



PEPFAR

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

CHAPTER SIX.

PROVIDING THE VMMC MINIMUM PACKAGE OF SERVICES

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

A Service Guide for Site Operations

Acknowledgments

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CHAPTER 6.

Providing the VMMC Minimum Package of Services

GOALS

To ensure site staff are able to:

- Provide clients with all components of the VMMC service package, in accordance with national, World Health Organization (WHO) and U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) recommendations.
- Provide VMMC services that are compliant with PEPFAR policies.

WHAT USERS NEED TO KNOW

WHO recommends that all clients receiving VMMC service receive a comprehensive package of services to support HIV/STI prevention or care and safe recovery [See [WHO Manual for Male Circumcision Under Local Anaesthesia, 1st edition](#) and [PEPFAR Technical Considerations for COP/ROP 2016](#)]. The “minimum package of services” (see Figure 6.1)—which should be available to all VMMC clients at all sites—includes: 1) optional HIV testing and counseling services for all male clients and, where possible, their partners; 2) active referral of clients determined to be HIV-positive to HIV care and treatment programs, including determination of successful linkage 3) age-appropriate sexual risk reduction counseling, including recommendations for abstinence during wound healing; pre-procedure clinical screening (focused physical exam and medical history) to detect sexually transmitted infections (STI) and contraindications to circumcision; 4) screening and treatment of STIs; 5) circumcision by a medical method approved by WHO; 6) post-procedure follow-up, including systematic assessment of adverse events and, 7) provision and promotion of correct and consistent use of condoms, preferably both male and female condoms.

To ensure high quality VMMC services, the VMMC team in general and providers in particular must be competent in assessing clients for VMMC eligibility including evaluation of clients for tetanus immunity or vaccination against tetanus in countries where it is appropriate [See [WHO Guidelines on Tetanus and VMMC July 2015 and September 2016](#)] use of at least one WHO-approved VMMC method; anesthetic dosing (by use of weight based dosing anesthetic charts or calculation of an appropriate minimum dose) and adequate infection control practices [See [Chapter 9](#)]. This chapter describes the WHO comprehensive package of services including what providers need to consider as they attend to VMMC clients from client screening, through the procedure, recovery and follow up.

FREQUENTLY REFERENCED INFORMATION

Figure 1.1. WHO/UNAIDS Recommendations WHO Minimum Package of VMMC Services



HIV TESTING SERVICES

The recommendation for and offer of onsite HIV testing services (HTS) [See [Guidance on Provider-Initiated HIV Testing and Counseling \(PITC\) in Health Facilities](#)]: Clients declining HIV testing during VMMC services should be informed of alternative sources of HTS at the VMMC site (if static site) and other sites where such services may be obtained. However, clients should never be denied VMMC because they decline HIV testing or based on the results of their tests.

VMMC represents a rare and valuable opportunity to provide HIV testing services (HTS) to men and if necessary to link them to HIV care and treatment [see below]. HTS in the facility and in the community can contribute to demand creation for VMMC services. It is important to capitalize on this opportunity by ensuring that HTS facilities are referring eligible clients to VMMC services.

As part of the WHO-recommended minimum package of services, PITC (provider-initiated HIV testing and counseling) should be offered as part of the VMMC program [See [Guidance on Provider-Initiated HIV Testing and Counseling \(PITC\) in Health Facilities](#)]. Implementers should adhere to WHO guidance on PITC, including the minimum standards of pre-test information, informed consent post-test counseling based on serostatus, maintaining confidentiality, and use of point-of-care rapid HIV testing algorithms, as appropriate [See [Chapter 12](#)]. It is also critical to ensure that clients understand that while recommended, HIV testing is not required to access VMMC services. In addition, it is important—as part of the WHO minimum package of services—to develop strong linkages to HIV care and treatment for clients who test HIV-positive. QA (quality assurance) systems for HTC components should be in place to ensure high-quality HTC services in these settings, including systematic laboratory-based HTC results validation procedures (see [Chapter 10](#)).

REFERRAL TO HIV AND AIDS CARE AND TREATMENT:

Active linkage of HIV-positive clients identified at VMMC sites to HIV care and treatment programs. As part of the VMMC program, men who test HIV-positive should be referred promptly to a care and treatment site for evaluation and appropriate antiretroviral therapy (ART), when clinically indicated. This may require that sites develop and implement novel mechanisms to facilitate and confirm successful linkage to care (e.g., escorting clients from the VMMC center to the ART center, or enabling staff to register clients for ART at the VMMC center). The limits of the protective benefits of VMMC should be explained to HIV-positive men and their partners, and if a client requests VMMC anyway (for reasons other than HIV prevention) and is healthy enough for minor surgery

(i.e., a CD4 of at least 350 and not in WHO clinical cancer stage III or IV), VMMC should be made available to him. It is important for HIV-positive men to be counseled about the increased risk of transmission to female partners if they resume sex before full healing. Records of referred clients should be maintained at site.

EDUCATION AND COUNSELING

Age-appropriate sexual risk-reduction counseling, including recommendations for abstinence during wound healing, information provided through group and individualized sessions about the benefits and risks of VMMC, and sexual and reproductive health education including healthy male norms and gender-based violence. [See [Counseling Resource Guide](#)]. When men seek VMMC services, it provides an ideal opportunity to address several important aspects of sexual and reproductive health needs. Additionally, because many of the males accessing VMMC services are adolescents, VMMC provides a forum to educate young males about a variety of sexual health issues. **Targeted counseling for clients testing HIV-positive or declining HIV testing on the increased risk of HIV transmission to female partners if they resume sex before full healing should also be addressed.** As part of the VMMC program services, men who test HIV-negative should be counseled and given specific information about how to protect themselves from HIV infection besides just circumcision.

SEXUALLY TRANSMITTED INFECTION (STI) SERVICES

Syndromic screening for STIs prior to VMMC and treatment for those diagnosed [See [Guidelines for the Management of Sexually Transmitted Infections \(STIs\)](#)]. VMMC should be recommended to all HIV-negative males who receive HTC services in any setting, especially those men who are at high risk of HIV acquisition from heterosexual sex (e.g., STI clinic clients and those in discordant partnerships). **It is especially important for program staff to follow up actively with males whose circumcision procedure has been deferred because of an STI.** It is crucial that VMMC programs develop routine systems to follow up with these males, who show evidence of having had unprotected sex, to ensure that they return to the VMMC facility for circumcision immediately following their STI treatment. VMMC programs should also give particular priority to HIV-negative males in HIV-discordant partnerships. Special packages should be planned for HIV-negative males, preferably through demand and communication approaches to ensure these men remain uninfected [See [Chapter 4](#)].

MALE CIRCUMCISION AND RELATED CLINICAL CARE

Circumcision should be provided by a method approved by WHO, and pre- and post-procedure care should be provided that meet the accepted standards of care for conventional circumcision surgery under local anesthesia [See [WHO Manual for Male Circumcision Under Local Anaesthesia, 1st edition](#)], PrePex [See [PrePex Instructions for Use](#)], and ShangRing [See: [ShangRing Instructions for Use](#)]. To ensure client safety and high quality services, the following should be considered for each client before, during and following circumcision.

- **VMMC eligibility assessment:** All clients seeking circumcision should undergo appropriate screening before they receive circumcision to reduce adverse events and to ensure a good outcome of circumcision. Eligibility for VMMC includes i) Provision of a signed informed consent or parental consent/assent and its documentation on the clients' file. ii) Documentation of the client's age. This helps to determine an age appropriate VMMC method; iii) ensuring proper screening through history and examination to document contra-indications (high blood pressure, diabetes, prolonged bleeding, etc) and indications of circumcision (phimosis, paraphimosis, genital warts, epispadias and hypospadias) and/or indications of surgery in general that may require the services of a specialist doctor or a higher medical center.

- **Circumcision methods:** Providers should use age-appropriate, WHO approved VMMC methods. Although three conventional surgical methods (Sleeve resection, Forceps guided, Dorsal slit) are currently approved, and can be used, the dorsal slit method is specifically recommended for boys 10-14. Since the release of the first edition of the “PEPFAR’s Best Practices for VMMC Site Operations: A Service Guide for Site Operations”, two medical circumcision devices which provide alternatives to the conventional surgical procedures have obtained WHO prequalification: PrePex in 2013 [See [WHO Prequalification PrePex Abstract](#)] and ShangRing in 2015 [See [WHO Prequalification ShangRing Abstract](#)]. In 2013, WHO also issued guidelines and considerations to assist national VMMC programs in their decision-making regarding the use of devices in VMMC scale-up strategies. [See [Use of Devices for Adult Male Circumcision for HIV Prevention in East and Southern Africa](#)].

- **Competency of providers and their assistants:** Circumcision providers should be well qualified, trained and certified to provide at least one of the VMMC methods approved by WHO. The assistants to providers should also receive appropriate training and be in position to give full support to the circumcision team, including in emergency management [See Chapter 5]. The surgical team should be competent to observe and maintain adequate IPC processes, including a clean OR, cleaning hands, waste segregation and disposal, surgical site prep, and use of sterile materials.

- **Tetanus risk mitigation in VMMC programs:** Beginning in 2014, issues of tetanus risk among VMMC clients and strategies to mitigate this risk have garnered increased attention. WHO convened experts to provide recommendations to national programs in defining tetanus risk mitigation strategies, including the clean care approach and options for vaccination. [See [Technical Consultation Update to the WHO March 2015 Meeting — WHO Informal Consultation on Tetanus and Voluntary Medical Male Circumcision](#) and [Technical Consultation Update to the WHO March 2015 Meeting and Tetanus and VMMC: Risk According to Circumcision Method and Risk Mitigation](#)]. Clients must receive written instructions on recommended post-procedure wound care that explicitly address the risk of wound infection and specifically tetanus risk mitigation including the danger of using traditional remedies for wound care. Written informed consent must be retained for clients or parental/guardian consent for minor clients. Additional information about tetanus risk and mitigation in VMMC programs can also be found in other chapters through this second edition of *PEPFAR’s Best Practices for VMMC Site Operations: A Service Guide for Site Operations*.

- **Post-procedure follow-up:** This includes systematic assessment and management of adverse events (AEs). [See Chapter 7.]

MALE AND FEMALE CONDOMS

Promotion, demonstration, and onsite provision of condoms. Personnel at all sites providing VMMC for HIV prevention services with PEPFAR support should have a thorough understanding of the current VMMC Technical Considerations prepared annually as part of Country Operational Plan (COP) Guidance. [See: [PEPFAR VMMC Technical Considerations 2016](#) and [PEPFAR Country/Regional Operational Plan \(COP/ROP\) Guidance 2017](#).] The Technical Considerations summarize the PEPFAR VMMC Technical Working Group’s (TWG) additional recommendations for program implementation, as well as the policy-level requirements in effect as a condition of receiving PEPFAR VMMC funding.

PEPFAR POLICY GUIDANCE DIRECTIVES FOR VMMC

Excerpted VMMC Technical Considerations, PEPFAR Country/Regional Operational Plan (COP/ROP) Guidance 2017

“Voluntary Medical Male Circumcision (VMMC) VMMC reduces the risk of heterosexual HIV acquisition for men by at least 60 percent and helps to break the cycle of transmission to future sexual partners as the preventive effect remains strong throughout aging. To have the most impact, VMMC programs should be implemented in scale-up districts with a high HIV burden and low coverage of male circumcision services in the fourteen priority countries (Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe).

In COP17, programs should continue to prioritize clients aged 15–29 years, especially those at high risk such as STI clients and partners in serodiscordant couples, for immediate impact. As prioritized areas approach saturation in this population group (e.g., 80% or more among males 15–29 years in select geographic areas are circumcised), programs are urged to extend the prevention benefit to adolescent boys 10–14 years of age and to begin policy discussions with governments about neonatal circumcision. Teams must also ensure that PEPFAR-supported VMMC programs include the WHO-recommended minimum package of accompanying services, including the offer of HIV testing, risk reduction counseling, condoms, and STI screening and treatment or referral. HIV testing services should be offered only on request, and not routinely, to boys and adolescents who have not yet had sexual debut, given low rates of HIV infection in these populations. In addition, WHO recommendations on tetanus immunization and the clean care approach for all circumcisions must be followed.”

Rare tetanus cases in VMMC clients have been reported; WHO has issued a meeting report on an informal consultation regarding tetanus mitigation in service delivery and communication with clients. [See [Tetanus and Voluntary Medical Male Circumcision: Risk According to Circumcision Method and Risk Mitigation Report of the WHO Technical Advisory Group on Innovations in Male Circumcision—Consultative Review of Additional Information, 12 August 2016](#)]. PEPFAR programs should support Ministries of Health/Defense as they implement the recommendations outlined by WHO. Immediate reporting of any death or notifiable adverse event is required per the 2015 PEPFAR Reporting Protocol for VMMC Client Death and Notifiable Adverse Events. Implementing partners should check with their funding agency to ensure they have the current version of the protocol, since it is subject to updates.

Implementing mechanisms funded to support VMMC program implementing must fully comply with the following policy directives. All programs must put systems in place to monitor and report VMMC indicators and required disaggregations and to document coverage trends in scale-up SNUs [subnational units] and age groups. Geographic prioritization of VMMC should focus on (1) DREAMS [Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (Women) Project] districts, and (2) non-DREAMS scale-up districts (with high HIV burden and low male circumcision prevalence). The priority age group for VMMC is males 15–29 years of age. Programs should ensure external quality assessment and continuous quality improvement activities are routinely conducted. VMMC should not be withheld from healthy HIV-positive males, but they should receive appropriate counseling so that they understand that male circumcision (MC) is not known to lower their risk of transmitting HIV to their sexual partners and will not reverse their own HIV status, and that resuming unprotected sex prior to full wound healing will increase the risk of transmission. However, no males should be required to test for HIV in order to access VMMC. Programs should confirm that any male testing HIV-positive is linked to care

and treatment services. Any reimbursement to clients for travel and any rewards to teams of mobilizers to increase uptake of VMMC should be carefully evaluated to assure there is no one-for-one remuneration for VMMCs performed, and no actual or perceived coercion of clients.

Programs should plan for timely procurement and distribution of VMMC commodities and equipment including: pharmaceuticals, surgical instruments, devices, consumables and medical and waste management supplies. Programs can use PEPFAR funds to procure WHO pre-qualified devices and use them in routine service delivery, following WHO guidance. Currently, ShangRing and PrePex devices are pre-qualified for ages >13 years. Additionally, pre-qualified sizes must be used.

One issue noted during COP and POART [PEPFAR Oversight Accountability Response Team] reviews was that many programs continue to see a high proportion of VMMC procedures in 10-14 year olds rather than 15-29 years old. Programs should prioritize clients aged 15–29 years of age for immediate impact and make sure that the focus is to reach 80% coverage among that group in a very short period of time. Once an SNU has reached 60% coverage in the 15–29 year age groups, the prioritization of clients aged 10–14 years can increase.

WEIGHT-BASED DOSING OF LOCAL ANESTHETIC AGENTS

(Excerpted from [Adverse Event Action Guide for VMMC by Surgery or Device, 1st Edition, 2016](#))

Table 6.1. Starting and Maximum Doses of 2.0% Lidocaine (Lignocaine) without Bupivacaine, by Volume

Safe Local Anesthetic Dosing—Starting* and Maximum** Values		
2% LIDOCAINE		
Weight in kg	Starting Volume	Maximum Safe Volume
20–29 kg***	2 ml	Additional 1 ml to TOTAL of 3 ml
30–39 kg***	3 ml	Additional 1 ml to TOTAL of 4 ml
40–50 kg	4 ml	Additional 2 ml to TOTAL of 6 ml
More than 50 kg	5 ml	Additional 2 ml to TOTAL of 7 ml

*Starting dose lidocaine (lignocaine) 2 mg/kg.

**Maximum safe dose lidocaine 3 mg/kg.

***Use 5 ml syringe so that volumes can be measured accurately.

Starting volume usually adequate; increase up to **maximum** volume (dose) only if required for pain control up to the **maximum**.

Table 6.2. Starting and Maximum Doses of 2.0% Lidocaine (Lignocaine) with Bupivacaine, by Volume

If bupivacaine is to be used with lignocaine 2.0%, use concentration of 0.5% with 1:1 combination.

Safe Local Anesthetic Dosing—Starting* and Maximum** Values		
MIXTURE OF 2% LIDOCAINE AND 0.5% BUPIVACAINE (1:1 MIXTURE; EQUAL VOLUMES OF EACH)		
Weight in kg	Starting Volume (1:1 mixture)	Maximum Safe Volume (1:1 mixture)
20–29 kg***	1 ml of each (2 ml total)	Additional 1 ml of each drug to TOTAL of 4 ml (maximum 2 ml of each)
30–39 kg***	2 ml of each (4 ml total)	Additional 1 ml of each drug to TOTAL of 6 ml (maximum 3 ml of each)
40–50 kg	3 ml of each (6 ml total)	Additional 1 ml of each drug to TOTAL of 8 ml (maximum 4 ml of each)
More than 50 kg	4 ml of each (8 ml total)	Additional 1 ml of each drug to TOTAL of 10 ml (maximum 5 ml of each)

*Starting dose lidocaine 1 (lignocaine) .5 mg/kg / bupivacaine 0.3 mg/kg

**Maximum safe dose lidocaine 2.0 mg/kg / bupivacaine 0.5 mg/kg

***Use 5 ml or smaller syringe so that volumes can be measured accurately

Starting volume usually adequate; increase up to **maximum** volume (dose) only if required for pain control up to the **maximum**.

Table 6.3. Starting and Maximum Doses of 1.0% Lidocaine without Bupivacaine, by Volume

Safe Local Anesthetic Dosing—Starting* and Maximum** Values		
1% LIDOCAINE		
Weight in kg	Starting Volume	Maximum Safe Volume
20–29 kg***	4 ml	Additional 2 ml to TOTAL of 6 ml
30–39 kg	6 ml	Additional 3 ml to TOTAL of 9 ml
40–50 kg	8 ml	Additional 4 ml to TOTAL of 12 ml
More than 50 kg	10 ml	Additional 5 ml to TOTAL of 15 ml

*Starting dose lidocaine (lignocaine) 2 mg/kg

**Maximum safe dose lidocaine 3 mg/kg

***For those weighing less than 30 kg, use 5ml syringe so that volumes can be measured accurately Starting volume usually adequate; increase up to **maximum** volume (dose) only if required for pain control up to the **maximum**.

Table 6.4. Starting and Maximum Doses of 1.0% Lidocaine (Lignocaine) with Bupivacaine, by Volume

If bupivacaine is to be used with lignocaine 2.0%, use concentration of 0.25% with 1:1 combination.

Safe Local Anesthetic Dosing—Starting* and Maximum** Values		
MIXTURE OF 1% LIDOCAINE AND 0.25% BUPIVACAINE (1:1 MIXTURE; EQUAL VOLUMES OF EACH)		
Weight in kg	Starting Volume (1:1 mixture)	Maximum Safe Volume (1:1 mixture)
20–29 kg***	3 ml of each (6 ml total)	Additional 1 ml of each drug to TOTAL of 8 ml (maximum 4 ml of each)
30–39 kg***	4 ml of each (8 ml total)	Additional 2 ml of each drug to TOTAL of 12 ml (maximum 6 ml of each)
40–50 kg	5 ml of each (10 ml total)	Additional 3 ml of each drug to TOTAL of 16 ml (maximum 8 ml of each)
More than 50 kg	5 ml of each (10 ml total)	Additional 5 ml of each drug to TOTAL of 20 ml (maximum 10 ml of each)

*Starting dose lidocaine (lignocaine) 1.5 mg/kg/bupivacaine 0.3 mg/kg

**Maximum safe dose lidocaine 2.0 mg/kg/bupivacaine 0.5 mg/kg

Starting volume usually adequate; increase up to **maximum** volume (dose) only if required for pain control up to the **maximum**.

To improve provider efficiency through minimizing numbers of syringes needed, starting doses have been kept at or below 10 ml and maximum doses at or below 20 ml.

FOR ADDITIONAL INFORMATION

Suggested Staffing Roles for VMMC Programs: See [Chapter 5](#) on staff training.

CASE STUDIES

[Case Study 6.1. Improving Active Referral and Linkages to HIV Care and Treatment Services for HIV-Infected Men Identified through VMMC Services in Lesotho](#)

TOOLS, INSTRUMENTS & GUIDANCE DOCUMENTS

The following documents, which are available online and in the accompanying external media (included with the hard copy version of this Guide), provide the background information or procedural guidance used for development of this chapter.

1. [WHO Manual for Male Circumcision Under Local Anaesthesia, 1st edition](#)
2. [PEPFAR Technical Considerations for COP/ROP 2016](#)
3. [Guidance on Provider-Initiated Testing and Counseling in Health Facilities](#)
4. [VMMC In-Service Communication: Best Practices Guide](#)
5. [Guidelines for the Management of Sexually Transmitted Infections \(STIs\)](#)
6. [PrePex Instructions for Use](#)
7. [ShangRing Instructions for Use](#)
8. [PEPFAR Country/Regional Operational Plan \(COP/ROP\) Guidance 2017](#)
9. [WHO PQ PrePex Abstract](#)
10. [WHO PQ ShangRing Abstract](#)
11. [Use of Devices for Adult Male Circumcision for HIV Prevention in East and Southern Africa](#)
12. [Technical Consultation Update to the WHO March 2015 Meeting—WHO Informal Consultation on Tetanus and Voluntary Medical Male Circumcision](#)
13. **Considerations for PEPFAR-Supported VMMC Programs Incorporating Tetanus Vaccination and Other Risk Mitigation Activities**
14. **2015 PEPFAR Reporting Protocol for VMMC Client Death and Notifiable Adverse Events:** Can be obtained by contacting in-country USAID Mission staff.

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Lesotho Ministry of Health and Social Welfare. 2009. *Lesotho Demographic and Health Survey, 2009*. Maseru, Lesotho and Calverton, Maryland, USA: ICF Macro. Available online at: <http://dhsprogram.com/pubs/pdf/FR241/FR241.pdf>.

Population Services International and College of Surgeons of East, Central, and Southern Africa. 2016. *Adverse Event Action Guide for Voluntary Medical Male Circumcision by Surgery or Device, 1st ed.* Available online at: <https://www.malecircumcision.org/resource-bundle/adverse-event-guide>.

ABBREVIATIONS

AE	adverse event
ART	antiretroviral therapy
COP	Country Operational Plan
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (Women) Project
GIS	geographic information systems
HIV	human immunodeficiency virus
HTC	HIV testing and counseling
HTS	HIV testing services
MC	male circumcision
PEPFAR TWG	Technical Working Group
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief
PITC	provider-initiated HIV testing and counseling
RHSP	Rakai Health Sciences Program
SNU	subnational units
STI	sexually transmitted infection
STI	sexually transmitted infection
VMMC	voluntary medical male circumcision
WHO	World Health Organization



CASE STUDY 6.1.

Improving Active Referral and Linkages to HIV Care and Treatment Services for HIV-Infected Men Identified through VMMC Services in Lesotho

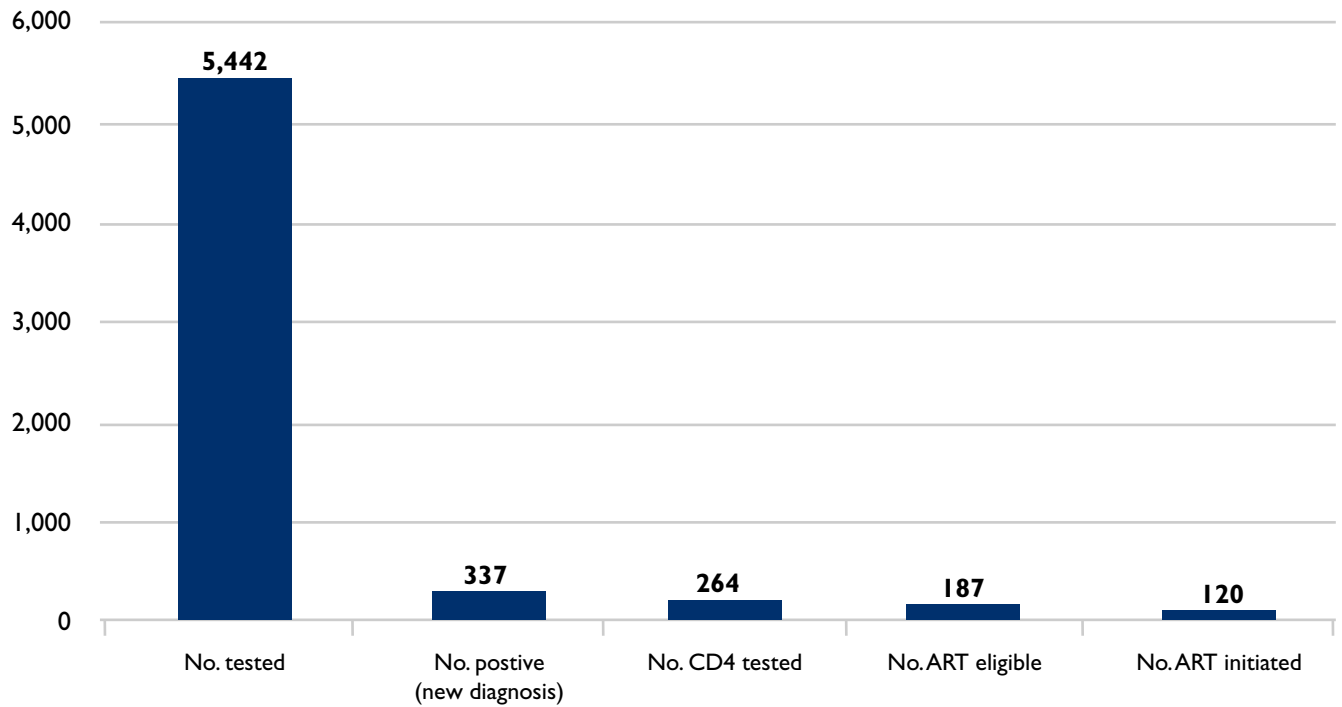
The World Health Organization (WHO) now recommends that any individual infected with HIV should begin antiretroviral treatment (ART) as soon as possible after diagnosis, irrespective of CD4 count. This expanded use of ART is called *Test and Start*; it is supported by clinical trial findings confirming that early use of ART helps people living with HIV live longer and stay healthier while reducing their risk of transmitting the virus to partners.

The critical first step in the HIV continuum of care is diagnosis of infection through HIV testing services (HTS). In Lesotho, uptake of HTS among men increased with scale-up of voluntary medical male circumcision (VMMC) services. Of the more than 100,000 males circumcised, more than 80 percent received HTS at the VMMC sites, which is impressive especially considering that fewer than 40 percent of men had ever tested prior to the start of the VMMC program (DHS 2009).

With PEPFAR funding through USAID, Jhpiego supported the Lesotho Ministry of Health to scale up VMMC services. To ensure that HIV-positive clients identified at VMMC sites were enrolled into HIV care and treatment services, active referral and linkages were introduced by the Lesotho VMMC program at two pilot sites in 2013 and expanded to all VMMC sites the following year. All clients testing HIV-positive received point-of-care CD4 testing and were offered the option of receiving HIV care and treatment at the same private clinic where they were circumcised. Clients also received information about additional HIV clinics where they would start ART, such as public facilities or specialized ART centers run by the AIDS Healthcare Foundation.

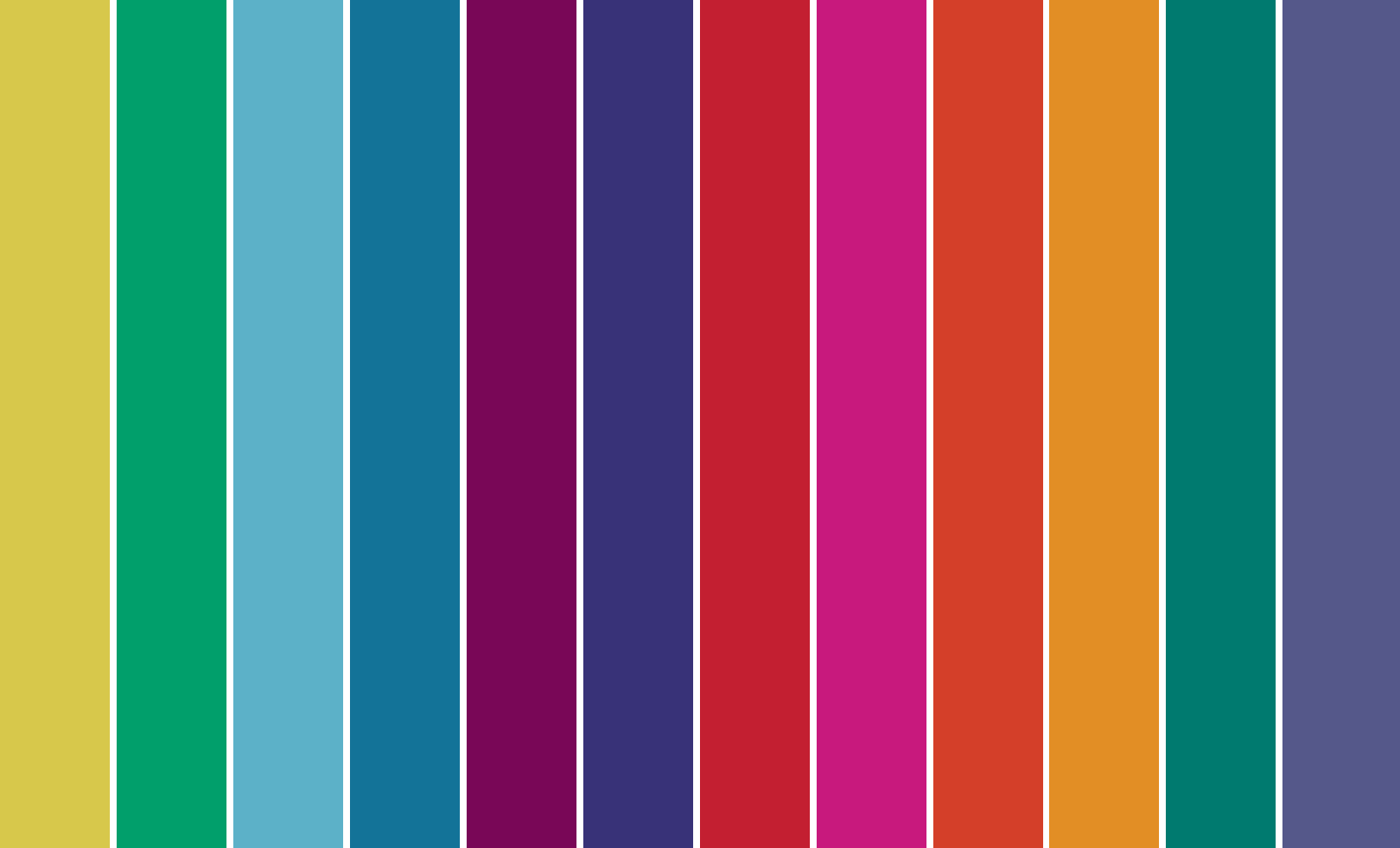
From October 2013 to August 2015, the period following the introduction of the active linkages for HIV-infected clients, 6,540 men were circumcised, and of those, 5,442 (83%) tested for HIV. Of these testers, 568 (8.6%) were HIV-positive, including 337 (59%) newly diagnosed at the 2 VMMC sites. Of those newly diagnosed, 264 (78%) had a CD4 count documented; 187 (70%) were ART-eligible and 120 (64%) initiated and were confirmed to be on ART within a month of diagnosis.

Figure 6.1.1. Cascade of HIV Linkage at Jhpiego Clinics in Lesotho



From this review, two key lessons can be noted. First, VMMC services can increase HTS uptake among men and contribute to the identification of HIV-infected men and young male adolescents. Second, active and closely monitored referrals of HIV-positive clients to care and treatment services will facilitate timely initiation of ART.





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