

**PREVENTING HIV THROUGH SAFE
VOLUNTARY MEDICAL MALE CIRCUMCISION
FOR ADOLESCENT BOYS AND MEN IN
GENERALIZED HIV EPIDEMICS**

WEB ANNEX 6.1

**SUSTAINING VOLUNTARY MEDICAL MALE
CIRCUMCISION SERVICES AND LINKAGES
WITH ADOLESCENT SEXUAL AND
REPRODUCTIVE HEALTH: THE ZIMBABWE
SMART-LYNKAGES PROJECT**

Preventing HIV through safe voluntary medical male circumcision for adolescent boys and men in generalized HIV epidemics: recommendations and key considerations. Web Annex 6.1. Sustaining voluntary medical male circumcision services and linkages with adolescent sexual and reproductive health: the Zimbabwe Smart-LyncAges Project

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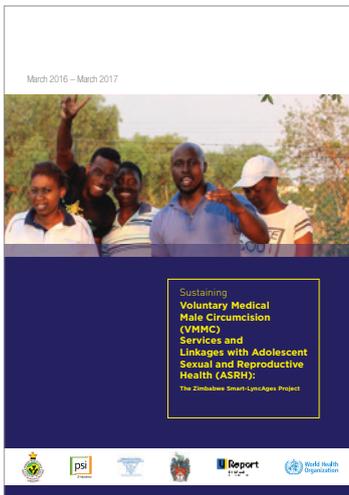
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WEB ANNEX 6.1 SUSTAINING VOLUNTARY MEDICAL MALE CIRCUMCISION SERVICES AND LINKAGES WITH ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH: THE ZIMBABWE SMART-LYNCAGES PROJECT. EXECUTIVE SUMMARY



This annex contains the summary and lessons learned from the Zimbabwe Smart-LyncAges Project. A more comprehensive report can be found at: <https://www.malecircumcision.org/resource/sustaining-voluntary-medical-male-circumcision-services-and-linkages-adolescent-sexual-and>.

Project summary

Sexual and reproductive health and HIV prevention are top priorities for the Ministry of Health and Child Care (MOHCC) of Zimbabwe. To strengthen sustainable delivery of adolescent sexual and reproductive health (ASRH) and voluntary medical male circumcision (VMMC), the MOHCC conducted a participatory pilot project to initiate, inform and strengthen integration and linkages of these two programmes and services. The World Health Organization (WHO) provided technical and financial support through the Bill & Melinda Gates Foundation and the United States President's Emergency Plan for AIDS Relief/Centers for Disease Control and Prevention.

Adolescent males already constitute a major proportion of all VMMC acceptors. This segment of the population otherwise has little contact with the health system. Thus, VMMC services provide an important opportunity to offer adolescent boys other HIV prevention and ASRH information and services and to link them with other interventions. An integrated and linked approach to VMMC and ASRH has many potential benefits. These include strengthening the competence of service providers, improving the quality and coverage of services for adolescents, making better use of resources by decreasing duplication and so saving time and money for both the health system and the clients.

However, systematic and joint delivery of these services is new. Pilot-testing is needed to determine how best to realize these services and maximize their potential benefits. This report describes the design, implementation and findings of a participatory learning project that was conducted to explore implementation and inform scale-up of integrated VMMC and ASRH services in Zimbabwe.

In 2017 the VMMC programme was in the catch-up phase, addressing men of all ages as well as increasing the focus on those adolescents and adult men most at risk. Now it is entering a maintenance phase, serving mostly young men as or before they enter puberty. Thus, this project sought to inform the design of longer-term, sustainable VMMC services by bringing together the strengths of the ASRH and HIV/VMMC programmes. The objectives were to assess the feasibility and capacity-strengthening needs for enhancing linkages between ASRH and VMMC services and interventions, while incorporating interventions to transform young men's gender norms.

The participatory learning project was designed to test, within the current systems, what sustainable ASRH and VMMC services to deliver and how to deliver them.

An assessment phase, undertaken in 2014–2015, included mapping of the available service delivery; information, education and communication (IEC) materials; and messages. Stakeholder engagement was key throughout the steps and the selection of districts for the pilot project. The pilot project followed this preparatory phase.

The project was deliberately designed to test within current systems and services in order to determine feasibility and capacity building needs for sustainable services within current systems. The intent of participatory testing was to engage those involved from the beginning and develop a model that would later be more rigorously evaluated in the next phase of activity.

The interventions tested included community engagement, capacity-building of providers and peer educators, use of referral slips, joint demand generation activities for VMMC and ASRH, and use of social media to disseminate ASRH and VMMC information. UNICEF's U-Report messaging platform was also used to disseminate information and gather young people's opinions on various ASRH and VMMC topics. Project activities started in March 2016 with sensitization meetings and training of service providers and peer educators (PE) as well as to develop IEC materials with both ASRH and VMMC messages. The pilot phase ended in March 2017 with a meeting to review the implementation and to plan for the next phase. Among other impacts, the project contributed to a revision of the National ASRH Strategy 2017–2020 and the ASRH training manuals to incorporate VMMC in both.

Lessons learnt

The most feasible components of the project proved to be community engagement, including engagement of young people; aspects of capacity-building; provision of basic ASRH and VMMC information by both ASRH and VMMC service providers; development of IEC materials with joint messages; and using social media to disseminate information as well as to coordinate stakeholders.

Pilot implementation taught many lessons. The five main lessons were that:

1. **Integration and linkages should be undertaken from a systems perspective.** A strong, resilient health system is needed to facilitate and sustain integration and strong linkages. Without strong systems, the linkages are weak.
2. **Collaboration within the health sector and across sectors is key** for sustaining adolescent health services. Different departments offer health programmes in a predominantly vertical manner. Partnerships are key to maximize the return on limited resources and increase impact on the overall health of adolescent boys.
3. **Commitment by leadership is essential to ensure that staff time is dedicated to the intervention**, particularly to strengthen coordination with stakeholders across the health system and from national to subnational levels and to identify sufficient funding.
4. **Meaningful and active community engagement strengthens ownership and linkages** throughout the community (among community health workers, parents, peer educators, traditional leaders, opinion leaders and others). Youth engagement and participation is critical to assure age-relevant messaging and services, and engagement of other relevant community resources.
5. **Service delivery models need to be informed by context-specific issues.** Models vary with context, but youth-friendly service provision and appropriate referrals by competent providers are the foundation.

The participatory pilot project suggests that the project interventions are sustainable, but several issues need further policy, programme and research action. Evaluation of the project activities and interventions relied on routine data collection and feedback from stakeholders during monitoring visits. Going forward, quantitative evaluation and research methodologies are needed to better gauge impact. Research should explore key underlying issues, including costs, and test the validity of the observations from this participatory pilot project. The next phase of the project will further evaluate the interventions while continuing to support implementation in the initial districts as the next step towards integrated programming.

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