



Ministry of Health



POLICY GUIDELINES FOR SUSTAINING MEDICAL MALE CIRCUMCISION SERVICES IN KENYA

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Policy guidelines for sustaining medical male circumcision services in Kenya

National AIDS & STI Control Programme

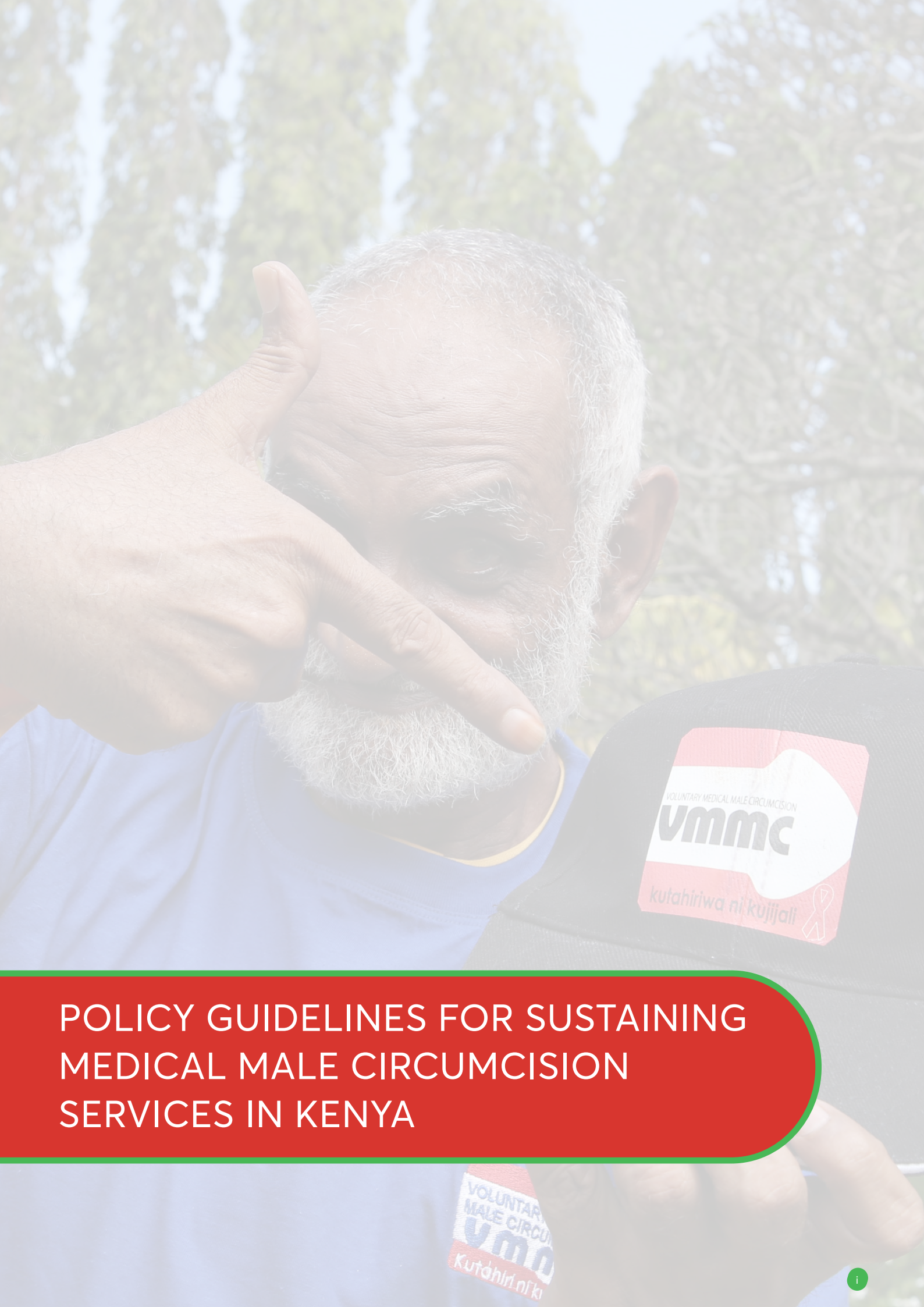
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Definitions

Sustainability - Ongoing effective delivery of health programmes beyond donor funding, institutionalized in health services and social systems with the aim of sustaining high coverage of male circumcision that contributes to reduction of new HIV infections and improved health. Sustainability is characterized by

- Local ownership (political, social and financial)
- Integration with the basic package of health services (routinized service delivery)
- Affordable cost
- Easily accessible and scalable programme
- Rooted in community social norms

Integration - All-inclusive service delivery or management of health services so that clients/patients get the care they need, when they need it (access), in ways that are provider-friendly and user-friendly, while achieving the desired goal. Integration also refers to policy making and management that brings together decisions about different parts of the health service at different levels.

Routinizing - Provision of services alongside other primary health care services in a normal setup within a health facility.

Abbreviations

| | |
|----------------|--|
| AE | Adverse Event |
| AIDS | Acquired Immune Deficiency Syndrome |
| BMGF | Bill & Melinda Gates Foundation |
| CASCO | County AIDS and STI Coordinator |
| CDC | Centers for Disease Control and Prevention |
| CHMT | County Health Management Team |
| DHIS | District Health Information System |
| EMR | Electronic Medical Records |
| HIV | Human Immunodeficiency Virus |
| HMIS | Health Management Information System |
| HTS | HIV Testing and Counselling Services |
| IEC | Information Education and Communication |
| KEPI | Kenya Expanded Programme on Immunization |
| KMTC | Kenya Medical Training College |
| M&E | Monitoring and Evaluation |
| MC | Male Circumcision |
| MMC | Medical Male Circumcision |
| MNCH | Maternal, Neonatal and Child Health |
| MoEST | Ministry of Education Science and Technology |
| MoH | Ministry of Health |
| NACC | National AIDS Control Council |
| NASCOP | National AIDS and STI Control Programme |
| NGO | Non-Governmental Organization |
| NHSSP | National Health Sector Strategic Plan |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| QA | Quality Assurance |
| SCASCO | Sub-County AIDS and STI Coordinator |
| STI | Sexually Transmitted Infection |
| TSU | Technical Support Unit |
| TWG | Technical Working Group |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNICEF | United Nations International Children's Emergency Fund |
| WHO | World Health Organization |

Foreword

The Kenya Ministry of Health (MoH) together with stakeholders has developed this MMC Policy 2018–2022 to guide the sustainability of medical male circumcision (MMC) services in Kenya. MMC has been identified as an effective HIV prevention method and has been prioritized in the HIV response in Kenya to reduce new infections.

The MoH made MMC part of its national HIV prevention strategy and started its implementation in 2008 with the objective of scaling up MMC, especially in traditionally non-circumcising communities. The MoH in partnership with various stakeholders has ensured the availability of supplies and equipment, human resources and infrastructure to meet the programme service delivery targets. Deliberate efforts have been made to minimize adverse events, to promote MMC through community-based advocacy, and to harmonize government and donor activities at national and county levels.

After a successful scale-up phase, the Kenya MMC Programme is moving towards a sustainability phase, in which we hope to sustain gains made in the catch-up phase and sustain the MMC services to adult men, adolescent boys and infants beyond donor funding. To sustain MMC services, MMC will be offered as part of the essential health services package while adhering to the WHO quality assurance guidance on enhancing the safety and quality of services. This will require assessment of facilities, capacity strengthening of the health workforce in these facilities, a robust information system, an integrated system of supply and distribution of supplies and equipment, demand generation and community engagement, and strong leadership and coordination from national and county government. Programme-based budgeting and planning will be essential to integrate MMC into routine services. We have to also ensure that services are available for the most difficult to reach people in the most difficult to reach geographies to attain universal health coverage. Domestic funding for the HIV response in Kenya needs to be increased for long-term sustainability of the services.

This policy guideline is anchored in the Kenya Health Policy 2014–2030 with the objective of reducing the burden of communicable diseases by combating HIV/AIDS. I urge every stakeholder—including the county governments, implementing partners, training institutions, professional associations and regulatory bodies, mass media, and community households and individuals—to work together to make implementation of this policy successful.



A stylized, handwritten signature in black ink, appearing to read 'Kioko Jackson'.

Dr. Kioko Jackson K., OGW, MBS

Director of Medical Services

Ministry of Health

Government of Kenya

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The Ministry of Health through the National AIDS and STI Control Programme (NASCOP) has developed this MMC Policy 2018–2022 in collaboration with many individuals and multiple institutions. This document has been developed through extensive consultations and the commendable efforts of multiple stakeholders, individuals and institutions, led by NASCOP's MMC Programme.

This policy guidance is developed pursuant to the objectives of the Kenya Health Policy 2012–2030, the Kenya AIDS Strategic Framework 2014/15 – 2018/19, the National Guidelines for MMC in Kenya 2008 and the National Voluntary Medical Male Circumcision Strategy 2014/15 – 2018/19. I would like to thank Dr. Peter Cherutich, MoH, for his vision, leadership and support during development of this policy. I appreciate Ambrose Juma, the national programme manager for MMC at NASCOP, for his guidance in developing this policy. I especially appreciate the leadership and technical support of the MMC Technical Support Unit (TSU) at NASCOP, implemented by the University of Manitoba, in spearheading the development process and bringing it to a conclusive end. I also appreciate significant contributions of the key Ministry of Health staff at national and county levels, Kenya Medical Training College, MMC implementing partners, donors—especially the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Bill & Melinda Gates Foundation (BMGF)—and technical agencies whose staff spent many hours reviewing, writing and finalizing this document.

Special thanks to the MMC policy guidelines development secretariat, which included Ambrose Juma of NASCOP, Kennedy Serrem, Isaac Oguma, Saida Kassim, Rabbecca Songoi, Milton Koyier, Isaac Kimani Mbugua from the MMC TSU at NASCOP, Manaseh Bocha at MoH, Dr. Carol Ngunu, John Anyango, John Odira, Charles Okal at county MoH, Fidel Asol, George Otieno at UoM and Nandi Owuor at Jhpiego. I also acknowledge the inputs of the following national and international experts who reviewed the document and provided invaluable insights:

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Executive Summary

This is the second national policy document on voluntary medical male circumcision (MMC) since the programme's rollout in Kenya in 2008. It guides integration of MMC into Kenya's health system in order to sustain the services by routinizing them as part of essential health services package. Routinizing MMC services will require strengthening the capacity of the health workforce in Ministry of Health (MoH) facilities, integrating MMC records with the health management information system (HMIS), strengthening MMC leadership and coordination from national and county government, integrating MMC supplies and equipment with the medical supply chain, mobilizing financial support from domestic sources, and enhancing community engagement to increase demand for MMC.

The policy has defined the following implementation considerations for the national MMC programme:

- The minimum package for MMC that includes; service provision to all target age groups; linkages and referrals of infants, adolescents and adults to appropriate services; a coordinated approach to ensure safety and to prevent infections, including tetanus vaccine and proper wound care after MMC.
- Quality standards through adherence to guidelines and compliance with infection prevention and control measures in order to improve and maintain safety of services.
- Service delivery models as tiers 1–4; namely, community health services, primary care services, county referral services, and national referral services.
- Health system requirements that include commodity and supply chain, human resource and capacity building, monitoring and evaluation (that includes HMIS and program operation research), demand creation, financing and infrastructure, and coordination and management.
- Management and coordination through technical working groups at national, inter-county and county level, including sub-county steering committees.
- The roles of MoH at national and county levels, implementing partners, training institutions, professional associations, mass media, and other stakeholders.



A handwritten signature in black ink, appearing to read 'Kigen B. Bartilol'.

Dr. Kigen B. Bartilol
Head, National AIDS and STI Control Programme Ministry of Health
Government of Kenya





01

Introduction

1.1 Background

Male circumcision is the surgical removal of penile foreskin.¹ Medical male circumcision (MMC) is a simple, one-time intervention with benefits for the circumcised individuals and a high impact on the HIV epidemic at population level.² The Kenya Ministry of Health (MoH) made MMC part of its national HIV prevention strategy and started its implementation in 2008.³ This decision was taken after studies in Kenya, South Africa and Uganda conclusively demonstrated that the intervention reduces men's risk of acquiring HIV infection through vaginal sex by about 60%,^{4,5,6} and the World Health Organization (WHO) and UNAIDS recommended MMC as a key component of combination HIV prevention in countries with high HIV prevalence and low levels of male circumcision.⁷

The MMC Programme in Kenya began in Nyanza, the region with the highest rates of HIV infection and the lowest coverage of male circumcision.⁸ It was later expanded to other traditionally non-circumcising regions in the country. Since its inception, the MMC Programme has been funded mainly by the United States President's Emergency Plan for AIDS Relief (PEPFAR), with limited support from other external collaborators, such as the Bill & Melinda Gates Foundation and the Global Fund.⁹ About 1.7 out of 1.8 million targeted males were circumcised between 2008 and 2018.¹⁰ The national coverage of MC increased from 85% to 92.5% between 2008 and 2018, but more significantly increased from 48% to 72% in the Nyanza region.¹¹

1.2 Profile of the MMC Programme - Progress made since 2008

The Kenya MMC Programme has completed the implementation of its First National Strategy (catch-up phase, 2008–2013) and has transitioned to a longer term sustainability phase detailed in the Second National Strategy, which runs from 2014 to 2019.¹² The goal of Kenya's First National MMC Strategic Plan was to circumcise 80% of eligible uncircumcised men aged 15–49 by July 2013.¹³ The national MC prevalence increased from a baseline of 84% in 2007 to 91% in 2012, with the coverage in traditionally non-circumcising communities increasing from 48% to 66% during the same period. Other achievements include an enabling environment for implementation of MMC, partnerships with donors and implementing organizations, increased MMC demand and uptake, and 575 service provision facilities (static and outreach) established with 3,600 healthcare providers trained on MMC. About 860,000 male circumcisions were done, achieving 90% of the target. For this initial phase, 100% of the funding was externally sourced from PEPFAR.

The second phase of MMC implementation (sustainability/integration phase), 2014–2019,¹⁴ is aligned to the Kenya AIDS Strategic Framework 2014–2018¹⁵ and operationalizes the National Guidance for Voluntary Male Circumcision in Kenya (2008). The target in this second phase is to circumcise 1.2 million men by 2019 while progressively integrating MMC services into routine health services to sustain MMC services. The specific objectives are to

- increase the proportion of males aged 15–49 years circumcised in Kenya from 91% to 95%,
- increase the proportion of males aged 15–49 years circumcised in traditionally non-circumcising communities from 66% to 80%,
- focus on early adolescent boys (10–14 years) as a priority target population,
- initiate early infant male circumcision services as a component of MNCH in eligible health facilities within counties,
- maintain severe adverse events (AEs) at below 2% of all MMC performed, and
- introduce devices for male circumcision.

1 Lissauer T and Clayden G. 2011. *Illustrated Textbook of Paediatrics*, Fourth edition. Elsevier. pp. 352–353.

2 USAID program brief. 2015 Scaling up voluntary medical male circumcision for HIV prevention in Kenya's Nakuru County.

3 National AIDS and STI Control Programme. 2008. National Guidance for Voluntary Male Circumcision in Kenya. Nairobi: Ministry of Health, Republic of Kenya.

4 Auvert B, Taljaard D, Lagarde E, et al. 2005 Randomized controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 Trial. *PLoS Med* 2(11):1112. DOI: 10.1371/journal.pmed.0020298.

5 Bailey R, Moses S, Parker C, Agot K, Maclean I, Krieger JN et al. 2007. Male circumcision for HIV prevention in young men in Kisumu, Kenya: A randomised controlled trial. *Lancet* 369(9562):643–56.

6 Gray R, Kigozi G, Serwadda D, Makumbi F, Watya S, Nalugoda F et al. 2007. Male circumcision for HIV prevention in men in Rakai, Uganda: A randomised trial. *Lancet* 369(9562):657–66.

7 World Health Organization. 2007. New data on male circumcision and HIV prevention: policy and programme implications. WHO/UNAIDS technical consultation. Male circumcision and HIV prevention research implications for policy and programming. Geneva: WHO.

8 Talbot JR, Cole C, May M, Weintraub R. 2012. Voluntary Medical Male Circumcision in Nyanza Province, Kenya. Harvard Business Publishing.

9 Okumu G. 2017. Challenges facing male circumcision programme. Standard Digital. 2 June. <https://www.standardmedia.co.ke/article/2001241877/challenges-facing-male-circumcision-programme>

10 District Health Information Software 2, 2017.

11 Government of Kenya. 2014. Kenya Demographic and Health Survey, 2014. Nairobi: Government of Kenya

12 Republic of Kenya. Ministry of Public Health & Sanitation. 2009. Kenya National Strategy for Voluntary Medical Male Circumcision. Nairobi: National AIDS & STI Control Programme.

13 Government of Kenya, Ministry of Public Health and Sanitation, NASCOP. 2010. Progress Report on Kenya's Voluntary Medical Male Circumcision Program, 2008–2009: Summary. Nairobi: National AIDS & STI Control Programme.

14 Government of Kenya, Ministry of Health, NASCOP. 2015. National Voluntary Medical Male Circumcision Strategy, 2014/15 - 2018/19. Nairobi: National AIDS & STI Control Programme.

15 Ministry of Health. Kenya AIDS Strategic Framework 2014/2015 – 2018/2019. Nairobi: National AIDS Control Council.

Kenya's phased approach to sustainable MMC programming prioritizes inclusion of early adolescent boys (10–14 years) and early infant male circumcision. The traditionally non-circumcising geographies remain the priority locations, with an increased focus on younger boys and infants.

In the second phase, the MMC Programme has mapped MMC services and done gap analysis for service integration; established 217 service provision centres in five priority counties (Kisumu, Siaya, Migori, Homa Bay and Turkana); established a centre of excellence for training and management of adverse events; included MMC in KMTC pre-service training curriculum; developed an MMC sustainability matrix; developed a county-based transition plan for MMC; developed a policy guideline to integrate MMC into routine health services; increased the number of county focal persons on MMC from 1 to 4; and done 1.7 million circumcisions.

Modelling studies conducted in Kenya show that the MMC Programme has already had impact, and that its benefits will grow significantly in the future.¹⁶ The programme is very efficient, with as few as five to 15 circumcisions necessary to prevent one new HIV infection. There would be substantial savings in the future due to treatment costs averted, and MMC is seen as an important component in ending AIDS as a public health threat by 2030. For example, in the Homa Bay region, expanding ART to the 95–95–95 goals for 2030 was projected to reduce the annual number of new HIV infections to 2100 without the MMC Programme, but to 1100 if combined with the continued expansion and maintenance of MMC. The modelling studies also show a strong rationale for prioritizing MMC programmes by geography and age.

1.3 Toward sustaining MMC

As the MMC Programme evolved in the second phase, it was determined that to achieve the desired and long-term reduction of HIV infection, **five sustainable interventions as listed in the strategy** needed urgent attention:

- Integrating MMC service provision into public, private and faith-based facilities as a routine HIV prevention service
- Establishing MMC centres of excellence to offer the optimum MMC services while maintaining patient safety (capacity building, management of adverse events, monitoring and evaluation, MMC learning resource centre, correction of congenital malformations)
- Including MMC in the pre-service curriculum for nurses, clinical officers and medical doctors in addition to inclusion in continuing medical education
- Mainstreaming the procurement of MMC commodities and supplies through MoH mechanisms, such as the Kenya Medical Supplies Authorities
- Mainstreaming advocacy and demand creation through community strategy

The following gaps were identified as a barrier to sustaining MMC services:

- The county was still operating in the scale-up mode by providing MMC through ad hoc methods like conducting rapid result initiatives or camps.
- Implementation of MMC services was still dependent on implementing partners being funded by donors.
- Training of service providers was conducted by implementing partners as and when they needed service providers to scale up the programme.
- Incentivizing the MoH staff to conduct MMC created a perception that MMC was an additional task.
- Counties demonstrate low ownership, leadership and investment towards the programme.
- Guidance on sustaining services in a devolved system of governance is lacking.

The need for a policy framework to sustain MMC services arose from these identified gaps. This policy takes a health systems approach and takes into account the underlying characteristics, connectivity and relationships of the entire health system. Article 43 (1) of the Constitution of Kenya (2010) states, "Every person has the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare." This policy shall support access to and provision of high quality and affordable male circumcision services at all levels of health service provision.

¹⁶ World Health Organization. 2017. Models to Inform Fast Tracking Voluntary Medical Male Circumcision in HIV Combination Prevention: Report from World Health Organization and UNAIDS meeting, 23–24 March 2016. Geneva: World Health Organization.



A Message to the
Help reduce HIV

Voluntary Medical Male Circumcision (VMMC) today:
... from local clinics and hospitals to talk to your community.
... to visit the local health
... find out more information about VMMC and
...
... Steering Committee, Ministry of Health and
... about how else you can help



02

MMC Policy 2018–2022

2.1 Vision



A Kenya free of new HIV infections, stigma, discrimination and AIDS-related deaths.

2.2 Policy Mission



To facilitate provision of safe, accessible, equitable and sustainable MMC services that maintain high coverage and contribute to the reduction of new HIV infections

2.3 Goal



To sustain MMC through integration into the health system.

2.4 Policy statement

This MMC Policy guides the integration of MMC into Kenya's health system in order to sustain MMC services by routinizing them as part of the essential health services package. Routinizing MMC services will require strengthening the capacity of the health workforce in MoH facilities, integrating MMC records with the health management information system, strengthening MMC leadership and coordination from national and county government, integrating MMC supplies and equipment with the medical supply chain, mobilizing financial support from domestic sources, and enhancing community engagement to increase demand for MMC.

2.5 Specific objectives

POLICY OBJECTIVE:

- 1 To routinize effective, safe and quality MMC services as part of the health system structure
- 2 To develop a well-performing health workforce that is competent to conduct MMC, responsive, productive and effective
- 3 To establish a well-functioning health information system for MMC, integrated within routine data collection and monitoring systems, to produce, analyse, disseminate and use reliable and timely information on MMC
- 4 To facilitate national and county leadership and governance towards sustaining MMC services with effective oversight, coordination and accountability
- 5 To strengthen the national and county procurement and supply chain mechanism to integrate procurement and distribution of MMC supplies and equipment
- 6 To enhance resource mobilisation and effective allocation and use of domestic and donor funding towards sustainable services for MMC
- 7 To enhance engagement with the community to increase demand for MMC services

2.6 Guiding principles

- i. MMC services are provided safely, respecting the rights of clients, and without stigma or discrimination for circumcising and non-circumcising communities.
- ii. People-centred MMC is integrated with adolescent, maternal, neonatal, child and male reproductive health services; HIV treatment and care; vaccination and other relevant services.
- iii. MMC is part of a comprehensive HIV prevention package that is based on informed consent, HIV testing and counselling services (HTS), risk-reduction counselling, condom promotion and provision, and STI screening and management.
- iv. MMC is performed by well-trained, certified practitioners in settings that meet the standards prescribed in the national service guidelines.
- v. Sustainable financing for MMC is achieved through increased domestic resources at national and county levels, including public-private partnerships, and ensures that MMC does not interrupt or divert resources from other primary healthcare services.
- vi. MMC leadership, ownership and accountability within the country and county.
- vii. Operations research and participatory learning are carried out where and when necessary to inform the strengthening of MMC services.
- viii. Data and evidence driven; community driven and owned; affordable and cost effective.

2.7 Supporting documents for the policy

This policy is anchored within the Kenya Health Policy 2014–2030 on the objective of tackling the burden of communicable diseases, which is based on the principle of equitable distribution of health services and interventions, with a focus on inclusiveness. The policy builds on and leverages the Kenya AIDS Strategic Framework 2014/15 – 2018/19, which prioritizes MMC as a key HIV prevention strategy. The policy also operationalizes the national guidance for MMC in Kenya, which mandates development of sustainable MMC services. The policy also draws on the WHO framework for action for strengthening health systems by adapting the building blocks framework for the policy. Finally, the policy draws on the UNAIDS-led *HIV Prevention 2020 Road Map of 2017*, which identified MMC as one of the five prevention pillars for reducing new HIV infections.



2.8 WHO health system strengthening framework

The WHO recognizes the health systems approach as key to transitioning to sustainable services for MMC. The WHO health systems building framework describes the six blocks of a health system.

THE SIX BUILDING BLOCKS OF A HEALTH SYSTEM

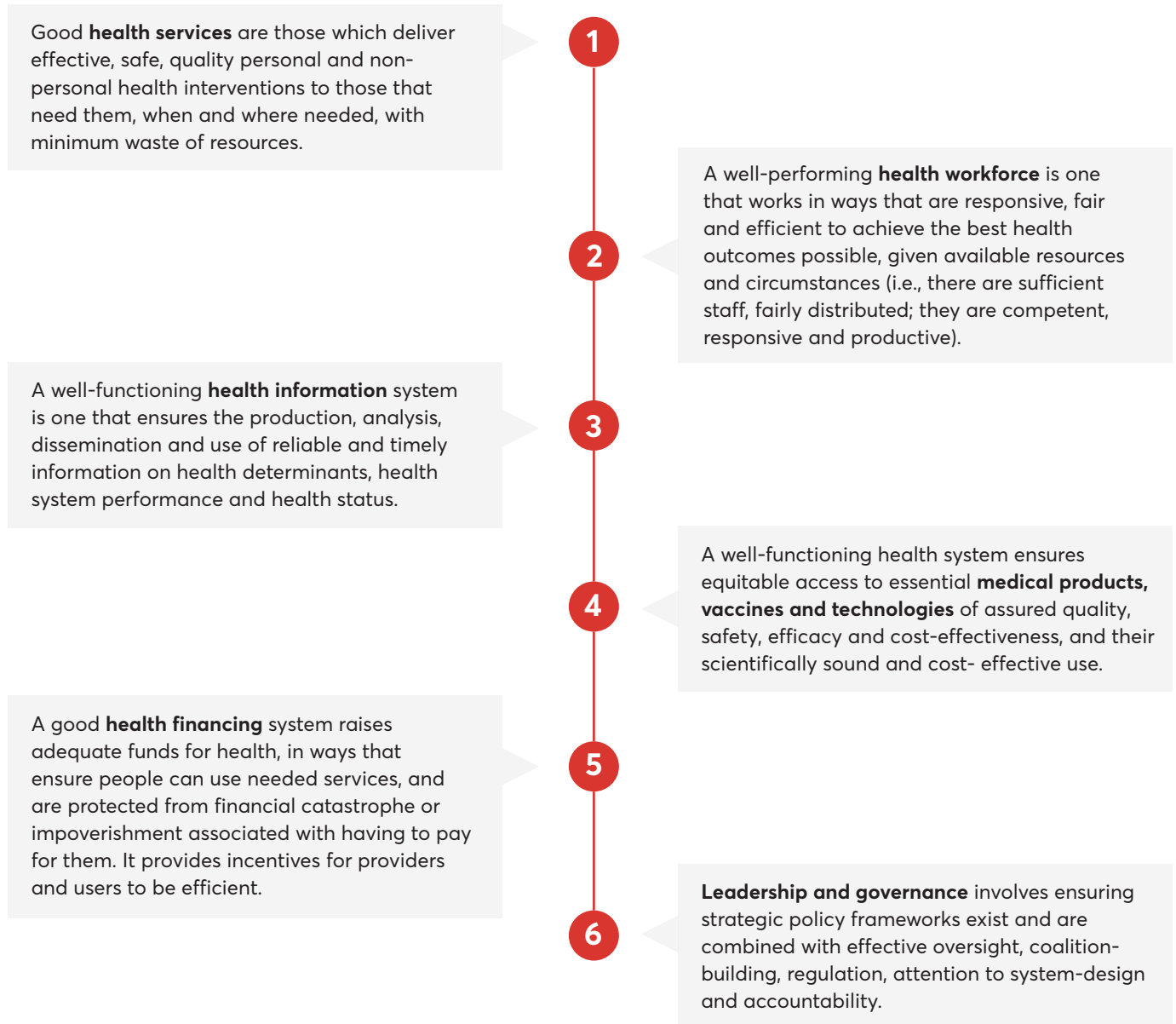


Figure 1: Description of the six building blocks of a health system. Source: Everybody's business: Strengthening health systems to improve health outcomes: WHO framework for action. Geneva: World Health Organization. 2007

This policy framework is built on the WHO framework for action on strengthening health systems to improve health outcomes. Each health system building block has been further unpacked in the Kenyan context to make it relevant for sustaining MMC services in Kenya. Alongside the six building blocks, a seventh block—community engagement and demand generation—is added as a critical enabler for sustaining MMC services in Kenya.¹⁷

¹⁷ W Ameyan and J Samuelson. 2018. Programme and operational considerations with focus on sustaining services for adolescent boys. Draft.

2.9 Policy development process

The policy development process included a series of consultations, deliberations and discussions with various stakeholders through workshops, small group meetings and document reviews. The development of this policy was spearheaded by the National AIDS and STI Control Programme (NAS COP) in the Ministry of Health, and was guided by extensive consultations and discussions with stakeholders at both the national and county level, as well as inputs from donors and other stakeholders. This consultation culminated in a three-day workshop in May 2018 that brought together stakeholders and representatives from the 10 priority counties for MMC.

The aim of the workshop was to build consensus on approaches to sustain MMC services while maintaining high coverage. The specific objectives of the workshop were to

- build national consensus on both national and county understanding on sustainability of MMC services,
- develop a national policy framework (national policy direction) for sustaining MMC services by integrating within routine health services, and
- develop county-based implementation plans for sustainability of MMC services.

The workshop discussed in detail the essential “pillars” for sustainability of the MMC services:

- Service delivery and integration
- Health workforce and capacity building
- Strategic information system
- Leadership and governance
- Community engagement and demand generation
- Supply and distribution of commodities
- Financing

Deliberation in the workshop provided guidance to develop the first draft of the policy document, which was reviewed in July 2018 by a small group of national- and county-level experts from the MoH, technical experts from donor and implementing partner agencies and research institutions.



03

Policy Provisions

3.1 Policy objective 1

To routinize effective, safe and quality MMC services as part of the health system structure

Provision of effective, safe, quality and continuous health interventions to those that need them, when and where needed is key for good health services. For MMC services to be sustained, MMC needs to be routinized as part of the health system service delivery structure. For MMC to have public health impact, high coverage of MMC services must be maintained with minimal risks.



Main challenges

MMC is not provided as a routine service, but as an ad hoc and separate service supported by donors and delivered by implementing partners. The challenges of routinizing MMC services include limited space, human resources, systems and structures within the facilities that can facilitate provision of quality and safe MMC services.



Priority areas

Health services should be planned strategically to increase MMC service accessibility, quality, safety and continuity. Service design and delivery must be informed by assessment and mapping of the MMC service delivery points to understand the delivery infrastructure and resources necessary for routinizing MMC in these facilities. The model of care for service delivery needs to be defined to ensure that MMC services are delivered within an integrated package of services as part of the routine platforms at prioritized facilities. Standards of safety and quality of MMC services are key components of service sustainability.



Policy direction

- Facilitate mapping and assessment of existing service delivery infrastructure and resources for MMC to inform decision making on integrated service delivery.
- Establish a mechanism to develop master facility plans to address gaps identified through the assessment to provide MMC through routine services.
- Integrate a comprehensive package of MMC services into routine services at facility level and out of facility platforms.
- Integrate a comprehensive package of MMC services within routine adolescent health services.
- Establish effective referral systems to refer serious adverse events /complications to specialized services.
- Establish and strengthen quality assurance (QA) systems for MMC at national, county and facility levels and implement within routine national and county systems.
- Include MMC in national standardized surgical protocol focused on patient safety.
- Improve access to MMC services for difficult to reach populations and difficult to reach geographies (underserved populations and geographies).
- Engage with County Integrated Development Planning to incorporate infrastructural development in facilities where needed to integrate MMC.

3.2 Policy objective 2

To develop a well-performing health workforce that is competent to conduct MMC, responsive, productive and effective

All Kenyans have the right to quality health services that are provided in a client-friendly manner. For that to be actualized there must be sufficient health personnel, fairly distributed, competent, responsive and productive, such that the best health outcomes are achieved.



Main challenges

A significant number of health facilities do not offer MMC due to inadequate staffing and training in MMC procedures. Capacity building of healthcare providers on the comprehensive package of MMC depends largely on donor funding. The health workforce involved in the MMC Programme is currently donor funded and thus not integrated within the facility workforce or duty roster. In some facilities, even though there are trained service providers, they cannot provide MMC services due to competing priorities or constraints related to health facility infrastructure and systems.



Priority area

There is a need to establish a system that can produce a well-performing health workforce that is skilled, motivated, responsive and effective. County health workforce plans must assess MMC needs and ensure adequate staffing in facilities. MMC should be included in pre-service training for students preparing to work in health and in continuous education for service providers, so that human resource and capacity building systems ensure adequately trained and motivated providers.



Policy direction

- County government should coordinate all aspects of staff hiring, human resource and capacity development for service delivery in facilities. Consider MMC needs in the county health workforce plans.
- Establish centres of excellence to train and certify the existing health workforce in performing MMC.
- Integrate the MMC training curriculum into pre-service training and continuing education for nurses and clinical officers.
- Integrate vertical health workforce employed or deputised for MMC in a facility into the clinical team at the service delivery point where necessary.
- Boost health workforce morale through short-term training and refresher courses, career development, appreciation and rewards for best performers.
- Assess health providers' knowledge and skills, conduct training based on needs, and award certification by relevant technical and professional bodies.
- Facilitate a mechanism of staff deployment based on professionalism, technical ability, service need and equity.
- Establish a system of supportive supervision and support for service providers by the national and county ministries of health.

3.3 Policy objective 3

To establish a well-functioning health information system for MMC, integrated within routine data collection and monitoring systems, to produce, analyse, disseminate and use reliable and timely information on MMC

A well-functioning health information system ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status. This system allows results, processes and experiences to be documented and used to steer decision making and planning. A functional system should be put in place to measure MMC service effectiveness, efficiency and impact to ensure sustainability of a programme.



Main challenges

There is data disparity between the MoH and partners' facility reports on MMC. This could be caused by parallel target setting and reporting. The community-based health information system barely captures MMC indicators. Data quality assessment and supervision activities depend on partners' support. There is minimal use of programme data for decision making and research at health facilities.



Priority area

Target setting and monitoring of MMC activities should be led by MoH, so that quality national-, county- and facility-level information acceptable to the donor can be provided. MMC data desegregated by age and geography should be made available. Data should be used for reporting, planning, staffing, logistics management and QA. In collaboration with stakeholders, routine data quality checks should be done, and safety monitoring systems should be put in place at nation, county and facility levels.



Policy direction

- Harmonize MMC reporting platforms and tools with routine health reporting platforms of Ministry of Health to reduce duplication of data entry, management and reporting systems.
- Reduce over-reliance on paper-based data collection system by developing an electronic medical records system.
- Routinize the data and safety monitoring system with national and county systems.
- Establish facility-level monitoring plans to facilitate facility-level data use and feedback.
- Facilitate county ownership of data by creating a system of data use, including target setting.
- Strengthen capacity of human resources for efficient data management at all levels.
- Strengthen community-based health information systems.
- Promote operations research and documentation of best practices to improve programme science and decision making.

3.4 Policy objective 4

To facilitate national and county leadership and governance towards sustaining MMC services with effective oversight, coordination and accountability

Health interventions involve partners who supplement the government's work in reversing the negative trend of health indicators through various programmes. However, the government has the mandate to lead, govern and coordinate all stakeholders involved in health to ensure that quality, accessible, affordable and equitable healthcare reaches all Kenyans. The national and county governments should ensure an enabling policy framework and provide oversight, coalition building, attention to system design, and accountability.



Main challenge

The MMC programme is vertical and partner-driven, with minimum involvement of the Ministry of Health and county government in decision making and governance. Since the inception of the MMC Programme in the country, the county coordination is largely done by technical working groups, which tend to be partner-supported, with limited leadership of the County Health Management Team.



Priority area

For effective leadership and governance, the MoH should lead the mechanisms for coordinating partner involvement in MMC activities at all levels. Existing partnership and coordination structures, such as the technical working groups, should be strengthened and effectively utilized for coordination, advocacy, implementation, reporting and QA of MMC services. MMC focal points should be established within MoH at various operational levels. County-driven governance, management and coordination are essential for government ownership and long-term sustainability.



Policy direction

- Establish functional integrated HIV technical working groups led by MoH, institutionalized within the County Health Management Team (CHMT), and cascaded to sub-county level. These mechanisms facilitate coordination, advocacy, implementation, reporting and QA of MMC services.
- Integrate MMC as part of the national and county health strategy and operational planning process.
- Integrate MMC as a part of the national essential package of health services.
- Develop comprehensive county budgets and plans including MMC activities funded by donors and domestic funding.
- Donors and implementing partners to establish partnership with all relevant departments of the MoH to engage them in implementing, coordinating and overseeing MMC activities.
- Identify MMC focal points within MoH at national, county and sub-county levels.
- Conduct regular stakeholders' forums, dialogue and consultative arenas for progress updates and learning.
- Facilitate development of accountability mechanisms, memoranda of understanding and corporate agreements between partners and national and county government.

3.5 Policy objective 5

To strengthen the national and county procurement and supply chain mechanism to integrate procurement and distribution of MMC supplies and equipment

Commodity security and efficient management are essential for provision of quality MMC services in Kenya. Maintaining high coverage of MMC as it is integrated with routine services requires uninterrupted supplies, commodities and equipment. Timely forecasting and quantification of commodities and efficient systems of procurement and distribution of MMC supplies and equipment are therefore necessary for ensuring availability and continuity of quality services in the facilities.



Main challenge

Forecasting, quantification and procurement of supplies and equipment are primarily conducted by implementing partners, with minimum support from the MoH, thus posing a challenge for MoH ownership.



Priority area

The involvement of national, county and sub-county authorities in procurement and management of MMC supplies and equipment needs to increase. MMC essential commodities need to be procured and distributed through the existing national and county procurement and supply chain management systems.



Policy direction

- Integrate MMC commodity and equipment procurement, supply and distribution with the MoH procurement and supply chain at national and county levels.
- Set national standards for quality of supplies and for assurance of continuous procurement.
- Set guidelines for rational use of MMC supplies and equipment.
- Establish systems for evidence-based forecasting and quantification of MMC supplies and equipment at facility level.
- Develop integrated procurement and distribution plans with government and donors to ensure availability of MMC supplies and equipment at all times at the facilities.
- Build capacity at the facilities to manage and requisition supplies to prevent stock-outs and shortages.

3.6 Policy objective 6

To enhance resource mobilisation and effective allocation and use of domestic and donor funding towards sustainable services for MMC

Adequate funding and dependency on donor funding for the HIV response in Kenya remain challenges that need to be addressed in order to provide sustainable health services for HIV prevention. Kenya currently relies on domestic (national revenues and county resources) and external (bilateral, multilateral and private foundations) sources for health financing. For effective integration of MMC into health systems for long-term sustainability, the government (national and county) needs to explore funding opportunities from sources such as corporate social investment, informal sectors and matching funds.



Main challenges

Health programming has been experiencing limited financing, which leads to unexecuted health plans. Health fund allocation and disbursement are affected by competing priorities, delaying implementation of activities. There is high dependence upon donor funding, especially for HIV prevention and care programmes.



Priority area

Resource mobilisation and leveraging mechanisms, along with programme-based budgeting and allocation, need to be institutionalised by national and county governments. Functional financial management systems need to be put in place, with the aim of improving access to finances, utilization and accountability for domestic and donor funding, so as to realise consistency in allocation and spending for HIV prevention programmes, including MMC.



Policy direction

- Conduct programme-based financial forecasting and quantification (costing) of national and county resource needs for MMC within national and county health plans.
- Include MMC surgical procedure for HIV prevention as part of the national essential package of intervention.
- Establish mechanisms for development of integrated implementation plans with government and donors with an aim of co-funding MMC alongside other health services.
- Establish mechanisms to leverage resources through private public partnerships.
- Engage with county government through the legislature and executive to increase funding for HIV and to finance integration of MMC through county health budgets.
- Include MMC surgical procedure for HIV prevention as part of national insurance schemes as a financial risk measure for clients.

3.7 Policy objective 7

To enhance engagement with the community to increase demand for MMC services

Effective demand creation and community mobilisation are essential for the success and uptake of MMC services. MMC communication and engagement mechanisms need to be developed and integrated with existing systems and mechanisms that promote behaviour change and health seeking behaviour among the public.



Main challenges

The implementing partners currently support demand generation efforts for MMC, with MoH involvement at the coordination level. These demand generation activities are not part of the community health service package. The MMC demand creation communication package implemented by partners is not tailored and sensitive to the diverse needs of individuals, families and communities. For example, demand creation largely targets men, with less focus on spouses or partners. There is no age-appropriate messaging targeting adolescents, and there is little understanding of barriers and motivators for age-appropriate demand creation. The current communication strategy also lacks engagement on MMC with other sectors. At the same time, the demand generation component being implemented by partners remains vertical and is not integrated within the government-led communication strategy for health promotion.



Priority area

MMC-related demand creation activities need to be integrated with government-led demand creation and health promotion activities at the national, county, facility and community levels. There is a need to enhance multisectoral partnerships for health programming. There is need to adopt client/human-centred demand creation approaches to address specific barriers and motivators of the client subpopulations.



Policy direction








- Customize the national MMC communication strategy to meet county and client subpopulation specific needs.
- Integrate MMC communication strategy with the national and county health promotion and community mobilisation strategy and structures.
- Establish functional platforms for strategic and operational engagement on MMC with other sectors.
- Establish mechanisms for developing integrated demand generation implementation plans with government and donors, with an aim of integrating and implementing innovative demand generation activities.
- Advocate with policy makers, corporate institutions and prospective donors to generate support towards sustainability of MMC services.



04

Implementation Considerations

There are several considerations while operationalizing the policy. Key considerations include the following:

-  Defining the minimum package of MMC
-  Adhering to quality standards
-  Service delivery arrangements, including identification of facilities
-  Health system requirements
-  Levels of coordination and roles of institutions
-  Roles and responsibilities
-  Monitoring, evaluation and research

An implementation framework is attached for more details.

4.1 Medical male circumcision minimum package

The MMC services will be offered as part of a comprehensive HIV prevention package that is relevant to age groups, which will include the following:

- **HIV testing and counselling and MC education**

HIV counselling and testing will be offered using an opt-out approach, and the necessary support systems must be in place. The recommendation is to offer on-site HTS.¹⁸ Clients declining HIV testing during MMC services should be informed at the MMC site of alternative sources of HTS.

- **Active exclusion of symptomatic STIs and syndromic treatment**

Syndromic screening for STIs prior to MMC and treatment for those diagnosed are imperative. MMC should be recommended to all males who receive HTS services in any setting, especially those men who are at high risk of HIV acquisition from heterosexual sex. It is especially important for programme staff to follow up actively with males whose circumcision procedure has been deferred because of an STI. It is crucial that MMC programmes develop routine systems to follow up with these males to ensure that they return to the MMC facility for circumcision immediately following their STI treatment.

- **Promotion, demonstration, and onsite provision of condoms**

Personnel at all sites providing MMC for HIV prevention services should have a thorough understanding of the current condom promotion and distribution strategy. Condoms are a centrepiece of any HIV prevention package, since they are effective, widely available outside clinical settings, relatively inexpensive and easy to use. Consistently and correctly used, male condoms are highly effective in reducing the risk of HIV and other STIs during sexual intercourse, cutting the risk of transmission by as much as 96%.¹⁹

- **Counselling on risk reduction and safer sex**

Plan and prioritize education and counselling, so that sufficient opportunity for these critical services is incorporated at appropriate stages into the male circumcision process. In male circumcision, as in other health services, education and counselling are usually integrated rather than being separate from other aspects of care. For example, in some settings, most procedure counselling may occur while the client is being screened for his eligibility to undergo the procedure because both counselling and screening require privacy. Also, asking a client about his sexual and reproductive health history can readily lead to a discussion about risk reduction, the need for HIV testing and other issues relevant to the decision to undergo male circumcision.²⁰

- **MMC for all age groups**

MMC for infants, adolescents and adults must be performed as per the current national guidelines and clinical manuals published by the MoH.²¹

18 National AIDS and STI Control Programme, Ministry of Health, Kenya. 2015. Guidelines for HIV Testing Services in Kenya. Nairobi: NASCOP.

19 Welsh MJ, Feldblum PJ, Kuyoh MA, Mwarogo P, Kungu D. 2001. Condom use during a community intervention trial in Kenya. *International Journal for STD and AIDS* 12(7).

20 World Health Organization. 2018. Manual for Male Circumcision under Local Anesthesia and HIV Prevention Services for Adolescent Boys and Men. Geneva: World Health Organization.

21 Ministry of Health. 2014. Clinical Manual on Early Infant Male Circumcision (EIMC) Under Local Anaesthesia. Nairobi: Ministry of Health.

- **Linkages and referrals of infants, adolescents and adults to appropriate services**

Effective linkage from the MMC facility to HIV care ensures that people living with HIV receive the services they need to improve their health. Linkages help clients access HIV care that is seamless and client centred. Referrals from HIV testing in MMC to HIV medical and support services help newly diagnosed HIV positive individuals.

- **A coordinated approach to ensure safety and to prevent infections, including anti-tetanus vaccine and proper wound care after MMC**

Infection prevention and control are cornerstones of clinical care in all healthcare settings. Service delivery points should observe infection control policy guidelines.²² The purpose of introducing tetanus toxoid in the MMC Programme is to prevent tetanus-related morbidity and mortality among males seeking MMC. This calls for coordination between KEPI and the MMC Programme to avail the commodities.

4.2 Quality standards

MMC services should adhere to national QA policies and guidance documents and the standards of the WHO's guidance²³ for enhancing the safety and quality of MMC services.

The WHO's standards are as follows:

- i. An effective management system is established to oversee the provision of male circumcision services.
- ii. A minimum package of male circumcision services is provided.
- iii. The facility has the necessary medicines, supplies, equipment and environment for providing safe male circumcision services of good quality.
- iv. Providers are qualified and competent.
- v. Clients are provided with information and education on HIV prevention and male circumcision.
- vi. Assessments are performed to determine the condition of clients.
- vii. Male circumcision surgical care is delivered according to evidence-based guidelines.
- viii. Infection prevention and control measures are practiced.
- ix. Continuity of care is provided.
- x. A system for monitoring and evaluation is established.

4.3 Service delivery models

The service provision model identified by Kenya for sustaining MMC services is to integrate MMC into routine health services for adults, adolescents and infants. Support from donors and implementing partners will be sought for integrating MMC into routine services rather than providing vertical services within MoH facilities or involving MoH staff.

The policy shall be implemented in a devolved health system across the following tiers of facilities as defined in the Kenya NHSSP III.²⁴

- **Tier 1 – Community Health Services** – this is the foundation of the service delivery system, with both demand creation (health promotion services) and specified services that are most effectively delivered at the community. All non-facility based health and related services are classified as community health services.
- **Tier 2 – Primary Care Services** – this is the first physical level of the health care system. It comprises level 2 (Dispensaries) and level 3 (Health Centres).
- **Tier 3 – County Referral Services** – comprises level 4 (services complement the primary health care level to allow for a more comprehensive package of close-to-client services) and level 5 (provides a more comprehensive set of services, together with internship services for medical staff, research and training) .
- **Tier 4 – National Referral Services** – this is a level 6 facility whose highly specialized services complete the set of care. These facilities offer training and internships for specialists and biomedical research.

22 Ministry of Public Health and Sanitation and Ministry of Medical Services, Republic of Kenya. 2010. National Infection Prevention and Control Guidelines for HealthCare Services in Kenya. Nairobi, Kenya: Government of Kenya.

23 World Health Organization. 2008. Male circumcision quality assurance: a guide to enhancing the safety and quality of services, Geneva: World Health Organization.

24 Kenya Health Sector Strategic and Investment Plan 2014-2018

The county governments shall be responsible for Tier 1, Tier 2 and Tier 3 services, while the national government shall be responsible for Tier 4. The referral system shall be strengthened to ensure that clients at all levels gain access to appropriate skilled care. The services shall be offered in a nonjudgmental and confidential way that fully respects human rights and dignity.

In terms of implementation, integration of MMC services would happen in a phased manner after assessing maps of facilities. Every county would have to develop an implementation plan to ensure that high coverage is maintained while integration of services takes place. County plans may look different even though they will follow similar principles and objectives.

4.4 Health systems requirements

A functional health system is a key determinant of service quality. In order to provide efficient, effective and sustainable MMC services, the following health system building blocks are essential:

a) Commodity and supply chain

Proper systems for commodities identification, planning, forecasting, sourcing, storage and distribution to the service provision points shall be put in place to minimize stock-out time for critical supplies. Procurement of MMC commodities shall be integrated into the MoH supply chain. Supply chain synergies shall be coordinated between county government, donors and partners to ensure sustainable service provision.

b) Human resource and capacity building

Training of MMC-relevant cadres (e.g., medical officers, clinical officers, nurses, HTS providers, infection prevention officers) on conventional surgical MC will be based on an appropriate curriculum. Specific training guidelines will be developed for approved MC devices. In-service training for providers will be improved through the existing training infrastructure.

Capacity building based on routine competency assessment is essential for all service providers to ensure consistent quality at all health facilities. MMC trainers will provide oversight for MMC services and will participate actively in training, mentorship, supervision and evaluation of MMC services where necessary.

Accredited medical training institutions shall be supported to integrate the appropriate competencies for comprehensive MMC in their curricula. Proficiency in MC shall be a requirement for course completion. There shall be processes to verify qualification and competencies, and in addition there will be periodic assessment and ongoing education/training to provide updates within the existing centres of excellence.

To address the shortage of providers and to replace those exiting the service, it is recommended that health care managers ensure that all facilities have at least two staff members trained in MMC. National, county and partners shall provide increased human resources to support MMC as the programme transitions towards sustainability. This will ensure smooth transition of the programme from implementing partners to the national and county governments. In addition, private medical practitioners will be engaged to provide MMC services to those male clients who prefer to pay for the service. All private practitioners who provide MMC for HIV prevention will be appropriately trained and certified as MMC providers and will be supported to report through the national health information system.

A male circumcision facility, supplies, equipment and other necessary resources should be prepared and ready for the provision of MMC services before staff are trained to provide these services.

c) Monitoring and evaluation

A Health Management Information System (HMIS) is critical in the implementation of this policy, because quality data inform MMC programming.

The policy shall

- i. strengthen HMIS at facility level for MMC and establish linkages with the national level, ensuring harmonization of M&E tools and reporting structures;
- ii. promote routine collection, analysis and use of quality data for decision making at all levels; documentation of best practices and operational research to improve implementation science; and
- iii. promote the use of modern technology to improve management of MMC Programme information at all levels (e.g., digitize the external quality assurance processes and integrate MMC indicators into the electronic medical records [EMRs]).

A system for data collection, collation and use will be implemented at service delivery, county and national levels. The District Health Information System (DHIS) will be used for data reporting.

d) Demand creation

MMC advocacy and demand creation are key to the success of the MMC Programme. Advocacy will be done to reach policy makers, donors, managers, and service providers regarding budgeting, planning, resource allocation, and policy implementation. Innovative demand creation approaches will target beneficiaries.

To sustain demand creation, MMC demand creation will be integrated into the existing MoH community strategy, and MMC messaging will be included in the existing school curriculum on HIV. The policy shall ensure provision of customized IEC materials that are culturally and age appropriate.

e) Financing and infrastructure

This policy recognizes the need to increase financial and infrastructural resources to create sustainable mechanisms for effective and efficient provision of MMC services to eligible clients.

In this regard, the MoH shall do the following:

- i. Use evidence-based MMC data to justify resource allocation to MMC programmes.
- ii. Seek increased budgetary allocation for provision of MMC services at national and county levels.
- iii. Empower households, communities and stakeholders to take more responsibility in healthcare financing and resource mobilisation by exhausting the existing resource mobilisation mechanisms like domestic funding, the National Hospital Insurance Fund, user fee, co-funding, and medical insurance for school going youths (presidential initiative).
- iv. Ensure the efficient and effective use of all available resources from government, non-governmental organizations, the private sector, faith-based organizations and donors for universal access to safer MMC, and improve efficiency and accountability in resource allocation and use.

f) Coordination and management

The policy shall ensure appropriate coordination structure, partnership and collaboration. The MoH will align MMC coordination with the existing MoH structures.

4.5 Management and coordination

The MMC policy shall be implemented in line with the existing national policies and strategies through a multisectoral approach that includes collaboration and partnerships with national actors, county actors and the communities. The collaboration and partnerships shall be realized through multisectoral committees, Health Sector Coordinating Committees, County Health Stakeholders' Forum, Sub-County Health Stakeholders' Forum and Community Health Committees. The Policy recommends formation of integrated TWGs at county and sub-county levels.

4.5.1 Levels of management and core functions

Coordination and management of MMC will be done by technical working groups at national, inter-county and county levels through the following core functions:

- i. Advise the MoH on operationalization of MMC strategies.
- ii. Ensure continuous provision of safe and quality MMC.
- iii. Ensure professional, technical, ethical and administrative excellence in MMC.
- iv. Regularly review MMC guidelines and update them with new developments.
- v. Ensure accurate production and dissemination of information on MMC.
- vi. Promote MMC within the context of the overall improvement of health care services.
- vii. Ensure equitable distribution of MMC services.
- viii. Provide guidance on target setting and development of innovations for demand creation.
- ix. Monitor and evaluate MMC at the various levels.
- x. Ensure involvement of key players and multisectoral stakeholders in MMC.
- xi. Facilitate learning forums for sharing best practices and learning from safety monitoring.
- xii. Facilitate operational research and use of the findings to improve MMC services.

4.5.2 National Technical Working Group

This TWG will meet quarterly. The Head of NASCOP will be the chair, and the NASCOP MMC manager will be the secretary. Its mandate will be to support the MoH in developing policies and guidelines and standard operating procedures for MMC and to provide strategic direction for the implementation of the MMC Programme. The TWG will have the following members:

- i. Head of NASCOP
- ii. The MMC manager at NASCOP
- iii. Health promotion unit representative
- iv. Health management information systems representative
- v. Integrated disease surveillance and response representative
- vi. Community strategy focal person
- vii. Head of MMC Technical Support Unit in NASCOP
- viii. Division of Reproductive, Maternal and Child Health representative and the unit responsible for safe essential surgery and infection prevention and control
- ix. Representatives from development and implementing partners, such as CDC, USAID, WHO, Walter Reed, UNICEF and others
- x. Representative from NACC
- xi. Co-opted members from regulatory institutions, learning institutions, private sector and counties.

4.5.3 Inter-County Technical Working Group

The Inter-County TWG shall be established with the aim of bringing counties together to exchange learning and share best practices. Its mandate will be to ensure that all counties providing MMC comply with SOPs and quality standards. The meetings shall be quarterly and rotational to the member counties. The County Director of Health in the hosting county shall chair the meeting.

Its members shall be

- i. County Directors of Health
- ii. CASCOs
- iii. County MMC focal persons
- iv. County health promotion officers
- v. County health records and information officers
- vi. Community strategy focal persons
- vii. MMC manager at NASCOP
- viii. Members of the MMC TSU, NASCOP
- ix. NACC regional coordinators
- x. Representatives from MMC implementing partners

4.5.4 County Technical Working Group

The County Health Department team under the leadership of the County Health Director shall establish subcommittees and develop an integrated TWG with the following mandates:

- i. Strategic and operational planning
- ii. Supportive supervision
- iii. Monitoring and review of MMC Programme
- iv. Strengthen MoH leadership, collaboration and creation of synergies with stakeholders
- v. Ensure integration of MMC services into the existing MoH structure
- vi. Advocate and mobilize resources for the MMC Programme

Members will be

- County Directors of Health (chair),
- CASCO (convener)
- County MMC focal person (secretary)
- County health promotion officer
- County community strategy focal person
- County health records and information officer
- Sub-county TWG representative
- Representative from MMC implementing partners

The MMC TWG will be integrated into the overall HIV TWG in the counties. The TWG will operate under the following subcommittees:

- i. Service delivery
- ii. Communication
- iii. Monitoring and evaluation

4.5.5 Sub-County Steering Committee

This committee will be established at the sub-county level. Its mandate shall be ensuring access to safe and quality MMC services. Members will be

- i. Sub-county MoH (chair)
- ii. SCASCO (secretary)
- iii. Sub-county health promotion officer
- iv. Sub-county community strategy focal person
- v. Sub-county health records and information officer
- vi. Representative of MMC implementing partners

4.6 Roles and responsibilities

4.6.1 Ministry of Health at national level

The MoH shall have the following responsibilities:

- i. Develop and disseminate national MMC policy guidelines and strategic directions.
- ii. Regularly review and update existing national policy guidelines and strategies for MMC.
- iii. Support counties to build staff capacity and give technical assistance for adequate equipment and supplies.
- iv. Set standards and regulatory mechanisms for professional, technical, ethical and administrative excellence in MMC.
- v. Regulate and coordinate MMC training and information sharing.
- vi. Coordinate activities supported by development partners at national level.
- vii. Ensure equitable distribution of MMC services support through rationalization and distribution of partners across the country.
- viii. Mobilise resources for MMC programmes.
- ix. Develop standardized national M&E tools for MMC programmes.
- x. Facilitate learning forums for sharing best practices.
- xi. Identify gaps in MMC and develop the national operational research agenda to improve MMC services.

The MoH shall collaborate closely with the Ministry of Education, Science and Technology for in-school boys, who form the largest proportion of the MMC population. It shall also ensure collaboration among departments and divisions within and outside the ministry. The multisectoral coordinating committee shall be the key mechanism for involving other ministries and development partners in resource mobilisation and allocation.

4.6.2 County level

County governments are responsible for health service delivery. Within the devolved governance structure, the county governments shall mobilize resources to implement the MMC Policy. The planning, implementation, reporting, supervision and coordination of all MMC Programme activities shall be done by

- i. county health management teams,
- ii. sub-county health management teams (SCHMTs),
- iii. health facility management teams,
- iv. health facility management committees, and
- v. community health committees.

The county and sub-county health committees, health facility management teams, health facility management committees and community health committees have the following responsibilities:

- i. Ensure operationalization and delivery of integrated MMC services.
- ii. Play an oversight role on MMC matters.
- iii. Develop evidence-based investment plans for integration of MMC services.
- iv. Mobilise resources for the MMC Programme.

- v. Coordinate county MMC actors at all levels.
- vi. Coordinate adverse events referral systems and management.
- vii. Ensure quality MMC service delivery.
- viii. Monitor and evaluate MMC services.
- ix. Convene stakeholders dialogue/meeting forums and provide avenues for private public partnership in MMC issues.

4.6.3 Implementing partners

- i. Mobilize and allocate resources for implementing national MMC policy guidelines and strategies.
- ii. Provide technical assistance to all levels of government for the MMC Programme.
- iii. Support counties to carry out demand creation, service delivery, monitoring and evaluation of the MMC Programme.
- iv. Human resource support at all levels of government for the MMC Programme.
- v. Support operational research for MMC.
- vi. Joint planning with national and county governments for coordinated implementation of the MMC Programme.

4.6.4 Training institutions

- i. Incorporate MMC content in curricula for medical officers, clinical officers, nurses and HTS providers at pre- and in-service levels.
- ii. Conduct continuous research on MMC and generate information for decision making, including policy revision and/or development.

4.6.5 Professional associations and regulatory bodies

- i. Accredite MMC training institutions.
- ii. License MMC health providers in matters related to MMC.
- iii. Discipline members who violate code of conduct on matters relating to MMC.

4.6.6 Mass media

- i. Advocate and create public awareness on MMC.
- ii. Participate in the development of MMC key messages and enhance communication skills of MMC mobilisers.
- iii. Participate in research and knowledge sharing on MMC.

4.6.7 Community, household and individuals

- i. Provide MMC information to age-appropriate target populations.
- ii. Own and use MMC services.
- iii. Participate in planning, implementation and M&E of the MMC Programme at the community level.
- iv. Champion MMC interests through existing relevant structures at the community level for age-appropriate clients.
- v. Foster participation and inclusion of women.

4.6.8 Other stakeholders

A multisectoral approach shall be promoted in the implementation of the policy guideline.

4.7 Monitoring, evaluation and research

4.7.1 Health management information systems

The MoH shall provide overall strategic leadership in monitoring and evaluating implementation of the policy, with technical assistance from a multisectoral TWG that includes implementing partners.

An M&E framework for assessing implementation and impact shall be established based on the overall goal and objectives of the policy and targets set in the plans of action. The MoH and partners shall mobilize sufficient resources to support M&E of the policy and its plan of action. The M&E framework for the policy shall link to HMIS. The policy shall advocate for integration of MMC-relevant indicators in other relevant M&E frameworks.

Data from the source documents (i.e., from client forms, minor theatre register) will be aggregated in reporting tool MoH 731 and keyed into DHIS 2. At each level, data quality is addressed by ensuring completeness, timeliness, accuracy, consistency, validity and reliability to inform decision making.

Impact analysis shall document the success of interventions to account for funds, to illustrate how MMC integration impacts local people and to advocate for changes in behaviours and attitudes. Impact analysis shall document the means of integration and sustainability, identify all models that might have to be modified to incorporate integration and identify the tasks required for implementation.

4.7.2 Medical male circumcision operational research

Several operational research projects on MMC have been conducted or are ongoing in order to identify feasible innovative service delivery approaches. Such innovative approaches include devices and models of service delivery to improve efficiency and service uptake.

To facilitate the quick translation of research to practice, a national MMC task force was formed in 2007, an MMC policy was implemented in early 2008, and Nyanza Province—the region with the highest HIV prevalence (15%) and low rates of circumcision (48%)—was prioritized for services under the direction of a provincial medical officer of health.



Annex

Implementation Framework / Logical Framework

| Strategy | Output | Indicators |
|---|---|---|
| Policy objective 1: To routinize effective, safe and quality MMC services as part of the health system structure | | |
| 1.1 Assessment and planning of health services for integration of MMC in routine services | <p>1.1.1 Mapping and assessment of existing service delivery infrastructure and resources for MMC conducted</p> <p>1.1.2 Facilities prioritized for integration of MMC services are selected</p> <p>1.1.3 A mechanism to develop and implement a master facility plan in selected facilities established</p> <p>1.1.4 County Integrated Development Planning incorporates infrastructural development in facilities where needed to integrate MMC</p> | <p>Number of MMC service delivery sites mapped and assessed for site readiness and preparedness</p> <p>Number of facilities prioritized for integration</p> <p>Proportion of facilities with a master facility plan</p> <p>Proportion of counties with MMC incorporated in the County Integrated Development Planning</p> |
| 1.2 Provision of MMC through routine health services | <p>1.2.1 An integrated comprehensive package of MMC services within routine services provided</p> <p>1.2.2 Effective referral systems to refer serious adverse events /complications to specialized services established</p> | <p>Proportion of facilities with an integrated comprehensive package of MMC</p> <p>Number of severe adverse events / complications referred</p> |
| 1.3 Improvement in quality of MMC services in the facilities | <p>1.3.1 QA systems for MMC at national, county and facility levels established</p> <p>1.3.2 QA systems for MMC implemented within routine national and county systems</p> <p>1.3.3 MMC is included in national standardized surgical protocol focused on patient safety</p> | <p>Functional QA system</p> <p>Proportion of counties implementing QA systems for MMC</p> <p>Standardized surgical protocol focused on patient safety with MMC included</p> |
| Policy objective 2: To develop a well-performing health workforce that is competent to conduct MMC, responsive, productive and effective | | |
| 2.1 Effective planning of health workforce to support integration | <p>2.1.1 County health workforce plan keeping in mind integration developed</p> <p>2.1.2 Required personnel needed for effective integration in facilities recruited</p> <p>2.1.3 Recruited personnel in the facility trained to conduct safe MMC</p> | <p>Proportion of counties with integration plan developed</p> <p>Number of personnel recruited</p> <p>Number of recruited staff trained on MMC</p> |
| 2.2 Capacity strengthening on MMC for pre-service or in-service health workforce | <p>2.2.1 Centres of excellence to provide practical training and certification to health workforce to conduct MMC developed and operational</p> <p>2.2.2 MMC training curriculum integrated into pre-service training for nurses and clinical officers</p> | <p>Number of trainings conducted at the COE</p> <p>Functional MMC training curriculum integrated into pre-service</p> |

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| | 2.2.3 MMC curriculum integrated into continuous medical training for existing health workforce | Number of MMC Continuous Medical Education sessions conducted |
| 2.3 Management and provision of support to providers | 2.3.1 MMC is included in the system of supportive supervision and support for services providers by the national and county ministries of health | Number of integrated supportive supervision conducted by national and county ministries |

Policy objective 3: To establish a well-functioning health information system for MMC, integrated within routine data collection and monitoring systems, to produce, analyse, disseminate and use reliable and timely information on MMC

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| 3.1 System of data collection and management strengthened | 3.1.1 Platforms and tools for reporting MMC harmonized with routine health reporting platforms of Ministry of Health | Proportion of facilities using the revised and harmonized tools |
| | 3.1.2 An EMR system with MMC module included for data collection established | Proportion of EMR facilities with MMC module included and in use |
| 3.2 Enhance use of data for decision making | 3.2.1 Facility-level monitoring plans to facilitate facility-level mechanisms of data use and feedback established | Proportion of facilities with effective mechanisms on data use |
| | 3.2.2 Target setting and monitoring conducted by county and sub-county MoH | Proportion of counties setting and monitoring MC targets |
| | 3.2.3 Capacity of human resources at county, sub-county and facility level built for efficient data management at all levels | Number of county staff capacity built on data management |
| | 3.2.4 MMC data is included on community based health information systems | Proportion of counties with MMC data included in the community based health information system |
| | 3.2.5 Operations research and documentation of best practices is conducted | Number of best practices documented in the counties |
| 3.3 Monitoring of safety and quality of data enhanced | 3.3.1 MMC data and safety monitoring system routinized with national and county systems | Proportion of counties with effective MMC data monitoring systems |
| | 3.3.2 MMC indicators included in the integrated data quality audits at the facility and other levels | Proportion of counties conducting integrated data quality audits with MMC indicators |

Policy objective 4: To facilitate national and county leadership and governance towards sustaining MMC services with effective oversight, coordination and accountability

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| 4.1 MoH-led effective leadership and governance coordination mechanism for coordination of MMC activities at all levels | 4.1.1 Establish functional integrated technical working groups led by MoH institutionalized within the CHMT and cascaded to sub-county level | Number of counties implementing the integrated HIV technical working groups |
| | 4.1.2 Integrate MMC as part of the national and county health strategy | Proportion of facilities with integrated MMC services |

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| | <p>and operational planning process</p> <p>4.1.3 Develop comprehensive county budget and plans including MMC activities funded by donors and domestic funding</p> <p>4.1.4 Establish partnership with all relevant departments of the MoH to engage them in implementing, coordinating and overseeing MMC activities</p> | <p>Proportion of County Annual Work Plans with MMC included</p> <p>Proportion of counties with relevant MoH departments engaged in MMC implementation</p> |
| <p>4.2 Focal points established within MoH at different operational levels to champion coordination and operations of MMC service at county level</p> | <p>4.2.1 Identify MMC focal points within MoH at national, county, sub-county levels</p> <p>4.2.2 Regular stakeholder forums, dialogue and consultative arena for progress updates and learning convened by the focal persons</p> <p>4.2.3 Facilitate development of accountability mechanisms, memoranda of understanding and corporate agreements between partners and national and county government</p> | <p>Number of counties with MMC focal persons identified</p> <p>Number of county stakeholder forums conducted</p> <p>Proportion of counties with established accountability mechanisms and memoranda of understanding with partners</p> |

Policy objective 5: To strengthen the national and county procurement and supply chain mechanism to integrate procurement and distribution of MMC supplies and equipment

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| <p>5.1 Procurement and distribution of MMC essential commodities included in the existing national and county procurement and supply chain management systems</p> | <p>5.1.1 Integrate MMC commodity and equipment procurement, supply and distribution into the MoH procurement and supply chain at national and county level</p> <p>5.1.2 Set national standards for quality of supplies and assurance of continuous procurement without disruption</p> <p>5.1.3 Establish systems of evidence-based forecasting and quantification of MMC supplies and equipment at facility level</p> | <p>Proportion of counties with integration of MMC commodities and equipment in the supply chain management system</p> <p>National standards for quality of supplies established</p> <p>Number of facilities with systems for forecasting and quantification of MMC supplies and equipment</p> |
| <p>5.2 Roles of national, county and sub-county authorities in procurement and management of MMC supplies and equipment expanded</p> | <p>5.2.1 Build capacity at the facilities to manage supplies—including requests for refills on time—such that there is no stock-out situation</p> | <p>Number of facility staff capacity built on supply management</p> |

Policy objective 6: To enhance resource mobilisation and effective allocation and use of domestic and donor funding towards sustainable services for MMC

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| <p>6.1 Institutionalisation of resource mobilisation and leveraging mechanisms along</p> | <p>6.1.1 Conduct programme-based financial forecasting and quantification (costing) of national and county</p> | <p>Proportion of counties with MMC financial forecasting and quantification included in the county health plans</p> |
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| with programme-based budgeting and allocation by national and county governments | <p>resource needs for MMC within national and county health plans</p> <p>6.1.2 Include MMC surgical supplies as part of national essential supplies package of intervention</p> | Number of counties including MMC surgical procedure as part of HIV prevention |
| 6.2 Functional financial management systems in place | <p>6.2.1 Establish mechanisms for development of integrated implementation plans with government and donors, with an aim of co-funding MMC alongside other health services</p> <p>6.2.2 Establish mechanism to leverage resources through private public partnerships</p> <p>6.2.3 Engage with county government through the legislature and executive to increase funding for HIV prevention and financing of integration of MMC through county health budget</p> <p>6.2.4 Include MMC surgical procedure for HIV prevention as part of national insurance schemes as a financial risk measure for clients</p> | <p>Proportion of counties with integrated implementation plan with government and donors</p> <p>Number of counties leveraging resources for MMC</p> <p>Proportion of counties with increased HIV funding</p> <p>Inclusion of MMC surgical procedure as part of universal health coverage</p> |

Policy objective 7: To enhance engagement with the community to increase demand of MMC services

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| 7.1 Integration of MMC-related demand creation activities within government-led demand creation and health promotion activities | <p>7.1.1 Customize the national MMC communication strategy to meet county and client subpopulation specific needs</p> <p>7.1.2 Integrate MMC communication strategy with the national and county health promotion and community mobilisation strategy and structures</p> <p>7.1.3 Establish functional platforms for strategic and operational engagement on MMC with other sectors</p> <p>7.1.4 Establish mechanisms for development of integrated implementation plans for demand generation with government and donors, with an aim of integrating and implementing innovative demand generation activities</p> <p>7.1.5 Advocate with policy makers, corporate institutions and prospective donors to generate support towards sustainability of MMC services</p> <p>7.1.6 Increased client/human-centred demand creation approaches</p> | <p>Reviewed national MMC communication strategy in place, (integrated with health promotion and community mobilisation strategy)</p> <p>Number of strategic and operational engagements on MMC with other sectors</p> <p>Proportion of innovative demand creation activities</p> <p>Proportion of counties with support towards sustainability of MMC services</p> |
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