Sustainability Transition Implementation Plan

2019 – 2021

VOLUNTARY MEDICAL MALE CIRCUMCISION

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ACRONYMS

AE	Adverse Events
ASCOP	Accelerated Strategic Costed Operational Plan
ASRH	Adolescent Sexual Reproductive Health
BMGF	Bill and Melinda Gates Foundation
CDC	United States Center for Disease Control
CeSSHAR	Centre for Sexual Health and HIV/AIDS Research
DFID	Department for International Development
DHE	District Health Executive
DHIS2	District Health Information System 2
DQA	Data Quality Assessments
EAMC	Early Adolescent Male Circumcision
EIMC	Early Infant Male Circumcision
EIP	Empathy Immersion Prototyping
EQA	External Quality Audits
GF	The Global Fund
GHSC-PSM	USAID Global Health Supply Chain Program- Procurement and Supply Management
HCD	Human-Centered Design
HR	Human Resources
IQA	Internal Quality Audit
M&E	Monitoring and Evaluation
MOHCC	Ministry of Health and Child Care
MOPSE	Ministry of Primary and Secondary Education
NGO	Non-Governmental Organisation
PHE	Provincial Health Executive
PMD	Provincial Medical Director
PSI	Population Services International
PVO	Provincial VMMC Officer
QA	Quality Assurance
RBF	Results-Based Financing
TTCV	Tetanus Toxoid Containing Vaccine
WHO	World Health Organization
ZACH	Zimbabwe Association of Church Hospitals
ZAZIC	ZACH, ZICHIRE, ITECH Consortium
ZICHIRE	Zimbabwe Community Health Interventions Research Project

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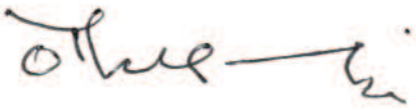


Dr. O. Mugurungi
Director, STI/HIV/AIDS and TB Programmes

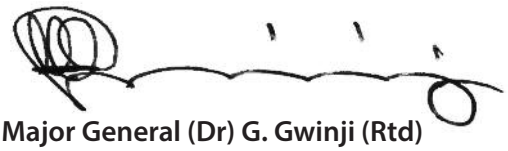
FOREWORD

Zimbabwe has mounted a rigorous comprehensive HIV prevention response that has brought new HIV infections down by an estimated 44% compared to 2010. In 2009, the country adopted Voluntary Medical Male Circumcision as part of its comprehensive HIV prevention package. Initially, uptake of VMMC was low. The country was introducing VMMC in a context where it was not a social norm for the majority of the population so a novel and strategic approach was required to effectively scale-up the program. In 2014, the MOHCC launched the Accelerated Strategic and Costed Operational Plan (ASCOP), a strategy aimed at catalyzing VMMC scale-up through a 'business unusual' approach which emphasized enhancing program coordination, increasing service delivery capacity and innovative demand generation. The result was a steep increase in program outputs that led the country to achieving its scale-up target of 1.3 million MCs.

The country's scale-up goal is to reach 80% VMMC coverage in males aged 10-29 and transition to maintaining the coverage by circumcising early adolescents. While overall progress towards reaching the scale-up goal has been impressive, there is a lot of variation in coverage across districts, some have reached the 80% coverage while others are still far from it. The VMMC program is now in a place where it requires a dual focus on scale-up and maintenance. Maintenance will be long-term and requires the country's VMMC program to be sustainable in order to continue service provision. The goal of this Sustainability Transition Implementation Plan is to lay out a road map of how the country will transition from scale-up programming which has been highly effective but is also unsustainable due to its parallel implementation and high cost.

Through implementation of this plan, we aim to integrate the VMMC program with routine MOHCC activities by decentralising services, capacitating service providers and health managers at sub-national level and strengthening partnerships. Our implementing partners will continue to play an essential role in the implementation of this plan, however, focus will be on capacitating MOHCC sub-national structures to facilitate integration. This plan also emphasizes the need to realize cost-efficiencies and sustainable financing. Given the overall decline in global health spending for HIV, it is imperative that we lower the cost of MC and have long-term funding visibility for the program.

Finally, this plan provides strategic and operational direction for VMMC implementation before a new consolidated HIV/AIDS strategic plan takes effect in 2021. I urge all stakeholders to embrace the plan and collaborate towards achieving the set goals.



Major General (Dr) G. Gwinji (Rtd)
Permanent Secretary, Ministry Of Health and Child Care, Zimbabwe

EXECUTIVE SUMMARY

Zimbabwe has made significant strides in addressing the HIV epidemic, with adult prevalence dropping from 15% in 2015 to 13.3% in 2018[1]. Annual incidence of HIV among persons aged 15 to 64 years is 0.47%: 0.33% among males and 0.60% among females. This corresponds to approximately 33,000 new cases of HIV annually among persons aged 15 to 64 in Zimbabwe[2]. At the heart of this response is combination HIV prevention, with VMMC being one of the core intervention, in addition to other key HIV prevention strategies. Following initial pilots, the VMMC programme was then scaled up and a National Strategy (ASCOP) launched in 2014 and 2015 respectively. The programme aimed to scale up and circumcise 1.3 million males by 2018 when the programme would then transition to sustainability in order to realize the impact of 212,000 infections averted and $1.13 billion financial savings realized by 2025. The ASCOP provided much impetus in scaling up VMMC services to all 63 districts across the country, resulting in a significant increase in trained staff and wider access for communities.

By the end of 2017, Zimbabwe had reached 60% of its scale up target, with variances observed across districts, meaning that some districts are saturated and ready to transition to a maintenance phase, while others are still pursuing scale up targets. Progress to date has been driven by strong national coordination, innovative approaches in demand generation and service delivery, and evidence based target setting and resource allocation. While actual service delivery and demand generation is largely carried by MOHCC staff, programme implementation has been heavily donor funded and often perceived as a parallel programme. While this approach was arguably necessary at programme inception, given the uncertain funding landscape there is need to transition to a more sustainable approach to VMMC programming in the upcoming years. Given the need to guide the overall transitional phase to sustainability, this Sustainability Transitional Operational Plan (2019-2021) will be key in providing in-depth processes and intended outcomes.

The approach to VMMC sustainability, a key feature in this plan, is premised on the integration of VMMC into existing health service: Decentralisation of key VMMC programme functions to ensure effective contextualized programming; development of key partnerships between government, donors, implementing partners and community stakeholders to ensure buy in and involvement. In pursuit of the sustainability agenda, and with the realization of the need to create sustained demand, the VMMC programme will explore context specific demand creation

[1] UNAIDS estimate

[2] ZIMPHIA 2015-2016 estimate of HIV prevalence among men and women ages 15-29

strategies, the optimum being natural demand for VMMC services across the country.

The plan will also hinge on scaling up innovative training modalities in order to decentralize and ensure circumcisions are done at the lowest level across most health facilities. The programme will continue to scale-up identified service delivery innovations that are cost efficient. This is particularly important when considering the transition to sustainability where there will be less funding available. In addition, programme quality will also emerge as a vital cog to Zimbabwe's VMMC programme sustainability aspirations. While the country has consistently recorded an adverse events rate of less than 0.2% on an annual basis, stronger AE surveillance and reporting will be prioritized, while making use of already existing Ministry of Health and Child Care surveillance systems. With this in mind, a robust surveillance, monitoring and evaluation and operational research is a key pillar of this plan. The VMMC programme will continue to increase effectiveness and efficiencies in the use of available resources. This will be achieved through adoption of results based financing frameworks, which advocate for optimum use of resources and 'value for dollar' approach to programme financing. This is in line with the Government of Zimbabwe's Transitional Stabilization Plan (TSP), a plan premised on the principle of sustained funding for development.

INTRODUCTION

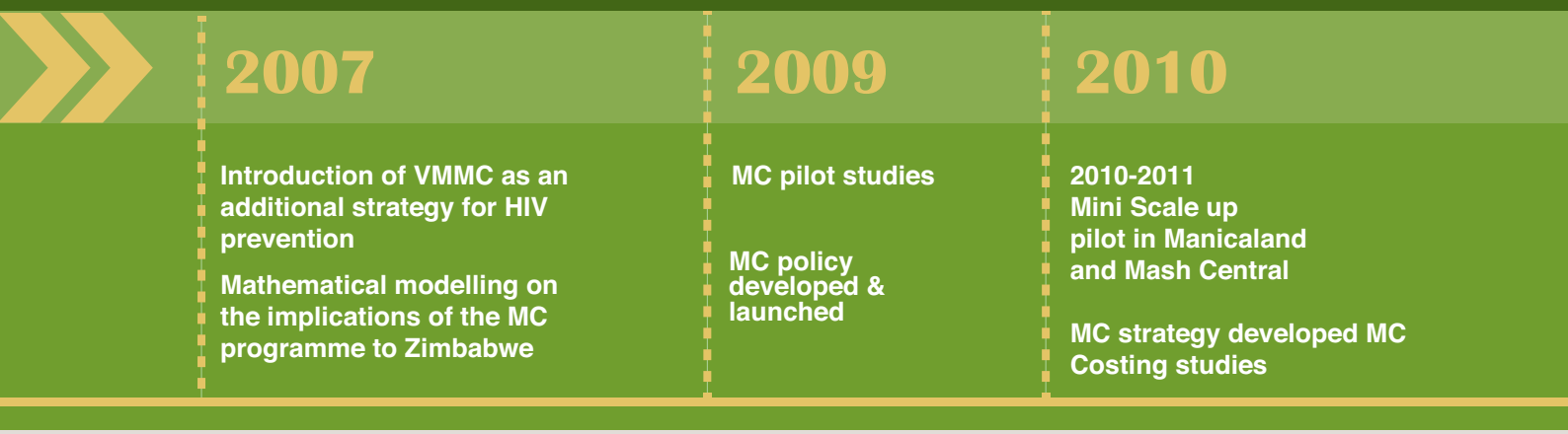
Zimbabwe VMMC Programme to Date

Zimbabwe is one of fifteen countries in Eastern and Southern Africa that is implementing a Voluntary Medical Male Circumcision (VMMC) programme to reduce the risk of female-to-male sexual transmission of HIV. Compelling scientific evidence has shown that circumcision reduces the risk of female-to-male sexual transmission of HIV by up to 60% . In Zimbabwe, the programme was introduced in 2009 after the World Health Organization (WHO) recommended male circumcision to countries that had a generalized HIV epidemic and low rates of male circumcision. Following initial pilots, the VMMC programme was then scaled up and a National Strategy (ASCOP) launched in 2014 and 2015 respectively. The programme aimed to scale up and circumcise 1.3 million males by 2018 when the programme would then transition to sustainability in order to realize the impact of 212,000 infections averted and $1.13 billion financial savings realized by 2025.

The trajectory of the programme has since diverged from original expectations since the WHO VMMC recommendation for HIV prevention over 10 years ago. Initially, VMMC was intended to be a time-limited intervention that would accelerate scale-up and rapidly, transition to sustainability where only a small cohort of males would need services routinely. Despite marked progress during scale-up, the programme faced some glaring obstacles to achieving the set targets, delaying the start of a "sustainability phase".

By the end of 2017, Zimbabwe had reached 60% of its scale up target, with variances observed across districts (Fig.2), meaning that some districts are saturated and ready to transition to a maintenance phase, while others are still pursuing scale up targets. Progress to date has been driven by strong national coordination, innovative approaches in demand generation and service delivery, and evidence based target setting and resource allocation. While actual service delivery and demand generation is largely

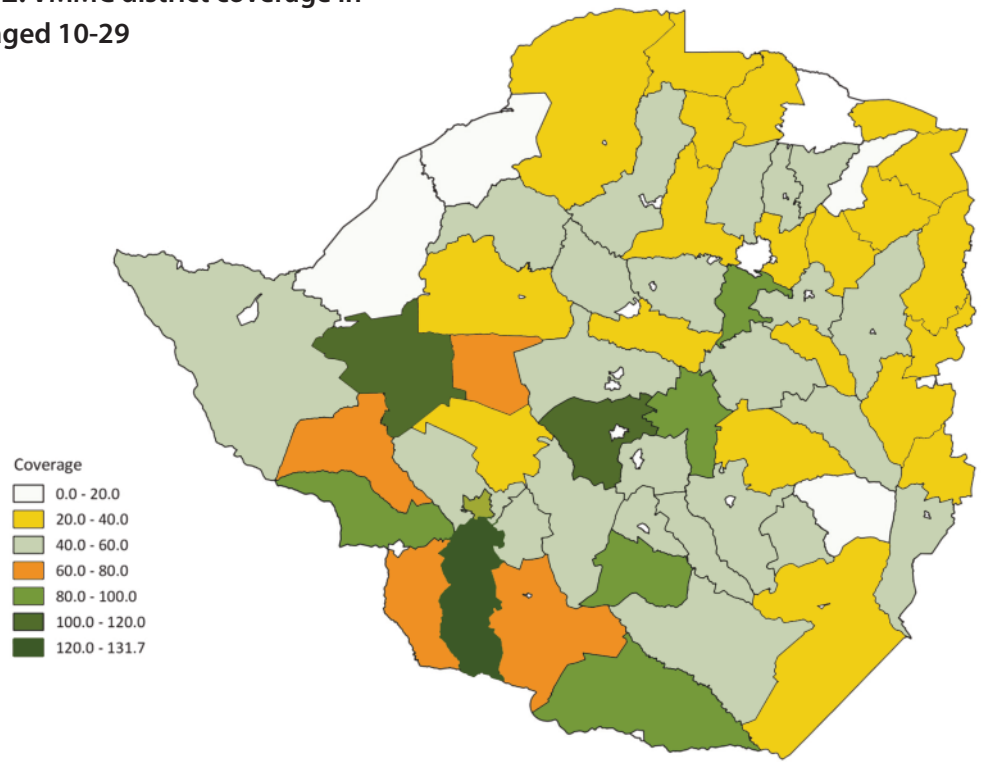
Figure 1. Timeline of VMMC implementation up to 2015



carried by MOHCC staff, programme implementation has been heavily donor funded and often perceived as a parallel programme. While this approach was arguably necessary at programme inception, given the uncertain funding landscape there is need to transition to a more sustainable approach to VMMC programming in the upcoming years.

Given the future funding outlook, revised programme targets to circumcise 2 million males by 2021 and the geographical variances observed in district's progress towards targets, the emerging hypothesis is to consider the transition to sustainability as a concurrent activity, rather than as a distinct phase to be implemented subsequent to scale-up.

Figure 2. VMMC district coverage in males aged 10-29



2012

2012-2013 MC device studies (PrePex and Neonatal devices)

2013

Nationwide scale up and r eview of targets from 2015 to 2017

Cost reimbursement schedule finalized

2014

Approval of Task-shifting

Prepex Surveillance, active to now passive phase

2015

Launch of the national Accelerated Strategic Costed Operational Plan for VMMC

Strategy Development Methodology

Similar to the development of the previous Strategy, the transition to sustainable programming will require buy-in from at all levels. Given this, the development of this Strategy was a highly consultative process that involved multiple stakeholders.

To kick off the Plan development process, a national stakeholder meeting was held in January, 2018 with the following objectives:

- To share global guidance on sustainability and provide a country overview
- To agree on what a country definition of VMMC sustainability should include for Zimbabwe
- To agree on where we are and what aspects of VMMC sustainability still need to be addressed
- To map a way forward on the next steps towards the transition to sustainability

This was a highly consultative meeting with representatives from different departments within the Ministry of Health, Ministry of Education, provincial and district leadership for health and education, donors, UN representatives, implementing and technical partners and young people. Key components of a sustainability definition were established and stakeholders worked in groups to identify and highlight key themes across the different programme dimensions when considering sustainability. A full report is available.

Following this meeting, in-depth interviews and focus group discussions were conducted with key stakeholders at national and subnational levels in order to gain more insights and strengthen buy-in. Table 1 shows the full list of stakeholders that were engaged.

Using validated insights from the national sustainability kick off meeting, an in-depth literature review, key informant interviews, focus group discussions and sustainability pilots, the Ministry developed the following Strategy to inform programme transition to sustainability. This Plan will highlight the key steps to be taken to ensure districts efficiently and effectively transition to sustainability.

Figure 3. Process and timelines for Strategy development

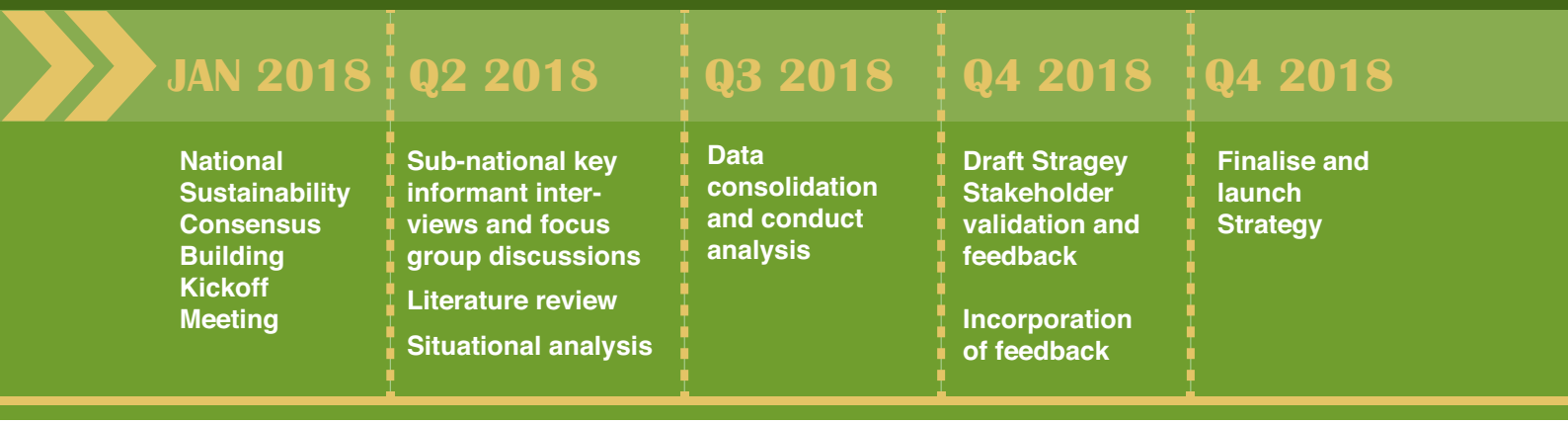


Table 1. List of stakeholders engaged during the Strategy development process

NATIONAL	SUB-NATIONAL
Ministry of Health	**Provincial Health Executive**
- AIDS & TB Department	**District Health Executive**
- Reproductive Health Department	**Service Delivery and Demand Creation Teams**
- M&E Department	**School Heads**
- Nursing Services	**Community Leaders**
- Quality Assurance Department	- Council leaders
- Clinical Mentorship Department	- Chiefs
Ministry of Education	- Religious leaders
Implementing Partners	- Business leaders
Donors	**Parents**
National AIDS Council	**Adolescent Boys**
Zimbabwe National Family Planning Council	

Group work during the first sustainability stakeholders meeting in harare

SITUATION ANALYSIS

To understand current programme successes and challenges, a situational analysis was carried out across all pillars of the Strategy to review implementation of the last Strategy (ASCOP).

PROGRAMME LEADERSHIP, MANAGEMENT AND COORDINATION

National Level

In line with strategies outlined in the ASCOP, technical and analytical capacity at national level has expanded in order to increase effectiveness in the implementation of the national level MOHCC policy and strategic mandate. More specifically, a Data and Research Officer (DRO) and a VMMC-ASRH Linkages Officer were added forming an eight member VMMC Programme Management Unit (PMU) at national level. The addition of a DRO has strengthened the national level use of data for decision making through use of the weekly dashboard as well as strengthening monitoring, reporting and data quality functions. The Linkages Officer has provided necessary insights into adolescent behavior within the programme and potential for integration with other services. While the PMU provides overall guidance on the rapid scale up of the VMMC programme, there are still existing challenges such as lack of resources, which limit the scope of work the PMU can undertake.

Sub-national Level

The addition of Provincial VMMC Officers (PVOs) in all rural provinces has given the PMD/PHE oversight of programme implementation while also effectively increasing visibility and prioritization of VMMC activities. The PVOs are working with districts to ensure timely planning and coordination of activities while also identifying and scaling up effective demand and service delivery strategies to ensure that targets are met. In addition PVOs support districts in QA activities, campaign reviews and planning meetings, engagement of community opinion leaders, planning and coordination of trainings and mentorship visits among others. The addition of this role has been seen as a key driver to the achievement of programme outputs at a stage where it was felt that the hard-to-reach males had been exhausted.

A major barrier for optimization of provincial level functions has been the fact that resources are managed by implementing partners at national level and are also restricted to partner geographies therefore limiting the PVOs ability to prioritise and optimize the use of resources within their province. In addition, there remains room to strengthen interaction between officers within the Ministry of Health at provincial level in order to increase integration of planning and coordination activities between programmes. Stakeholder interviews revealed that there is need for the PVO go beyond VMMC and to take on a broader HIV prevention role in line with the need for integrated programming for HIV prevention and linkages with other programmes.

For the greater part of implementation no focal persons were introduced in the cities. This saw Harare city in particular continue to perform below expectation. A PVO was introduced in Harare in July, 2018 to try address the gap and unique challenges faced.

Donor and Implementing Partners

Across all levels of the MOHCC health system, VMMC partners play a key role in resource mobilization, allocation and disbursement; technical assistance in target setting, training, quality assurance as well as support for advocacy and communication, service delivery and supply chain management activities. Partners are guided by the Ministry's policy guidance and directive, working within the limits of their funding.

VMMC Technical Working Groups and Steering Committee

The VMMC programme currently has one Steering Committee and three Technical Working Groups (TWGs) for service delivery, demand generation and M&E. These groups have been able to effectively carry out their mandate by ensuring correct invitation and attendance of participants as well as deliberate follow up of activities following meetings. These groups have served as routine platforms for updates on programme progress, policy changes, and course correction among others.

VMMC SERVICES

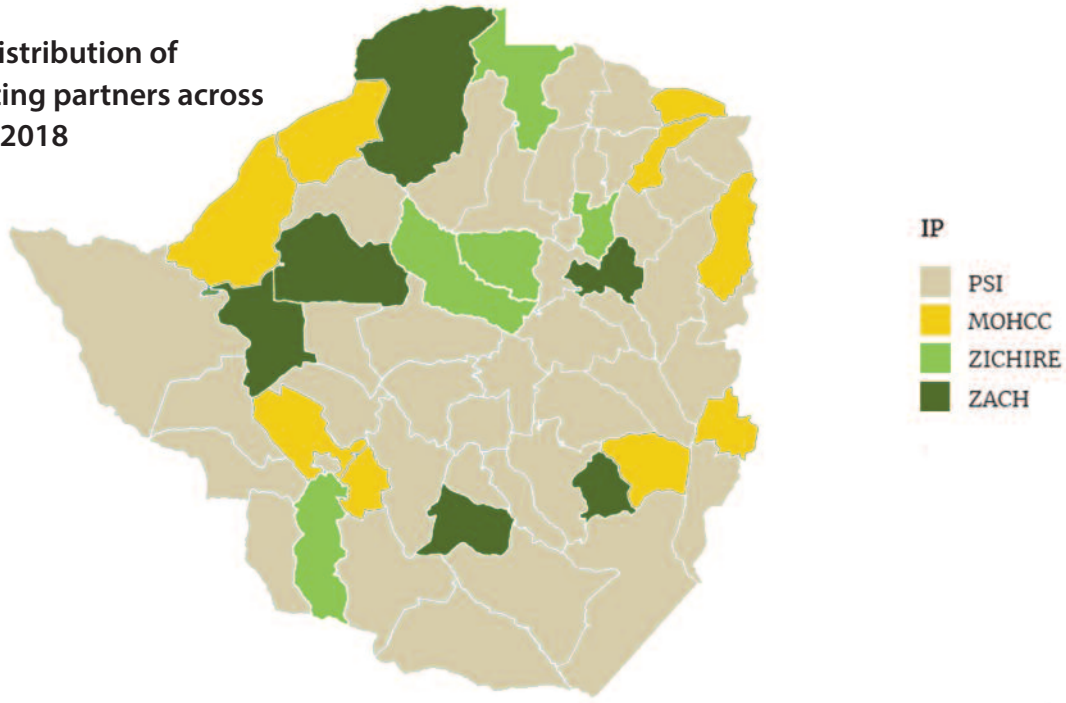
Implementing Partner Landscape

The VMMC programme in Zimbabwe started in 2009 with some initial pilots and scale up occurred in 2013 where all 63 districts were allocated between three different implementing partners. As of August 2018, VMMC services are now being implemented by the MOHCC and two implementing partners, PSI and the ZAZIC consortium made up of I-TECH, ZICHIRE and ZACH. Of the 63 districts, 43 are supported by PSI, 14 by ZAZIC while the remaining districts are wholly supported by MoHCC.

Target Age Group and Service Delivery Methods

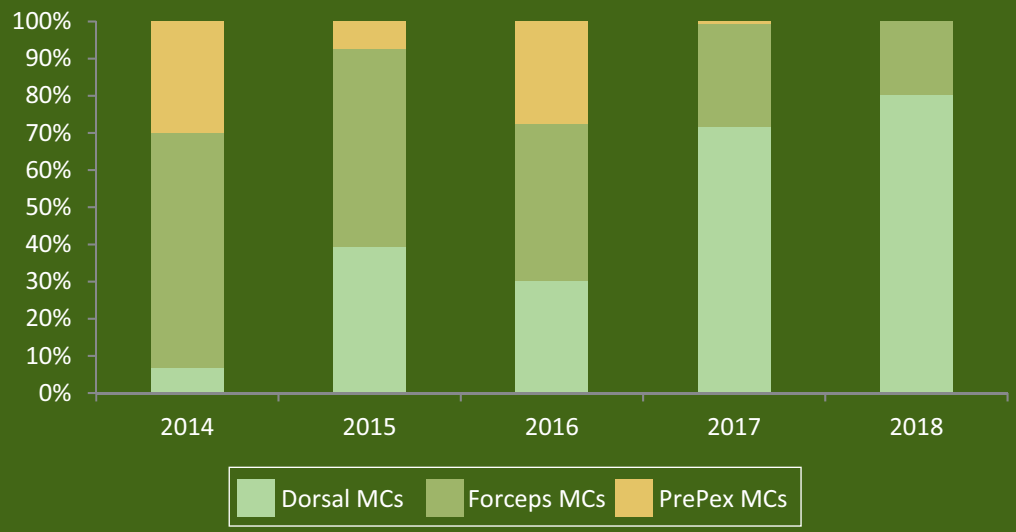
The VMMC programme currently targets males 10-29 years of age. Service delivery is conducted by VMMC trained nurses and doctors using either the surgical dorsal slit method for all ages or forceps guided method for those 15 years and above or non-surgical method, PrePex. In 2015, Zimbabwe adopted WHO guidance which gave a strong caution regarding the use of the forceps-guided method in younger adolescents (<15 years) and expressed a preference for other surgical circumcision methods that allow direct visualization of the glans such as dorsal slit. In addition, also following WHO guidance to only offer circumcision by elastic collar compression devices such as the PrePex device to men who are adequately protected against Tetanus i.e. have documented evidence of receipt of a full five- to six doses of Tetanus Toxoid Containing Vaccine (TTCV) or in an individual who never received any TTCV dose, two TTCV doses four weeks apart, with the second dose preferably 14 days, but at least 7 days, before the VMMC procedure. After effecting the WHO guidance on mitigating the risk of tetanus infection through vaccination, PrePex device contribution to total MC outputs went down to zero. Currently, an implementation pilot is being conducted

Figure 4. Distribution of implementing partners across districts in 2018



to develop practical delivery strategies for providing tetanus vaccination in the context of other VMMC services. Preliminary findings from the pilots indicate that the need for tetanus vaccination is a barrier to getting PrePex. The attrition rate during the 6 weeks from the time of receiving the first dose to getting PrePex placement was as high as 100% due to clients being either lost to follow up or opting to get the surgical circumcision. The effect of the two WHO recommendations on the use of forceps guided method for under 15 years and PrePex with TTCV is shown by Figure 5 below.

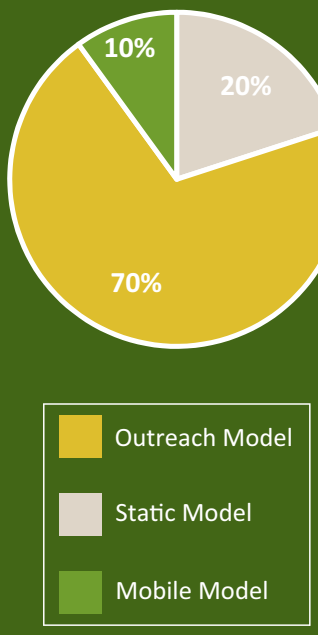
Figure 5. VMMC method mix 2014-2018



There are currently three service delivery models being implemented:

1. Static Model- Circumcisions are done at health facilities using staff stationed at that site as well as supplies from that same site.
2. Outreach Model- VMMC team travels to do circumcisions at another health facility, usually a rural or remote site which does not have the capacity to conduct MCs themselves.
3. Mobile Model- VMMC team does circumcisions in caravans or tents that are set up as theatres and not in a health facility. The mobile model is used for very remote areas with no access to a health facility or during campaigns when there are high volumes.

Figure 6. Proportion of VMMCs done by service delivery model in 2018



Government nurses and doctors make up the service delivery clinical teams for all three models but additional capacity is sometimes provided by implementing partners in the form of roving staff to support and complement the MOHCC teams in districts that have gaps in capacity. For all three models, most clients are transported to the site of circumcision then back to their homes after the procedure. Transport costs for VMMC are currently supported by implementing partners.

VMMC Trainings and Human Resource Capacity

There are VMMC programme trainings available for circumcisers, nurse assistants/counsellors, data reporting officers, pharmacy technicians and mobilisers. Below is a list of all the trainings available within the VMMC programme:

The number of staff trained in VMMC has increased significantly since the launch of the ASCOP whose objective was to scale-up programme capacity to deliver safe

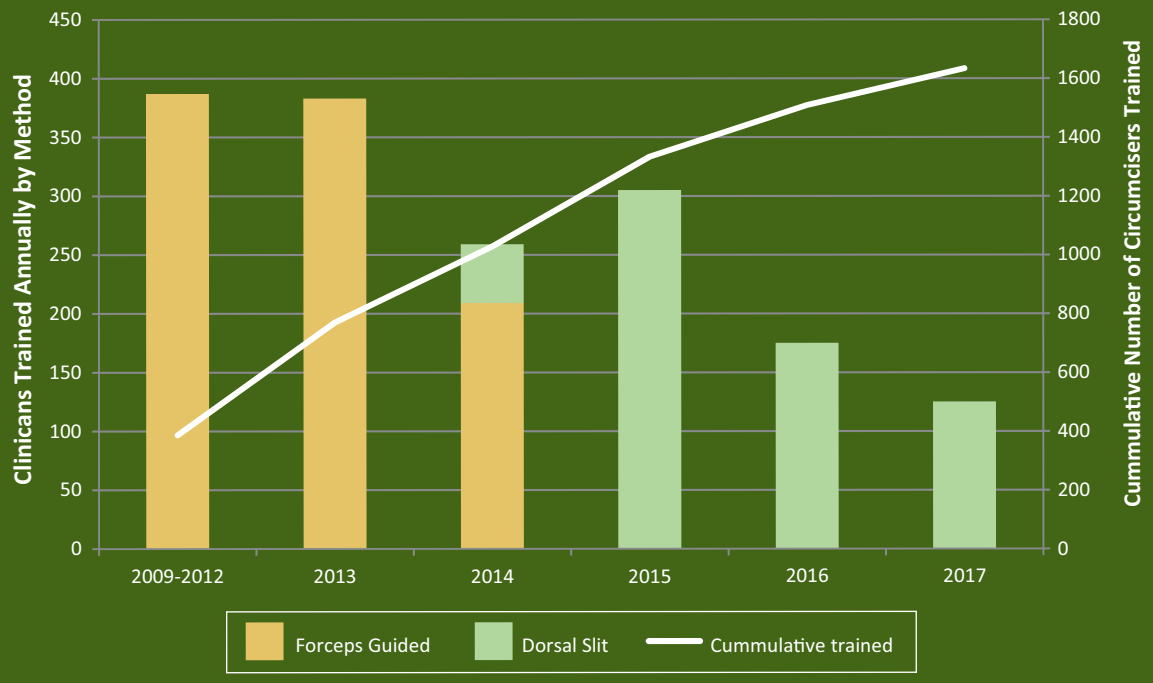
Table 2. Summary of VMMC trainings available (2018)

TYPE OF TRAINING	PARTICIPANTS	DESCRIPTION
Basic VMMC Training	Circumcisers, Nurse counsellors, Nurse assistants	6 days standard VMMC training which includes theoretical lectures and practical of counselling and circumcision of actual clients
Conversion Training	Nurse circumcisers	3 day surgical training which includes MC procedure, screening and examination of clients. 6 months as a VMMC nurse assistant OR 3 months as an assistant and assisted on 200 MC procedures Trainee will do 20 additional MCs on the job under supervision of qualified circumciser before certification
Training of Trainers (ToT)	Provincial based trainees	3 day training for VMMC surgical doctors and nurse counsellors. ToT is immediately followed by basic 6 day VMMC training for trainers to practice their training skills.
Emergency Management Training	Circumcisers, Nurse assistants/ counsellors	2 day training conducted to equip VMMC service providers with knowledge and skills on how to prevent, identify and manage medical emergencies with refresher trainings every two years. This is a requirement and recommendation for the international and national VMMC Quality Assurance standards to ensure safe provision of VMMC services
VMMC Supply Chain Management Training	Pharmacy technicians, VMMC team leaders, District Pharmacists	Training conducted by the Department of Pharmacy Services and the logistics technical partner on ordering, reporting and stock management related to VMMC commodities and medicines
Data Entry and Data Management Training	Health Information Officers and Assistants	Training conducted during the conventional trainings for dorsal slit
Demand Generation Training	Mobilizers, Driver mobilizers	Training conducted by implementing partners based on the MoHCC VMMC demand generation training manual which is adaptd to suit each context and incorporate new innovations. Duration and location of trainings vary. Due to high attrition, replacement mobilizers might get on the job training to quickly fill in gaps

circumcisions. Of the available health workers, 95% of doctors are trained in at least one method while only 16% of nurses are trained. Utilization of the health workers in VMMC services is at ~52% for nurse assistants, 25% for nurse circumcisers and 20% for the doctors. In-service trainings have been decentralized to provincial level, where staff from different districts in the province are trained at a central location by provincial trainers and one national trainer who oversees the training. Provincial training coordination is done by the PVO whose role is to identify gaps in capacity, identify cadres to be trained and organize the logistics for the training. Funding for training activities are supported by implementing partners.

Although capacity has improved, there are still HR gaps observed in most districts. District hospitals have on average of two or three VMMC teams with lower level facilities having incomplete or no VMMC teams trained. Trained nurses are mostly on VMMC duty, doing MCs at the facility or on outreach at other health facilities that do not have staff trained in VMMC. Demand for VMMC trained staff sometimes gets very high such that they have to work weekends or during their days off. The current VMMC capacity situation has caused some challenges within facilities where staff who are not trained in VMMC feel that the VMMC trained staff are neglecting their other facility duties, always leaving for outreach work where they get allowances and cost

Figure 7. Clinicians trained in surgical circumcision by year



reimbursement privileges that the rest of the staff do not get[1,2]. Attrition of staff, an estimated 56%[3], also remains a challenge with some trained clinicians no longer active due to transfers, retirement or being unable to handle the stressful nature of constantly travelling to outreach areas.

VMMC Programme Infrastructure

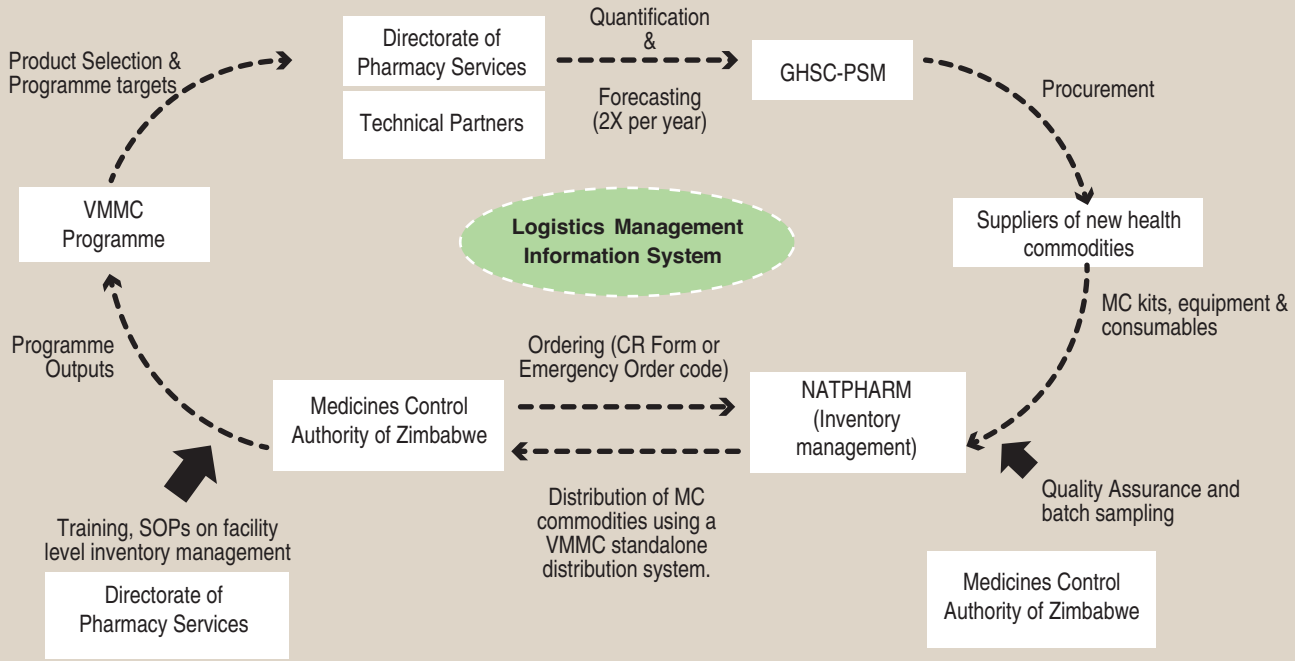
VMMC is integrated into the existing health facilities but space remains limited as most facilities do not have designated VMMC rooms. While there is an average number of 21 procedure rooms available for MC in a district, the average number available for MC on demand is two since theatres are usually prioritized for other activities that are not VMMC[4]. To address space constraints, tents have been secured for some sites.

Based on the 2018 Internal Quality Audit (IQA) visits, 85% of facilities have functional incinerators or Ottoway pits. The challenge in waste disposal is that there was no cadre assigned to have oversight of the waste management facilities in most cases. This compromises the way in which VMMC waste is managed at facility level.

Supply chain for VMMC commodities and medical supplies

Support for VMMC commodities and medical supplies is provided by USAID through the Global Health Supply Chain Procurement and Supply Management (GHSC-PSM) Programme. GHSC-PSM works closely with VMMC programme management and MoHCC Directorate of Pharmacy Services to quantify the projected needs of the programme. Once

Figure 8. Illustration of Supply Chain Management for VMMC Commodities



the commodities and supplies are procured and delivered to Zimbabwe, NatPharm is in charge of storage and they use the normal MoHCC distribution channels.

Quantification of commodities relies on a feedback loop where facilities report their consumption periodically allowing technical partners to make more accurate estimates of future requirements. The feedback loop also ensures that facilities get stock to replenish their supplies before they run out.

At national level, the key challenge has been lack of and delayed reporting of consumption and ordering data from facility level, which has affected stock availability at facilities. Due to lack of sufficient consumption data, quantification has been done using norms/standards, which do not always align with actual consumption. This has resulted in inefficiencies such as over-stocking and stock-outs at central level. Moving forward, improved reporting and quantification based on reported consumption will be prioritised for supply chain optimization.

VMMC PROGRAMME QUALITY

Adverse Events

Despite the high number of circumcisions done to date, the VMMC programme in Zimbabwe has managed to maintain an adverse event (AE) rate of 0.1%[5]. This is well below the internationally recommended threshold of 2%. However, the programme's incidence of fistulas, a severe AE, has notably been above the average incidence observed in the other 13 priority countries that are implementing VMMC for HIV prevention. In addition, while reporting of severe AEs is generally good, reporting rates for moderate AEs still remains an area of concern.

The programme manages AEs that have been identified through the public and private health facilities in the country. Moderate and severe AEs are reported on the monthly return form with severe AEs being reported at all levels within 48 hours. Mild AEs are not reported but captured in the registers and client intake forms. A National Adverse Guide is available to support service providers in the identification, management and reporting of adverse events. Current AE referrals follow a standardised MoHCC referral pathway but AE management remains funded by implementing partners resulting in different standard of care.

Quality Supervision

The VMMC programme manages the quality of services offered through multiple quality assurance exercises such as a biannual Internal Quality Audit (IQA) led by the national VMMC Programme Management Unit, biennial External Quality Audit (EQA) with the programme's

1 Feldacker C, Bochner AF, Herman-Roloff A, Holec M, Murenje V, Stepaniak A, et al. (2017) Is it all about the money? A qualitative exploration of the effects of performance-based financial incentives on Zimbabwe's voluntary male medical circumcision program. PLoS ONE 12(3): e0174047. https://doi.org/10.1371/journal.pone.0174047

2 Subnational Interview Report

3 VMMC Estimated Capacity Tool 2018

4 VMMC Estimated Capacity Tool 2018

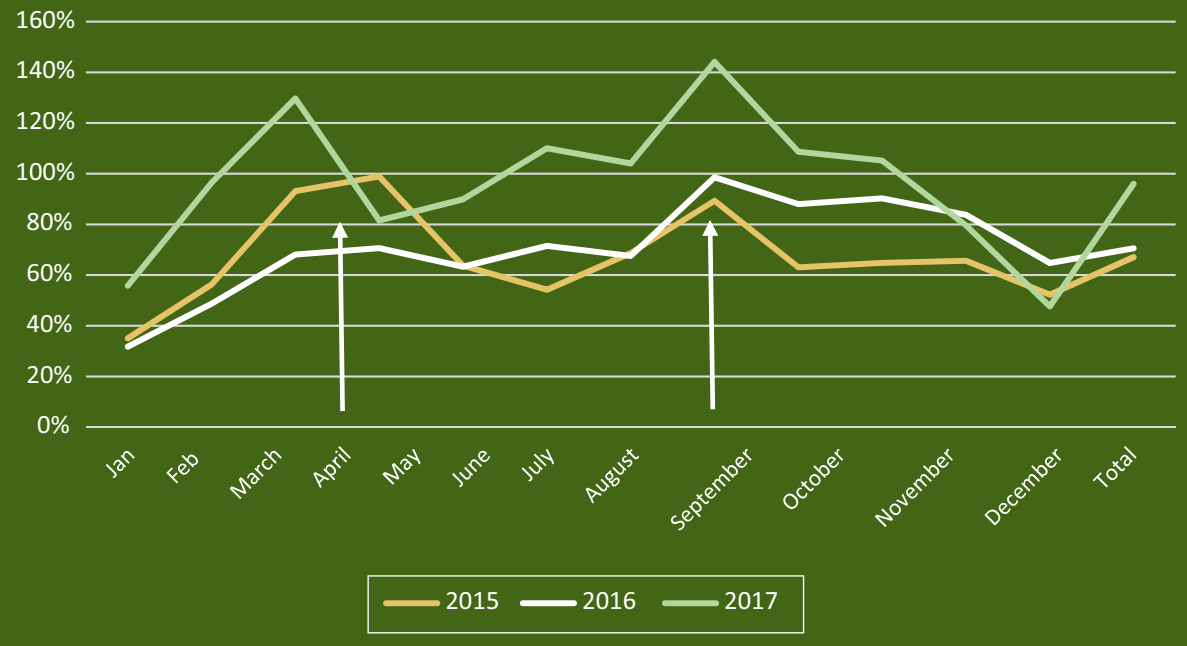
5 MOHCC VMMC Programme Data

funding partners and provincial level quality assurance supervision led by the PMD's office. IQAs are done using paper based tools however, an electronic based tool called Health Network Quality Improvement System (HNQIS) is currently being piloted. QA visits are done to randomly selected sites with limited follow up after the initial visit. However, immediate feedback of IQA audits has historically not consistently been provided to sites and results communicated to other levels. There is need to establish a follow up system for QA findings identified at all levels.

Clinical Mentorship

The programme started a clinical mentorship programme in 2016 by identifying eight specialist surgeons who offer clinical mentorship to the VMMC circumcisers at provincial level. The mentors make quarterly visits to their designated province and supervise MC procedures, address some of the complicated adverse events and mentor the teams on technique for continued skill enhancement. While VMMC teams have found these visits to be useful, there have been some challenges with the clinical mentorship programme. The mentors are currently centrally based therefore given the large pool of trained staff, not all circumcisers are able to get face to face time with the mentors within the allocated quarterly visits. Secondly, competing priorities for the mentors means they cannot always make the quarterly visits.

Figure 9. Historical annual performance highlighting increased performance during March/April and August school holiday campaigns



There is a general lack of specialist surgeons in the country, particularly at sub-national level but the government is working on plans to deploy provincial level surgeons across all provinces.

Informed Consent

VMMC policy states that all clients provide written informed consent before circumcision. Clients who are under 18 years give assent to the procedure and a parent or legal guardian should also consent on their behalf. The programme has experienced challenges arising from lack of due diligence in terms of ensuring that each circumcision is done only after the proper consent is obtained. Cases involving circumcision of under-18 boys without the consent of parents or legal guardians have resulted in litigation cases against the national programme. A reassessment of the protocol for obtaining informed consent is required for the programme to maintain high ethical standards and retain the essential trust of the community.

DEMAND GENERATION

National Plan

Demand generation and advocacy for the VMMC programme is currently guided by a National Advocacy and Communication Plan that was developed after synthesis of implementation best practices and market research analysis. The Plan provides comprehensive strategies around VMMC advocacy, effective communication through key messages, the role of community mobilizers in driving demand, and the importance of broad stakeholder engagement and monitoring and evaluation in ensuring that demand generation activities are dynamic yet evidence based. Results from IPSOS, a market research company that carried out extensive research to inform the Zimbabwe VMMC programme in 2016, highlighted the need for the programme to move away from large investment in mass media and to shift more towards interpersonal communication for effective creation of demand. Their analyses revealed that mass media had reached saturation and was no longer making a return on investment. Although there is this robust plan, a rift between activities outlined in the plan and their implementation on the ground is still observed.

HR for Demand Generation

Significant investment in training of Interpersonal Communication (IPC) agents expanded the pool of demand generation mobilizers who are critical in demand generation. Implementing partners were also able to engage VHWs, circumcised men and school health coordinators as advocates and mobilizers. Mobilizers contracted by implementing partners receive compensation per client recruited which has been a strong motivator for mobilizers. However, attrition of mobilizers has been a challenge due to competing economic activities and increasing difficulty in reaching uncircumcised men. At sub-national level health promotion officers, community nurses and implementing partner officers have played a key role in coordinating demand creation efforts and conducting the support and supervision of community based cadres.

Demand Generation Activities

School based demand generation, though not institutionalized has been the main

source of clients with school based campaigns consistently contributing to over 30% of MCs annually (Fig 9).

Other methods of increasing awareness and creating demand have been conducting road shows, soccer galas and community dialogues. The use of local champions is another effective demand generation activity that has seen greater uptake of services in communities where they are identified and roped into the programme. These include chiefs, headmen, and religious leaders among others. Innovations identified from the market research conducted such as the Pain'O'Meter and the Segmentation Tool have also been implemented in select districts and led to success in mobilizing some previously hard to reach target groups but there were also challenges in operationalizing them. For instance, the Segmentation Tool reportedly took a lot a time which dis-incentivized its application for mobilizing high volumes.

STRATEGIC INFORMATION

Strategic information for the VMMC programme is currently generated and managed following the framework provided for by the AIDS and TB Department and the Health Information Management System. This includes three components which are M&E, Surveillance and surveys and operational research.

Monitoring and Evaluation (M&E)

The M&E system for VMMC is one of the key contributing factors of success recorded within the programme due to its role in providing evidence for decision making and for showing progress against targets. All of the indicators that the system is able to collect are for service delivery. Non-collection of demand creation indicators is complicated by the fact that activities are conducted by lay cadres who are not under the control of the MOHCC. Other key areas that the M&E system has failed to adequately collect and report on include effectiveness, efficiency and supply chain indicators.

Health Information Generation and Management

Paper based registers and client intake forms are the primary sources of information completed by health workers during their interaction with clients. Aggregate data collection, collation and management is supported by the Health Information Management System (DHIS2). Despite having a VMMC electronic patient management system module developed, the system is not yet able to collect patient level data due to technical and human resource limitations. High-level streamlined indicators for service delivery are collected and reported monthly into the monthly return form and subsequently entered into DHIS2.

Weekly VMMC Dashboard

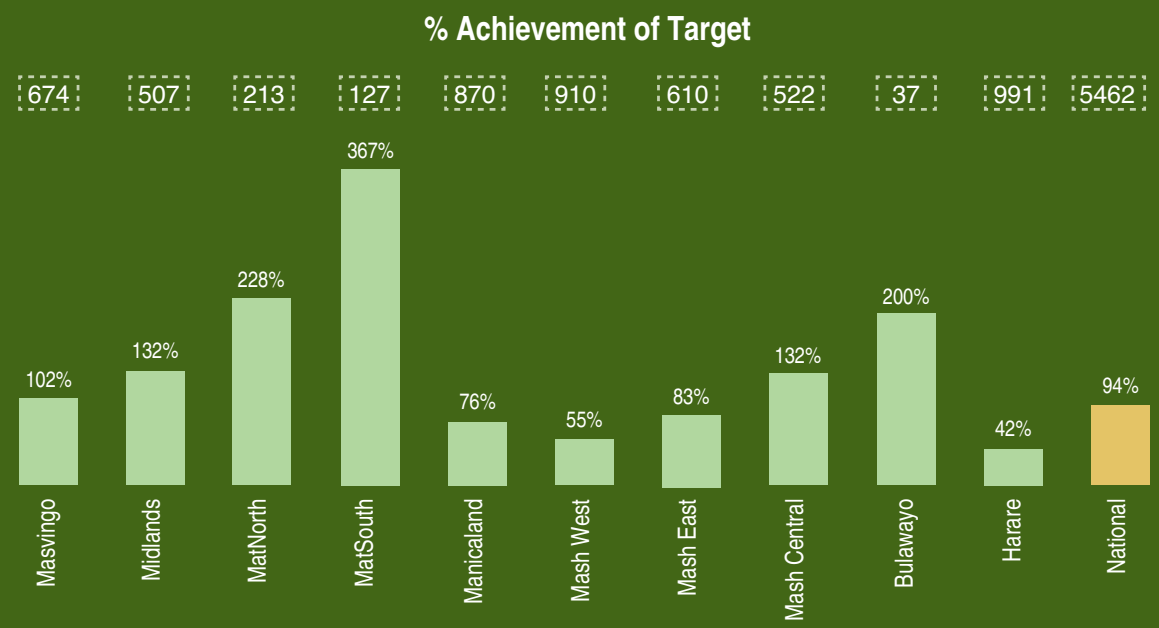
To meet the need for real time data during scale-up, a weekly Microsoft Excel-based dashboard designed to be a simple, visual and dynamic Tool to inform swift programme decision making, was introduced in 2016. At the end of each week, the MC team leads are responsible for ensuring data is sent to their respective Provincial VMMC Officers (PVO). At the beginning of the following week, each PVO consolidates the data and sends it to the national VMMC Data and Research Officer who inputs the week's data into the Excel workbook which automatically creates an updated dashboard for the

week showing views at district, province and national level. One key challenge of the dashboard is that it is not automated and relies on people at various points of the keychain who are not always available. The key indicators reported on are performance against target, service delivery model used, surgical circumcision methods used, number of clients in target age group, number of service delivery teams, number of AEs and mobilizers that were active in that week. Despite investment in generating and managing M&E data, there is an opportunity to optimize the system culture towards evidence based decision making.

Data Quality Audits (DQA)

In addition to routine reporting, scheduled data quality audits are done at the subnational level, spearheaded by national level to validate reported data on a quarterly basis. Ad hoc DQAs have also been done as and when required to address data quality issues in selected districts. During DQAs, data is collected from facilities, comparing the VMMC register, client intake records, monthly return form, DHIS2 data, and data reported by the implementing partner. Over the four years the audits have revealed that there is inconsistency across all these sources. Key issues leading to these inconsistencies are lack of adequate storage across all sites, lack of standardization with regards to outreach and static site reporting into DHIS2 and incomplete and inconsistent documentation practices amongst clinicians conducting MCs.

Figure 10. Snapshot of the National view of the Weekly Dashboard



Operational Research Agenda

A number of VMMC research studies ranging from demand generation to service delivery were conducted during the course of implementation from 2014-2018. These studies helped to optimise the delivery of the VMMC programme and answer questions that are not fully addressed through routine M&E, surveillance and surveys. This increases the programme ability to leverage research findings to improve the programme. Notable operational research that has improved or informed implementation is:

- The IPSOS led qualitative and quantitative market research that was done to understand men's attitude to VMMC and to equip IP's with the means to convert intent to circumcise into action, and how they can go about converting those that have not taken action
- The ZAZIC led reusable kits pilot that was done to determine the feasibility of scaling up reusable male circumcision kits
- The WHO supported ASRH-VMMC Linkages study has found that the VMMC programme provides an opportunity to increase boys knowledge about ASRH services and integration of these services makes better use of available resources and could reduce duplication therefore generating savings.

Capacity Building

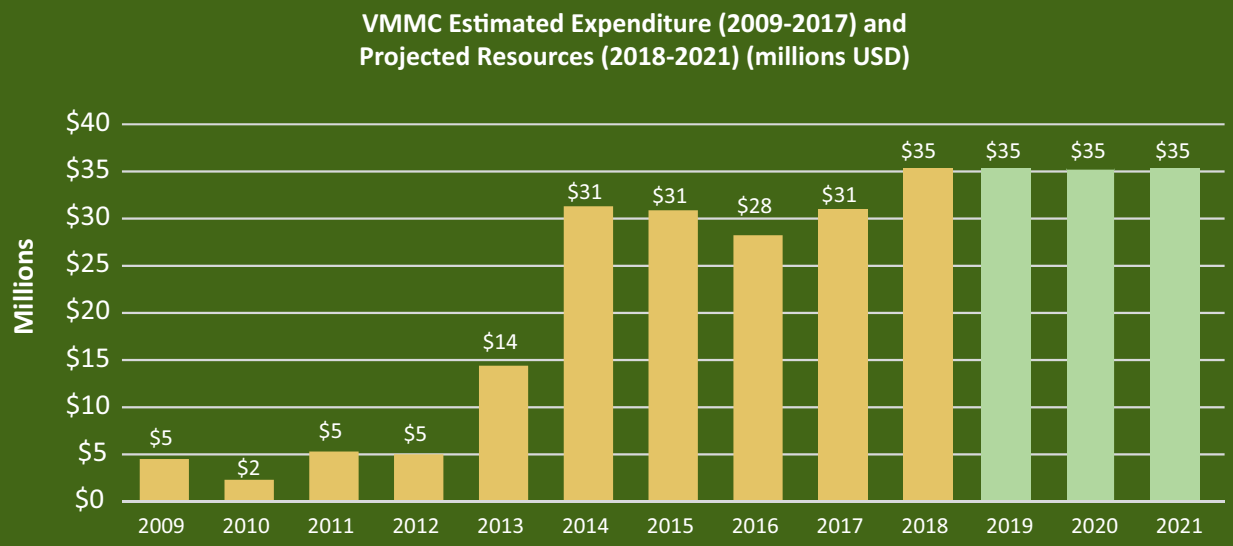
As part of the broader HIV/AIDS M&E capacity building, training in VMMC M&E has been integrated with other programme areas and various officers are trained as a package of existing five day training workshops. In spite of this, there is still a gap in translating training into practice. This is partly caused by the fact that most capacity building training does not involve implementation level cadres (i.e. those responsible for data generation and data management).

PROGRAMME FINANCING

To date, the VMMC programme has been largely externally funded – mainly by PEPFAR, Global Fund, BMGF and DFID – with most of the government spending going to healthcare worker salaries. The donor funding landscape continues to be volatile, and visibility into future funding remains uncertain (Figure 11).

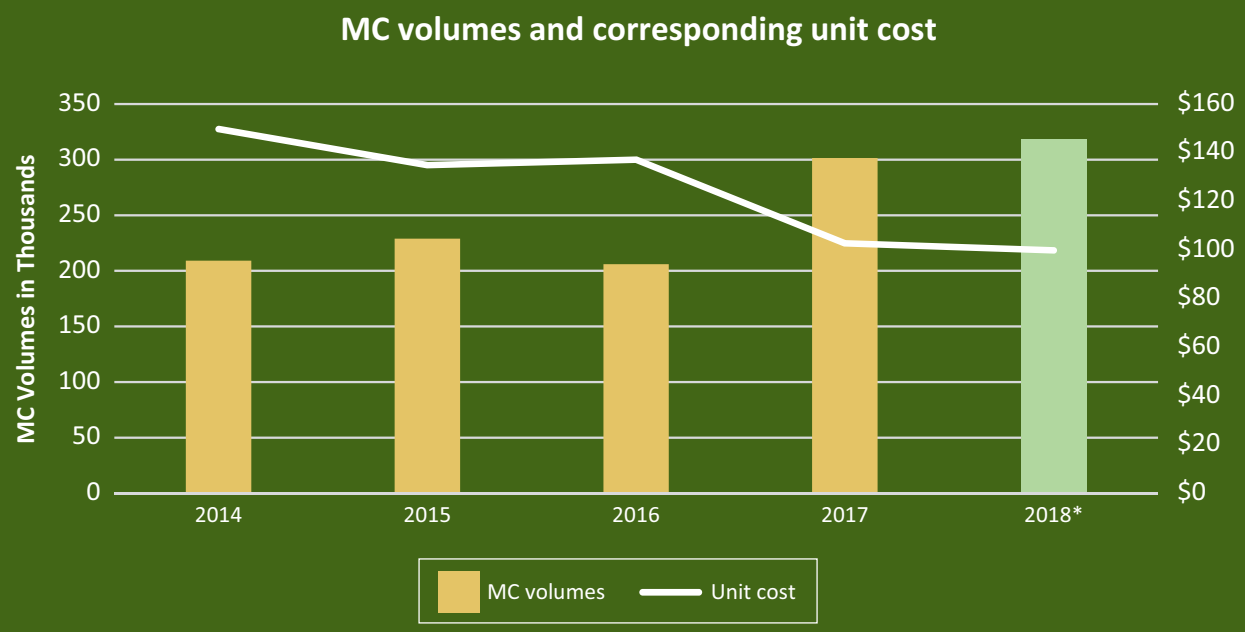
Despite a clear and compelling economic and programmatic case for maintaining high VMMC coverage rates, Zimbabwe's VMMC programme is continuously affected by global shifts in HIV financing priorities, particularly the decrease in HIV prevention funding as a result of growing treatment needs. On the other hand, most government support towards the HIV response has focused on HIV drugs procurement rather than on prevention services. As a result, during the implementation of the ASCOP there has been an overall programme funding gap, and fears are that this is likely to continue. To compound the effect of this funding gap, is the further variation in funding levels by geography. In 2016 PEPFAR implemented a geographic prioritisation exercise which discontinued funding and implementation support in nine low HIV prevalence districts. These districts were shifted to Global Fund support until this

Figure 11. Estimated and projected VMMC expenditure 2009-2021)



Note: Future projections (2019-2021) have been flat-lined based on 2018 funding.

Figure 12. VMMC unit cost trend (2014-2018)



Note: 2018 Unit has been calculated based on budget data while other years are based on expenditure data - 2018 MC volumes have been projected for the last 3 months of the year

funding lapsed at the end of 2017. To date these districts only have government funding to implement the VMMC programme. From the time they stopped receiving PEPFAR or GF support, these districts have failed to continue providing VMMC at the required scale for the programme targets due to lack of key resources to routinely conduct mobilisation and service delivery. Despite this, they have managed to leverage on three sources of funding to do a few male circumcisions during campaigns: 1) The National AIDS Council funding, 2) MoHCC subnational funds from hospital services fund and 3) targeted partner support.

In light of the volatile funding landscape some initiatives have been carried out to reduce the overall unit cost of male circumcision allowing for more to be done with less while preparing strategically for the transition to an anticipated further reduction in future programme funding. More specifically the following cost-cutting initiatives have been implemented:

- The scaling up of task shifting from having a doctor led to a nurse-led circumcision team has reduced personnel costs due to cost associated with nurses and a general increase in productivity.
- Following the decentralisation of VMMC in-service training; use of affordable local venues has been scaled up for the theoretical components leading to reduction in costs.
- The strengthening or alignment of demand creation and service delivery has led to reduced outreach perdiems costs.
- Operational research conducted in two pilot districts showed that introduction and scale-up of re-usable kits will lead to further cost reduction on the procurement of commodities.
- There has also been a reduction in cost reimbursement from $25 in 2014 to $19 in 2016 then to the current $12. Cost reimbursement was introduced in 2010 to improve programme performance towards the attainment of ambitious national VMMC scale-up targets. It further served the purpose of minimising staff attrition and the strengthening of the health system which was severely underfunded at the inception of the programme. Cost reimbursement started out at $25 per surgical MC, was revised downwards in January 2016 to the current figure of $19 per MC, a further revision to $12.50 per MC is under review.

Of note is that these cost-cutting measures have been done within the framework of maintaining programme quality.

TRANSITION TO SUSTAINABLE VMMC PROGRAMMING (2019- 2021)

Rationale for the Transition to Sustainable VMMC Programming

Initially, scale-up, sustainability and maintenance were thought to be sequential- three distinct phases of the programme . However following in-depth stakeholder consultations it has become clear that while scale-up and maintenance remain distinct phases within the VMMC programme, sustainability is not a phase but rather a state or an approach that is applicable to both phases of the programme.

For the scale-up phase there is need for sustainable programming to ensure that limited resources are efficiently and effectively utilized allowing the programme to achieve more with the same resources in order to meet the underfunded scale-up targets. At the same time, in districts that have met or are near to meeting saturation there is need to employ sustainable delivery strategies to continue maintaining VMMC coverage, despite a change in target population and significantly reduced funding that is expected following programme scale-up. Modelling suggests that in the long-term, HIV incidence rates will rebound to the "no-intervention incidence rate" if the VMMC coverage is not maintained therefore a smooth transition is critical to maintaining the gains in impact made during scale-up. As these examples demonstrate, VMMC programming must framed and implemented through sustainable strategies in both the scale up and maintenance phases, particularly given the uncertain funding landscape

This Plan outlines clear and actionable strategies for transitioning both scale up and maintenance districts to sustainable VMMC programme implementation.

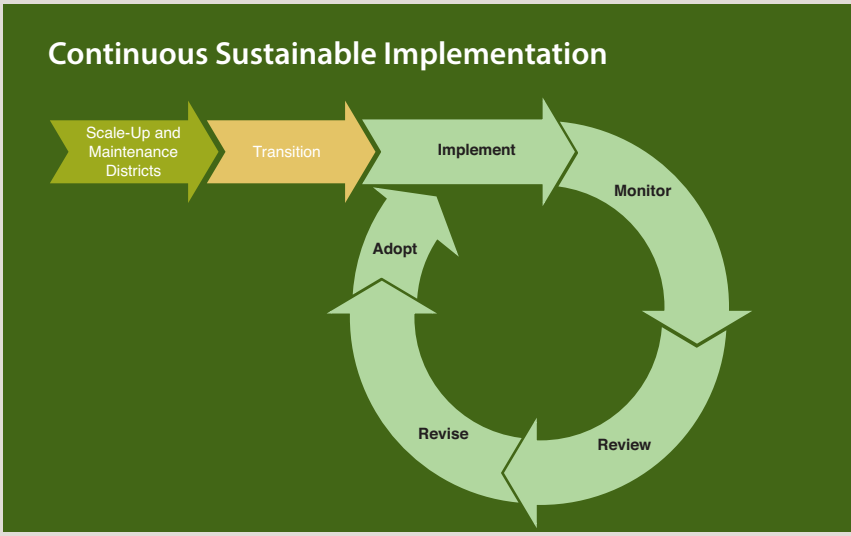
What is Sustainability?

While VMMC and most public health interventions in general are familiar with "scale-up" programmes, the term sustainability is a relatively new term that has been loosely referred to in different platforms over the last couple of years but has not been distinctly defined across programmes. VMMC is one of the first public health interventions to explore what it means to have a sustainable programme, with Zimbabwe pioneering this work. In the VMMC context, sustainability was originally associated with a transition from partner-support to government-led activities – as well as a transition around the target age population. While VMMC scale-up activities targeted men at highest risk of HIV infection in the near-term,

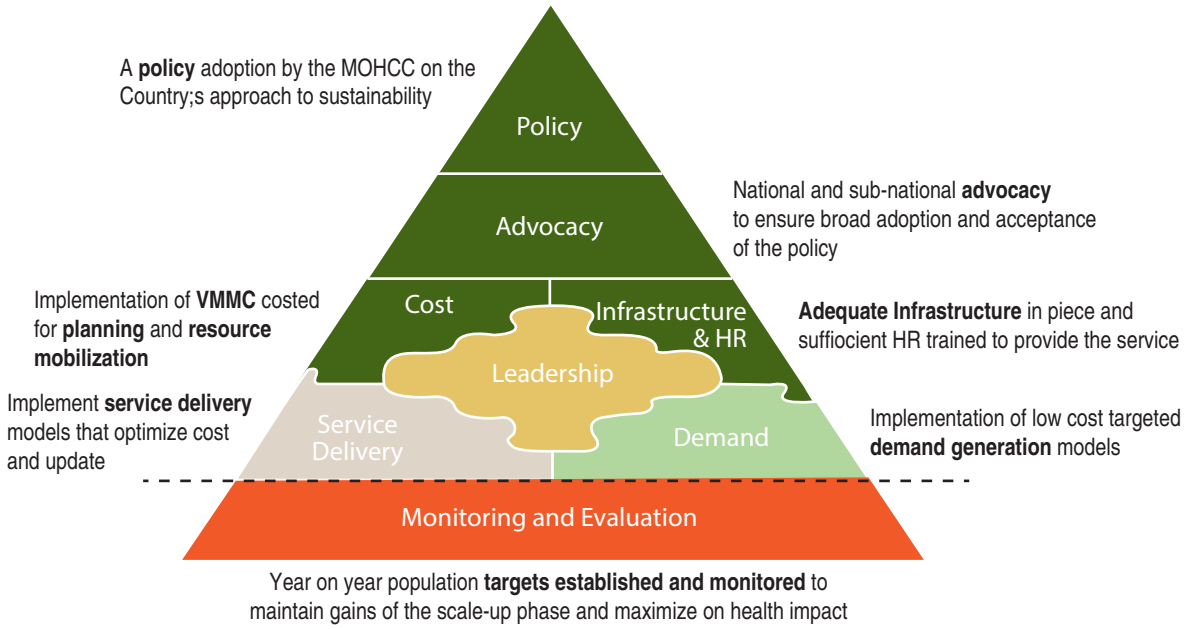
sustainability programming would focus on ensuring younger men were circumcised before sexual debut (either early-infants or early-adolescents). However, results from stakeholder engagements and interviews revealed that a sustainable VMMC programme is broader than just a financial or age-cohort definition; it would ideally have the following characteristics:

- **Integrated VMMC Programming-** Shift from vertical programming through the use of existing MOHCC staff for coordination of service delivery and demand generation activities, integrated M&E system, financial mechanisms and quality assurance platforms.
- **Operational Sustainability-** Effective government-led implementation of supply chain management, coordination, service delivery and demand generation functions with minimal technical assistance required
- **Extend Reach of Services-** Increasing access to services by capacitating more lower level health care facilities and training more staff
- **Tailored Programme targeted age cohort-** Age appropriate demand generation and counselling, partnerships with community and health organizations in order to reach and effectively serve adolescent males
- **Rooted in the Community-** Partnerships with traditional, community and religious leaders, parents, schools and teachers to foster local ownership which results in VMMC becoming a social norm that is driven by community demand for services
- **Policy Guided-** Amending the male circumcision policy to reflect sustainability strategy elements, including refining the school health policy to strengthen the link with the education Ministry
- **Evidence Guided –** Continued evidence based target setting to reach and sustain saturation coverage of appropriate target population, while leveraging impact modelling and other sources ofdata for decision making at all levels
- **Cost-effective–** Long term visibility into MC funding and adoption of cost effective strategies eg. Use of re-usable kits

A fully sustainable programme is the overall result of a successful **transition** from a vertical, heavily partner and donor supported programme to a more locally-owned and managed intervention. However, for most health interventions in Zimbabwe, VMMC included, sustainability is neither a state nor a phase. Rather, is an **ongoing process of continually strengthening local implementation and ownership with cost-effective approaches while maintaining the health benefits of the intervention.** Consequently, it requires frequent monitoring, review and adaptation overtime ensuring that interventions remain up to date and effective.



To implement the sustainability process as defined above for VMMC, Zimbabwe specifically identified the following elements as critical:



Zimbabwe Sustainability Work to Date

Zimbabwe's preparation for VMMC sustainability began even before the programme had formally defined what sustainability is. In accordance with the evidence-based and policy-guided characteristics mentioned above, some work has already been done in Zimbabwe to inform implementation of the transition to sustainable models:

2012

CeSSHAR Study qualitatively explored the acceptability of EIMC as aprevention intervention in Zimbabwe.

Findings concluded that **EIMC is likely to be an acceptable HIV prevention intervention** in Zimbabawe is barriers to uptake are appropriately addresses and fathers are specifically targeted by the program

2014

Excelsior Modelling

found that:

1. Adolescent MC is more impactful on HIV incidence reducation throughout the defined timeframe
2. EIMC unit cost was lower than for adolescents but the EIMC targets would be higher due to delayed impact resulting in the adolescent strategy having lower overall program costs with immediacy of impact

2015

IPSOS EIM/EAMC Study

Explored the drivers and barriers for parental decision making for EIMC and EAMC. Findings included:

1. Most respondents believe in MC before sexual debut
2. However parenst were inlikely to immediately opt for EIMC without sensitization
3. The father figure is most important in MC decision making
4. Doubts around community EIMC acceptability

Successful planning and implementation of this relies on strong government leadership and effective coordination by the MOHCC. This will involve decentralization of key functions from national level to sub-national officers. In addition, as partners began to phase out or change the focus of their support to the VMMC programme, programme planning, management, implementation and accountability should be integrated with other health programmes within the Ministry in order to maximize the use of the limited resources expected during this phase.

This Strategy reiterates the Government of Zimbabwe's commitment to the continued implementation of VMMC as part of a comprehensive HIV prevention programme.

Sustainability Definition

Through stakeholder consultations on the future of the VMMC programme, Zimbabwe has defined VMMC programme sustainability as:

"The managerial, financial and operational ability to deliver and maintain 80% voluntary medical male circumcision coverage to ensure long-term health benefits and reduction in new HIV infections. This is achieved through conformity to social norms, l ocal ownership rendering the programme affordable, accessible and acceptable to all."

2016-2018

WHO ASRH linkages Study
Has found the following:

1. The MC program provides an opportunity to increase boys knowledge about ASRH services
2. Integration makes better use of available resources and could reduce duplication therefore generating savings

2017

VMMC Impact Modeling showed that that VMMC has already made an impact with 6,000 - 19,000 infections verted between 2009 - 2016 with benefits growing significantly in the future.

Project SOAR DMPPT2 Modelling results also showed that adding EIMC increases impact by 4% and costs by 11% (2017 - 2050)

2018-2019

Sustainability Pilots are exploring the feasibility and acceptability of some of the proposed sustainability approaches. They will be carried out in five districts that are close to 80% saturation in the 15 - 29 target group.

A Human Centred Design approach was used to collect insights, ideate on potential sustainability models and test prototypes with intended users.

Sustainability Definition

Through stakeholder consultations on the future of the VMMC programme, Zimbabwe has defined VMMC programme sustainability as:

The managerial, financial and operational ability to deliver and maintain 80% voluntary medical male circumcision coverage to ensure long-term health benefits and reduction in new HIV infections. This is achieved through conformity to social norms, local ownership rendering the programme affordable, accessible and acceptable to all.

How Will the Transition to Sustainable Programming be Measured?

Transition to sustainable programming will be carried out in both scale up and maintenance districts on an ongoing basis. Given the variation in progress towards saturation, different implementation modalities and levels of funding, districts are likely to adopt, implement and maintain sustainable activities and processes at different rates. Thus, it will be important to initially measure district's baseline sustainability levels and subsequently assess their progress towards becoming more sustainable. A Transition Assessment Dashboard will be developed based on key indicators agreed upon by MoHCC and stakeholders with a plan for routine measurement overtime.

The Transition Assessment Dashboard indicators will span across all pillars of the programme and any other dimensions that emerge as important for sustainability, broken down into quantifiable steps towards the ideal state of sustainable programming. For instance indicators could be set for sustainable management and coordination, service delivery, demand generation, M&E as well as programme financing highlighting the ideal "sustainability end state" as the end goal then setting milestone indicators towards reaching this state against which districts will be measured by. Indicators will be established for both national and sub-national level with greater emphasis on sub-national indicators where implementation occurs. This will allow for districts to establish where they are towards reaching sustainability, highlighting where they are excelling and where they should improve. Indicators will also be differentiated into those that apply for both scale up and maintenance districts as well as those that only apply for districts having reached or approaching sustainability.

A baseline assessment will be carried out in 2019 across all districts with the province and national level will be responsible for monitoring and accounting for progress overtime.

Target Age Group

For the scale-up phase of the programme, Zimbabwe will continue to target males between the ages of 10-29 as done in the previous Strategy. For the maintenance phase, **Zimbabwe will adopt the early adolescent male circumcision (EAMC) approach, circumcising boys between the ages of 10-14 years of age.**

Zimbabwe will adopt EAMC rather than an EIMC (Early Infant Male Circumcision) approach given the advantages the former has over the latter in the Zimbabwean context. This was validated through stakeholder consultations, literature review and current global guidance. Specifically, EAMC offers the advantages of an already established capacity for service provision which minimizes start-up costs, the relative immediacy of impact[6] latent adolescent demand and existing community acceptance which has been cultivated during scale-up which saw consistently high uptake with almost 50% of all MCs, within this age group (Figure 13).

Target Age Group	
SCALE-UP	10-29 years
MAINTENANCE	10-14 years

[6] Excelsior Modeling, 2014

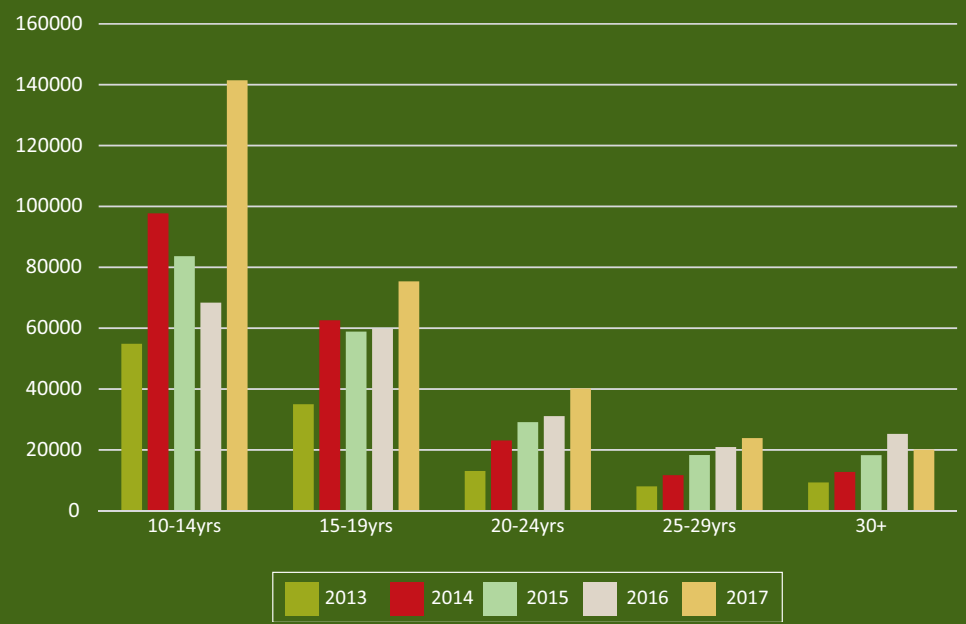
Initially there were also recommendations to explore a hybrid EIMC-EAMC approach which would be an ideal approach to close the gap as infants age into adolescents, but due to funding constraints, continuing with an adolescent-led approach is the most feasible and financially viable option for Zimbabwe. However, the country will continue to have EIMC as a potential option to be included if circumstances change. A detailed summary of the considerations for EAMC, EIMC and the EIMC-EAMC approach can be found in the Annex.

Target Setting

Evidence-based target setting is critical in ensuring VMMC achieves the desired epidemiological impact overtime. The ultimate aim of the VMMC intervention in Zimbabwe is to attain and maintain 80% coverage of the target age group nationally in a short a time frame as possible. For Zimbabwe this translates to a target of ~2M males by 2024. These targets were set in December, 2018 in a district-led approach using the following tools:

1. **DMPPT2-** The Decision Makers' Program Planning Tool which estimates district-level scale-up targets that can be varied to examine the numbers required to reach specified coverage rates by within a particular time frame (coverage scenarios)
2. **Capacity Assessment Tool-** District estimated capacity modeled from self-reported resources available within the district.
3. **Coverage Data-** A heat map informing districts of their current VMMC coverage/saturation level (used as the baseline/starting point)
4. **Historical Data-** District level performance since inception to inform districts of their current and highest achievements to date
5. **Target Setting Tool-** Customized tool allowing districts to set rationalized

Figure 13. Historical uptake of VMMC services by age group (2013-2017)



district target based off coverage scenarios selected

Provinces and districts used the tools above to set rationalized and achievable targets for their districts. To ensure progress towards this target by 2024 the VMMC programme will continue this annual target setting exercise. These tools will be updated to assess progress in the previous year allowing for room to course correct and reset the upcoming years target to ensure Zimbabwe is still on track to achieving 80% saturation by 2024. While the national level will continue to play a coordinating role, it is important that targets are set and informed by the districts and provinces to ensure targets set are realistic and have the necessary buy-in. On a technical level, the tools used for target-setting should be progressively simplified, automated and then handed over to government cadres in order to foster data-driven decision-making and programme ownership

To address the challenge of districts with unfunded targets, the programme will explore a clustering approach to target setting which would group funded and unfunded districts to leverage available funding to meet clustered targets. Evidence will be generated to support the advocacy of this approach to existing VMMC donors.

Cross-Cutting Themes

The following cross-cutting themes emerged as central to sustainable VMMC programming in Zimbabwe.

Decentralization

The need to decentralize services, demand, QA and even coordination stems from the desire to move VMMC to being managed locally within Ministry structures at national and sub-national levels, right down to community structures. Decentralization across all pillars will not only increase buy-in from key stakeholders but it will also foster a sense of accountability that is critical for programme sustainability success.

Integration

Integration can be defined in different ways depending on the context. For VMMC, the need for integration stems from the current programme being largely perceived as vertical in implementation. There is need to ensure that VMMC moves from being a standalone programme to being more integrated in existing Ministry structures and systems. For example, the ongoing VMMC linkages project aims to focus on this, demonstrating how youth services can be directly integrated in VMMC programming. Results from this study are expected to inform sustainability plans towards effective integration in existing health systems and structures.

Quality

When considering sustainability, the need to maintain quality programming given limited resources becomes critical. There is need to ensure that quality of services and general programme management are monitored and maintained overtime to ensure programme impact gains are sustained.

M&E

As previously described, sustainability is an ongoing process requiring revision and refinement overtime as the programme progresses towards its ideal state. Given this there is need to ensure routine monitoring and evaluation of strategies implemented across all pillars to maintain effectiveness.

Transition to Sustainable VMMC Programming (2019- 2021)

Strategic Goal 2019-2021

To support the smooth transition of the VMMC programme to sustainable programming in both scale up and maintenance districts by 2021 by achieving the managerial, financial and operational ability to reach and maintain 80% male circumcision coverage in 10-29 age group ensuring the long term impact of reduced HIV infection in Zimbabwe

Strategic Objectives

1. Programme Management and Coordination	To foster programme ownership & buy-in for VMMC as a part of Combination HIV Prevention across all key stakeholders
2. VMMC Services	To efficiently decentralize and strength VMMC services to ensure they are accessible, affordable and effective enough to meet both scale-up and maintenance phase targets
3. Programme Quality	Provision of high quality, safe male circumcision services through enhanced quality assurance and strengthened clinical mentorship
4. Demand Generation	To create sustainable, effective and efficient demand generation approaches that will eventually result in the transition to a state of high natural demand for VMMC services
5. Strategic Information	Strengthen the VMMC monitoring and evaluation system to ensure accountability and learning while integrating with other HIV prevention programmes
6. Programme Financing	To reach a state where there is adequate and predictable financing for the VMMC programme

1 PROGRAMME LEADERSHIP, MANAGEMENT & COORDINATION

Strategic Objective

To foster local programme ownership and buy-in for VMMC as a part of Combination HIV Prevention across all key stakeholders

Key Strategies

I: Decentralize key VMMC programme functions to ensure effective contextualized programming

II: Streamline current dedicated VMMC roles at national and provincial levels to broaden the scope to include HIV prevention functions

III: Establish a multi-sectoral approach to VMMC by developing partnerships with relevant inter and intra Ministerial departments; donors and implementing partners as well as community stakeholders to ensure effective buy-in and involvement at the different levels

During the next three years of VMMC implementation, the programme will transition from being vertical to a more integrated programme. This programme transition will require buy-in and ownership from relevant national and subnational leadership within government as well as community stakeholders in order to ensure effective implementation. This transition process will involve shifting of roles and responsibilities from current partners to government leadership. Three key focus areas for transition are:

1. Governance/Institutional transition – changes in the institutions/entities responsible for leading and managing the programme
2. Programmatic transition – e.g. changes in the modalities , scope and level of services provided
3. Financing transition – changes in the source of financing or the level of financing available

Leadership

Zimbabwe is traditionally a non-circumcising country and as such there is need for political will to play a strong advocacy role in justifying the continued implementation of the VMMC programme. More specifically, there is need to advocate for increased allocation of resources to VMMC and HIV Prevention as a whole. The resources needed to implement the

programme lie in different sectors thus there is need for a multi-sectoral approach in order to unlock these resources for the programme. In addition, current demand generation has focused on men in the target age groups, however moving forward there is need to target the whole community due to the appreciation of the reciprocal, virtually inseparable link between the community and men. Leaders have a role to play to ensure that appropriate stakeholders are identified, trained and activated to support the programme.

Management and Coordination

Internally within the MOHCC and across all levels there is need for an increase in programme ownership with well-defined roles, responsibilities and performance management mechanisms. This will involve decentralized programme management with sufficient and qualified staff at sub-national level as the decision making unit. Opportunities for integrating management and coordination functions need to be explored for efficient implementation and use of resources. Partnerships with donors and other government departments to accelerate the integration of VMMC services will also need to be deliberately managed. The success of the programme moving forward will rely on clearly defined roles and responsibilities across all levels which will strengthen accountability, effectiveness and efficiency of programme delivery.

Key Strategy I: Decentralize key VMMC programme functions to ensure effective contextualized programming

The VMMC programme will decentralize select functions from national to subnational level in order to allow for greater context specific innovation and control of programme activities at lower levels. Table 3 below shows how the roles will be delineated across the levels of the MOHCC system. This decentralization will not be limited to districts that are near to or have reached saturation. In order to ensure effective capacity building nationally, leadership functions across all districts will be decentralized, however this will be implemented using a step-wise approach starting with districts already in the maintenance phase.

A **Transition Plan** will be developed to ensure effective transition of roles and functions across the programme. In order to ensure these roles are effectively transitioned and implemented, a results based management approach will be adopted. This will include the results based financing (RBF) mechanism where a transition from the current cost reimbursement which is not linked to results will be substituted by a performance based financing framework. Furthermore, transformational leadership and VMMC specific capacity training to targeted leaders across all levels will be conducted in order to increase their ability to execute evidence based decision making as well as financial management.

Priority functions to be decentralized include:

Beyond decentralization of roles of Ministry duties at national level, a partner stakeholder mapping exercise will also be carried out to identify which partner functions will also be transitioned to the Ministry at both national and subnational level. For example, AE management activities will have to be transitioned to be

Table 3. Key roles and responsibilities across the MOHCC system

	National Level	Provincial Level	District Level	Facility Level
Annual Targets & Plans	Consolidate national VMMC targets and implementation plans Monitor national programme progress towards saturation	Use target setting tool(s) to revise and redefine targets annually Monitor progress against district implementation plans	Conduct ongoing analysis towards development and revision of targets Develop District Implementation Plans	Conduct ongoing analysis towards development and revision of targets Develop District Implementation Plans
Technical & Strategic Policy Development	Advocate for policy change and manage change and effecting of new policies based on evidence collected Convene and manage partnerships, facilitate policy resolutions on technical and strategic issues.	Gather evidence; synthesize findings from research and analysis to develop recommendations on key issues of strategic and technical concern. Provide analysis to support VMMC PMU and policymakers wishing to advocate for policy change.	Document implementation best practices and lessons learnt for sharing Conduct ongoing research	Identify and report best practices and lessons learned Participate in research studies
Quality Standards	Develop and disseminate QA standards and tools. Identify areas of non-compliance, and review challenges with relevant implementers.	Support QA activities routinely Identify areas of non-compliance, and review challenges with relevant implementers	Maintain quality standards in the implementation of the VMMC programme based off guidelines	Conduct VMMC services according to set quality standards and guidelines
Human Resources and Training	Develop and update training guidelines Regulate standards, quality of training and staffing skills	Facilitate trainings of providers Maintain database with inventory of trained staff, analysis of training needs; Develop human resources training plans	Routinely identify and share training gaps	Report on staff trained, attrition and training needs
Performance and Progress Review	Liaise with provincial offices to review progress and performance, and to identify opportunities for improved performance; address issues of non-adherence to policy, and support convening of provincial and district coordination committees.	Develop and produce reports to highlight performance gaps and suggest opportunities for course correction.	Manage data collection, analysis and development of reports. Convene district coordination meeting with relevant stakeholders	Report on staff trained, attrition and training needs

included into existing MoHCC management systems. In addition to partner functions, the transition plan will also outline the plan for transitioning VMMC assets currently managed by partners.

Key Strategy II: Streamline current dedicated VMMC roles at national and provincial levels to broaden the scope to include HIV prevention functions

Scale-up of the VMMC programme called for a vertical, stand-alone approach in order for the programme to meet the high targets set. The management and coordination functions also called for an increase in dedicated VMMC staff at both national and sub-national level. However, as the programme starts the transition to sustainable programming, the need for dedicated staff will decrease and roles will have more focus on ensuring VMMC is integrated with other HIV prevention programmes in line with the national policy on HIV combination prevention.

National Level

During this dual track scale-up and maintenance phase, the VMMC PMU team composition will remain the same, maintaining the roles outlined for scale up but also adding functions that ensure integration with key Ministries (education) and departments (ASRH) as well as strengthening of other HIV prevention programmes within the Ministry. Similar to the current role of the Advocacy and Communications Officer, the cadres will support other prevention programmes while ensuring VMMC is optimally integrated into existing activities. This approach aims to not only ensure effective integration of VMMC but also aims to strengthen existing prevention programmes, optimizing the use of available resources across programmes.

The Steering Committee and TWGs will continue to function as is and an additional Group will either be formed or the sustainability agenda will be integrated into existing Groups to support the transition of the programme to sustainability, reporting to the Steering Committee.

Provincial Level

The addition of PVOs successfully resulted in increased prioritization and visibility for the programme. During this transition to sustainable programming, the PVO's role will evolve ensuring that:

1. Some of the VMMC scale up functions have been successfully transitioned to the relevant staff at provincial and district level and
2. Their scope is broadened to support more linkages activities at provincial level ensuring integration and optimization of HIV prevention activities

This streamlining of responsibilities both at national and provincial level will require a mapping exercise that clearly delineates roles and responsibilities between existing cadres and the VMMC staff therefore preventing issues to do with overlap and redundancy of roles. A mapping of role alignment and support plan will be developed and with both national and provincial roles gradually transitioned/integrated to support the combination HIV prevention agenda.

Key Strategy III: Establish a multi-sectoral approach to VMMC by developing partnerships with relevant inter and intra Ministerial departments; donors and

implementing partners as well as community stakeholders to ensure effective buy-in and involvement at the different levels

In order for success of the programme to be realized, there is need for a multi-sectoral approach to doing business. A robust stakeholder mapping exercise will be carried out in order to identify key stakeholders at all levels as well as existing financial, programmatic and governance gaps and the bottlenecks and risks that need to be addressed across all of the VMMC implementation pillars.

Inter-Ministerial

Systematic linkages will need to be established between the education, sports and entertainment sectors and their various leadership. The education sector is particularly important because the adolescents 10-14 years who spend most of their times in school will be the focus for sustainability. Given this, the Ministry of Primary and Secondary Education (MOPSE) will play a key role in all transition to sustainability activities. The Ministry of Finance will also be engaged to ensure advocacy for increased local funding for VMMC and HIV Prevention as a whole.

Intra-Ministerial

Within the Ministry of Health, the following departments will continue to be engaged at relevant times:

- **Adolescent and Reproductive Sexual Health (ASRH)–** to explore and identify opportunities for linkages for service provision to adolescents.
- **Nursing Services-** to strengthen the training curricula and advocate for the inclusion of VMMC for pre-service training
- **Health Information and IT-** To strengthen the integration of the VMMC M&E system
- **Quality Assurance-** To integrate QA/QI processes and procedures for MC into MoHCC processes
- **Health Promotion-** To ensure continued engagement and implementation of the school health policy

At provincial level, VMMC as a part of combination HIV prevention, will be adopted as a key agenda item for all PHT and DHT meetings to ensure activities are monitored and remain a priority.

Donors and Implementing Partners

While funding for the VMMC is expected to decline as the programme transitions to sustainability, partners will continue to play a critical role in supporting the Ministry in meeting the targets. Partners will continue to provide the following support:

- Implementation of effective service delivery and demand generation approaches
- Technical assistance in data, quality and training issues
- Operational research
- Effective transition of roles to the Ministry among others

Additional partner support will also be identified as the programme shifts to integrate with other HIV prevention activities. However, it is expected thatthe partner's role may change in the long term to be more of technical assistance and not implementation.

In order to ensure effective partnerships, ***accountability mechanisms*** *will be developed and signed between relevant Ministries, MoHCC departments and partners to ensure there are agreed upon integration deliverables to be monitored and reviewed annually.*

Community

As with scale-up, the community will continue to play a critical role within the programme. Given this, the programme will clearly map out and identify key players in the community, outlining a plan of key stakeholders to be engaged particularly during the transition to sustainability to ensure VMMC becomes part of a social norm to drive demand in Zimbabwe. Community leaders such as religious and traditional leaders will continue to be leveraged as they play a key role in driving community norms and practices. The community will also play a pivotal role in ensuring programme quality with parents, caregivers and teachers participating in wound care management post circumcision. By providing consent, parents also play a role in increasing access to services for adolescents. Successful interventions observed during programme scale up such as the engagement of religious leaders in the community will be scaled up to ensure programme success.

EQA Team views VMMC Caravan

Strategies Summary Table: Programme Management and Coordination

To foster local programme ownership and buy-in for VMMC as a part of Combination HIV Prevention across all key stakeholders

Key Strategies for 2019-2021

I: Develop a Transition Plan outlining revised roles and responsibilities within Ministry and between Ministry and VMMC partners

- Implement and monitor transition plan over time
- Conduct transformational leadership and VMMC specific capacity training to targeted leaders across all levels
- Conduct partner mapping exercise identifying roles to be transitioned at national and sub-national level
- Develop tools to improve data for decision making

II: Streamline current dedicated VMMC roles at national and provincial levels to broaden the scope to include HIV prevention functions

- Conduct mapping exercise for the national HIV Prevention Department streamlining roles and responsibilities to match department needs
- Conduct mapping exercise at provincial level to broaden the scope of the PVO
- Implement and monitor streamlined roles and responsibilities at national and subnational level overtime
- Establish VMMC Sustainability TWG platform

III: Establish a multi-sectoral approach to VMMC by developing partnerships with relevant inter and intra Ministerial departments; donors and implementing partners as well as community stakeholders to ensure effective buy-in and involvement at the different levels

- Establish accountability mechanisms with relevant Ministries, MoHCC departments and partners to be routinely monitored
- Conduct a robust stakeholder mapping exercise outlining plans to ensure continued engagement necessary for programme sustainability goals
- Identify key community stakeholders and develop an engagement plan
- Implement and monitor stakeholder engagements plans at all levels

2 VMMC SERVICES

Strategic Objective

To efficiently decentralize and strengthen VMMC services to ensure they are accessible, affordable and effective enough to meet both scale-up and maintenance phase targets

Key Strategies

I: Effectively increase human resource capacity to provide quality VMMC services through the scaling up of innovative, cost efficient strategies

II: Adequately equip and strengthen lower level health facility capacity to provide quality VMMC services

III: Decentralized approach to planning, coordination and implementation of VMMC services, capacitating the district and provincial level to effectively use data for decision making

IV: Scale-up identified innovations for cost efficient service delivery

As the programme transitions to sustainable implementation, stakeholder consultations consistently highlighted the need for the decentralization and implementation of an integrated, effective and efficient VMMC service delivery model that is accessible, acceptable and affordable. **A model where services are offered on a routine basis at static sites is considered ideal for VMMC sustainability.** Decentralizing service delivery means moving away from the expensive outreach model and having VMMC services offered at as many health facilities as possible. In order for this to happen, facilities will need to be adequately equipped and require their staff to be trained to offer services.

However, there are real constraints in achieving this ideal state as currently most lower level health facilities do not have VMMC trained staff to offer the service and some remote areas do not have adequate or any health facilities. There is need to further investigate the role and associated costs for continued outreach services particularly for these remote site. In addition, planned outreaches akin to the approaches for child health week, HTS campaigns and nutrition weeks will also be explored for integration with VMMC activities. The objective of this Strategy is to address steps that can be taken to achieve this goal of decentralizing VMMC services.

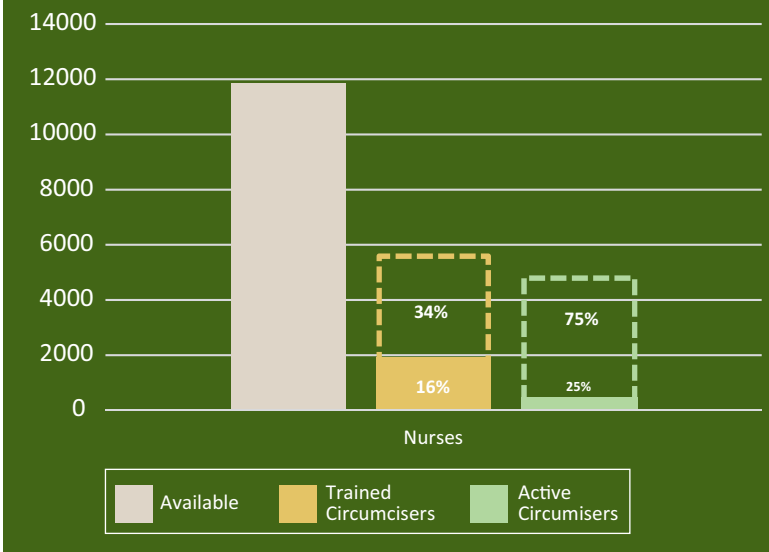
Increasing the district's capacity by training more staff at more health facilities can ensure that those facilities are able to offer VMMC services, and if needed go for outreach in the catchment areas they serve. This approach of increasing the number of static sites would reduce costs by ensuring that utility of the outreach model which constitutes 70% of current services is reduced therefore saving on transportation costs. A sufficient number of staff trained in VMMC will allow for decentralization of the services and generate a rotating pool of VMMC trained staff who can be assigned to VMMC on the duty roster at major institutions. Increasing the number of trained staff will also address resentment issues identified from staff previously not involved in the programme.

Given that VMMC requires space and a team of at least two people with a client at a time, space and staff constraints at lower health facilities such as Rural Health Centers (RHC) might limit the feasibility of these facilities offering VMMC on a routine basis. However with trainings, they would only need one or two complementary team members to join them from a larger health facility if demand is high. Once VMMC coverage is high the maintenance targets might be so low that even RHCs can cater to those one or two clients a day who come in for VMMC.

Key Strategy I: Effectively increase human resource capacity to provide VMMC services through the scaling up of innovative, cost efficient training modalities

In order to decentralize and ensure circumcisions are done at the lowest level across most health facilities, the number of trained VMMC cadres will need to increase. Increasing capacity for VMMC will take a systematic approach that involves the **development of an In-service Training Plan** that takes into account the current gaps (Figure 14) while at the same time **establishing a Pre-service Training Module for VMMC** to ensure that the annual pool of new clinicians that enter the health system already have the competences required for VMMC service delivery. Concurrent to increasing the number of health workers trained in VMMC service delivery will be the need to increase utilization of those trained cadres. The focus of this plan will be to increase the training of nurses as these are most likely to provide the VMMC service. **The goal is to decentralize and increase the number of trained nurses from 16% to 50% of the currently available pool of health workers by 2021 with the aim of 100% of them being active (Figure 14).** The sustainability implementation pilots will also be used to inform the programme of the optimal number of health workers that need to be trained per district.

Figure 14. National cascade of trained nurses in VMMC service delivery and identified training gap



Note-Dotted lines indicate the target

Given this, modalities for both in- and pre-service training need to adapt to cater to the increased training needs. The status quo of six day trainings, at a hotel at provincial level will not suffice as it will be too costly and time consuming to train large numbers of staff this way. **A blended learning approach** will be adopted to address this bottleneck. This approach uses a mixture of online modules which cover the theoretical sessions and in-person sessions at facilities to learn the practical skills. This will reduce the overall number of in-person training days from the current six days as well as reducing conferencing costs. **Further decentralization of training of trainers** will also be done to increase the number of provincial trainers allowing for concurrent trainings and certifications to occur in different parts of the country eliminating the bottleneck of waiting for centrally based trainers.

In addition to having trained surgical staff, the number of staff trained in support roles such as theatre assistant, VMMC clerical work, supply chain coordination and health promotion will also need to increase. All trainings will be followed by certification of trained service providers.

For existing VMMC staff, **refresher trainings** will be conducted to update staff on new policy issues, strengthen identified programmatic challenges and for maintenance of existing practical skills. There is also need for **ongoing capacity building and mentorship**. Attachment of trained service providers to experienced facilities (centres of excellence) and follow-up support and supervision will facilitate transfer of practical skills needed for safe and efficient provision of male circumcision services. Regular facility mentorship and support for new sites to be carried out by district executive teams. A tracking system for VMMC trained staff clinicians will need to be developed to keep track of staff when they transfer to other facilities or districts. The programme will explore integrating VMMC into existing MoHCC HR tracking platforms.

Key Strategy II: Adequately equip and strengthen lower level health facility capacity to provide quality VMMC services

The goal for sustainability is to shift the ratio of MCs done using the outreach model in favour of the less expensive static model where possible. In addition to having trained staff, health facilities that are to become static sites also need to be adequately equipped. Increasing the number of static sites offering VMMC will be done in a phased approach by prioritizing high volume rural health centers. Site Capacity Readiness Assessments will be conducted to determine the gaps and readiness of the potential sites. The assessment will take into account the space to conduct services, number of available beds, theatre availability, waste management facilities and autoclaving capabilities among others. The existing indicators in the assessment tool currently used will be revised and edited where necessary.

Key Strategy III: Decentralized approach to planning, coordination and implementation of VMMC services, capacitating the district and provincial level to effectively use data for decision making

District-level planning, coordination and implementation of VMMC activities is critical in ensuring effective, locally owned service delivery. Sustainable programming at implementation level will likely differ

across districts with no set strategies that can be applied across all districts due to the heterogeneity that exists between regions. Given this, sustainable programming will need to be informed and implemented in a bottom-up approach. VMMC team leads and district leadership will be trained in VMMC programme management and equipped with tools to allow them to effectively determine the service delivery approaches to adopt in order to meet their target, given their resources. Emphasis will also be made on the need to effectively match supply and demand to allow for efficient use of resources.

To capacitate districts to make data driven decisions for VMMC planning and management, a dynamic decision making tool will be designed to help with decision making for various decisions such as determining the number of teams their district requires, selecting a service delivery model that allows the district to meet itstarget, or identify catchment areas that could use a mop up campaign based off MCs done by facility.. Customized tools such as this one will be developed and rolled out to ensure effective, context specific, tailor-made VMMC programming. Routine monitoring of strategies deployed will be required to ensure effective implementation.

Key Strategy IV: Scale-up identified innovations for cost efficient service delivery

The programme will continue to scale-up up identified service delivery innovations that are cost efficient. This is particularly important when considering the transition to sustainability where there will be less funding available.

One approach is **the use of one circumcision method in order to minimize costs associated with procurement and training.** Dorsal slit will be adopted as the surgical circumcision method for Zimbabwe. It is the most ideal method as it can be employed in all age groups unlike the current restrictions observed with the forceps guided and non-surgical methods. In-line with the need to reduce costs the programme will also **scale-up the use of re-usable kits** in a phased approach with the goal of reaching 100% reusable kits across all districts by 2021 (43% in 2019 and 51% in 2020). For lower level facilities that do not have surgical capacity, the potential to use non-surgical devices will also be explored.

The effectiveness of integrated **school health programme innovations** such as the use of school health coordinators for coordination of VMMC services are anticipated to be informed by the sustainability pilots currently being carried out. Results will inform how services, particularly for adolescents will be scaled up and utilized to meet programme needs.

Operational research and lessons learned locally and within the region will continue to be conducted and tracked to inform scale-up of cost efficient strategies for the VMMC programme in Zimbabwe.

Strategies Summary Table: VMMC Services

To efficiently decentralize and strengthen VMMC services to ensure they are accessible, affordable and effective enough to meet both scale-up and maintenance phase targets

Key Strategies for 2019-2021

I: Effectively increase human resource capacity to provide quality VMMC services through the scaling up of innovative, cost efficient strategies

- Continued in-service training and introduction of pre-service training
- Introduction of online blended learning
- Further decentralisation of training to lower health facilities
- Refresher trainings and conversion to dorsal slit
- Training of support staff
- Facility mentorship and support for new staff. Attachment to experienced facilities (centres of excellence or to outreach team) and follow-up support and supervision

II: Adequately equip and strengthen lower level health facility capacity to provide quality VMMC services

- Increase number of static sites offering VMMC in a phased approach
- Update and conduct capacity site readiness assessments for potential static sites
- Upgrade of infrastructural capacity to cover gaps identified

III: Decentralized approach to planning, coordination and implementation of VMMC services, capacitating the district and provincial level to effectively use data for decision making

- Train district level leadership in VMMC programme management and decision making
- Develop customized tools to inform district level planning and coordination
- Routinely monitor strategies deployed

IV: Scale-up identified innovations for cost efficient service delivery

- Focus on one surgical method which is dorsal slit
- Scale up the use of re-usable kits in a phased approach
- Explore potential devices for scale-up in RHCs
- Adopt effective integrated school health strategies informed by sustainability pilots

3 VMMC PROGRAMME QUALITY

Strategic Objective

Provision of high quality, safe male circumcision services through enhanced quality assurance and strengthened clinical mentorship

Key Strategies

I: Strengthen and decentralize VMMC programme quality assurance initiatives at all levels of care

II: Decentralize VMMC clinical mentorship from national to sub-national level to strengthen quality of VMMC service delivery

III: Strengthen adverse event surveillance and management to improve reporting and management of AEs

Moving forward, the VMMC programme will place a greater emphasis on quality and extra measures will be put in place to ensure provision of high quality, safe male circumcision services through enhanced quality assurance and clinical mentorship activities. Quality assurance covers all aspects of VMMC programming including routine counselling activities, HIV testing, infection prevention and control practices, as well as demand creation.

Key Strategy I: Strengthen and decentralize VMMC programme quality assurance initiatives at all levels of care

National biannual IQA and biennial EQA exercises will continue to be carried out led by the national VMMC team. **IQAs will be done using an electronic platform** which allows for the data to be collected and stored in a manner that is easily accessible. PSI Health Network Quality Improvement System (HNQIS) software has been identified and piloted as a potential electronic IQA platform for use that provides quick and relevant analyses down to facility level such as trends of quality improvement over time. The programme is currently developing a platform that links the use of HNQIS to DHIS2 Tracker, a national data management system to allow for improved integration with national systems.

Additional **QA exercises will be decentralized to sub-national level** to allow for more frequent monitoring and supervision of all circumcision teams. The revised cost reimbursement schedule (2018) has made provisions for district level supervision by DHE members to occur monthly and PHE supervision every

quarter. Follow-ups for continuous quality improvement will be strengthened and integrated into existing QA programmes at sub-national level. Relevant staff will be trained on the VMMC IQA process to facilitate this integration. In addition, integrated DHE and PHE checklists for continuous quality assurance improvement implementation will be developed and rolled out. The checklist will include indicators capturing number of AEs and the number of reviews conducted per client. The programme will **leverage the use of incentives through cost reimbursement and/or RBF** to ensure that CQI activities are conducted at sub-national level. In addition, there is need for continuous revolving fund for the management for long term AEs.

Key Strategy II: Decentralize VMMC clinical mentorship from national to sub-national level to strengthen quality of VMMC service delivery

The clinical mentorship programme will grow to meet the needs of an expanding VMMC workforce which needs to keep up with the latest and safest techniques for VMMC. The programme will look beyond the current centrally-based specialist surgeons for mentors and **identify doctors and/or surgeons based at sub-national level** to allow for more frequent visits therefore strengthening the quality of the programme. **A VMMC module will eventually be built into the broader AIDS and TB department's Clinical Mentorship Programme** so that VMMC is integrated with other AIDS and TB programmes' therefore strengthening programme sustainability. There is need for development of a guide for clinical mentorship which includes competencies informed by a skills assessment.

Key Strategy III: Strengthen adverse event surveillance and management system to improve reporting and management of AEs

Clinicians at health facilities should be able to identify AEs, classify them and refer them for management using the appropriate channels. AE reporting rates still need to improve until such a time when all AEs are reported for monitoring purposes. The programme will explore alternative ways to validate and strengthen AE reporting. In addition, **Clinicians will be sensitized to be able to identify and report AEs** referring to AE guidelines. There is need for development of poster case definitions as reference guides. In addition, **active surveillance of AEs during the review period will be strengthened** ensuring that reviews are correctly conducted at day 2, 7 and day 42. The number of day 2, day 7 and day 42 reviews done will be part of the indicators used for the incentive based RBF mechanism to be introduced, linking follow-ups with performance incentives.

To strengthen surveillance, the programme will advocate that **VMMC severe AEs be included as a weekly notifiable condition** on the national platform. This will involve engagement of the Health Information department. In addition, resource mobilization activities will be carried out to ensure that in the future, adverse events are managed using MoHCC referral pathways with MoHCC covering the cost of AE management.

Strategies Summary Table: VMMC Programme Quality

Provision of high quality, safe male circumcision services through enhanced quality assurance and strengthened clinical mentorship.

Key Strategies for 2019-2021

I: Strengthen and decentralize VMMC programme quality assurance initiatives at all levels of care

- Multi-level IQA routinely conducted (Facility monthly, District IQA every 2 months, Quarterly integrated District & Provincial IQA, Biannual National IQA)
- Capacitate sub-national level staff in the VMMC IQA process
- Adoption of electronic and mobile tools to monitor quality improvement e.g. use of HNQIS
- Leverage the use of incentive based systems to strengthen programme quality

II: Decentralize VMMC clinical mentorship from national to sub-national level to strengthen quality of VMMC service delivery

- Increase the number of clinical mentors at sub-national level
- Develop guide for clinical mentorship
- Include VMMC as a part of the national Mentorship Programme

III: Strengthen adverse event surveillance and management to improve reporting and management of AEs

- Sensitize and train clinicians on the identification and reporting of VMMC AEs
- Strengthen active surveillance during the review period
- Advocate for the inclusion of VMMC severe AEs as a weekly notifiable condition
- Integrate AE reporting and management into routine MoHCC system for the reporting, referral and management of health complications

4 DEMAND GENERATION

Strategic Objective

To create sustainable, effective and efficient demand generation approaches that will eventually result in the transition to a state of high natural demand for VMMC services

Key Strategies

I: Create sustained demand for EAMC through integration of VMMC education in schools

II: Employ a decentralised approach to planning, coordination and implementation of VMMC Demand Generation to establish context specific implementation

III: Strengthen the role of the community in demand creation to allow for implementation of locally grown strategies

IV: Integration of VMMC Advocacy and Communication as part of Comprehensive HIV Communication Strategy

V: Define what needs to be done in order for the VMMC to transition to a state of high natural demand

Most communities in Zimbabwe do not circumcise traditionally so VMMC is therefore a unique programme to market. It is a prevention intervention with benefits that are not realized immediately, targeting males, and a group with low health seeking behavior and there are still a lot of myths and misconceptions about the procedure. **An ideal state is where VMMC becomes a social norm and males seek out services without being actively mobilized** and leverage existing health promotion platforms. In order to fully understand what it will take to reach this state, interdisciplinary research will be conducted to investigate the building blocks needed to engineer a shift that can result in VMMC becoming a social norm.

Scale Up

The programme will continue to identify and implement effective demand generation strategies for scale-up. At this stage of the programme the easy to reach males have already been circumcised so it is critical to ensure that strategies being employed are effective in reaching the target population of 15-29. Inclusion of existing successful strategies such as the use of service providers as mobilizers and targeting religious groups. Market research for VMMC will continue to be updated to

ensure that there remains a clear understanding of the male segments in Zimbabwe.

Sustainability

For the transition to sustainability, the programme will identify and scale-up cost effective mobilization strategies. As Zimbabwe has adopted EAMC (10-14years), it is expected that ongoing sustainability pilots will inform effective adolescent mobilization strategies to be adopted. The use of school health coordinators and youth centers is expected to play a critical role in reaching these males.

Key Strategy I: Create sustained demand for EAMC through integration of VMMC education in schools

VMMC in the School Health Curriculum

In Zimbabwe, an estimated 97.4%[7] of 10-14 year olds are enrolled in school, presenting an opportunity to mobilize large volumes of this target age group through schools, where they are congregated. Instead of using schools simply as a location for IPCs to mobilize adolescents, they can be an avenue to overcome one of the biggest barriers to accessing EAMC— lack of adequate, age-appropriate knowledge on VMMC among adolescent boys. There is need to prevent coercion on implementation of EAMC, particularly if incentives are involved. Measures will be put in place to ensure that circumcision remains a voluntary, elective procedure.

Among adolescent boys, there is a strong belief in myths and misconceptions about VMMC which are often spread through peer networks and a lack of an understanding of the various immediate and long-term benefits of VMMC[8]. To increase knowledge of VMMC in early adolescents, the MoHCC will work closely with MOPSE to introduce VMMC in the school health curriculum. VMMC content will be taught to students with age-appropriate messaging which communicates the benefits of VMMC and corrects known myths and misconceptions. VMMC education will help adolescents not only overcome their own knowledge barrier but it will create a ripple effect where they are able to effectively communicate about and advocate for VMMC to their parents, guardians and peers. With time, the knowledge of VMMC benefits will contribute to creating passive demand for the programme, men who do not need to be actively mobilized but seek out VMMC services because they understand the health benefits.

In addition, there is need to continuously innovate on demand creation approaches for men and boys to identify effective strategies and messaging. These innovations will assist in reaching the last males who are hard to reach.

Training of Teachers and School Health Coordinators in VMMC

Mobilizing students in schools will continue to happen with some process modifications. Instead of IPC agents going to schools to address students directly about VMMC, school teachers and health coordinators will play the role of sensitizing students about VMMC. The

[7] Calculated based on 2017 MOPSE Statistics report

[8] Insights from PSI EIP exercises with adolescent boys, community leaders, parents and health workers during the development of sustainability pilot models.

teacher is a trusted source of information for students and parents. The fidelity of information provided by teachers is believed to be greater given their training and relationship with students. The MoHCC will train teachers and school health coordinators in VMMC so that they assume the role of teaching students about VMMC.

MOPSE and MOHCC Interaction Pathway

At the district level, MOHCC and MOPSE will work on establishing an interaction pathway that defines how health facilities will work with schools to get students circumcised. At that level the stakeholders will decide how consent forms are distributed, consent form verification, scheduling of VMMC services, organizing transport for service delivery and identification of focal persons from both the education and health sector who coordinate activities.

Key Strategy II: Employ a decentralised approach to planning, coordination and implementation of VMMC Demand Generation to establish context specific implementation

Demand generation and advocacy for VMMC needs to be tailored made for the audience. Cultural beliefs, patterns of economic activity, demographics are just a few of the variables that determine what message will be accepted and where. It is imperative that the coordinating of VMMC advocacy and demand generation activities happens at a level where proximity to the target audience is high, making it more likely to come up with effective strategies for mobilizing men and creating community buy in for VMMC. The MOHCC will decentralize demand generation planning to the district level.

District Demand Generation Plans

Districts will be responsible for developing their own demand generation plans which outline which stakeholders the MOHCC will work with to create demand for VMMC, which platforms are to be used for advocacy and when the required activities will take place. Microplanning at the sub-national level also allows for opportunities to iterate the approaches being used to achieve set district targets. Districts will have the autonomy to make decisions on how they will tap into the existing demand in traditionally circumcising communities or maximize numbers elsewhere in the district if they have communities that are highly resistant to VMMC.

Routine monitoring and evaluation of the district's demand generation micro-plan is necessary for assessing the effectiveness and quality of their demand generation activities. Districts will track demand generation activities, their cost and rate of turn-over so they can easily identify which methods are working and can be scaled-up and which methods are not yielding any results.

Demand Generation Capacity

To achieve the demand generation and advocacy goals, additional human resource capacity for VMMC will be required. Not all health workers at district level are trained in VMMC advocacy and communications. Depending on their available capacity and set target, districts will leverage community health workers, village health workers, community nurses, EHTs among other staff to implement their

demand generation plans. Training of district identified cadres in VMMC demand generation and advocacy will be required to fully capacitate districts to carry out demand generation activities in the community. There is need to standardize training for VMMC demand generation by using the national demand generation training manual and providing certification of attendance for VHW and school health coordinators. Existing trained healthcare workers can be sensitized in VMMC demand generation. Given the high attrition rate of mobilizers, there is need to develop a system to effectively track trained VMMC mobilizers in the community.

Key Strategy III: Strengthen the role of the community in demand creation to allow for implementation of locally grown strategies

The community is a key stakeholder in VMMC demand generation. Community perceptions and peer-influence shape the uptake of VMMC by men. As such it is important that community systems of flow of information are understood and utilized for VMMC information dissemination. Using community influencers and champions for VMMC advocacy has been done before with varied success. Mass advertisements with paid celebrities drew public attention to VMMC and raised awareness. The programme has matured to a stage where people know what VMMC is though they might not necessarily have adequate knowledge. Influencers bridge the gap between knowledge of VMMC and the action of going for male circumcision. They are especially important for adolescents who need a parent or guardian to sign the consent forms. Stakeholder consultations revealed that mothers, fathers, older brothers, peers and health workers were key influencers in the decision pathway. VMMC communications and advocacy efforts have to reach the influencers as well as the target males to be successful.

Community Based Advocacy and Communication

The VMMC programme, through district health teams, will continue to conduct community sensitization and demand generation efforts in the community that have active involvement of local influencers—traditional, religious and local leaders, circumcised men, mothers and fathers who are VMMC champions. Local leaders are more likely to be effective in convincing men to take action because of their rapport, understanding of barriers to VMMC uptake in the community and their ability to follow up.

Utilize Existing Community Health Structures

The MoHCC and its partners have developed community health structures that seek to promote health and wellness in the community. These include sanitation action groups and health centre committees. In addition, in 2016 the Ministry adopted the use of health facility-wide youth friendly service provision in line with global standards. This requires every entry point for adolescent health services to be friendly to adolescents instead of limiting them to a specific room/ward. The friendly services extend to support staff also needing to appreciate how to communicate and engage with adolescents. VMMC advocacy and communications will be integrated with such platforms to expand reach and promote programme sustainability.

Key Strategy IV: Integration of VMMC Advocacy and Communication as part of Comprehensive HIV Communication Strategy

VMMC is part of a comprehensive package of HIV prevention services which means it is one part of an arsenal of weapons to fight HIV. The current status quo where VMMC is marketed in a silo is not consistent with the goal of providing comprehensive HIV prevention and achieving the second of the 90-90-90 targets. The VMMC programme has had significant success with awareness campaigns, interpersonal communication mobilization and getting men to health facilities for preventive services. The programme has an opportunity to use that access to men to promote other HIV prevention methods that the MOHCC offers such as condoms, PrEP, HIV testing and treatment. MOHCC is developing a comprehensive HIV communications strategy with a focus on integration of communications recognizing the all programs are working to achieve the same goal, eradicating HIV. VMMC communications will be integrated with other HIV prevention communications wherever possible to maximize opportunities to share information on comprehensive HIV prevention. Training for cadres who mobilize for VMMC and provide counselling should emphasize talking about HIV as part of a package.

Key Strategy V: Define what needs to be done in order for the VMMC to transition to a state of high natural demand

The desired state for a sustainable VMMC programme is one in which there is natural demand for MC— men seeking VMMC services without being actively mobilized. The programme has gained significant insights into how to actively generate demand for VMMC through the different market research studies and lessons learnt in programme implementation. However, there is a knowledge gap when it comes to steps to be taken to go from the current state of intensive active demand generation to a desired state of natural demand and VMMC as a social norm. There are lessons to be learnt from traditionally circumcising communities in and around Zimbabwe, a role for the community, approaches from marketing, behavioral science and the social sciences that could be applied in filling that programmatic knowledge gap to come up with a model to guide the programme towards one day reaching the desired end state for VMMC demand. The current Advocacy and Communications Strategy will also be evaluated to determine what has worked and what has not therefore informing future strategies.

A consultant will be hired to further understand what it will take for VMMC to become part of the social norm in Zimbabwe The consultant is expected to provide clarity on what structures need to be established and what information needs to be communicated in order to realise this goal.

Strategies Summary Table: Demand Generation

To create sustainable, effective and efficient demand generation approaches that will eventually result in the transition to a state of high natural demand for VMMC services

Key Strategies for 2019-2021

I: Create sustained demand for EAMC through integration of VMMC education in schools

- Develop VMMC module in national School Health Curriculum
- Establish interaction pathways between MoPSE and MoHCC, specifically for the VMMC programme.
- Capacitating School Health Coordinators as IPC agents

II: Employ a decentralised approach to planning, coordination and implementation of VMMC Demand Generation to establish context specific implementation

- Development of District Demand Implementation Plans
- Capacitating Health workers in VMMC demand generation as well as establishing a system to effectively track trained mobilizers
- Routine evaluation of district implementation of demand creation activities

III: Strengthen the role of the community in demand creation to allow for implementation of locally grown strategies

- Establish community based advocacy and communications strategies
- Utilise existing community health structures for VMMC mobilization

IV: Integration of VMMC Advocacy and Communication as part of Comprehensive HIV Communication Strategy

- Incorporate VMMC activities into national Communications Plan integrated with other HIV prevention activities for HTS, PrEP and Condom Promotion

V: Define what needs to be done in order for the VMMC to transition to a state of high natural demand

- Implement social and behavioural change models and approaches to inform programme sustainability
- Evaluate Advocacy and Communications Strategy to inform strategies for scale up

5 STRATEGIC INFORMATION

Strategic Objective

Strengthen VMMC monitoring and evaluation system to ensure evidence based decision making, and learning while integrating with other HIV prevention programmes

Key Strategies

Monitoring and Evaluation

I: Strengthen MoHCC capacity to collect, report, manage, analyse and effectively utilize VMMC data

II. Conduct annual review of programme targets and periodic impact modeling exercise to inform programme progress towards saturation

III. Conduct routine sustainability readiness assessments

Operational Research, Surveys and Surveillance

I. Establish weekly notification system for severe AEs to strengthen AE reporting rates

II. Inform and utilize national population surveys to inform programme progress towards targets

III. Conduct relevant operational research to inform scale up of innovative and cost effective interventions

IV. Ensure learning at all levels of the MOHCC system through the routine documentation and dissemination of best practice or evidence from research findings

The ideal state for strategic information is to leverage on the resources (which includes the HIV&TB monitoring and evaluation, surveys and surveillance and research structure) that the MOHCC health system already possesses in driving and informing the programme. The focus is the creation of effective and efficient sustainable systems for VMMC. More specifically it will involve the following:

- Harmonised data generation, management, and analysis and reporting between all stakeholders within and outside of the MOHCC.
- Shared research outputs and best practices to inform policy and VMMC implementation
- An activated survey and surveillance system that informs decision making as well as address quality issues

In order to adequately track progress, promote accountability and transparency in programme implementation, a comprehensive M&E framework that contains a detailed set of indicators covering all pillars of the programme has been developed (Table 4. VMMC Monitoring and Evaluation Framework). The framework will be used to monitor and evaluate the resources, activities, outputs and outcomes of the Plan. The core indicators, baselines and targets have been developed through document review, consultative Technical Working Group meetings and sector-wide consultation.

Indicator	Baseline	Target	Data Source	Frequency Reported		Responsible	Reporting
				National	Sub-national		
Outcome							
Number of districts reaching 80% coverage among the 10-29 year age group	9	60	Modeling	Annually	Annually	PMU	Heat Map
AE rate by district		< 2 % threshold	DHIS2	Monthly	Monthly	PMU-PVO	Monthly report
Transition	Not available		Survey	Annually	Bi-annually	PMU/PHE	Report
Outputs							
Number of clients circumcised by HIV status, age and district	District specific	99% HIV -	DHIS2	Monthly	Monthly	PMU-PVO	Monthly report
Number of clients circumcised by method, age and district	District specific	TBD	DHIS2	Monthly	Monthly	PMU-PVO	Monthly report
Number of clients experiencing at least one moderate to severe adverse event during or following circumcision		< 2 % threshold	DHIS2	Monthly	Monthly	PMU-PVO	Monthly report
Number of sites offering VMMC	1000	TBD	DHIS2	Monthly	Monthly	PMU-PVO	Monthly report
Number of district implementation plans produced	0	64	Reports	Annually	Annually	PVO	Report
Number of provincial implementation plans	0	10	Reports	Annually	Annually	PVO	Report
Number of VMMC HCW trained	TBD	TBD	Training Report	Annually	Annually	PVO	Training Report
Funding levels by district	District specific	64	District Financing Tool	Annually	-	PMU	Resource mapping report
Number of districts using re-usable kits for >80% of VMMCs	0	64	MOHCC DHIS2	Monthly	Monthly	PVO	Monthly report

Monitoring and Evaluation (M&E)

The focus of ongoing monitoring is the collection, management, analysis, reporting and use of programme data to influence decision-making. In order to meet the needs of the transitioning programme, within each of the ten provinces, an operationally decentralized adaptive system will need to be developed. As with other HIV programmes, the VMMC M&E system will be driven from national level. However, institutionalisation of an effective M&E mindset or culture at implementation level will be the ultimate determinant for programme success. Information gathered through M&E will be fed back to health providers and the community as part of regular planning cycles. The following key strategies organized around **data origination, data and information management** and **information utilization** will be implemented to strengthen the VMMC monitoring and evaluation system while ensuring integration with other HIV prevention programmes.

Key Strategy I: Strengthen MoHCC capacity to collect, report, manage, analyse and effectively utilize VMMC data

Current gaps in collection, reporting and analysis of data have been outlined in data quality audits and point to lack of capacity of health workers and other resource constraints. Health worker capacity will be strengthened through support and supervisory visits, mentorship visits and review meetings. The programme will continue to ensure that the use of **data for decision making is institutionalized into routine programming** particularly at sub-national level through periodic training on evaluative and reflective thinking. Innovative methods to incentivize and monitor this will also be explored. The table below highlights how strengthening data for decision making at all levels will result in effective VMMC programming.

Table 5. Example highlighting decision making action points at different levels

Indicator: Progress towards target	Decision/Action Point
National	Identify which regions are performing well to identify best practices and which regions require additional support
Provincial	Identify which districts require additional support or resources in order to meet their target
District	Identify which strategies need to be maintained or adapted based on achievement towards target
Facility	Measure of efficiency in matching supply of services to demand.

Adopt HMIS DHIS2 Tracker for client data management

The DHIS2 Tracker is an event based reporting tool, which is an appendage of the monthly DHIS2 database. The application reports client level data as and when the circumcision happens, allowing for real-time reporting of data for decision making. This platform will be adopted by the VMMC programme with plans to eventually transition away from the current weekly dashboard and fully adopt and utilize DHIS2 Tracker for VMMC programming.

Strengthen the use of MOHCC DHIS2 aggregate as the main reporting platform

The DHIS2 aggregate system is a monthly reporting tool used by the MoHCC to report all health data from primary care facilities to tertiary facilities. The VMMC programme, inclusive of all implementing partners, will use this same platform for all official reporting thereby eliminating all parallel reporting structures. This will be done through extensive training of DHIS2 aggregate to implementing partners and MoHCC staff at all levels.

Link MC Data reporting to a rewards system

The MoHCC is already implementing the results based financing (RBF) model for maternal and child health programmes. The VMMC programme will adopt a similar concept, although contextualized, which uses data to determine the reward to be given to the institution/individual. Data will be generated from the implementation level and verification will be done to inform payment. Tools will be developed for VMMC verification and trainings and sensitization meetings will be held for health workers. To limit parallel reporting systems, payments under the VMMC-RBF mechanism will also be based on data obtained solely from DHIS2.

Key Strategy II: Conduct annual review of programme targets and periodic impact modeling exercise to inform programme progress towards saturation

The use of modelling data has historically provided insight on the implementation and expected impact of the VMMC programme. It is against this background that routine reviews of targets are important so as to provide strategic direction, taking into cognizance the ever-changing operational environment. This will be done through a participatory bottom-up approach where districts will be able to determine their own targets. A **target setting tool** will be developed to standardise the process. In addition, a periodic impact modelling exercises to update the expected impact of the programme will also be conducted. Dissemination reports will be generated to inform programme progress and direction as well as to advocate for continued support of the programme.

Key Strategy III: Conduct routine sustainability readiness

In order to effectively monitor the transition to sustainability, there is need to conduct routine readiness assessments which will measure progress towards sustainable VMMC implementation at national and sub-national level. Readiness assessments will use the Transition Assessment Dashboard to evaluate progress using indicators developed for all implementation pillars. Indicators will be determined through a national and sub-national consultative process to ensure

buy-in and effective implementation of contextualized activities. Once a saturated district is deemed ready to transition, the Sustainability Index Dashboard will be used to routinely monitor and track the districts progress ensuring saturation is maintained while also allowing for course corrective measures to be taken where required.

Operational Research, Surveys and Surveillance

Operational research or evaluation (ORE) is panacea to providing evidence which informs course correction and decision making. ORE will be done to provide validated evidence for decision making in order to improve the programme through innovations in implementation.

Surveys provide an opportunity to investigate the characteristics of a given population by means of collecting data from a sample of that population and estimating their characteristics through the systematic use of statistical methodology. A key area for surveys moving forward is to supplement modeled data and measure the protective effect of male circumcision at population level.

Surveillance is the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice. Surveillance is critical in ensuring programme quality is maintained and evidence-based decisions continue to guide VMMC programming.

Key Strategy I: Establish a notification system for reporting AEs to strengthen AE reporting rates

The national weekly disease surveillance system, also known as the Rapid Disease Notification System (RDNS), is a weekly reporting tool which provides summaries of notifiable diseases and conditions as prescribed by the Public Health Act. Due to perceived underreporting of VMMC AEs and to some extent mismanagement of reported cases by clinicians, VMMC will be advocated for inclusion on the list of notifiable adverse events. Inclusion of the VMMC AEs will improve reporting and strengthen implementation of appropriate management.

To supplement the identification of acute adverse event detection, the system will also be built to passively notify the health system of cold adverse event cases that have been re-surfacing overtime to ensure that these cases are adequately captured and monitored.

Key Strategy II: Inform and utilize national population surveys to inform programme progress towards targets

Local level population health data is instrumental in policy making and analysis, advocacy, programme planning and evaluation, as well as research. National surveys such as the Demographic and Health Survey (DHS) are an important source of data on health of families in developing countries. Both at national and international level, DHS surveys provide much-needed data on fertility and family planning, mortality and nutrition, and on health services utilization. The use of uniform survey instruments allows for detailed international and sub-national comparisons of health status and health care.

Historically, DHS questionnaires did not extract information on VMMC however,

this has changed with VMMC prevalence and coverage being reported in population based surveys such as ZDHS and ZimPHIA. Although now included, questions were raised as to the validity of the data given the discrepancies observed between survey reports and programmatic data. Going forward, it is not only important to ensure that more VMMC variables are included but that the programme is involved in survey design and implementation processes, so as to actively influence what data needs to be collected and how it should be collected to inform policy and practice.

Key Strategy III: Conduct relevant operational research to inform scale up of innovative and cost effective interventions

The focus of the operational research will be determined by programme needs and also in line with the National Health Research Agenda. Relevant topics will be identified through baseline assessments of identified challenges, consultative meetings with implementers and other key stakeholders. The completed research will also be published in peer-reviewed journals hence the need to convene manuscript writing meeting and also to take part in Structured Operational Research trainings (SORT IT Course).

Key Strategy IV: Ensure learning at all level of the MoHCC system through the routine documentation and dissemination of best practice or evidence from research findings

Sharing and dissemination of evidence is critical for an ever-evolving programme such as VMMC. In addition to conducting operational research, there is need to routinely document best practices in programme implementation. This is critical as the lessons learned may be generalised to other regions, for the good of the programme. This will be done through dissemination meetings and programme participation at established platforms such as the University of Zimbabwe Annual Medical Research Day, National AIDS Council Research Dissemination Workshops, Annual VMMC Review and Planning meeting etc. The VMMC programme will continue to inform the international body of knowledge as it pioneers in the work of sustainability planning and implementation for VMMC.

Potential Topics for Operational Research

- Evaluating the Impact of VMMC on the male population.
- Effectiveness of community based mobilization strategies on VMMC demand creation.
- Prevalence of MC among STI clients
- Gender dynamics in VMMC: the role of women.

Strategies Summary Table: Strategic Information

Strengthen the VMMC monitoring and evaluation system to ensure evidence based decision making, and learning while integrating with other HIV prevention programmes

Key Strategies for 2019-2021

I. Monitoring and Evaluation

- Strengthen the capacity to collect, report, manage, analyse and effectively utilize VMMC data
- Conduct annual review of programme targets and periodic impact modelling exercise to inform programme progress towards saturation
- Conduct routine sustainability readiness assessments for districts nearing saturation (>70%)

II. Operational Research Surveys and Surveillance

- Establish weekly notification system for severe AEs to strengthen AE reporting rates
- Inform and utilize national population surveys (ZIMPHIA, ZDHS etc.) to inform programme progress towards targets
- Conduct relevant operational research to inform scale up of innovative and cost effective interventions
- Ensure learning at all levels of the MOHCC system through the routine documentation and dissemination of best practice or evidence from research findings

6 PROGRAMME FINANCING

Strategic Objective

To reach a state where there is adequate and predictable financing for the VMMC programme

Key Strategies

I: Increase effectiveness and efficiencies in the use of available resources

II: Continue with periodic resource mapping and financial gap analysis to inform planning, allocation efficiencies and mobilization of resources

III: Explore local and other predictable sources of funding at all levels

An ideal state would be to have **a fully independent and locally funded VMMC** programme and while there is acknowledgment that this may not be achievable in the near future, there are steps that can be taken to reduce the current cost of VMMC and mobilize for funding locally. To strive towards achieving this goal, the following key strategies will be implemented.

Key Strategy I: Increase effectiveness and efficiencies in the use of available resources

Despite limited resources, **opportunities for reducing VMMC unit cost exist and need to be further explored** to ensure that those that work are scaled up to maintain programme delivery over time. For example, while cost reimbursement is a major incentive for health workers, it is also a significant cost driver for programme delivery. In light of current funding uncertainaties, considerations on the future of cost reimbursement need to be made as the programme transitions to sustainability.

One potential option to address is this **adoption of the results based financing (RBF) model.** RBF, introduced in 2012, is an instrument that links financing to pre-determined results, with payment made only upon verification that the agreed-upon results have actually been delivered. RBF has two main advantages when considering VMMC:

1. **Quality and Quantity Driven Programming.** Links the cost incurred under cost reimbursement to agreed quantitative and quality indicators therefore providing motivation for target driven activities while still incentivizing the need to maintain quality services

2. **Financial Sustainability.** Strategically prepares the programme for sustainability since RBF is the government preferred method of performance based management with plans to transition from external funding to domestic resourcing by 2020. The cost of introduction of VMMC in RBF is also expected to be lower than the current cost reimbursement cost of $12/MC.

One major challenge for adopting RBF is the donor restrictions in their ability to pool funds. Given this various options will be explored to identify ways to implement this strategy through pilots. The adoption of RBF for VMMC will follow step wise transition with constant iteration to ensure that the implementation of the mechanism does not impact the achievement of scale-up targets. Districts that are reaching saturation will be targeted first for piloting with an ongoing evaluation to determine areas of improvement and scale up to the next. Considerations will need to be made

Other opportunities that exist for reduction in VMMC unit cost are the adoption of reusable kit commodities and the adoption of low cost demand generation models. Additional opportunities will continue to be explored.

Given the expected decline in donor resources for VMMC, there is need to strengthen financial management of resources for VMMC at implementation level. For this to be achieved, tailor-made training and support and supervision will be conducted to build VMMC financial management capacity at provincial and district levels. It is anticipated that this will lead to the alignment of service delivery and demand generation services to increase efficiencies.

Key Strategy II: Continue with periodic resource mapping and financial gap analysis to inform planning, allocation efficiencies and mobilisation of resources

The systematic economic analysis of programme data will continue to be conducted to develop robust arguments for use during international, regional, national and sub-national advocacy for the prioritization of VMMC in the allocation of available resources. National and sub-national funding gap analyses will be routinised to strengthen the alignment of available funding with geographic needs. Capacity will be strengthened and institutionalized within the Ministry to conduct these annual exercises.

In line with evidence that will be generated to justify and further prioritise VMMC, national advocates will be identified to lobby or advocate for sustainable VMMC funding from domestic and external sources.

Key Strategy III: Explore local and other predictable sources of funding at all levels

One of the prerequisites for a sustainable VMMC programme is adequate and predictable financing. Donor funding for HIV in low and middle-income countries is decreasing, as such increasing the contribution of locally driven financing mechanisms is one way of assuring adequate and predictable financing. VMMC will continue to be advocated for inclusion in financing mechanisms such as the Global Fund that offer slightly more long term funding visibility and government control. Partnership of the VMMC programme with the private sector will also be explored.

Strategies Summary Table: Programme Financing

To reach a state where there is adequate and predictable financing for the VMMC programme

Key Strategies for 2019-2021

I: Increase effectiveness and efficiencies in the use of available resources

- Adoption of RBF for VMMC
- Alignment of services delivery and demand generation services to increase efficiencies
- Introduction and scaling up of reusable kits
- Identify additional opportunities to reduce VMMC unit cost
- Conduct financial management trainings at sub-national level

II: Continue with periodic resource mapping and financial gap analysis to inform planning , allocation efficiencies and mobilization of resources

- Conduct annual resource mapping exercise
- Conduct national and sub-national financial gap analysis for geographic prioritization of the available funding
- Strengthen MoHCC capacity to conduct financial exercises and analyses

III: Explore local and other predictable sources of funding at all levels

- Advocate for greater investment in programme related costs by the government
- Identify and use of local resources to support programme activities at community level
- Involvement of private sector in supply of VMMC services
- Explore the inclusion of VMMC in longer term funding sources such as the Global Fund

COSTED OPERATIONAL PLAN

To guide the implementation of this plan, a comprehensive costed operational plan has been developed. The operational plan translates the strategies into actionable activities with corresponding implementation timeframes, activity costs and expected outputs. As done previously, the plan will be updated annually to account for new developments affecting implementation activities. Table 6 and 7 below highlight the VMMC cost breakdown by cost components and by strategic objectives respectively.

Table 6. 2018 VMMC Cost by Unit Cost Components

	2019	2020	2021	3 Yr Unit Costs
Outreach allowances	$2,803,200	$2,887,296	$ 2,973,915	$ 7.75
Commodities - Consumables and Non Consumables	$6,989,792	$ 6,137,195	$ 5,002,451	$ 16.22
Personnel costs - Cost Reimbursement	$ 3,067,500	$2,773,275	$ 2,784,863	$ 7.72
Training costs	$1,529,225	$1,456,497	$ 1,496,743	$ 4.01
Capital costs	$2,560,000	$ -	$ -	$ 2.29
Waste management costs	$91,580	$94,327	$97,157	$ 0.25
Maintenance and utility costs	$1,649,900	$1,528,005	$ 1,573,845	$ 4.25
National Management costs	$ 764,750	$ 726,794	$ 631,899	$ 1.90
Program supervision costs	$924,166	$951,891	$ 980,448	$ 2.56
Program supervision costs - Cost Reimbursement	$1,840,500	$1,663,965	$1,670,918	$ 4.63
Quality Assurance costs - Internal and External	$360,600	$250,831	$258,356	$ 0.78
Transportation costs	$800,370	$822,064	$844,697	$ 2.21
National level demand creation costs	$1,645,700	$1,629,563	$1,678,450	$ 4.43
Local level demand creation costs	$2,741,824	$2,513,859	$ 2,464,513	$ 6.91
Local level demand creation costs - Cost Reimbursement	$ 409,000	$369,770	$371,315	$ 1.03
Other Additional Costs	$ 1,390,508	$1,244,891	$1,277,393	$ 3.50
Total	**29,568,615**	**25,050,223**	**$24,106,960**	**$ 70.42**

Table 7. Total Cost of Each Strategic Objective from 2019-2021

Strategic Objective	2019	2020	2021	Total	% Share of Costs
To foster programme ownership and buy-in for VMMC as a part of Combination HIV Prevention across all key stakeholders	$ 1,509,695	$ 1,528,335	$1,574,185	$4,612,214	6%
To efficiently increase and strengthen VMMC services to ensure they are accessible, affordable and effective enough to meet both scale-up and sustainability phase targets	$ 21,111,737	$ 17,147,606	$ 16,228,598	$ 54,487,941	69%
Provision of high quality, safe male circumcision services through enhanced quality assurance and strengthened clinical mentorship.	$382,600	$ 250,831	$258,356	$ 891,786	1%
To create sustainable, effective and efficient early adolescent demand generation approaches that will eventually result in the transition to a state of high natural demand for VMMC services	$ 5,044,100	$ 4,761,938	$4,765,008	$14,571,046	19%
To reach a state where there is adequate and predictable financing for the VMMC programme	$ 750	$ 773	$796	$ 2,318	0%
Strengthen VMMC monitoring and evaluation system to ensure evidence based decision making, and learning while integrating with other HIV prevention programmes	$1,519,733	$1,360,741	$1,280,018	$4,160,492	5%
Total	**$29,568,615**	**$25,050,223**	**$24,106,960**	**$78,725,798**	

Strategic Objective	Sub-Strategic Objective	Activities	Budget Assumptions	Quantity Descriptions	
1. PROGRAMME LEADERSHIP, MANAGEMENT AND COORDINATION- To foster programme ownership and buy-in for VMMC as a part of Combination HIV Prevention across all key stakeholders					
	I. Decentralize key VMMC programme functions to ensure effective contextualized programming	*Conduct internal national MoHCC and partner mapping exercise to identify gaps and VMMC functions to be transitioned*	*Consultant time will be shared across a number of activities*	*45 days for consultant time including any relevant travel*	
		Conduct subnational MoHCC and community mapping exercise to identify gaps and VMMC functions to be transitioned	*Field travel costs associated*	*5 teams of 4 individuals each (including driver), for one week, 10 provinces*	
		Develop Transition Plan outlining revised roles and responsibilities from national to sub-national level	*Staff & Consultant time. No additional cost*	*No associated costs*	
		Conduct transformational leadership and VMMC specific capacity training at all levels to ensure transition to sustainable leadership, management and coordination practices	*Provincial level consultant training meeting with accomodation, travel expenses & consultant time (consultant time under the partner mapping activity)*	*Transport allowance @ USD 30 per person*	
				30 people per province X 5 days X USD 95 per day	
		Advocate for the inclusion of VMMC indicators in the high level joint support and supervision activities -joint monitoring between NPA and National level	*Staff time, no additional costs*	*No associated costs*	
		Conduct VMMC quality improvement, support and supervision integrated with other MOHCC interventions (National level)	*Cost share with other programmes National Level*	*10 people X 5 days X 2 times a year X USD125*	
		Conduct VMMC support and supervision integrated with other MOHCC interventions (Provincial Level)	*Cost share with other programmes Provincial Level*	*4 people X 5 days X 4 times a year X USD110*	
		Conduct VMMC support and supervision integrated with other MOHCC interventions (District Level)	*Cost share with other programmes District Level*	*4 people X 5 days X 6 times a year X USD75 X 64 districts*	
		Develop a VMMC Provincial Implementation Plan	*Staff time. No additional cost*	*No associated costs*	
		Develop a VMMC District Implementation Plan	*Staff time. No additional cost*	*No associated costs*	
		Organize coordination meetings to discuss programme performance and planned activities including all districts as part of other MOHCC planning meetings.	*Conducted as part of DHT meeting (cost sharing component)*	*Residential Meeting with transport allowance USD75 per person X average 60 DHT staff X 10% (share of total costs for a day)*	
		Organize coordination meetings to discuss programme performance and planned activities. Provincial level, as part of other MOHCC planning meeting.	*Conducted as part of PHT meeting (cost sharing component)*	*Residential Meeting with transport allowance USD110 per person X 100 staff X 10 provinces X 10% (share of total costs)*	
	II. Streamline current VMMC roles at national and provincial levels	*Conduct mapping exercise for the national HIV Prevention Department streamlining roles and responsibilities to match sus department needs*	*Conducted as part of consultant work on internal MOHCC stakeholder mapping*	*No associated costs*	

				Implementation Timeframe												Outputs
	2019 Costs	2020 Costs	2021 Costs	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	
	$ 25,875	*$ 0*	*$ 0*		*x*											*Partner Mapping Report*
	$ 11,000	*$ 11,330*	*$ 11,670*		*x*											*Partner Mapping Report*
						x										*Transition Plan*
	$ 9,000	*$ 9,270*	*$ 9,548*			*x*				*x*				*x*		*District management and leadership capacity trainings*
	$ 142,500	*$ 146,775*	*$ 151,178*			*x*				*x*				*x*		
	$ 12,500	*$ 12,875*	*$ 13,261*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*District level support and supervision conducted*
	$ 88,000	*$ 90,640*	*$ 93,359*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*Provincial level support and supervision conducted*
	$ 576,000	*$ 593,280*	*$ 611,078*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*National level support and supervision conducted*
				x			*x*				*x*					*Provincial implementation plan produced*
				x			*x*				*x*					*District implementation plan produced*
	$ 28,350	*$ 29,201*	*$ 30,077*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*Coordination meetings at district level conducted*
	$ 11,000	*$ 11,330*	*$ 11,670*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*Coordination meetings at provincial level conducted*
					x											

Strategic Objective	***Sub-Strategic Objective***	***Activities***	**Budget Assumptions**	**Quantity Descriptions**	
		Conduct mapping exercise at provincial level to streamlining roles and responsibilities to match sustainability needs- redefine the scope of the PVO	*Conducted as part of consultant work on internal MOHCC stakeholder mapping*	*No associated costs*	
		Support VMMC HR salaries at national and provincial levels	*Director, National Coordinator, HIV Prevention Coordinator, Demand Creation Officer, Training and Quality Assurance officer, M&E Officer, DRO, PO, PA*	*Monthly salary for 13 months starting Jan 2019-Dec 2021*	
			10 PVO Salaries	*Monthly salary for 13 months starting Jan 2019-Dec 2021*	
		Support PMU operational costs	*Operational costs*	*Operational costs @ 2000 per year*	
		Support PVO operational costs	*Operational costs*	*Operational costs @ 2000 per year*	
		Maintain PVO vehicles for management & and coordination	*Budget for vehicle maintenance*	*Cost of vehicle maintenance*	
			Budget for fuel costs	*Cost of fuel*	
		Review and revise ToRS for TWGs and VMMC Steering Committee (MCSC)	*Staff time. No additional cost*	*No associated costs*	
		Conduct quarterly Male Circumcision Steering Committee meetings	*Budget for 20 people half-day national meeting*	*20 people*25 USD*3 times*	
		Conduct quarterly TWG meetings	*Budget for 20 people half-day national meetings for 4 TWGs*	*20 people * 25 USD*4 TWGS* 4 times*	
	III. Ensure integration and multi-sectoral partnerships within MoHCC and with key stakeholders	*Conduct a robust stakeholder mapping exercise*	*Conducted as part of consultant work on internal MOHCC stakeholder mapping*	*No associated costs*	
		Establish national level accountability mechanisms with relevant Ministries, MoHCC departments and partners	*Included as part of national level PMU financial support*	*No associated costs*	
		Establish community level engagement plan as a part of sub-national implementation plans	*Included as part of provincial level PVO financial support*	*No associated costs*	
		Routinely monitor accountability mechanisms with VMMC stakeholders	*Staff time. No additional cost*	*No associated costs*	
	IV. Streamline management and coordination for Cities	*Establish VMMC programme leadership, management and coordination within the City Health Department management structures*	*Staff time. No additional cost*	*No associated costs*	

				Implementation Timeframe												Outputs
	2019 Costs	2020 Costs	2021 Costs	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	
					x											*Number of DHEs and PHEs sensitized*
	$ 350,000	*$ 360,500*	*$ 371,315*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Staff salaries paid*
	$ 216,000	*$ 222,480*	*$ 229,154*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Staff salaries paid*
	$ 2,000	*$ 2,060*	*$ 2,122*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Operational cost met*
	$ 20,000	*$ 20,600*	*$ 21,218*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Operational cost met*
	$3,500	*$3,605*	*$3,713*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*15 vehicles maintained*
	$4,470	*$4,604*	*$4,742*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*15 vehicles maintained*
				X												*Revised TORs developed*
	$ 1,500	*$ 1,545*	*$ 1,591*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Meeting minutes*
	$ 8,000	*$ 8,240*	*$ 8,487*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Meeting minutes*
					x											*Stakeholder mapping exercise conducted*
					x											*National VMMC stakeholder accountability mechanism established*
					x											*Community level engagement plan developed as part of subnational plnas*
				X	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*VMMC RBF implementation model developed*
																VMMC programme leadership, management and coordination conducted under the City Health Department management structures

Strategic Objective	Sub-Strategic Objective	Activities	Budget Assumptions	Quantity Descriptions	
2. VMMC SERVICES- To efficiently increase and strengthen VMMC services to ensure they are accessible, affordable and effective enough to meet both scale-up and sustainability phase targets					
	I. Effectively increase human resource capacity to provide quality VMMC services through the scaling up of innovative, cost efficient training strategies	*Consultative meetings on pre-service training*	*Costs under operation national PMU level*	*No additional cost*	
		Review pre-service health worker training curricular and integrate VMMC component	*Local Consultant*	*30 days of consultant time*	
			Ongoing Dissemination Meetings	*5 Meetings X 30 people X USD30*	
		Develop online training VMMC module for blended learning approach (refresher training component can use the online platform)	*Consultant time*	*30 days of consultant time*	
			Ongoing Dissemination Meetings	*5 meetings X 30 people X USD30*	
			Piloting 10% of all sites 7 districts static sites 2 per static site. Post pilot we integrate with the current blended learning platform	*Costed as part of operational research*	
		Develop provincial level capacity building training plans for decentralization	*Staff time*	*No additional cost*	
		Train personnel in basic training VMMC service delivery sites provincial trainings - 6-day standard training- nurses	*Increase number of nurses trained from 16% to 50% of available nurses*	*1329 per year nurses x USD 75 x 5 days*	
		Train personnel in basic training VMMC service delivery sites provincial trainings - 6-day standard training - doctors	*Train 4 doctors per province per year*	*40 doctors x USD 75 x 5 days*	
		Conversion training for all VMMC service delivery personnel, provincial level trainings - Nurse conversion	*Each trained nurse will need to be converted including current conversion gaps*	*1329 nurses x USD 75 x 5 days*	
		Conduct training in rapid HIV testing at local level	*3 people per district annually*	*3 people X 64 districts X 5 days X USD75*	
		Routinely track and analyze availability and utilization of trained cadres	*Collate HR data from database*	*No additional cost*	
		Attachment of new trained nurses to VMMC high volume sites/centers of excellence for certification	*Costed as part of service delivery outreach costs*	*No additional cost*	
		Conduct mentorship at provincial level for the service delivery	*Multidisciplinary teams receive training in VMMC mentorship*	*Training in mentorship (3 people per province) * 3 days*	

				Implementation Timeframe												Outputs
	2019 Costs	2020 Costs	2021 Costs	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	
				X	X	X	X	X	X	X	X	X	X	X	X	*Meetings conducted*
	$ 12,000	*$ 0*	*$ 0*	X	X	X	X	X	X	X	X	X	X	X	X	*Curriculum developed*
	$ 4,500	*$ 0*	*$ 0*	X	X	X	X	X	X	X	X	X	X	X	X	
	$ 12,000	*$ 0*	*$ 0*	X				X				X				*Online training module developed*
	$ 4,500	*$ 0*	*$ 0*	X	X	X	X	X	X	X	X	X	X	X	X	
				X				X				X				
				X				x				x				*Provincial level training plans developed (i.e. identifying number of sites and cadres that need to be trained for decentralisation to happen)*
	$498,500	*$513,455*	*$528,859*	X	X	X	X									*Nurses trained in general VMMC service delivery*
	$15,000	*$15,450*	*$15,914*	X	X	X	X									*Doctors trained in general VMMC service delivery*
	$571,325	*$513,455*	*$528,859*	X				X				X				*Nurse circumcisers trained*
	$72,000	*$74,160*	*$76,385*		X				X				X			*Nurses trained in HTC*
	$0			X	X	X	X	X	X	X	X	X	X	X	X	*HR capacity tracked and analyzed*
	$90,000	*$92,700*	*$95,481*	X				X				X				*Certified nurses*
	$ 9,900	*$ 10,197*	*$ 10,503*	X	X	X	X	X	X	X	X	X	X	X	X	*Mentorship visits conducted*

Strategic Objective	Sub-Strategic Objective	Activities	Budget Assumptions	Quantity Descriptions	
			Conference facility use during mentorship visit	*Conferencing 32 mentee +2 mentors X 10 provinces per quarter*	
			Cost of local travel by mentees	*Travel 30 mentees per province X USD 30 per person per quarter*	
			Cost of travel by mentors	*Perdiem 2 mentors per provinces per quarter*	
		Train personnel in VMMC supply chain	*Costed under VMMC commodities distribution and monitoring.*	*No additional costs*	
	II. Adequately equip and strengthen health facility capacity to provide quality VMMC services	*Conduct baseline facility assessments to identify needs for additional static sites*	*Conducted as part of CQI at district level*	*No additional costs*	
		Equip static service delivery sites as necessary	*Four static sites need to be equiped in each district*		
		Equip outreach service delivery sites as necessary	*Assume four outreach site has to be equpied for each new static site*		
		Renovate and maintain static/outreach service delivery sites as necessary	*Maintain service delivery sites*		
		Purchase and install incinerators at facilities that do not have incinerators	*13% (estimate from IQA visits) of sites currently do not have incinerators*	*256 sites; $5000/incinerator, once off payment*	
		Refurbish, maintain and repair incinerators for all sites that have a functioning or non-functioning incinerator	*256 sites; $500/incinerator, annually*		
		Dispose used steel/metallic medical waste to smelting companies	*Perdiems for two people per district per province, fuel*	*5 days X 10 provinces X 2 people X 100 L per day (quartely)*	
			Perdiem	*5 days X 10 provinces X 2 people X USD75*	
		Standardize waste management for VMMC at district level (according to Adopt WHO guidelines on)	*Conducted as part of refresher trainings*		
		Provide disinfectants for medical waste before disposal	*Disinfectants for all facilities, cidex to reduce smell/clorox at $40 per 5 liter*		
		Procure VMMC commodities and consumables	*Procure reusable use dorsal slit kits @$11.96/MC*	*Assume 43% surgical in 2019, 51% in 2020 and 95% in 2021*	

				Implementation Timeframe												Outputs
	2019 Costs	2020 Costs	2021 Costs	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	
	$ 64,000	*$ 65,920*	*$ 67,898*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	
	$ 36,000	*$ 37,080*	*$ 38,192*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	
	$ 8,800	*$ 9,064*	*$ 9,336*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	
				X	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Health Workers trained*
				X												*Facility assessment report*
	$512,000	*$0*	*$0*	*X*	*X*	*X*	*X*									*Equiped, renovated and maintained static and outreach sites*
	$2,048,000	*$0*	*$0*	*X*	*X*	*X*	*X*									
	$1,352,000	*$1,392,560*	*$1,434,337*	*X*				*X*				*X*				
	$166,400	*$0*	*$0*	*X*				*X*				*X*				*Incinerators installed*
	$128,000	*$131,840*	*$135,795*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Incinerators renovated*
	$30,000	*$30,900*	*$31,827*													*VMMC waste properly disposed*
	$7,500	*$7,725*	*$7,957*													
				X	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	
	$54,080	*$55,702*	*$57,373*	*X*				*X*				*X*				*Waste management training conducted*
	$1,799,980	*$2,255,449*	*$4,218,881*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*MC kits procured*

Strategic Objective	Sub-Strategic Objective	Activities	Budget Assumptions	Quantity Descriptions	
			Procure disposable dorsal slit kits and consumable @19.10	*Assume 52% surgical in 2019, 44% in 2020 and 0% in 2021*	
			Procure PrePex kits and consumables (including wastage)	*Assume 75% surgical in 2019, 100% in 2021*	
			Procure TTCV vaccine		
		Distribute and monitor VMMC commodities	*Annual distribution including training and monitoring cost*		
		Provide fuel for service delivery	*Unit cost for a litre of fuel*fuel per MC*target per quarter*	*600L per district per month@$1.55 64 districts*	
		Provide cost-reimbursement to deliver VMMC services	*Individual level*	*USD 7.5 per MC done*	
		Provide cost-reimbursement to deliver VMMC services	*facility level*	*USD 4.5 per MC done*	
		Provide per diems for 5-day short trip outreach activities	*Per diem*	*5 working days x 12 x $5 x 5 people per team x 64 districts annually*	
		Provide per diems for 17-day long trip outreach activities	*Per diem*	*17 working days x 12 x $40 x 5 people per team x 64 districts annually*	
	III. Decentralized approach to planning, coordination and implementation of VMMC services	*Develop customized tools to inform district level planning and coordination*	*Staff time. No additional cost*	*No associated costs*	
		Train district level leadership in VMMC programme management and decision making	*Covered as part of sub-national leadership capacity building above*	*No associated costs*	
		Routinely monitor strategies deployed	*Staff time. No additional cost*	*No associated costs*	
3. VMMC Programme Quality- Provision of high quality, safe male circumcision services through enhanced quality assurance and strengthened clinical mentorship.					
	I. Strengthen and decentralize VMMC programme quality assurance initiatives at all levels of care	*Develop standardized guidelines for decentralized and continuous VMMC quality assurance - national, provincial, district level*	*Drafting and adoption of guidelines based on regional templates and partner tool, meeting to disseminate guidance. Staff time. No additional cost*	*No associated costs*	
		Scale up the use of HNQIS from national level to district level	*Procument of additional devices - 1 device each for 64 districts + 10 provinces*	*Each device costs USD600.00*	
		Conduct annual internal quality assurance for VMMC (national level)	*Bi-annual IQA exercise*	*5 teams, 4 people per team, 10 provinces, one facility per province; $500 fuel, annually (200x10x2)*	

				Implementation Timeframe												Outputs
	2019 Costs	2020 Costs	2021 Costs	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	
	$3,476,200	*$3,107,547*	*$0*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*MC kits procured*
	$507,850	*$536,536*	*$538,778*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*MC kits procured*
	$230,740	*$237,662*	*$244,792*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*MC comodities and consumables distributed*
	$714,240	*$735,667*	*$757,737*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Fuel provided for service delivery*
	$2,625,000	*$2,773,275*	*$2,784,863*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Cost reimbursement paid*
	$1,575,000	*$1,663,965*	*$1,670,918*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Cost reimbursement paid*
	$192,000	*$197,760*	*$203,693*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Per diems for outreach paid*
	$2,611,200	*$2,689,536*	*$2,770,222*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Per diems for outreach paid*
				X				*X*				*X*				*Ongoing monitoring of VMMC service delivery*
				X				*X*				*X*				
				X	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	
				X												*QA guidelines drafted and adopted*
	$ 44,400	*$ 0*	*$ 0*													*HNQIS used for CQI/QA*
	$ 50,000	*$ 51,500*	*$ 53,045*			*X*				*X*				*X*		*IQA conducted*

Strategic Objective	Sub-Strategic Objective	Activities	Budget Assumptions	Quantity Descriptions	
		Conduct annual external quality assurance for VMMC	*Annual EQA exercise*	*5 teams, 4 people per team, 10 provinces, one facility per province; $500 fuel, annually (200x10x2)*	
		Capacity building/mentorship of sub-national staff on QA exercises for VMMC	*CQI/QA formal training*	*30 people per province X 3 days X USD 95 per day*	
		Conduct quarterly provincial QA exercise	*Integrated into provincial QA activities (RBF)*	*2 people per province X 5 days X 10 provinces X USD95 X 3 times a year*	
		Conduct bi-monthly district QA exercise	*Integrated into district QA activities (RBF)*	*64 districts x 4 Qs x USD300*	
		Conduct monthly facility QA exercise	*Integrated into facility QA activities (RBF)*	*No additional costs*	
		Strengthen Quality Assurance Activities	*Migrate QA tool HNQIS from Partner to MoHCC by March 2019*	*No additional costs*	
			Provide per diems	*12 individuals, for one week*	
	II. Decentralization of VMMC mentorship from national to sub-national level	*Identify additional provincial clinical mentors for VMMC program*	*Staff time. No additional cost*	*No additional costs*	
		Training of VMMC clinical mentors	*Staff time. No additional cost*	*10 people per province x 2 days x 10 provinces X USD110*	
		Conduct VMMC skills assessment to identify competencies for improvement	*Staff time. No additional cost*	*No additional costs*	
		Operationalize facility level mentoring for quality assurance	*Staff time. No additional cost*	*No additional costs*	
	III: Strengthen adverse event surveillance and management	*Sensitize and train clinicians on the identification and reporting of VMMC AEs*	*Conducted as part of the mentorship curricula*		
		Advocate for the inclusion of VMMC severe AEs as a weekly notifiable condition	*Staff time. No additional cost*	*No additional cost*	
4. DEMAND GENERATION- To create sustainable, effective and efficient early adolescent demand generation approaches that will eventually result in the transition to a state of high natural demand for VMMC services					
	I. Create sustained demand for EAMC through integration of VMMC education in schools	*Integrate age appropriate VMMC education into the school health curriculum*	*National level meetings between MOHCC, partners and MOPSE*	*5 days, 30 people, national level, conference participant package rate of $30 per person*	
			Curriculum validation meeting between MOPSE, MOHCC, Partners	*2 days, 10 people national level meeting*	
		Develop age appropriate IEC materials for schools	*National level meetings to review IEC existing materials between MOHCC, partners and MOPSE*	*1-day meeting with 20 people*	

				Implementation Timeframe												Outputs
	2019 Costs	2020 Costs	2021 Costs	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	
	$ 25,000	*$ 25,750*	*$ 26,523*	*X*				*X*				*X*				*EQA conducted*
	$ 85,500	*$ 13,210*	*$ 13,606*													
	$ 28,500	*$ 29,355*	*$ 30,236*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*QA report*
	$ 76,800	*$ 79,104*	*$ 81,477*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*QA report*
				X	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*QA report*
	$ 50,400	*$ 51,912*	*$ 53,469*	*X*		*X*		*X*		*X*		*X*		*X*		DQA visits conducted
				X				*X*				*X*				*Provincial level clinical mentors identified*
	$ 22,000	*$ 0*	*$ 0*	*X*				*X*				*X*				*Clinical mentors trained*
				X				*X*				*X*				
				X	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Facilities mentored on QA*
				X	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	
				X	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	
	$4,500	*$0*	*$0*	*X*												*VMMC content in school health curriculum*
	$600	*$0*	*$0*	*X*												
	$600	*$618*	*$637*	*X*				*X*				*X*				*VMMC IEC materials for adolescents*

Strategic Objective	Sub-Strategic Objective	Activities	Budget Assumptions	Quantity Descriptions	
			Budgeted for under IEC flyers, posters and calendars		
			Distribution of materials to schools. Budget under routine activities	*No Additional cost*	
		Quarterly planning meetings between district education and MOHCC, partner teams	*Refreshments, Lunch for participants*	*Half day meeting, 10 people, 64 districts*	
		Conduct joint district quarterly MoPSE and MoHCC school support and supervision visits	*Budget for transport*	*Fuel for 1 car, 150km, 64 districts, 4 times per year*	
			Budget for per-diems	*Budget for 8 people, 64 districts, 4 times per year*	
		Joint bi-annual provincial MoPSE and MoHCC school support and supervision	*Budget for transport*	*Fuel for 1 car per province, 10 provinces, 2 times a year, 300km per trip*	
			Budget for per-diems	*Budget for 4 people, 10 provinces, 1 day, 2 times a year*	
		Joint annual national level MOPSE and MOHCC school support and supervision	*Budget for transport*	*Budget for 2 cars, 120 litres per trip*	
			Budget for per-diems	*Budget for 4 people, 3 days, once a year*	
		Conduct VMMC sensitization for District Education Team	*Budget for venue and refreshments*	*3 education team members per district, 2 facilitators, 64 districts.*	
		Conduct VMMC sensitization for school teachers	*Budget for refreshments*	*$50 per school, 6000 primary schools*	
		Conduct training for Guidance Counsellors/School health teachers at district level	*Budget for district level conferencing, 1 day,*	*6000 teachers over 3 years*	
		VMMC education integrated with health education sessions in schools	*No extra cost, part of school curriculum*		
		Equip school health clubs with integrated ASRH/HIV IEC materials	*Budgeted for under development of integrated IEC materials*		
		Conduct annual health worker ASRH and HIV sessions in schools	*Transport from health facility to schools in catchment area*	*150km per district per year*	
		VMMC sponsored sports/edutainment functions at schools	*Budget per district per year*	*3 galas per district per year @ $1000 each*	

				Implementation Timeframe												Outputs
	2019 Costs	2020 Costs	2021 Costs	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	
	$0			*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	
	$25,600	*$26,368*	*$27,159*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Minutes from meeting held*
	$57,600	*$59,328*	*$61,108*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*District level school-based VMMC education report*
	$36,864	*$37,970*	*$39,109*													
	$900	*$927*	*$955*		*X*		*X*		*X*		*X*		*X*		*X*	*Provincial level school-based VMMC education report*
	$1,200	*$1,236*	*$1,273*													
	$360	*$371*	*$382*			*X*				*X*				*X*		*National level school-based VMMC education report*
	$1,320	*$1,360*	*$1,400*													
	$5,184	*$0*	*$0*	*X*	*X*	*X*	*X*									*Number of District Education executives sensitized*
	$100,000	*$103,000*	*$106,090*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Number of teachers sensitized*
	$34,000	*$35,020*	*$36,071*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Number of school health coordinators/guidance counsellors trained*
				X	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Number of males reached*
				X	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Number of clubs activated*
	$1,440	*$1,483*	*$1,528*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Number of adolescents reached by health workers*
	$192,000	*$197,760*	*$203,693*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Number of adolescents reached through sponsored events*

Strategic Objective	Sub-Strategic Objective	Activities	Budget Assumptions	Quantity Descriptions	
	II. Decentralised approach to planning, coordination and implementation of VMMC Demand Generation	*Conduct quarterly district level VMMC demand generation planning and review with relevant stakeholders*	*Budget for venue and refreshments*	*40 people per district,half day meeting*	
		Conduct quarterly district level support and supervision of demand generation activities	*Transport*	*100km per district per quarter*	
			Perdiems for district health team members	*4 people, 1 day a quarter, 64 districts*	
		Create monthly district demand generation report to accompany reports for cost reimbursement	*No additional costs*		
		Support district level demand generation activities, demand generation cost reimbursement	*Demand generation cost reimbursement to district*	*Annual target*	
	III. Strengthen the role of the community in demand creation	*Map district community stakeholders to identify key influencers and entry points for engagement*	*Budgeted for under VMMC communications for program sustainability consultancy work*		
		Conduct sensitization meetings with district key influencers, identify stakeholders to include in quartely demand generation planning meeting	*Budget for the venue and refreshments*	*40 participants, half day meeting, 64 district*	
		Equip district influencers with IEC materials and promotional items for their use and reference	*Budgeted for under promotional materials*		
		Engage the local traditional leaders on VMMC progress and demand generation strategy	*Budget for community leader meeting*	*400 leaders*	
			Budget for transport	*100km per district per year*	
		Conduct community dialogues with key groups and community members (women groups, church meetings, community leaders, traditionally circumcising communities)	*Budget for refreshments*	*2 community meetings per district per year @$150 per meeting*	
		Refresher training VHWs in VMMC communications targeted at parents and boys	*Budget for refreshments*	*2 refresher trainings per district per year @ $100 per training*	
		Support VHW advocacy and communications activities	*Budgeted for under demand generation cost reimbursement*		
		Recruit and train community mobilizers (other cadres identified by district) on VMMC messaging and materials	*Budget for venue and conference*	*2 day, district level conference, 300 per year nationally*	
			Budget for transport	*300 people district level local travel*	
		Conduct refresher training for existing IPC agents	*Budget for conference*	*1 day conference, district level, 1500 per year nationally, discount 15% each year*	

				Implementation Timeframe												Outputs
	2019 Costs	2020 Costs	2021 Costs	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	
	$102,400	*$105,472*	*$108,636*	X	X	X	X	X	X	X	X	X	X	X	X	*Minutes from meeting held*
	$3,840	*$3,955*	*$4,074*	X	X	X	X	X	X	X	X	X	X	X	X	*Quarterly supervision report*
	$18,432	*$18,985*	*$19,555*													
				X	X	X	X	X	X	X	X	X	X	X	X	*Monthly district demand generation report*
	$350,000	*$369,770*	*$371,315*	X	X	X	X	X	X	X	X	X	X	X	X	
				X	X	X	X									*Number of community stakeholders engaged*
	$25,600	*$26,368*	*$27,159*	X				X				X				*Minutes from meeting held*
				X				X				X				*Number of community influencers reached*
	$20,000	*$20,600*	*$21,218*	X	X	X	X	X	X	X	X	X	X	X	X	*Number of leaders engaged*
	$960	*$989*	*$1,018*													
	$19,200	*$19,776*	*$20,369*	X	X	X	X	X	X	X	X	X	X	X	X	*Minutes from meeting held*
	$12,800	*$13,184*	*$13,580*	X	X	X	X	X	X	X	X	X	X	X	X	*Number of VHWs trained*
				X	X	X	X	X	X	X	X	X	X	X	X	
	$10,200	*$10,506*	*$10,821*	X	X	X	X	X	X	X	X	X	X	X	X	*Number of clients mobilized by VHWS*
	$3,000	*$3,090*	*$3,183*													*Number of community mobilizers trained*
	$25,500	*$22,325*	*$19,546*	X	X	X	X	X	X	X	X	X	X	X	X	*Number of IPC agents trained*

Strategic Objective	Sub-Strategic Objective	Activities	Budget Assumptions	Quantity Descriptions	
			Budget for transport	*1500 district level local travel*	
		Attend community leadership forums such as chief's council meetings, RDC meetings to engage community stakeholders on VMMC	*No associated costs*		
		Engage community stakeholders (e.g community health committees) in annual review of demand generation strategy and key messages in the district	*No associated costs*		
		Provide health worker initiated VMMC education to males in target age groups who visit health facilities	*No associated costs*		
		Conduct campaign road shows raising awareness on HIV prevention in every district	*Road show host, security, session planning, materials and sound system*	*20 road shows per district per year at $500 per road show, reduce by 15% each year*	
		Use social media channels to communicate integrated HIV prevention messages	*Budget for VMMC social media marketing*	*1,500 per month, 1 months each quarter*	
			Bulk SMS, integrated messages	*10,000 sms per year @0.05 per SMS*	
		Community mobilization of clients by IPC agents	*Budget for mobilizer allowance per client circumcised*	*Annual target*	
		Conduct inter-personal communication (IPC) sessions at district level	*Compensation for IPC agents and demand generation activities*	*100 sessions per district at $150 per session*	
		Conduct workplace (including farms and industries) IPC sessions	*IPC sessions*	*10 sessions per district at $150 per session*	
		Produce radio spots for VMMC campaigns	*Designing and production costs*	*6 every campaign, at $2000 each*	
		Sponsorship of concerts and festivals for cities	*Budget for sponsorship fee*	*1 concert/festival sponsorship per month*	
		Market VMMC at major exhibition shows	*Budget for exhibition fees*	*3 exhibitions per year*	
		Develop VMMC leaflets in all the main languages of Zimbabwe	*Designing and production costs*	*12 insertions at $2000 each*	
		Develop VMMC posters/calendars in all the main languages of Zimbabwe	*Designing and production costs*	*12 posters at $2000 each*	
		Develop VMMC banners in all the main languages of Zimbabwe	*Designing and production costs*	*4 types at $1000 each*	
		Place 60 seconds radio advertisements for HIV prevention	*Air radio ads*	*100 spots at $300 each*	

				Implementation Timeframe												Outputs
	2019 Costs	2020 Costs	2021 Costs	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	
	$15,000	*$13,133*	*$11,498*													
				X	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Number of community stakeholders reached*
				X	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Demand generation strategy and plan*
				X	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Number of men reached at health facility*
	$640,000	*$560,320*	*$490,560*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Individuals reached with VMMC messages*
	$6,000	*$6,180*	*$6,365*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Individuals reached with innovative VMMC messages*
	$500	*$515*	*$530*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	
	$1,400,000	*$1,479,080*	*$1,485,260*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Clients mobilized for MC*
	$960,000	*$988,800*	*$1,018,464*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Individuals reached with VMMC messages*
	$96,000	*$98,880*	*$101,846*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Individuals reached with VMMC messages*
	$36,000	*$37,080*	*$38,192*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Number of radio spots produced*
	$24,000	*$24,720*	*$25,462*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	
	$6,000	*$6,180*	*$6,365*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	
	$24,000	*$24,720*	*$25,462*	*X*	*X*			*X*	*X*			*X*	*X*			*Number of leaflets developed*
	$24,000	*$24,720*	*$25,462*	*X*	*X*			*X*	*X*			*X*	*X*			*Number of posters/calendars developed*
	$4,000	*$4,120*	*$4,244*	*X*	*X*			*X*	*X*			*X*	*X*			*Number of banners developed*
	$30,000	*$30,900*	*$31,827*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Number of radio ads aired*

Strategic Objective	Sub-Strategic Objective	Activities	Budget Assumptions	Quantity Descriptions	
		Place radio program for HIV prevention	*Air radio programmes*	*30 episodes at $1200 each*	
		Print VMMC leaflets	*Print and distribute leaflets*	*1.5 million at 1 cent each*	
		Print VMMC posters and calendars	*Print and distribute posters and calendars*	*100000 at 70 cents each*	
		Print HIV prevention outreach event announcement posters	*Print and distribute event posters*	*100000 at 50 cents each*	
		Produce and distribute promotional materials	*T-shirts, wrist bands, water bottles etc.*	*$200000 per year*	
	IV. Integration of VMMC Advocacy and Communication as part of Comprehensive HIV Communication Strategy	*Incorporate VMMC activities into national Communications Plan integrated with other HIV prevention activities*	*Staff time. No additional cost*		
	V. Define what needs to be done in order for the VMMC to transition to a state of high natural demand	*Develop a VMMC communications for program sustainability strategy aimed at increasing community acceptance of VMMC and transitioning to natural demand for sustainability*	*Engage an external consulting agency to develop the strategy*	*Once off lump sum costs for agency X (approx $1300 a day, engage the agency for 30 days)*	
			Hold 2 consultative workshops to support the strategy development	*2 national level workshops, 30 people, 1 day meeting*	
			Design the strategy document	*Advocacy and communication strategy document design*	
			Print the strategy	*500 copies*	
			Disseminate strategy	*1 day meeting with 40 people - national level and provincial FPs*	
5. STRATEGIC INFORMATION- Strengthen VMMC monitoring and evaluation system to ensure evidence-based decision making, and learning while integrating with other HIV prevention programmes					
MONITORING AND EVALUATION					
	I. Strengthen MoHCC capacity to collect, report, manage, analyse and effectively utilize VMMC data	*Routinely collect, enter and submit information for reporting on the monthly return form to be uploaded on DHIS*	*Falls under routine VMMC staff responsibilities. Includes cost of printing M & E tools. Cost of Registers = $15 for 2,000, Client intake form (triplicate) = 8,000 @ $30 each, Consent forms National = 2,000,000 (i.e target x 5), Monthly progress report forms = 20,000 (3/Site/x12 months), Adverse Event Register (AE) Registers - 16 page = 2,000 (1/Site x 4 years), VMMC Card and Information booklet = 400,000 (1 per client =*	*Register: Number of registers = National target/2000 per register, $15 per book*		
				Consent forms 2,000,000	
				Monthly progress report forms = 20,000	
				Adverse Event Register (AE) Registers x 2,000	

				Implementation Timeframe												Outputs
	2019 Costs	2020 Costs	2021 Costs	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	
	$36,000	*$37,080*	*$38,192*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Number of radio programmes aired*
	$15,000	*$15,450*	*$15,914*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Number of leaflets printed*
	$70,000	*$72,100*	*$74,263*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Number of posters/calendars printed*
	$50,000	*$51,500*	*$53,045*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Number of outreach event posters printed*
	$200,000	*$206,000*	*$212,180*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*Number of promotional materials distributed*
				X	*X*											
	$39,000	*$0*	*$0*	*X*	*X*											*VMMC Communications for program sustainability strategy*
	$1,800	*$0*	*$0*	*X*	*X*											
	$1,500	*$0*	*$0*		*X*											
	$15,000	*$0*	*$0*			*X*										
	$1,200	*$0*	*$0*			*X*										
	$ 2,625	*$ 2,773*	*$ 2,785*				*X*				*X*					VMMC Register
	$ 175,000	*$ 184,885*	*$ 185,658*				*X*				*X*					Consent forms
	$ 20,000	*$ 20,600*	*$ 21,218*				*X*				*X*					Monthly return form
	$ 30,000	*$ 30,900*	*$ 31,827*				*X*				*X*					AE register

Strategic Objective	Sub-Strategic Objective	Activities	Budget Assumptions	Quantity Descriptions	
			Target), Referal Register = 2,000 (1/Site)	*VMMC Card and Information booklet = 400,000*	
				Referal Register = 2,000	
		Maintain the excel VMMC weekly dashboard	*Airtime for service delivery teams*	*USD 5 x 64 Districts x 12 months*	
		Conduct training on the VMMC M&E reporting system - Strengthen/ give more time and importance the M & E in the Conventional training	*Conducted as part of service delivery trainings*	*No additional costs*	
		Continuous skills development x 5 days - Data analysis, New Soft wares e.g STRATA, ARCGIS National & Partner level	*National Strategic Information/M & E officer,Partners Strategic Information officers*	*20 people x 5 days x 25 USD*	
		Conduct refresher training on the VMMC M&E reporting system	*To be conducted as part of district level refresher training*	*District level - PHIO, DHIO, M & E officer DNO,Community nurse, Nurses*	
		Develop and deploy an online VMMC client data management system (DHIS 2 Tracker)	*Develop client & data flow. Developed as part of routine programme staff duties at no additional cost*	*No additional cost*	
			Hire consultant to develop module	*40 days of TA services*	
			Procure portable devices for all VMMC service delivery entry points/sites) and software required for VMMC module pilot	*desktop computers per site, Internet connectivity*	
				Number of tablets equivalent to the sites/service delivery teams	
				M&E Software	
			Carry out pilot in all districts within the chosen two provinces	*2 provinces, no additional cost, part of routine activities*	
			Review VMMC module using results from the pilot	*No additional cost*	
			Conduct service delivery team training at provincial level	*10 residential provincial level one day training for at least 2 VMMC service delivery team members, 1 DHE FP and 1 PHE*	

				Implementation Timeframe												Outputs
	2019 Costs	2020 Costs	2021 Costs	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	
	$ 100,000	*$ 103,000*	*$ 106,090*				*X*				*X*					VMMC client card
	$ 30,000	*$ 30,900*	*$ 31,827*				*X*				*X*					Referral register
	$ 3,840	*$ 3,955*	*$ 4,074*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	VMMC output dashboard updated every week
					X											
	$ 2,500	*$ 2,575*	*$ 2,652*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	
					X											Programme staff (by cadre) trained on the VMMC M&E reporting system
							X									DHIS2 Tracker application programmed for VMMC service delivery data management and visualisation.
	$ 23,000	*$ 0*	*$ 0*				*X*									
	$ 39,000	*$ 0*	*$ 0*				*X*									Service delivery teams able to use the DHIS2 tracker application
	$ 80,000	*$ 41,200*	*$ 42,436*				*X*									
	$ 6,000	*$ 0*	*$ 0*				*X*									
	$ 0						*X*									
							X									
	$ 32,000	*$ 0*	*$ 0*				*X*									

Strategic Objective	Sub-Strategic Objective	Activities	Budget Assumptions	Quantity Descriptions	
			Airtime for service delivery teams		
		Conduct bi-monthly DQA at facility level	*Site Teams to conduct DQA bi-monthly - data cleaning*	*No additional costs*	
		Conduct DQA monthly (District level)	*Conducted as part of CQI/QA activities*	*No additional costs*	
		Conduct DQA quarterly (provincial level)	*Conducted as part of support and supervision*	*No additional costs*	
		Conduct bi-annual DQA (national level) stand alone and targeted	*Conduct bi-annual DQA (national team)*	*3 teams of 4 (including driver), 3 provinces/team bi-annually*	
		Develop a VMMC monthly report (district level)	*Staff time*	*No additional costs*	
		Develop a quarterly VMMC report (provincial level)	*Staff time*	*No additional costs*	
	II. Conduct periodic evaluation (review) of programme performance against targets	*Conduct quarterly M&E TWG meeting*	*Costed under management and coordination*	*No additional costs*	
		Strategic information workshop 3 day meeting- data analysis projections	*Annually (Data cleaning, Analysis, DATIM & DHIS2 Reconciliation, Data for decision making etc*	*No additional costs*	
		Conduct periodic review meetings	*Conducted as part of DHT, PHT & ATP review and planning meeting*	*No additional costs*	
		Conduct target setting meeting	*One day target setting meeting during PHT meeting*	*No additional costs*	
		Conduct periodic impact modelling exercise	*Costed as part of operational research*	*No additional costs*	
	III. Conduct routine sustainability readiness assessment	*Develop indicators, tools and dashboard for sustainability readiness assessment*	*Consultant time*	*Once off lump sum costs for agency X (approx $1300 a day, engage the agency each year)*	
		Conduct baseline district sustainability readiness assessment	*National Stakeholder Meetings to develop sustainability indicators*	*3 National Meetings to validate consultant work*	
			Data collection	*5 teams of 4 individuals each (including driver), for one week, 10 provinces*	
		Conduct annual sustainability readiness assessment	*Data collection*	*5 teams of 4 individuals each (including driver), for one week, 10 provinces*	

				Implementation Timeframe												Outputs
	2019 Costs	2020 Costs	2021 Costs	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	
							X									
	$ 0			X	X	X	X	X	X	X	X	X	X	X	X	Bi-monthly DQA report
	$ 0															
	$ 12,750	$ 13,133	$ 13,526	X	X	X	X	X	X	X	X	X	X	X	X	Quarterly DQA report
	$ 9,000	$ 9,270	$ 9,548	X		X		X		X		X		X		Biannual DQA report
				X	X	X	X	X	X	X	X	X	X	X	X	District quarterly report produced
				X	X	X	X	X	X	X	X	X	X	X	X	Provincial Monthly report produced
	$ 1,200	$ 1,236	$ 1,273	X	X	X	X	X	X	X	X	X	X	X	X	Routine TWG Meetings conducted
				X	X	X	X	X	X	X	X	X	X	X	X	
	$ 12,500	$ 12,875	$ 13,261			x				x				x		Evaluation reports produced
							x				x				x	Updated national targets for VMMC
							x				x				x	
	$ 25,875	$ 8,884	$ 9,150	x												
	$ 24,000	$ 8,240	$ 8,487		x											Baseline sustainability assessment report
	$ 110,000	$ 0	$ 0													
	$ 0	$ 113,300	$ 0						x				x			Annual sustainability assessment report or dashboard

Strategic Objective	Sub-Strategic Objective	Activities	Budget Assumptions	Quantity Descriptions	
	I. Establish a weekly notification system for reporting AEs	*Lobby for inclusion of VMMC AE into the weekly disease notification*	*Meeting at national level no additional costs*	*No additional cost*	
		Lobby for inclusion of VMMC AE into the monthly National Quality Assurance Audit meetings	*Meeting at national level no additional costs*	*No additional cost*	
		Sensitisation of standard AE reporting for Health Workers	*Conducted as part of health worker refresher trainings*	*No additional cost*	
	II. Inform and utilize national population surveys	*Submit VMMC questions to population-based surveys during the design stage*	*Meeting at national level no additional costs*	*No additional cost*	
		Conduct secondary data analysis of population surveys to glean VMMC insights	*Software costs*	*STATA perpetual license*	
	III. Conduct relevant operational research	*Conduct relevant operational research*	*Ethical approval, data collection, publishing, travel and any other costs*	*Estimated at USD750.000 annually*	
	IV. Ensure learning at all level of the MoHCC system through the routine documentation and dissemination of best practice or evidence from research findings	*Conduct M&E mentorship visits*	*Conducted as part of support and supervision*	*No additional cost*	
		Publish VMMC best practice during conferences and on the MOHCC website	*Costed as part of operational research*	*No additional cost*	
6. PROGRAMME FINANCING- To reach a state where there is adequate and predictable financing for the VMMC programme					
	I. Increasing effectiveness and efficiencies in the use of available resources	*Conduct VMMC RBF pilots*	*Costed as part of operational research*	*No additional cost*	
		Capacity building on the implementation and financial management of VMMC at sub-national level	*Training and support and supervision of PMU, PHE, DHE and facilitie. Costed as part of management training*	*No additional cost*	
		Conduct coordination meeting on budgets, planning with NAC so that funding can be directed towards districts without external partner support	*Meetings*	*No additional cost*	
		Align demand creation to service delivery	*Conducted as part of service delivery staff plan*	*No additional cost*	
	II. Continue with periodic resource mapping and financial gap analysis to inform planning, allocation	*Conduct annual program review and cost the updated implementation plan*	*Conducted as part of routine MOHCC meetings*	*No additional cost*	
		Conduct an annual resource mapping and financial gap analysis exercise	*Staff time, dissemination conducted during routine MSC meetings*	*No additional cost*	

				Implementation Timeframe												Outputs
	2019 Costs	2020 Costs	2021 Costs	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	
				X	X	X	X	X	X	X	X	X	X	X	X	VMMC AE included in the MOHCC weekly disease notification
				X	X	X	X	X	X	X	X	X	X	X	X	VMMC AE discussed during the monthly audit meetings
				X	X	X	X	X	X	X	X	X	X	X	X	Complete and consistent reporting of AE within the month return form
				X	X	X	X	X	X	X	X	X	X	X	X	VMMC questions part of the ZDHS 2020/21 and other relevant population-based surveys
	$ 500	*$ 515*	*$ 530*	X	X	X	X	X	X	X	X	X	X	X	X	Secondary data analysis reports produced
	$ 750,000	*$ 772,500*	*$ 795,675*	X	X	X	X	X	X	X	X	X	X	X	X	Research reports developed
				X	X	X	X	X	X	X	X	X	X	X	X	Mentorship visits conducted
				X	X	X	X	X	X	X	X	X	X	X	X	Dissemination of research, evaluation and best practice reports
				X	X	X	X	X	X	X	X	X	X	X	X	
							X				X				X	PHEs, DHEs, Facility Managers and programme staff trained on the RBF mechanism (VMMC Component)
				x			x				x				x	
				x	x	x	x	x	x	x	x	x	x	x	x	
							X									Costed implementation plan
					X				X				X			Resource mapping and gap analysis report

Strategic Objective	***Sub-Strategic Objective***	***Activities***	**Budget Assumptions**	**Quantity Descriptions**	
	efficiencies and mobilization of resources	*Monitor and evaluate the plans for resource mobilisation and financial sustainability*	*Reviews and updates conducted by the PMU*	*No additional cost*	
		Conduct resource mobilisation and funding coordination meetings integrated with other MOHCC meetings	*No additional costs*	*No additional cost*	
		Conduct advocacy and resource mobilisation meetings with public sector, private sector, civil society and international partners	*National level meeting with snacks provided*	*30 people * $25*	
	III. Explore local and other predictable sources of funding at all levels	*Identify and engage possible sources of funding*	*Staff time*	*No additional cost*	
		Fund raising and grant application to local potential funders for key VMMC activities	*Capacity building on fundraising and grant application*	*No additional cost*	
		Engagement of NAC on available funding where VMMC activities can be implemented	*No additional costs*	*No associated costs*	

				Implementation Timeframe												Outputs
	2019 Costs	2020 Costs	2021 Costs	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	
				X	X	X	X	X	X	X	X	X	X	X	X	
				X	X	X	X	X	X	X	X	X	X	X	X	VMMC resource mobilisation and funding coordination meetings conducted as part of other routine MOHCC meetings like Ministers Briefing, MODO, PHT, DHT etc
	$ 750	*$ 773*	*$ 796*		*x*				*x*				*x*			Meetings conducted
				X	X	X	X	X	X	X	X	X	X	X	X	A document listing partners in each district and other community sources such as community ownership trusts
				X	X	X	X	X	X	X	X	X	X	X	X	Funding proposals written
				X	X	X	X	X	X	X	X	X	X	X	X	Alignment of VMMC funding from NAC with district needs

ANNEX

Annex 1. EIMC vs EAMC Considerations for Zimbabwe

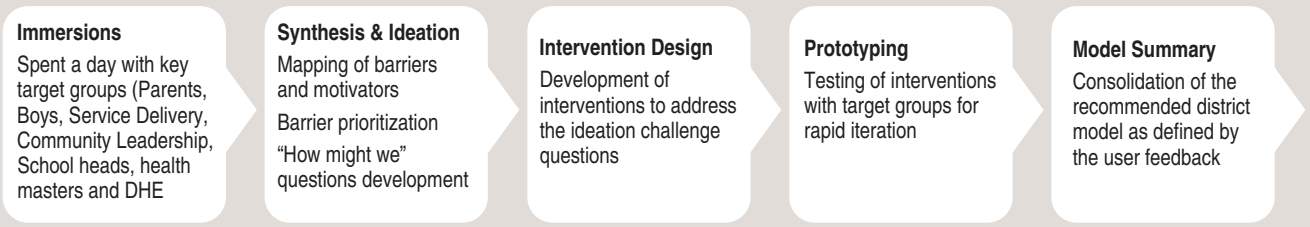
APPROACH	PROS	CONS
EAMC Adolescent-led strategy	● Capacity has been built nationwide ● Method choices of surgical and PrePex, widely available ● Experience with quantification process for adolescents ● Infrastructure at sites already set up for service ● Cost of EAMC strategy is cheaper compared to EIMC in the long run ● VMMC-ASRH linkages pilot provides early insight into integration of VMMC into ASRH services ● Increased awareness of EAMC among the population due to scale up phase ● Global guidance is targeted towards providing a comprehensive prevention health package to adolescent boys ● VMMC is usually the first opportunity for adolescents to interact with health services and if VMMC if offered as a comprehensive package, adolescent VMMC can potentially increase public health benefits and offers opportunities for addressing gender norms ● VMMC among adolescent boys and men aged 15–29 years has a more immediate effect on HIV acquisition risk	● Difficult to reach adolescents outside of school environment ● Current programme has limited involvement of the Ministry of Education (MOPSE) ● Current challenge in obtaining legitimate consent forms
EIMC Infant-led strategy	● Pilot conducted showed that EIMC was safe with minimal aftercare needed ● Can be integrated with neonatal care programme ● Research showed high acceptance by mothers to have their infants circumcised.	● Need to build new capacity of servic providers ● AcuCirc device used in pilot not yet qualified by WHO ● Cultural barriers for mothers to give consent for babies to be circumcised ● EIMC more costly than EAMC to implement due to higher numbers required ● EIMC is a new concept therefore strong efforts required to build buy in ● Infrastructure would need to be identified or developed to cater for EIMC ● Benefit for HIV acquisition risk is in the longer term
EIMC/EAMC Hybrid model	● Concurrent circumcision of infants at birth and adolescents circumcision in schools to close the gap ● Provides an alternative option for parents not opting for EIMC, increasing access and coverage of MC services	● Staff constraints as circumcisers for both models are in same pool for some sites. Potentially added workload for already overburdened staff ● Still need to train new circumcisers on EIMC ● Costly to conduct both simultaneously. Potentially limited resources available to cover this

Annex 2. Sustainability Pilots

In addition to the body of evidence already available, additional evidence is currently being generated from ongoing EAMC sustainability pilots to inform implementation of sustainable approaches to VMMC programming. Although results will only be available in 2019 post the development of this Strategy, there are already some lessons learnt from the development of the pilot models which informed this Strategy. Best practices from the pilot districts will be implemented and scaled up in districts transitioning to sustainability.

These pilots are exploring the feasibility and acceptability of some of the proposed sustainability approaches. They will be carried out in five districts that are close to 80% saturation in the 15-29 target age group. A Human Centered Design approach which included Empathy, Immersion and Prototyping (EIP) exercises with programme stakeholders— circumcised and uncircumcised adolescent boys, parents, school health coordinators and District Schools Inspectors, Provincial Education Directors, community leaders and health service providers— was used to collect insights, ideate on potential sustainability models and test prototypes with intended users.

The diagram below describes the EIP process in more detail:



From the EIP exercises, district specific sustainability models were created for piloting. The pilots will include frequent evaluations and iterations of approaches until an optimal, sustainable state is reached. For service delivery, pilots are exploring the decentralization of VMMC services to local clinics using the surgical method where possible. Training and mentoring of staff to capacitate them on VMMC service delivery is on-going. The pilots will also explore the utilization of existing approaches such as school holiday campaigns. For demand creation, pilots are designed to evaluate the impact of including VMMC in the school health curriculum. Working with school health coordinators, adolescents will be mobilized for specific service delivery days outside of exam and learning periods. Pilots are also exploring ways to mobilize parents and out of school boys using community based health workers such as VHWs.

In addition to service delivery and demand generation, considerations are also being made for programme management and coordination. Programme management and coordination functions that are currently part of Implementing Partner officers are being transitioned to members of the provincial and district health teams, facility managers and VMMC team leaders. The sustainability pilots present an opportunity to learn what it takes to decentralize VMMC services and sustain EAMC in a programme wholly managed by MoHCC.

[i] Auvert B, Taljaard D, Lagarde E, Sobngwi-Tambekou J, Sitta R, et al. (2005) Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 trial. PLoS Med 2(11): e298.Protective effect = 60% (32%-76%) ii. Gray RH, Kigozi G, Serwadda D, Makumbi F, Watya S, Nalugoda N et al. Male circumcision for HIV prevention n men in Rakai, Uganda: a randomized trial. Lancet 2007; 369: 767-66.Protective effect = 55% (22%-75%)Bailey RC, Moses S, Parker CB, Agot K, Maclean I, Krieger JN, et al. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial. Lancet 2007; 369: 643-56. Protective effect = 60% (32%-77%)

[ii] VMMC Accelerated Scale Up Costed Operational Plan 2014-2018