

Progress in scaling up voluntary medical male circumcision for HIV prevention in East and Southern Africa

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LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
CDC	Centers for Disease Control and Prevention
DfID	Department for International Development
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICASA	International Conference on AIDS and STIs in Africa
IEC	Information, Education and Communication
MC	Male Circumcision
M&E	Monitoring and evaluation
MOVE	Models for Optimising the Volume and Efficiency
NAC	National AIDS Council
NGOs	Non-Governmental Organizations
PEPFAR	President's Emergency Plan for AIDS Relief
PSI	Population Services International
PMTCT	Prevention of Mother-to-Child Transmission of HIV
SADC	Southern African Development Community
STI	Sexually Transmitted Infection
TAG	Technical Advisory Group on Innovations in Male Circumcision
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

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EXECUTIVE SUMMARY

Introduction

Following the recommendation in 2007 by WHO and UNAIDS that voluntary medical male circumcision (VMMC) becomes an additional intervention for HIV prevention, 13 countries in East and Southern Africa were identified for expanding VMMC. These countries are Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. The Gambella Province in Ethiopia was subsequently added, making Ethiopia the 14th priority country. Many local and international organizations have contributed to the scale-up of VMMC. The President's Emergency Plan for AIDS Relief (PEPFAR) and the Bill and Melinda Gates Foundation have provided significant technical and financial support. United Nations (UN) agencies have supported countries in the scale-up of VMMC by helping to develop normative guidance, tools and policy advice such as the Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV prevention in Eastern and Southern Africa: 2012–2016.

Summary of progress

Leadership and advocacy

Key global partners collaborated with UN agencies, led by WHO, to develop the Joint Strategic Action Framework. They are now implementing and monitoring progress of activities identified in the framework. At regional level, the Champions for an HIV-Free Generation¹, a group of former African Heads of State and other eminent personalities, carried out several advocacy visits to Lesotho and Malawi among others. They also attended the Southern African Development Community (SADC) Heads of State Summit where His Excellency, former President of Botswana, Festus Mogae delivered a keynote address. They also led and participated in several important sessions at the International Conference on AIDS and STIs in Africa (ICASA) in 2011 where they emphasized the need for scientific evidence to demonstrate the role of VMMC in HIV prevention. In collaboration with PEPFAR, the Gates Foundation and UNAIDS, the Champions inspired the production of a male circumcision song by three prominent artists from Botswana and Zimbabwe.

Since the 2007 recommendations, most countries have been developing policies and strategies and getting staff in place to support VMMC for HIV prevention. By the end of 2011:

- nearly all the national programmes had key elements in place for scaling up service delivery.
- All except two priority countries had a VMMC focal point;
- 10 countries had an advocacy strategy;
- eight countries had a national VMMC champion and
- nine countries used key events such as the World AIDS Day, traditional ceremonies and trade fairs to build support for VMMC.

¹The aim of Champions for an HIV-free Generation is to mobilize the leadership in Africa and to catalyze actions needed to invigorate HIV prevention efforts in Africa.

Expanding access to VMMC services

At the end of 2011, a cumulative total of more than 1.4 million male circumcisions conducted since the beginning of 2008 in all age groups were reported in the priority countries. The increase from 2010 to 2011 alone was more than 880,000 from 2010. The majority of the countries more than doubled the number of VMMCs performed compared with 2010, with the greatest increases reported in Rwanda, Malawi and Tanzania. Swaziland, however, performed fewer male circumcisions in 2011 than 2010. No data was available for Lesotho. The more than 1.4 million VMMCs performed represented a maximum of 7 percent of the more than 20 million male circumcisions needed among men aged 15 to 49 years in the 14 priority countries - a figure that has been estimated to result in a significant public health impact measured in terms of HIV infections averted and cost savings.

This increase in the number of VMMCs performed reflects that the stage has been set in most of the priority countries. Similarly, all countries had VMMC integrated into adolescent and adult programmes and a few had VMMC integrated into infant programmes. To achieve the goal of reaching men 15 - 49 years, a majority of the countries had outreach/mobile services; half of them had stand-alone sites, while eight had conducted male circumcision campaigns. Inadequate procurement and supplies were a serious challenge. Ten countries had quality assurance measures in place. Diverse cadres of health workers had been trained to provide the minimum package of services and selected cadres could perform surgical male circumcision for HIV prevention. All the priority countries had target-driven plans for VMMC.

Innovations

Devices for adolescent and adult VMMC may provide a simpler method that is at least as safe as the current standard surgical methods. However, devices for adolescent and adult male circumcision for HIV prevention are currently not recommended by WHO, as evidence on safety and performance is limited. Several clinical studies have either been completed or are underway to provide required evidence including comparisons with the currently recommended standard surgical methods. The studies are in line with the *Framework for Clinical Evaluation of Devices for Male Circumcision* which defines a pathway for the clinical evaluation of male circumcision devices for use in public health programmes for HIV prevention. In 2011, WHO established a Pre-qualification of Male Circumcision Devices Programme to promote and facilitate access to safe, appropriate and affordable male circumcision devices of good quality. Currently, no specific devices for adolescent and adult male circumcisions have been pre-qualified through this programme.

Staffing innovations involved the use of selected aspects of the Models for Optimizing the Volume and Efficiency (MOVE) of male circumcision, the use of volunteers and task shifting. Nine countries reported applying these aspects of MOVE to their service delivery. Swaziland had used volunteers to provide VMMC. Ten countries implemented task shifting to conduct surgical procedures and anaesthesia, with four having in place a policy on task shifting.

Communication

Ten countries had communication strategies in place and used community mobilization by champions, civil society organizations, community leaders and church leaders; mass media; interpersonal communication through students in the locality; posters/billboards and health extension workers in the target community to create demand for VMMC. There were varying levels of involvement of women and young people in VMMC activities.

Resource mobilization

In general, funds were available to support VMMC in most countries. Sources of funding included governments, bilateral partners such as PEPFAR and the Gates Foundation, the UN system and other multilateral partners and the private sector. Funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria was available for VMMC services in four countries.

Monitoring and evaluation

Monitoring and evaluation (M&E) systems are in various stages of development in most of the countries. Between September 2011 and June 2012, UNAIDS and WHO supported an assessment and documented M&E systems and capacities related to male circumcision in fourteen countries (including South Sudan² but excluding Ethiopia), for the period ending December 2011. Among the findings was that only two countries did not have a VMMC M&E framework, six had a VMMC-specific M&E focal person and another eight countries had their VMMC indicators harmonized with existing HIV indicators and in line with those suggested by WHO/UNAIDS. The same countries also had their data collection tools harmonized with existing HIV tools. A majority of countries reported adverse events rates of below 2 percent.

Coordination and accountability

By the end of 2011, all the priority countries had established multi-sectoral task forces to coordinate partners' inputs. Countries had different types of partners such as bilateral agencies, international and national NGOs, the private healthcare sector, health professional bodies, youth groups and women's groups.

Challenges

Although the pace is increasing, the limited number of voluntary medical male circumcisions for HIV prevention performed reflects key challenges as described below:

Limited demand for VMMC services: Low demand and limited acceptability among 'older' men (older considered above 25 to 29 years) was seen across a number of countries. However, uptake amongst 15 to 25 year olds was also limited in many countries.

Human resource constraints: The limited number of healthcare workers and staff available to rapidly scale up VMMC services was one of the main barriers. Although task shifting of MC from physicians to other cadres has occurred in several countries, regulatory issues remain a barrier to the performance of MC by selected non-physician cadres.

² Plans are underway to include male circumcision in the national HIV prevention strategy but have not started scale-up as yet.

Leadership and coordination: A few countries still had inadequate buy-in from key stakeholders, inconsistent leadership and weak coordination of partners.

Sustainable funding: Most priority countries depended on external funding. Several countries have insufficient funds. There was need for increased domestic funding for VMMC services, as well as increased funding from the Global Fund.

Procurement, supplies, equipment and infrastructure: Shortages and delays in procurement of surgical kits —both re-usable and disposable, emergency kits, and other supplies were common in most countries, mostly due to sub-optimal planning and forecasting of commodity needs. Inadequate space for service provision impeded scale-up efforts in some countries.

Integration into routine services: Most priority countries had not yet started making plans for integrating VMMC into their infant and adolescent care programmes.

Weak M&E systems: Most countries still had weak M&E systems that did not adequately provide timely, accurate and complete data on the progress of male circumcision services. Of particular concern is the limited reporting of VMMCs disaggregated by age. In some countries inconsistencies occurred across national and partner reporting systems.

Opportunities

Strong political will and leadership: Some countries had sustained and strong political leadership, which could be used as examples for other countries where the support was more variable.

Funding and technical support: Many partners remain committed to providing financial and technical support to priority countries in scaling up their VMMC programmes. The Global Fund regards VMMC in priority countries as a high impact intervention.

Innovations: Evidence on effectiveness and safety of male circumcision devices as an additional method for adolescent and adult male circumcision is expanding. It is hoped that sufficient data will become available for WHO to issue decisions and recommendations on the use of male circumcision devices in the near future. The use of devices for adolescent and adult medical male circumcision may provide additional options that may expand the provision of services by selected cadres of non-physician providers.

Experience in scaling up sound HIV prevention programmes: Most countries had programmatic experiences in scaling up other sound HIV prevention programmes such as prevention of mother-to-child transmission (PMTCT), from which VMMC programmes can learn.

Partnerships: Many partners were supporting the scale-up of VMMC. With effective coordination and collaboration, each partner brings complementary skills and comparative advantages that can expand and increase the pace of scale-up if used optimally.

Best/good practices, experiences and operational research: Some countries had identified local solutions to challenges. These practices can be shared with other countries to inform programmes across the sub-region.

Conclusion and way forward

Overall the pace of scale-up of VMMC for HIV prevention among the 14 priority countries in East and Southern Africa has increased, with a doubling of the number of VMMCs performed in 2011 compared to 2010. Most countries have now set the stage by establishing essential programmatic elements. Nonetheless, much needs to be done to increase the pace and strive for the goal of 80 percent prevalence of male circumcision in order to achieve the desired public health impact.

This report provides an overview of scaling up male circumcision for HIV prevention. Solutions to many of the challenges are possible. Innovations learned through implementation and potential new technologies provide optimism that the pace can intensify, balanced by feasible expectations for implementation. More detailed assessments on selected challenges will be required to identify and implement critical interventions to improve success.

Key areas that need to be addressed in the coming year include cultivating stronger and more consistent leadership at all levels to maximize this proven effective intervention; enhancing demand creation; making progress on innovative approaches to service delivery, including potential inclusion of devices for adolescent and adult male circumcision; sustaining and diversifying funding from both partners and government sources; improving monitoring and evaluation; improving procurement and supply management systems and establishing infant and adolescent male circumcision services. Well-designed evaluations of the HIV impact, cost-effectiveness and return on investment of VMMC in priority countries should be conducted.

CHAPTER 1: INTRODUCTION

Following the recommendation in 2007 by WHO and UNAIDS that male circumcision becomes an additional intervention for HIV prevention³, thirteen countries in East and Southern Africa were identified as priority countries for scaling up male circumcision. These countries are Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. The Gambella Province in Ethiopia was subsequently added, making Ethiopia the 14th priority country.

Over the past five years, many international and local organizations have contributed to VMMC implementation. PEPFAR and the Gates Foundation have provided significant technical and financial support, while non-governmental organizations (NGOs) and academic institutions have provided support in countries to assist with VMMC scale-up efforts. The UN Inter-agency Task Team has supported countries in the scale-up of VMMC through development of normative guidance, tools and policy advice. UNAIDS and WHO published the Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa: 2012–2016⁴ at the end of 2011, so as to catalyze VMMC scale-up. The desired goal of the Joint Strategic Action Framework is:

“By 2016 countries with generalized HIV epidemics and low prevalence of male circumcision have:

- (a) VMMC prevalence of at least 80 percent among 15–49 year old males, and*
- (b) Established a sustainable national programme that provides VMMC services to all infants up to two months old and at least 80 percent of male adolescents.”*

This progress report provides an update on VMMC scale-up in the 14 priority countries in East and Southern Africa in 2011. The report includes information on progress under the seven pillars of the Joint Strategic Action Framework:

- i) Leadership and advocacy
- ii) Country implementation
- iii) Innovations for scale-up
- iv) Communication
- v) Resource mobilization
- vi) Monitoring and evaluation
- vii) Coordination and accountability

The report only includes available information on the seven pillars of the Joint Strategic Action Framework that was verified by the Ministry of Health of individual VMMC priority countries. Chapter 1 provides the background and context to the report. Chapter 2 provides an overview of progress under the seven pillars, while

³ WHO/UNAIDS, *New Data on Male Circumcision and HIV Prevention: Policy and Programme Implications*, WHO Geneva, 2007.

⁴ WHO/UNAIDS, *Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa*, UNAIDS Geneva, 2011.

Chapter 3 gives a profile of each of the priority countries. Chapter 4 outlines the key challenges faced in scaling up VMMC and the opportunities for further acceleration and expansion of services in 2012 and beyond.

CHAPTER 2: OVERVIEW OF PROGRESS IN SCALING UP VMMC SERVICES

This chapter provides an overview of the status of VMMC implementation as of December 2011. It has been structured around the seven pillars of the Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa: 2012–2016.

Leadership and advocacy

Sustained national political leadership, advocacy and the engagement of key stakeholders play a pivotal role in successful scale-up of VMMC². Below is an overview of the current status of leadership and advocacy at global, regional and country levels.

Global and regional levels

The Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa: 2012–2016 was jointly developed by key partners (UN agencies, PEPFAR, the Gates Foundation) led by WHO. It was launched at a press event in December 2011 at the ICASA in Ethiopia. The key partners are collaborating in the implementation and monitoring of the Joint Strategic Action Framework in support of Ministries of Health.

At the regional level, the Champions for an HIV-Free Generation⁵ is an NGO that brings together former African Heads of State and other eminent personalities to mobilize the leadership in Africa and catalyze HIV prevention efforts. The Champions advocate for increased commitment to HIV prevention, provide peer support to country leadership and work directly with Heads of State and senior government officials in sub-Saharan Africa. Additionally, they address government ministers, parliamentarians, policy makers, heads of National AIDS Commissions, traditional leaders, religious leaders, youth leaders, people living with HIV, and other NGOs and development partners at national, regional and global levels.

In 2011, the Champions visited Angola, Ethiopia, Lesotho and Malawi where they met with national leaders.⁶ They advocated for VMMC as part of scaling up HIV prevention in Lesotho and Malawi. In Angola, His Excellency Festus Mogae, former President of Botswana, delivered a keynote address at the SADC Heads of State Summit in August 2011, where he reiterated, among other things, the Champions' support for VMMC. The Champions also led and participated in several important sessions at the 2011 ICASA.

⁵ www.hivfreechampions.org

⁶ *Champions for a HIV-Free Generation Report*, 2011 (unpublished).



Champion, His Excellency Festus Mogae, former President of Botswana at ICASA 2011 (3rd from left). From L to R: Catherine Hankins (then with UNAIDS), Michel Sidibe (UNAIDS Executive Director) and Ambassador Eric Goosby (United States Global AIDS Coordinator).

The Champions, in collaboration with PEPFAR, the Gates Foundation and UNAIDS, supported a song on VMMC. Three prominent African artists composed and produced the male circumcision song: Zimbabwean and international guitarist, vocalist, performer and composer, Oliver 'Tuku' Mtukudzi; Botswana-based and internationally recognized Vee Wa Mampela; and Zimbabwean reggae-dancehall artist, Winky D. The song urges men and boys to get circumcised. Its key messages are that VMMC is good, clean, protective, quick, pain free and saves lives.



Artists Winky D, Oliver 'Tuku' Mtukudzi, and Vee Wa Mampela performing the male circumcision song.

Country level

Leadership by Ministries of Health

It is encouraging to note that all except two countries (Tanzania and Uganda) had a VMMC focal point in the Ministry of Health, thus enhancing government leadership, as well as technical guidance and stewardship from Ministries of Health.

Developing/revising advocacy strategy

The majority of the priority countries (10 out of 14) reported that they had a VMMC advocacy strategy by the end of 2011. These countries were Botswana, Kenya, Malawi, Namibia, Rwanda, South Africa, Swaziland, Uganda, Zambia and Zimbabwe. The channels through which messages were being communicated included the mass media (TV, billboards, radio, strip advertisement and newspapers); interpersonal communication; community mobilization and health education sessions in healthcare settings. Different materials such as brochures, pamphlets, posters and leaflets had been developed and were being used.

Identifying, cultivating and mobilizing VMMC champions at local and country levels

Eight countries (Botswana, Kenya, Namibia, Rwanda, South Africa, Swaziland, Zambia and Zimbabwe) reported having a national VMMC champion. Although no information was available on the presence of VMMC champions at the local level within countries, all the priority countries reported having engaged in advocacy for VMMC during 2011. Often, advocacy activities included the involvement of civil society organizations, community leaders, church leaders and youth organizations at the grass roots level.

Strategically using key events to build support for VMMC scale-up

Nine countries (Botswana, Kenya, Malawi, Rwanda, South Africa, Swaziland, Uganda, Zambia, Zimbabwe) took advantage of existing national events to promote and build support for VMMC activities. The events included the following:

- Month of Youth Against AIDS campaign (Botswana)
- Monthly national community work (Rwanda)
- World AIDS Day (South Africa, Uganda, Zambia and Zimbabwe)
- HIV counseling and testing campaigns (South Africa and Zambia)
- Trade fair (Swaziland)
- Soccer matches (Swaziland)
- Male circumcision campaigns, including those conducted during school holidays (Botswana, Malawi, Swaziland and Zimbabwe)
- Traditional ceremonies (Zambia)
- Training journalists on accurate VMMC reporting (Kenya)

The table below summarizes the progress made in leadership and advocacy in the 14 priority countries as of December 2011

Table 1: Status of VMMC leadership and advocacy in the 14 priority countries

Country	Existence of Ministry of Health VMMC focal person	Existence of national advocacy strategy	Existence of National VMMC champion	Use of events to support VMMC
Botswana	Yes	Yes	Yes	Yes
Ethiopia	Yes	No	No	No
Kenya	Yes	Yes	Yes	Yes
Lesotho	Yes	No	No	No
Malawi	Yes	Yes	No	Yes
Mozambique	Yes	No	No	No
Namibia	Yes	Yes	Yes	No
Rwanda	Yes	Yes	Yes	Yes
South Africa	Yes	Yes	Yes	Yes
Swaziland	Yes	Yes	Yes	Yes
Tanzania	No	No	No	No
Uganda	No	Yes	No	Yes
Zambia	Yes	Yes	Yes	Yes
Zimbabwe	Yes	Yes	Yes	Yes
TOTAL	12	10	8	9

Country implementation

Expanding access to VMMC services

Progress in VMMC service provision

At the end of 2011, a total of 1,451,505 male circumcisions, in all age groups, had been performed in the priority countries, an increase of more than 880,000 procedures from 2010. This represented a doubling of the number of male circumcisions conducted in 2011 compared to 2010. The more than 1.4 million VMMCs performed represented a maximum of 7 percent of the more than 20 million male circumcisions needed among men aged 15 to 49 years in the 14 priority countries - a figure that has been estimated to result in a significant public health impact due to HIV infections averted and cost savings, as shown in Table 2. As countries are not yet consistently reporting VMMCs performed by age, it is not possible to determine the proportion performed among men 15 to 49 years old.

Table 2: Potential impact and number of male circumcisions performed in the 14 priority countries, 2008–2011

Country	Estimated number of MCs needed to reach 80% prevalence	Potential infections averted by scaling up MC to reach 80% prevalence in five years	Number of MCs carried out per year					% achieved of estimated number of MCs needed to reach 80% prevalence
			2008	2009	2010	2011	Total	
Botswana	345,244	62,773	0	5,424	5,773	14,661	25,858	7.5%
Ethiopia	40,000	1,479	0	769	2,689	7,542	11,000	27.5%
Kenya*	860,000	73,420	11,663	80,719	139,905	159,196	391,483	45.5%
Lesotho**	376,795	106,427	No data	No data	No data	No data	No data	N/A
Malawi	2,101,566	240,685	589	1,234	1,296	11,881	15,000	0.7%
Mozambique	1,059,104	215,861	0	100	7,633	29,592	37,325	3.5%
Namibia	330,218	18,373	0	224	1,763	6,123	8,110	2.5%
Rwanda	1,746,052	56,840	0	0	1,694	25,000	26,694	1.5%
South Africa	4,333,134	1,083,869	5,190	9,168	131,117	296,726	442,201	10.2%
Swaziland	183,450	56,810	1,110	4,336	18,869	13,791	38,106	20.8%
Tanzania	1,373,271	202,900	0	1,033	18,026	120,261	139,320	10.1%
Uganda	4,245,184	339,524	0	0	21,072	77,756	98,828	2.3%
Zambia	1,949,292	339,632	2,758	17,180	61,911	85,151	167,000	8.6%
Zimbabwe	1,912,595	565,751	0	2,801	11,176	36,603	50,580	2.6%
Total	20,855,905	3,364,344	21,310	122,988	422,924	884,283	1,451,505	7.0%

Source: MCs performed from Ministries of Health modeling estimates from Njeuhmeli E, Forsythe S, Reed J, Opuni M, Bollinger L, et al. (2011) Voluntary medical male circumcision: modeling the impact and cost of expanding male circumcision for HIV prevention in Eastern and Southern Africa. PLoS Med 8: e1001132. doi:10.1371/journal.pmed.1001132.

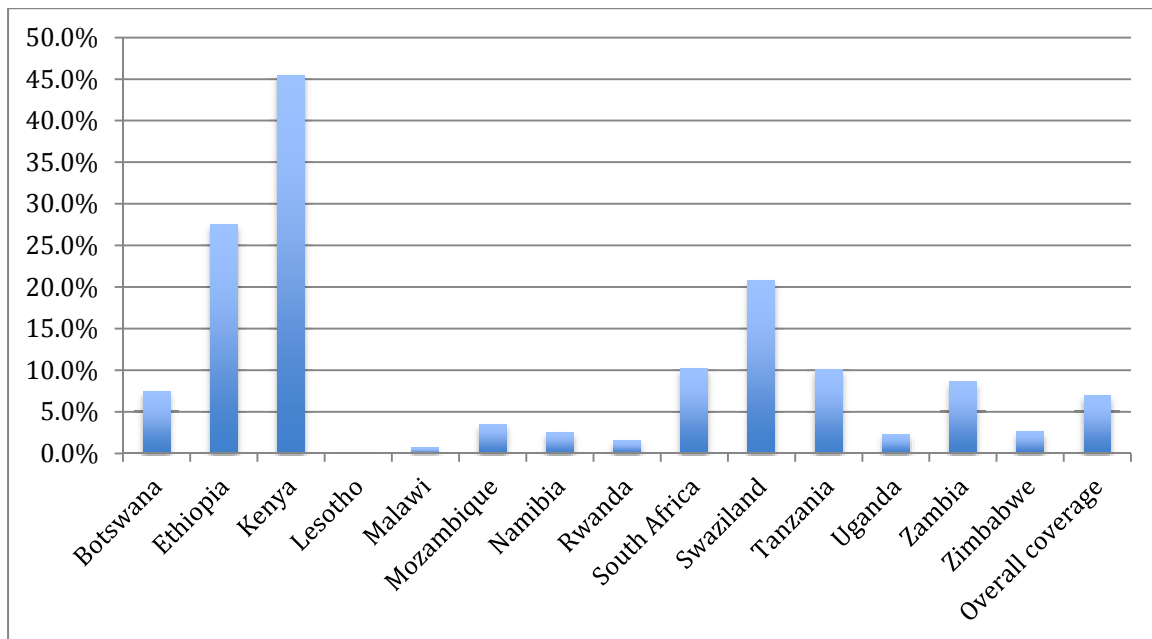
* Kenya's estimate is based on the national goal of 94 percent coverage for males aged 15 to 49 years

**2011 data for Lesotho not available

The majority of the countries at least doubled the numbers of VMMCs performed from 2010 to 2011. The greatest increase in the pace of scale-up occurred in Rwanda, Malawi and Tanzania. All other countries also made progress except Swaziland where fewer male circumcisions were performed in 2011 compared to 2010. South Africa performed the highest number of male circumcisions followed by Kenya. Tanzania and Zambia performed at least 100,000 male circumcisions by the end of 2011. Although the numbers of VMMCs were smaller for Ethiopia and Swaziland, by the end of 2011 both countries had performed over 20 percent of the numbers needed to achieve 80 percent prevalence. Namibia performed the lowest number of male circumcisions over the four years. From 2010 to 2011, however, Namibia experienced a three-fold increase in the number of VMMCs performed. No data for 2011 was available for Lesotho.

Figure 1 shows that achievement toward 80 percent prevalence ranged from less than 1 percent in Malawi to almost 46 percent in Kenya. It should be noted that Kenya's estimate is based on the national goal of 94 percent coverage for males aged 15 to 49 years.

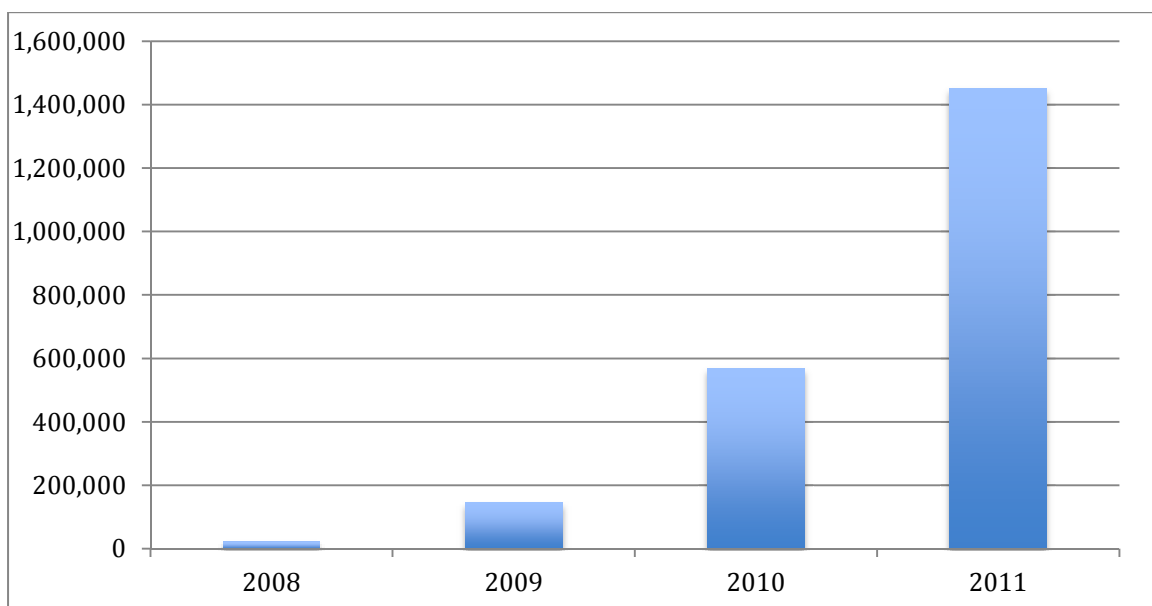
Figure 1: Percent of male circumcisions needed to achieve 80 percent prevalence that were performed by country by end of 2011



Source: Ministries of Health
 **2011 data for Lesotho not available

The overall coverage of VMMC increased about 41-fold between 2008 and 2011. The cumulative number of male circumcisions performed increased from 567,222 in 2010 to 1,451,505 in 2011. This is shown in Figure 2 below.

Figure 2: Cumulative number of male circumcisions performed from 2008 to 2011



Source: Ministries of Health
 **2011 data for Lesotho not available

Therefore, while countries have made progress in programme development and increases are noted in the number of VMMCs performed, focused efforts are needed to accelerate implementation.

Optimal service delivery approaches

All the priority countries had adopted the comprehensive minimum package recommended by WHO/UNAIDS, which includes the provision of HIV testing and counseling services; treatment for sexually transmitted infections (STIs); promotion of safer sex practices; provision of male and female condoms and promotion of their correct and consistent use. Additionally, among those who are identified to be HIV positive, referral and linkage to HIV care and treatment should be provided. Countries implemented the minimum package through service delivery approaches that use either one or a combination of the following modes: health facility-based male circumcision services integrated into routine activities; stand-alone male circumcision services; outreach services; mobile services and specific VMMC mass campaigns. These approaches have been developed to address particularly males 15 to 49 years old.

While the majority of countries had outreach/mobile services, three countries (Botswana, Mozambique and Rwanda) did not use either of these approaches. Eight countries (Botswana, Kenya, Namibia, South Africa, Swaziland, Tanzania, Uganda and Zambia) had conducted male circumcision campaigns as shown in Table 3.



A young man undergoing surgical male circumcision.

To also address sustainable services that will be needed, by the end of 2011, all countries had integrated VMMC into adolescent and youth-friendly services; two countries (Ethiopia and Swaziland) had male circumcision integrated into infant programmes. Seven countries (Kenya, Ethiopia, Malawi, South Africa, Swaziland, Zambia and Zimbabwe) had stand-alone sites. Experience to date suggests that a

mixed service delivery model offers advantages, including geographic access. However, further assessment would better inform an optimal model.

Table 3: Service delivery approaches in the 14 priority countries

Country	Service delivery approach					
	Integrated into adolescent services	Integrated into infant care services	Stand-alone sites	Outreach services	Mobile services	Other
Botswana	Yes	No	No	No	No	Campaigns
Kenya	Yes	No	Yes	Yes	Yes	Moonlighting, campaigns
Ethiopia	Yes	Yes	Yes	Yes	Yes	-
Lesotho	Yes	No	No	Yes	No	-
Malawi	Yes	No	Yes	Yes	Yes	-
Mozambique	Yes	No	No	No	No	
Namibia	Yes	No	No	Yes	No	Campaigns
Rwanda	Yes	No	No	No	No	-
South Africa	Yes	No	Yes	Yes	Yes	Campaigns
Swaziland	Yes	Yes	Yes	Yes	Yes	Campaigns
Tanzania	Yes	No	No	Yes	Yes	Campaigns
Uganda	Yes	No	No	Yes	Yes	Campaigns
Zambia	Yes	No	Yes	Yes	Yes	Campaigns
Zimbabwe	Yes	No	Yes	Yes	Yes	-
TOTAL	14	2	7	11	9	8

Examples of innovative service delivery include Kenya’s innovative ‘moonlight’ service delivery approach for some hard-to-reach men described in Box 1.

Box 1: KENYA INNOVATION ON SERVICE DELIVERY– ‘MOONLIGHT SERVICES’

In an effort to get more men circumcised to prevent HIV infection, the Kenyan Ministry of Health began providing VMMC services at night during the Rapid Results Initiative started in 2009 in Nyanza Province, Western Kenya. Dubbed ‘moonlight circumcision’, the practice has gained fame and is attracting people in large numbers. The VMMC services are available at various circumcision centres in the province from 5 pm to midnight. The moonlight centres were established in areas where day activities hindered many men from accessing VMMC, especially around Lake Victoria and its islands, and where men refused to get circumcised because they were embarrassed to be seen going for the procedure.

The moonlight centres have contributed to achieving the targets of the campaign and have made it easier to reach men aged 15 to 49 years. More than 50,000 men were circumcised, 80 percent of whom were sexually active. In addition to offering moonlight services in some districts, the VMMC programme enlisted satisfied clients to share their experiences with their peers and encourage them to go for circumcision.

Source: Government of Kenya, Ministry of Public Health and Sanitation, *Voluntary Medical Male Circumcision for HIV Prevention in Kenya. Report of the first Rapid Results Initiative*, June 2011.

Procurement and supply management

A generic standard list of commodities has been developed for disposable surgical supplies, infection prevention and emergency toolkits. VMMC kit options and

modules have also been developed to meet countries' varying needs for quality assured standard kits. Eleven of the priority countries reported having experienced challenges related to inadequate supplies, delayed procurement and inadequate funding in 2011. Kenya, Namibia and Swaziland, however, did not report any challenges pertaining to procurement and supply management.

Quality assurance

Quality assurance processes and mechanisms to maintain the quality of VMMC services need to be in place as services expand. This entails developing a quality assurance strategy and plan, and conducting regular quality checks with feedback that serves to improve quality. Ten countries indicated that they had VMMC quality assurance mechanisms in place. Tanzania, for example, had in place measures to improve the quality of HIV services such as quality improvement guidelines and a training package. PEPFAR also conducted external quality assurance exercises, which help to inform the quality of services and provide recommendations for improvements.



A young man who is pleased with the male circumcision procedure he has undergone.

Capacity building

Training of service providers on safe VMMC for HIV prevention is a core activity for the scale-up of VMMC services. All priority countries conducted training, with support from partners, as part of their male circumcision scale-up activities. By December 2011, various categories of health workers had been trained on VMMC. These included doctors, nurses, midwives, clinical officers, health auxiliaries, counselors, health officers, programme directors, lay counselors, expert clients, licentiates and theatre assistants. Some countries also trained doctors from the private sector.



Training of service providers in male circumcision

An example of capacity building efforts conducted in Rwanda is described in Box 2.

Box 2: VMMC CAPACITY BUILDING EFFORTS IN RWANDA IN 2011

Rwanda's capacity building efforts, for example, involved training healthcare providers in district hospitals, health centres and private clinics in a cascaded approach as follows:

- i) Training of 31 surgeons and post-graduate students as master trainers was carried out in collaboration with the Rwanda Surgical Society.
- ii) Master trainers conducted a national training of trainers for trainees from district hospitals. These comprised one doctor and one nurse from each of the 41 district hospitals.
- iii) The 82 national trainers continued to cascade trainings to public health centres and private clinics, as well as carrying out ongoing decentralized trainings in district hospitals. A total of 340 out of 447 health centres in the country had completed trainings on male circumcision as an additional HIV prevention strategy. Training of staff of all 447 health centres is planned to be completed by May 2012.

In addition to the above, 5,400 community health workers were trained to increase knowledge on male circumcision so that they effectively carry out the role of motivating eligible men to go for male circumcision; motivating women to support male circumcision decisions made by partners and sons; providing accurate information to men and women and addressing misconceptions.

Source: Male circumcision update report on Rwanda, May 2012 (unpublished).

Country-specific operational plans

By December 2011, all the priority countries had developed target-driven, multi-year plans for VMMC. Most of the plans had a target of 80 percent prevalence of VMMC among males aged 15 to 49 years by 2015. It is estimated that if this target was met by 2015 and maintained in all the priority countries, 22 percent of the new HIV infections could potentially be averted between 2011 and 2025⁷. The plans had different endpoints, ranging from 2009 in Lesotho, 2012 in Rwanda and 2016 in Botswana and Malawi (Table 4).

Following the release of the Joint Strategic Action Framework, some countries were considering reviewing their VMMC plans to ensure that they adequately addressed the 'catch-up phase' where uncircumcised adults and adolescents are the main target for VMMC and the 'sustainability phase' where male circumcision is routinely offered to infants and adolescents. Some countries also wanted to develop costed, annual operational plans.

Table 4: Status of VMMC planning in the 14 priority countries

Country	Target-driven plan in place	Time frame
Botswana	Yes	2009–2016
Kenya	Yes	2008–2013
Ethiopia	Yes	2009–2012
Lesotho	No	Plan ended in 2009
Malawi	Yes	2011–2016
Mozambique	Yes	2010–2012
Namibia	No	Still being developed
Rwanda	Yes	2010–2012
South Africa*	Yes	2012–2016
Swaziland	Yes	2009–2013
Tanzania	Yes	2010–2015
Uganda	Yes	2011–2015
Zambia	Yes	2012–2015
Zimbabwe	Yes	2010–2015

*VMMC plan included in National Strategic Plan for HIV, AIDS, STI and TB.

Innovations for scale-up

Male circumcision devices

Several challenges to accelerating scale-up have been identified including limited human and material resources required to perform the standard surgical male circumcision procedure for adolescents and adults. Male circumcision devices have the potential to address some of the challenges as they would potentially be as safe as the current standard surgical procedure but less resource demanding, usable by non-physicians and acceptable to both clients and providers.

Devices are currently used for the circumcision of male infants, but experience with

⁷ Njeuhmeli E, Forsythe S, Reed J, Opuni M, Bollinger L, et al. (2011) Voluntary medical male circumcision: modeling the impact and cost of expanding male circumcision for HIV prevention in Eastern and Southern Africa. PLoS Med 8: e1001132. doi:10.1371/journal.pmed.1001132

male circumcision devices for adolescents and adult males is limited, particularly in countries in East and Southern Africa. WHO established the Technical Advisory Group on Innovations in Male Circumcision (TAG) in 2009, which, along with earlier expert consultations, defined a pathway for the clinical evaluation of male circumcision devices for use in public health programmes for HIV prevention. The pathway includes an initial efficacy and safety study in one of the priority countries, followed by a series of clinical studies consisting of two comparative and two field studies (that assess clinical performance of the device by mid-level providers) in different countries. Research studies that follow the recommended evaluation pathway were completed or were underway on adult devices in several countries, namely Kenya, Rwanda, Zambia and Zimbabwe, as well as Botswana where research focused on a new infant device.

WHO also established a Pre-qualification of Male Circumcision Devices Programme in 2011. The aim of the programme is to promote and facilitate access to safe, appropriate and affordable male circumcision devices of good quality in an equitable manner through a comprehensive assessment of submitted products. Once a WHO decision is made to pre-qualify a specific device from a unique manufacturing site, the product is included in the WHO list of pre-qualified male circumcision devices and becomes eligible for procurement processes by UN agencies, WHO Member States and other interested organizations so as to guide their procurement decisions. Pre-qualification of a device does not imply approval by WHO since approval is the sole prerogative of national regulatory authorities.

Human resource innovations

Innovations to optimize service delivery, particularly given the scarce human resource situation, were being implemented in line with options described in *Considerations for implementing Models for Optimizing the Volume and Efficiency (MOVE) of male circumcision services* published by WHO in 2010, and the use of volunteers to provide VMMC services in accordance with the *Guidance on engaging volunteers to support the scale-up of male circumcision services* published by WHO in 2009. MOVE involves sharing of tasks and techniques that make the clinical surgical component of the male circumcision procedure more efficient. It permits more clients to receive VMMC services while assuring a safe service of high quality and a higher number of boys and men accessing male circumcision services. Nine countries were applying selected aspects of MOVE approach to their service delivery, namely Botswana, Ethiopia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. In addition, Swaziland had used volunteer doctors and nurses to provide VMMC services.

Task shifting involves the rational redistribution of tasks among health workers. Specific tasks are reassigned from highly qualified health workers to those who possess less extensive training and fewer qualifications, as appropriate. This can help diminish the problems associated with health worker shortages. Task shifting for adult VMMC was implemented in 10 countries, namely Ethiopia, Kenya, Malawi, Mozambique, Namibia, Rwanda, Swaziland, Tanzania, Uganda and Zambia. Four countries reported having task shifting policies (Kenya, Rwanda, South Africa and Zambia) and had shifted tasks to clinical officers and/or nurses. Six countries (Malawi, Mozambique, Namibia, Swaziland, Tanzania and Uganda) did not report

having task shifting policies but were implementing task shifting as shown in Table 5 below.

Table 5: Task shifting status for adult VMMC in the 14 priority countries

Country	Existence of task shifting policy	Implementation of task shifting activities	Non-physician cadres authorised to perform VMMC
Botswana	No	No	N/A
Ethiopia	No	Yes	Nurses
Kenya	Yes	Yes	Clinical officers and nurses
Lesotho	No	No	N/A
Malawi	No	Yes	Clinical officers and registered nurses
Mozambique	No	Yes	Nurses
Namibia	No	Yes	Registered nurses
Rwanda	Yes	Yes	Nurses
South Africa	Yes	No	N/A
Swaziland	No (draft policy exists)	Yes	Midwives perform neonatal MC
Tanzania	No	Yes	Clinical officers and nurses
Uganda	No	Yes	Clinical officers, nurses and midwives
Zambia	Yes	Yes	Clinical officers and registered nurses
Zimbabwe	No	No	N/A
TOTAL	4	10	10

Box 3 gives a description of some task shifting activities in selected countries.

BOX 3: TASK SHIFTING IN SELECTED COUNTRIES

Ethiopia: Although there is no task shifting policy in Ethiopia, the Federal Ministry of Health has allowed nurses to perform the whole VMMC surgical procedure by themselves after undergoing standardized in-service training.

Kenya: Clinical officers, upon training, are competent to perform the entire procedure, starting from skin preparation, local anaesthetic injection, cutting, bleeding control, stitching and dressing of the wound. In addition, doctors, clinical officers and nurses are also trained in VMMC counselling so that they can complement the counsellors when there is high demand.

Malawi: Clinical officers and registered nurses are trained in all aspects of VMMC, namely health promotion and understanding the implications of VMMC, screening, administration of anaesthesia, cutting, stitching, dressing and conducting post-operative reviews. Less qualified cadres do the wound dressing.

Mozambique: Trained nurses perform the entire VMMC surgical procedure.

Rwanda: Trained registered nurses are allowed to perform both surgical VMMC and male circumcision using the Prepex male circumcision device as part of a continuing study.

Tanzania: The Tanzanian Male Circumcision Strategy states that clinical officers and nurses will do male circumcision surgery after proper training and will be closely supervised by doctors. In the field, the clinical officer and various cadres of nurses are performing the entire VMMC surgical procedure.

Uganda: Task shifting to clinical officers, nurses and midwives who frequently support general theatre activities involves performing the VMMC surgical procedure. For example, theatre nurses and midwives were trained as nurse anaesthetists, with some trained to perform surgical VMMC as is the case in Kilembe Hospital, Kasese district.

Zambia: Clinical officers and nurses are trained to offer pre- and post-operative counselling and perform surgical VMMC as well. They are also able to review clients post operatively and refer those with adverse events they cannot handle to medical officers.

Communication

Communication is designed to create a favorable environment and acceptance of and demand for male circumcision services. Progress is reported on communication in terms of availability of communication and demand creation strategies used by priority countries.

Communication and demand creation strategies

Ten countries (Botswana, Kenya, Malawi, Namibia, Rwanda, South Africa, Swaziland, Uganda, Zambia and Zimbabwe) had communication strategies that used mass media (TV, billboards, radio, strip advertisement and newspapers), interpersonal communication, community mobilization, health education sessions in healthcare settings and social media as the main channels for communication. A variety of materials such as brochures, pamphlets, posters and leaflets had also been developed and distributed. The World Bank worked with several countries to design and implement demand-side and supply-side incentive programmes in order to address insufficient VMMC service uptake and scale-up in specific settings.

Countries had predominantly used the following demand creation strategies: community mobilization by national VMMC champions, civil society organizations; community leaders and church leaders; mass media; interpersonal communication through students in the locality; posters/billboards and health extension workers in the target community. Community mobilization was the predominant method used by countries for demand creation as only one country (Lesotho) indicated that it did not use community mobilization. Despite these activities, demand creation remained a challenge in most countries.

Involvement of women and young people in VMMC

There were varying levels of involvement of women and young people in VMMC activities as detailed in Table 6.

Table 6: Involvement of women and young people in VMMC activities

Country	Involvement of women	Involvement of young people
Botswana	Specific brochures developed to mobilize women	Young males are the main target population for VMMC
Kenya	Mobilizers and service providers	Mobilizers, service providers and satisfied male clients
Ethiopia	Women involved when married clients are counseled	Young people 15–24 years targeted for service delivery
Lesotho	Not involved	Not involved
Malawi	Programme development through a consultation process	Programme development through a consultation process
Mozambique	Not involved	Young males are the target group
Namibia	Through media, group health education and community mobilization	Through media, school programmes, group health education and community mobilization to support VMMC
Rwanda	Specific tools developed to mobilize women to support VMMC	Specific tools have been developed to mobilize young people to support VMMC
South Africa	National communication strategies, schools and mass media developed to mobilize women	National communication strategies, schools and mass media developed to mobilize young people
Swaziland	Supporting partners and children who present for VMMC	Young people take part in IEC during the Back-to-School programme
Tanzania	No specific involvement	Young people are represented in VMMC working groups.
Uganda	Work with NGOs to support VMMC activities	Work with NGOs to support VMMC activities
Zambia	Through demand generation mobilization and couple counseling	Young people act as peer educators and mobilizers in tertiary institutions
Zimbabwe	Social mobilization to support their partners and children and in advocacy with women activists' groups	<ul style="list-style-type: none"> - Mobilize other young people in schools and tertiary institutions - Main conveyers of information to parents and guardians - Constitute main target
TOTAL	11	13

Women's involvement in VMMC included providing support to their partners and sons, advocacy, mobilization activities and participating in couples counselling sessions. Young people's involvement included receiving VMMC services, mobilization, participating in school programmes, participation in technical working groups, as peer educators and mobilizers in tertiary institutions, and conveying VMMC information to parents.



Women supporting surgical male circumcision among adolescents during a traditional initiation ceremony.

Resource mobilization

Achieving the goal of scaling up VMMC to reach 80 percent of males aged 15 to 49 years and establish sustainable services for infants and adolescents requires sufficient and sustained financial resources. Governments in all the priority countries contributed financial, human and material resources to scale up male circumcision services. Based on projected costs, additional resources for scaling up male circumcision were being mobilized through bilateral partners such as PEPFAR, the Gates Foundation, the UN system, other multilateral partners and the private sector such as the sugar companies in Swaziland. Global Fund funding for VMMC was still available in four countries from earlier funding rounds as follows: Lesotho (Round 8), Rwanda (National Strategic Plan), South Africa (Round 10) and Zambia (Round 8).

Monitoring and evaluation

An effective M&E system is essential for tracking progress towards the goals and objectives of VMMC scale-up and improving programme performance. Between September 2011 and June 2012, UNAIDS and WHO supported an assessment and documented M&E systems and capacities related to male circumcision in fourteen countries (including South Sudan⁸ but excluding Ethiopia), for the period ending December 2011. The objective of the assessment was to review progress, identify gaps and opportunities for strengthening country-level VMMC M&E systems.⁹

Among the findings was that only Mozambique and Lesotho did not have a VMMC M&E framework — neither draft nor was it integrated into existing M&E systems. Six

⁸ Plans are underway to include male circumcision in the national HIV prevention strategy but have not started scale-up as yet.
⁹ *Assessment and Documentation of the M&E Systems and Capacities Related to Male Circumcision in fourteen Selected Countries: Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, Swaziland, South Africa, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe*, UNAIDS, 2011 (unpublished).

countries, namely Botswana, Kenya, Swaziland, Tanzania, Mozambique and Zambia, had a VMMC-specific M&E focal person. Malawi, Namibia and South Africa have VMMC M&E coordinated as part of the overall HIV M&E system.

Eight countries (Kenya, Malawi, Namibia, Rwanda, South Africa, Swaziland, Tanzania and Zimbabwe) had their VMMC indicators harmonized with existing HIV indicators and in line with those suggested by WHO/UNAIDS. The same countries also had their data collection tools harmonized with existing HIV tools (Table 7).

Table 7: Status of VMMC M&E systems in the 14 priority countries

Country	Availability of M&E frameworks	Availability of VMMC M&E focal person	Availability of harmonized indicators	Availability of harmonized data collection tools
Botswana	In draft	Yes	No	No
Ethiopia	Not assessed	Not assessed	Not assessed	Not assessed
Kenya	Completed and integrated into Health Information Management System (HIMS)	Yes	Yes	Yes
Lesotho	No	No	No	No
Malawi	Available with reporting formats	Part of HIV M&E	Yes	Yes
Mozambique	No	Yes	No	No
Namibia	National HIV M&E plan includes M&E matrix for male circumcision	Part of HIV M&E	Yes	Yes
Rwanda	Completed and integrated into HIV M&E system	No	Yes	Yes
South Africa	Integration into national M&E system in progress	Part of HIV M&E	Yes	Yes
Swaziland	Completed	Yes	Yes	Yes
Tanzania	Completed and integrated into HIV M&E system	Yes	Yes	Yes
Uganda	Integrated into HIMS	No	No	No
Zambia	In draft	Yes	No	No
Zimbabwe	Completed and integrated into HIV and AIDS M&E plan	No	Yes	Yes
TOTAL	11	9	8	8

Some of the key M&E challenges highlighted through this assessment included weak M&E in most countries (including collection of data, disaggregation, quality and

timely reporting). In some countries, data from the private sector and traditional practitioners was also not captured. There was limited availability and capacity of human resources for M&E, and partnerships at service provision level were either not being replicated or were not functional in relation to M&E.

Standardized and complete reporting of adverse events¹⁰ is challenging. However, the majority of the countries that reported on adverse events showed rates of less than 2 percent (Malawi, Mozambique, Namibia, Rwanda, Tanzania, Zambia and Zimbabwe). Kenya, Swaziland and South Africa showed rates of less than 5%.

Coordination and accountability

Scaling up VMMC services will only be done efficiently with strong coordination and accountability as well as active partnerships.

Coordination mechanisms

Global and regional-level partners provide technical support to country-level implementers. All priority countries had established multi-sectoral task forces to provide coordination, although overall accountability remained with the Ministry of Health. While many country task forces are working relatively well, many need to be strengthened.

Partnerships

Priority countries had technical partners that included bilateral agencies, international and national NGOs, the private healthcare sector, health professional bodies, youth groups and women's groups. These partners played various roles that included provision of financial, human and technical support as well as service delivery. All priority countries reported that they had a multi-sectoral VMMC task force in place. The effectiveness and best practices of partnerships were not assessed for this report. The list of partners supporting each of the priority countries is detailed in Table 8.

¹⁰ An adverse event is defined as "an injury that was caused by medical management and not due to the underlying condition of the patient. An unexpected and undesired incident directly associated with the care or services provided to the patient." Adverse events related to surgery are graded as mild (no treatment needed), moderate (require treatment) and severe (require surgical intervention).

Table 8: VMMC partners in the 14 priority countries

Country	Main supporting partners
Botswana	WHO; UNAIDS; African Comprehensive HIV/AIDS Partnership; PEPFAR; I-Tech; Jhpiego; Population Services International (PSI); Tebelopele VCT Centre; UN agencies; Botswana Harvard Partnership
Ethiopia	WHO; PEPFAR; Global Fund; World Bank
Kenya	The Male Circumcision Consortium (Family Health International, University of Illinois and Engender Health); Nyanza Reproductive Health Society; Impact Research and Development; Marie Stopes International; International Medical Corps; AIDS, Population and Health Integrated Assistance; (Engender Health; PATH; PSI); UNICEF; PEPFAR; WHO; UNAIDS; Gates Foundation and the World Bank
Lesotho	JHPIEGO; PSI; PEPFAR; WHO; UNAIDS; UNICEF; UNFPA
Malawi	WHO; UNAIDS; UNICEF; UNFPA; World Bank; Christian Health Association of Malawi; PEPFAR; PSI; Banja La Mtsogolo; Jhpiego
Mozambique	PEPFAR; PSI; WHO; UNAIDS; UNICEF; UNESCO; Jhpiego
Namibia	WHO; UNAIDS; PEPFAR; Intrahealth; I-Tech; PSI, other civil society organizations
Rwanda	WHO; UNAIDS; UNICEF; PEPFAR; Global Fund; Jhpiego; civil society organizations, especially youth groups
South Africa	UN agencies; PEPFAR; Global Fund; Centre for HIV and AIDS Prevention Studies; Anova Health; Johns Hopkins Health and Education South Africa; Jhpiego; Maternal, Adolescent and Child Health; Right To Care; Southern African Clothing and Textile Workers' Union; Provincial Health and Research Unit; Centre for the AIDS Programme of Research in South Africa; Soul CITY; Aurum Institute; Foundation for Professional Development; Catholic Medical Mission Board; McCord Hospital; St Mary's Hospital
Swaziland	WHO; UNICEF; UNAIDS; PEPFAR; Family Life Association of Swaziland; male circumcision partnership (PSI; Jhpiego; Marie Stopes Swaziland; Population Council and Futures Group)
Tanzania	National Institute for Medical Research; WHO; PEPFAR; UNICEF; Jhpiego; Association of Private Hospitals
Uganda	WHO; UNAIDS; UNICEF; UNFPA; PEPFAR; Family Health International; Irish AID; DfID and Makerere University School of Public Health
Zambia	University Teaching Hospital; PEPFAR; WHO; male circumcision partnership (Society for Family Health; Jhpiego; Population Council); Zambia Prevention, Care and Treatment; Family Health International; Marie Stopes International; Churches Health Association of Zambia and Centre for Infectious Disease Research in Zambia
Zimbabwe	WHO; UNFPA; PEPFAR; DfID; PSI; Zimbabwe National Family Planning Council; church organizations; Gates Foundation; University of Zimbabwe; College of Health Sciences

CHAPTER 3: PROFILES OF PRIORITY COUNTRIES

This section of the report presents the profile of each of the 14 priority countries and the progress they have made in providing VMMC services as of December 2011. It includes key health and demographic information; HIV and male circumcision statistics; progress made in implementing the seven pillars of the Joint Strategic Action Framework; challenges; opportunities and future plans for VMMC.

BOTSWANA¹¹

Profile

1. Population: 2.0 million (2011)*
2. Adult HIV prevalence: 17.6% (2008)**
3. MC at baseline: 11% (2008)**
4. Adult MC target: 345,244
5. Total no. MCs 2008–2011: 25,858

Leadership and advocacy

Leadership: There are VMMC champions and the national Ministry of Health VMMC focal person is at post.

Advocacy: Advocacy strategy is available. Events used to support VMMC include the school holidays campaign and Month of Youth Against AIDS campaign.

Country implementation

Operational planning: A national strategy for 2009–2016 has been developed

Service delivery approach: Static health facility-based with integration of VMMC into existing services; outreach services and mass campaigns.

Task shifting policy: No policy on task shifting; only doctors perform male circumcision.

Service delivery statistics: Total male circumcisions by December 2011: 25,858.

Adverse events rate = <2%.

Quality assurance (QA): QA plan is in place.

Capacity building: Categories of staff trained are doctors, nurses, auxiliaries and counselors.

Involvement of women and young people: Specific brochures have been developed for women and girls whereas young males are mobilized through the Botswana National Youth Council.

Procurement and supplies: The main challenges are difficulty in forecasting and inadequate monitoring of commodities and supplies.

Innovations

Male circumcision devices: AccuCirc device for infants has been evaluated.

Human resource innovations: MOVE is used.

Communication

Communication strategy: A communication strategy has been in place since 2009.

Media and social network: TV adverts, radio jingles and newspaper inserts are used for communication.

Demand creation strategies: Community mobilization is done through champions, edutainment, interpersonal communication and use of gatekeepers.

Resource mobilization

Funding sources: Government of Botswana and development partners.

Global Fund: No Global Fund grant currently.

Monitoring and evaluation

M&E systems: M&E system is in place providing disaggregated data by (age, sex, HIV status and adverse events data).

¹¹ * Source for population data: State of the World Population 2011. UNFPA, New York, USA

** Source for HIV prevalence and MC at baseline data: *Botswana AIDS Impact Survey III* (BAIS III, 2008)

Coordination and accountability

Coordination mechanism: VMMC task force is in place to provide a platform for coordination of partners.

Partners: WHO; UNAIDS; African Comprehensive HIV/AIDS Partnership; PEPFAR; I-Tech; Jhpiego; PSI; Tebelopele VCT centre; UN agencies; Botswana Harvard Partnership

Best/good practices

- Use of school holidays for targeted campaigns
- Liaising with traditional leadership to incorporate VMMC during initiation ceremonies for boys as they enter adulthood

Challenges

- Human resource constraints
- Poor logistics management leading to long delays in procurement of equipment and kits
- Weak coordination of services
- Space constraints are impeding implementation of MOVE

Opportunities

- Strong political will and support from the government
- Strong financial and technical support from development partners
- Sound HIV prevention programmes
- Good health infrastructure

Future plans

- Strengthen coordination at national and district levels
- Strengthen procurement of equipment, supplies and kits
- Consider volunteer programme
- Strengthen community involvement and interpersonal communication
- Carry out benchmarking visits to observe implementation of MOVE and use of the elastic ring controlled radial compression male circumcision device called PrePex.

ETHIOPIA¹²

Profile

1. Population: 84.7 million (2011)*
2. Adult HIV prevalence: 1.5% (2005)**
3. MC at baseline: 93% (2005)**
4. MC 80% target in Gambella Province: 40,000
5. Total number MCs: 2008–2011: 11,000

Leadership and advocacy

Leadership: No VMMC champions but a national Ministry of Health VMMC focal person is at post.

Advocacy: Advocacy and communication strategy is still being developed.

Country implementation

Operational planning: National strategy in place since 2009.

Service delivery approach: Static and outreach services. Male circumcision is integrated into infant programmes. Neonatal male circumcision is almost universal in Ethiopia except in Gambella Province and to a lesser extent in Southern Nations, Nationalities and People's Region (SNNPR).

Task shifting policy: There is no policy on task shifting.

Service delivery statistics: Total male circumcisions performed by December 2011: 11,000. Age disaggregated data is not available.

Adverse events rate: < 0.5%.

Quality assurance (QA): QA plan is available.

Capacity building: Cadres trained are doctors, nurses, health officers and programme directors.

Involvement of women and young people: Women involved when married clients are counseled. Young people aged 15–24 years are targeted for service delivery.

Procurement and supplies: Main challenges are long procurement procedures to import medical supplies and shortage of local medical supplies for VMMC.

Innovations

Human resource innovations: MOVE and task shifting are used.

Communication

Communication strategy: A communication strategy is still being developed.

Media and social network: TV and local radio are used for communication.

Demand creation strategies: Community mobilization is done through mass media, interpersonal communication through students in the locality, health extension workers in the target communities, and through posters and billboards.

Resource mobilization

Funding sources: Government and development partners.

Global Fund: No Global Fund grant currently.

Monitoring and evaluation

M&E systems: There is a M&E system that is capable of providing disaggregated and adverse events data.

Coordination and accountability

Coordination mechanism: Male circumcision task force is in place but needs revitalization.

Partners: WHO, PEPFAR, Global Fund; World Bank

Best/good practices

- Established a neonatal male circumcision system for cultural and religious reasons
- Effective counseling and testing system
- Task shifting and task sharing implemented
- Use of local radio in local language for demand creation

¹² * Source for population data: State of the World Population 2011. UNFPA, New York, USA

** Source for HIV prevalence and MC at baseline data: Ethiopia Demographic and Health Survey, 2005.

Challenges

- Human resource constraints
- Inadequate funding for demand creation, especially to address myths among adults in Gambella region
- Inadequate infrastructure and equipment i.e. space, electricity for equipment sterilization and disposable male circumcision kits
- Nationally there is lack of reliable male circumcision data disaggregated by region
- Scattered population in Gambella region

Opportunities

- Leadership commitment
- Task shifting is practiced
- Inclusion of male circumcision within the comprehensive national HIV prevention strategies
- Presence of established community conversation sessions
- Availability of government 'villagization' programme, pulling scattered populations together
- Almost universal practice of neonatal male circumcision in other regions of Ethiopia except Gambella

Future plans

- Conduct outreach and mobile services
- Address infrastructure challenges
- Conduct situation assessment of unmet need for male circumcision countrywide
- Provide male circumcision services in second region – SNNPR

KENYA¹³

Profile

1. Population: 41.6 million (2011)*
2. Adult HIV prevalence: 6.3% (2009)**
3. MC at baseline: 86% (2007)#
4. Adult MC 94% target: 860,000
5. Total number MCs 2008–2011: 391,483

Leadership and advocacy

Leadership: There are national and local VMMC champions and a national Ministry of Health VMMC focal person is at post.

Advocacy: Advocacy strategy is in place.

Events to support VMMC include stakeholder meetings to lobby for support from the community and training of journalists to ensure accurate reporting on VMMC.

Country implementation

Operational planning: Strategic plan covers 2008–2013, with the aim of circumcising 860,000 men aged 15–49 years, mainly in four provinces.

Service delivery approach: Static/fixed sites, outreach sites, mobile sites, moonlight male circumcision sites and mass campaigns. VMMC is not currently integrated into infant programmes.

Service delivery statistics: Cumulative male circumcisions by December 2011: 391,483.

Adverse events rate: 2%

Task shifting policy: VMMC has been fully task shifted to clinical officers and nurses. Once trained, they can perform or assist in the surgical procedure. This policy is reflected in the VMMC policy guidance document, strategy, surgical manual and training materials.

Quality assurance (QA): Facility-based internal QA and annual external QA are in place.

Capacity building: Main categories of staff trained are doctors, clinical officers, nurses and HIV testing counselors.

Involvement of women and young people: Women and young people are involved as mobilizers, service providers and satisfied clients (boys).

Procurement and supplies: There have been no major challenges.

Innovations

Male circumcision devices: Safety and acceptability studies have been undertaken for Alisklamp and Shang Ring. Further studies are ongoing for Shang Ring. There are plans to do a study on the Prepex device.

Human resource innovations: Task sharing and task shifting are practiced.

Communication

Communication strategy: A communication strategy is in place.

Media and social network: Media organizations run campaigns, mainly on FM radio stations with large listenership. Road shows/caravans to sensitize communities on VMMC are also conducted. Journalists have also been trained on factual reporting on VMMC.

Demand creation: Community mobilization is done through stakeholder meetings, community meetings, churches and other social gatherings like women's groups meetings. Influential elders in the community are also used to mobilize communities. Students in secondary schools are also mobilized. Most community-based organizations have been sensitized to subsequently inform their members.

Resource mobilization

Funding sources: Government and development partners.

Global Fund: No Global Fund grant currently.

Monitoring and evaluation

M&E systems: M&E system in place providing disaggregated and adverse events data.

Coordination and accountability

¹³ * Source for population data: State of the World Population 2011. UNFPA, New York, USA

**Source for HIV prevalence data: Kenya Demographic and Health Survey, 2009.

#Source for MC at baseline data: Kenya AIDS Impact Survey, 2007.

Coordination mechanism: National and provincial task forces that provide partner coordination are in place.

Partners: The Male Circumcision Consortium (Family Health International, University of Illinois and Engender Health); Nyanza Reproductive Health Society; Impact Research and Development; Marie Stopes International; International Medical Corps; AIDS, Population and Health Integrated Assistance; (Engender Health; PATH; PSI); UNICEF; PEPFAR; WHO; UNAIDS; Gates Foundation and the World Bank

Best/good practices

- Implementation of task shifting, which has resulted in many men accessing services
- Strong government leadership and political will
- Many sites – bringing services closer to the people
- Very flexible and innovative programme, allowing partners to continuously discover new approaches (such as the moonlight services)

Challenges

- Reliance on PEPFAR funding
- Slow progress in achieving national target: currently in three provinces, but focus remains on one province – Nyanza Province
- Delay in full integration of male circumcision into routine services
- Availability of medical circumcision services and their quality in circumcising populations needs attention
- Reaching the older population in the target age group of 15–49 years remains a challenge. The unmarried 15–19 year-olds present more readily for male circumcision
- Coordination of male circumcision still remains largely with National AIDS and STI Control Programme (NASCOP). The Departments of Surgery and Reproductive Health who routinely provide surgical and reproductive health have not fully come onboard

Opportunities

- Task shifting fully implemented
- High scale-up rate
- PEPFAR funding
- Strong research agenda with funding from the Gates Foundation

Future plans

- Diversify funding sources – government financial input needed
- Mid-term review of current strategy
- Full integration of male circumcision into routine services
- Address availability and quality of services among circumcising communities
- Implement WHO guidance on male circumcision devices when received
- Strengthen participation of surgery and reproductive health departments in national coordination

LESOTHO¹⁴

Profile

1. Population: 2.2 million (2011)*
2. Adult HIV prevalence: 23% (2009)**
3. MC at baseline: 17.7% (2009)
4. Adult 80% MC target: 376,795
5. Total number MCs: 2008–2011: No data available

Leadership and advocacy

Leadership: There is no VMMC champion but a national Ministry of Health VMMC focal person is at post.

Advocacy: No advocacy strategy.

Country implementation

Operational planning: 2009 strategy will be reviewed to cover 2012–2016.

Service delivery approach: Integrated services, outreach services envisaged.

Service delivery statistics: There is no data for 2011.

Adverse events rate: Not yet known.

Task shifting policy: There is no policy on task shifting.

Quality assurance (QA): QA plan being developed.

Capacity building: Doctors, nurses and counselors trained.

Involvement of women and young people: None for 2011.

Procurement and supplies: Plan for procurement and supply management is not yet developed.

Innovations

Male circumcision devices: No work in this area during 2011.

Human resource innovations: No work in this area during 2011.

Communication

Communication strategy: No communication strategy.

Media and social network: Not yet used for communication.

Demand creation: Not yet implemented.

Resource mobilization

Funding sources: Government and development partners.

Global Fund: Included in Global Fund Round 8 grant.

Monitoring and evaluation

M&E systems: There is an M&E system but adverse events data is not currently analyzed.

Coordination and accountability

Coordination mechanism: Male circumcision focal person and task force are in place and provide partner coordination.

Partners: JHPIEGO, PSI, PEPFAR, WHO, UNAIDS, UNICEF, UNFPA

Best/good practices

None at the moment.

Challenges

- Low level of buy-in by key stakeholders
- Human resources – no task shifting
- Campaigns may antagonize traditional circumcisers
- Grassroots advocacy and community mobilization not yet done

Opportunities

- Political will and country ownership of the male circumcision programme;
- Senior Ministry of Health management has pledged to support male circumcision scale-up, providing clear direction to partners

¹⁴ * Source for population data: State of the World Population 2011. UNFPA, New York, USA

**Source for HIV prevalence and MC at baseline data: Lesotho Demographic and Health Survey, 2009.

- USAID and PEPFAR financing male circumcision scale-up
- WHO and other UN agencies involved in male circumcision activities
- Interest from partners like the Gates Foundation to provide resources to support male circumcision

Future plans

- Resource mobilization
- Advocacy to engage traditional initiators
- Identify male circumcision champion for district male circumcision advocacy
- Develop strategies to address HR concerns since task shifting for adult male circumcision not yet agreed to
- Consider task shifting for neonatal and early infant male circumcision
- WHO to facilitate holding of male circumcision stakeholder meeting

MALAWI¹⁵

Profile

1. Population: 15.4 million (2011)*
2. Adult HIV prevalence: 10.6% (2010)**
3. MC prevalence at baseline: 21% (2010)#
4. Adult 80% MC target: 2,101,566
5. Total number MCs 2008–2011: 15,000

Leadership and advocacy

Leadership: There is no VMMC champion but a national Ministry of Health VMMC focal person is at post.

Advocacy: Advocacy strategy is in place. Events to support VMMC include a national campaign launch presided over by the Minister of Health.

Country implementation

Operational planning: Five-year strategic plan (2011–2016)

Service delivery approach: Static and outreach (mobile) services using efficiency models to maximize volumes, especially during campaigns. VMMC not yet integrated into infant programmes.

Service statistics: Total male circumcisions performed by Dec. 2011: 15,000.

Adverse events rate: <2%.

Task shifting policy: There is no task shifting policy.

Quality assurance (QA): There is a QA plan.

Capacity building: Registered nurses and clinical officers have

been trained.

Involvement of women and young people: Women and young people were involved through a consultation process.

Procurement and supplies: All items are to be procured through a pool (USAID). The main challenge is that planned procurement of VMMC essential items not yet effected and this has affected trainings and scale up in some areas.

Innovations

Male circumcision devices: No report on any device studies.

Human resources innovations: Implementation of task shifting to clinical officers and registered nurses and task sharing for other less complicated tasks to be done by lower cadres, i.e. attendants, nurse aids, health surveillance assistants and medical assistants.

Communication

Communication strategy: Communication strategy in place.

Media and social network: Use of live radio debates, public lectures and community film.

Demand creation: Use of radio stations, live debates, public lectures, community mobilization campaigns, community filming, use of traditional leaders, use of the churches, and involvement of civil society to a lesser extent.

Resource mobilization

Funding sources: Government and development partners.

Global Fund: No Global Fund grant for male circumcision currently.

Monitoring and evaluation

M&E systems: M&E system that is capable of collecting data on adverse events is available.

Coordination and accountability

Coordination mechanism: Task force is in place.

¹⁵ * Source for population data: State of the World Population 2011. UNFPA, New York, USA

**Source for HIV prevalence data: Malawi Demographic and Health Survey, 2010.

#Source for MC at baseline data: MC Situation Analysis, 2010

Partners: WHO, UNAIDS, UNICEF, UNFPA, World Bank, Christian Health Association of Malawi, PEPFAR, PSI, Banja La Mtsogolo, Jhpiego

Best/good practices

- Involvement of religious leaders
- Engaging traditional leaders in community mobilization is a useful tool to create a good referral system
- Public lectures on VMMC are a good tool for community mobilization since these involve interaction

Challenges

- Funding is mainly from PEPFAR. No Global Fund finances. Equipment and kits are inadequate. This has led to a downward revision of male circumcision target figures
- Human resources
- Cultural barriers in non-circumcising communities
- Difficult access to male circumcision services because of a mainly rural population
- Older men not presenting for male circumcision

Opportunities

- Good referral linkage between hospitals and traditional initiators in circumcising communities
- Political will from the Office of President, Cabinet and NAC
- Good support from implementing partners
- Strong stakeholder buy-in i.e. traditional leaders, members of Parliament and military medical services
- Traditional leaders have been sensitized and their input included in policy documents
- Task shifting to lower cadres

Future plans

- Resource mobilization
- Demand creation strategies for older men
- Involvement of women in VMMC
- Strengthen M&E system
- Ascertain prevalence of partial male circumcision in the country
- Carry out male circumcision cost and impact analysis

MOZAMBIQUE¹⁶

Profile

1. Population: 23.9 million (2011)*
2. Adult HIV prevalence: 11.5% (2009)**
3. MC prevalence at baseline: 52% (2009)**
4. Adult 80% MC target: 1,059,104
5. Total number MCs 2008–2011: 37,325

Leadership and advocacy

Leadership: There is no VMMC champion but a national Ministry of Health VMMC focal person is at post.

Advocacy: The advocacy strategy has been oriented towards getting political commitment and support for VMMC services. No specific national events have been used to support VMMC.

Country implementation

Operational planning: Operational plan 2010–2012.

Service delivery approach: VMMC services are delivered at selected health facilities to clients on a first-come-first-served basis. Male circumcision is not yet integrated into infant programmes.

Service delivery statistics: Total male circumcisions by December 2011: 37,325.

Adverse events rate: <2%.

Task shifting policy: No task shifting policy but specifically trained nurses are providing male circumcision services.

Quality assurance: There is no QA plan.

Capacity building: Registered nurses with surgical background have been trained.

Involvement of women and young people: Women and young people are not involved in a structured way.

Procurement and supplies: Main challenge is delays in procurement of VMMC commodities.

Innovations

Male circumcision devices: No work underway in 2011.

Human resources innovations: Task shifting to nurses.

Communication

Communication strategy: No communication strategy in place.

Media and social network: Not used.

Demand creation: Community mobilization through NGOs.

Resource mobilization

Funding sources: Government and development partners.

Global Fund: No Global Fund grant for male circumcision.

Monitoring and evaluation

M&E systems: There is an M&E system that tracks adverse events.

Coordination and accountability

Coordination mechanism: Male circumcision task force is in place.

Partners: PEPFAR, PSI, WHO, UNAIDS, UNICEF, UNESCO, Jhpiego

Best/good practice

None.

Challenges

- Insufficient funding
- Weak coordination and collaboration, involvement of NAC

¹⁶ * Source for population data: State of the World Population 2011. UNFPA, New York, USA

** Source of data for Adult HIV prevalence and male circumcision prevalence at baseline: *Population-based HIV Sero-Behavioral Survey*, MoH-INE 2009 (INSIDA 2009)**

- Weak M&E system
- No male circumcision policy, strategy and operational plan
- Inadequate prioritization of specific populations

Opportunities

- Mozambique has conducted a successful pilot study of scaling up VMMC in four provinces demonstrating feasibility and cost implications
- Support of many partners, including PEPFAR, who finance male circumcision in four pilot provinces
- Ministry of Health staff (nurses) were trained in VMMC in the four pilot provinces demonstrating therefore that task shifting for male circumcision is feasible
- Demand and acceptability of male circumcision are high, especially among youth and young adults as demonstrated by the results of the pilot study

Future plans

- Advocacy for better commitment to male circumcision from political leaders and development partners
- Develop male circumcision policy, strategic plan, QA plan and M&E system
- Include male circumcision in national HIV plans and solicit government funding for male circumcision
- Provide catalytic funding to WHO Country Office for providing technical support and coordination to mainstream VMMC in national, provincial and district health plans of action

NAMIBIA¹⁷

Profile

1. Population: 2.3 million (2011)*
2. Adult HIV prevalence: 13.5% (2011)**
3. MC prevalence at baseline: 21% (2007)#
4. Adult 80% MC target: 330,218
5. Total number of MCs 2008–2011: 8,110

Leadership and advocacy

Leadership: There are VMMC champions and a national Ministry of Health and Social Services VMMC focal person is at post.

Advocacy: Advocacy strategy is available.

Country implementation

Operational planning: A national strategy is still being finalized and not yet costed.

Service delivery approaches: Static sites within health facilities and small-scale campaigns. VMMC not yet integrated into infant programmes.

Services deliver statistics: Cumulative male circumcisions by December 2011: 8,110

Adverse events rate: Moderate = 2%, severe = 1%.

Task shifting policy: Registered nurses have started performing VMMC but this is not yet been adopted as a policy.

Quality assurance (QA): QA plan is available.

Capacity building: Categories of staff trained are doctors, nurses and community counselors.

Involvement of women and young people: Women and young people have been involved through media, school programmes, group health education and community mobilization.

Procurement and supplies: No procurement challenges so far.

Innovations

Male circumcision devices: No work in this area during 2011.

Human resource innovations: Efforts are underway to shift the task of VMMC to registered nurses in order to increase coverage. One dedicated team has been established and it has started supporting district hospitals to undertake VMMC through small-scale campaigns.

Communication

Communication strategy: A communication strategy is in place.

Media and social network: Electronic and print media.

Demand creation strategies: Community mobilization through focus group discussions, one-on-one talks, group education by Nawalife Trust; media (music motivating and educating public on the benefits of male circumcision) IEC materials in different local languages.

Resource mobilization

Funding sources: Government and development partners.

Health Insurance: VMMC in the private sector is covered by health insurance.

Global Fund: No Global Fund grant currently.

Monitoring and evaluation

M&E systems: VMMC reporting is not integrated. Data is collected separately, however it provides disaggregated data including adverse events information.

Coordination and accountability

Coordination mechanism: Male Circumcision Technical Working Group is in place and provides advice and guidance to the VMMC programme and facilitates the coordination of partners.

Partners: WHO, UNAIDS, PEPFAR, Intra Health, I-Tech, PSI and other civil society organizations

¹⁷ * Source for population data: State of the World Population 2011. UNFPA, New York, USA

**Source for HIV prevalence data: Spectrum, 2011.

#Source for MC at baseline data: Namibia Demographic and Health Survey, 2006/7.

Best/good practices

- HIV testing rate is >95% for all male circumcision clients
- Outreach services, which are effective in reaching clients in hard-to-reach areas

Challenges

- Human resources
- Staff retention – no budget for paying nurses for additional male circumcision skills
- Lack of funding for campaigns and volunteer programme

Opportunities

- Male circumcision focal point at national level
- Task shifting – nurses trained but task shifting not yet approved by the Ministry of Health (discussions still underway). Doctors supervise trained nurses when they perform male circumcision

Future plans

- Resource mobilization
- Organize volunteer programme
- Address human resource issues including task shifting
- Engage partners to help scale up male circumcision

RWANDA¹⁸

Profile

1. Population: 10.9 million (2011)*
2. HIV prevalence: 3.0% (2010)**
3. MC prevalence at baseline: 12.0% (2005)#
4. Adult 80% MC target: 1,746,052
5. Total number of MCs 2008–2011: 26,694

Leadership and advocacy

Leadership: There is a VMMC champion and a national Ministry of Health VMMC focal person is at post.

Advocacy: Advocacy and communication strategy is in place. Events to support VMMC include national community work (*Umuganda*) done every month end.

Country implementation

Operational planning: There is a national plan for 2010–2012.
Service delivery approach: Integrated approach, however not yet integrated into infant services.

Service delivery statistics: Total male circumcisions performed by December 2011: 26,694.

Adverse events rate: <1%.

Task shifting policy: There is a policy on task shifting to nurses.

Quality assurance (QA): A QA plan is available.

Capacity building: Staff trained on VMMC are doctors and

nurses.

Involvement of women and young people: Tools targeting women and young people have been developed. These tools include IEC materials such as flipcharts to be distributed to all villages and health facilities countrywide.

Procurement and supplies: The main challenges are difficulty in forecasting and inadequate monitoring of commodities and supplies.

Innovations

Male circumcision devices: Prepex device for adult male circumcision has been evaluated in Rwanda.

Human resource innovations: Use of MOVE and weekend outreach services.

Communication

Communication strategy: A communication strategy is in place.

Media and social network: National TV, radio stations and online avenues are used for communication. These include newspapers and web-based media outlets, e.g. Igihe.com and Umuganga.com

Demand creation: Community mobilization through collaboration with community health workers and civil society/private sector.

Examples include:

- Working with local NGOs to conduct door-to-door campaigns
- Training/capacity development of community health workers to address misconceptions and rumours
- Orientation of media personnel (electronic and print)
- Social mobilization including sensitization of community leaders
- Use of mass media including radio spots, town hall meetings, radio discussions, episodes on Urunana Radio Drama, Umuhoza Radio magazine and popular programmes
- Selecting and using communication materials
- Role play and simulation

Resource mobilization

Funding sources: Government and development partners.

Global Fund: Global Fund grant for VMMC is currently ongoing.

¹⁸ * Source for population data: State of the World Population 2011. UNFPA, New York, USA

**Source for HIV prevalence data: Rwanda Demographic and Health Survey, 2010.

#Source for MC at baseline data: Rwanda Demographic and Health Survey, 2005

Monitoring and evaluation

M&E systems: M&E system in place providing disaggregated and adverse events data.

Coordination and accountability

Coordination mechanism: MC Task Force is in place and provides coordination and partnerships.

Partners: WHO, UNAIDS, UNICEF, PEPFAR, Global Fund, Jhpiego, civil society organizations, especially youth groups

Best/good practices

- Monitoring and evaluation tool TRACnet, which is used to report on male circumcision indicators and weekend provision of services to increase male circumcision uptake and meet the demand.

Challenges

- Insufficient funding
- Limited equipment and supplies
- Human resource constraints
- Transport challenges for clients
- Lack of male circumcision communication strategy

Opportunities

- Strong political will
- Community engagement to influence behavioural change and existence of decentralised community network
- Availability of hotline to answer questions on male circumcision and HIV in general

Future plans

- Develop male circumcision communication strategy
- Intensify resource mobilization
- Address quality of services
- Strengthen M&E system
- Increase private sector involvement
- Conduct exchange visits to countries that have successfully rolled out male circumcision
- Scale up use of PrePex male circumcision device

SOUTH AFRICA¹⁹

Profile

1. Population: 50.5 million (2011)*
2. HIV prevalence: 18.0% (2009)**
3. MC prevalence at baseline: 42.0% (2009)#
4. Adult 80% MC target: 4,333,134
5. Total number of MCs 2008–2011: 442,201

Leadership and advocacy

Leadership: There are VMMC champions and a national Ministry of Health VMMC focal person is at post.

Advocacy: There is a communication and advocacy strategy. Events used to support VMMC include HIV counseling and testing campaigns and World AIDS Day commemoration.

Country implementation

Operational planning: 2012–2016 National Strategic Plan for HIV, AIDS, STI and TB has a very strong male circumcision component.

Service delivery approaches: Integrated; stand-alone high volume sites; camps and roving teams. VMMC is not yet integrated into infant programmes.

Service delivery statistics: Total male circumcisions performed by December 2011: 442,201.

Adverse events rate: <3%.

Task shifting policy: There is a policy on task shifting but not yet implemented for VMMC service provision.

Quality assurance (QA): QA plan in place.

Capacity building: Categories of staff trained on male circumcision are doctors, nurses and lay counselors.

Involvement of women and young people: Women and young people are involved through national communication strategies, schools and mass media.

Procurement and supplies: No challenges in procurement of equipment and commodities so far.

Innovations

Male circumcision devices: No work in this area during 2011.

Human resource innovations: MOVE approach.

Communication

Communication strategy: A communication strategy is in place.

Media and social network: TV adverts, radio talk shows, billboards, TV serials/drama (Soul City), text message system, Brothers for Life website, Facebook (Soul City).

Demand creation: Community mobilization through community outreach teams, partnering with NGOs, in clinic facilitation, school-based interventions.

Resource mobilization

Funding sources: Government and development partners.

Global Fund: Global Fund grant Round 10 has been approved for VMMC.

Monitoring and evaluation

M&E systems: M&E system in place providing disaggregated data and adverse events data.

Coordination and accountability

Coordination mechanism: VMMC Task Force is in place.

Partners: UN agencies; PEPFAR; Global Fund; Centre for HIV and AIDS Prevention Studies, Anova Health; Johns Hopkins Health and Education South Africa; Jhpiego; Maternal, Adolescent and Child Health;

¹⁹ * Source for population data: State of the World Population 2011. UNFPA, New York, USA

**Source for HIV prevalence data: Department of Health, 2010. National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2009.

#Source for MC at baseline data: (NCS) Second National HIV Communication Strategy. 2009

Right To Care; Southern African Clothing and Textile Workers' Union; Provincial Health and Research Unit; Centre for the AIDS Programme of Research in South Africa; Soul CITY; Aurum Institute; Foundation for Professional Development; Catholic Medical Mission Board; McCord Hospital; St Mary's Hospital.

Best/good practices

- Integration of traditional and medical circumcision
- The Lesedi project – combining community media social mobilization with service delivery using a public/private partnership
- Use of roving mobile teams for high volume high quality male circumcisions in hard-to-reach areas
- School camps during the school holidays

Challenges

- Concerns about waste management associated with disposable male circumcision kits
- Human resource constraints
- Weak M&E system

Opportunities

- National Strategic Plan for HIV, AIDS, STI and TB 2012–16 has a very strong component for scaling up male circumcision
- Male circumcision is a national priority for HIV prevention
- Strong political will and commitment – government allocated substantial five-year budget for male circumcision
- Additional funds from Global Fund
- Strong private/public partnership for male circumcision
- Strong involvement of UN, NGOs, civil society and major companies in South Africa in the male circumcision campaign
- Collaboration with traditional circumcisers in some provinces

Future plans

- Strengthening of the adverse events surveillance system
- Develop strategies for health system and traditional circumcisers to work together
- Prioritize neonatal male circumcision

SWAZILAND²⁰

Profile

1. Population: 1.2 million (2011)*
2. Adult HIV prevalence: 26% (2007)**
3. MC prevalence at baseline: 8.2% (2007)#
4. Adult 80% MC target: 183,450
5. Total number MCs 2008–2011: 38,106

Leadership and advocacy

Leadership: There are national and local VMMC champions and a national Ministry of Health VMMC focal person is at post.

Advocacy: Advocacy and communication strategy is in place. Events to support VMMC include the launch of the Soka Uncobe campaign by King Mswati III, thus fully endorsing male circumcision for Swazis ii) Trade Fair held in August/September; iii) Soccer matches with soccer players acting as champions for youth iv) Ministry of Health public events such as launches of various documents and annual MTN Swaziland bushfire festival.

Country implementation

Operational planning: National Strategic Plan for the period 2009–2013

Service delivery approaches: Free standing facilities, health facility-based and outreach to communities. One sugar company provides VMMC services to its employees. MC services are integrated into infant programmes.

Service delivery statistics: Total male circumcisions performed by December 2011: 38,106.

Adverse events rate: <5%.

Task shifting policy: There is a draft policy on task shifting.

Quality assurance (QA): QA plan is in place.

Capacity building: Categories of staff trained are doctors, nurses, counselors and expert clients (people living with HIV who counsel clients for HIV testing and counseling).

Involvement of women and young people: Women are involved in supporting partners and children who come for VMMC. Young people take part in IEC during back-to-school programmes.

Procurement and supplies: No major procurement and supply challenges.

Innovations

Male circumcision devices: No work in this area in 2011

Human resource innovations: Use of MOVE and weekend outreach services. Only doctors currently perform adult VMMC while midwives in a few hospitals have been trained to perform infant male circumcisions.

Communication

Communication strategy: A communication strategy in place.

Media and social network: These include use of TV, newspapers, weekend events at shopping malls (where music session is followed by education talks) and use of interpersonal communication agents.

Demand creation: Community mobilization through interpersonal communication agents, road shows at shopping malls and competitions.

Resource mobilization

Funding sources: Government and development partners. Private sector involvement through sugar companies providing VMMC services to employees.

Global Fund: No Global Fund grant for VMMC.

Monitoring and evaluation

M&E systems: M&E system is in place providing disaggregated data and adverse events data

²⁰ * Source for population data: State of the World Population 2011. UNFPA, New York, USA

**Source for HIV prevalence data: Swaziland Demographic and Health Survey, 2007.

#Source for MC at baseline data: Futures Group Costing Study, 2007.

Coordination and accountability

Coordination mechanism: Male circumcision focal person, male circumcision technical working group and Male Circumcision Technical Advisor are in place.

Partners: WHO, UNICEF, UNAIDS, PEPFAR, Family Life Association of Swaziland; male circumcision partnership (PSI, Jhpiego, Marie Stopes Swaziland, Population Council and Futures Group).

Best/good practices

School boys' VMMC programme targeting 15–21 year-old boys without interfering with schooling.

Challenges

- Human resource capacity
- Poor uptake by 15–49 year olds with 15 percent declining HIV testing and counselling
- Infrastructural challenges
- Poor rural coverage

Opportunities

- Availability of support by partners including UN Agencies, PEPFAR and NGOs
- Generous allocation of financial and material resources during the male circumcision campaign
- Lack of competition from traditional male circumcision practitioners

Future plans

- Develop culturally sensitive, socially acceptable social mobilization messages to overcome resistance to male circumcision
- Adopt strategies to increase rural coverage
- Adopt task sharing/shifting approaches and all doctors to be trained to perform male circumcision procedures
- Integrate both adult and neonatal male circumcision into health facilities

TANZANIA²¹

Profile

1. Population: 46.2 million (2011)*
2. Adult HIV prevalence: 5.7% (2008)**
3. MC at baseline: 70% (2008)**
4. Adult 80% MC target: 1,373,271
5. Total number MCs 2008–2011: 139,320

Leadership and advocacy

Leadership: There is no VMMC champion but a national Ministry of Health VMMC focal person is apst.

Advocacy: Events used to support VMMC include coordination meetings of the national technical working group. The Ministry of Health conducted sensitization meeting with policy and decision makers in the 8 priority regions.

Country implementation

Operational planning: A National Strategic Plan for period 2010–2015

Service delivery approaches: These include services provided at static health facilities, mobile services for hard to reach communities and male circumcision campaigns using mobile services and temporary camps. VMMC services are currently not integrated into infant programmes but plans are underway.

Service delivery statistics: Total male circumcisions by December 2011: 139,320.

Adverse events rate: <2%.

Task shifting policy: There is no policy on task shifting but lower

cadres than doctors (clinical officers and nurses) have been allowed to do male circumcision surgery after training and under supervision by doctors in their sites.

Quality assurance (QA): There is a quality improvement guideline and training package for HIV but training has not yet been rolled out for VMMC due to lack of funds.

Capacity building: Categories of staff trained are assistant medical officers, clinical officers (medical assistants), clinical assistants (rural medical aids) and nurses.

Involvement of women and young people: No specific involvement of women. Young people are represented in VMMC working groups.

Procurement and supplies: The main challenge is erratic supplies and shortages of commodities especially when partners have not provided financial support.

Innovations

Male circumcision devices: Some partners have approached the Ministry of Health to introduce use of male circumcision devices, but no device is yet prequalified by WHO.

Human resource innovations: Use of MOVE, training of lower cadres to perform VMMC and providing incentives to male circumcision teams when working extra hours and holidays. Nurses and clinical officers are allowed to perform male circumcision after training.

Communication

Communication strategy: VMMC is included in the HIV/AIDS communication strategy.

Media and social network: Media and social network are not used for communication

Demand creation strategies: Community mobilization through involvement of some churches and political leaders.

Resource mobilization

Funding sources: Government and development partners, mainly PEPFAR.

Global Fund: No Global Fund grant has been secured for VMMC.

Monitoring and evaluation

M&E systems: M&E system in place providing disaggregated and adverse events data. Still needs to be rolled out for partners and implementers to use.

Coordination and accountability

²¹ * Source for population data: State of the World Population 2011. UNFPA, New York, USA

** Source of data for Adult HIV prevalence and male circumcision prevalence at baseline: *Tanzania HIV and Malaria Indicator Survey* (THMIS) 2007/08.

Coordination mechanism: VMMC task force is in place.

Partners: National Institute for Medical Research, WHO, PEPFAR, UNICEF, Jhpiego, Association of Private Hospitals.

Best/good practices

- Periodic campaigns using male circumcision camps.

Challenges

- Human resource constrains – health sector has serious shortage of staff – operating at about 40 percent of the required number
- Non-use of male circumcision services by older men above 24 years of age
- Insufficient funding including lack of funds to support two of the eight priority regions
- Lack of clear guidance from WHO on use of male circumcision devices
- M&E system – partners have parallel M&E systems

Opportunities

- Supportive leadership at national, regional, district, ward, village and health facilities
- Acceptability of male circumcision is generally high, even in groups where male circumcision was not part of their tradition – no anti-male circumcision groups
- Task shifting to clinical officers and nurses
- PEPFAR partners provide support

Future plans

- Appoint male circumcision focal point in Ministry of Health
- Diversify funding sources – mobilize internal resources
- Seek financial support for rolling out harmonized M&E tools
- Implement WHO guidance on use of male circumcision devices

UGANDA²²

Profile

1. Population: 34.5 million (2011)*
2. Adult HIV prevalence: 6.4% (2005)**
3. MC prevalence at baseline: 25% (2005)**
4. Adult 80% MC target: 4,245,184
5. Total number MCs 2008–2011: 98,828

Leadership and advocacy

Leadership: There is no VMMC champion or national Ministry of Health VMMC focal person.

Advocacy: There is a communication and advocacy strategy. Events to support VMMC include World AIDS Day, Joint AIDS Review, partners' meetings and meetings with parliamentarians

Country implementation

Operational planning: National Strategic Plan for period 2011-2015 is not yet costed.

Service delivery approaches: Static sites, mobile sites and camps.

Services delivery statistics: Total male circumcisions by Dec 2011: 98,828.

Adverse events rate: Data not available.

Quality assurance:(QA): QA plan is not in place.

Task shifting policy: Not available.

Capacity building: Categories of staff trained are doctors, clinical officers, nurses and midwives.

Involvement of women and young people: Working with NGOs to bring women and young people to support VMMC.

Procurement and supplies: Main challenge is funding.

Innovations

Male circumcision devices: Shang ring studies.

Human resource innovations: Task-shifting, allowing nurses and midwives to carry out VMMC.

Communication

Communication strategy: Communication strategy is in place.

Media and social network: There is a very good understanding between media, policy makers and implementers. Civil society implementers carry out a lot of media promotion of VMMC.

Demand creation: Community mobilization by engaging civil society organizations at different levels.

Resources Mobilization

Funding sources: Government and development partners.

Global Fund: No Global Fund grant for VMMC.

Monitoring and evaluation

M&E systems: M&E system is not yet in place to provide disaggregated data and adverse events data at facility level

Coordination and accountability

Coordination mechanism: Male circumcision task force is in place.

Partners: WHO, UNAIDS, UNICEF, UNFPA, PEPFAR, Family Health International, Irish AID, DfID and Makerere University School of Public Health.

Best/good practices

None for now

Challenges

- No national male circumcision programme – projects only

²² * Source for population data: State of the World Population 2011. UNFPA, New York, USA

**Source of data for adult HIV prevalence and male circumcision prevalence at baseline: *Uganda AIDS Indicator Survey*, 2004–05.

- Weak M&E system
- Inadequate human resources and no national Ministry of Health male circumcision focal point
- Facility constraints hampering male circumcision service provision

Opportunities

- Funding available for recruitment of full time male circumcision focal point in the Ministry of Health
- Many partners provide technical and financial support for male circumcision
- Sizable Muslim community that is increasingly having male circumcision procedures performed in health facilities
- UN Joint Team obtained funding from Dfid and Irish Aid to support six districts in implementing combination HIV prevention with male circumcision as one of the biomedical activities where a surgical team and at least one male circumcision facility per district will be established, and piloting of a male circumcision M&E system

Future plans

- Capacity building for male circumcision service providers
- Establish functional M&E system

ZAMBIA²³

Profile

1. Population: 13.5 million (2011)*
2. Adult HIV prevalence: 14.3% (2007)**
3. MC prevalence at baseline: 12.8% (2007)**
4. Adult 80% MC target: 1,949,292
5. Total number MCs 2008–2011: 167,000

Leadership and advocacy

Leadership: There are national HIV champions as well as a VMMC champion (traditional leader Chief Mumena). A national Ministry of Health VMMC focal person is at post.

Advocacy: There is a national HIV communication and advocacy strategy and a VMMC communication and advocacy strategy. Other advocacy platforms include the national HIV prevention convention that took place in November 2011.

Events to support VMMC: Events during school holidays and traditional ceremony events. Other events where male circumcision activities are integrated include national health days such as VCT Day and World AIDS Day.

Country implementation

Operational planning: Strategic plan covers the period 2012–2015 costing at US\$196.4 million.

Service delivery approaches: These include static sites and mobile/outreach services in NGOs, public and private sectors. VMMC is not yet integrated into infant programmes. Early infant male circumcision services available in five static sites.

Task shifting policy: There is a policy on task shifting. Clinical officers and nurses are allowed to conduct male circumcisions.

Service delivery statistics: Total male circumcisions performed by 31 December 2011: 167,000.

Adverse events rate: <1.5%.

Quality assurance (QA): QA plan is in place.

Capacity building: Categories of staff trained are clinical officers, nurses, doctors and medical licentiates (90 percent of those trained are clinical officers and nurses).

Involvement of women and young people: Women are involved through demand generation mobilization and couple counseling. Young people act as peer educators and mobilizers in tertiary institutions.

Procurement and supplies: The main challenge is resources for procurement of kits and commodities.

Innovations

Male circumcision devices: Research has been conducted on the Shang ring male circumcision device.

Human resource innovations: Using staff who are off duty or on leave, especially over weekends.

Communication

Communication strategy: Communication strategy is in place.

Media and social network: TV and radio spots and billboards are used.

Demand creation strategies: Community mobilization is through traditional leaders, religious leaders, community health workers and adherence supporters.

Resource mobilization

Funding sources: Government and development partners.

Global Fund: Global Fund Round 8 Grant was reprogrammed to address some VMMC issues.

Monitoring and evaluation

M&E systems: M&E system in place. It provides adverse events data but does not provide disaggregated data.

Coordination and accountability

Coordination mechanism: VMMC task force is in place.

Partners: University Teaching Hospital; PEPFAR; WHO; male circumcision partnership (Society for Family Health, Jhpiego, Population Council); Zambia Prevention, Care and Treatment; Family Health International;

²³ * Source for population data: State of the World Population 2011. UNFPA, New York, USA

**Source for HIV prevalence and MC at baseline data: Zambia Demographic and Health Survey, 2007.

Marie Stopes International; Churches Health Association of Zambia and Centre for Infectious Disease Research in Zambia.

Best/good practices

None

Challenges

- Insufficient funding of the programme in relation to the targets to be achieved by 2015
- Supply chain management system - lack of commodities in facilities that are not supported by partners
- Limited demand creation - related to strong culture and traditional beliefs
- Male circumcision not traditionally practiced in most parts of the country

Opportunities

- Political will;
- Government commitment with strategic direction
- Trained health workers including the task shifting policy
- Availability of space and infrastructure
- Mobile hospital services and the Community Outreach Programme
- Partners' commitment and resources
- Coordination mechanism is in place

Future plans

- Resource mobilization
- Engagement of community leadership especially the traditional leaders
- National campaigns and rural outreach programmes
- Train more health workers in male circumcision
- Strengthen supply chain management system
- Strengthen M&E system, especially the data management system

ZIMBABWE²⁴

Profile

1. Population: 12,8 million (2011)*
2. HIV prevalence in 2011: 15% (2011)**
3. MC at baseline: 10% (2007)#
4. Adult MC 80% target: 1,912, 595
5. Total number MCs 2008–2011: 50,580

by December 2011: 50,580.

Adverse events rate: <1%.

Quality assurance (QA): QA plan is in place.

Capacity building: Categories of staff trained are nurses, doctors, receptionists and theatre assistants.

Involvement of women and young people: Women are involved in social mobilization to support their partners and children and in advocacy with women activists' groups. Young people mobilize other young people in schools and tertiary institutions e.g. 'Bring a buddy' promotion"; are the main conveyers of male circumcision information to parents and guardians; and they constitute the main target group for the male circumcision programme.

Procurement and supplies: The main challenges are inadequate funding and disposal of used kits.

Innovations

Male circumcision devices: The country is in the process of evaluating the PrePex device for adult male circumcision.

Human resource innovations: Application of the MOVE model in male circumcision service provision.

Communication

Communication strategy: Communication strategy is in place.

Media and social network:

- i) Male circumcision has been branded as a trademark for smart people and mass media is used to communicate benefits of male circumcision by promoting the brand. A song on male circumcision, composed by three popular musicians (two from Zimbabwe, one from Botswana), is being flighted in the media both in the country and in the region.
- ii) Male circumcision champions are used to promote change in social norms and to increase social support for male circumcision among peers.
- iii) Interpersonal communication – to address barriers that cannot be addressed/ discussed through the use of mass media i.e. pain associated with the procedure, abstinence during healing, etc.

Demand creation strategies: Community mobilization is carried out through community leaders, community mobilizers and interpersonal communication.

Resource mobilization

Funding sources: Government and development partners.

Leadership and advocacy

Leadership: There are national VMMC champions and a national Ministry of Health VMMC focal person is at post.

Advocacy: Communication and advocacy strategy is in place. Events used to support VMMC include World AIDS Day and male circumcision campaigns during school holidays.

Country implementation

Operational planning: Strategic plan for 2010–2015. Cost: US\$80 million.

Service delivery approach: Combination of health facility-based services integrated into routine activities; stand-alone male circumcision service sites; outreach and mobile services. VMMC not yet integrated into infant programmes.

Task shifting policy: There is no policy on task shifting.

Service delivery statistics: Total male circumcisions performed

²⁴ * Source for population data: State of the World Population 2011. UNFPA, New York, USA

**Source for HIV prevalence data: Zimbabwe Demographic and Health Survey, 20010/2011

#Source for MC at baseline data: Zimbabwe Demographic and Health Survey, 2007

Global Fund: No Global Fund grant funds for VMMC as the funds earmarked for HIV prevention activities in Round 8 Phase II were reallocated to PMTCT by the Global Fund Technical Review Panel and the Board.

Monitoring and evaluation

M&E systems: M&E system is in place providing disaggregated and adverse events data.

Coordination and accountability

Coordination mechanism: Male circumcision task force is in place.

Partners: WHO; UNFPA; PEPFAR; DfID; PSI; Zimbabwe National Family Planning Council; church organizations; Gates Foundation; University of Zimbabwe; College of Health Sciences

Best/good practices

- The successful application of the MOVE model in service provision.

Challenges

- Insufficient funding – limited equipment and supplies
- No task shifting policy
- Disposal of used male circumcision devices
- Unavailability of a variety of options for male circumcision service provision

Opportunities

- Political and government support for male circumcision
- Local and international partners willing to support male circumcision
- Well-coordinated national response to HIV/AIDS
- Traditionally circumcising communities' willingness to support the male circumcision programme has had a positive effect on the general male population
- Zimbabwe conducting a study to evaluate the effectiveness of the adult male circumcision PrePex device

Future plans

- Resource mobilization;
- Advocate for task shifting policy
- Introduction of male circumcision devices on a larger scale
- Review hours of providing male circumcision services
- Neonatal male circumcision study to commence with support from UNFPA and UNICEF. The country is planning to conduct a pilot of neonatal male circumcision services in 2012.

CHAPTER 4: CHALLENGES, OPPORTUNITIES AND CONCLUSION

Although each of the priority countries had its own specific challenges, this section highlights the main challenges affecting most of the 14 priority countries. There are also opportunities that could be used to rapidly scale up VMMC.

Challenges

Increase in number of male circumcisions performed but only a fraction of target met

Although the priority countries had made good progress in setting the stage and putting in place key elements of programmes for VMMC, an increased pace is needed to reach the desired 80 percent of males circumcised by 2016, and establish sustainable infant and adolescent programmes. The pace of scale-up will affect the HIV prevention benefit. The limited pace of service delivery is affected by the key challenges described below.

Limited demand for VMMC services

Limited demand creation and acceptability of VMMC among older men (above 24 to 29 years of age) was seen across countries. Among older men, social, cultural and employment considerations appeared to affect VMMC uptake. However, in some countries even uptake among young people was a challenge, and at the current pace, reaching the target of 80 percent males circumcised by 2016 may not be achievable. In some countries, cultural and traditional beliefs negatively affected demand.

Human resource constraints

Human resource constraints are among the main barriers to rapid scale-up of VMMC services. Inadequate human resources at all levels of the health system restrict the pace of implementation. This may be compounded by the lack of task shifting policies in the majority (10/14) of the priority countries. Inadequate human resources affect all levels of the health system in most countries. Although experience shows that task shifting to non-physicians is effective and safe, a number of priority countries had still not reviewed and/or revised their policies to allow for more readily available providers to perform VMMC. This is crucial because eleven of the priority countries (Botswana, Ethiopia, Lesotho, Malawi, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda and Zimbabwe) cited limited skilled healthcare personnel as the main bottleneck to the scale-up of VMMC.

Leadership and coordination

In some countries, the lack of a national VMMC focal point in the Ministry of Health restricted overall programme coordination. Although several countries had demonstrated national leadership and coordination of partners, in a few of the priority countries there was still inadequate buy-in from key stakeholders, few or no VMMC champions and weak coordination of partners.

Sustainable funding

Most priority countries depended on partner funding, especially from PEPFAR, the Gates Foundation and to a more limited degree the Global Fund and the UN family for the scale-up of their VMMC services. While the achievement of the goals of catch up will most likely require external sources of funding, the sustained phases of the VMMC programme will need to rely on domestic sources of funding. Funding challenges were cited by nine countries, namely Ethiopia, Kenya, Malawi, Mozambique, Namibia, Rwanda, Tanzania, Zambia and Zimbabwe.

Procurement, supplies, equipment and infrastructure

Four of the 14 priority countries (Botswana, Malawi, Rwanda and Zambia) stated that they had major challenges with procurement and supply management. Shortages and delays in procurement seemed to be common in countries that had sub-optimal planning and forecasting of commodity needs. Substantial investment is still required to improve availability of supplies and equipment to match the expected demand for services. A few countries (Ethiopia, South Africa and Zimbabwe) were also facing problems related to safe disposal of used VMMC kits.

Adequate space for carrying out VMMC services should be available. A few countries (Botswana, Ethiopia, Swaziland and Uganda) faced challenges with having adequate infrastructure for service provision.

Integration into routine services

For long-term programme sustainability, there is need to integrate male circumcision for HIV prevention into routine services, especially early infant care and adolescent services. Most priority countries, however, had not yet put in place plans for integrating male circumcision into their infant care programmes. In a few countries, limited buy-in from reproductive health programmes was noted.

Weak M&E systems

The priority countries were at various stages of putting in place effective M&E systems. However, most countries still had weak M&E systems, hampering the provision of timely, accurate and complete data on the progress of male circumcision service provision. The limited available information on MCs performed by age restricts interpretation and programme decision making. Furthermore, countries are expected to integrate M&E for VMMC into the main M&E systems, in accordance with the 'Three Ones' principle. The five countries that mentioned having major M&E challenges were Ethiopia, Mozambique, South Africa, Tanzania and Uganda.

Opportunities

The priority countries also noted a number of opportunities that could be used to accelerate the pace of service delivery towards the 80 percent male circumcision prevalence target. Some of the opportunities included the following:

Strong political will and leadership

Some countries had shown sustained and strong political leadership, which could be used as examples for other countries where support was more variable. At the regional level, the Champions for an HIV-Free Generation continued showing leadership and were vigorously advocating for VMMC.

Funding and technical support

Many partners remain committed to providing financial and technical support to priority countries in scaling up their VMMC programmes. There is also a window of opportunity for funding through the reprogramming of Global Fund funding.

Innovations

Evidence of the effectiveness and safety of male circumcision devices as an additional method for adolescent and adult male circumcision is expanding. Recommendations regarding the safety of the devices and use in national programmes should be forthcoming from WHO. Devices currently being evaluated would potentially require fewer resources, be usable by non-physicians and be potentially more acceptable to both providers and clients. If such devices are determined to be appropriate for use in medical male circumcision for HIV prevention programmes, service delivery options may be more easily expanded to settings that are geographically closer to men.

Experience in scaling up sound HIV prevention programmes

Most countries have had ample programmatic experiences in scaling up other sound HIV prevention programmes such as PMTCT programmes. Countries can tap into these experiences in scaling up VMMC services.

Partnerships

Many partners, including PEPFAR and the Gates Foundation, are currently supporting the scale-up of VMMC. There is, however, need for more effective coordination and collaboration, with an emphasis on each partner's complementary skills and comparative advantages.

Best/good practices, experiences and operational research

Different countries have various good practices and creative solutions to challenges, which should be shared between countries. Operational research is underway to learn and improve performance of services and programmes.

Conclusion and way forward

The overall pace of the scale-up of VMMC for HIV prevention among the 14 priority countries in East and Southern Africa has increased with more than double the number of male circumcisions performed in 2011 compared to 2010, and more countries moving at an increased pace.

Most priority countries now have the essential elements for scaling up VMMC such as effective leadership, support from partners, plans for scale-up, communication strategies and funding, especially from partners. Several countries have demonstrated that it is possible to reach a large number of men in a few years and provide them with VMMC services.

Substantial challenges, however, still remain with regard to sufficient creation of demand, availability of skilled human resources, adequate supplies, equipment and infrastructure, and effective M&E systems. Innovations learned while implementing, as well as research on new technologies, are providing optimism that the pace can continue to intensify.

Focused actions are required to increase the pace of VMMC service delivery in the coming years towards 80 percent prevalence.

- Strong leadership, advocacy and ownership have been shown to be effective in galvanizing action for accelerated implementation. Leadership and advocacy therefore need to be strengthened at all levels within countries to optimize their effectiveness.
- Enhanced demand creation, which includes community mobilization, coupled with innovative approaches to service delivery, is required to escalate the pace of scale-up.
- Funding for VMMC needs to be sustained from both government sources and partners.
- As programmes expand rapidly, it is imperative to strengthen monitoring and evaluation capabilities to better guide programmes and assure quality. Submission of regular reports on all VMMC services by all implementing partners to the Ministry of Health will ensure coordination and identification of bottle necks.
- There is also need to improve procurement and supply management systems to ensure that commodities and equipment are always available.
- In the long term, the impact of male circumcision on HIV transmission will be sustained through infant male circumcision and adolescent services. Establishment of infant male circumcision programmes and integration of adolescent VMMC services into appropriate settings become essential as the catch-up phase continues to expand.
- There is also a need to conduct well-designed evaluations of the HIV impact, cost-effectiveness and return on investment of VMMC in priority countries. This will help to guide future advocacy and resource allocation for full-scale and sustainable VMMC programmes.