

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

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LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome	NAC	National AIDS Council
ACHAP	African Comprehensive HIV/AIDS Partnership	NGOs	Non-Governmental Organizations
ASI	Accelerated Saturation Initiative	PEPFAR	President's Emergency Plan for AIDS Relief
CBO	Community Based Organization	PSI	Population Services International
CDC	Centers for Disease Control and Prevention	PMTCT	Prevention of Mother-to-Child Transmission of HIV
BMGF	Bill and Melinda Gates Foundation	QA	Quality Assurance
DfID	Department for International Development	SADC	Southern African Development Community
DoD	Department of Defense	STI	Sexually Transmitted Infection
EIMC	Early Infant Male Circumcision	TAG	Technical Advisory Group on Innovations in Male Circumcision
HIV	Human Immunodeficiency Virus	TWG	Technical Working Group
HMIS	Health Management Information System	UN	United Nations
HTC	HIV testing and counselling	UNFPA	United Nations Population Fund
ICASA	International Conference on AIDS and STIs in Africa	UNICEF	United Nations Children's Fund
IEC	Information, Education and Communication	UNAIDS	Joint United Nations Programme on HIV/AIDS
ITECH	International Training & Education Center for Health	USAID	United States Agency for International Development
MC	Male Circumcision	USG	United States Government
M&E	Monitoring and evaluation	VMMC	Voluntary Medical Male Circumcision
MOVE	Models for Optimising the Volume and Efficiency	WHO	World Health Organization

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EXECUTIVE SUMMARY

Introduction

Since voluntary medical male circumcision (VMMC) was shown to reduce the risk of heterosexually acquired HIV infection in men and recommended in 2007 by the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), 14 priority countries in East and Southern Africa have added VMMC as a component of their national HIV prevention programmes. Each of the 14 priority countries has a high prevalence of HIV and a low prevalence of male circumcision.

Numerous partners have supported priority countries in scaling VMMC. In an effort to maximize coordination and impact, diverse partners collaborated to create the “Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa: 2012–2016”. The framework is designed to guide implementation by diverse stakeholders according to its seven pillars, namely:

1. Leadership and advocacy
2. Country implementation
3. Innovations for scale-up
4. Communication
5. Resource mobilization
6. Monitoring and evaluation
7. Coordination and accountability

This report updates on progress in 2012 in scaling up VMMC services in the 14 priority countries. Data was collected and validated by the ministries of health of the 14 priority countries. As with previous VMMC progress reports, it summarizes gains and challenges under the seven pillars of the Joint Strategic Framework.

Summary of progress leadership and advocacy

In 2012, countries displayed leadership and commitment on VMMC. All 14 countries reported the presence of a VMMC focal person at the Ministry of Health, an improvement from 2011 where 12 of the 14 countries reported the presence of VMMC focal point. In several countries, multiple ministries contributed to VMMC advocacy, community mobilization, demand creation, resource allocation and service delivery. Eleven countries have advocacy strategies in place to support VMMC scale-up, carrying out such activities as mass media, school campaigns, home-to-home and mass outreach and mobilization, and engagement of elders and community leaders. Numerous global and international meetings focused on political and technical issues associated with accelerated uptake of VMMC.

National champions for VMMC scale-up have emerged in at least nine priority countries, although sub-national champions were identified in only seven countries. Regionally, the Champions for an HIV-Free Generation actively advocated with senior political leaders to prioritize VMMC scale-up, including sponsorship of a special session at the 2012 International AIDS Conference that issued a “call to action” on VMMC.

Countries demonstrated leadership on VMMC through the development and implementation of numerous guidelines to strengthen VMMC programming. Global and regional guidelines that supported national guideline development included the Communication Materials Adaptation Guide by C-Change project; WHO’s Framework for Clinical Evaluation of Devices for Male Circumcision; Best Practices for Voluntary Medical Male Circumcision Site Operations and a Service Guide for Site Operations by the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR).

In a quest to bring VMMC to scale, priority countries are learning from one another. In 2012, six countries undertook missions to other countries to exchange experiences in VMMC programming. South-South collaboration built the capacity of priority countries on such issues as preparation for roll-out of male circumcision devices, collaborating with traditional leaders, new service delivery models for VMMC, data collection and management of HIV testing and counselling components of VMMC programmes. Countries also shared experiences in managing the transition from doctor-led to nurse-led VMMC programmes.

Country implementation

All priority countries had target-driven, multi-year plans for VMMC in place in 2012. Plans differ from country to country, with targets in Ethiopia and Rwanda ending in 2012. Among priority countries overall, the Joint Strategic Framework aims to achieve 80% VMMC coverage among men ages 15-49, requiring approximately 20 million men to be circumcised, and to establish sustainable services for adolescents and /or infants to maintain coverage.

More than 3 million VMMC procedures were performed among males of all ages in priority countries from 2008 to 2012. The number of procedures performed in 2012 was almost double the number performed in 2011. The greatest increase in the pace of scale-up between 2011 and 2012 occurred in Mozambique, Rwanda, Uganda and Zambia. The number of procedures performed increased in 2012 (in comparison to 2011) in all countries except Swaziland, where the number of male circumcisions declined in 2012 due to a major funding reduction at the end of the Accelerated Saturation Initiative (ASI) implemented from 2010 to 2011. South Africa performed more male circumcisions than any other priority country, followed by Uganda, Tanzania, Zambia, Kenya, Rwanda and Mozambique – with each country performing more than 130 000 MCs in 2012.

Acceptance of HIV testing and counselling (HTC) ranged from 75% in South Africa to 100% in Zambia, with 8 countries reporting acceptance rates above 90%. Among clients who had an HIV test, HIV positivity rates ranged from 0.4% in Ethiopia to 5% in Lesotho.

All countries conducted training of various cadres of health and lay workers in 2012 to support VMMC service delivery. While countries prioritize the scale-up of VMMC for males between ages 15 and 49 years, they are encouraged to lay the foundation for long-term sustainability by introducing early infant male circumcision (EIMC) or adolescent services. As of December 2012, only three countries had commenced EIMC services.

Ensuring an uninterrupted supply of VMMC commodities remained a challenge in 2012, with 10 countries reporting inadequate supplies, delayed procurement and insufficient funding. Nine countries had a quality assurance (QA) plan in place in 2012; eleven countries reported conducting QA activities, with three not carrying out any QA activities in 2012.

Innovations

In 2012, eight countries conducted research relating to male circumcision devices, such as PrePex and Shang Ring. Other diverse types of VMMC-related research took place in at least five countries.

Other cadres besides doctors performed VMMC surgical procedures, with or without specific task shifting policies in place in the majority of the countries. However, Botswana, Lesotho, Namibia, South Africa and Zimbabwe only allowed doctors to perform VMMC surgical procedures during 2012.

Communication

Twelve countries had communication strategies by end of 2012, with six having costed plans. All countries reported undertaking strategies to mobilize communities and create demand for VMMC. Strategies included mass media interpersonal communication; school campaigns; road shows; peer-to-peer communication; community mobilization; edutainment; and social media.

Eleven countries reported varying approaches for involving grassroots organization and networks in VMMC scale-up through information dissemination; involvement of community leaders and religious leaders; training and sensitization; and use of community mobilizers, existing community structures, health workers, schools, community outreach teams, various district and village committees and community-based organizations.

Resource mobilization

As in prior years, PEPFAR remained the largest single funder for VMMC activities. Financing from the Global Fund to Fight AIDS, Tuberculosis and Malaria was available to support VMMC programmes in five countries. Other sources of funding for VMMC activities in 2012 included the World Bank, the Bill & Melinda Gates Foundation and the One-UN Fund. Some countries such as South Africa have VMMC covered by some private medical health insurance schemes.

Monitoring and evaluation

In 2012, thirteen countries reported having a routine VMMC information system, although only 6 countries had integrated VMMC reporting into the national monitoring and evaluation system. Ten countries reported having a forum for discussion of VMMC-related monitoring and evaluation. About half the countries reported that they have annual VMMC reports and carried out annual programme performance reviews.

Coordination and accountability

All priority countries had multisectoral Technical Working Groups in place to support coordination of VMMC programmes. Coordination bodies meet on a regular basis, although only six countries reported that these bodies had conducted annual VMMC programme reviews.

Challenges

Although the pace of scale-up is increasing, several important challenges persist:

- **Leadership for VMMC:** Leadership for VMMC continues to grow in the majority of countries but consistency at all levels is needed. . At sub-national level, leadership on VMMC primarily derives from international partners who are providing VMMC services.
- **Low demand for VMMC services:** The demand for VMMC remains relatively variable, with a particular need to consider the age group to focus on increased demand. Negative media coverage and impact of traditional circumcisions may be contributing to low demand by men over 25 years of age.
- **Setting more realistic targets:** The early VMMC targets were unrealistically ambitious in some countries. As the challenges associated with introducing VMMC have become more apparent, some countries revised targets to make them more achievable.
- **Procurement and supply:** Countries are experiencing challenges with stock outs of MC kits, inadequate equipment and supplies as well as waste management challenges.
- **Inadequate human resources remain a challenge.** Most VMMC programmes are doctor-led and some countries do not allow other cadres to carry out the surgical procedure.
- **Inadequate financial resources pose a challenge in most countries.** There is need for increased government contribution with less reliance on partners for financial support. External partners provide the bulk of funding for VMMC activities in most countries and such countries must increase their financial contributions to reduce dependency on international donors and inadequacy of resources for VMMC scale-up.

- **Establishing sustainable services.** Integration of Early Infant Male Circumcision with a routine offer to parents has not been implemented in the majority of countries. Adolescent services are a part of most current programmes but will need to be integrated within broader adolescent health services rather than provided only as part of catch-up approaches.
- **Monitoring and Evaluation:** VMMC reporting systems, in the majority of countries, remain parallel to national HMIS, with heavy reliance on partners for data and reporting.

Successes and opportunities

Several favourable results were reported for 2012:

- Most priority countries continue to benefit from strong political will and leadership at various levels in the scale-up of VMMC. Multi-sectoral involvement is illustrated by the engagement of multiple ministries and the support of partners remains robust.
- Although VMMC coverage remains well below the 80% target, uptake is accelerating in many countries.
- Many countries are using schools-centred initiatives to mobilise young males to seek VMMC.
- Due, in part, to important research in 2012, introduction of male circumcision devices is likely to provide a simpler option and permit a larger number of providers to perform VMMC.
- In most countries, health cadres other than doctors are performing male circumcision procedures.
- The majority of countries have communication/ mobilization strategies which are pivotal for demand creation.
- Most countries are making use of community engagement and media sensitization to influence behaviour and increase demand.
- Partners are making technical and financial support available to support accelerated scale-up.
- Coordination structures and reporting systems for VMMC are in place at the national level in most countries.

Way forward

Overall, priority countries continue to make progress in scaling up VMMC. However, substantial gaps remain to be addressed as the coverage is still far below the targeted 80%. The main areas of challenge remain matching supply and demand; demand creation; availability of sufficient and consistent resources to meet demand; committed leadership; and innovations to address the barriers and gaps. The way forward is therefore:

- **Assisting countries in setting realistic VMMC targets to achieve maximum number of HIV infections averted, based on experiences and new data including more age-specific information.**
- **Continuing to cultivate strong national and subnational leadership.**
- **Enhancing demand creation through innovative advocacy and communication approaches.**
- **Continuing to develop innovative approaches to service delivery, including use of MC devices.**
- **Diversifying funding from both government and partner sources in order to ensure sustainability of the scale-up phase.**
- **Improving monitoring, evaluation, programme review and analysis to provide complete and timely information for learning and decision making.**
- **Improving procurement and supply management systems.**
- **Initiating infant and establishing sustainable adolescent MC services.**
- **Documenting and sharing of innovative approaches to help countries improve their performance.**
- **Conducting a mid-term review of progress in implementation of the Joint Strategic Framework to further strengthen partnerships with global and regional partners.**

CHAPTER 1: INTRODUCTION

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Since voluntary medical male circumcision (VMMC) was shown to reduce the risk of heterosexually acquired HIV infection in men and recommended in 2007 by the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), 14 priority countries in East and Southern Africa have added VMMC as a component of their national HIV prevention programmes. Each of the 14 priority countries have a high prevalence of HIV and a low prevalence of male circumcision.

In order to strengthen and coordinate support for VMMC scale-up, in 2011 WHO and UNAIDS launched a five-year joint strategy: “*Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa: 2012–2016*”¹. The Joint Strategic Framework aims to unite diverse global, regional and county-level stakeholders in a common endeavour to bring VMMC to scale.

The Joint Strategic Framework seeks to accelerate progress towards two goals: (a) VMMC prevalence of at least 80% among 15–49 year old males, and (b) Establishing a sustainable national programme that provides VMMC services to all infants up to two months old and at least 80% of male adolescents.

It focuses on both key phases of VMMC scale-up:

- (i) The “catch-up” phase that aims to optimize coverage for adult males, and (ii) The “sustainability” phase, which seeks to implement programmes that reach uncircumcised adolescents as they attain an age to receive VMMC services and integrates a routine offer of VMMC in early infant care.

The Joint Strategic Framework has seven pillars:

1. Leadership and advocacy
2. Country implementation
3. Innovations for scale-up
4. Communication
5. Resource mobilization
6. Monitoring and evaluation
7. Coordination and accountability

This report updates on progress in 2012 in scaling up VMMC services in priority countries in East and Southern Africa. It is the fourth in a series of annual progress reports published since 2009 by WHO and UNAIDS. Like the previous report for 2011, the summary progress in 2012 is organized by the seven pillars of the Joint Strategic Framework. In addition to highlighting key achievements in 2012, the report identifies remaining challenges and notes where support and intensified action is most needed to accelerate the pace of scale-up.

Chapter 2 overviews progress in each of the seven pillars. Chapter 3 outlines the challenges while Chapter 4 gives a profile of each of the priority countries. Chapter 5 outlines key successes, opportunities and the way forward in scaling up VMMC in priority countries.

¹ WHO/UNAIDS, Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa, UNAIDS, Geneva, 2011.

CHAPTER 2: OVERVIEW OF PROGRESS IN SCALING UP

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2.1 Pillar 1: Leadership and Advocacy

Leadership and commitment are essential to achieving VMMC targets, and advocacy plays a vital role in strengthening these in order to accelerate VMMC scale-up.

2.1.1 Leadership

Activities carried out in the 14 priority countries in strengthening leadership for VMMC at global, regional and country levels during 2012 are discussed below.

2.1.1.1 Global and Regional Leadership

In 2012, global partners continued to support ministries of health in the implementation and monitoring of the Joint Strategic Framework.

- (a) Development of normative guidelines to support implementers in scaling up VMMC.

Global partners developed the following guidelines/documents in 2012 to support country action on VMMC:

- Communication Materials Adaptation Guide by C-Change project
- Framework for Clinical Evaluation of Devices for Male Circumcision by WHO
- Best Practices for Voluntary Medical Male Circumcision Site Operations by PEPFAR
- A Service Guide for Site Operations by PEPFAR

- (b) Global/regional meetings and conferences

Many global and regional meetings in 2012 focused on strategies to support VMMC scale-up, including:

- Meeting of the Technical Advisory Group on Innovations (TAG) in Male Circumcision: 19-20 January 2012 in Geneva, Switzerland.
- WHO/UNAIDS workshop for monitoring and evaluation for the scale-up of VMMC in 15 countries in East and Southern Africa: 18-20 September 2012 in Johannesburg, South Africa.
- Joint PEPFAR/WHO Meeting on Accelerating the Scale-up of Voluntary Medical Male Circumcision (VMMC) for HIV Prevention in East and Southern Africa: 25-28 September 2012 in Johannesburg, South Africa.

- **The 19th International AIDS 2012 Conference: A Call to Action for Voluntary Medical Male Circumcision for HIV Prevention Satellite: 22-27 July 2012 in Washington, USA.**

(c) Advocacy by “Champions for an HIV-Free Generation”²

The Champions for an HIV-Free Generation, a regional organization of distinguished leaders in different fields, continued to advocate for increased commitment to HIV prevention and provide peer support to country leadership in 2012.

The champions were key partners in a special session on VMMC at the 19th International AIDS 2012 Conference. The session’s moderated discussion explored challenges and lessons learned and outlined the road ahead to accelerate the scale-up of VMMC. The session generated a call to action to increase efforts on HIV prevention generally, and VMMC in particular.



Musician “Winky D”, a Regional VMMC Champion, performing a song to encourage youth to undergo VMMC.

² www.hivfreechampions.org

2.1.1.2 Country Leadership

Priority countries themselves will ultimately determine whether VMMC is brought to scale. In 2012, countries displayed leadership on VMMC in a variety of ways as shown in Table 1.

Table 1: Summary of status of VMMC leadership in the 14 priority countries

Country	Existence of Ministry of Health VMMC focal person	Involvement of other Ministries or programmes in VMMC	Existence of VMMC champion at national level	Existence of VMMC champion at local level	Support from partners	Missions conducted to other countries in 2012
Botswana	Yes	Yes	Yes	Yes	Yes	Yes
Ethiopia	Yes	No	No	Yes	Yes	No
Kenya	Yes	Yes	Yes	Yes	Yes	No
Lesotho	Yes	Yes	No	No	Yes	Yes
Malawi	Yes	Yes	No	No	Yes	Yes
Mozambique	Yes	Yes	No	No	Yes	No
Namibia	Yes	Yes	Yes	No	Yes	No
Rwanda	Yes	Yes	Yes	Yes	Yes	No
South Africa	Yes	Yes	Yes	Yes	Yes	Yes
Swaziland	Yes	Yes	Yes	Yes	Yes	Yes
Tanzania	Yes	Yes	No	No	Yes	No
Uganda	Yes	Yes	Yes	No	Yes	No
Zambia	Yes	Yes	Yes	Yes	Yes	No
Zimbabwe	Yes	Yes	Yes	No	Yes	Yes
TOTAL	14	13	9	7	14	6



March in support of Members of Parliament making the choice to undergo VMMC

(a) Leadership by Ministry of Health

All priority countries reported the presence of a VMMC focal point at the Ministry of Health level in 2012. This represents an improvement from 2011, when 12 of 14 priority countries reported the presence of VMMC focal point.

Box 1: Government Leadership in VMMC in Zambia

When Zambia launched VMMC as part of a comprehensive HIV prevention strategy in 2009, there were several partners with disparate plans, resources and M&E systems. Leadership by the Ministry of Health ensured coordination of these disparate efforts. The Zambia Ministry of Health launched VMMC as a public health prevention strategy, created a multi-stakeholder coordination body chaired by the Ministry of Health, and appointed a focal person within the Ministry of Health to oversee VMMC coordination.

The Ministry of Health oversaw the development of a VMMC operational plan that outlined national goals and targets for VMMC scale-up. In addition to advocating directly with parliamentarians to support the VMMC initiative, the Ministry spearheaded development of an advocacy plan on VMMC. Working to extend support for VMMC scale-up from national to sub-national levels, the Ministry established VMMC focal points at sub-national levels.

These efforts have achieved results. Whereas 3 000 male circumcisions were performed in Zambia in 2008, a total of 340 000 men received VMMC services in 2012.

Source: Ministry of Health, Zambia

(b) Involvement of other Ministries/Programmes in VMMC

Engagement of other ministries and programmes in VMMC maximizes on resources and brings to the fore the comparative advantage of each player. Thirteen countries (all but Ethiopia) reported involving non-health ministries in national efforts to bring VMMC to scale. According to country reports, ministries engaged in VMMC-related work include: Education; Defense; Finance; Local Government and Rural Development; Information and Broadcasting; Home Affairs; Correctional Services; and the Department of Maternal and Child Health. Non-health ministries were especially active in advocacy, social mobilization, demand creation, resource allocation and service delivery.

(c) Existence of VMMC champions at national and sub-national level

Nine countries (Botswana, Kenya, Namibia, Rwanda, South Africa, Swaziland, Uganda, Zambia, Zimbabwe), reported having national VMMC champions. Seven countries (Botswana, Ethiopia, Kenya, Rwanda, South Africa, Swaziland, Zambia) had sub-national level champions, who are often more locally relevant, especially at community levels. The national and sub-national champions included prominent citizens, politicians, traditional leaders, sports figures and leading artists (e.g. musicians). Champions engaged in numerous activities to support VMMC scale-up in 2012, including advocacy, public education and motivation of potential VMMC clients.

(d) Support from partners

In the case of VMMC, as for all other important prevention efforts, no single stakeholder has the capacity or standing to undertake all essential activities. In the push to bring VMMC to scale, partnerships are vital, helping mobilize resources, address training and other logistical needs, secure and distribute key commodities and prepare national programmes for long-term sustainability.

In 2012, all priority countries received support from partners who played various roles ranging from provision of financial, human and technical resources to service delivery. As Table 2 indicates, partners included bilateral and multilateral donors, UN agencies, foundations, international NGOs and country-level leaders in health care delivery. Annex1 details the partners' support to each country.

Table 2: VMMC Partners in 2012 by country

Country	Partner
Botswana	African Comprehensive HIV/AIDS Partnership (ACHAP); PEPFAR; World Bank/ Botswana National HIV/AIDS Prevention Support (BNAPS); WHO
Ethiopia	Jhpiego; WHO
Kenya	PEPFAR; World Bank; WHO
Lesotho	WHO; USAID/ Maternal and Child Health Integrated Program (MCHIP) through Jhpiego; Population Services International (PSI); Lesotho Planned Parenthood Association (LPPA)
Malawi	CDC; WHO; International Training & Education Center for Health (ITECH); USAID; World Bank, Banja Lamtsogolo (BLM) Marie Stopes International; PSI; Christian Hospital Association of Malawi (CHAM); MCHIP; Department of Defense (DOD); MSF France
Mozambique	JHPIEGO/CDC; PSI/DoD; WHO
Namibia	PEPFAR; WHO
Rwanda	WHO, UNICEF, PEPFAR, Global Fund
South Africa	PEPFAR; Global Fund; WHO, World Bank
Swaziland	PEPFAR; World Bank; WHO,
Tanzania	PEPFAR; WHO; Bill & Melinda Gates Foundation (BMGF) through WHO
Uganda	PEPFAR through USAID and CDC; UN Agencies financed by Irish Aid and DFID
Zambia	WHO; PEPFAR; BMGF; Global Fund, World Bank; Clinton Health Access Initiative (CHAI)
Zimbabwe	UNFPA; PSI; WHO; PEPFAR; Department for International Development (DfID); National AIDS Council

Country missions promote knowledge transfer and enable partners to plan and adapt collaborative activities with national health ministries and other partners. Missions are especially valuable in facilitating the sharing of information, strategies and experiences between priority countries. In 2012, six countries (Botswana, Lesotho, Malawi, South Africa, Swaziland, Zimbabwe) undertook learning missions to other countries (see Table 3).

Table 3: Location country and purpose of missions by priority country

Country	Where mission conducted	Purpose
Botswana	South Africa, Rwanda, Kenya	Understand VMMC service delivery strategies, use of male circumcision devices (PrePex, Tara Klamp and Shang Ring); learn roles and coordination of development partners and stakeholders in the VMMC programme and appreciate demand creation strategies for men.
Lesotho	Zimbabwe	Learn more about PrePex
	Botswana	Chiefs from Lesotho to learn more about collaboration between the traditional sector and medical male circumcision service provision
Malawi	Botswana	Orientation on VMMC service delivery models, utilization of research evidence, data collection and management of HIV testing and counseling in VMMC programmes
South Africa	Rwanda	Benchmarking for the PrePex device
Swaziland	Zimbabwe	Observe use of PrePex Device
Zimbabwe	Zambia, Kenya	Learn about shifting from doctor-led to nurse-led VMMC
Total	6	

2.1.2 Advocacy

Advocacy plays a crucial role in VMMC scale-up, mobilizing support from key decision makers and from the public at large. In 2012, priority countries undertook a broad array of advocacy activities to support accelerated VMMC scale-up (Table 4).

Table 4: Summary of progress on advocacy by priority country

Country	Existence of advocacy strategy	More successful advocacy activities	Events used to support VMMC	Involvement of women and girls
Botswana	Yes	June/July 2012 School campaign	School campaigns; Launch of Safe Male Circumcision (SMC) Sites; Smart men camps	Yes
Ethiopia	No	Mass mobilization; house to house mobilization	None	Yes
Kenya	Yes	Engagement of elders from Teso and Turkana in a stakeholders meeting	Launch of VMMC in North Pokot	Yes
Lesotho	No	December/January VMC campaign for school children	VMMC Stakeholders meeting celebrating 10,000 MCs; Jhpiego regional MC technical meeting	Yes
Malawi	Yes	National Launch of the VMMC policy; Launch of VMMC; Standard Operating Procedures	Launch of the National VMMC Policy	Yes
Mozambique	Yes	VMMC presentation made to Government officials & led by Prime Minister; VMMC meetings held with communities, religious leaders, civil society, private sector & NGOs	Promoting VMMC in schools and on national days	Yes
Namibia	Yes	None	None	Yes
Rwanda	Yes	Campaign targeting young people at 2 universities	VMMC campaigns	Yes
South Africa	Yes	King Goodwill Zwelithini and MEC for Health and Premier of KZN launched MC Campaign for all males to be medically circumcised in health facilities across the province; Minister of health launched MC campaign for tertiary institutions, with MCs performed at the launch; Deputy President publicly announced on World AIDS Day that all males get circumcised for HIV prevention and advocated for integration of MC into traditional practice; Minister participating in community events, radio talk shows and TV adverts on MC; Brothers for Life campaign use soccer and cricket stars to promote MC	First thing first campaign for higher education was launched by the Minister of Health; World AIDS Day	Yes
Swaziland	Yes	Collaboration in the launch of the Back to school campaign by Ministry of Education	Back to School campaign; Trade Fair; Document launches by MoH	Yes
Tanzania	No	School visits; use of mass media & influential people; distribution of posters & leaflets	None	Yes
Uganda	Yes	Mobilization of local leaders and launch of VMMC in Ngora district by high level MoH and political leaders	District-based VMMC capacity building camps in 5 districts	Yes
Zambia	Yes	Advocacy to members of parliament & traditional chiefs especially among non-circumcising communities; two VMMC national campaigns	Launch of 2012 -2015 Country Operational Plan for the Scale – up of VMMC in Zambia; national VMMC campaign	Yes
Zimbabwe	Yes	Circumcision of members of parliaments	World AIDS Day; Trade Fair; National HIV testing and counselling and MC campaign	Yes
TOTAL	11	12	11	14

Eleven countries (all but Ethiopia, Lesotho and Tanzania) reported having a VMMC advocacy strategy, although even countries lacking an advocacy strategy undertook VMMC-related advocacy. One country having an advocacy strategy, Namibia, did not report any advocacy activities in 2012.

According to country reports, the more successful advocacy activities carried out in 2012 included the following:

- School campaigns (Botswana, Lesotho, Rwanda, Swaziland, Tanzania)
- Home-to-home and mass mobilization (Ethiopia)
- Engaging elders and other influential people (Kenya, Mozambique, Tanzania, Uganda, Zambia)
- Launch of VMMC documents (Malawi)
- Use of mass media for advocacy (Tanzania)
- Launch of VMMC programme (Uganda)
- Launch of VMMC sites (Botswana)
- National VMMC campaign (Swaziland, Zambia)
- VMMC for parliamentarians (Zimbabwe)

Box 2: Advocacy for VMMC in Malawi

After identifying deep cultural and religious resistance to VMMC, Malawi developed a three-phased approach to engage stakeholders in an effort to improve support for VMMC.

Firstly, efforts were undertaken to engage and obtain buy-in from the Ministry of Local Government and Rural Development which deals with traditional leaders, the Parliamentary Committee on health, HIV & AIDS, and religious bodies through a faith-based organisation, Malawi Interfaith AIDS Association (MIAA). This was followed by three national consultative meetings with all key stakeholders. Finally, diverse stakeholders, strategically selected to represent their respective constituencies, participated in three regional consultative meetings. As a result of all these efforts, recommendations were drafted and adopted and an inclusive VMMC policy was launched with the blessing of these key constituencies.

Source: Ministry of Health, Malawi

All 14 countries reported having involved women and girls in their VMMC programme. Strategies used to engage women include community mobilization, peer education and health promotion in higher education campuses. These efforts are aimed at influencing men's decisions to be circumcised, cultivating VMMC champions and providing post-operative support to men who have been circumcised. The degree to which women have been engaged in VMMC scale-up is unclear from country reports, and information is similarly lacking as to whether these efforts have had an impact.

2.2 Pillar 2: Country Implementation

Consistent with the overarching goal of country ownership in the HIV/AIDS response, countries are expected to lead national efforts to implement VMMC. Activities of partners in support of VMMC scale-up are guided by target-driven, costed national operational plans to ensure efficient, effective and sustainable VMMC services.

2.2.1 Operational planning

By December 2012, all priority countries had developed target-driven, multi-year plans for VMMC, with two countries developing these plans in 2012. National plans have different timeframes, with those for Ethiopia and Rwanda ending in 2012 while Botswana's extends from 2009 to 2016.

Several countries amended their targets in 2012, taking into account such factors as experiences to date in programme implementation and the availability of financial resources. In 2012, Mozambique and Tanzania almost doubled their earlier targets, while Uganda raised its target by about 255,000. Lesotho, Zambia and Zimbabwe reduced their targets by about 60,000; 85,000 and 600,000 respectively (Table 5).

Table 5: Status of VMMC planning in the 14 priority countries initially and in 2012

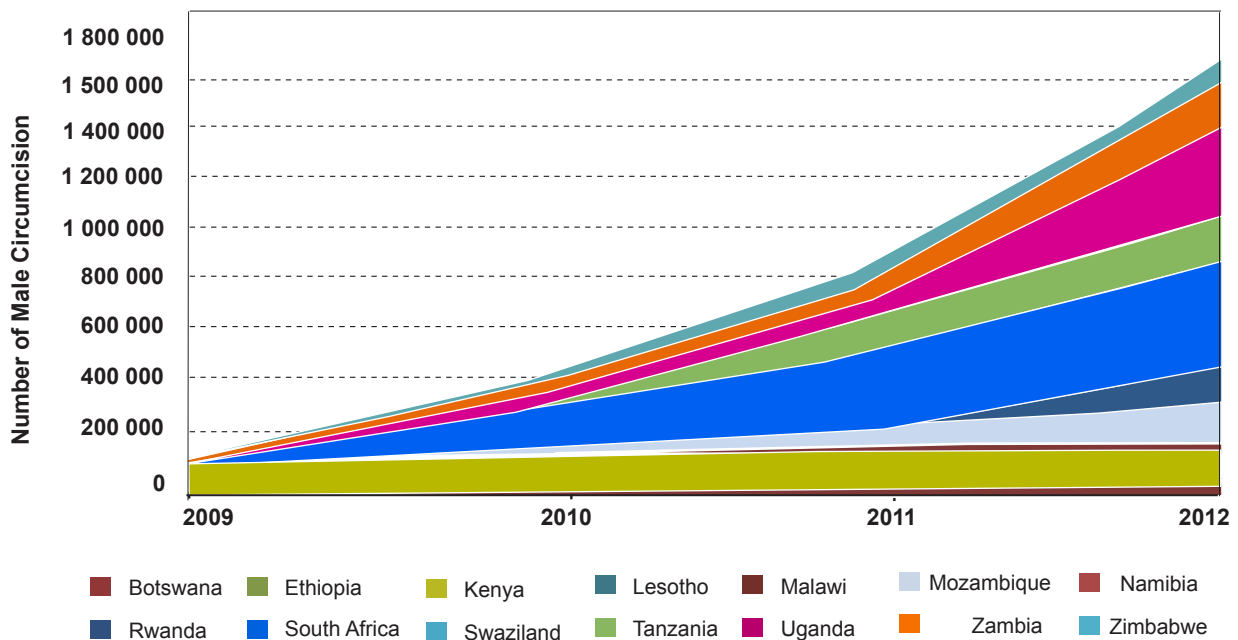
Country	2011		2012		
	Target-driven plan in place	Time frame	Plan in Place	Time frame	Overall Target
Botswana	Yes	2009–2016	Yes	No change	345,244
Kenya	Yes	2008–2013	Yes	No change	860,000
Ethiopia	Yes	2009–2012	Yes	No change	40,000
Lesotho	No	Plan ended in 2009	Yes	2012/13 – 2016/17	317,215**
Malawi	Yes	2011–2016	Yes	2011-2016	2,101,566
Mozambique	Yes	2010–2012	Yes	2013-2017	2 million**
Namibia	No	Still being developed	Yes	2012/13 – 2014/15	330,218
Rwanda	Yes	2010–2012	Yes	2 years	700,000**
South Africa	Yes	2012–2016	Yes	2011/12-2012/2013	4,333,134
Swaziland	Yes	2009–2013	Yes	No change	183,450
Tanzania	Yes	2010–2015	Yes	No change	2,830,000**
Uganda	Yes	2011–2015	Yes	No change	4,500,000**
Zambia	Yes	2012–2015	Yes	No change	1,864,000**
Zimbabwe	Yes	2010–2015	Yes	2013-2017	1,300,000**
Total	12		14		

Source: Ministries of Health ** Targets revised

2.2.2 Service delivery

As of December 2012, a total of 3,162,036 VMMC procedures in all age groups were performed in the 14 countries. The number of VMMC procedures performed in priority countries in 2012 (1,710,531) represents a 1.9-fold increase over the number performed in 2011 (884,283), revealing that the pace of VMMC uptake is quickening as seen in Figure 1. The greatest increase in the pace of scale-up between 2011 and 2012 occurred in Mozambique, Rwanda, Uganda and Zambia.

Figure 1: Annual number of voluntary medical male circumcision, selected countries 2009-2012



Source: UNAIDS GARPR 2013; WHO and Ministries of Health 2013

Large variability occurred across all the countries in their achievement towards coverage of 80 percent MC prevalence ranging from a low of about 2% percent in Malawi to a high of about 63 percent in Kenya as shown in Table 6. With the exception of Swaziland, all other countries also performed more male circumcisions in 2012 than 2011, where South Africa performed the greatest number of male circumcisions (422,009) followed by Uganda, Tanzania, Zambia, Kenya, Rwanda and Mozambique – with each of these countries performing at least 130 000 male circumcisions in 2012 (Table 6). Swaziland performed 3,814 less male circumcisions in 2012 because there was a major funding reduction from the resources that had been available for the Accelerated Saturation Initiative (ASI) which was implemented from 2010 to 2011. The 20 service delivery sites operated during ASI were reduced to 5 only.

Table 6: Potential impact and number of male circumcisions performed in the 14 priority countries, 2008–2012

Country	Estimated number of MCs needed to reach 80% prevalence	Potential infections averted by scaling up MC to reach 80% prevalence in five years	Number of MCs performed among all ages, by year and total						% Achievement towards estimated number of MCs to reach 80% prevalence
			2008	2009	2010	2011	2012	Total	
Botswana	345,244	62,773	0	5,424	5,773	14,661	38,005	63,863	18.5%
Ethiopia	40,000	1,479	0	769	2,689	7,542	11,961	22,961	57.4%
Kenya*	860,000	73,420	11,663	80,719	139,905	159,196	151,517	543,000	63.1%
Lesotho**	376,795	106,427	No data	No data	No data	No data	10,521	10,521	2.8%
Malawi	2,101,566	240,685	589	1,234	1,296	11,881	21,250	36,250	1.7%
Mozambique	1,059,104	215,861	0	100	7,633	29,592	135,000	172,325	16.3%
Namibia	330,218	18,373	0	224	1,763	6,123	4,863	12,973	3.9%
Rwanda	1,746,052	56,840	0	0	1,694	25,000	138,711	165,405	9.5%
South Africa	4,333,134	1,083,869	5,190	9,168	131,117	296,726	422,009	864,210	19.9%
Swaziland	183,450	56,810	1,110	4,336	18,869	13,791	9,977	48,083	26.2%
Tanzania	1,373,271	202,900	0	1,033	18,026	120,261	183,480	322,800	23.5%
Uganda	4,245,184	339,524	0	0	21,072	77,756	368,490	467,318	11.0%
Zambia	1,949,292	339,632	2,758	17,180	61,911	85,151	173,992	340,992	17.5%
Zimbabwe	1,912,595	565,751	0	2,801	11,176	36,603	40,755	91,335	4.8%
Total	20,855,905	3,364,344	21,310	122,988	422,924	884,283	1,710,531	3,162,036	15.2%

Source: Ministries of Health

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

** Lesotho's data for 2011 was not available

In 2012 a total of 1,710,531 circumcisions were performed in the 14 priority countries. Some, but not all, countries provided age disaggregated data and there was some inconsistency in the age groups reported. For eight countries (Botswana, Ethiopia, Lesotho, Namibia, Rwanda, Swaziland, Zambia and Zimbabwe) the proportion of circumcisions among men aged 15 years and over could be computed and ranged from 50% in Swaziland to almost 100% in Ethiopia (Table 7). The weighted average over the eight countries was 85%. In six of these countries numbers of circumcised males in the 15-19 year age group were also provided and showed that these represented about half of the circumcisions in the age range of 15-49 years.

Table 7: Number of male circumcisions performed by age stratum and country, 2012

Country	Age < 1	Age 1-9	Age 10-14	Age 15-19	Age 20-24	Age 25-49	Age >49	Total
Botswana	48	258	7,355	11 868	7 999	10 121	356	38 005
Ethiopia	1	5	0	5 560	2 476	3 799	120	11 961
Kenya				151 517				151 517
Lesotho	0	0	1,588	4,312	2,914	1,690	17	10,521
Malawi				21 250				21 250
Mozambique				135 000				135 000
Namibia		63	853	1 173	1 082	1 634	53	4 863
Rwanda	714		16 485			121 512		138 711
South Africa				422 009				422 099
Swaziland	7	111	4 818	2 610	1 161	1 223	47	9 977
Tanzania				183 480				183 480
Uganda 0-4 yrs								4573
Uganda 5-17 yrs								93 899
Uganda >=18 yrs								270 018
Zambia		67 401				106 591		173 992
Zimbabwe		11 087		12568	6916	9696	488	40 755
TOTAL								1 710 531

Source: Ministries of Health

2.2.3 Service delivery approaches

Priority countries provide VMMC services as part of a comprehensive package that includes HIV testing and counseling (HTC), diagnosis and treatment of other sexually transmitted infections (STIs), promotion of safer sex practices (including reduction of sexual partners, provision of male and female condoms and promoting their consistent and correct use), and linkage to HIV care and treatment for individuals with diagnosed HIV infection.

Among VMMC service recipients, acceptance of HTC ranged from 75% in South Africa to 100% in Zambia, with 8 countries reporting acceptance rates of above 90% (Ethiopia, Lesotho, Malawi, Mozambique, Swaziland, Tanzania, Zambia, Zimbabwe). The proportion of individuals receiving HTC through VMMC services who tested HIV-positive ranged from 0.4% in Ethiopia to 5% in Lesotho.



VMMC client undergoing HIV testing and counseling

Box 3: Adult VMMC Clinic in Lesotho

As men in their 20s and 30s are at greatest risk for acquiring HIV in priority countries, they are the top priority in VMMC scale-up. While circumcising young men aged 10-18 years supports the long-term sustainability of prevention efforts, circumcisions in this age group are less likely to yield an immediate prevention benefit, as most young men in this age group have yet to become sexually active.

To improve uptake among 'older men', Lesotho established a VMMC clinic that caters to males over 29 years of age. Lesotho decided to create the specialized clinic after programme implementation experiences that indicated that these "older men" were uncomfortable receiving VMMC services together with boys and young men. Men over 29 years of age receive the same package of VMMC services as other programme recipients but are now able to do so in a more consumer-friendly environment. Following creation of the clinic, an improvement was reported in the number of "older men" presenting for VMMC. The country plans to consider replicating this approach in other parts of the country where older men are not presenting for VMMC in sufficient numbers.

Source: Ministry of Health, Lesotho

Although priority countries are advised to implement early infant male circumcision (EIMC) services at the same time that "catch-up" services for men aged 15-49 years are brought to scale, countries have been slow to implement services for infants. As of December 2012, only three countries (Swaziland, Tanzania, Zambia) reported that they had commenced EIMC services.

2.2.4 Procurement and supply

Effective scale-up and sustainability of VMMC services depend on an efficient national procurement system for essential VMMC commodities. To ensure access to essential supplies, countries should quantify commodity needs, identify gaps and develop measures to address gaps and mobilize needed resources.

Ten countries (Botswana, Ethiopia, Lesotho, Malawi, Mozambique, Namibia, Tanzania, Uganda, Zambia, Zimbabwe) experienced challenges in 2012 relating to stock-outs, delayed procurement and inadequate funding. On the other hand, however, two countries (Kenya and Swaziland) did not report challenges pertaining to procurement and supply management in 2012. In Kenya, VMMC procurement and supply management is managed by partners who are very responsive to demand and supply issues. Swaziland has enough supplies that were left over from the Accelerated Saturation Initiative which was conducted from 2010 to 2011. However, the excess supplies have resulted in MC kits expiring on the shelves because of the reduced numbers of MC procedures performed.

2.2.5 Capacity building

The Joint Strategic Framework recommends that countries implement and/or strengthen tailored, evidence-based training programmes for physicians, nurses, facility and hospital managers, programme managers, counselors, volunteers and community workers. The framework advises countries to prioritize training on key components of VMMC service provision, including community mobilization, post-operative care and demand creation. Countries are also encouraged to integrate training in pre-service education in health training institutions and in refresher courses for those in practice.

All countries reported having conducted VMMC training programmes in 2012. Staff cadres trained included doctors, nurses, counselors, health education officers, health officers, clinical officers, health facility managers, lay counselors, community outreach officers, health promoters, peer educators, trainers of trainers and assistant clinical officers.

2.2.6 Quality Assurance

Maintaining high standards of services requires a quality assurance strategy and plan that provides for regular quality audits and ongoing feedback to inform efforts to improve service quality.

Nine countries (Botswana, Ethiopia, Kenya, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Zimbabwe) reported having a Quality Assurance (QA) plan in place in 2012. The number of countries with QA plans in place represented a decline over the 10 countries that reported QA plans in 2011. Ten countries reported at least one QA activity. Malawi and Mozambique reported neither having a QA plan nor carrying out any QA activities (Table 8). PEPFAR plays a pivotal role in the conduct of QA activities in the VMMC priority countries.



A young man undergoing male circumcision

Table 8: Existence of quality assurance plans and activities

Country	Existence of Quality Assurance Plan	Quality assurance activities
Botswana	Yes	QA/QI of selected facility; Workshops to review post-op complications; Data audit and; Post school campaigns workshops
Ethiopia	Yes	M&E team in collaboration with Jhpiego have conducted two rounds data quality assurance for all MC sites
Kenya	Yes	Support supervision
Lesotho	No	Site visit
Malawi	No	None
Mozambique	No	None
Namibia	Yes	Proficiency assessment
Rwanda	Yes	None
South Africa	Yes	SYMMACS study by Center for HIV Prevention Studies (CHAPS) and PEPFAR QA site visits
Swaziland	Yes	Facility readiness assessments were conducted for those facilities which were about to provide VMMC services either fixed public sites or outreach sites
Tanzania	Yes, (For General HIV Services)	PEPFAR EQA was conducted
Uganda	No	Developed quality assurance tools which are in process of approval by Ministry of health; PEPFAR EQA
Zambia	No	PEPFAR External QA process
Zimbabwe	Yes	Quality assurance audit
TOTAL	9	11

2.3 Pillar 3: Innovations for scale up

As VMMC is one of the newest of all core HIV prevention activities, bringing VMMC to scale requires, among other things, innovative methods of service delivery and demand creation. As innovation has played an important role in identifying best practices for scale-up of antiretroviral therapy and services to prevent mother-to-child HIV transmission, innovation is also vital to accelerate scale-up of VMMC.

2.3.1 Research

Research plays a crucial part in the scale-up of VMMC, informing the development of policies and programmes and accelerating the development and validation of new technology. In 2012, eight countries conducted research on male circumcision devices. Experts believe new devices could improve the efficiency of VMMC scale-up and provide men with a choice of VMMC options. Botswana, Kenya, Rwanda, South Africa, Tanzania, Uganda, Zambia and Zimbabwe carried out studies on the PrePex device in accordance with WHO guidance. Kenya and Tanzania conducted studies on another device, the Shang Ring.

Four other countries conducted non-device-related male circumcision studies. These included a client survey on VMMC-seeking behavior in Lesotho; the Systematic Monitoring of Male Circumcision Scale-up (SYMMACS) study; a National Communication Survey; and Demand Creation Qualitative studies in South Africa; a Study to identify determinants and barriers to EIMC uptake; Qualitative study on the low utilization of male circumcision services; Study on service uptake, coverage and adverse events during Soka Uncobe male circumcision campaign in Swaziland; and a Longitudinal study of sexual behavior post male circumcision in Zambia (Table 9).

2.3.2 Human resource innovations

As an intervention delivered in health care settings, VMMC scale-up is inevitably affected by the broader health systems in which these services are delivered. In particular, efforts to bring VMMC to scale, like other health services, must grapple with the underlying shortage of human resources for health in priority countries. One strategy increasingly used to extend service access in the context of human resource shortages is task-shifting, whereby certain services are delivered by lower-cadre health care workers.

Other cadres besides doctors performed VMMC surgical procedures, with or without specific task shifting policies in place in the majority of the countries. However, Botswana, Lesotho, Namibia, South Africa and Zimbabwe only allowed doctors to perform VMMC surgical procedures during 2012.

Table 9: Research carried out on MC devices and other MC research by country

Country	VMMC Device research	Other MC research
Botswana	Preparation for PrePex studies; AccuCirc studies	None
Ethiopia	None	None
Kenya	(i) Shang Ring research completed (ii) Preparation for PrePex study	None
Lesotho	None – planned for study in 2013	Clients' view study: why are first clients seeking MC? Underway and; VMMC-HTC- ART linkages: abstract submitted and accepted to IAS AIDS conference. (programme data)
Malawi	None – planned for study in 2013	None
Mozambique	Planning for pilot study	None
Namibia	None	None
Rwanda	PrePex study	None
South Africa	Planning for pilot study on safety and acceptability of PrePex device in 3 provinces	(i) Systematic monitoring of male circumcision scale-up (SYMMACS) study; (ii) National Communication survey iii) Demand creation qualitative studies
Swaziland	None	(i) Study on the determinants and barriers to EIMC uptake (ii) Qualitative Study on the Low Utilization of Male Circumcision Services in Swaziland (iii) Service Uptake, Coverage, and Adverse Events during a VMMC campaign (Soka Uncobe)
Tanzania	PrePex and Shang Ring	None
Uganda	PrePex study	None
Zambia	Protocol for PrePex acceptability submitted	Longitudinal Study of Sexual Behavior Post Male Circumcision in Zambia
Zimbabwe	i) Assessment of the safety and efficacy of the PrePex device when utilized by Registered General Nurses with 2 yrs experience ii) PrePex bridging studies among adolescents, HIV positive clients, diabetics as well as when the device is applied by Primary Care Nurses.	None
TOTAL	8	4

Box 4: Broadening the Scope of Practice for nurses and midwives in Zimbabwe

In order to support accelerated scale-up of VMMC services, Zimbabwe developed the “Broadening the Scope of Practice for Nurses and Midwives” policy. Through a consultative process with the Health Professions Authority, the Zimbabwe councils of nurses and medical and dental practitioners explored the feasibility of allowing nurses to conduct medical male circumcisions. It was determined that The Health Professions Council Act Chapter 27:19 Part VII clauses 1a) and e) had sufficient provisions for the nurses and midwives to shoulder added responsibilities, including VMMC. Under the agreed new approach, the Nurses Council is now able to authorize appropriately trained and mentored nurses and midwives to take on added responsibilities that include the surgical VMMC procedure and provision of VMMC services using MC devices.

Source : Ministry of Health and Child Welfare, Zimbabwe

2.4 Pillar 4: Communication

Effective, population-focused communication is central to the success of VMMC campaigns. VMMC communications involve numerous channels and strategies, including public education, community mobilization, demand creation and prevention of potential risk compensation.

All countries except Lesotho and Tanzania (12 countries) had communication strategies by end of 2012. Six countries (Botswana, Kenya, Namibia, Rwanda, South Africa, and Zimbabwe) had costed plans, while communications plans had yet to be costed in the other six countries (Ethiopia, Malawi, Mozambique, Swaziland, Uganda, and Zambia).

All countries reported undertaking strategies to mobilize communities and create demand. Strategies included mass media (TV, billboards, radio, strip advertisement and newspapers); interpersonal communication; school campaigns; road shows; peer-to-peer communication; community mobilization; edutainment; and social media. Moving forward, evaluation of communications strategies and identification of best practices are urgently needed.

Eleven countries (all except Lesotho, Namibia and Tanzania) reported varying approaches for involving grassroots organizations and networks in VMMC scale-up. These included information dissemination; involvement of community leaders and religious leaders; training and sensitization; and use of community mobilizers, existing community structures, health workers, schools, community outreach teams, various district and village committees and community-based organizations (Table 10).



Community mobilization for Safe Male Circumcision by a Civil Society Organization (CSO)

Table 10: Communication strategy and involvement of grassroots organizations by country

Country	Existence of Communication strategy (Costed and Funded)	Involvement of grassroots organizations and networks
Botswana	Yes	i) Mobilization of clients for VMMC ii) Counselling services; iii) Information dissemination
Ethiopia	Yes (not costed/ funded)	Through involvement of community elders and religion leaders
Kenya	Yes	Training and sensitization
Lesotho	No	No Information
Malawi	Yes (not costed/ funded)	i) Use of community mobilizers ii) Briefing sessions with existing institutions such as Community Based Organizations, Village Development Committees and District Executive Committees
Mozambique	Yes (not costed/ funded)	There are various levels of involvement of grassroots organizations
Namibia	Yes	Not done in 2012
Rwanda	Yes	i) Collaboration with community health workers and civil society and private sector to conduct door-to-door, campaigns ii) Training/capacity development of community health workers iii) Orientation of media personnel (electronic and print) iv) Sensitization of community leaders.
South Africa	Yes	i) Through focus group discussions ii) Designing and testing communication material iii) Training of community outreach teams for MC social mobilisation
Swaziland	Yes (not costed/ funded)	MoH has created a network of community structures that play a pivotal role in the implementation of MC demand creation activities i.e. School based headmasters, School champions (Circumcised boys who are now MC advocates), School support teams (Comprised of School 2 school teachers, two students, parents, and community based police), Church leaders and Soccer team coaches
Tanzania	No	None
Uganda	Yes (not costed/ funded)	Use the network of Mayors and Municipal leaders for community engagement especially in urban areas
Zambia	Yes (not costed/ funded)	i) Community based organizations are contracted in selected areas to do demand generation/communications for VMMC and refer potential clients to service provision ii) Support to community based phone radio shows for VMMC demand generation especially during MC campaign months iii) Partnership with Grassroots Soccer during 2012 to offer MC services at soccer tournaments. Grassroots soccer has included MC as part of their core educational curriculum.
Zimbabwe	Yes	i) Involvement of village health workers ii) Behaviour change facilitators, and community mobilisers, all identified by the local community to work in the same community iii) Local NGOs and CBOs also meet periodically to discuss HIV/AIDS issues in general & VMMC has also been included in the these community meetings.
TOTAL	12	11

Box 5: Civil Society Organizations' (CSOs) Involvement in Social Mobilization for Safe Male Circumcision in Uganda

In Uganda, the Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL) engaged Mama's Club, a vibrant CSO, to support delivery of combination, community-level HIV prevention. This included VMMC, prevention of mother-to-child transmission, family planning and HTC in six priority districts. The collaboration sensitized key national and district stakeholders about the programme through a national orientation meeting, followed by orientation of target districts. The partners used radio talk shows, mobile vans, dissemination of materials, exhibitions and dramas, district-level launches and actual service provision to mobilize communities and promote HIV prevention services. Mayors and district leaders led mobilization of communities for participation in the various activities.

Major achievements included a high level of awareness about VMMC and other prevention services, high demand for services, involvement of local leadership in advocacy and community mobilization and increased public enthusiasm about HIV prevention programmes. The collaboration was especially successful in involving men in HTC services. **Key success factors** in this programme include the active engagement and involvement of political leaders as an entry point into the local community, the use of multi-pronged mobilization strategies and joint implementation of the programme between urban authorities and districts, which strengthened district leadership for the HIV response.

Source: Ministry of Health, Uganda

2.5 Pillar 5: Resource Mobilization

Although VMMC is among the most cost-effective of all HIV prevention interventions, sufficient and predictable financing is nevertheless required to accelerate VMMC scale-up. Some countries such as South Africa have VMMC covered by some private medical health insurance schemes.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) continues to be the primary source of financing for VMMC programmes in priority countries. In five countries – Lesotho (Round 8), Rwanda (National Strategic Plan), South Africa (Round 10); Uganda and Zambia (Round 8) – grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria were used to support VMMC activities. Other sources of funding include the World Bank, Bill & Melinda Gates Foundation and the One-UN Fund supported VMMC services in Rwanda (Table 11).

Table 11: Status of resource mobilization by country

Country	Availability of funding through GFATM	Other Non-PEPFAR sources of funding
Botswana	None	World Bank
Ethiopia	None	None
Kenya	No	World Bank
Lesotho	Yes (Round 8)	None
Malawi	None	World Bank
Mozambique	None	None
Namibia	None	None
Rwanda	Yes (National Strategic Plan),	One-UN Fund
South Africa	Yes (Round 10)	None
Swaziland	No	None
Tanzania	No	None
Uganda	Yes (Round 8)	None
Zambia	Yes (Round 8)	Bill and Melinda Gates Foundation (BMGF)
Zimbabwe	No	None
Total	5	5

Box 6: World Bank Potential Financial Support for VMMC

Upon the request of the national government as part of the country partnership strategy, financial support from the World Bank may be mobilized to support VMMC services. Increasingly, World Bank-supported projects are not stand-alone HIV projects but rather development support projects with an HIV or health systems support component.

Through the World Bank, results-based financing (RBF), which uses supply-side incentives (such as payment to health facilities per procedure performed) has successfully been used by the World Bank to finance VMMC procedures in Burundi. Such incentive-based funding models potentially hold promise for VMMC priority countries as well. In countries where RBF schemes are operating for health, scope exists to include VMMC as part of the scheme. Incentivising VMMC delivery is especially important in areas where VMMC scale-up is slow due to low demand, where scale-up has slowed because early adopters have been circumcised, and where the supply side requires stimuli to develop and broaden service provision (e.g. through the use of non-surgical devices).

Source: World Bank

2.6 Pillar 6: Monitoring and Evaluation

The Joint Strategic Framework recommends that “countries should collect, disseminate and make optimal use of strategic information on effectiveness, epidemiological impact, economic impact, and programme performance and management”. The framework also recommends that “collection and analysis of strategic information on VMMC should be incorporated into existing mechanisms for monitoring and evaluation”.

In 2012, all countries except Ethiopia reported having in place a routine VMMC information system. However, only six countries (Kenya, Malawi, Namibia, South Africa, Uganda and Zambia) had integrated the VMMC reporting system into the national health information system. Ten countries (Botswana, Kenya, Lesotho, Malawi, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Zambia) reported having a forum for discussing VMMC monitoring and evaluation issues. Thirteen countries (all but Ethiopia) reported having national indicators for VMMC. Seven countries (Ethiopia, Lesotho, Mozambique, Namibia, Rwanda, South Africa, Swaziland and Zambia) report having generated an annual VMMC report for 2012, while six countries (Botswana, Ethiopia, Kenya, Rwanda, South Africa, Tanzania) report having conducted annual reviews of VMMC programme performance (Table 12).

Table 12: Status of VMMC M&E systems in the 14 priority countries

Country	Availability of routine VMMC information system	Integrated in national system	Existence of VMMC M&E forum	Availability of national indicators	Availability of Annual report	Annual review
Botswana	Yes	No	Yes SMC Governance Board	Yes	No	Yes
Ethiopia	No	No	No	No	Yes	Yes
Kenya	Yes	Yes	Yes, VMMC Task Force	Yes	No	Yes
Lesotho	Yes	No	Yes, TWG	Yes	Yes	No
Malawi	Yes	Yes	Yes	Yes	No	No
Mozambique	Yes	No	No	Yes	Yes	No
Namibia	Yes	Yes	Yes, TWG	Yes	Yes	No
Rwanda	Yes	No	Yes, TWG	Yes	Yes	Yes
South Africa	Yes	Yes	Yes National quarterly meeting	Yes	Yes	Yes
Swaziland	Yes	No	Yes, TWG	Yes	Yes	No
Tanzania	Yes	No	Yes, through MC TWG Meetings	Yes	No	Yes
Uganda	Yes	Yes	No	Yes	No	No
Zambia	Yes	Yes	Yes, TWG	Yes	No	No
Zimbabwe	Yes	No	No	Yes	No	No
TOTAL	13	6	10	13	7	6

2.7 Pillar 7: Coordination and Accountability

The Joint Strategic Framework recommends that national programmes lead in coordinating VMMC efforts. Countries are advised to establish milestones to mark progress towards national goals.

All priority countries reported the existence of a multi-sectoral Technical Working Group to coordinate VMMC activities. A senior official from the Ministry of Health typically chairs these national-level working groups, and a wide range of multisectoral partners are included in the membership. These structures are intended to provide a forum for key partner coordination in all processes of introducing and scaling up VMMC services as well as in reviewing progress towards national goals. In a possible indication of increasing effectiveness of coordination, all countries report that their Technical Working Groups meet regularly (in most cases, quarterly). Only 6 countries (Botswana, Ethiopia, Kenya, Rwanda, South Africa, Tanzania) reported that the coordination structures carried out annual performance reviews of the VMMC programme as shown in Table 13. Moving forward, evaluation efforts are needed to determine the degree to which these working groups are improving coordination and facilitating scale-up.

Table 13: Progress on coordination by Technical Working Groups

Country	Existence of TWG	Chair of TWG	Frequency of meeting	TWG carrying annual performance reviews of VMMC Programme
Botswana	Yes	MoH, Director Department of HIV/AIDS Prevention and Care.	Weekly	Yes, through annual stakeholders workshop
Ethiopia	Yes	Regional Health Board (RHD)	Quarterly	Yes, through annual team discussions
Kenya	Yes	MoH	Monthly	Yes
Lesotho	Yes	MoH	Quarterly	No
Malawi	Yes	MoH	Quarterly	No
Mozambique	Yes	MoH focal person	Monthly	No
Namibia	Yes	National MC Coordinator	Monthly	No
Rwanda	Yes	Head of HIV prevention unit	Quarterly	Yes
South Africa	Yes	MoH VMMC focal person	Bimonthly	Yes, through quarterly review
Swaziland	Yes	National VMMC Focal person	Quarterly	No
Tanzania	Yes	MOHSW	Quarterly	Yes, during 1st quarter TWG meeting
Uganda	Yes	MoH	Quarterly	No
Zambia	Yes	MoH, The Director of Mother and Child Health	Monthly	No
Zimbabwe	Yes	MoHCW	Quarterly	No
TOTAL	14			6

CHAPTER 3: CHALLENGES

CHAPTER 3: CHALLENGES

The VMMC programme faces a number of challenges which are discussed below.

Leadership for VMMC

Although most countries have shown commitment to scaling up VMMC, external partners provide the bulk of funding for VMMC activities in most countries. As a result, the implementing partners that are active at sub-national levels assume the leadership role for VMMC. The national programme is then perceived as a partner-led programme.

Low demand for VMMC services

In the majority of countries, “older men” aged between 25 and 49 years are not presenting for VMMC services in sufficient numbers. However, in Uganda, there is strong demand for VMMC among older men, although the country is currently failing to meet this demand. In some countries, men are facing transport challenges as they try to access VMMC services.

Negative media publicity is hampering demand for services in a few countries, while in others, the effects of traditional circumcisions on demand for services is unknown and needs to be investigated. This is also tied in with the challenge of accessing traditionally circumcising communities to provide medical male circumcision.

Setting realistic targets

The initial MC targets set at the inception of the VMMC programmes in priority countries are proving difficult to achieve due to limited supplies, health care providers and finances. As a result, some countries have revised these targets taking into account their experience to date.

Procurement and supply

A number of countries are experiencing challenges with stock-outs of MC kits, equipment and supplies. Botswana

reported facing challenges with waste management.

Inadequate human resources

The number of service providers remains a challenge. In most countries, the surgical approach to providing VMMC services is limited to doctors, although this may change as countries increasingly introduce VMMC devices. Some countries are facing challenges of trained VMMC providers who are not providing VMMC services partly due to low remuneration in the public sector. Delays have been experienced by some countries with regard to ministries of health giving approvals for nurses and other non-doctors to carry out VMMC procedures.

Inadequate financial resources

Although there has been an increase in the number of VMMC procedures performed, inadequate resources for VMMC remain a challenge. Most governments have limited financial resources allocated to VMMC. Sustainability of the current level of funding for VMMC programmes remains questionable, as most countries are still dependent on external funding.

Establishing sustainable services

Integration of early infant male circumcision with a routine offer to parents has not been implemented in the majority of countries. Adolescent services are a part of most current programmes but will need to be integrated within broader adolescent health services rather than provided only as part of catch-up approaches.

Monitoring and evaluation

Although most countries have reported establishing VMMC reporting systems, most remain parallel to the Health Management Information System. Countries also rely heavily on partners for data collection and reporting. Data needs to be age disaggregated.

CHAPTER 4: COUNTRY PROFILES

This section profiles each of the 14 priority countries and the progress each has made as of December 2012 in scaling up VMMC. It includes key health and demographic information; HIV and male circumcision statistics; progress in implementing the seven pillars of the Joint Strategic Action Framework together with successes and challenges.

BOTSWANA³

Profile

1. Population: 2.1 million (2012)*
2. Adult HIV prevalence: 17.6% (2008)**
3. MC at baseline: 11% (2009)**
4. Adult MC target: 345,244
5. Total no. MCs 2008 – 2012: 63,863



Pillar 1: Leadership and advocacy

Existence of VMMC focal person: A national Ministry of Health (MoH) VMMC focal person is in post.

Partners' support:

- (a) African Comprehensive HIV/AIDS Partnerships (ACHAP): In planning, infrastructure, human resource, supplies, transport and service delivery;
- (b) CDC/PEPFAR: Funding of implementing partners, human resources and supplies
- (c) World Bank/Botswana National HIV/AIDS Prevention Support (BNAPS): Supplies and system strengthening.

Involvement of other Ministries/programmes:

- (a) Ministry of Education and skills development: school campaigns contributing to >70% of all male circumcisions performed
- (b) Ministry of Defense, Justice and Security: Service provision linked to national programme.

Existence of national VMMC champions: A young renowned musician serves as Botswana's national champion. His most successful activities in 2012 included a school VMMC campaign; Edutainment at a consumer fair targeting the general population; motivational speeches in various districts; motivational radio talks; participation in 2 site launches; being part of posters, billboards and newspaper advertisements and composing a song on VMMC in Botswana.

Existence of sub-national level VMMC champions: There are local champions in 16 out of 28 districts composed of influential people of different backgrounds. Their most successful activities in 2012 were health talks and motivational speeches.

³ * Source for population data: State of the World Population 2012. UNFPA, New York, USA

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

Missions conducted: Mission to South Africa, Rwanda and Kenya.

Purpose: to learn about other service delivery strategies, including their pros and cons; understand the use of devices such as PrePex, Tara Klamp and Shang Ring; learn about coordination of partners and stakeholders; and learn about other demand creation strategies. Lessons learnt are:

- (i) PrePex is associated with less pain, is easy to use, does not require a sterile setting, has lower commodity costs, and requires minimal time lost from work. Currently available sizes are suitable for adults only.
- (ii) Shang Ring comes in different sizes that are suitable for all ages; does not require sutures; requires injectable local anaesthesia, sterile environment and functional surgical backup for emergency cases.
- (iii) Moonlight (night-time), sunrise and weekend services might increase the number of older and working class men who need to be circumcised but have no time during the day.
- (iv) Strengthening district level capacity to plan and coordinate VMMC activities is vital.
- (v) Campaigns are crucial in increasing numbers but need to be well planned and coordinated.

Existence of advocacy strategy: Advocacy strategy is available. The most successful advocacy activity carried out was a school campaign conducted in June/July 2012 which resulted in 9,668 males circumcised.

Events used to support VMMC: School campaigns; Launch of VMMC sites; and Smart men camps.

Involvement of women and girls: Yes

Pillar 2: Country implementation

Planning: A national strategy is in place for 2009–2016. Detailed operational plan for 2012 is available.

Service delivery statistics: MCs Jan-Dec 2012 = 38,005. Age disaggregation: <1yr=48; 1–9yrs=258; 10–14yrs=7,355; 15–19yrs=11,868; 20–24yrs=7,999; 25–29yrs=5,305; 30–39yrs=3,891; 40–49yrs=925; >50 yrs=356.

HIV Testing: 83% of VMMC clients had an HIV test and 1% tested HIV-positive.

Service delivery approach: VMMC is not yet integrated into infant and adolescent health services.

Procurement and supplies: The main challenges are: stock-out of HIV test kits; difficulty forecasting test kit needs; shortage of diathermy machines; and disposal of used instruments.

Capacity building: Staff trained in 2012 comprised of medical officers, nurses, counselors and health education officers.

Quality assurance (QA): QA plan is in place. QA activities conducted in 2012: QA/QI of selected facilities; workshops to review post-op complications; data audit and post school campaigns workshops.

Moderate and severe Adverse Events (AE) rate = 1.59% (145). AE registers are available at all sites. Intra-operative AEs are registered within operation registers. AEs reporting forms are also available together with event reporting forms. A monthly AE report is compiled at site level, and is sent to District Health Management Team (DHMT) M&E office with a copy to national level.

Pillar 3: Innovations for scale-up

Research on male circumcision devices: Preparation for PrePex study was done in 2012. This includes writing of study proposal, requesting for ethical clearance and resource mobilization for the study.

Other male circumcision research: None

Human resource innovations: There is no specific national policy on task shifting. However, task shifting is implemented through the MOVE strategy, with only doctors allowed to perform surgical procedures.

Pillar 4: Communication

Existence of communication strategy and plan: A communication strategy is in place. There is also a costed and funded communication plan.

Strategy for community mobilization: Mass Media; Interpersonal Communication; School Campaigns and Health camps.

Demand creation strategies: Mobilization of clients for VMMC; counseling services and information dissemination.

Involvement of grassroots organizations and networks: Yes, these organizations are involved in mobilization of clients for VMMC, counseling services and information dissemination.

Pillar 5: Resource mobilization

GFATM funding: No Global Fund financing for VMMC.

Other Non-PEPFAR funding sources: World Bank. Government provides funding for VMMC.

Pillar 6: Monitoring and evaluation

VMMC reporting systems: There is a VMMC routine reporting system that is parallel to the existing national monitoring and evaluation system.

VMMC partners' data coordination: All data is submitted to MoH from where it is disseminated to relevant partners.

Forum for VMMC data discussion: VMMC data is discussed by the safe male circumcision (SMC) project Governance Board before being reported to WHO.

National VMMC indicators:

- # and % of persons trained in behavior change intervention and communication (BCIC) for SMC; # of target communities sensitized on SMC messages;
- # and % of SMC cases with moderate or severe AEs;
- # and % of SMC Teams trained to provide SMC package according to national guidelines;
- # and % of SMC clients who return for 48 hours review;
- # and % of SMC clients who return for day seven (7) review;
- # and % of SMC clients who return for day forty two (42) review;
- # and % of eligible clients booked for SMC procedures;
- # and % of males circumcised in the intended population;
- # and % of males circumcised who received risk reduction counseling;
- # and % of HIV negative males aged 0-49 who are referred for SMC services; and % of SMC service sites with no stock out of tracer commodities.

Annual report and programme review: 2012 report writing is still ongoing. Annual programme review has been conducted.

Pillar 7: Coordination and accountability

Coordination mechanism: MoH uses 5-year strategic plan to guide all stakeholders and coordinate partners.

Existence VMMC Technical Working Group: Technical Working Group exists and chaired by Director of Department of HIV/AIDS Prevention and Care. It meets weekly and comprised of the following organizations: Department of HIV/AIDS Prevention & Care (MoH); Office of Strategic management (MoH); National SMC Programme (MoH); Department of Clinical Services (MoH); CDC/PEPFAR; I-TECH; ACHAP; Jhpiego; PSI; NACA; Men's sector; Tebelopele; BOCAIP; Ministry of Education and Skills development; Ministry of Local Government; Ministry of Youth, Sport and Culture; Supply Chain Management System and; Central Medical Stores (MoH).

TWG conducts annual reviews through a three-day stakeholders' workshop conducted annually.

Successes

- Use of Performance Based Remuneration for mobilizers
- Programme ownership by the District Health Management Teams (DHMTs)

Challenges

- **Low client uptake towards set targets**
- **Post-op care during outreach and campaigns**
- **Inadequate transport**
- **Inadequate funding for VMMC services at DHMT level**
- **Inadequate waste management during outreach services and campaigns**
- **Negative media coverage for VMMC**
- **Obtaining consent from working parents/ guardians**
- **Inadequate space in some facilities**
- **Little is known on the effect of traditional circumcising communities on VMMC programme (either positive or negative)**

ETHIOPIA⁴



Profile

1. Population: 86.5 million (2012)*
2. Adult HIV prevalence: 1.5% (2005)**
3. MC at baseline: 93% (2005)**
4. MC 80% target in Gambella Province: 40,000
5. Total number MCs: 2008–2012: 22,961

Pillar 1: Leadership and advocacy

Existence of VMMC focal person: There is no national Ministry of Health (MoH) VMMC focal person, but a regional VMMC focal person at Gambella region is in post.

Partners' support: In 2012 MoH received support from Jhpiego who helped with human and institutional capacity building, awareness creation to Health Extension Workers (HEW) and supported counselors.

Involvement of other Ministries/programmes: No other Ministry is involved in VMMC.

Existence of national VMMC champions: There are no national champions.

Existence of sub-national level VMMC champions: There are sub-national VMMC champions who cover all sites in Gambella province.

Missions conducted: No missions were conducted in 2012.

Existence of advocacy strategy: There is no advocacy strategy. The most successful advocacy activities in 2012 were: mass mobilization that was carried out through community mobilization, and orientation of HEWs by Jhpiego for house-to-house mobilization.

Events to support VMMC: None.

Involvement of women and girls: Women Health Extension Workers (HEW) participated in orientation sessions on male circumcision benefits.

Pillar 2: Country implementation

Planning: National strategy in place from 2009 to now. Overall 4-year target is 40,000. Annual target is 8,000.

³ * Source for population data: State of the World Population 2012. UNFPA, New York, USA

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

Financial resource: Regional Health Bureaus provide salaries for health workers who provide VMMC services in health facilities, and Jhpiego supports capacity building and supplies. There are 2012 and 2013 operational plans.

Service delivery statistics: Total MCs Jan-Dec 2012 = 11,961. Age group disaggregation: <1yr=1, 1-5yrs=5, 15-20yrs=5,560, 21-25yrs=2,476, 26-30yrs=1,699, 31-35yrs=1,084, 36-40yrs=522, 41-45yrs=310, 46-50yrs=184 and >50yrs=120.

HIV Testing: 95% of VMMC clients had an HIV test, and 0.4% tested HIV positive.

Service delivery approach: VMMC has not been integrated into infant care programme but integrated into adolescent health services. HIV is linked to the following programmes: STI; HTC and ART as part of service provision or referral in the case of ART.

Procurement and supplies: The availability of medical supplies in the local market is major challenge.

Capacity building: Categories of staff trained in 2012 were: health officers, nurses and doctors.

Quality assurance (QA): QA plan is available. Two rounds of data quality assurance were conducted for all MC sites in 2012.

Moderate and severe Adverse Events (AE) rate: Moderate and severe AEs were 0.4% in 2012. The AE reporting system involves reporting by health facilities through a monthly report and during campaigns to national level based on a reporting format.

Pillar 3: Innovations

Research on male circumcision devices: None.

Other male circumcision research: None.

Human resource innovations: There is a national policy on task shifting. Health officers and nurses perform male circumcision. No other innovative staffing model implemented in 2012.

Pillar 4: Communication

Existence of communication strategy and plan: A communication strategy is still being developed.

Strategy for community mobilization: Effective oral presentation with group discussion and question & answer sessions in the community.

Involvement of grassroots organizations and networks: Through involvement of community elders and religious leaders.

Pillar 5: Resource mobilization

GFATM funding: None for VMMC.

Other Non-PEPFAR funding sources: None. Government does not provide funding for VMMC activities.

Pillar 6: Monitoring and evaluation

VMMC reporting systems: None.

VMMC partners' data coordination: Reported as part of HIV activities.

Forum for VMMC data discussion: No forum for discussing VMMC data.

National VMMC indicators: No national indicators, Jhpiego format are used.

Annual report and programme review: There is a 2012 annual report. Annual review conducted in Q1.

Pillar 7: Coordination and accountability

Coordination mechanism: MoH supervises all partner activities.

Existence VMMC Technical Working Group: There is a TWG chaired by head of Regional Health Board. TWG meets quarterly and is comprised of all partners working in the health sector. TWG does an annual review through team discussion about challenges facing the programme and their solutions.

Successes

- Achieved more than the target planned for the year.
- In collaboration with Jhpiego increased demand by using local radio and television for Gambella region.
- Expansion of the MC sites from 3 to 11 sites and 8 outreach sites.

Challenges

- Lack of community awareness on the importance of VMMC
- Absence of electricity in many health centres
- Scattered community from health facilities

KENYA⁵



Profile

1. Population: 42.7 million (2012)*
2. Adult HIV prevalence: 6.3% (2009)**
3. MC at baseline: 86% (2009)#
4. Adult MC 94% target: 860,000
5. Total number MCs 2008–2012: 543,000

Pillar 1: Leadership and advocacy

Existence of VMMC focal person: A national Ministry of Health (MoH) VMMC focal person is in post.

Partners' support:

- (a) PEPFAR through its US Government agencies and implementing partners and;
- (b) The World Bank: For service provision in Teso and Turkana regions.

Involvement of other Ministries/programmes: Multisectoral approach is used.

Existence of national VMMC champions: The Prime Minister and the Minister of Health, who endorsed and supported VMMC activities in 2012, serve as VMMC national champions.

Existence of sub-national level VMMC champions: Several members of parliament from Nyanza province, covering about 70% of sites. Most successful activity in 2012 was participation in 5th stakeholders' meeting.

Missions conducted: No missions conducted to other countries.

Existence of advocacy strategy: Advocacy strategy is in place. The most successful VMMC advocacy activities in 2012 include engagement of elders from Teso and Turkana region and; the 5th stakeholders meeting in Nyanza province.

Events to support VMMC: The most successful event used to support VMMC was the launch of VMMC in North Pokot.

Involvement of women and girls: Women and girls are engaged as key players in decision-making.

Pillar 2: Country implementation

Planning: Strategic plan covers 2008–2013; with overall target of 860,000 men aged 15–49. Annual target is 235,000. The total cost is estimated at US\$60 million. Partners contributed \$12 million.

⁵ * Source for population data: State of the World Population 2012. UNFPA, New York, USA **Source for HIV prevalence data: Kenya Demographic and Health Survey, 2009. #Source for MC at baseline data: Kenya AIDS Impact Survey, 2007.

Service delivery statistics: Total MCs Jan-Dec 2012 = 151,517

HIV testing: No information available.

Service delivery approach: VMMC is not integrated in the infant care programme. However, VMMC is integrated into adolescent health services and linked to HTC, STI and couples counseling where clients are referred for VMMC.

Procurement and supplies: There have been no major challenges because partners are in charge of PSM and react timeously.

Capacity building: Main categories of staff trained are nurses and registered clinical officers.

Quality assurance (QA): QA plan is in place and support supervision was conducted in 2012.

Moderate and severe Adverse Events (AE) rate: No information available.

Pillar 3: Innovations

Research on male circumcision devices: Studies on Shang Ring completed and preparing for PrePex study.

Other male circumcision research: None.

Human resource innovations: There is a policy on task shifting, which has been practiced since 2009.

Pillar 4: Communication

Existence of communication strategy and plan: Communication strategy and plan are in place and funded.

Strategy for community mobilization: Radio, interpersonal communications, road shows, involvement of chiefs and Barazas.

Involvement of grassroots organizations and networks: Through sensitization and training.

Pillar 5: Resource mobilization

GFATM funding: None.

Other Non-PEPFAR funding sources: World Bank. Kenyan Government did not provide funding for VMMC

Pillar 6: Monitoring and evaluation

VMMC reporting systems: There is a VMMC routine reporting system that reports through existing Health Management Information System.

VMMC partners' data coordination: Data from each facility is transmitted to District Health Record and Information Officer (DHRIO) and to national level.

Forum for VMMC data discussion: Data is discussed in the VMMC task force for reporting to WHO.

National VMMC indicators: These are available.

Annual report and programme review: No annual report but an annual review is conducted.

Pillar 7: Coordination and accountability

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

Existence VMMC TWG: A national VMMC task force chaired by MoH meets quarterly, while a Provincial Task Force meets monthly. Agencies that constitute the TWG include MoH, CDC, WHO, USAID and partners. The TWG carries out an annual programme review.

Successes

- High coverage

Challenges

- Demand creation

LESOTHO⁶

Profile

1. Population: 2.2 million (2012)*
2. Adult HIV prevalence: 23% (2009)**
3. MC at baseline: 17.7% (2009)
4. Adult 80% MC target: 376,795
5. Total number MCs: 2008–2012: 10,521



Pillar 1: Leadership and advocacy

Existence of VMMC focal person: A national Ministry of Health (MoH) VMMC focal person is in post.

Partners' support:

- (a) WHO: Technical support for operational plan development;
- (b) USAID/MCHIP through Jhpiego: Technical assistance to MOH, training and Quality Assurance and service delivery in public hospitals;
- (c) PSI: Service delivery for the military.
- (d) Lesotho Planned Parenthood Association (LPPA): Service delivery.

Involvement of other Ministries/programmes:

- (a) Ministry of Finance: Through its Global Fund coordinating unit, provided financial support.
- (b) MCH: Supporting the early infant male circumcision component that is being introduced in hospitals.

Existence of national VMMC champions: No national champion.

Existence of sub-national level VMMC champions: None.

Missions conducted:

- (a) Visit to Zimbabwe to obtain information on PrePex;
- (b) Chiefs visit to Botswana to learn about collaboration between the traditional sector and medical MC provision.

Existence of advocacy strategy: None.

⁶ * Source for population data: State of the World Population 2012. UNFPA, New York, USA

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

Events to support VMMC: Most successful events used to support VMMC were VMMC stakeholders meeting to celebrate 10,000 male circumcisions, and Jhpiego regional MC technical meeting opened by the Minister of Health.

Involvement of women and girls: Posters on VMMC where women encourage men to go for VMMC.

Pillar 2: Country implementation

Planning: The strategy covers the period 2012/13 to 2016/17. Overall target = 317,215 MCs. Annual target for 2012 = 3,886 MCs (15-49); 2013 = 37,469 MCs (15-49). The resources required for VMMC is \$26,842,476. There was a detailed operational plan for 2012.

Service delivery statistics: Total MCs Jan-Dec 2012 = 10,521. Age group disaggregation <1yr=0; 1-9yrs=0; 10-14yrs=1,588; 15-19yrs=4,312; 20-24yrs=2,914; 25-49yrs=1,690; >50yrs=17.

HIV Testing: 97% of clients accepted testing, and 5% tested HIV-positive.

Service delivery approach: VMMC is not integrated into infant and adolescent health services. Linkages to other programmes:

- (a) **HTC:** As part of VMMC services provided at hospital level.
- (b) **ART:** Counselors ensure VMMC clients who test positive enter HIV care and treatment.
- (c) **STI:** VMMC clients are screened for STI. If found with an STI, the doctor in charge consult on the spot and prescribe the medication that will be offered on site.
- (d) **Sexual and Reproductive Health:** Group education provided to clients includes various topics that cover SRH issues. Condoms are also provided to MC clients.

Procurement and supplies: Shortage of test kits; Stock-outs of idocaine, paracetamol and povidone iodine.

Capacity building: Categories of staff trained in 2012 were doctors, nurses, MoH managers and counselors.

Quality assurance (QA): QA plan being developed.

Moderate and severe Adverse Events (AE) rate: Not yet known.

Pillar 3: Innovations

Research on male circumcision devices: None.

Other male circumcision research: Clients' views study underway to determine why early clients are seeking VMMC; VMMC-HTC-ART linkages: abstract submitted and accepted to IAS AIDS conference (programme data)

Human resource innovations: There is no policy on task shifting; task shifting was not implemented in 2012.

Pillar 4: Communication

Existence of communication strategy and plan: None.

Strategy for community mobilization: Posters at sites; meeting with district public health nurses and orientation of health facility nurses.

Involvement of grassroots organizations and networks: No information available.

Pillar 5: Resource mobilization

GFATM funding: GFATM funds from Round 8 grant are available for some VMMC services.

Other Non-PEPFAR funding sources: None. Government provides financial resources for VMMC.

Pillar 6: Monitoring and evaluation

VMMC reporting systems: There is a parallel VMMC routine reporting system. No integration into the national Health Information Management System.

VMMC partners' data coordination: Sites with support from partners report monthly to the MoH.

Forum for VMMC data discussion: VMMC is discussed at TWG before reporting to WHO.

National VMMC indicators: Numbers of VMMC procedures; HIV status of VMMC service recipients; number of follow up visits and; number of AEs.

Annual report and programme review: There is a 2012 annual report but annual review not conducted.

Pillar 7: Coordination and accountability

Coordination mechanism: Through VMMC Technical Working Group meetings.

Existence VMMC Technical Working Group: There is a VMMC TWG that is chaired by the MoH and meets quarterly. The agencies that constitute TWG include: MOH, WHO, USAID, Jhpiego, PSI, Military, LPPA, select private practitioners providing MC. TWG has not conducted annual reviews, but is expected to do so.

Success

- MC procedures conducted exceeded target set for the first year of implementation

Challenges

- Human resources shortage

MALAWI⁷



1. Population: 15.9 million (2012)*
2. Adult HIV prevalence: 10.6% (2010)**
3. MC prevalence at baseline: 21% (2010)#
4. Adult 80% MC target: 2,101,566
5. Total number MCs 2008–2012: 36,250

Pillar 1: Leadership and advocacy

Existence of VMMC focal person: There is a national Ministry of Health (MoH) VMMC focal person in post.

Partners' support: CDC, WHO, USAID/ITECH, Banja Lamtsogolo (BLM) Marie Stopes International, Population Services International (PSI), Christian Hospital Association of Malawi (CHAM), Maternal and Child Health Integrated Program (MCHIP), US Department of Defense and MSF France.

Involvement of other Ministries/programmes:

- (a) Ministry of Local Government and Rural development: advocacy by engaging traditional leaders and their subordinates. Participated in development of the MC policy.
- (b) Ministry of Defense: Through military health services offered VMMC services to eligible males in their institutions and also surrounding communities. Participated in VMMC campaigns organized by the Ministry of Health.
- (c) Ministry of Education: Allowed demand creation teams into schools for public lectures.

Existence of national VMMC champions: None.

Existence of sub-national level VMMC champions: None.

Missions conducted: Visit to Botswana to learn VMMC programme implementation. The main lesson learnt is that coordination, collaboration and government leadership are always key. Country will apply this lesson by engaging traditional leaders in non-circumcising communities to institutionalize medical male circumcision; involving the private sector in scaling up VMMC services and managing VMMC campaigns.

Existence of advocacy strategy: Advocacy strategy is in place. The most successful advocacy activity was the national launch of the VMMC policy and launch of VMMC Standard Operating Procedures.

⁷ * Source for population data: State of the World Population 2012. UNFPA, New York, USA **Source for HIV prevalence data: Malawi Demographic and Health Survey, 2010. #Source for MC at baseline data: MC Situation Analysis, 2010

Events to support VMMC: The national launch of the VMMC policy and VMMC standard operating procedures presided by the Minister of Health and Principal Secretary Nutrition, HIV and AIDS in the Office of the President and Cabinet.

Involvement of women and girls: Women participated in communications that were targeting older, men and girls participated in all communications targeting boys as well as sensitization on other health benefits VMMC.

Pillar 2: Country implementation

Planning: There is no operational plan for 2012, but one is expected for 2013 with the final strategic document. Strategic documents have just been reviewed; final costed document is expected in 2013. Funding gap for new strategic plan has not yet been determined.

Service delivery statistics: Total MCs Jan-Dec 2012 = 21,250

HIV Testing: 95% accepted testing and 2.6% tested HIV-positive.

Service delivery approach: VMMC is not yet integrated into infant programmes. VMMC has been integrated into adolescent health services. VMMC is linked to other programmes such as:

- (a) **STI & HTC:** At VMMC service delivery sites, clients are screened and managed for sexually transmitted infections. HTC is also offered using the opt-out strategy. Drugs for managing STIs are always available under this programme in accredited facilities,
- (b) **ART:** Those who test HIV positive are referred for WHO staging and further assessment. The only available ART services at static sites is HIV Post exposure prophylaxis,
- (c) **Condom programming:** as integral part of VMMC programming.

Procurement and supplies: Main challenge is that VMMC kits are procured through partners, as kits did not appear on the essential commodity list for the Malawi government. This implies that the implementing partners procure VMMC kits for their respective districts, which creates gaps in districts where partner programmes do not exist. VMMC commodities are now just being included in the country's list of essential commodities and the forecasting into the national needs is being adjusted for, to avoid stock-outs.

Capacity building: Categories of staff trained in 2012 were: registered nurses and clinical officers.

Quality assurance (QA): None.

Moderate and severe Adverse Events (AE) rate: <2%. Reporting system uses a standardized tool, the register, that captures clients at every review. Seven adverse event variables are reportable. Each facility in a district produces a facility monthly report that feeds into district quarterly reports, which in turn are sent to the central office in the HIV and AIDS department.

Pillar 3: Innovations for scale-up

Research on male circumcision devices: None.

Other male circumcision research: None.

Human resource innovations:

- (i) A policy on task shifting is in place. It allows State-registered nurses to provide surgery to male clients. This applies to the forceps-guided method that has been adopted for efficiency. Registered nurses have been trained in clinical skills and are providing surgery. Trained nurses are able to perform any task in the VMMC client care management, including the actual surgery and administering of local anesthesia.
- (ii) Another innovative staffing model involves using both nurse counselors and HTC lay counselors to provide health education and administer testing prior to the procedure.
- (iii) Other lower cadres are oriented to VMMC so that they are able to review clients and attend to some minor AEs as has been the case with other surgeries. Medical assistants screen and review patients post VMMC.

Pillar 4: Communication

Existence of communication strategy and plan: Communication strategy in place, but there is no communication plan.

Strategy for community mobilization: These include branded banners or sign posts displayed at the facility; meetings with local leaders, religious leaders and other influential people in the community; meetings with older men and women surrounding the service delivery point; distribution of communication materials; utilization of village discussion groups/meetings/gatherings; meetings with initiators; utilize health facility health education talks to include VMMC; using community mobilizers; village discussion groups; public talks in schools and workplaces; interactive drama sessions; letters to mosques and churches; briefing health centre staff and allied workers; strategic partnership with the private sector and; community film shows

Involvement of grassroots organizations and networks: Through use of community mobilizers and holding briefing sessions with other existing institutions such as community based organizations, village development committees and district executive committees.

Pillar 5: Resource mobilization

GFATM funding: No GFATM grant for VMMC currently.

Other Non-PEPFAR funding sources: World Bank. The Malawi Government provides funding to VMMC; partners that provide funding include US Department of Defense, World Bank, CDC and USAID.

Pillar 6: Monitoring and evaluation

VMMC reporting systems: There is a reporting system integrated into HMIS.

VMMC partners' data coordination: Districts report to MoH, who then shares the report with partners.

Forum for VMMC data discussion: Reports are shared with stakeholders for inputs before reporting to WHO

National VMMC indicators: number of MCs done against the target; number of accredited sites offering VMMC; and number of trained providers.

Annual report and programme review: There is no annual report, and a review has not been conducted.

Pillar 7: Coordination and accountability

Coordination mechanism: Through quarterly coordination meetings with all implementing partners. A structured agenda is used. Ministry of Health chairs the coordination meetings and National AIDS commission is the secretariat.

Existence VMMC Technical Working Group: There is VMMC subgroup, chaired by MoH, that reports to HIV prevention TWG, meets quarterly and is constituted by the following agencies: Ministry of Health led by the HIV and AIDS department; Department of Nutrition HIV & AIDS in the office of the President and Cabinet; National AIDS commission; USAID; CDC; DOD; WHO; MSF; Ministry of Local Government; ITECH; BLM; PSI; PCI; Military health services; MCHIP/Jhpeigo; Ministry of Youth; Malawi Interfaith AIDS Association. TWG does not carry out annual review.

Successes

- Mass VMMC campaigns modeled around HTC week makes the services more accessible.
- Outreach/mobile services are ideal in bringing out numbers, making the service accessible.
- Engagement of traditional leaders and other gatekeepers is key in breaking deep-rooted cultural values pertaining to VMMC.
- Combined communication/mobilization strategies are an important tool, collectively.
- School-centred mobilization activities have been very important and above 85% of the responsive clients are from secondary schools and other higher educational institutions.
- Task-shifting and task-sharing have been key to service delivery.
- Use of efficiency models that apply task-shifting and task-sharing are an ideal approach to balance demand and supply.

Challenges

- **Inadequate resources to scale up nationally.**
- **Limited stock of VMMC disposable kits.**
- **Inadequate number of providers to accelerate services in non-PEPFAR supported districts.**
- **Lack of vehicles to support supervision.**
- **Few VMMC mobilization campaigns.**
- **Absence of National Strategy has led to uncoordinated preference for district allocations without priorities set.**

MOZAMBIQUE⁸

Profile

1. Population: 24.5 million (2012)*
2. Adult HIV prevalence: 11.5% (2009)**
3. MC prevalence at baseline: 52% (2009)**
 4. Adult 80% MC target: 1,059,104
5. Total number MCs 2008–2012: 172,325



Pillar 1: Leadership and advocacy

Existence of VMMC focal person: A national Ministry of Health VMMC focal person is in post.

Partners' support: (a) Jhpiego/CDC: Commodities, supplies, logistics, training; (b) PSI and US Department of Defense; (c) WHO: Technical support and catalytic funding for planning meetings.

Involvement of other Ministries/programmes: The ministries of Defense and Education are involved in advocacy, demand creation and commodity procurement.

Existence of national VMMC champions: None.

Existence of sub-national level VMMC champions: None.

Missions conducted: No mission was conducted in 2012.

Existence of advocacy strategy: There is a draft advocacy strategy.

Events to support VMMC: Promotion in schools and national days.

Involvement of women and girls: Women involved in promotion activities between partners and others; girls are involved in cultural groups, schools and church

Pillar 2: Country implementation

Planning: A new national strategy covers the period 2013 -2016. Overall target 2 million VMMC procedures by 2017. Annual target is 350,000-400,000. There is no operational plan for 2012 but there is an operational plan for 2013.

⁸ * Source for population data: State of the World Population 2012. UNFPA, New York, USA

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

Service delivery statistics: Total MCs Jan-Dec 2012 = 135,000. Information on age group disaggregation is not available.

HIV Testing: 99% accepted testing, and 4% tested HIV-positive.

Service delivery approach: VMMC is not integrated in infant programmes but has been integrated in adolescent programme. VMMC is linked to STI and ART as part of the national strategy.

Procurement and supplies: Challenge with quality of instruments and gloves. Delayed replacements of supplies and consumables.

Capacity building: Categories of staff trained in 2012 were: mid-level nurses, medical doctors (MD) and MD assistants

Quality assurance (QA): There is no QA plan.

Moderate and severe Adverse Events (AE) rate: = 2%. The adverse events (infections and hematomas) reporting system starts at the MC facility then reported to district, provincial and national programme levels.

Pillar 3: Innovation for scale-up

Research on male circumcision devices: None.

Other male circumcision research: None.

Human resource innovations: There is no task shifting policy but nurses are trained to perform MC procedure.

Pillar 4: Communication

Existence of communication strategy and plan: Draft communication strategy available but there is no plan.

Strategy for community mobilization: Community engagement and community counselling

Involvement of grassroots organizations and networks: Yes.

Pillar 5: Resource mobilization

GFATM funding: None.

Other Non-PEPFAR funding sources: None. The Government of Mozambique does not provide funding for VMMC.

Pillar 6: Monitoring and evaluation

VMMC reporting systems: Parallel reporting exists.

VMMC partners' data coordination: Through quarterly reporting.

Forum for VMMC data discussion: None.

National VMMC indicators: Number of procedures; % tested; % complication and satisfaction rate

Annual report and programme review: There is a 2012 annual report but a review has not yet been done.

Pillar 7: Coordination and accountability

Coordination mechanism: Through regular meetings and reporting.

Existence VMMC Technical Working Group: There is a TWG, chaired by the MoH focal person, which meets monthly. It is constituted by the following organizations: CDC/PEPFAR, Jhpiego, WHO, UNAIDS, PSI and NAC. It has not yet conducted annual reviews.

Successes

- Community counselor and client transportation to improve demand for VMMC.

Challenges

- Lack of resources (e.g. materials, financial etc.)
- Lack of government funding for VMMC activities.

NAMIBIA⁹



Profile

1. Population: 2.4 million (2012)*
2. Adult HIV prevalence: 13.5% (2011)**
3. MC prevalence at baseline: 21% (2007)#
4. Adult 80% MC target: 330,218
5. Total number of MCs 2008–2012: 12,973

Pillar 1: Leadership and advocacy

Existence of VMMC focal person: A national Ministry of Health and Social Services VMMC focal person is in post.

Partners' support: PEPFAR (to implement VMMC programme activities).

Involvement of other Ministries/programmes:

- (a) Ministry of Finance;
- (b) Ministry of Education;
- (c) Ministry of Defense and
- (d) MCH and Adolescent Sexual and Reproductive Health (ASRH) programmes.

Existence of national VMMC champions: There is a national champion but he did not carry out any activity in 2012 due to lack of funding.

Existence of sub-national level VMMC champions: None.

Missions conducted: None.

Existence of advocacy strategy: Advocacy strategy is available.

Events to support VMMC: None.

Involvement of women and girls: IEC materials, educational materials on benefits of VMMC, support to partners undergoing VMMC.

⁹ * Source for population data: State of the World Population 2011. UNFPA, New York, USA **Source for HIV prevalence data: Spectrum, 2011.
Source for MC at baseline data: Namibia Demographic and Health Survey, 2006/7.

Pillar 2: Country implementation

Planning: A national strategy covers the period 2012-2015 with an overall target of 330,218. The annual target per year is 110,043. Total financial resources required are \$23,272,403. There is no detailed operational plan.

Service delivery statistics: Total MCs Jan-Dec 2012 = 4,863. Age group disaggregation; <4yrs= 27; 5-9yrs=36; 10-14yrs=858; 15-19yrs=1,173; 20-24yrs=1,082; 25-29yrs=796; 30-34yrs=444; 36-39yrs=234; 40-44yrs=114; 45-49yrs=46; 50+yrs=53.

HIV testing: 88% accepted, and 1.3% tested HIV-positive.

Service delivery approach: VMMC has not yet been integrated into infant care programmes but has been integrated into adolescent health services. VMMC is not currently specifically linked to other programmes.

Procurement and supplies: Lack of funding because budget was frozen.

Capacity building: Categories of staff trained in 2012: health facility managers and VMMC trainers - Training of Trainers (TOTs) conducted.

Quality assurance (QA): QA plan is available. Three proficiency assessments were conducted.

Moderate and severe Adverse Events (AE) rate: 0.46%. AE is recorded at site level and reported to regional and national levels.

Pillar 3: Innovation for scale-up

Research on male circumcision devices: None

Other male circumcision research: None.

Human resource innovations: There is no policy on task shifting but about 30 registered nurses have been assessed for proficiency and were issued proficiency certificates for surgical VMMC.

Pillar 4: Communication

Existence of communication strategy and plan: A funded communication strategy is in place.

Strategy for community mobilization: Interpersonal communication, engagement of traditional leaders, mass media and peer to peer mobilization.

Involvement of grassroots organizations and networks: Minimal activities in 2012.

Pillar 5: Resource mobilization

GFATM funding: Application for phase 2 grant has been submitted, awaiting response.

Other Non-PEPFAR funding sources: None. Government of Namibia provides funding.

Pillar 6: Monitoring and evaluation

VMMC reporting systems: VMMC routine reporting system is in place. Data is collected separately.

VMMC partners' data coordination: Data flows through health sector.

Forum for VMMC data discussion: Discussion is done through the Technical Working Group committee.

National VMMC indicators: Number of adolescent and adult males circumcised by health professionals.

Annual report and programme review: Draft annual report available but annual review not yet conducted.

Pillar 7: Coordination and accountability

Coordination mechanism: Coordination of partners is done through Ministerial management meetings at all levels.

Existence VMMC Technical Working Group: TWG is chaired by the national VMMC Coordinator. Meets monthly. Agencies involved include PEPFAR, CSO, WHO, UNFPA, NGOs, MOD, MOIT & MOE. TWG does not carry out annual review.

Challenges

- Critical shortage of dedicated staff
- Low demand for MC services almost in all regions
- Frozen funds

Successes and lessons learnt

- MC programmes driven by dedicated staff members will facilitate service delivery
- Approval of task shifting by the Nursing Council - task shifting is really good and it is evident that trained registered nurses perform MC procedures with minimal or no adverse events.

RWANDA¹⁰



Profile

1. Population: 11.7 million (2012)*
2. HIV prévalence: 3.0% (2010)**
3. MC prevalence at baseline: 12.0% (2005)#
4. Adult 80% MC target: 1,746,052
5. Total number of MCs 2008–2012: 165,405

Pillar 1 : Leadership and advocacy

Existence of VMMC focal person: MoH VMMC focal person is in post.

Partners' support: (a) WHO; (b) UNICEF; (c) PEPFAR (d) GFATM (technical assistance in preparing country documents).

Involvement of other Ministries/programmes:

Ministry of Defense: Has a special team working with Jhpiego for VMMC in men in uniform (military and police);

Education: Involved in sensitization on VMMC in schools

Existence of national VMMC champions: There are national VMMC champions. Their most useful activity was a radio spot targeting the media and dispelling myths and misconceptions.

Existence of sub-national level VMMC champions: There are also sub-national champions covering the entire country. Their most successful activities were advocacy to national and community decision makers.

Missions conducted: A mission to Botswana for training was conducted in 2012.

Existence of advocacy strategy: Advocacy strategy is available.

Events to support VMMC: VMMC campaigns

Involvement of women and girls: Tools targeting women, girls and young people have been developed. Female partners (women and girls) of uncircumcised men have played a crucial role in encouraging men to undergo MC; encouraging men to take part in couple counseling and testing as part of the MC process and; encouraging men to adhere to the recommended sexual abstinence period and other behaviours post-MC.

¹⁰ * Source for population data: State of the World Population 2011. UNFPA, New York, USA **Source for HIV prevalence data: Rwanda Demographic and Health Survey, 2010. #Source for MC at baseline data: Rwanda Demographic and Health Survey, 2005

Pillar 2: Country implementation

Planning: Strategic and operational plan covers 2 years and is costed at US\$5,905,620. Annual target is 350,000. Detailed operation plans for 2012 and 2013 are available.

Service delivery statistics: Total MCs Jan-Dec 2012 = 138,711. Age group disaggregation: < : <1yr=714, 1-14yrs=16,485 and >15yrs=121,512

HIV Testing: 80% of clients accepted HIV testing, and 0.6% tested HIV-positive.

Service delivery approach: VMMC is not integrated into infant services, but into adolescent health services.

Procurement and supplies: No information available.

Capacity building: Category of staff trained on VMMC in 2012: Doctors and nurses.

Quality assurance (QA): A QA plan is available. No QA activities carried out in 2012.

Moderate and severe Adverse Events (AE) rate: 0.002% (533/277376). AE reporting system is not defined

Pillar 3: Innovation for scale-up

Research on male circumcision devices: Research on VMMC using PrePex method was conducted on 1,000 men.

Other male circumcision research: None.

Human resource innovations: Task-shifting policy is in place and being implemented.

Pillar 4: Communication

Existence of communication strategy and plan: Costed communications strategy in place, funded by UNICEF.

Strategy for community mobilization: National TV, radio stations and online avenues are used for community mobilization. These include web-based media outlets such as Igihe.com and Umuganga.com. Community Health Workers are also used to mobilize communities.

Involvement of grassroots organizations and networks: Through collaboration with community health workers, civil society, and the private sector to conduct door-to-door campaigns; Training/capacity development of community health workers; Orientation of media personnel (electronic and print); Sensitization of community leaders.

Pillar 5: Resource mobilization

GFATM funding: GFATM grant for VMMC is currently ongoing.

Other Non-PEPFAR funding sources: One UN Fund. Government of Rwanda provides funding for VMMC.

Pillar 6: Monitoring and evaluation

VMMC reporting systems: There is a routine reporting system which is parallel to the HMIS.

Forum for VMMC data discussion: There is a forum where data is discussed and agreed upon before it is sent to WHO.

National VMMC indicators: Number of people circumcised disaggregated by age group as well as adverse events rate.

Annual report and programme review: 2012 annual report is incorporated into HIV annual report.

Pillar 7: Coordination and accountability

Coordination mechanism: VMMC Technical Working Group

Existence VMMC Technical Working Group: The TWG is chaired by the HIV prevention unit, meets quarterly and membership includes RBC, UNICEF, CDC, USAID.

Successes

- Strong political will for VMMC scale-up
- Community engagement to influence behavioral change-decentralized community network exists
- Hotline to answer questions on MC and HIV in general
- Monitoring & Evaluation system in place: TRACnet.

Challenges

- Limited equipment and supplies
- Low-income population
- Rapid scale up
- Human resource challenges
- Transport challenges for clients.

SOUTH AFRICA¹¹



Profile

1. Population: 50.7 million (2012)*
2. HIV prevalence: 18.0% (2009)**
3. MC prevalence at baseline: 44.0% (2009)#
4. Adult 80% MC target: 4,333,134
5. Total number of MCs 2008–2012: 864,210

Pillar 1: Leadership and advocacy

Existence of VMMC focal person: A national MoH VMMC focal person is in post.

Partners' support: In 2012, the MoH received support from PEPFAR (technical support and service delivery).

Involvement of other Ministries/programmes:

- (a) Ministry of Correctional Services: Provide onsite services to offenders.
- (b) Ministry of Education: Provide onsite services to students.

Existence of national VMMC champions: The national VMMC champions are the Minister of Health and King Goodwill Zwelithini.

Existence of sub-national level VMMC champions: There are 9 Provincial Champions covering 100% of sites. The most successful activities carried out by sub-national champions in 2012 involved creating awareness and demand; setting up and coordinating service delivery sites; training and providing staff; procuring supplies and equipment; and monitoring and evaluation of performance.

Activities of regional/country bodies: SADC supported policy update and resource mobilization for VMMC

Missions conducted: Conducted a mission to Rwanda to benchmark PrePex device. Lessons that were learnt include that it is good clinical practice to use the PrePex device; it is easy to use; has a short procedure time; can be used by lower cadre of health staff and has few adverse events.

Existence of advocacy strategy: There is a communication and advocacy strategy.

¹¹ * Source for population data: State of the World Population 2011. UNFPA, New York, USA **Source for HIV prevalence data: Department of Health, 2010. National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2009. #Source for MC at baseline data: National Community Survey on HIV/AIDS 2009.

Events to support VMMC: Successful events supporting VMMC were the “first things first campaign” for higher education launched by the Minister of Health and the World AIDS Day.

Involvement of women and girls: Issues of gender-based violence are part of group education for VMMC clients. Couple counseling has been introduced for VMMC. As part of communication strategy women are involved as mothers and sexual partners. Girls are involved as part of community mobilisers, peer educators and health promoters on campuses of higher education.

Pillar 2: Country implementation

Planning: Plan covers the period 2011/12 to 2012/13. The overall target is 4.3 million procedures. Annual targets for 2011/12 and 2012/13 are 500,000 and 600,000 respectively. There are detailed operational plans for 2012 and 2013.

Service delivery statistics: Total MCs Jan-Dec 2012 = 422,009.

48,751 of these were conducted during traditional ceremonies by General Practitioners.

HIV Testing: 75% of clients accepted HIV testing.

Service delivery approach: VMMC is not integrated in infant programmes but is integrated in adolescent health services as part of school health and out-of-school youth programmes. VMMC is linked to HIV testing and counselling (Provider Initiated HIV Testing) and STI screening through referral of clients for VMMC.

Procurement and supplies: No information available.

Capacity building: Categories of staff trained on VMMC in 2012: doctors, nurses, lay counselors and community outreach staff, health promoters, higher education peer educators.

Quality assurance (QA): QA plan in place. QA activities carried out in 2012 include SYMMACS study by Center for HIV Prevention Studies (CHAPS) and PEPFAR QA site visits.

Moderate and severe Adverse Events (AE) rate: <2% of moderate AE. There is a tool for VMMC surveillance through which AEs are reported to the MMC technical working group.

Pillar 3: Innovation for scale-up

Research on male circumcision devices: Pilot study on safety and acceptability of PrePex device in 3 provinces.

Other male circumcision research: VMMC research includes: SYMMACS study (Systematic monitoring of male circumcision scale-up); National Communication Survey; Demand creation qualitative studies where 9 post graduate students at University of Kwa-Zulu Natal will conduct research on MMC

Human resource innovations: Although there is no official policy on task shifting, the Department of Health has consulted with the South African nursing council, and permission has been granted for professional nurses to conduct circumcisions. However, task shifting has not been implemented.

Other staffing model innovations include: Use of clinical associates, community facilitators recruited through community based organizations to promote VMMC as part of sexual HIV prevention.

Pillar 4: Communication

Existence of communication strategy and plan: A communication strategy and plan are in place. The plan is costed and funded.

Strategy for community mobilization: Door-to-door mobilization, campaigns, community events and entertainment education (Brothers for Life), use of community/traditional leaders.

Involvement of grassroots organizations and networks: Through focus group discussions, designing and testing communication material, training of community outreach teams for MMC social mobilization.

Pillar 5: Resource mobilization

GFATM funding: GFATM grant Round 10 has been approved for VMMC.

Other Non-PEPFAR funding sources: None. Government provides 100% funding for the national target.

Pillar 6: Monitoring and evaluation

VMMC reporting systems: There is a VMMC reporting system through the existing Health Management Information Systems.

VMMC partners' data coordination: VMMC services by partners are provided at government health facilities. There are no stand-alone sites. Data are reported from facility level to district level, then to provincial level and finally national level.

Forum for VMMC data discussion: National MoH quarterly meetings and quarterly PEPFAR partners meeting are used to discuss data before reporting to WHO.

National VMMC indicators: Number of health facilities providing MMC services; number of clients counseled and tested for HIV; number of medical male circumcisions performed; and number of adverse events reported.

Annual report and programme review: There is a 2012 annual report, and quarterly reviews were conducted.

Pillar 7: Coordination and accountability

Coordination mechanism: MoH coordinates partners through quarterly meetings.

Existence VMMC Technical Working Group: The VMMC TWG is chaired by MoH VMMC focal person, meets bimonthly and is constituted by the following organizations: CDC, USAID, GFATM), device delivery partners, SANAC representative UNAIDS and WHO country focal persons. VMMC TWG does not carry out annual review of VMMC programme performance.

Successes

- Integration of MMC into traditional practice in Limpopo province – using general practitioners to conduct circumcisions at initiation schools
- Permission granted by the South African Nursing Council for professional nurses to conduct circumcisions
- Use of roving mobile teams to conduct high volume circumcisions in underperforming provinces

Challenges

- Human resources shortage
- Seasonality of circumcisions - high demand during winter months
- Integrating MMC into traditional practice

SWAZILAND¹²

Profile

1. Population: 1.2 million (2012)*
2. Adult HIV prevalence: 26% (2007)**
3. MC prevalence at baseline: 8.2% (2007)#
4. Adult 80% MC target: 183,450
5. Total number MCs 2008–2012: 48,083



Pillar 1: Leadership and advocacy

Existence of VMMC focal person: A national MoH VMMC focal person is in post.

Partners' support: (a) PEPFAR: All VMMC programmatic issues (b) WHO: technical support

Involvement of other Ministries/programmes:

- (a) Ministry of Education & Training: Advocacy and Demand creation for Back to School Campaign for in-school youth;
- (b) Ministry of Defense: Setting up and training of Surgical Marquees for VMMC Back To School (BTS) Campaign;
- (c) Ministry of Information and Broadcasting: Demand creation through mass communication-National radio and print media;
- (d) Maternal and Child Health Department: EIMC Integration programme in Public and Private Health Facilities

Existence of national VMMC champions: A Senior Prince who is a political leader and Regional Administrator serves as a national VMMC champion. He is circumcised and encourages traditional leaders to circumcise.

Existence of sub-national level VMMC champions: There are two local champions: A school teacher and Mr. Swaziland who conducted media interviews and recruited schoolboys for VMMC.

¹² * Source for population data: State of the World Population 2012. UNFPA, New York, USA **Source for HIV prevalence data: Swaziland Demographic and Health Survey, 2007. #Source for MC at baseline data: Futures Group Costing Study, 2007.

Missions conducted: Visits to Zimbabwe to observe the use of the PrePex device. Learnt about PrePex, demand creation; involvement of traditional circumcision and VMMC linkage; linkage with other health programmes. Based on lessons learnt, the country expects to implement programming for the PrePex; device and an improved referral system for the VMMC programme.

Existence of advocacy strategy: Advocacy strategy is in place. The most successful advocacy activities carried out in 2012 were: Ministry of Education involvement in VMMC school holidays activities with the launch of Back To School (BTS) campaign; National BTS Campaign co-launched by the Principal Secretaries of the ministries of Health and of Education and Training.

Events to support VMMC: Launch of the Soka Uncobe campaign by King Mswati III, thus fully endorsing male circumcision for Swazis; Trade Fair in August/September; soccer matches with soccer players as VMMC champions for youth; and Ministry of Health public events such as launches of various documents and annual MTN Swaziland bushfire festival.

Involvement of women and girls: Women as advocates and supporters of their sexual partner when circumcised. Girls, as school based VMMC promoters in support of and encouraging boys to circumcise.

Pillar 2: Implementation

Planning: A costed National Strategic Plan for the period 2009–2013. The national target is 80% of males 10-24 years circumcised by 2014. Annual targets are 10,000 MCs in 2012 and 12,000 MCs in 2013. Operational plan for 2012 is available. Currently working on the 2013 new strategic plan and operational plan. No information on funding for VMMC contributed by Government, partners and private sector.

Service delivery statistics: Total MCs Jan-Dec 2012 = 9,977. Age group disaggregation: <1yr=7;

1-9yrs=111; 10-14yrs=4,818; 15-19yrs=2,610; 20-24yrs=1,161; 25-49yrs=1,223; 50+yrs=47.

HIV Testing: 92% of clients had an HIV test. 1.7% tested HIV-positive.

Service delivery approach: VMMC services are integrated into infant and adolescent health services. VMMC is linked to (a) STI care (b) HTC services; (c) Clients tested positive for HIV as part of VMMC services are provided ART care including CD4 count

Procurement and supplies: A large consignment of VMMC equipment and supplies was handed over to the implementing partner by Supply Chain Management System (SCMS) to manage at the same time that processes to empower the central medical stores (CMS) to take up the responsibility are being implemented. Challenges: Contract between SCMS and PSI will expire this year while supplies will run till April 2014; expiring circumcision kits and space for bulk procurement; and CMS is undergoing systems change and therefore not ready to assume procurement role for VMMC.

Capacity building: Categories of staff trained in 2012: doctors and nurses.

Quality assurance (QA): QA plan is in place. Facility readiness assessments were conducted for those facilities that were about to provide VMMC services either at fixed public sites or outreach sites.

Moderate and severe Adverse Events (AE) rate: Lowest rate was 1.4% and highest rate of 2.1% during campaign mode in 2012.

Pillar 3: Innovation for scale-up

Research on male circumcision devices: None

Other male circumcision research: i) PSI conducted a study on the determinants and barriers to EIMC uptake. Findings were: Parents' fears that baby is too small to be exposed to circumcision; Basic knowledge on EIMC is still low in the country; Decision to circumcise should be left to the child to take when they are old enough. ii) Qualitative study on the low utilization of male circumcision services in Kwaluseni, Findings were: Fear of loss of sexual pleasure among uncircumcised men; VMMC perceived to be less protective than condoms in preventing HIV transmission; Men's fear of irreversibility of VMMC and suspicion of tempering with God's natural creation; and Sexual partners fear of lowered risk perception among circumcised men (disinhibition)

Human resource innovations: A draft task shifting policy is in place.

Pillar 4: Communication

Existence of communication strategy and plan: A communication strategy is in place.

Strategies for community mobilization: Societies Tackling AIDS through Rights (STAR) emphasises the need for community-led solutions that are derived from sex and gender specific community dialogue groups that last more than eight weeks, followed by community open health days. This approach helps resolve negative social norms and other barriers that impede VMMC scale-up. The strategy is being implemented alongside other community-friendly activities such as street soccer, a strategy that specifically targets men and boys to create VMMC demand. Through community-based facilitators, the nation is able to mainstream and create demand for VMMC in churches, schools and other traditional structures.

Involvement of grassroots organizations and networks: As much as VMMC in Swaziland is currently led by the MoH and international NGOs, a deliberate effort to capacitate grassroots organizations such as Family Life Association (FLAS) and The Luke Commission (TLC) is ongoing. The Ministry of Health has created a network of other community structures that play a pivotal role in the implementation of the VMMC demand creation activities, including school-based headmasters, school champions (circumcised boys who are now MC advocates), school support teams (comprised of 2 school teachers, 2 students, parents and community-based police), church leaders and soccer team coaches.

Pillar 5: Resource mobilization

GFATM funding: Anticipated in second half of 2013.

Other Non-PEPFAR funding sources: None. No information on VMMC funding by Government

Pillar 6: Monitoring and evaluation

VMMC reporting systems: Routine reporting system available. Aim is to have a fully integrated MC M&E system into the HMIS at national level on key indicators. National MC reporting tool is being piloted.

VMMC partners' data coordination: Agreed indicators and data collection tools among MC stakeholders form the basis of the coordination with ad hoc consultative meetings.

Forum for VMMC data discussion: Technical Working Group.

National VMMC indicators: Number of circumcisions done disaggregated by age, region, and HIV status; number of adverse events disaggregated by severity; proportion of clients presenting for VMMC with STI.

Annual report and programme review: Annual report is available. Annual programme review not done.

Pillar 7: Coordination and accountability

Coordination mechanism: Stakeholder meetings and regular Technical Working Group meetings.

Existence VMMC Technical Working Group: National VMMC focal person chairs the TWG which meets quarterly. TWG constituted by PSI, PEPFAR, UNAIDS, Department of Defense, FLAS, PLWHA, UNICEF, WHO. TWG does not conduct programme review currently.

Successes

- The younger males of school age are more willing to go for VMMC services
- Campaigns targeting specific groups of the male population like the BTS campaign tend to attract all men across all ages
- Integration of EIMC services in public and private health facilities.

Challenges

- Skilled personnel for adult VMMC, especially doctors, hard to find
- Unwillingness of the adult male population to come for VMMC services
- Not all public sector facilities have integrated the VMMC service as part of daily services available
- Uncertainty of funding of MoH led activities, as PEPFAR does not fund MoH directly
- Using lessons learnt from the integration of EIMC services in health facilities into adult MC integration.

TANZANIA¹³

Profile

1. Population: 44.9 million (2012)*
2. Adult HIV prevalence: 5.1% (2008)**
3. MC at baseline: 70% (2008)**
4. Adult 80% MC target: 2,860,825
5. Total number MCs 2008–2012: 322,800



Pillar 1: Leadership and advocacy

Existence of VMMC focal person: A national MoH VMMC focal person is in post.

Partners' support:

- (a) WHO: Technical support
- (b) PEPFAR: Technical and financial support
- (c) Bill & Melinda Gates Foundation: Financial support through WHO.

Involvement of other Ministries/programmes: None.

Existence of national VMMC champions: None.

Existence of sub-national level VMMC champions: None.

Missions conducted: No missions to other countries.

Existence of advocacy strategy: There is currently no advocacy strategy. Locally targeted advocacy activities include visits to schools to encourage students to seek VMMC; announcement through local radio and TV spots; use of influential people such as local authorities & religious leaders; and distribution of posters and leaflets.

Events to support VMMC: No specific events were used to promote VMMC.

Involvement of women and girls: Women are involved in supporting men and boys to circumcise and girls are involved in advocacy.

¹³ * Source for population data: State of the World Population 2011. UNFPA, New York, USA ** Source of data for Adult HIV prevalence and male circumcision prevalence at baseline: Tanzania HIV and Malaria Indicator Survey (THMIS) 2007/08.

Pillar 2: Country implementation

Planning: The National Strategic Plan is for period 2010–2015. Overall VMMC target is 2,830,000. Regional operational plans 2011-12 costed at US\$33,926,552 are in place. There is no detailed national operational plan. There is no information available on the proportion of resources provided by the Government of Tanzania and partners to VMMC.

Service delivery statistics: Total MCs Jan-Dec 2012 = 183,480. No age disaggregation available.

HIV Testing: 99% of clients accepted testing and 1% tested HIV-positive.

Service delivery approach: VMMC integration into infant services has started with a demonstration project in one province. VMMC is not yet integrated into adolescent programmes

Procurement and supplies: Erratic supplies and shortages of commodities as a result of the lack of central national procurement system.

Capacity building: Categories of staff trained in 2012: Assistant Medical Officers, Clinical Officers, Assistant Clinical Officers, registered and Enrolled Nurses.

Quality assurance (QA): There is no VMMC specific QA plan but an integrated HIV/AIDS Quality Improvement Plan was developed in 2010. A national QA activity was conducted in 2012 with support from PEPFAR.

Moderate and severe Adverse Events (AE) rate: Information on AE rate not available.

Pillar 3: Innovation for scale-up

Research on male circumcision devices: Partners are conducting acceptability studies: Jhpiego – PrePex; and Engenderhealth – Shang Ring.

Other male circumcision research: None.

Human resource innovations: There is no task-shifting policy. Task-shifting and sharing activities are implemented for all health services in Tanzania

Pillar 4: Communication

Existence of communication strategy and plan: There is no VMMC specific communication strategy or costed plan. VMMC is included in the HIV/AIDS communication strategy.

Strategy for community mobilization: Visits to schools to encourage students to present for VMMC; announcements through local radio and TV spots; use of influential people (Local Authorities, Religious leaders) and; distribution of posters and leaflets with information on MC benefits and where and when to get services.

Involvement of grassroots organizations and networks: Through influential people in the community

Pillar 5: Resource mobilization

GFATM funding: No GFATM funding.

Other Non-PEPFAR funding sources: None. No information available on the proportion of resources provided by the Government of Tanzania.

Pillar 6: Monitoring and evaluation

VMMC reporting systems: National monitoring and evaluation tools are available for all partners to use.

Forum for VMMC data discussion: Through Technical Working Group.

National VMMC indicators: Number of VMMC procedures performed as part of the minimum package of VMMC for HIV prevention; proportion of males circumcised in the intended population; prevalence of circumcision among men aged 15-49; number and percentage of males circumcised who are tested for HIV; number and percentage of circumcised males experiencing at least one adverse event during or following surgery; number of circumcised males who return for follow up after 48 hrs and after 7 days; number of providers trained in MC according to national standards; number of MC clients referred for other services; and number of MC clients referred from other services.

Annual report and programme review: There is no annual report. Programme review conducted.

Pillar 7: Coordination and accountability

Coordination mechanism: Technical Working Group.

Existence VMMC Technical Working Group: MOHSW chairs the TWG, which meets quarterly. Its membership includes MOHSW, PEPFAR Implementing partners, Focal Points from implementing regions, WHO, UNICEF, UNAIDS, UNFPA. TWG conducts annual programme review during its first quarter meeting.

Successes

- Widely accepted VMMC in the non-circumcising regions.

Challenges

- Financial constrains
- Absence of national operational plan

UGANDA¹⁴

Profile

1. Population: 35.6 million (2012)*
2. Adult HIV prevalence: 6.4% (2004)**
3. MC prevalence at baseline: 25% (2004)**
4. Adult 80% MC target: 4,245,184
5. Total number MCs 2008–2012: 467,318



Pillar 1 : Leadership and advocacy

Existence of VMMC focal person: A national MoH VMMC focal person is in post.

Partners' support: (a) PEPFAR (CDC and USAID): Financial and technical support, (b) UN Agencies (financed through Irish Aid and DfID): Financial and technical support.

Involvement of other Ministries/programmes: (a) Ministry of Defense: Implemented SMC within the forces; (b) Ministry of Education: Through advocacy facilitated the targeting of school boys for SMC; (c) MCH, ASRH departments: mobilization.

Existence of national VMMC champions: There is a national VMMC champion, Dr. Wandira Kazibwe, a female, who is also a senior presidential adviser on health and part of the Champions for an HIV-Free generation.

Existence of sub-national level VMMC champions: None.

Activities of regional/country bodies: Helped conduct VMMC camps in 10 districts; trained 30 circumcisers; drafted VMMC recording and reporting forms and web-based reporting platform.

Missions conducted: No missions to other countries.

Existence of advocacy strategy: There is an advocacy strategy. The advocacy activities conducted included: mobilization of local leaders through the umbrella organization, AMICAALL. These included mayors of town councils and municipalities who were mobilized at the national level to promote the combination prevention strategy that includes VMMC. In several districts, champions conducted week-long community mobilization activities, linking VMMC with HTC.

Events to support VMMC: District-based VMMC capacity building camps in 5 districts.

¹⁴ * Source for population data: State of the World Population 2012. UNFPA, New York, USA

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

Involvement of women and girls: As mobilizers and educators.

Pillar 2: Country implementation

Planning: National Strategic Plan for period 2011-2015 is available; there is no operational plan. The Government of Uganda does not provide funding for VMMC. Partners provide 90% of funding.

Service delivery statistics: Total MCs Jan-Dec 2012 = 368,490. Age group disaggregation: <5 yrs=4,573; 5-17yrs=93,899; ≥18yrs=270,018.

HIV testing: Information not available.

Service delivery approach: VMMC is not integrated into infant and adolescent health services. VMMC is linked with HCT, STI, ART and RH either as part of a comprehensive service provision or through referral.

Procurement and supplies: Main challenge is stock out of surgical kits.

Capacity building: Categories of staff trained in 2012: clinical officers, nurses and midwives.

Quality assurance (QA): QA plan not in place. Developed QA tools that are in the process of approval by the Ministry of health.

Moderate and severe Adverse Events (AE) rate: Adverse event reporting form is used at operation level to report on adverse events. This feeds into the VMMC register from which the monthly reporting form is completed. Monthly reporting form captures indicators that are reported to national level through HMIS.

Pillar 3: Innovation for scale-up

Research on male circumcision devices: Research on Prepex is ongoing

Other male circumcision research: None.

Human resource innovations: There is no policy on task-shifting. However, in order to strengthen capacity for delivery of VMMC services beyond hospitals, clinical officers, nurses and midwives were oriented in various aspects of VMMC service delivery. These cadres were trained in counseling, recording and the conduct of MC in selected high impact districts in Uganda. A total of 150 such cadres have received this training.

Pillar 4: Communication

Existence of communication strategy & plan: Communication strategy in place but no communication plan.

Strategy for community mobilization: Engaging local leaders; using local media (radio); using mobile vans for community mobilization.

Involvement of grassroots organizations and networks: Through the network of mayors and municipal leaders for community engagement especially in urban areas.

Pillar 5: Resource mobilization

GFATM funding: Used mainly for procurement of antiretroviral medicines.

Other Non-PEPFAR funding sources: None. Government of Uganda does not provide funding for VMMC.

Pillar 6: Monitoring and evaluation

VMMC reporting systems: There is a routine VMMC reporting system through the Health Management Information System.

VMMC partners' data coordination: VMMC implementers are encouraged to integrate their VMMC data into monthly HMIS summary report of the facilities they support. VMMC data captured during camps is channeled through the nearby health unit for onward transmission to MoH through HMIS.

Forum for VMMC data discussion: No forum where VMMC data are discussed before reporting to WHO.

National VMMC indicators: Number of males circumcised as part of the minimum package of SMC for HIV prevention; proportion of males who underwent circumcision and HIV testing on site, as part of the SMC package in the reporting period; number of males who were circumcised and experienced at least one adverse event; proportion of males 15-49 years who are circumcised; proportion of males circumcised as part of the VMMC HIV prevention package having sex in the first 6 weeks post-operatively; and proportion of men and women, 15–49 years, who have correct knowledge about SMC for HIV prevention.

Annual report and programme review: No 2012 annual report. Annual review was not performed.

Pillar 7: Coordination and accountability

Coordination mechanism: The MoH established a national VMMC task force that has various representatives from key players. The task force serves as a Technical Working Group.

Existence VMMC Technical Working Group: The Assistant Commissioner chairs the TWG. It is supposed to meet quarterly but this is not adhered to. Membership includes: hospitals, implementing partners, MoH, UN agencies and AIDS development partners. TWG did not conduct annual review.

Successes

- Despite negative sentiments at local level, the demand for VMMC is overwhelming and there is a need to plan appropriately to meet the demand.
- Outreach model using camps to deliver huge outputs in a short time
- Training VMMC teams in facilities

Key challenges

Inability to meet the demand for VMMC due to shortage of surgical kits

ZAMBIA¹⁵

Profile

1. Population: 13.8 (July 2012 est.)
2. Adult HIV prevalence: 14.3% (2007)**
3. MC prevalence at baseline: 12.8% (2007)**
4. Adult 80% MC target: 1,949,292
5. Total number MCs 2008–2012: 340,992



Pillar 1: Leadership and advocacy

Existence of VMMC focal person: A national VMMC Coordinator based in the Ministry of Community Development Mother and Child Health (MCDMCH) is in post.

Partners' support:

- (a) WHO: Technical assistance
- (b) PEPFAR: Funding for service delivery, training, mass media and demand generation
- (c) BMGF: Funding for service delivery, research, and governance & coordination
- (d) Global Fund: Funding for service delivery and procurement of equipment.

Involvement of other Ministries/programmes:

(a) Ministry of Defense: provides MC services in their facilities, targeting their work force and their families; (b) Ministry of Finance and Education: demand generation in collaboration with MoH/MCDMCH; (c) Ministry of Home Affairs: MC services in prisons and their facilities.

Existence of national VMMC champions: There are national VMMC champions (2 traditional Chiefs & 2 Members of Parliament [MPs]). Most useful activities were TV adverts, media advocacy and outreach to parliament.

Existence of sub-national level VMMC champions: There are various sub-national level leaders who promote MC in communities across the country.

Missions conducted: No missions to other countries.

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

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

Existence of advocacy strategy: There is a national VMMC advocacy strategy. The most successful advocacy activities were: Advocacy to Members of Parliament (MPs); advocacy through chiefs in non-circumcising communities and national VMMC campaigns.

Events to support VMMC: VMMC operational plan launch and national VMMC campaign month.

Involvement of women and girls: A female Member of Parliament (MP) and a female Minister of Traditional and Chiefs Affairs are two national champions. Specific messaging aimed at female partners is also part of the communication strategy.

Pillar 2: Country implementation

Planning: Strategic plan covers the period 2012–2015 and is costed at US\$196.4 million. Overall target 1.864 million. Detailed operational plans for 2012 and 2013 are available. Government provides 14% and Donors 86%. Estimated funding gap is \$82.6 million.

Service delivery statistics: Total MCs Jan-Dec 2012 = 173,992.

Age group disaggregation: <15yrs=67, 401; >15 yrs=106,591.

HIV Testing: 100% of clients accepted testing, and 4% tested HIV-positive.

Service delivery approach: EIMC has been integrated into infant care programmes at selected sites in 3 provinces through partner support. Scale-up is planned as part of Operational Plan Phase II starting in 2016. VMMC is not integrated in adolescent services. VMMC is linked to HTC; STI screening; and ART either as part of the comprehensive VMMC services provision or through referrals.

Procurement and supplies: The main challenges are long lead times for procurement of consumables which lead to stock outs during December campaign in some provinces; slow procedures for UNDP procurement of reusable tools under the GFATM which led to inadequate number of sets at many MoH facilities; and global shortage of lignocaine led to stock outs in many provinces.

Capacity building: Categories of staff trained in 2012: doctors, clinical officers, nurses and midwives.

Quality assurance (QA): QA plan is in place. Quality assessment was conducted in partnership with PEPFAR External Quality Assurance (EQA) process.

Moderate and severe Adverse Events (AE) rate: 0.5% (of which 90% are moderate). AEs have been added to the national HMIS.

Pillar 3: Innovation for scale-up

Research on male circumcision devices: The protocol for a PrePex acceptability trial was developed and submitted for approval.

Other male circumcision research: Ongoing longitudinal study of sexual behavior post male circumcision.

Human resource innovations: There is a policy on task shifting. Clinical officers and nurses are allowed to conduct male circumcisions. Other innovative staffing models include: (i) At lower level health facilities with a trained MC provider, clients are booked in advance. (ii) Placing trained staff at general hospitals in selected provinces, as well as providing all the required support including renovations of the structures (MC theatres). During campaign months, general hospitals also conduct outreach in addition to static services.

Pillar 4: Communication

Existence of communication strategy and plan: Communication strategy is in place but not costed.

Strategy for community mobilization: Existing lower structures are being utilized for community mobilization. These are: Community Health Workers (CHWs) who are attached to health facilities and Neighborhood Health Committees (NHCs) which are based in the community – both conduct sensitizations in surrounding communities; and community radio stations which were found to be an effective demand generation tool. Implementing partners also partnered with Grassroots Soccer in 2012 to offer MC services at soccer tournaments. Grassroots Soccer has included MC as part of their core educational curriculum.

Involvement of grassroots organizations and networks: Through partner support from Communications Support for Health (CSH), community-based society organizations (CSOs) are contracted in selected areas to do demand generation/communications for VMMC. CSH also supports community-based phone radio shows for VMMC demand generation especially during MC campaign months.

Pillar 5: Resource mobilization

GFATM funding: There is GFATM funding through the Churches Health Association of Zambia for VMMC (42,000 MCs in 2012), and an additional US\$1.1M was proposed in the round 8 & 10 Phase II concept note that was recently submitted.

Other Non-PEPFAR funding sources: BMGF. Government provides 14% of MC funds

Pillar 6: Monitoring and evaluation

VMMC reporting systems: VMMC indicators have been included in HMIS, awaiting the rollout of HMIS. A monthly reporting template exists that is used to capture data from all implementing partners

VMMC partners' data coordination: All partners complete monthly reporting template and send to National MC Coordinator's office. The data is merged, analyzed, discussed in the TWG and then disseminated.

Forum for VMMC data discussion: TWG

National VMMC indicators: Number of MCs disaggregated by age (<1, 1-14, 15-49 & ≥50 years) & province

Annual report and programme review: No annual report. No annual review conducted.

Pillar 7: Coordination and accountability

Coordination mechanism: VMMC service delivery is now under the Ministry of Community Development Mother and Child Health (MCDMCH). VMMC is under the directorate of Mother and Child Health. National VMMC Programme Coordinator and VMMC focal point persons at provincial and district levels are in post.

Existence of VMMC Technical Working Group: Chaired by the Director of Mother and Child Health, who is deputized by Deputy Director Epidemiology and Disease Control and the VMMC National Coordinator in her absence. Meets monthly and as the need arises. Agencies constituting the TWG include: all implementing/collaborating partners that include Government of the Republic of Zambia, CHAZ, CIDIRZ, CSH, JHPIEGO, MSI, SFH, USAID/USA Embassy, CDC, ZDFHI360/ZPCTII, Population Council and WHO. TWG carries out annual reviews of the VMMC programme performance.

Successes

- **Improved Programme coordination.**
- **Launch of the National Operational Plan** which established district level annual targets of 80% coverage by 2015; provided the annual cost of scale as well as a funding gap analysis; defined the MoH governance structure for MC at national, provincial and district level; and defined the standardized list of MC supplies for all partners.
- **Media sensitization:** The national programme held a media sensitization event with journalists so they could act as champions to disseminate regular and correct information regarding VMMC and dispel any myths and misconceptions.
- **Advocacy:** high level advocacy with members of parliament and chiefs was conducted and three of them became national champions of the programme.

Lessons Learned

- Strong leadership and coordination at various levels is cardinal to the success of the programme: e.g. areas with better leadership and coordination at provincial and district levels are doing well.
- Advocacy among chiefs and parliamentarians is important in addressing myths and misconceptions, as well as creating demand especially among non-circumcising tribes.

Challenges

- **Leadership challenges at provincial level:** Coordination at various levels still remains a challenge (e.g. very few provinces hold routine or campaign coordination and planning meetings).

- **Delayed national monitoring and evaluation:** Delays in the rollout of revised HMIS have resulted in challenges in tracking VMMCs not captured by partner reporting.
- **Inactive VMMC service providers:** Despite having over 900 trained providers, very few remain actively involved in the programme.
- **High levels of knowledge, low uptake:** Despite research suggesting high levels of MC knowledge within Zambia, few clients actually take the step to access the service.
- **Competition among partners:** Has a negative impact on programme performance, with partners in some instances perceived as rivals to provincial staff.
- **VMMC supplies and kits:** Stock outs of VMMC consumables still occur, despite constant reminders for partners, provinces/districts to adequately plan for programme supplies especially in facilities that are not supported by partners.

ZIMBABWE

Profile

1. Population: 13.0 million (2012)*
2. HIV prevalence in 2011: 15% **
3. MC at baseline: 10%
4. Adult MC 80% target: 1,912, 595
5. Total number MCs 2008–2012: 91,335



Pillar 1: Leadership and advocacy

Existence of VMMC focal person: A national MoH VMMC focal person is in post.

Partners' support:

- (a) **UNFPA:** technical support; human resource capacity strengthened at local level via training of MOHCW personnel; financial support for PrePex study; IEC materials development and support for broadening the scope of nursing practice to include VMMC, through learning visit to Zambia;
- (b) **PSI:** funding for VMMC service delivery training and materials development and advocacy activities. Human resource capacity strengthening of MOHCW, support to PrePex and neonatal VMMC;
- (c) **WHO:** support to the broadening the scope of nursing practice through supporting the learning visit to Kenya;
- (d) **USG:** procurement and distribution of VMMC commodities, as well as supporting service delivery activities through PSI and Zimbabwe Association of Church Related Hospitals;
- (e) **DFID:** funding of VMMC activities in the integrated support programme; and
- (f) **National AIDS Council:** demand creation activities at local level and procurement of VMMC commodities using National AIDS Trust Fund (AIDS Levy).

Involvement of other Ministries/programmes:

- (a) **Ministry of Finance:** Drawing up budgets for HIV and AIDS in general and collection of the AIDS Levy and forwarding it to the National AIDS Council;

¹⁶ * Source for population data: State of the World Population 2012. UNFPA, New York, USA

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

- (b) Ministry of Education: Permitting mobilization of students within the appropriate age groups to be referred for MC in schools, and
- (c) Ministry of Defence: provides VMMC services to members of the uniformed forces as well as members of the public and provides back-up human resource base during VMMC campaigns.

Existence of national VMMC champions: National champions include two prominent musicians (Oliver Mutukudzi and Winky D), and members of parliament. One prominent activity during 2012 was formation of “Parliamentarians against AIDS Committee”.

Existence of sub-national level VMMC champions: None.

Missions conducted: Conducted missions to learn how countries managed to shift from doctor-led to nurse-led VMMC i.e. task-shifting from doctors to nurses – the term “Broadening the scope of nursing practice in Zimbabwe” will be used.

Existence of advocacy strategy: VMMC advocacy strategy is available.

Events to support VMMC: Events used to support VMMC include World AIDS Day and male circumcision campaigns during school holidays.

Involvement of women and girls: VMMC materials were produced for women to support their spouses and sons and other male relatives to undergo VMMC. There was no deliberate attempt to target girls in 2012.

Pillar 2: Country implementation

Planning: Strategic plan is for 2010–2015. Operational plan still to be developed. Overall target is 1.3 million male circumcisions. There was no detailed operational plan for 2012. There is a detailed operational plan for 2013. The Government of Zimbabwe provides 5% of funding and Partners, 95%. The private sector contribution has not been quantified.

Service delivery statistics: Total MCs Jan-Dec 2012 = 2 40,755. Age group disaggregation: 0-14yrs=11087; 15-19yrs=12568; 20-24yrs=6916; 25-29yrs=4503; 30-49yrs=5193; ≥50yrs=488.

HIV Testing: 98% of clients accepted HIV testing. Information on rate of seropositivity is not available.

Service delivery approach: VMMC has not yet been integrated into infant care programmes and adolescent health services. However, there are ongoing pilot studies on the Accu-Circ and the Mogen clamp devices.

Procurement and supplies: The major challenge has been shortages, especially of local anaesthesia, in Q1 of 2012 due to a global shortage. Gloves were usually of poor quality and not suitable for use.

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

Quality assurance (QA): QA plan is in place. A quality audit was carried out with support from PEPFAR.

Moderate and severe Adverse Events (AE) rate: 0.5% (191/40,775). A reporting system from site to national programme level using a specific tool exists.

Pillar 3: Innovation for scale-up

Research on male circumcision devices: Assessment of the safety and efficacy of the PrePex device when utilized by registered general nurses with two years' experience.

Other male circumcision research: PrePex bridging studies among adolescents and HIV-positive diabetics as well as when the device is used by primary care nurses (PCN). PCNs are the least qualified nurses with an instruction period of 18 months and are generally stationed at rural health facilities. All other nurses have a 3-4 year period of instruction.

Human resource innovations: Policy on task-shifting is included into the VMMC Policy and does not exist as a separate policy. The process of task-shifting to nurses i.e. "Broadening the Scope of Nursing Practice" has already been initiated.

Pillar 4: Communication

Existence of communication strategy and plan: Communication strategy is in place. No costed plan.

Strategy for community mobilization: Use of mass media, village health workers and behaviour change facilitators; production and distribution of VMMC IEC materials; edutainment through use of drama groups; periodic road shows are performed in specific localities.

Involvement of grassroots organizations and networks: Through village health workers, behaviour change facilitators, and community mobilisers who are all identified by the local community to work in that community. Local NGOs and CBOs hold periodic community meetings where HIV and AIDS issues in general and VMMC is discussed.

Pillar 5: Resource mobilization

GFATM funding: None.

Other Non-PEPFAR funding sources: None. Government provides 5% of MC funding

Pillar 6: Monitoring and evaluation

VMMC reporting systems: A routine reporting system exists.

Forum for VMMC data discussion: There is no formal forum but inputs are sought from partners before data are reported to WHO.

National VMMC indicators: Number of institutions providing VMMC; number of males receiving group education; number receiving individual counseling; number of males tested for HIV; number of adverse events reported; and number of those that undergo the surgical procedure vs the national target

Annual report and programme review: Production of the 2012 annual report in progress. No annual review

Pillar 7: Coordination and accountability

Coordination mechanism: National VMMC steering committee meets every two months. Technical Working Groups (TWGs) meet monthly i.e. TWGs include advocacy and communication; service delivery; training; and logistics. The MoHCW chairs the VMMC steering committee and is constituted by the following agencies: UN Agencies, (WHO and UNFPA) USG (USAID CDC) JSI, PSI, ZNFPC, NAC, MOHCW, ZACH, and Logistics dept. of MOH. TWGs are constituted by: PSI, ZACH, ZNFPC, UNFPA, NAC, ZICHIRE, JSI, Logistics unit, NATPARM (Directorate National Pharmaceutical Service).

Existence VMMC Technical Working Group: TWG is chaired by MoHCW. It meets monthly. The TWG includes the key organizations involved in the VMMC programme. In service delivery training and logistics TWG the following are members: PSI, ZACH, ZNFPC, UNFPA, NAC, ZICHIRE, JSI, logistics unit, NATPARM (Directorate National Pharmaceutical Services).

Successes and lesson learned

- Leadership at various levels, and, in particular, the engagement of parliamentarians .
- Completion of male circumcision devices study, which demonstrated that the device is safe and can be used safely by both physicians and nurses.
- The MOVE model has been critical in the attainment of better results with limited human resources especially doctors since the country is running a doctor led programme.

Challenges

- Inadequate personnel for VMMC
- VMMC programme is doctor-led and competing priorities in health facilities hamper scale up efforts.
- Inadequate financial resources for VMMC.
- Negative media publicity especially relating to the credibility of the randomized controlled trials as well as the meaning of 2010 results from the Demographic and Health Survey.
- Inadequate demand for services in some health facilities.
- Delays in reviewing allowing nurses to circumcise.
- Low levels of health workers` remuneration resulting in limited availability of some trained health workers as they seek better paying opportunities outside the country.
- Internal mobility of VMMC trained personnel.

CHAPTER 5: CONCLUSION

CHAPTER 5: CONCLUSION

As the previous discussions reveal, at the same time that important progress has been made in bringing VMMC to scale, key challenges slow VMMC uptake. However, a number of successes have been recorded and opportunities exist for rapid scale-up.

5.1 Successes and opportunities

Leadership

Most of the 14 priority countries have continued to show strong political will and leadership in the scale up of VMMC. Most ministries of health have provided technical leadership and strengthened their coordination roles by appointing focal persons for VMMC. Effective leadership on VMMC involves champions and leaders at various levels. Engagement of political and traditional leaders and other gatekeepers has helped improve acceptance of VMMC, address myths and misconceptions, and improve demand even among traditionally non-circumcising communities. Furthermore, support from partners continues to be strong, and multisectoral involvement in VMMC has become evident as other ministries and programmes participate in the VMMC scale-up.

Implementation

With support from various partners, most countries have expanded access to VMMC. This has resulted in an increased pace of scale-up in 2012. Most countries have developed targeted plans to guide implementation. Mass VMMC campaigns, outreach/mobile services and various demand creation innovations have made services more accessible. School-centred mobilization and service provision are being used by many countries. This is a valuable approach for the “catch up phase”, as an important share of the men in the target age group are in schools and other higher educational institutions.

Innovation

Growing interest in male circumcision devices has resulted in increased research attention. These devices have the potential to simplify the performance of the VMMC procedure and improve efficiency. Most countries are implementing staffing innovations, such as allowing non-doctors to perform VMMC procedures. This has helped alleviate the problem of limited human resources.

Communication

The majority of countries have communication/mobilization strategies, which are pivotal for demand creation. Community engagement and media sensitization to influence behaviour and increase demand is being used by most countries.

Resource mobilization

Technical and financial support is currently available from partners such as PEPFAR, World Bank, Bill & Melinda Gates Foundation and to a lesser degree the Global Fund and the UN family. Robust external support has made possible the scale-up of VMMC in resource-limited settings.

Coordination

Most countries have defined national coordination structures for VMMC, with similar structures also in place at sub-national levels in some countries. Coordinating bodies meet regularly and collaborate to accelerate scale-up, avoid duplication and harmonize service quality.

Monitoring and Evaluation

Most countries have reporting systems for VMMC and report data based on national indicators.

5.2 Way forward

Although priority countries continue to make progress in scaling up VMMC, substantial gaps persist, as coverage remains far below the targeted 80%. Key challenges include demand creation; availability of sustainable resources to meet demand; committed leadership at all levels of the health system; and innovations to address the resources gap.

The way forward is therefore:

- **Assisting countries in setting realistic MC targets**
- **Continuing to cultivate strong leadership at all levels**
- **Enhancing demand creation through innovative advocacy and communication approaches**
- **Continuing to develop innovative approaches to service delivery, including use of MC devices**
- **Diversifying funding from both government and partner sources in order to ensure sustainability**
- **Improving monitoring and evaluation to provide complete and timely information for decision making**
- **Improving procurement and supply management systems**
- **Establishing infant and adolescent MC services for the sustainability phase**
- **Documentation and sharing of innovative approaches to help countries improve their performance.**
- **Supporting the conduct of annual reviews in those countries**
- **Conducting a mid-term review of progress in implementation of the Joint Strategic Framework**
- **Strengthening partnerships with global and regional partners.**

ANNEX1: PARTNERS AND THEIR ROLES IN 2012 BY COUNTRY

Country	Partner	Role in VMMC
Botswana	ACHAP	<ul style="list-style-type: none"> • Programme planning • Campaign planning and implementation • Outreach SMC service provision • Data management and reporting • Performance based allowances for mobilisers and outreach teams • Transportation of personnel and clients during campaigns • Support for CBOs by sub-contracting them for community mobilization to generate demand for Safe Male Circumcision (SMC) services • Human resources at National level (SMC Advisor) • Human resources at districts levels: Doctors, Nurses, Health Auxiliaries, Counselors and Cleaners for 10 MOVE sites. • Infrastructures – Bought 4 porta cabins. • Procurement of supplies
	CDC/ PEPFAR	<ul style="list-style-type: none"> • Fully support the following Key SMC implementing partners in Botswana: Jhpiego; ITECH; PSI; Tebelopele; Supply Chain Management Services (SCMS) • Human resources at National level: SMC MOVE Project Manager, SMC data Officer, SMC Logistician, Two SMC Programme Officers. • Human resources at district level: Through ITECH and Jhpiego; Doctors, Nurses, Health Auxiliaries, Counselors, Cleaners, Site managers in 6 MOVE sites. Direct support to the DHMT 6 doctors. • All equipment for the above 6 MOVE sites • 2 “clinics in a box” • Stop-gap procurements of HIV test kits: 160,000 rapid HIV test kits • Procurement of 40,000 disposable MC kits
	World Bank/ BNAPS	<ul style="list-style-type: none"> • Procurement of Supplies and Equipment: 50,000 Disposable MC Kits; 20 Diathermy Machines and its accessories; 5 SMC-customized trucks/mobile self-contained procedure rooms (Delivery delayed); 4x4 vehicle for Support visits/ supervision; One Minibus for ferrying clients
		<ul style="list-style-type: none"> • System strengthening: Training of Volunteers; Support to local CBOs to conduct demand creation activities; Printing of various demand creation materials; District support (Funds disbursed to districts to implement VMMC services during campaigns) and; Strengthening of M&E
	WHO	<ul style="list-style-type: none"> • Technical support

Ethiopia	Jhpiego	Human and institutional capacity building through training health professionals and provision of VMMC supplies. Also provide awareness creation to Health Extension Workers (HEW) and Support counselors
	WHO	Technical support
Kenya	PEPFAR	Through USG agencies and implementing partners supported demand creation and services provision.
	World Bank	Provided funding used to support services provision in Teso and Turkana region.
Lesotho	WHO	Technical support
	WHO	Technical support for operational plan development
	USAID/ MCHIP through Jhpiego	Technical Assistance to Ministry of Health , trainings and quality assurance Service delivery of MC at public hospitals
	PSI	Service delivery for military
	LPPA	Service delivery
Malawi	CDC	Resources for coordination and supervision, development of strategic documents. Support for study tours. Support for capacity building in the public sector.
	WHO	Supported MOH to attend regional conferences, technical assistance in developing strategic documents. Key partner to the MC sub group
	ITECH	Support to one of the priority districts. VMMC training for service providers in the district. Site strengthening and establishing static site in Lilongwe. Procurement of VMMC kits for the district. Key to the development of national M&E tools
	USAID	Giving technical support and assisted in planning for scaling up. Coordinates 4 partners who are scaling up services in 4 different districts, Phalombe, Thyolo, Mulanje and Blantyre districts. Support in procurement and logistics management for VMMC.
	Banja Lamtsogolo (BLM) Marrie Stoppes International	Funded through USAID, is scaling up services in Phalombe, Thyolo and Mulanje districts. Engaged in capacity building, outreach services.
	Population Services International (PSI)	Funded through USAID, is scaling up services in Thyolo and Blantyre districts. Engaged in capacity building, outreach services. Both static and outreach services
	Christian Hospital Association of Malawi (CHAM)	Supported through both CDC and USAID, participated in scale up of VMMC services in Thyolo district, with Technical support from MCHIP they organized a successful VMMC campaign. CHAM support to the district has since come to an end. Built capacity on service provision for health care workers in the public sector.
	MCHIP	Offered technical support to the central office in the Ministry of Health, capacity building(Training of trainers). Gave support to partners under USAID . Full participation in strategic document development. Key to the development of M&E tools.
	DOD	Facilitating scale up of VMMC services in the military health services(capacity building, site identification) and procurement of kits.
	MSF France	Supports one of the districts outside PEPFAR-supported districts

Mozambique	JHPIEGO/CDC: PSI/DoD WHO:	Commodities, supplies, logistic, training Technical support and catalytic funding for planning meetings
Namibia	PEPFAR	Funds to implement MC program activities, though money has been suspended for the greater part of the year.
Rwanda	WHO, UNICEF, P E P F A R , Global Fund	Financial support and technical support in elaboration of national VMMC documents
South Africa	PEPFAR and Global Fund, WHO, World Bank	Technical assistance and service delivery
Swaziland	PEPFAR	All MC programmatic issues
	WHO	Technical assistance and knowledge exchange between countries
Tanzania	PEPFAR	Financial and technical support
	WHO	Technical support
	Bill & Melinda Gates through WHO	Financial support
Uganda	PEPFAR through USAID and CDC	Financial and Technical support
	UN Agencies (financed by Irish Aid and DFID)	Financial and Technical support
Zambia	WHO; PEPFAR; BMGF; Global Fund; CHAI, World Bank	Technical Assistance; Funding for service delivery, training, mass media and demand generation research, governance coordination; and procurement of equipment
Zimbabwe	UNFPA	Technical support; Human resource capacity strengthened at local level; Training of MOHCW staff; Financial support for the Prepex study Broadening the scope of nursing practice to include VMMC, through learning visit to Zambia
	PSI	IEC materials development
	WHO	Funding for VMMC service delivery training and Broadening the scope of nursing practice to include VMMC, through learning visit to Kenya
	USG	Materials developments and advocacy activities. Human resource capacity strengthening of MOHCW.
	DFID	Support for Prepex study and Neonatal MC
	National AIDS Council	Procurement and distribution of VMMC commodities and supporting service delivery activities through PSI and to a limited extent through ZACH Funding of VMMC activities in both Pillar One and Pillar two of the Integrated Support programme Demand creation activities at local level and
TOTAL	14	

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This publication profiles each of the 14 priority countries and the progress each has made as of December 2012 in scaling up VMMC. It includes key health and demographic information; HIV and male circumcision statistics; progress in implementing the seven pillars of the Joint Strategic Action Framework together with successes and challenges.