



**PEPFAR**

U.S. President's Emergency Plan for AIDS Relief

CHAPTER TWO.

PLANNING, PREPARATION, AND LAUNCH

# PEPFAR'S BEST PRACTICES FOR VOLUNTARY MEDICAL MALE CIRCUMCISION SITE OPERATIONS

A Service Guide for Site Operations

## Acknowledgments

This publication is made possible by the generous support of the American people through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) with the U.S. Agency for International Development (USAID) under the Cooperative Agreement Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project, number AID-OAA-A-14-00046. AIDSFree is implemented by JSI Research & Training Institute, Inc. with partners Abt Associates Inc., Elizabeth Glaser Pediatric AIDS Foundation, EnCompass LLC, IMA World Health, the International HIV/AIDS Alliance, Jhpiego Corporation, and PATH.

We are eternally grateful to Dr. Tigistu Adamu Ashengo of Jhpiego and Dr. Emmanuel Njeuhmeli of USAID, who developed the first edition of this manual.

The second edition was developed under the leadership of Dr. Valerian L. Kiggundu (USAID) and Mr. Jonathan Grund (CDC). Special thanks are given to the Male Circumcision Technical Working Group, who edited and contributed to the development of both the first and second editions.

Special appreciation is given to the AIDSFree staff members who coordinated with different authors, agencies and organizations to support the development of this document, including providing editing and graphic design support.

Finally, we are most grateful to the men who stepped forward to receive male circumcision for HIV prevention; the Ministries of Health from the 14 priority countries, and the implementing partners who generously shared the best practices that have been used throughout this document.

## Contact Info

D. Heather Watts, MD  
Director, HIV Prevention and Community, Program Quality Team  
Office of the Global AIDS Coordinator and Health Diplomacy  
1800 G Street NW, Room 10300  
Washington, DC 20006  
Office: 202-663-2547

## Authors

**1. United States Agency for International Development (USAID), Office of HIV/AIDS Bureau for Global Health, 1300 Pennsylvania Avenue NW, Washington, DC 20523**

Valerian Kiggundu, Kim S. Ahanda, Reden Sagana, Meghan Mattingly, Nithya M, Mani, Maria Carrasco, Gina Sarfaty, Nida Parks, Emmanuel Njeuhmeli

**2. United States Centers for Disease Control and Prevention (CDC), 1600 Clifton Road, Atlanta, GA 30329**

Naomi Bock, Carlos Toledo, Stephanie Davis, Jonathan Grund, Paran Pordell, Dan Rutz, Marta Bornstein

**3. United States Department of Defense HIV/AIDS Prevention Program, Naval Health Research Center, 140 Sylvester Rd., San Diego, CA 92106-3521**

Anne G. Thomas, Jonathan Davitte

**4. Office of the Global AIDS Coordinator, 1800 G Street NW, Washington, DC 20006**

Renee Ridzon

**5. The Health Communication Capacity Collaborative (HC3), Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs, 111 Market Place, Suite 310, Baltimore, MD 21202**

Elizabeth Gold

**6. University Research Co., LLC/USAID ASSIST Project, 5404 Wisconsin Avenue, Suite 800, Chevy Chase, Maryland 20815**

Donna Jacobs, Lani Marquez, Haley Brightman, John Byabagambi

**7. GHSC-PSM Global Health Supply Chain Project, Chemonics, 1717 H Street NW, Washington, DC 20006**

Mary Lyn Field-Nguer, Scott Ackerson

**8. Project SOAR/Population Council, 4301 Connecticut Avenue NW, Suite 280, Washington, DC 20008**

Liz Nerad, Andrea Vazzano

**9. USAID's AIDSFree Project, JSI Research & Training Institute, Inc. 1616 Fort Myer Drive, 16th Floor, Arlington, VA 22209**

Erin Broekhuysen, Lauren Alexanderson, Zebedee Mwandu, Tracy McClair, Victoria Rossi, Jackie Sallet, Marya Plotkin, Tigistu Adamu Ashengo, Augustino Hellar, Alice Christensen, Kait Atkins

# CHAPTER 2.

## Service Site Selection, Planning, Preparation, and Launch

---

### CHAPTER GOALS

To ensure staff are able to:

- Select appropriate locations/facilities to serve as VMMC service delivery sites.
- Develop shared understanding, ownership, and support among the facility management, administration, VMMC program staff, and the community.
- Prepare the site for launch of VMMC services that meet the minimum WHO/UNAIDS, PEPFAR, and national standards.
- Ensure a smooth start-up of new VMMC services.
- Reinforce the knowledge, attitudes, and skills of new VMMC teams, and ensure that they have the necessary confidence, skills, and systems to provide quality services.

### WHAT USERS NEED TO KNOW

Before starting VMMC implementation, it is critical to ensure that appropriate facilities/locations are selected to serve as VMMC service delivery sites. Selected sites must be able to provide all components of the VMMC minimum package of services [[WHO Manual for Male Circumcision Under Local Anaesthesia, 1st edition](#)] and meet other criteria set and agreed upon by stakeholders in the country [See [Site Selection Criteria Tool](#)]. Site selection is followed by a careful assessment of the site's ability to perform the full VMMC minimum package of services [See [Site Readiness and Preparation Tool](#)]. Site staff are responsible for ensuring availability of all resources, including the definition of roles and responsibilities for all staff [See [Site Action Plan Tool](#)]. Once VMMC services begin, assessments of quality through external quality assessment (EQA) and continuous quality improvement (CQI) [See [EQA Instruments and CQI Self Assessment Tool](#)], should commence immediately and occur on a regular schedule for as long as clients are receiving VMMC services at the site. [Table 2.1](#) depicts the sequence of steps leading to the first day of service delivery, and [Table 2.2](#) shows the relative timing of these early activities in the overall scheme of site operations.

## FREQUENTLY REFERENCED INFORMATION

**Table 2.1. Phases in Site Selection, Planning, and Preparation**

Table for Tracking Key Activities for Opening a New VMMC Service Delivery Location

SITE SETUP ACTIVITIES	WHEN (START DATE MINIMUM)	NEEDS	RESPONSIBLE STAFF	REMARKS
Site selection	4 weeks before launch of services	Site selection criteria		
Site layout—Develop site setup guide, including secure areas for supply storage	12 working days before start date	Site map		
Supplies to new site	7 working days before start date	Supply checklist Receiving form		
Site setup—setting up rooms, tents, etc.	5 working days before start date	Site setup guide, including tent or marquee setup		
Site readiness assessment	3 days before start date	Site readiness tool		
Site orientation	First day of service	Orientation package, objectives		

**Table 2.2. Site Action Planning Template/Tool: Timing of Overall Site Operations, including Early Activities Leading to Service Start**

ACTION ITEM	PROJECTED PERIOD OF IMPLEMENTATION (MONTHS)												TOOLS	
	1 <sup>ST</sup>	2 <sup>ND</sup>	3 <sup>RD</sup>	4 <sup>TH</sup>	5 <sup>TH</sup>	6 <sup>TH</sup>	7 <sup>TH</sup>	8 <sup>TH</sup>	9 <sup>TH</sup>	10 <sup>TH</sup>	11 <sup>TH</sup>	12 <sup>TH</sup>		
Service site selection														
Site assessment														Site assessment tool
Site-specific feedback														Optional site report
Service site preparation														
Adequate space: rooms, lighting, client flow														Site action plan template/tool
Site set-up/reorganization plan, orientation (site action planning)														Site action plan template/tool
Staffing														
Numbers adequate (doctors, nurses, counselors, etc.)														Site action plan template/tool
Training completed														
Mentoring, use of tools, SOPS, guidelines, etc.														Site action plan template/tool
Procurement of commodities														
List of commodities														Tools from supply chain/logistics team
Procurement of commodities														
Emergency kit														
<b>VMC skills training</b>														
Clinical skills training														WHO Manual for Male Circumcision under Local Anaesthesia, 1st edition

ACTION ITEM	PROJECTED PERIOD OF IMPLEMENTATION (MONTHS)												TOOLS			
	1 <sup>ST</sup>	2 <sup>ND</sup>	3 <sup>RD</sup>	4 <sup>TH</sup>	5 <sup>TH</sup>	6 <sup>TH</sup>	7 <sup>TH</sup>	8 <sup>TH</sup>	9 <sup>TH</sup>	10 <sup>TH</sup>	11 <sup>TH</sup>	12 <sup>TH</sup>				
TIME IN MONTHS																
Counseling and communication skills training																Counseling Guide
<b>Creating demand</b>																
Creating demand-training																
Creating demand—IEC (information, education, and communication) materials																
Creating demand—for VMMC services																WHO Manual for Male Circumcision under Local Anaesthesia, 1st edition
<b>Implementation of WHO VMMC minimum package</b>																
<b>Support launch of VMMC services</b>																
<b>Routine monitoring, reporting and evaluation</b>																
Data collection																
Reporting																
<b>Continuous quality improvement (CQI)</b>																WHO Quality Toolkit
<b>External quality assessment (EQA)</b>																EQA Tools
<b>Adverse event management, monitoring, and reporting</b>																PEPFAR Reporting Protocol for Notifiable Adverse Event
<b>Health care waste management</b>																

Download an [Excel version of the Site Action Planning Template on AIDSFree's website.](#)

# FOR ADDITIONAL INFORMATION

## SERVICE SITE SELECTION

Information on HIV prevalence and male circumcision prevalence, which can help prioritize VMMC sites in specific regions, can be obtained from nationally published documents such as Demographic and Health Surveys (DHSs) and other published research. If other data are available (e.g., mapping of available services, site inspections, and assessments), they should be consulted for additional site-specific information. The community and local community organizations must be integrally involved in the site selection process. Adhering to clear criteria for site selection is helpful, as is fostering strategic partnerships and productive working relationships among health facility staff and implementing partners. Mobile units can also be used to provide VMMC services in locations that have limited health care facilities and in catchment areas that have little or no existing infrastructure.

Some suggested criteria and/or considerations for site selection include (but are not limited to):

- The prevalence or burden of HIV and male circumcision coverage in the catchment area; in general, areas with higher male HIV prevalence and lower male circumcision coverage are preferable, as the impact of scaling up VMMC is greater. An area with lower ART coverage might also be preferred over a similar one with higher coverage, because transmission of HIV will be more intense in such an area.
- The size and density of the catchment population; initially, men in dense population areas may be easier to attract to VMMC services.
- Sub-district, district, provincial, and national support for selected site or area (for fixed or mobile services).
- An estimate of unmet need for VMMC (based on estimated male population, male circumcision prevalence, HIV prevalence).
- Expected demand for VMMC services [See [Chapter 4](#)].
- Potential physical space that can be dedicated (temporarily or permanently) to VMMC services, including school classrooms, churches, government buildings, or space for a tent or extension of an existing building.
- Presence of other high-volume VMMC services in the area and ability to coordinate resources and recruitment to avoid competition for clients.
- Existing infrastructure and equipment and availability of skilled human resources.
- Accessibility of sites/facilities by the target population.
- The types of facilities available.
- Space with potential for good client flow among the various services.
- Referral networks: services and facilities that can refer potential clients for VMMC. These include:
  - » Sexually transmitted infection clinics
  - » Emergency services



- » Employer or worksite occupational health centers
- » voluntary counseling and testing (VCT) centers
- » Primary health care clinics, including antenatal care clinics where men may accompany their partners
- » Schools
- » Community outreach services.
- Service linkage and referral from VMMC to additional services. Facilities available for care and treatment, post-operative care, and support/AE management may include:
  - » HIV care and treatment sites for those who test HIV-positive
  - » Clinics able to perform post-operative care
  - » Regional tertiary hospitals for management of adverse events that exceed the capabilities of the VMMC site.
- Transport routes that ensure coverage of the catchment area, identifying pick-up and delivery points.
- Availability of equipment and supplies for VMMC services.

## OPTIONS FOR VMMC SERVICES

Various site options, service delivery models, and staffing options are available for the delivery of VMMC services. These should be chosen based on the specific needs of the community, the site location, and the VMMC program. Below is a description of various options that can be implemented in different settings, based on the VMMC program, geographical location logistics, seasonality demands, and other external factors. It is important to review the following three specific components when determining the best way to implement VMMC sites:

1. Determine the site options
  - a. Fixed sites
  - b. Mobile sites
  - c. Outreach sites
2. Determine the type of service delivery
  - a. Regular service delivery (offered throughout the year rather than at specific times)
  - b. Campaign service delivery (offered during specific weeks/months)
3. Determine the staffing options
  - a. Determine what human resources (HR) are available
  - b. Determine staff positions based upon service delivery model(s) (task shifting, models for optimizing volume and efficiency [MOVE], etc.)
  - c. Calculate HR needs.

There are three different types of VMMC sites: fixed, mobile, and outreach. These three types of sites can be mixed and matched to serve the community most effectively within the constraints of the program. The suggestions below are not prescriptive, but need to be matched to the resources that are available and linked with the supply and demand for services:

## 1. Determine the Site Options

- a. **Fixed sites** are permanent structures—often located near or within existing health care facilities—that offer VMMC on a continuous basis. Using fixed sites for VMMC service delivery may be most appropriate in urban areas with high population density, substantial VMMC client demand, and easy accessibility. Fixed sites may also serve as a hub for multiple mobile units or outreach services. Fixed sites need to dedicate adequate space to accommodate all of the components of VMMC services: reception, waiting area, private counseling rooms, surgical theater, post-operative care, and follow-up review areas. Existing fixed sites often lack space to accommodate all the elements of service delivery, or they cannot dedicate existing space. In these instances, additional space needs to be created by using semipermanent structures or tents.
- b. **Mobile sites** are sites where the commodities and staff are moved from one site to another (moving to follow demand and/or supplement existing services). Mobile sites can provide services out of a health center (i.e., co-located with other services) or can be combined with outreach services. Mobile sites may be most appropriate in rural areas or communities that are not expected to have high demand for VMMC services, in areas that have high client demand only at certain times of the year (seasonal demand), or as additional sites in an area with other existing site types when a VMMC campaign temporarily increases demand. Mobile sites are usually temporary structures, often tents and prefabricated structures or trucks ([Figure 2.2](#)).
- i. **Basic tents** are easy to install and are movable, though they may have poor air circulation and are generally not durable. These tents are most often used for HIV testing services (HTS) at the VMMC site. Although tents can provide very flexible space for service provision when they are present, procuring tents can pose a significant delay to programs if adequate lead time is not planned.

Additional uses for tents include:

- Creating extra space at an existing fixed health care facility.
  - Preventing bottlenecks in service delivery. For instance, a mobile structure for HTS or FU services, set up adjacent to the fixed site, can provide space where clients can be tested or reviewed for follow-up visits without crowding the fixed site.
  - Creating extra space dedicated solely to VMMC surgery at a fixed health care site.
- ii. **Mobile trucks/vans** are used to provide VMMC services on board; also known as “clinics on wheels” ([Figure 2.1](#)). Mobile trucks are built with fully equipped VMMC clinics that are partitioned to include necessary room for screening, counseling, operating, and recovery rooms. The truck is chauffeured to a specific area and parked, and services commence on board. Some services such as registration and health education may be conducted outside the truck, in a tent, under a shade, or in an existing structure. The duration of stay is determined by demand and how the team has planned. It may be parked for one day, one week, or other time period. It may also come in every day.

- iii. **Prefabricated structures** are sturdier and more durable than tents, and they are most suitable for locations where a high volume of VMMC clients is expected. Prefabricated, semipermanent structures can provide space for other medical services when VMMC services are no longer needed. These structures require significant lead time to ensure proper installation. Cranes may be needed to deliver prefabricated structures and to move them once they are set, given that foundations are needed and the overall space within the structure is not as flexible as in tents.
- c. **Outreach sites** may be used during periods of high demand for VMMC, such as short-term campaigns. Outreach sites are generally small sites that provide VMMC services for a temporary time period, such as in areas with limited infrastructure and in “hard-to-reach” areas. They are different from mobile sites in that they can be permanent structures (e.g., primary clinic, school, or community center), modified for VMMC purposes. In sites that may be rural and far from a fixed site, tents or prefabricated structures may be used to increase available space and allow more clients to receive VMMC services. A “hub and spoke” approach can be used for selecting hubs that act as the headquarters (fixed sites) with various “spokes” (outreach sites) that can be set up in lower level facilities, non-health facilities, or mobile sites. Outreach sites are more flexible than fixed sites alone, as services can be offered in an area according to demand or until it reaches saturation, and then moved to another location. Outreach sites are often supplied by a fixed site from which goods are transported on a daily or weekly basis.

## 2. Determine the Type of Service Delivery

- a. **Routine service delivery at selected site** ensures the availability of VMMC services at existing (fixed) health care facilities, outreach sites, and mobile sites year round. Although space within a facility may be dedicated for VMMC services, the services are integrated with the facility and offered consistently throughout the year. Referral networks are established and in place, and clients are referred to and from other services and facilities. Client volume is typically steady, so HR and commodity needs are at consistent levels throughout the year.
- b. **Campaign service delivery at selected sites** provides VMMC services in high-volume places for short periods of time. With campaign service delivery, HR and commodities are dedicated for the duration of the campaigns. Demand creation and community sensitization are crucial components to ensure a high volume of demand for VMMC services during the campaign period. Services are often offered on consecutive days for a specified time period to capture as many clients as possible. Campaigns are often designed to target certain populations (e.g., during school holidays to provide VMMC to adolescents or during certain times of year to align with cultural practices or traditions or seasons). Campaigns can also be used to “kick start” services in a district or region. Campaigns can be effective in attracting large numbers of VMMC clients, but considerable logistical planning is needed to ensure adequacy of sites, staff, clients, and commodities. It should be noted that any type of service delivery, routine or campaign, may be conducted at any of the three types of sites, either at fixed, mobile, or routine.

For more information on effective campaigns and their impact on provision of services, see the articles, “Voluntary Medical Male Circumcision: Translating Research into the Rapid Expansion of Services in Kenya, 2008–2011,” [Mwandi 2011] and “Voluntary Medical Male Circumcision: Matching Demand and Supply with Quality and Efficiency in a High-Volume Campaign in Iringa Region, Tanzania” [Mahler 2011]. For efficiency in campaign planning, there is a need to preplan all the sites beforehand so that no time is wasted in selecting sites again once the campaign is under way. In some programs,

all sites are preselected before the campaign, including sites where services will move in case demand runs low in the main sites. Thus there are “satellite” sites for each “mother” site and all needs for the additional sites are projected beforehand. This “hub-and-spoke” model saves the time the team would spend to find additional sites once the campaign is underway.

---

Note: The service delivery focus may change depending on the maturity of the program. For example, at the beginning of the program, when there is much demand for VMMC services, campaigns are the best approach since they may reach a large number of males in a relatively short period of time. As the program matures and demand for VMMC services decreases, conducting campaign-based services may not be the most efficient use of resources. Instead, mobile and outreach services may be the best approach to reach men in their communities. Static sites may always be needed since that is where most providers are based and they need to continue circumcising even in small volumes to ensure that they don't lose their skills.

---

### 3. Determine the Staffing Options

- a. **The HR staffing lists** that follow ([Table 2.3](#)) are suggested for fixed sites where demand is consistent. These suggestions would not apply to sites where demand fluctuates with seasonality, school holidays, etc. Staffing is not prescribed and should be modified and adjusted based on the volume of clients and the country context. Innovative ways to address HR constraints in VMMC programs include using surgical efficiencies, non-surgical efficiencies, task-shifting and task-sharing, temporary redeployment through the public sector via task shifting, and volunteer medical staff from other countries (Curran 2011).

**Figure 2.1. Using Mobile Trucks/Vans for VMMC Service Provision**



**Figure 2.2. Examples of a Medical Examination Room and Tents**



**Table 2.3. Human Resource Staffing Options for High-, Middle-, and Low-Volume Surgical Sites**

ITEMS	HIGH-VOLUME SITES	MIDDLE-VOLUME SITES	LOW-VOLUME SITES
Beds	8+	4–7	Less than 4
VMMCs performed per day	Greater than 80 (with task sharing)	30–80 (with task sharing)	Less than 30
Site Manager	1	1	Shared role
VMMC Provider <sup>1</sup>	2	1	1
Nurse <sup>2</sup>	8	4	Shared role
Theater Assistant—“Suture Nurse”	1	1	1
Post-Operative Care Nurse	1	1	Shared role
Hygienist/Cleaner/Infection Prevention Officer	1	1	Shared role
Counselor—can overlap with trained nurses for efficiency	3 (minimum)	2 (minimum)	Shared role
Expert Client	2	1	N/A
Community Health Worker	8–10	5–8	1–4

ITEMS	HIGH-VOLUME SITES	MIDDLE-VOLUME SITES	LOW-VOLUME SITES
Runner	1	1	Shared role
Data Clerk	1	1	Shared role
Receptionist	1	1	Shared role
Driver (for mobile sites)	1	1	N/A

Notes:

1. VMMC providers are dedicated to the actual procedure: removal of the foreskin. These providers can represent a variety of health care worker cadres, depending on the laws by which these cadres are regulated.
2. Nurses perform a variety of tasks including documentation, assisting the VMMC provider, prepping the room, and prepping the patient for the procedure. Depending on the country context, VMMC assistants may be doctors, nurses, clinical officers, or medical officers.

## SERVICE SITE PLANNING

Once a site has been selected, a thorough approach to site preparation can greatly affect a VMMC program’s success. Conducting a thorough site readiness assessment, will guide what is needed to get the site “operational” [See [Site Readiness and Preparation Tool](#) and [Site Action Plan Tool](#)]. Site preparation has two primary objectives: 1) to develop ownership of and support for the VMMC site by site managers and community members; and 2) to agree on a site preparation action plan for developing and providing a minimum package of safe VMMC services.

Normally, the service site planning activity uses a designated facility management team composed of hospital director, director of clinical care, sister-in-charge or chief nursing officer, the key administrative staff responsible for budgeting and procurement, and those clinical staff who would be expected to lead the provision of services. In addition, other cadres of health workers (e.g., community health workers, home-based care workers, health promoters) can be included in the orientation because they can be used to aid implementation. Some countries have used community health workers as mobilizers for demand creation and client follow-up visits.

The site readiness assessment can be conducted by the facility management team, or just certain team members. It is crucial that a site manager is designated and is an integral part of the site assessment process. The [Site Readiness and Preparation Tool](#) should be used to evaluate:

- The current state of basic services (e.g., infection prevention, waste disposal, and monitoring and evaluation) [See [Male Circumcision Waste Management Plan](#)]
- The space identified for VMMC services and the map of client flow ([Figure 2.3](#)) [See [Site Readiness and Preparation Tool](#)]
- The catchment area and to identify potential feeder clinics and points for post-operative care and support
- Existing community health workers or other health care worker cadres to be trained in VMMC service delivery (demand creation, VMMC counseling, clinical procedures, etc.)
- The capacity of feeder clinics and points for postoperative care to manage adverse events (AEs) that require hospitalization

- Transport routes to ensure that the catchment area is covered and that pick-up and delivery points are identified
- The equipment and the current supply availability specific to VMMC services (what the site currently has and what the gaps are) [See [SCMS E-catalog](#)].

The site assessment should also:

- Identify additional service outlets and establish linkages and referral centers that could be used to provide:
  - » Community-based information, education, and communication (IEC); group education; community-based HIV testing center (HTC); and community-based client screening
  - » VMMC messages—about where VMMC information is available, where VMMC services are provided, and where clients are referred (outpatient departments, STI clinics, antenatal clinics, family planning clinics)
  - » Referrals to care and treatment—VMMC clients may be referred for additional care and treatment, HIV prevention, HIV care and treatment, STI management, and reproductive health services
  - » Screening and follow-up of clients based outside the catchment area.
- Identify the key personnel who will be involved at the various stages of the VMMC process: management, communication, and demand creation; booking, reception, and registration; HTC; preprocedure clinical screening; VMMC procedure; post-operative care and counseling; reviews and follow-up services; data management; waste management, [Male Circumcision Waste Management Plan](#); and infection prevention.
- Reach agreement with the site management on developing signage and branding that can be placed in defined locations—within and outside the facility—to direct prospective clients to VMMC-related services.
- Identify and assess locations for temporary space if needed.

Based on the findings of this assessment, the team should work together to develop a detailed [VMMC Site Action Plan Tool](#) to get the site ready to provide safe VMMC services. The site action plan provides a clear outline of what must be completed (by whom and when) so that the site is ready to provide VMMC services (e.g., HR to be hired, commodities to be ordered, renovations or restructuring of space to be completed, etc.) This site action plan can be used as a task log that outlines specific activities and timelines and designates staff members to be responsible for ensuring that each task is complete. The site action plan should be based on a clear understanding of how the services will be provided, and it should link community demand creation with clinical service provision [See Chapter 6.] This [VMMC Site Action Plan](#) should be specific and time-bound, and it should clearly identify who is responsible for achieving specific actions, the resources required, and the source of support. At this stage, the site action plan may be useful in developing an agreement between partners, clarifying roles and responsibilities, and ensuring that the planned timeline is reasonable.

After the VMMC Site Assessment has been conducted and the site action plan has been developed, it can be useful to conduct a general orientation for all staff at the facility. Site orientation is used to sensitize all staff to VMMC for HIV prevention services; it includes an overview of how and when these services will be offered at the facility. Site orientation helps to reinforce ownership by the health facility staff and management team, and

ensures that key concepts concerning VMMC are internalized. In addition, site orientation minimizes the chances that misinformation will be disseminated while the site preparation action plan activities are getting started. The orientation may include:

- A review of the national VMMC strategy
- Specifics related to the site and the plan for services (regular versus campaign services, outreach sites, targeted numbers for VMMC, existing cultural beliefs, any research conducted or planned, etc.)
- How the site fits into the implementation plan.

## SERVICE SITE PREPARATIONS

It is essential that the site's facilities, equipment, and commodities are ready to provide VMMC services **before** staff are trained to provide VMMC services [See [SCMS E-catalog](#)]. Training is most effective when the learned skills are put to use immediately after training. Staff should complete their training and then be transitioned into service delivery without delay. Starting services before a site is fully operational runs the risk of compromising the quality of services provided and creating potential bottlenecks with imbalances of supply and demand for VMMC services. Based on the site strengthening plan developed collaboratively during site planning, all the necessary activities should be carried out and completed prior to scheduling training and launching services. Various activities may be required, such as facility repairs or remodeling, procurement of equipment and supplies, reshuffling of staff, or hiring additional staff. Specific training may also be conducted, such as training in infection prevention and control. All the parties involved should report on their responsibilities; one qualified individual (often the site manager) should be charged with verifying that all the necessary actions are completed and that the site is ready to start providing VMMC services [See [VMMC Service Site Preparation Planning Template](#)].

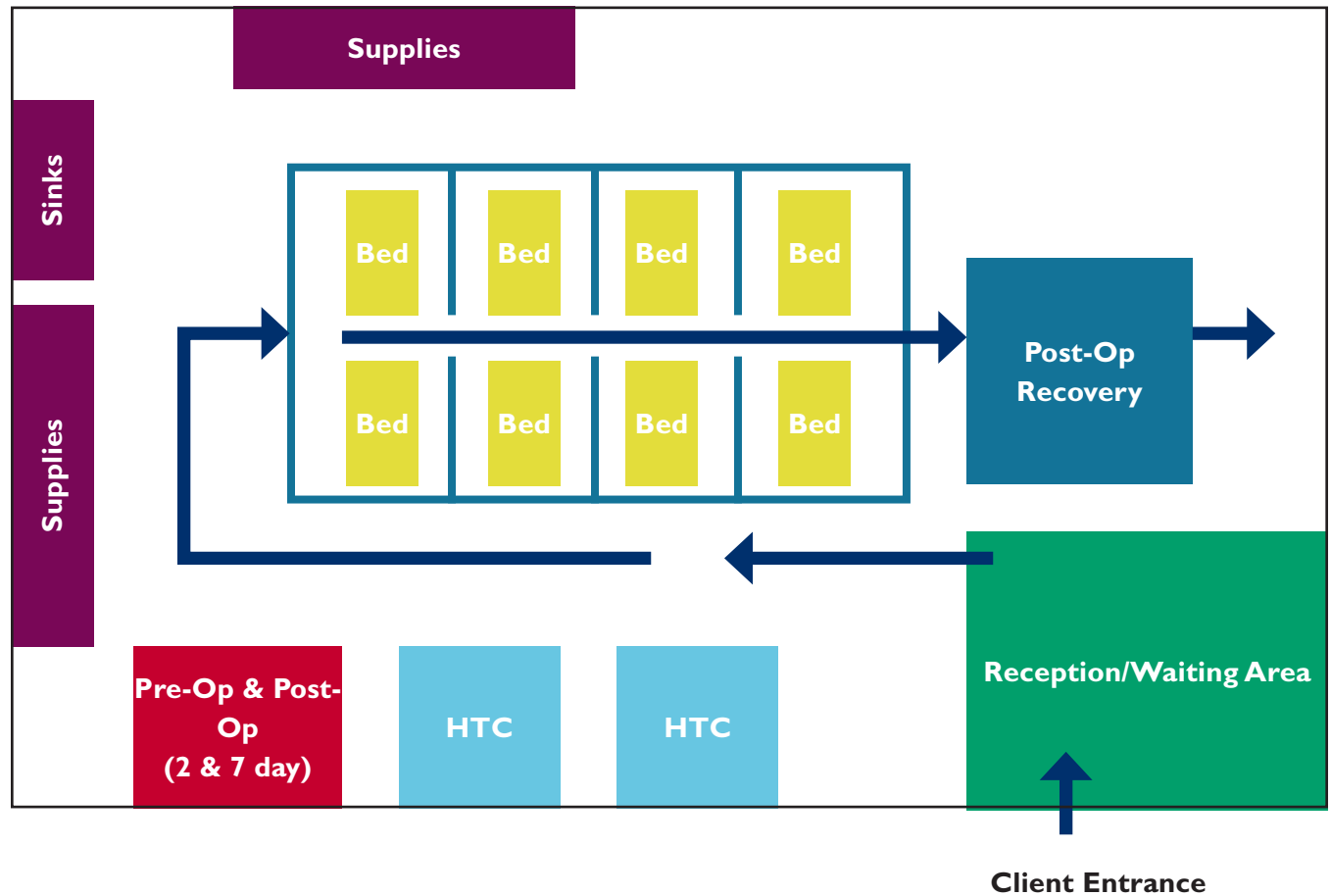
The overarching goal of site preparation and design is to ensure efficient client flow. Client flow should be unidirectional and allow clients to flow—from education and HTC to discharge—with ease ([Table 2.3](#)). With good planning, existing space can often be improved—with little infrastructural modification—to maximize utilization of space and improve client flow.



**Figure 2.3.VMMC Client Flow Diagram**

Large static site configuration that optimizes client flow

*Note: the client flow is unidirectional.*



### **Tips for Organizing Facility Space for VMMC Services**

- Client flow should be unidirectional.
- Recovery space should accommodate more clients than surgical space. Because recovery time can be longer than procedure time, bottlenecks can occur if recovery space is inadequate.
- If space permits, client follow-up reviews should be conducted in an area that is separate from surgical areas. Separating the two areas will simplify client flow and reduce stress to staff.

## SERVICE SITE LAUNCH

VMMC staff should begin providing VMMC services as soon as possible after training has been completed and providers pass competency assessments. By this point in the timeline, the VMMC site will have been prepared and demand generation activities will have begun [See [Chapter 4](#)]. Demand generation should target a service launch date that occurs shortly after the completion of staff training—the shorter the gap between training and clinical practice, the higher the rate of education retention and the greater the likelihood that the trained team will provide services that follow the recommended standards.

Despite the best efforts to prepare new VMMC sites, issues often arise that need to be addressed as service provision progresses. Even though the VMMC staff members will have been trained in their respective specialties (e.g., counseling, clinical, etc.), if they are not already experienced in providing VMMC services, it is important to provide them with immediate on-site support and mentoring by a proficient VMMC provider, ideally by one of their trainers [See Chapter 5]. This support will help them incorporate what they learned during training within their own service delivery setting. Designating an experienced, proficient VMMC provider as a mentor can help the team resolve any startup challenges. Mentors can provide support and advice to program managers and site managers in the areas of training, procurement, demand creation, client flow, and space designation. The use of mentors can ensure that from the very beginning, the services are indeed being provided according to the accepted standards. During the launch of the site, the mentor can also help orient the team to the standards for quality service provision [See [CQI Self Assessment Tool](#) and [EQA Instruments](#)], and help ensure early and ongoing incorporation of efficiency models such as those proposed by WHO [See [Considerations for Implementing Models for Optimizing the Volume and Efficiency of Male Circumcision Services \(MOVE\)](#)].

## CASE STUDIES

[Case Study 2.1. Setting Up Private VMMC Clinics in Namibia](#)

[Case Study 2.2. Opening and Coordinating New VMMC Sites in Hard-to-Reach Areas in Tanzania](#)

## TOOLS, INSTRUMENTS & GUIDANCE DOCUMENTS

1. [WHO Manual for Male Circumcision Under Local Anaesthesia, 1st edition](#)
2. [Site Selection Criteria Tool](#)
3. [Site Action Plan Tool](#)
4. [Site Readiness and Preparation Tool](#)
5. [EQA Instruments](#)
6. [CQI Self-Assessment Tool](#)
7. [Male Circumcision Waste Management Plan](#)
8. [Site Assessment Tool](#)

9. [SCMS E-catalog \(including male circumcision kit options\)](#)
10. [VMMC Service Site Preparation Planning Template](#)
11. [Considerations for Implementing Models for Optimizing the Volume and Efficiency of Male Circumcision Services \(MOVE\)](#)

## REFERENCES

- Curran, K, et al. 2011. "Voluntary Medical Male Circumcision: Strategies for Meeting the Human Resource Needs of Scale-Up in Southern and Eastern Africa." *PLOS Medicine* 8(11): e1001129. doi: 10.1371/journal.pmed.1001129.
- Mahler, HR, et al. 2011. "Voluntary Medical Male Circumcision: Matching Demand and Supply with Quality and Efficiency in a High-Volume Campaign in Iringa Region, Tanzania." *PLOS Medicine* 8(11): e1001131. doi: 10.1371/journal.pmed.1001131.
- Mwandi, Z, et al. 2011. "Voluntary Medical Male Circumcision: Translating Research into the Rapid Expansion of Services in Kenya, 2008–2011." *PLOS Medicine* 8(11): e1001130. doi:10.1371/journal.pmed.1001130.

## ABBREVIATIONS

<b>AE</b>	<b>adverse event</b>
<b>CQI</b>	<b>continuous quality improvement</b>
<b>EQA</b>	<b>external quality assessment</b>
<b>HR</b>	<b>human resources</b>
<b>HTC</b>	<b>HIV testing center</b>
<b>HTS</b>	<b>HIV testing services</b>
<b>IEC</b>	<b>information, education, and communication</b>
<b>MOVE</b>	<b>models for optimizing volume and efficiency</b>
<b>SCMS</b>	<b>Supply Chain Management System</b>
<b>SD</b>	<b>start date</b>
<b>VCT</b>	<b>voluntary counseling and testing</b>

# CASE STUDY 2.1.

## Setting Up Private VMMC Clinics in Namibia

The majority of medical doctors in Namibia are practicing in the private sector. Namibia's private medical sector is robust, with well-established facilities that include outpatient consulting rooms.

**Figure 2.1.1. Establishing new VMMC sites**



In October 2014, through funding from PEPFAR and the USAID SHOPS Project (Strengthening Health Outcomes through the Private Sector), SHOPS/Namibia embarked on a program to engage private medical providers to contribute to the national VMMC scale-up strategic plan. They conducted meetings and information sessions town by town and after 10 months, 45 providers had expressed interest in joining the network of providers.

To understand provider competencies and areas of improvement, initial site assessments were conducted that consisted of an assessment of the entire facility's resources, management structure, provision of the minimum package of VMMC services, quality improvement systems, emergency supplies and level of emergency preparedness, waste management protocol, and infection prevention and control practices. Whereas private facilities were of a very high standards ([Figures 2.1.1.](#) and [2.1.2.](#)), they were not optimally using their resources, including space, staff, and supplies.

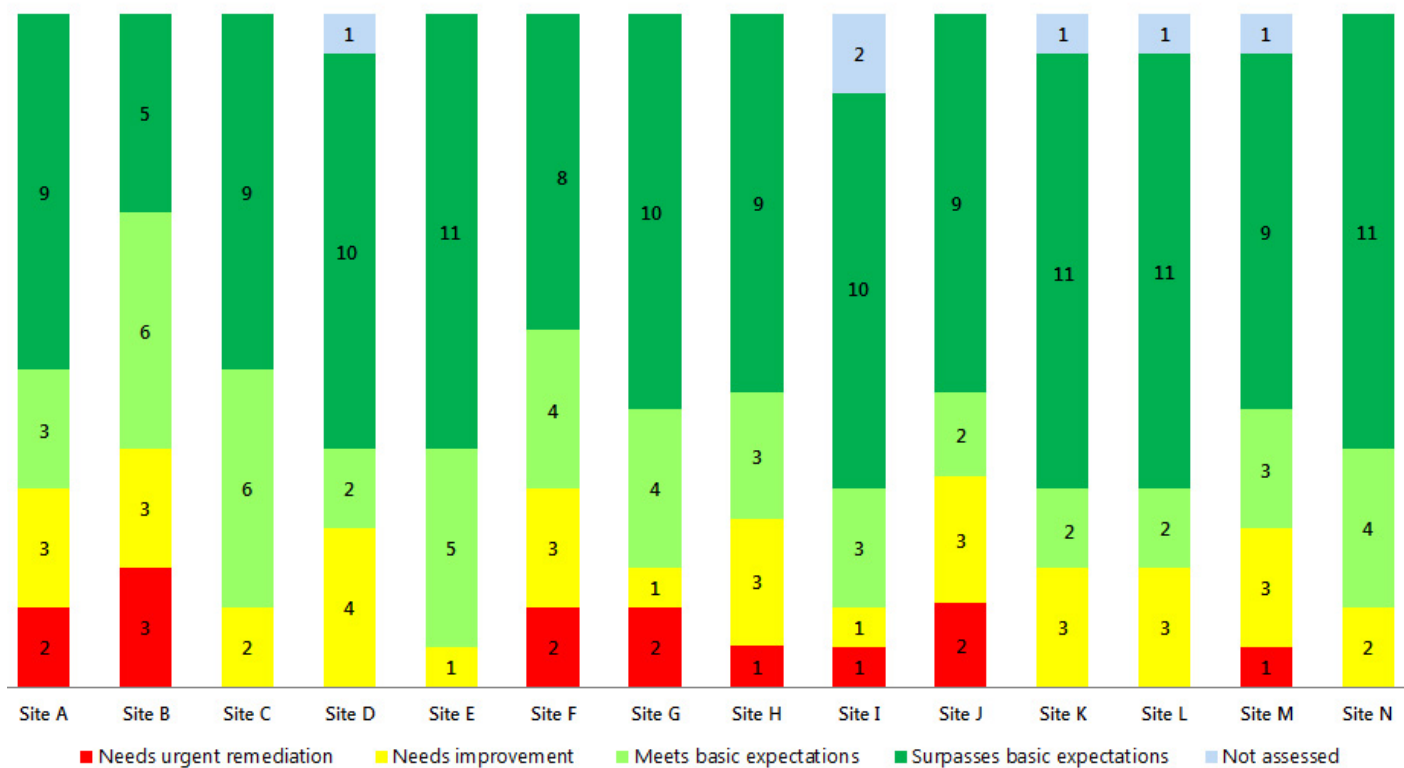
Following this assessment, the sites received onsite coaching to scale up VMMC services by an experienced VMMC private provider and a demand creation expert. Every new entry into the network received orientation on inventory management of VMMC commodities, emergency preparedness, and the WHO VMMC minimum package of services. SHOPS/Namibia mobilized insurance companies to agree on a standard VMMC tariff that would cover the VMMC WHO minimum package of services, allowing all the insured clients to be covered for VMMC.

There was a clear growth in VMMC numbers in these sites, with some sites reporting monthly VMMC numbers as high as the cumulative total for the previous calendar year. The network of private providers has also continued to grow, with more medical doctors throughout the country expressing their interest to be enrolled.

The main lessons learned through working with private providers were:

1. Private providers (SHOPS) contribute to a pool of providers that are scarce in Namibia, where VMMC must be conducted by medical doctors only.
2. SHOPS had sufficient resources to conduct VMMCs immediately and, although they were all low volume sites, the network combined greatly contributed to the total national coverage.
3. SHOPS providers are able to reach clients who are usually older and working and who may not otherwise seek services from public facilities.
4. SHOPS sites are open longer hours and weekends, hence allowing clients to receive services any time at their convenience.

**Figure 2.1.2. Site Readiness Assessment of Private Health Facilities for VMMC Services in Namibia**



## CASE STUDY 2.2.

# Opening and Coordinating New VMMC Sites in Hard-to-Reach Areas in Tanzania

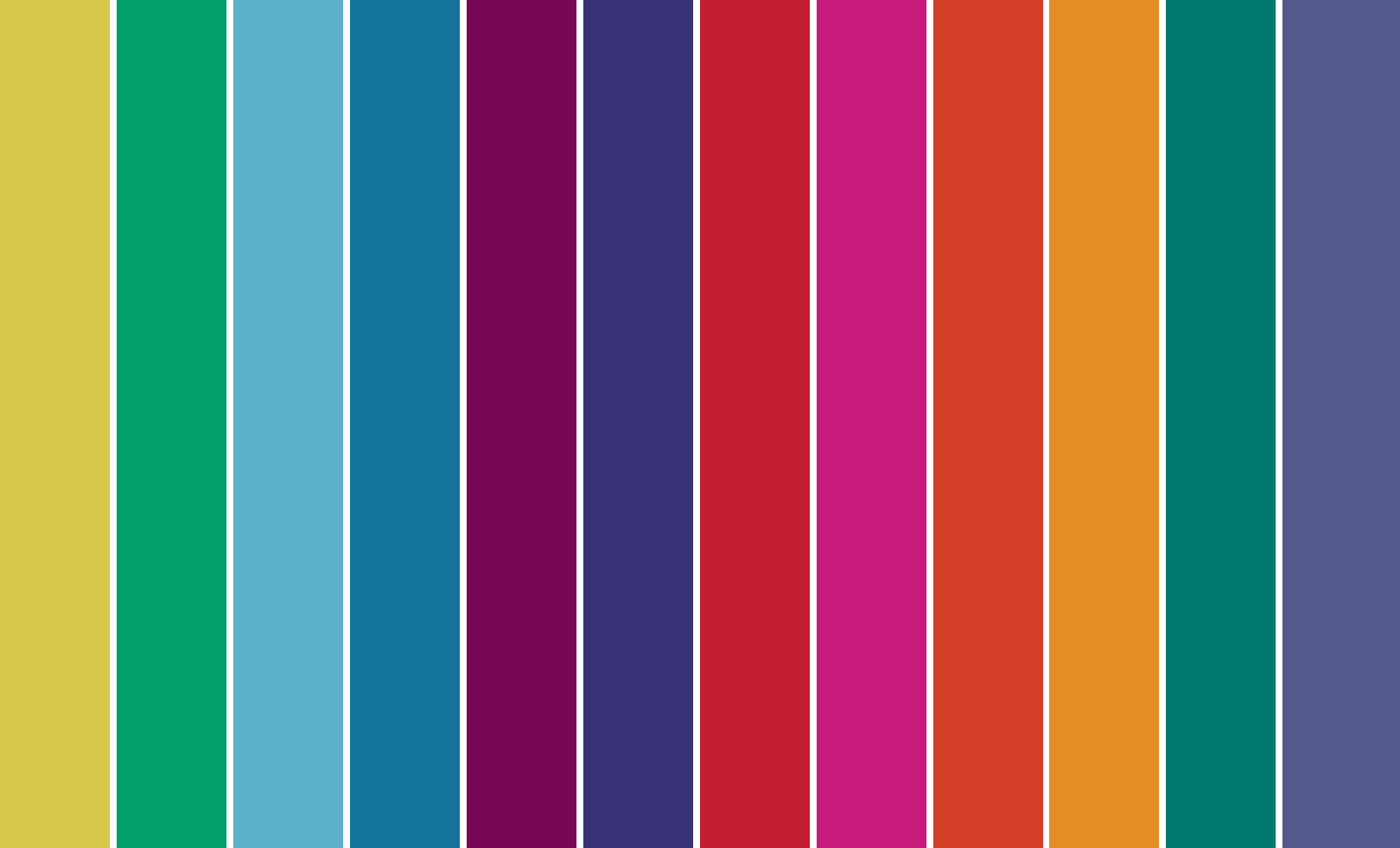
---

In Tanzania, the AIDSFree Project with funding from PEPFAR under USAID, supports the Ministry of Health, Community Development, Gender, Elderly and Children (MHCDGEC) to provide VMMC services in three regions, Iringa, Njombe, and Tabora. The program is well established and has conducted almost 500,000 VMMCs. In 2014–15, the program provided VMMC services in 488 sites (hospitals, health centers, and dispensaries). Many sites were used, as VMMC services were needed in hard-to-reach areas, because the more accessible areas had reached or surpassed VMMC saturation. The program employed three primary modalities of VMMC services: static sites, outreach (mobile), and campaigns.

With a large number of sites used in a year, the team has streamlined opening new sites to ensure high quality and efficient service delivery. The team employed modified approaches depending on the type of site being opened. The approaches are as follows.

**To open new static sites:** The team reviewed key data such as population (residents) of the catchment area (number of wards, villages) and also reviewed potential demand for a site. Often the data are pulled from the GIS system that was developed for the program. A short list of potential sites was then identified. The team—comprising technical and demand creation personnel, a data manager, District Medical Officers, District AIDS Control Coordinators, a District Health Management Information System focal person, and the government regional VMMC focal person—conducted an assessment of the proposed site. This tool addressed power availability, infection prevention and control practices, human resources, community leadership, security, integrated services, existing programs, and linkage to care. Shortly after the assessment, the team discussed and selected qualified sites. A needs assessment list was developed, an MOU was drafted, and the team prepared for site opening.

**To open new outreach or campaign sites:** AIDSFree used a hub and spoke model for campaigns using a “mother” hub site with spinoff spokes known as “baby” sites. The mother sites stayed open throughout the campaign and housed providers and supplies, while new baby sites were opened and closed as demand fluctuated throughout the campaign. New sites were selected by the demand creation team in the weeks before the campaign. The VMMC team then started the services while observing recommended standards. Once demand in a baby site began to decline, the next site that was already identified opened the next day. Key to this approach was having an adequate number of VMMC providers at the mother site to support the baby sites and having enough equipment at the mother site (including emergency kits) to support two to three baby sites.



# PEPFAR

U.S. President's Emergency Plan for AIDS Relief

## Contact Info

D. Heather Watts, MD

Director, HIV Prevention and Community, Program Quality Team

Office of the Global AIDS Coordinator and Health Diplomacy

1800 G Street NW, Room 10300

Washington, DC 20006

Office: 202-663-2547

