5 PILLARS FOR HIV PREVENTION

Issue Brief

4.

The Missing Piece of the Puzzle

RIGHTS+EQUITY+JUSTICE for HIV PREVENTION

Voluntary medical male circumcision (VMMC)

When enough men in a community have undergone voluntary medical male circumcision, it will not only reduce risk for men. It will in turn reduce women's overall risk of acquiring HIV as well.

Voluntary medical male circumcision (VMMC) is a once-off, cost-effective, biomedical intervention, which reduces men's risk of acquiring HIV from their female partners by roughly 75%.

The UNAIDS Fast-track target sets an ambitious goal:

circumcising

90%

of men and boys

age 10 - 29

in **14 priority countries** in East and Southern Africa

=

27

million

men and boys

between 2016 and 2021

In order to achieve this target, most countries will have to **double the number of voluntary circumcisions** performed per year.

This issue brief describes the structural barriers which stand in the way of reaching the VMMC targets, and proposes some strategic areas for addressing those barriers.

ARASA AIDS & Rights Alliance for Southern Africa

The HIV epidemic in East and Southern Africa: where are we now?

The 2020 targets

In June 2016, at the United Nations High-Level Meeting (HLM) on Ending AIDS, countries pledged to leave no one behind and: **end the AIDS epidemic** as a public health threat by **2030** and **reach ambitious milestones** by **2020.**

- reduce AIDS-related deaths
- reduce new infections

} to less than 500 000[1]

The HLM, for the first time, set specific programme targets for HIV prevention, supported by 5 pillars:

Pillar	Target
adolescent girls and young women (AGYW)	1 reduce new HIV infections among young women and girls to under 100 000
key populations	2 ensure that 90% of people at risk of HIV can access prevention services
condom programming	3 make 20 billion condoms available annually in low and middle-income countries
voluntary medical male circumcision (VMMC)	4 provide 25 million more men with VMMC
pre-exposure prophylaxis (PrEP)[ii]	5 provide PrEP to 3 million people at risk of HIV

For VMMC, the global target set by UNAIDS is to provide:

25 million

more men with VMMC

While reductions in global AIDS-related deaths continue at a pace that puts the 2020 target within reach, the rate of new HIV infections is not falling fast enough to reach the 2020 target of under half a million new infections per year.

Out of all regions of the world, East and Southern Africa is in fact faring the best, with new HIV infections declining by 30% between 2010 and 2017.

In order to reach the global targets, SADC has committed to reduce the amount of new infections by 230 000 per year. This is a 75% reduction from the levels in the SADC region in 2010.

PROGRESS TOWARDS 2020 HIV PREVENTION TARGETS IN SADC

Progress is still too slow, and if the region continues at the current trajectory, it will fail to meet the 2020 targets.[iii]

[New HIV Infections per year]

1990 — 669 856

1995 — 1 276 730

2010 — 903 576

30% decline in new infections between 2010 and 2017

2017 — 532 946 — 590 590

2019 — 328 242 — 501 174

2020 — 225 890 — 456 466

[Political Declaration Target] [Projection on currrent trends]

Treatment as Prevention is not enough

The goal of getting people onto antiretroviral treatment has surpassed everyone's expectations. Treatment has been shown to be an effective means of HIV prevention.

Estimates shows that achieving UN treatment goals alone can only reduce 60% of new infections.[i,v] We therefore need a renewed focus on primary prevention[1].

Principles of programme interventions for all 5 pillars

Effective and efficient prevention programmes have the following elements:[v]

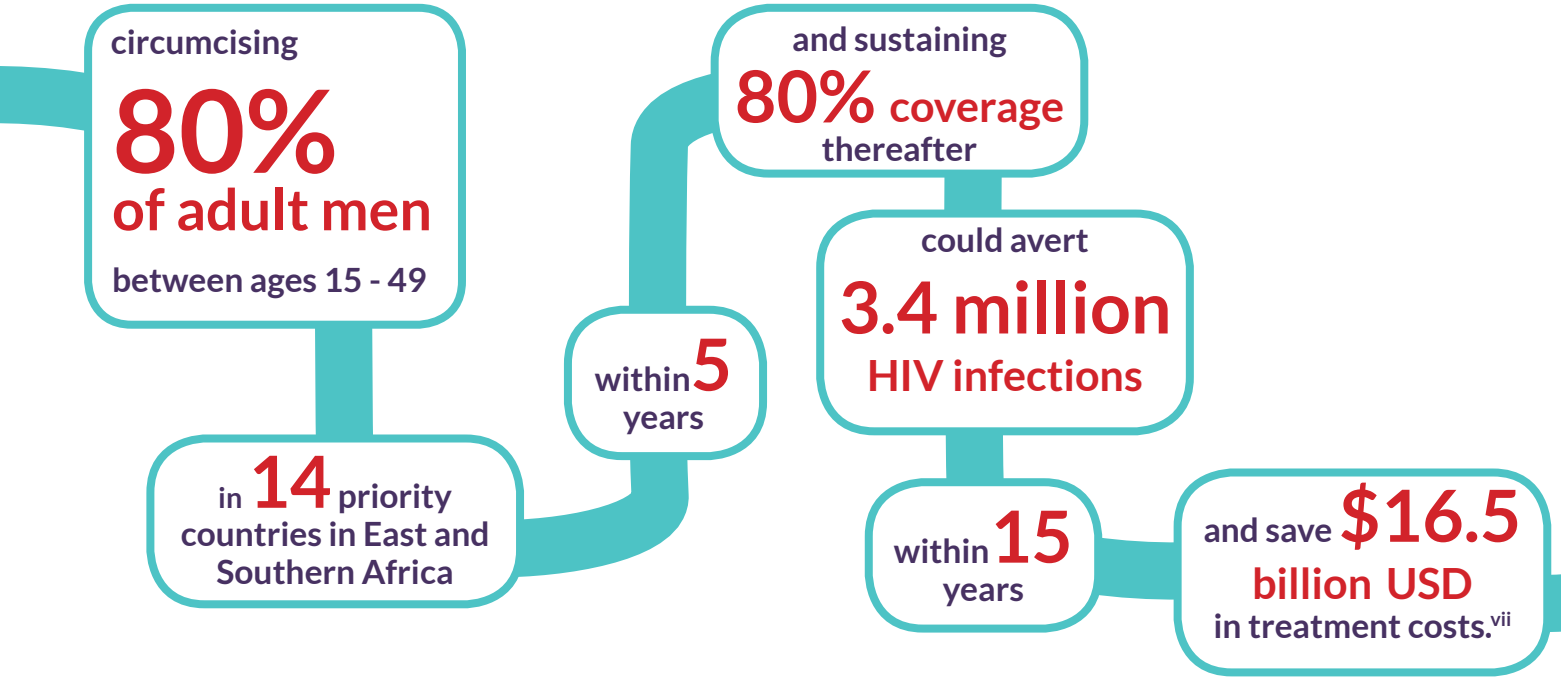
- They are comprehensive and integrated
- They are smart: they ask, "What works?", "With which populations?" and "In which settings?"
- They respect and protect human rights
- They are gender-sensitive and/or gender-transformative[2]
- Services are delivered at community level
- They make use of local programme data to for continuous improvement.
- They can be scaled up.

The 5 HIV prevention pillars are components of an integrated response.

Why VMMC?

VMMC reduces men's risk of acquiring HIV from their female partners by roughly 75%. And, when enough men in a community have undergone the procedure, then women's overall risk of acquiring HIV drops too.[vi]

Modelling studies conducted in 2009 and 2011 estimated that:



In some communities with high coverage of VMMC, these models are turning into reality. Rates of HIV acquisition are dropping in men and women as VMMC coverage expands.

Targets for VMMC

The UNAIDS Fast-track target sets a goal of circumcising 90% of men and boys age 10-29 in 14 priority countries. These 14 countries are:

- Botswana
- Ethiopia
- Kenya
- Lesotho
- Malawi
- Mozambique
- Namibia
- Rwanda
- South Africa
- Swaziland
- Uganda
- Tanzania
- Zambia
- Zimbabwe

The 90% target is equivalent to 27 million men and boys between 2016 and 2021. In order to achieve this target, most countries will have to double the number of circumcisions performed per year.

The age group which yields the lowest prevention benefits of VMMC is men over 30.

How should VMMC be programmed?

- In countries with high levels of HIV prevalence and low levels of male circumcision as a religious and/or cultural practice, VMMC should be offered as part of wider sexual and reproductive health service provision for men and boys.

- Certain age groups, risk groups and regions with the highest incidence[3] should be prioritised. In terms of age, short-term impact is the greatest in age groups at current high HIV risk (the 15-29 age group).
  Focusing on men at higher sexual risk can boost the HIV prevention impact of VMMC. This implies focusing on, for example, STI clinic patients, or some occupational groups at higher risk, such as truck drivers, armed forces and migrant mine workers for example.

How are countries faring with VMMC?

The Global Prevention Coalition monitors countries' progress on the 5 HIV prevention pillars, including VMMC.[4] Up-to-date country scorecards are available online at: https://hivpreventioncoalition.unaids.org.

The following scorecard shows that there is variation in performance between the VMMC priority countries.

Ethiopia
Kenya
Tanzania
Uganda and
Zambia

} have either already reached their VMMC targets, or are close to doing so.

Botswana,
Malawi and
Namibia

} Botswana, Malawi and Namibia and some other countries, still have very low rates relative to their targets.

VMCC Thematic Summary

Outcome			Countries	Output			
National MC prevalence (15-24)	National MC prevalence (15-49)	% of cumulative national VMMC target achieved		% of annual VMMC target achieved	# of VMMCs performed per year (2017, in thousands)	# of VMMCs performed in 2016	% change in number of VMMCs in the two most recent years
23	26	16	Botswana	35	20	24	-18
91	93	90	Kenya	100	234	219	7
70	72	31	Lesotho	65	25	34	-26
29	28	10	Malawi	28	166	130	28
66	47	20	Mozambique	54	315	253	25
22	36	16	Namibia	41	30	27	10
70	62	26	South Africa	66	511	497	19
5	8	20	Swaziland	50	18	17	4
82	80	53	Tanzania	100	730	548	33
49	27	27	Uganda	92	848	411	106
25	22	33	Zambia	100	484	312	55
19	14	20	Zimbabwe	58	301	206	46

very good | good | medium | low | very low

Structural Barriers to VMMC

There are a number of structural barriers to scaling up VMMC so that it can have the impact which it is able to have on HIV prevention. These barriers include:

Other challenges relate to:

supply of human resources

infrastructure and materials

financing shortages

1. Limited demand for VMMC

- Reluctance amongst young men:

In some countries, many young men are reluctant to be medically circumcised. There are many reasons for this reluctance, including fear of pain; not believing that they were at risk of HIV; fear of HIV testing; partner refusal or reluctance; reluctance to abstain from sex; as well as myths and misconceptions.[viii]

- Religious and ethnic identity:

Attitudes to VMMC are strongly influenced by ethnic and religious identity. Male cultural circumcision forms part of the rites of passage during adolescence for many ethnic groups in Africa. For these groups, the idea of circumcision is more acceptable, however, there is a reluctance to undergo medical circumcision. On the other hand, in surveys with groups that do not traditionally circumcise, the main reason given for both opposing circumcision is ethnic and religious identity.[ix]

- Barriers to SRHR for adolescents: The barriers to VMMC are linked to the broader barriers faced by adolescents in accessing sexual and reproductive health and rights services (SRHR) Adolescents experience challenges in accessing and receiving health services because of laws and policies that prevent them from independently seeking services without parental consent, judgmental provider attitudes about sexual activity among young people, and services that are not tailored to the needs of youth. Adolescent men are particularly difficult to reach because their limited knowledge of health services and their perception that SRH services are for women influences their desire to access services.[x]

In Zimbabwe, for example, adolescents younger than 16 years are barred by law from accessing contraceptives and those aged 16 and 17 years can only access contraception with parental consent, which most are unlikely to seek.

- Men's low health-seeking behaviour:
In general, men have lower health-seeking behaviour than women, and are less likely to access HIV prevention, treatment and care. Across sub-Saharan Africa, men and boys living with HIV are 20% less likely than women and girls living with HIV to know their HIV status, and 27% less likely to be accessing treatment.[xi] Globally, (including in East and Southern Africa), while there are more women infected with HIV than men, men are more likely to die of AIDS-related causes.[xii]

- Limited demand creation for VMMC: VMMC is a significant and irreversible decision. It is also an elective procedure. The benefits are long-term but not immediately apparent. Without smart, persuasive, appropriate and adequately funded demand creation activities, uptake of VMMC will remain low. However, in many countries, demand generation is inadequate, and where it does occur, is driven solely by PEPFAR partners.[xiii]

2. Supply-side challenges

Supply-side challenges include severe human resource constraints, with low numbers of health workers trained in VMMC in some countries. There are also shortages of VMMC commodities in some countries, due in part to weak in-country logistics and coordination.

3. Financing of VMMC

VMMC priority countries are highly dependent on donor funding, in particular from PEPFAR, to fund all aspects of VMMC programmes. Furthermore, VMMC programmes have largely been implemented as standalone programmes. There is real cause for concern about the sustainability of VMMC when donor funding declines.

Addressing the barriers to VMMC

The barriers outlined above can be addressed, using a range of smart strategies.

These include:

- ramping up appropriate demand generation interventions
- looking at issues of integration, including integrating VMMC into adolescent sexual and reproductive health and rights (ASRHR) services
- addressing VMMC for gay men and other men who have sex with men
- improving data collection and use, and
- strengthening capacity and mobilising resources.

1. Increase and improve demand generation

- There is a need to ramp up smart, evidence-informed, demand creation activities, which address the multiple attitudinal barriers to VMMC. Demand creation is especially important in countries or regions where traditional male circumcision is low. VMMC demand-creation messages need to be specifically tailored for different ages and should emphasize non-HIV prevention benefits, such as improved hygiene and sexual appeal, and need to address men's fear of pain.[xiv]

    - Qualitative research into VMMC has shown how influential other men (both peers and role models) are in their decision-making around VMMC. This is especially true for especially adolescents and young men, for whom peer approval plays an important part in identity and self-esteem. VMMC programmes should make use of both peer educators and male champions enlist charismatic men who have undergone VMMC and can promote the benefits.

Three potential change agents can be harnessed to shift attitudes towards VMMC and increase uptake:

- male champions
- wives, girlfriends and mothers, and
- traditional leaders.

Success Story

By the end of the project, more than

408,000 men

in East Central Uganda had been circumcised, increasing coverage

from 37% to 57%[1]

In Uganda, the STAR-EC project worked from 2009-2016 to increase access to VMMC and other HIV prevention and treatment services in East Central Uganda.

The project engaged Village Health Teams, peer educators, civil society organisations, and 'satisfied clients' to promote VMMC through organised events such as fairs, market days, couples testing and counselling weeks, and youth football competitions. It also used mobile surgical tents (often referred to as 'camps') to offer VMMC services in communities.

These camps took place on weekends and on district, regional, and national commemoration days. Community resources were relied on to raise awareness about the benefits of VMMC and provide advance marketing for the outreach clinics.

- Women play a pivotal role in VMMC's scale-up—influencing partners' and sons' decisions, and providing clear messages in the community. For example, one study in Kenya assessed women's beliefs about male circumcision (MC) for HIV prevention and the implications for sexual preferences and behaviour. The women understood that MC provided partial protection against HIV acquisition for men, and that being circumcised did not mean that men were HIV-negative. Overall, they preferred circumcised men as sex partners. They associated male circumcision with cleanliness, perceived circumcised men as less likely to have sexually transmitted infections, and thought that circumcised men could provide greater sexual satisfaction for women.[xv]

- In areas where traditional circumcision is not practiced, and culture is cited as a reason for opposition to VMMC, traditional leaders can be engaged as change agents.[xvi]

2. Transition from VMMC-specific to integrated or linked health services

To date, most of the VMMC successes have hinged on campaigns that saturate specific geographies and then move on.[xvii] Going forward, however, measures have to be taken to strengthen the capacity of public health systems to plan, coordinate, implement, monitor and sustain VMMC at national, district and local levels.

In addition, VMMC should be part of a core package of health services for men and boys, using approaches that are tailored for various age groups and locations.

3. Integration of VMMC into adolescent sexual and reproductive health services

Adolescence presents a crucial opportunity to introduce VMMC as a gateway to broader sexual and reproductive health (SRH) interventions, including HIV prevention, because most adolescent boys are not yet sexually active:

data in some priority VMMC settings show the age of sexual debut in these regions to be on average around 18 years, and HIV incidence rates suggest that most men become infected between the age of 20–29 years.

VMMC for adolescents has several advantages:

- uptake of services among adolescents is culturally and socially more acceptable than for adults;
- there are fewer barriers regarding sexual abstinence during healing or female partner pressures;
- VMMC performed before the age of sexual debut has maximum long-term impact on reducing HIV risk at the individual level and consequently reduces the risk of transmission in the population.

Offered as a comprehensive package, adolescent VMMC can potentially increase public health benefits and offers opportunities for addressing gender norms.[xviii]

4. Addressing VMMC for gay men and other men who have sex with men

It remains unclear whether medical male circumcision could have an impact on HIV transmission among gay men and other men who have sex with men. Protection might depend on whether the individual is insertive or receptive during anal sex.[xix]

Recent findings suggest circumcision might help reduce transmission in MSM who report a preference for insertive sex.

5. Improving data collection and analysis

PEPFAR, national governments and WHO/UNAIDS all track annual numbers of VMMCs performed, but data is released at different times and sometimes reflect different trends. There must be better coordination of data collection and sharing amongst these key players to improve efficiency.

Several countries which are members of the Global HIV Prevention Coalition have launched real-time health situation room monitoring mechanisms, to help programme managers visualize data from their health information systems. These situation room platforms include a range of HIV prevention indicators, including VMMC.[xx]

6. Strengthening capacity and competencies

In addition, the capacity of health care workers to conduct VMMC must be increased and improved. Ways of achieving this include task-shifting – training nurses to be able to conduct VMMC at primary health care level – and the scale up of new non-surgical VMMC methods.[xxi]

7. Keeping sustainability in mind

Increases in domestic funding will be required to ensure the sustainability of programmes in countries that currently rely on international funding for the majority of their programme budgets.

A sustainable VMMC programme is one where local stakeholders maintain a high prevalence of circumcision through transition to domestic financing, by incorporating either early infant male circumcision, early adolescent VMMC, or both, into routine newborn and adolescent service delivery systems.

Resources

1. Policy Brief: A framework for Voluntary Male Medical Male Circumcision
   Available at: http://apps.who.int/iris/bitstream/handle/10665/246234/WHO-HIV-2016.17-eng.pdf;jsessionid=F4B04DFB7E20BFA521D3756EFC7A0931?sequence=1

2. HIV Prevention 2020 Road Map: Accelerating HIV Prevention to reduce new infections by 75% . UNAIDS
   Available at http://www.unaids.org/sites/default/files/media_asset/hiv-prevention-2020-road-map_en.pdf

3. Members of the Global Prevention Coalition report on VMMC as part of a prevention scorecard, which is available online. https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/

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[xv]Riess, T., Achieng, M., Bailey, R (2014) Women's Beliefs about Male Circumcision, HIV Prevention, and Sexual Behaviors in Kisumu, Kenya, PLOS ONE, 9(5): e97748.
[xvi]NAC, UKAID, Invest in Knowledge, World Bank (2015). Report on a qualitative study of barriers and facilitators to voluntary male medical circumcision in Malawi. Available at: http://www.ehpsa.org/all-documents/general/62-vmmc-malawi/file
[xvii]https://www.avac.org/vmmc/basics
[xviii]Njeuhmeli, E. et al. (2014) Lessons learned from scale-up of voluntary medical male circumcision focusing on adolescents: benefits, challenges, and potential opportunities for linkages with adolescent HIV, sexual, and reproductive health services, J Acquir Immune Defic Syndr. 2014 Jul 1;66 Suppl 2:S193-9
[xix]https://www.avert.org/professionals/hiv-programming/prevention/voluntary-medical-male-circumcision
[xx]https://hivpreventioncoalition.unaids.org/wp-content/uploads/2018/06/JC2927_UNAIDS-WHA-Report.pdf
[xi]UNAIDS Prevention Gap report (2016)

About ARASA

The AIDS and Rights Alliance for southern Africa (ARASA) was established in 2002 as a regional partnership of civil society organisations working in 18 countries in Southern and East Africa. Between 2019 and 2021, the partnership will work to promote respect for and the protection of the rights to bodily autonomy and integrity for all in order to reduce inequality, especially gender inequality and promote health, dignity and wellbeing in southern and east Africa.

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ARASA AIDS & Rights Alliance for Southern Africa

The Partnership to Inspire, Transform and Connect the HIV response (PITCH) enables people most affected by HIV to gain full and equal access to HIV and sexual and reproductive health services.

The partnership works to uphold the sexual and reproductive health and rights of lesbian, gay, bisexual, and transgender people, sex workers, people who use drugs and adolescent girls and young women. It does this by strengthening the capacity of community-based organisations to engage in effective advocacy, generate robust evidence and develop meaningful policy solutions.

PITCH focuses on the HIV response in Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Uganda, Ukraine, Vietnam and Zimbabwe. Partners in these countries also share evidence from communities to influence regional and global policies that affect vulnerable populations.

PITCH is a strategic partnership between Aidsfonds, FrontlineAIDS and the Dutch Ministry of Foreign Affairs.

PITCH Partnership to Inspire, Transform and Connect the HIV response

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