

## **GPP Case Study: Voluntary Medical Male Circumcision**

### **Research Background**

Voluntary medical male circumcision (VMMC) involves the removal of the foreskin of the penis to prevent acquisition of HIV and other STIs. Male circumcision is one of the oldest and most common surgical procedures worldwide, undertaken for religious, cultural, social, or medical reasons.

Data from three randomized controlled trials, conducted in Orange Farm, South Africa; Kisumu, Kenya; and Rakai District, Uganda between 2005-2007, showed that the incidence of HIV infection was reduced by 50-60% in adult men who received VMMC. Subsequent follow-up data from Orange Farm show for the first time in 2014 that VMMC lowers HIV incidence in women.

In 2007, shortly after the research teams disseminated their VMMC results, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) responded by recommending that male circumcision be scaled up in countries with low circumcision and high HIV rates. Modeling completed by the US President's Emergency Plan for AIDS Relief (PEPFAR) and UNAIDS further demonstrated that VMMC has the highest impact on HIV when the majority of men are circumcised within the shortest possible time.

### **The Scenario**

After the first trial at Orange Farm was unblinded, free and immediate access to VMMC was offered to former trial participants and other adult male residents of Orange Farm. In 2007, WHO and UNAIDS produced operational and technical guidance for use by country and global stakeholders to accelerate the scale up of VMMC in 14<sup>1</sup> priority countries of East and Southern Africa.

The pace and progress of VMMC scale-up has varied across countries and has accelerated over time. The greatest success has occurred in Nyanza Province, Kenya, where a strong VMMC program was rolled out with buy-in from traditional leaders and substantial coverage was achieved in the target population following the WHO recommendations.

### **GPP-Relevant Issues**

**Building literacy.** All countries prioritized for rollout faced basic literacy and messaging challenges. Stakeholders across the board needed to understand basic concepts such as how the procedure was performed, that VMMC is not 100 percent protective, and that those undergoing the procedure need to abstain from sex until complete wound-healing. Coordinated resources, messaging, and communications planning has been critical to successful programs, and can help with increasing demand in the local population.

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<sup>1</sup> WHO and UNAIDS initially recommended 13 priority countries; PEPFAR later added Ethiopia, making 14 priority countries

**Myths and misconceptions.** Across the targeted countries some communities practice traditional male circumcision as a rite of passage and some don't. Beliefs around VMMC can vary widely, leading to myths and misconceptions. Common misconceptions and concerns can surround the procedure itself (e.g., pain, length of time required for aftercare, disposal of removed foreskin). Other concerns, though unfounded, include libido and sexual desirability. Some of these inaccuracies have been reinforced by anti-circumcision groups and negative press coverage.

**Engagement of national and multi-sectoral leadership.** VMMC programs have implications for a country's health systems, legal frameworks, and culture. Scale-up therefore requires close coordination among a range of stakeholders. These include national governments, donors, program implementers, traditional leaders and circumcisers, civil society, and health care providers. In some settings, challenges with establishing strong collaboration between implementing partners and the government resulted in a lack of country ownership and derailed progress.

### **GPP-Related Actions in Kenya**

**National leadership and commitment.** The Kenyan government developed a national strategy and identified key political champions who accelerated the country's post-trial access. The national Ministry of Health worked closely with USAID, WHO, the National AIDS Control Council, and other implementing partners, but they took primary ownership of the process and its outcome.

**Collaborative decision making.** The Kenyan government established a national multi-stakeholder task force to be ultimately responsible for overseeing the coordination, implementation, monitoring and evaluation of national strategies for VMMC scale-up. The strong and trusting relationships between members and their participatory decision-making resulted in positive outcomes, such as improved communication planning and the rollout of more innovative operational models (e.g., training of nurses to conduct VMMC surgery).

**Community education and capacity building.** With support from development partners and under the leadership of the VMMC taskforce and the Ministry of Public Health and Sanitation (MoPHS), communication sub committees were formed to operationalize the national communication strategy. Their community mobilization teams increased buy-in and support by engaging with a broad range of community stakeholders, including religious leaders, traditional MC practitioners, women, and young people. Support from the Luo Council of Elders, before the launch of VMMC and especially during a post-election period of heightened political and ethnic tension, was a key factor in mitigating cultural resistance. Culturally sensitive and gender specific messages were created for communities to help ensure that the medical benefits of VMMC were understood by both men and women, and that uptake of VMMC did not increase men's HIV risk behavior or reduce women's ability to negotiate condom use.

**Sustained engagement with media.** Under the leadership of the communication sub committees and implementing partners, a special project was created to train journalists about VMMC. These VMMC-themed workshops helped local journalists develop story ideas,

convey complex scientific concepts to the public, and access the frontlines, which included opportunities to visit VMMC sites, attend counseling sessions, and observe the procedure being performed.

### **Lessons Learned**

***Communications and messaging.*** Coordinated and customized communication is vital when a new prevention intervention is introduced. It helps build awareness, dispel myths, and change social norms to increase program uptake. Kenya's national communication strategy contained tailored messages that targeted both circumcising and non-circumcising communities and reinforced that VMMC was intended to provide a medical benefit rather than alter cultural traditions. Key stakeholders worked together to identify barriers to uptake, pre-test materials, and eventually create customized communication guides, community dialogue cards, counseling tools, and other multimedia materials.

***Strong national and community partnerships.*** The Kenyan government's commitment to advocacy and ongoing investment in partnerships at national and local levels led to consensus around VMMC services. Community stakeholders expressed support for the rollout, resistance in communities decreased, and substantial coverage was achieved in both circumcising and non-circumcising communities.