities to share the messages.
- Consider existing and new potential channels to share the messages.
- Create a social media campaign by sharing the different advocacy messages over a set timeframe. Remember to use AFRIYAN and key organization hashtags and social media handles, for example #AFRIYAN #VMMC2021.
- Translate the messages into your local language.
- Use the message to guide content for presentations, speeches and media interviews.

This work was supported by the World Health Organization, HIV Department.

World Health Organization

ANNEX 2. MEETING AGENDA

DAY ONE: Monday 27 February 2017

Chair: F. Lule, WHO
Rapporteurs: Lesotho, Zimbabwe

Time	Topic	Facilitator/Speaker
08.00 – 08.30	Registration	WHO
08.30 – 09.30	**Opening session** • Introductions • Welcome remarks • Opening remarks • Administration and security briefing • Meeting objectives, outcomes and agenda	Chair: Dr R. Chatora, WHO Representative C. Bonnecwe and Dr R. Ndaba, South African Department of Health, UNDSS B. Ncube, WHO
09.30 – 10.00	**Objective 1: To share progress, successes, impact and lessons learnt in scaling up VMMC**	
	Setting the scene	**Time:** 20 mins B. Ncube, WHO
	Perspectives and experiences of young people	**Time:** 10 mins L. Mosooane, AVAC J. Kayombo, AFRIYAN
10.00 – 10.30	Morning tea break & group photo	
10.30 – 12.30	**Key progress, successes and lessons learned towards the 2016 targets**	
	Country plenary presentations	**Time:** 40 mins Kenya MoH Zambia MoH Tanzania MoH Malawi MoH
	Discussion	**Time:** 15 mins
	Partners panel	**Time:** 30 mins C. Toledo, PEPFAR M. Sundaram, BMGF A. Kaggwa, AVAC C. Laube, Jhpiego
	Discussion	**Time:** 20 mins
12:30 – 13:30	Lunch break	

DAY ONE: Monday 27 February 2017 (continued)

Chair: R. Delate, UNFPA
Rapporteurs: Botswana, Zambia

13.30 – 14.00	**Objective 2: New strategies and technical updates**	
	Global and regional landscape Plenary presentations UNAIDS targets and strategies in the context of SDGs and engaging adolescents and men Three Frees: Stay Free HIV/AIDS: Framework for Action in the WHO African Region 2016–2020 Discussion	**Time:** 20 mins P. Somse, UNAIDS P. Nary, UNICEF F. Lule, WHO **Time:** 20 mins
14.00 – 15.00	**Evidence for focused strategic action** Plenary presentations Age, risk and geography modelling to inform VMMC strategy and targets VMMC coverage, modelling, and translation of results to inform national strategies Framework on VMMC: effective HIV prevention and a gateway to improving adolescent boys' and men' health by 2021 Discussion	**Time:** 30 mins T. Farley, Sigma3 P. Stegman, Avenir Health J. Samuelson, WHO **Time:** 30 mins
15.00 – 15.30	Afternoon tea break	
15.30 – 16.30	**Parallel sessions** Brief technical updates Manual on male circumcision under local anaesthesia Skin preparation Devices Research Method changes Tetanus-toxoid-containing vaccination Youth advocacy workshop	**Time:** 60 mins M. Mahomed, Jhpiego R. Ridzon, PEPFAR; C. Toledo, CDC J. Samuelson, WHO A. Kaggwa, AVAC; A. Armstrong, WHO
16.30 – 18.00	**Market place and informal discussions** Tools and guidelines Publications on promising practices Communication aides, videos Feedback zone Informal discussion tables 16.30–17.30: 1) Surgery and infection prevention and control, 2) Early infant MC, 3) Human resource issues	Materials to share from all organizations Facilitators for informal discussion tables J. Samuelson, C. Koa Affana, WHO Y. Aung, UNICEF B. Nube, WHO; G. Moyo, MoH Tanzania/ECSACON
18:00 – 18.30	Facilitators meeting	WHO

DAY TWO: Tuesday 28 February 2017

Chair: E. Njeuhmeli, PEPFAR/USAID
Rapporteurs: Kenya, Malawi

Time	Topic	Responsible/Speaker
08.00 – 08.30	Day 1 Recap	Rapporteur
08.30 – 09.15	**Objective 3: Evidence, lessons and promising practices to actions**	
	Focused action for males 20–29 years and most at risk men	**Time:** 35 mins
	Demand creation:	
	Overview of demand creation strategies	L. VanLith, JHCCP; C. Laube, Jhpiego
	Spotlight presentations	D. Taljaard, CHAPS
	Accelerate uptake among adult men:	C. Toledo, CDC
	Two approaches: 1) Interpersonal communication to reach men 18–49 years; 2) Expanding community mobilizers.	A. Machinda, PSI Zambia
	Implementation research on older men and demand creation among men aged 20–34 years	
	Market research – method and implementation	
	Discussion	**Time:** 10 mins
09.15 – 10.30	**Accessing services:**	**Time:** 40 mins
	Spotlight presentations	
	Evidence on patterns of services used	C. Toledo, CDC
	Male-friendly men's health service setting	V. Kikaya, Jhpiego
	Linkages to VMMC through HIV self-testing and partner notification	K .Hatzold, PSI Zimbabwe
	Reaching males at higher risk through services for sexually transmitted infections and in occupational settings	S. Mabhele, ILO; T. Teka Amero, PEPFAR Ethiopia
	Discussion	**Time:** 10 mins
	Policies that affect men's health and address masculinity	**Time:** 15 mins
		D. Peacock, Sonke Gender Justice
	Discussion	**Time:** 10 mins
10.30 – 10.45	Tea break	
12.00 – 13.15	**Focused action for adolescents:**	**Time:** 35 mins
	AA-HA! adolescent implementation framework – synergies with VMMC2021 gateway to adolescent boys	T. Desta, WHO
	Spotlight presentations	S. Mabaya, Zimbabwe WHO
	Adolescent SRH and VMMC programme linkages	E. Njeuhmeli, USAID
	Sustainable services for adolescent boys and seasonality considerations	
	Demand creation approaches for adolescent boys	P. Devos, JHCCP
	Discussion	
	Age-specific essential services for adolescents:	**Time:** 10 mins
	Spotlight presentations	
	Minimum service package: HIV testing services, condoms, management of sexually transmitted infections	**Time:** 25 mins
	Tetanus-toxoid-containing vaccination	E. Odoyo-June, PEPFAR Kenya
	Safer sex education, life skills, genital hygiene	
	Quality age-specific communications	Uganda MoH
	Discussion	Zimbabwe MoH
		L. Van Lith, JHCCP
		Time: 10 mins

DAY TWO: Tuesday 28 February 2017 (continued)

Chair: L. Singh, AFRIYAN
Rapporteurs: Uganda

13.15 – 14.15	Lunch break	
14.15 – 15.00	**Integration and linkages: a broader set of interventions for adolescent health** Plenary presentations Masculinity Linking to community, vocational and out of school youth Role of sports Psychosocial programmes Discussion	**Time:** 35 mins D. Peacock, Sonke Gender Justice Swaziland MoH C. Coakley, Grassroots Soccer R. Mophosho, Aurum Institute **Time:** 35 mins
15:00 – 15.30	Afternoon tea break	
15.30 – 17.00	**Breakout group work session:** Implementation consideration for adolescent boys	**Time:** 75 mins A. Armstrong, WHO
17.00 – 18.00	Facilitators meeting	WHO
18.00 – 20.00	Cocktail	WHO

DAY THREE: Wednesday 1 March 2017

Chair: B. Ncube, WHO
Rapporteurs: Swaziland, South Africa

Time	Topic	Responsible/Speaker
08.00 – 08.30	Day 2 Recap and group work feedback	Rapporteur
08.30 – 09.15	**Objective 3: Evidence, lessons and promising practices to actions**	
	Programming to sustain delivery:	
	Plenary presentation	**Time:** 10 mins
	Experience of transitioning to sustainable services (South Africa)	H. Humphries, CAPRISA
	Maintaining MC services for sustained coverage:	**Time:** 30 mins
	Panel	Chair
	Set the scene	Mozambique MoH and M. Galukande, Surgical Association of Uganda
	Essential safe surgery	V. Robertson, ICAZ/ICAN and G. Avorti, WHO
	Infection prevention and control	R. Delate, UNFPA
	Condoms and SRH	J. Samuelson, WHO
	Vaccine delivery (human papilloma virus and tetanus-toxoid-containing vaccines)	Botswana MoH
	Health promotion	
	Discussion	**Time:** 20 mins
09.30 – 10.15	**Policies and services for greatest impact**	
	Plenary presentations	**Time:** 30 mins
	Nursing and midwifery authorization and competency for sustainable VMMC services	J. Gross, CDC
	Institutionalizing training and innovative training approaches	A. Verani, African Regulatory Collaborative
		F. Mtshali, WHO Collaborating Centre for Nurses and Midwives
		C. Samkange, University of Zimbabwe and COSECSA
	Discussion	**Time:** 10 mins
10.15 – 10.45	**New and enhanced coalitions and partnerships: examples and factors for success**	
	Panel	**Time:** 30 mins
	Youth coalitions for SRH	Facilitator: D. Taljaard, CHAPS
	Ministry of Education/schools/universities	P. Mwesigye, AFRIYAN
	Public–NGO–private partnerships	L. Halimani, UNESCO
	Community coalitions	J. Salliet, AIDS Free
	Traditional medicine	N. Chibukire, SafAIDS
		Chief Mumena, Zambia

DAY THREE: Wednesday 1 March 2017 (continued)

10.45 – 11.45 with working tea/coffee	**Objective 4: Future priority directions**	
	Country group work: Priority programmatic and policy strategies and intervention	**Time:** 60 mins B. Ncube, WHO
11.45 – 13.15	**Objective 5: To determine roles and responsibilities of key stakeholders**	
	Accountability for quality and results	
	Plenary presentation	**Time:** 15 mins
	Overview	F. Ndenzako, WHO
	Financial gap analysis	Zimbabwe MoH
	Panel	**Time:** 20 mins
	Financing for acceleration and sustainability	Namibia MoH; South Africa MoH
	Domestic sources: MC in national budget, medical aide/insurance schemes and role of private sector	O. Onyekwena, Global Fund;
	External resources and financing frameworks	N. Fraser-Hurt, World Bank; E. Njeuhmeli, PEPFAR; M. Sundaram, BMGF
	Discussion	**Time:** 15 mins
	National monitoring	
	Plenary presentation	**Time:** 30 mins
	Programme monitoring	J. Cutler, WHO
	Safety monitoring: global and national adverse event reporting and response	R. Ridzon, OGAC Uganda MoH
	Quality improvement	Swaziland MoH
	Discussion	**Time:** 10 mins

DAY Three: Tuesday 28 February 2017 (continued)

Chair: F. Lule, WHO
Rapporteurs: South Sudan, Ethiopia

13.15 – 14.15	Lunch break	
14.15–15.30 with tea	**Roles and responsibilities of stakeholders** **Group work:** National and international partnerships for doing things differently Incorporated in feedback into group work	**Time:** 10 mins F. Ndenzako, WHO **Time:** 65 mins Mixed group work with donors and agencies
15.30–16.30	**Objective 6: To discuss country-specific national perspectives on strategic directions and technical support needs for VMMC scale-up**	
	Summary of key points and priority actions **Next steps** **Closing remarks**	**Time:** 60 mins R. Yekeye, WHO B. Ncube, WHO South African Department of Health , F. Lule, WHO

ANNEX 3. LIST OF PARTICIPANTS

Country	Organization	Name of participant	Designation
Botswana	MoH	Conrad Ntsuape	Safe Male Circumcision Coordinator
	MoH	Meriam Sesinyi	Senior Health Officer – SMC Communications
	WHO	Tebogo Madidimalo	NPO HIV
	AFRIYAN	Ishmael Chipoyo	Youth participant
Ethiopia	FMoH	Fethia Keder	HIV/AIDS Programme Officer
	WHO	Petros Olango Dubusho	NPO HIV
Kenya	MoH	Violet Otindo	VMMC focal point
	MoH	Jeanne Patrick	ASRH focal point
	MoH	Mercy Kasina	Nursing Service/Nursing Education
	WHO	Christine Kisia	NPO HIV
	AFRIYAN	Francis Mutua	Youth participant
	Faith-based organization	John Motoku	Representative
Lesotho	MoH	Mats'enase Ts'enase	VMMC focal point
	MoH	Mpoeetsi Makau	Nursing Services focal point
	WHO	Susan Tembo	County Officer
	AVAC	Lepheana Mosooane	AVAC fellow
Malawi	MoH	Simeon Lijenje	VMMC focal point
	MoH	Hans Katengeza	Reproductive Health
	MoH	Kondwani Chalulu	Clinical Officer
	WHO	Ishmael Nyasulu	NPO HIV
	AFRIYAN	Steve Kumvenji	Youth participant
Mozambique	MoH	Jotamo José Comé	National VMMC focal point
	MoH	Matcheane Cossa	Head, National Surgery Programme
	MoH	Jessica Seleme	National HIV/AIDS Programme
	MoH	Estela Mangueze	National Adolescent Reproductive Health Programme
		Isaias Domingos Nesse	Youth participant
Namibia	MoH	E Shihepo	VMMC Coordinator
	MoH	Ndapewa Hamunime	CMO/HIV/STI
	AFRIYAN	Ashwell Forbes	Youth participant
Rwanda	Military services	Leon Ngeruka	Representative responsible for VMMC
South Sudan	MoH	Agai Kherubino Akee	HIV/AIDS/STI Clinical Mentor
	WHO	David Lukudu	NPO HIV
South Africa	NDoH	Ronald Ndaba	KZN MMC Programme Manager
	NDoH	Dayanund Loykissoonlal	Programme Manager, MMC and HIV Prevention Strategies
	NDoH	Collen Bonnecwwe	Director, Medical Male Circumcision
	NDoH	Ayanda Nqeketho	VMMC and Traditional Male Circumcision Coordinator
	WHO	Busisiwe Msimanga	NPO HIV
	AFRIYAN	Levi Singh	Youth participant
Swaziland	MoH	Muhle Nimrod Dlamini	HIV Programme Manager
	MoH	Vusi Maziya	VMMC National Coordinator
	MoH	Simangele Mthethwa	SRHU Technical Advisor
	WHO	Sithembile Dlamini-Nqeketo	NPO HTH
	CHAPS	Ntokozo Mlotsa	VMMC champion/ youth participant
	MoH	Jesca Masanja	ASRH Programme Officer
	MoH	Jeremiah Mushi	VMMC SI Officer

	MoH	Gustav Moyo	Director of Nursing and Midwifery Services, ECSACON
	MoH	Lija Gissenge	VMMC focal person
	WHO	Bhavin Jani	NPO HIV
	AFRIYAN	Seifu Ibrahim	Youth participant
Uganda	MoH	Peter Kyambadde	VMMC focal point
	MoH	Agnes Chandia Baku	SRH focal point
	WHO	Mugagga Kaggwa	NPO HIV
	AFRIYAN	Patrick Mwesigye	Youth participant
	Makerere University	Moses Galukande	Head, Department of Surgery
Zambia	MoH	Francis Bwalya	Deputy Director of Public Health
	MoH	Albert Kaonga	HIV /TB Officer
	MoH	Marble Mweemba	Adolescent Reproductive Health Officer
	Traditional medicine	Chief Eshiloni Jonathan Mumena	Chief of the Kaonde Pipo
	WHO	Lastone Chitembo	County Officer
	AFRIYAN	Shuko Musemangezhi	Youth participant
Zimbabwe	MoH	Sinokuthemba Xaba	VMMC focal point
	MoH	Aveneni Mangombe	ASRH focal point
	MoH	Felicia Gwarazimba	Infection Prevention and Control and VMMC Training
	WHO	Simbarashe Mabaya	County Officer
	Young People's Network on Sexual Reproductive Health, HIV and AIDS	Tinotenda Kabai	National Facilitator
WHO – additional			
Switzerland	HQ HIV	Julia Samuelson	HIV focal
United Kingdom	HQ HIV	Alice Armstrong	Consultant
Switzerland	HQ	John Cutler	Strategic information and monitoring
	HQ	Bruce Dick	Consultant
Zimbabwe	HQ	Raymond Yekeye	Consultant – report writer
Switzerland	HQ	Clementine Koa Affana	Surgical fellow
Congo	AFRO HIV	Frank Lule	MO/Treatment and Care
Zimbabwe	AFRO HIV	Buhle Ncube	HIV Prevention focal
Zimbabwe	IST HIV	Fabian Ndenzako	Medical Officer – HIV/TB/Hepatitis Prevention
Zimbabwe	IST FRH	Teshome Desta Woldehanna	MO/CAH
Zimbabwe	IST HSS	Gertrude Avortri	Infection Control
UN and other agencies			
South Africa	UNAIDS	Pierre Somse	HIV Officer, Regional support team
South Africa	UNFPA	Richard Delate	HIV/SRH Programme Specialist
South Africa	UNFPA	Renata Tallarico	Regional SYP Coordinator
Zimbabwe	UNESCO Regional	Lucas Halimani	NPO – HIV and Health Education
Kenya	UNICEF Regional Office ESA	Paul Nary	Senior HIV/AIDS Specialist
South Africa	UNICEF	Yin Yin Aung	Health Specialist
South Africa	ILO Decent Work Team for East and Southern Africa	Simphiwe Mabhele	Technical Specialist on HIV/AIDS and the World of Work
USA	World Bank	Nicole Fraser-Hurt	HIV team VMMC focal point
Switzerland	Global Fund	Obinna Onyekwena	Disease Advisor – HIV

USA	BMGF	Maaya Sundaram	Programme Officer – Integrated Delivery/HIV
Kenya	NASCOP/ Partners in Health	Kennedy Serrem	Head, Technical Support Unit
	BMGF	Patrick Odawo	HIV VMMC Focal Point
Zimbabwe	BMGF/ PSI	Brian Maponga	Programme Director, Male Circumcision
USA	PEPFAR (CDC)	Jonas Hines	Medical epidemiologist
USA	PEPFAR (CDC)	Carlos Toledo	VMMC Team Lead
USA	PEPFAR (USAID)	Emmanuel Njeuhmeli	Senior Biomedical Prevention Advisor
USA	PEPFAR (USAID)	Jackie Salliet	Project Director AIDSFREE
USA	PEPFAR (OGAC)	Renee Ridzon	Consultant
USA	PEPFAR (USAID)	Lynn Van Lith	Technical Advisor – HIV
USA	PEPFAR (CDC, ARC)	Andre Verani	Policy analyst – health systems and human resources
USA	PEPFAR (CDC, ARC)	Jessica Gross	Team Lead – African Regional Collaborative
Botswana	CDC	Malaba Kananga	Medical officer
Ethiopia	DOD	Tesfaye Teka Amero	Public Health Specialist, DoD/PEPFAR Programme manager
Kenya	CDC	Elijah June Odoyo	Medical officer
Lesotho	PEPFAR	Neway Fida	Medical officer
Malawi	USAID	James Odek	Medical officer
Mozambique	CDC	Stanley Wei	Medical officer
Namibia	CDC	Brigitte Zemburuka	Public Health Specialist, VMMC Technical Advisor
South Africa	USAID	Enilda Martin	
South Africa	USAID	Isaac Choge	
South Africa	CDC	Alfred Bere	
Swaziland	USAID	Wendy Benzerga	USAID Country Director
Tanzania	CDC	Daimon Simbey	VMMC advisor
Uganda	CDC	Geoffrey Kabuye	Medical officer
Zambia	CDC	Omega Chituwo	Public Health Specialist (Biomedical Prevention)
Zimbabwe	CDC	John Mandisarisa	VMMC lead
Zimbabwe	USAID	Onesimo Maguwu	Public Health Specialist
South Africa	WHO Collaborating Center on Nursing and Midwifery / UKZN	Fikile Mtshali	Professor, School of Nursing
Zimbabwe	COSECSA / University of Zimbabwe	Chris Samkange	Director, Institute of Continuing Health Education
Zimbabwe	ICAN /ICANZ	Valerie Robertson	ICAN secretary / ICANZ President
South Africa	CHAPS	Dirk Taljaard	Chief Executive Officer
Swaziland	CHAPS	Alfred Adams	Technical Director
South Africa	Sonke Gender Justice	Dean Peacock	Executive Director
South Africa	Grassroots Soccer	Chelsea Coakley	Global Director of Strategy
Zimbabwe	SAfAIDs	Ngoni Chibukire	Regional Team Leader – Leadership, Gender and Human Rights
Tanzania	AFRIYAN	Jennifer Kayombo	Young woman
South Africa	AURUM Institute	Refilwe Mophosho	Technical Project Manager
South Africa	AURUM Institute	Jacqueline Pienaar	HIV Prevention (VMMC) Technical Advisor
Zimbabwe	PSI	Karin Hatzold	Global Deputy Director HIV/TB Clinical and Biomedical Interventions
Zambia	PSI / SFH	Albert Machinda	
Lesotho	Jhpiego	Virgile Kikaya	Country Director
Mozambique	Jhpiego	Mehebub Mahomed	HIV Technical Director

South Africa	CAPRISA	Hilton Humphries	Adolescent Programme Director
USA	Avenir Health	Peter Stegman	Senior Economist
USA	CHAI	Tichakunda Mangono	Programme Manager
Switzerland	Sigma 3 Services	Tim Farley	Consultant to WHO
USA	AVAC	Angelo Kaggwa	Programme Manager
USA	CHAI	Tichakunda Mangono	Programme Manager
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