

Learning from Safe Male Circumcision Project in Kayunga District

*How can the Lessons Inform Scale up of Safe Male Circumcision in
Uganda*



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Acronyms

ABC:	Abstinence, Being faithful and Condom use
CSO:	Civil Society Organization
HBC:	Home Based Care
HCT:	HIV Counseling & Testing
HIV:	Human Immunodeficiency Virus
MMC:	Medical Male Circumcision
MUWRP:	Makerere University Walter Reed Project
PACE:	Pan African Control of Epizootics
PEPFAR:	The U.S. President's Emergency Plan for AIDS Relief
PHCG:	Primary Health Care Grant
PLHIV:	People Living with HIV and AIDS.
PMTCT:	Prevention of Mother to Child Transmission
PREFA:	Protecting Families against HIV/AIDS
SMC:	Safe Male circumcision

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Forward

Uganda is one of the countries with a generalized HIV epidemic where rates of new infections are rising. As stakeholders in the response to HIV, we recognize that this situation is largely caused by heterosexual transmission, which is the most common mode of HIV transmission in our set-up. Therefore, our prevention efforts should reflect this reality.

The National HIV and AIDS Prevention Strategy 2011-15 front adoption of combination HIV prevention as the effective strategy to reverse the rising new HIV infections in our country. As we seek to diversify the prevention efforts, we need to focus on proven interventions like Safe Male Circumcision (SMC), and adopt them to curb down the rising HIV incidence.

I appreciate all the various stakeholders who have taken a lead in advancing SMC as an effective intervention in reducing the risk of HIV infection. It is my hope that with this new intervention, we shall see a reversal in the HIV incidence trends in our country.

I welcome the publication of this report which documents lessons learnt in mobilization, communication, human resource and finance planning during the implementation of SMC programme by Makerere University Walter Reed Project (MUWRP) in Kayunga District. I hope that the information presented in this report will play a key role in advocating and programming for SMC in this country.

I would like to acknowledge all those who provided support to the success of this document; the management and staff of Makerere University Walter Reed Project (MUWRP) who allowed the study to be conducted at their SMC site in Kayunga, the Kayunga District Health Office, the Kayunga Hospital Administration and all Individual respondents, AVAC for their financial and technical support, the Uganda AIDS Commission and the Ministry of Health for their support and guidance.

Bharam Namanya
Executive Director, UNASO.

Executive Summary

Uganda adopted Safe Male Circumcision (SMC) as part of the broader strategies for HIV prevention in the National Safe Male Circumcision Policy 2010, following results from three randomized trials in South Africa, Kenya, and Uganda that showed that male circumcision reduces the sexual transmission of HIV from women to men by at least 60%¹. Based on these results, World Health Organisation (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) issued a set of recommendations for the use of MC as one of the HIV prevention strategies in countries with low male circumcision rates like Uganda, where only 24.9% of its men aged 15-49 years are circumcised² and has a high HIV prevalence of 6.4%.

The purpose of this study was to gather evidence for advocacy for SMC. The study focused on documenting lessons learnt in mobilization, communication, human resource and finance planning during the implementation of SMC programme by Makerere University Walter Reed Project (MUWRP) in Kayunga district that started in 2009, one of the first Districts to implement SMC on a large scale outside the research setting in Uganda. This information will be used to inform programming among civil society organizations, the public, policy makers and leaders for action.

Key lessons learnt and recommendations

Mobilization

- The Kayunga SMC Programme had the District Health Technocrats first trained in SMC at Rakai Health Science Programme, who were then facilitated by MUWRP to sensitize the political, religious and cultural leadership on SMC.
- The number of men turning up for male circumcision was far more than the Programme team anticipated before the start of the programme.
- The successful entry into the community with the SMC programme was as a result of the commitment from the political leadership in the district right from the start of the SMC programme.
- Demand control for SMC service is crucial for the success of the programme..
- Use of local leaders and accepted is critical for successful mobilization..

Recommendations: Getting political commitment from the start of the SMC programme is key to the success of its scale up in the districts and at the national level because there will be very minimal resistance from top leadership.

¹ Siegfried et al. **Male circumcision for prevention of heterosexual acquisition of HIV in men.** *Cochrane Database of Systematic Reviews*, 2009, Issue 2. Art. No.: CD003362 DOI: [10.1002/14651858.CD003362.pub2](https://doi.org/10.1002/14651858.CD003362.pub2)

² Uganda National Behavioral Survey 2005

Mobilization for SMC service should be demand controlled in order to avoid frustrations and lack of trust in the service in communities and reduce chances of communities resorting to use of sub standard service providers.

Communication

- The message on partial protection of SMC against HIV infection was well understood among the circumcised men contrary to the fears the district leaders had before the start of the programme..
- The Kayunga SMC programme at recruitment, encouraged men to notify their partners before they came for circumcision, however, 65% of the circumcised respondents interviewed did not think it was a good idea because they thought it was not important, while others thought they would be discouraged by their spouses to be circumcised.
- Adherence to abstinence from sex until complete wound healing is still a challenge among circumcised men. 75% of the circumcised men interviewed believed that by 4 weeks; one's wound is much healed and fit to resume sex.
- Integration of services is very critical for supporting uptake of services like SMC.
- The post circumcision messages included; postsurgical instructions on the management of the wound healing, information on the follow up visit schedule of 1 week and then 30 days after, emphasis to abstain from sex until complete wound healing (6 weeks period after circumcision) and the need to continue using ABC plus for prevention of HIV and sexually transmitted infections.

Recommendations: SMC programmes should have clear messages on the benefits of women involvement by their spouses in SMC, which in turn will improve women's understanding of the risks involved in engaging in sex before complete wound healing (before 6 weeks after circumcision) and reduce their exposure to HIV and other sexually transmitted infections.

SMC programmes should be integrated in already existing health services. like; HIV counseling and testing, STI screening and treatment and effective counseling about the need to continue using other HIV protection methods after circumcision is very important given that SMC only provides a 60% risk reduction against HIV infection.

Human Resource

- All personnel providing SMC for HIV prevention have to be trained and certified at designated centers certified by the Ministry of Health. Currently there are 2 centres; at Rakai Health Science Programme and Kayunga hospital.
- For any static and mobile SMC site, there should be a team of at least 1 surgeon, 1 theatre nurse and 1 counselor; these can be supported by 1-2 volunteers to assist in directing the flow of clients. This level of staffing can be used when the flow of potential recipients is averagely 20-50 men per day.
- For successful SMC service delivery, there must be efficient programming, flexibility and knowledge of different service delivery models and there must be a good systems thinking right from the mobilization stage, planning for the human resource, packaging of supplies needed, model to be used, the space, team work to flow of clients.
- In Kayunga, because of the high proficiency of the staff providing the SMC service, the rate of adverse events (side effects as a result of SMC) was less than 1%.
- In Uganda, nurses are restricted by the Uganda Nurses and Midwives ACT 1996 from performing some simple tasks like administering anesthesia, these tasks are performed by doctors and clinical officers who are very few and highly skilled for the simple tasks during SMC surgery.
- For purposes of standardization and logistical management during the SMC roll out, the Ministry of Health recommends the use dorsal slit technique in the Minimum Standards of Procedures for SMC. However, it is known to take more time compared to forceps guided technique and not recommended for use especially when demand for SMC is very high according to the Kayunga SMC Programme team. The total procedure time taken for dorsal slit technique is 21.45 minutes compared to 19.20 minutes for the forceps guided technique.
- In situations where the demand is high especially during outreach services, it's advisable that the forceps guided technique is used and the MOVE principle is employed to maximize numbers circumcised, while maintaining the quality of service and efficient use of the available space.

Recommendations:

The Ministry of Health should also target nurses that are unemployed in communities and use them during SMC campaigns, during school holidays and weekends when the peak is high which will attract a small remuneration from the Ministry of Health.

The Ministry of Health should establish regional SMC training centres to be able to reach many health workers.

The Ministry of Health should reconsider training health workers in forceps guided technique after gaining proficiency in dorsal slit technique to increase skilled human resource in techniques that deliver high outputs.

Finance

- SMC scale up requires significant investment in materials, financial and human resource.
- A successful SMC service delivery depends on a good supply chain system where there is good forecasting, procurement, distribution, storage, stock in hand and disposal management.
- For Uganda, we need to circumcise 4.2 million men to hit the 80% in five years target, that is set in the National HIV Strategic Plan 2011-15 and this will cost us 120-200 million US\$, at a cost of US\$35 per SMC³.
- Kayunga district health budget is supported by the Government through the Primary Health Care Grant (PHCG), which has been thinning every financial year. Compared to the district health budget needs, this funding is very small.
- Inadequate funding for HIV prevention interventions especially SMC from the government has contributed to the slow scale up of SMC in the country despite communities showing a lot of interest in male circumcision.
- The SMC programme is mainly funded by PEPFAR in Uganda. The Government has contributed only 8.9% in the past 3 years to the total HIV and AIDS funding 8.9% and the balance - 90% is from donors. Due to the hard economic times in developed countries funding for HIV programmes in low developed countries reduced by 10% in 2010⁴.

Recommendations:

There is need for government to increase its investment in HIV programmes especially prevention programmes like SMC to supplement donor funding that is dwindling due to hard economic times.

The Ministry of Health should develop a costed SMC national action plan that specifies Ugandan and donor commitments, identifying funding gaps and opportunities for resource mobilisation

³ USAID/Health Policy Initiative: The Potential Cost and Impact of Expanding Male Circumcision in Uganda, 2009

⁴ <http://www.voanews.com/policy/editorials/>

SMC should be embraced in all HIV programmes by government, civil society organizations and donors, through community mobilization, monitor implementation and advocate for its scale up.

The Ministry of Health and the Uganda AIDS Commission must take lead in rolling out, mobilizing resources, monitor and coordinating SMC implementing partners to ensure quality service delivery.

For Uganda to benefit from SMC for HIV prevention, the above recommendation have to be considered in order to attain the 80% target set in the NSP 2011-15, thus averting 428,000 adult HIV infections and saving almost US\$ 2 billion between 2009-2025.

Introduction

1.1 Background

Globally the rate of new HIV infections continues to outpace the number of people initiated on treatment. Sub-Saharan Africa is more heavily affected by HIV and AIDS than any other region of the world. An estimated 22.5 million people are living with HIV in the region - around two thirds of the global total. In 2009 around 1.3 million people died from AIDS in sub-Saharan Africa and 1.8 million people became infected with HIV. In Uganda the HIV prevalence amongst adults aged 15-49 years is estimated at 6.4%⁵. Due to the burden of HIV infection Uganda decided to implement a comprehensive HIV prevention strategy that included ABC Plus any other proven intervention. Among the first proven intervention to be added on to the list in the National HIV Prevention Strategy 2011-15 was Safe Male Circumcision (SMC) following results from three randomized trials done in South Africa, Kenya, and Uganda that provided evidence that male circumcision reduces the sexual transmission of HIV from women to men by at least 60%⁶.

Based on these results, World Health Organisation (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) issued a set of guidelines for the use of SMC as one of the HIV prevention strategies in countries with low male circumcision rates like Uganda that has only 24.9% of its men aged 15-49 years circumcised.⁷ The guidelines highlight that SMC does not provide complete protection against HIV, it should be considered only part of a comprehensive package to prevent HIV; SMC should be encouraged along with the delay of onset of sex, abstinence, reduction in number of sexual partners, consistent condom use, HIV counseling and testing, and treatment of other sexually transmitted infections⁸.

In Uganda, 25% of the adult men are circumcised. Circumcision is done for religious purposes, rites of passage from childhood to adulthood and also for medical reasons. Circumcision was more common among men in the Eastern region (54.7%), Kampala

Minimum package for male circumcision services

- HIV testing and counseling
- Active exclusion of symptomatic sexually transmitted infections (STIs); syndromic treatment where required
- Provision and promotion of male and female condoms
- Counseling on risk reduction and safer sex
- Male circumcision surgical procedure

Source: WHO/UNAIDS Manual for male circumcision under local anaesthesia.

⁵ UNAIDS 2008 Report on the global AIDS epidemic

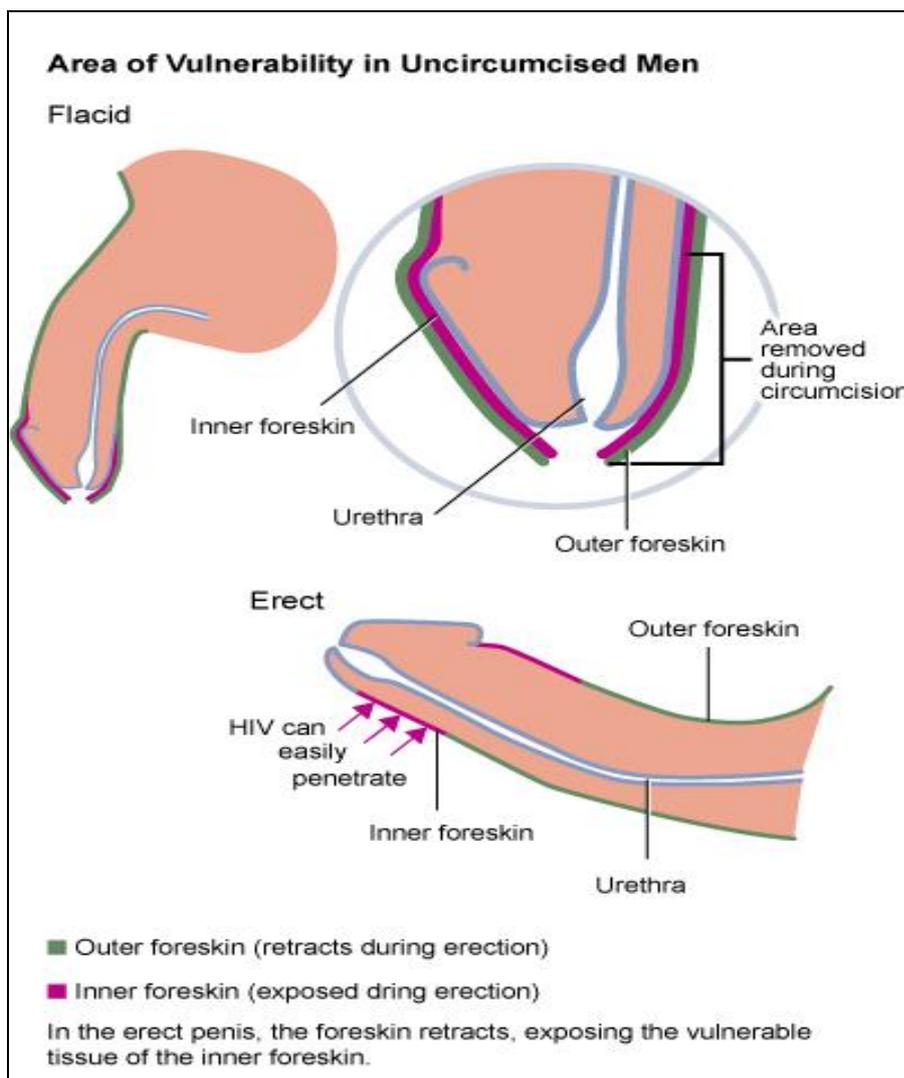
⁶ Siegfried et al. Male circumcision for prevention of heterosexual acquisition of HIV in men. *Cochrane Database of Systematic Reviews*, 2009, Issue 2. Art. No.: CD003362 DOI: [10.1002/14651858.CD003362.pub2](https://doi.org/10.1002/14651858.CD003362.pub2)

⁷ Uganda National Behavioral Survey 2005

⁸ Situation Analysis to Determine the Acceptability and Feasibility of Male Circumcision Promotion in Uganda 2008

(37.8%) and east central region (34.7%) and less than 10% in the north and south western regions. Circumcision is highest among Muslim men (97%) and lowest among Catholics (10%)⁹.

SMC reduces the risk of HIV in men because the inner mucosa of the foreskin has a high concentration of the Langerhans cells—immune cells that are target for HIV transmission. Without the keratin barrier, HIV can easily access these cells in the foreskin. Following infection, Langerhans cells not only serve as reservoirs for replicating the virus, but also transport the virus to nearby lymph nodes where HIV spreads to other immune cells¹⁰.



Source:

⁹ Situation Analysis to Determine the Acceptability and Feasibility of Male Circumcision Promotion in Uganda 2008

¹⁰ <http://www.scientificamerican.com/article.cfm?id=circumcision-and-aids>

The benefits of SMC to men include; 60% risk reduction in HIV infection, reduced risk of penile cancer, penis easy to keep clean, reduced risk of contracting Sexually Transmitted Infections (STIs) especially genital ulcerative diseases.

To women, having a male partner who is circumcised reduces a woman's risk of human papilloma virus (HPV) by about 25 percent, according to a study done among more than 1,000 Ugandan couples¹¹ and also benefit from having reduced risk of contracting some sexually transmitted diseases and cervical cancer.

SMC does not provide direct protection for women against HIV infection however, if the woman's partner reduces risk of his infection, this directly benefits her as well.

The WHO guidelines acknowledge that there are potentially harmful effects like increased HIV infection if correct information is not provided to men and women about the fact that SMC is not a 'magic bullet' and does not provide complete protection against HIV transmission¹² and if sex is resumed before complete wound healing.

The Government of Uganda developed a Safe Male Circumcision Policy and National Communication Strategy in 2010 as a way of operationalizing SMC as an additional HIV prevention strategy¹³ and a target to reach 80% of un circumcised men by 2015 has been set in the National HIV Prevention Strategy 2011-15,

The potential HIV infections to be averted in Uganda by scaling up safe male circumcision to reach 80% target is 428,000 adult HIV infections over a period of 2009-2025, resulting in a cumulative net saving of almost US\$ 2 billion over the same period and this would require approximately 2.4 million male circumcisions to be performed in the peak year 2012¹⁴.

1.2 Kayunga District

Kayunga district has a total population of 336,600 people. It's located in the Central region of Uganda and it has two counties. The district has 8 sub-counties, one town council, 61 parishes and 366 villages. The district has 1 hospital, 2 health centre IVs, 6 health centre IIIs, and 10 health centre IIs¹⁵. The District HIV prevalence rate is 6.5%, above the national rate of 6.4% (Uganda HIV/AIDS Sero-Behavioral Survey, 2005).

¹¹ The Lancet, 17 January 2011

¹² Situation Analysis to Determine the Acceptability and Feasibility of Male Circumcision Promotion in Uganda 2008

¹³ National Safe Male Circumcision Policy 2010

¹⁴ USAID/Health Policy Initiative: The Potential Cost and Impact of Expanding Male Circumcision in Uganda, 2009

¹⁵ Uganda Bureau of Statistics, July 2007

1.3 Makerere Walter Reed Project (MUWRP)

The Makerere University Walter Reed Project (MUWRP) is a non-profit partnership between Makerere University and the US Military HIV research Program has been conducting HIV research in Uganda since 1998 and expanded its portfolio to include prevention, care and treatment activities in 2005 under the President's Emergency Plan for AIDS Relief (PEPFAR).

The HIV Prevention Programme provides district-wide HIV Prevention activities and coordination in Kayunga, Mukono and Buvuma districts. Residents are routinely exposed to HIV counseling and testing, condom distribution, SMC services, health education talks on reproductive health, ART adherence, sexual and non-sexual HIV transmission, ABC prevention, post-exposure prophylaxis, positive living, couple counseling, stigma and discrimination, condom use, violence and gender issues, tradition male norm issues, the availability/importance of ART, location of nearest HIV clinics, and pediatric HIV issues¹⁶.

In 2009, MUWRP with support from PEPFAR and in partnership with Kayunga district started implementing SMC as a pilot project for one year to help them understand and learn what it takes to implement SMC as a service, given that SMC was being done by Rakai Health Science Programme under a highly controlled research environment. The SMC project started before the National SMC policy was out. To date the SMC programme has reached over 10,000 men.

1.4 Problem Statement

Male circumcision is mainly being done for religious purposes, rites of passage from childhood to adulthood and also for medical reasons in Uganda. Since the adoption of SMC by the Ministry of Health in 2010 as an addition HIV prevention strategy, few service providers have embraced it to a scale that it deserves despite a 59% of men willing to be circumcised¹⁷. For the few service providers that are implementing SMC there is very little documentation on their experiences so far hence minimal duplication of best practices and lessons so far learned.

1.5 Justification

Since SMC was adopted in Uganda as one of the HIV prevention strategies in 2010, scale up of its implementation has been limited to a few donor funded programmes. Documentation by advocates and civil society of experiences and lesson learnt from Kayunga SMC programme will contribute to knowledge building across all sectors of Ugandan society who need to be engaged in supporting SMC rollout.

¹⁶ <http://www.muwrp.org/>

¹⁷ Situation Analysis to Determine the Acceptability and Feasibility of Male Circumcision Promotion in Uganda 2008

1.6 Purpose of the Project

This civil-society-initiated project was designed to gather evidence on best practices in financing, human resources and messaging to inform advocacy for SMC scale up in Uganda.

1.7 Objective of the Project

- a) To document lessons learnt and good practices under mobilization, communication, human resource and finance during the implementation of SMC programme in Kayunga district
- b) To make recommendations to advocates seeking scale up of SMC in other parts of the country

The study focused on the following variables; mobilization, communication, human resource and finance only because they play a major role in the SMC programming.

2.0 Approach

2.1 Evidence-based advocacy

This project drew from techniques of evidence-based advocacy which have been used by civil society actors throughout Uganda and around the world to build knowledge and expertise on emerging issues and innovations in the AIDS response. The methodology is based on the principle that advocates can and must inform themselves about new developments and that their findings can be of value and quality even if and when they do not fit into traditional social science or other academic frameworks.

2.2 Evidence-gathering approach

One on one interviews were conducted with SMC programme and clinical team, hospital administration, district health office in Kayunga, project direct and indirect beneficiaries of SMC, women married to circumcised and non-circumcised men from Kayunga district. Policy makers from Uganda AIDS Commission and the Ministry of Health were interviewed. In addition, group dialogues were held in which **service receivers and their spouses described their experiences.**

2.3 Stakeholders interviewed for the project

. At district level, the District Health Officer, the Administrator of Kayunga hospital where SMC is done, the MUWRP staff; SMC Coordinator, a Safe Male Circumcision Surgeon and a Research Nurse were interviewed. At national level, two officials representing policy makers were interviewed from the Ministry of Health and the Uganda AIDS Commission. Information at these levels was collected to understand the national and district plans in implementing SMC as an HIV prevention strategy.

2.4 Group Dialogues

Three group dialogues were held with circumcised men, spouses of circumcised men and uncircumcised men. The issues discussed were communication during the

counseling sessions, their experience with SMC and mobilization done for circumcision. Other issues included views on the fears and hindrances affecting SMC in the community and how they were managed by the programme team.

3.0 Project Findings

The document presents experiences, lessons learnt from the Kayunga District Medical Male Circumcision Programme and recommendations for action. The project focus was on three variables: mobilization and communication, human resource and finance planning. The SMC programme started in 2009 before the National SMC Policy and Communication Strategy were released in 2010. The programme started as a pilot for a year within Kayunga Town Council and Kayunga Sub County to assess the strength, weaknesses and existing opportunities before spreading to the rest of the district.

At the start of the programme, the community through different structures was sensitized to prepare them for the SMC programme starting with the District Health Teams, district political leadership, health workers, Local Council Chairpersons, opinion leaders and the community. The health facilities were remodeled and equipped with the necessary equipment and human resource.

3.1 Mobilization and Communication

3.1.1 Involvement of Local Leadership

In 2009, MUWRP first had the District Health Technocrats sensitized in SMC for HIV prevention at Rakai Health Science Programme, who were then facilitated to sensitize the other district political, religious and cultural leaders and finally the local community in Kayunga town council which was the first targeted area for the SMC service at that time. SMC benefits, risks and community fears were discussed and addressed during these sensitization meetings. After getting support from the District Health Team, the programme team then embarked on remodeling the minor theatre and putting all the logistical requirements in place.

“When we started the response was very good, beyond our expectation. We also had many questions, how will SMC be received since there were many myths. Mobilization was done within the catchment area of the hospital, however, there were some people coming from outside these areas. Given that we were starting even before the policy was developed, we were very cautious not to mobilize many people for SMC and later we send them away because we cannot offer them the service. We had 2 operating tables and we would handle 10-15 surgeries a day” said the DHO

“So far the number of circumcised men is over 10,000 since we started in 2009. We didn’t think we could have such high numbers. This is because of the good political will and good mobilisation. We have always hit our targets” Surgeon 1.

Lesson Learnt: Getting political commitment from the start of the programme was key to the success of SMC scale up in Kayunga because entry into the community did not meet any resistance. The sensitised leaders became a resource in the community; they were a reference point on SMC information in their communities.

3.1.2 Circumcision Focal Persons (CFP): The Kayunga SMC programme, at the village level, through the Local Council 1 Chairpersons; identified the already existing health

mobilisers in the communities to mobilize for SMC and these were referred to as Circumcision Focal Persons (CFPs). The CFPs were sensitized on SMC and briefed good communication and mobilization skills. The CFPs did this task on a voluntary basis.

Each CFP was responsible for mobilizing the community for SMC sensitization meetings, recruiting, registering and referring men 15 years old and above interested in circumcision in his/her village to Kayunga hospital for sensitization talks on SMC and other health related education and services like HCT.

In the National SMC Policy, emphasis is put on use of Village Health Teams (VHT) to do mobilization for SMC. Currently more than three quarters of all districts have VHTs while 18 districts still lack them. The Village Health Team's role is to mobilize individuals and households for better health. However, districts have taken differing approaches to implementation and training of VHTs, while others train all their VHTs, some train a few of them. VHTs are successful where districts have strong leadership and all community based health interventions are channeled via the District Health Team¹⁸. As we plan to use VHTs to mobilize for SMC we should be mindful of this.

Role of Circumcision Focal Persons (CFPs)

To mobilize communities for SMC sensitisation talks, record and refer men and adolescents 15 years and above interested in being circumcised and refer them to the SMC sites.

3.1.3 Drama shows: The programme used drama shows during village meetings. These were also restricted to the targeted area. The drama shows were very good at pulling crowds. The shows lasted for 10-15 minutes and there after the health education started on HIV counseling and testing, ABC, family planning, domestic violence, sexually transmitted infections and SMC.

3.1.4 Mobile Surgical clinic – In the second year of the programme, numbers of men seeking SMC services at Kayunga hospital started to go down and this necessitated the need to reach out to areas far away from the hospital with the service, hence the launch of a Mobile Surgical Clinic in April 2011. Before the Mobile Surgical Clinic goes to a community to deliver SMC, sensitization is done for 1-3 months to ensure there is adequate demand for SMC to ensure efficiency of the available resources.

By mid-2011, an average of 40 and 70 men are reached daily at the hospital site and the Mobile Surgical Clinic respectively. During school holidays the number of circumcisions done daily goes higher than this.

¹⁸ Situation Analysis Village Health Teams Uganda 2009, Current Status, Activities and Actions to Improve Health and Survival, Ministry of Health.

Lessons Learnt: Demand control for SMC services was key for the success of the programme in Kayunga. The capacity of the programme to deliver SMC services was one of the driving factors in determining the channel to use for mobilization for SMC in the communities. Constant turning away of potential service recipients creates frustration and lack of trust in the programme.

3.2 Communicating SMC

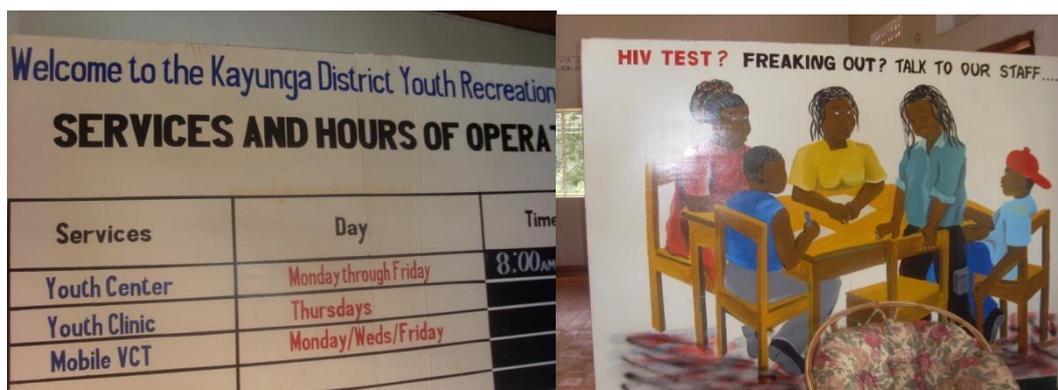
“The District leadership agreed to start advocacy and share information on the new evidence that SMC provides in preventing HIV infection” said the DHO. A communication strategy and communication tools were developed by the district and the MUWRP programme team. There were consultations with the team at the Rakai Health Science Programme and the AIDS Control Programme at the Ministry of Health.

The following different channels were used during mobilization for SMC;

3.2.1 Media – communication through radio was used however, it was limited to community loud speakers in the targeted areas. The programme was mindful of the radio coverage, in order to avoid attracting big crowds for circumcision especially from communities outside the targeted area which was Kayunga town council and Kayunga Sub County. The radio programmes were aired on days free from community events like weekly market days. The number to be circumcised however, was determined by the amount of resources available; including human resource, supplies, space and proficiency of the human resources.

3.2.2 IEC Materials: By the time the Kayunga SMC programme started there were no SMC materials from the Ministry of Health. The programme had to develop posters, fact sheets and bill boards for use in Kayunga. Currently the Ministry of Health has mandated Health Communication Partnership (HCP) to produce SMC Communication tools and materials which were launched in December 2011.

3.2.3 Youth Based Centre Health Talks – MUWRP established a Centre where youth came and played sports and at the same time got HIV prevention, support and care services. The Centre had a week’s programme put on the Notice Board for the youth participation. During the Health education talks the youth were sensitized about SMC alongside the other reproductive health issues, HIV prevention, support and care services. The Centre attracted many youth because of the sports, and a wide coverage of issues are covered during the health talks, the feedback mechanism was stronger, the youth were more free to share their concerns among their peers and some of the youth were used as mobilisers for SMC in their communities.



Above: Displays at the Kayunga District Youth Recreation Centre

Lessons learnt: use of youth centres is important to reach out to youth with HIV prevention, care and support services through sports. The Ministry of Health through the Ministry of Local government could adopt this strategy to reach out to the youth with HIV prevention services especially SMC given that they act as a meeting centres for the youth.

3.2.4 Myths Handling:

The programme documented all the common myths and made them part of the SMC sensitization topics. During the community sensitization talks, the team prompted the community to learn and address the myths. The SMC programme noted that myths around male circumcision differed from one community to another.

One of the CFPs confessed that despite mobilizing many men for SMC in his community he was still skeptical to do it because he had heard that SMC reduces one's sexual urge.

This perception was however refuted by 63% of the circumcised men who said that they did not feel any difference in their sexual performance and this was backed up by the spouses of the newly circumcised men; 75% of the women interviewed said that they enjoyed sex more than before their spouses were circumcised. 40% of the women also said that their spouses take longer to ejaculate which they said was good for them. All the women reported that they are happy because their men have a reduced risk of contracting STIs especially HIV.

Lessons Learnt: It's important to first understand the myths in the community to be able to correct them.

3.2.5 Women Involvement in SMC

It was noted that women's involvement in decision making prior to circumcision of their spouses was still minimal despite emphasis during the SMC sensitizations. Only 13% of them came with their wives to the counseling session and only 25% of the men informed their spouses about their intention to get circumcised, 38% of the respondents did not think it was a good idea to inform their spouses because they could instead discourage them while 25% of the circumcised men interviewed reported their decision to get circumcised was by impulse and they felt it would be time wasting if they waited until they informed their spouses. In addition, with

limited communication among the couples, 63% of the women respondents said that they learnt of their spouses' circumcision after they were circumcised.

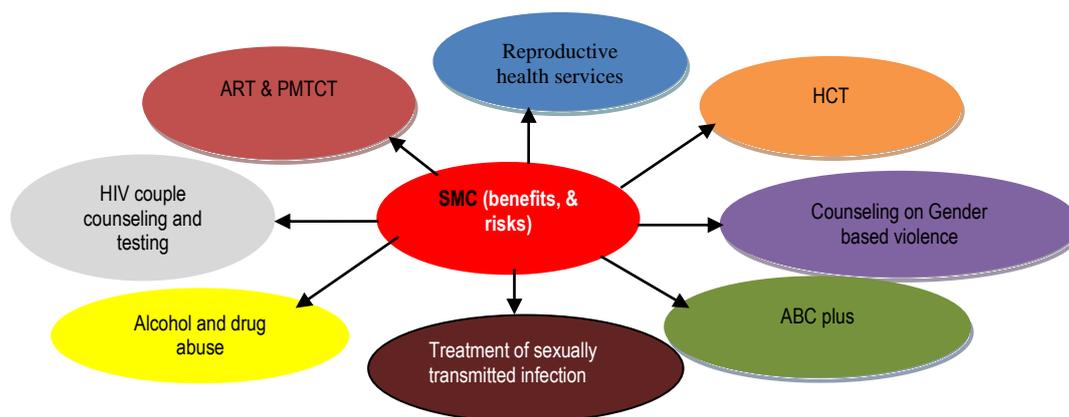
As a result there is little or no mutual support between the couple to wait for 6 weeks for the wound to heal so as to resume sex.

From the above finding a few of the circumcised men did complete the 6 weeks of abstinence after circumcision. In fact 75% of them believed that by 4 weeks; one's wound is much healed and fit to resume sex.

3.2.6 Messaging

The programme developed a Communication strategy aimed at creating awareness and providing information on SMC, increase demand and promote uptake of SMC for HIV prevention. The messages targeted uncircumcised men, men who were 15 years and above in the community. The SMC sensitization in the community was integrated with other HIV prevention methods like ART, PMTCT, ABC, and counseling on other related issues like alcohol and drug abuse, gender based violence, reproductive health needs, sexually transmitted infections and HIV counseling and testing.

Diagram1. Male circumcision as an entry point to other health services



Source: WHO/UNAIDS, Male circumcision under Local Anesthesia, 2008

3.2.7 Pre-Circumcision Counseling:

After the SMC sensitization talks, the men are then screened and those that pass the pre circumcision questionnaire are given an appointment card with their bio data filled in, to visit the hospital for further clinical assessment and then surgery. A consent form is signed by each prospective service recipient before surgery, for those boys between 15-17 years old their consent forms are signed by their guardians.

Inside the theater, high infection control measures are observed. During the surgery the research nurse keeps chatting with the client to calm his nerves.

Lesson learnt: The quality and availability of service is key to the success of SMC rollout. Care needs to be taken to minimize adverse events like excessive bleeding; as one incident has the potential to mess up the entire programme.



Inside the theatre



Civil Society members during a site visit to Kayunga SMC theatre during data collection process

3.2.8 Post Circumcision Counseling:

The Post Circumcision Counseling messages included post-surgical instructions on the management of the wound healing, information on the follow up visit schedule of 1 week and then 30 days after, emphasis to abstain from sex until complete wound healing which is usually 6 weeks after circumcision and the need to continue using ABC plus for prevention of HIV and sexually transmitted infections.

Due to the proficiency of the staff providing the service on average the adverse events (side effects as a result of SMC) have occurred in about less than 1% of the 10,000 and over circumcised men and these occur when the trainee surgeon did not tie the bleeders well, however, adverse events can also be caused by factors related to infrastructure, hygiene, health of the client, personnel or instruments used.

Areas of emphasis to the service recipients are:

- Report any excessive bleeding/ problem
- Wear clean and fitting under pants to help hold the penis in an upright position all the time. Boxer pants are discouraged because they allow dangling of the penis thus increasing blood flow to the wound hence pain and increase the penis resting on the scrotal sack which can be a source of infection.
- Wound cleaning and management
- Abstinence from sexual intercourse for 42 days after circumcision.
- SMC is not a ‘magic bullet’ and does not provide complete protection against HIV transmission, hence the need to use other HIV prevention strategies like ABC.

3.2.9 Fear of pain and being seen limping after circumcision in the community:

40% of the circumcised men interviewed said that they were convinced to go for circumcision after they saw their friends not in pain, walk normally and continue doing their business as usual.

“I was scared of wearing a skirt to class after circumcision, however I was surprised after circumcision I went back to class and even my friends did not believe I had just been circumcised until I showed them” said respondent in FGD of circumcised men.

Lesson learnt: Proper management and follow up during the post circumcision period helps in management of pain after circumcision. . A negative reaction due to circumcision in the community affects the numbers of future service recipients.

3.2.10 Age Category of Men Circumcised

The SMC programme is targeting the most sexually active age group; 15 years and above.. 15% of uncircumcised men interviewed said that circumcision was for the youth and young boys. They argued that if one is faithful in their marriage there is no need to go for circumcision.

“If you do then it will mean you are promiscuous hence portraying a bad picture to the children and the people in the community” said a respondent from the uncircumcised men FGD.

Could the reasons for big turn up for circumcision among the youth be attributed to the youth being more adventurous in trying out new innovations? Or it is that the circumcision messages are more appealing to the youth than the 50 year olds and above?

Question: Could the risk perception of an individual be a driving force for him to seek SMC services? Could this be the explanation as to why the youth outpace the older men in getting circumcision?

Recommendations:

Getting political commitment from the start of the SMC programme is key to the success of its scale up in the districts and at the national level because there will be very minimal resistance or sabotage from top leadership.

Mobilization for SMC service should be linked to service availability such that demand is met wherever possible and, where demand exceeds availability, there is clear communication in order to avoid frustrations and lack of trust in the service in communities and reduce chances of communities resorting to use of sub standard service providers.

SMC programmes should have clear messages on the benefits of women involvement by their spouses in SMC, which in turn will improve women's understanding of the risks involved in engaging in sex before complete wound healing (before 6 weeks after circumcision) and reduce their exposure to HIV and other sexually transmitted infections.

As SMC programmes are rolled out provision of a comprehensive package; HIV counseling and testing, STI screening and treatment and effective counseling about the need to continue using other HIV protection methods after circumcision is very important given that SMC only provides a 60% risk reduction against HIV infection.

3.3 Human Resource

Human resource is one of the major factor that affect the success of the SMC service delivery. Areas to take keen note of are the staffing levels, the training, the surgical methods to be used and efficient programming.

3.3.1 The staffing levels: at the start of the programme in Kayunga, MUWRP programme planners, supervisors, health workers, clinical staff, theatre nurses, and counselors underwent training at the Rakai Health Programme in their respective roles. The SMC service delivery team is comprised of 3 teams; a surgeon, a theatre nurse and a counselor.

In Kojja HC IV and Mukono HC IV, there is 1 surgeon, 1 theatre nurse, 3 counselors.

On the Mobile Surgical Clinic there is 1 surgeon, 2 theatre nurses, 2 counselors, 1 sanitary officer and a watch man. When the need arises there is always a back up team of surgeon(s) from Kayunga.

In Kayunga, there are 4 surgeons (2 of them are supervisors), 3 theatre nurses, 4 counselors and 2CFPs per village. The CFPs are community volunteers and only facilitated when they are called for trainings..

“For any community programme to succeed, use of money should be avoided. The programme will only survive when there is money. The communities get money minded, and when there is no money no work is done” Surgeon 1.

For any static SMC site, there should be at least 1 surgeon, 1 theatre nurse and 1 counselor these can be supported by 1-2 volunteers to assist in directing the flow of clients. This level of staffing can be used when the flow of potential recipients is averagely 20-50 men per day and the dorsal slit surgical procedure is used.

There are three surgical techniques used for SMC; the dorsal slit, the forceps guided and the sleeve resection. These techniques are all the same in terms of safety however they vary in the time required and supplies used.

In situations where the demand is high especially during outreach services, its recommended that the forceps guided technique is used and the MOVE principle is employed to maximize numbers circumcised, while maintaining the quality of service and efficient use of the available space.

The MOVE Principle:

It's a WHO pilot initiative that aims to maximise surgical results, minimising time and resources needed to perform high volumes of surgery.

Facilitates cost effective solutions to MC scale up in high volume/demand settings

In a space with 4 beds for example, there is 1 theatre nurse stationed at each bed and 3 surgeons moving from one bed to another, each doing a specific role of either; administering an anesthesia, another cuts and stops the bleedings and the third one sutures the wound. 4 service recipients are worked on in a short period of time. This principle is used for efficiency especially when demand is high.

The Uganda Nurses and Midwives ACT 1996 limits nurses from administering anesthesia for example. Anesthesia is only done by doctors and clinical officers. With these restrictions, simple tasks are done by highly skilled personnel, who are few in numbers. In the long run this becomes costly.

However, in the recently released Minimum Standards of Procedures for SMC for health facilities by the Ministry of Health, nurses and midwives are recognized as part of the list of circumcisers, in addition to the clinical Officers and doctors¹⁹. This is a new innovation contrary to the above mentioned ACT that calls for popularizing and training of nurses and midwives in SMC surgery.

In 2009/10, just 56 percent of the country's health worker positions are filled, and many are not trained in male circumcision²⁰ and these vary from district to district. With the onset of SMC, clinical officers had to be trained to provide the service. 30 district health staff have benefitted from this training. In Kayunga, the health staff stands at 63% of the total staff needs in the district, which is above the national staffing levels in majority of the districts. For districts with 56% and below total staff needs, effective implementation of SMC programmes might be hard because the existing staff are overburdened with the already existing work load.

In addition to that, the necessary SMC guidelines, kits and communication tools to use in facilitating SMC roll out are still under production by the Ministry of Health, 1 year now since the launch of the SMC policy in 2010. Use of the existing health staff is good however their productivity might be hindered by the above issues if not addressed.

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¹⁹ Minimum Standards of Procedures for Safe Male Circumcision, Guidelines for Health Facilities, Uganda, August 2011

²⁰ Ministry of Health Annual Sector Review report 2009/10

²¹ Minimum Standards of Procedures for Safe Male Circumcision, Guidelines for Health Facilities, Uganda, August 2011



Nurses performing SMC procedure at a health facility in Kenya.

3.3.2 Staff Remuneration and Benefits

The Kayunga SMC programme team is hired by MUWRP and their salary benefits are different from that of the government health workers in the hospital. They work five days a week from 8:00am to 5:00pm.

The programme co-opted on district health staff in SMC implementation on a rotational basis, to build their capacity in SMC. Primarily the district clinical officers are deployed at particular resident/health facilities in the community, so working on the SMC programme at the main hospital is an additional task that is not paid for.

While the SMC policy 2010 recognizes task shifting as a way to increase number of skilled SMC providers and also build capacity of trained health workers to offer SMC, the study established that in Kayunga the clinical officers have proved to be very effective in providing SMC with little adverse events (side effects as a result of SMC). However, there is need to expand it to include nurses and increase the number of service providers like in South Africa. This will ensure that when SMC is expanded, there will be ready staff to handle the increased in flow of clients, noted the DHO.

Question: With the current staffing levels how feasible is it for health centre IVs and hospitals to take on circumcision on top of the other duties at their facilities, given that male circumcision is not considered as an emergency?

3.3.3 Good Programming for SMC Service delivery

There must be efficient programming and engagement of the SMC team in planning. Prior planning and forecasting could be guided by the knowledge of the SMC programme in that area, the population – for example in areas where there is high demand for SMC services and with no service providers – one has to be well equipped with enough supplies, dedicated staff with high proficiency in both dorsal slit and forceps guided techniques.

Lessons learnt: In Kayunga areas of emphasis for a successful SMC service delivery are;

- **Efficient programming;** there must be a team that will program well to ensure successful SMC service delivery. The programmer should forecast and plan for efficient use of available resources. He/she should be conversant of the community where the service is to be delivered, what type of community, the load or demand and what kind of information this community has.
- **Flexible and knowledgeable of different service delivery models;** for example a good programmer will not stick on using dorsal slit technique when there are thousands of clients waiting, he/she should be able to change to use Forceps guided, use the MOVE principle and be able to forecast.
- **There must be good systems thinking** right from the mobilization stage, planning for human resource, packaging of supplies needed, model to be used, the space and flow of clients. This is done by the entire SMC team for good team work.

Lesson learnt: For efficient use of human resource there must be task shifting, task sharing and use of surgical efficient techniques.

3.3.4 SMC Training

Kayunga hospital is one of the 2 accredited centres for SMC training by the Ministry of Health. The training currently lasts for 1 week from 2 weeks and the training is done in teams of 3 below;

- i) The Surgeons
- ii) The Theatre Nurses
- iii) The Counselors

The trainees are already qualified medical surgeons and in practice. The SMC trainings are done to improve on their skills in providing SMC for HIV prevention. The trainees are mainly local government health centre staff. There are 2 training centres in the country; in Kayunga Hospital and Rakai.

Before any training is done for partners, there is pre site assessment done to advice on any amendments to be done on the proposed site. Proposed SMC sites must have the necessary medical supplies and a functional theatre. According to the National SMC Policy 2010, SMC services are to be delivered at all HC IVs, District Hospitals and Regional Hospitals. However, it was noted that most of the theatres at the HC IVs are either nonfunctional because of no human resource or sufficient supplies.

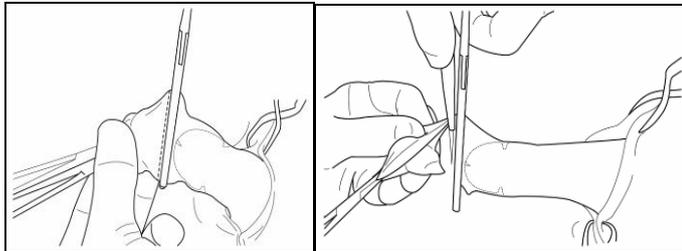
Training is only on dorsal slit technique, because it's the recommended technique by the Ministry of Health in Uganda and the supplies required for its use are easily accessible unlike the forceps guided technique. Every trainee must have done at least 15 circumcisions by the end of the 1 week's training.

Areas of Emphasis:

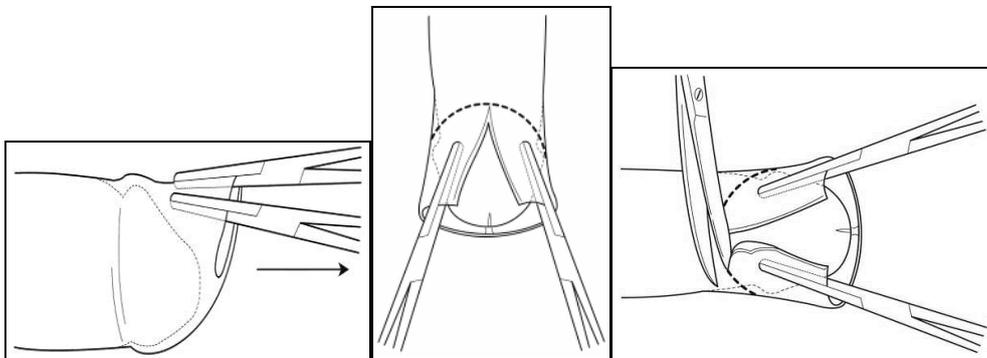
- A surgeon must use the technique that he or she has been trained in; dorsal slit method.

- When the demand for SMC services is high, however, the forceps guided technique has to be used. Although this is not recommended in the policy and the service providers are not trained in it.

WHO Recommended SMC Surgical Techniques used in Uganda



Left: Forceps guided method highly used in use in Kenya



Above: Dorsal slit technique recommended for use by Ministry of Health in Uganda

Table1: Sample comparison for the different surgical technique for circumcision

	Surgical technique	Time taken (minutes)		Comment
		Surgeon time	Total procedure time	
1.	Dorsal slit	8.45	21.45	<ul style="list-style-type: none"> • The supplies are easily accessible • Takes more time to do than the forceps guided • Recommended in Uganda by the Ministry of Health
2.	Forceps guided	6.20	19.20	<ul style="list-style-type: none"> • It's more efficient and yields higher volume in mass circumcision efforts, though cosmetic results may be compromised. • Supplies are not easily accessible; they are imported and quite expensive. • Commonly used in Kenya
3.	Sleeve resection	14.0	27.00	<ul style="list-style-type: none"> • Its more complicated to learn • Requires highly trained & skilled surgeons • It requires more time to perform one surgery

Question: Given that the training is only done for dorsal slit technique, and yet we know it's not very efficient when demand is very high, shouldn't trainees build their skills in using the forceps guided technique? With the 80% target for SMC to be

reached by 2015 by the government²², will Uganda be able to get there when we are fixed on training and using time consuming surgical techniques in high demand situations?

Recommendations:

Given that only 56% of the Uganda's health workers are filled and many not trained in male circumcision for HIV prevention²³, the Ministry of Health should widely disseminate and popularize the Minimum Standards of Procedures for Safe Male Circumcision, Guidelines for Health Facilities 2011 that recognize nurses and midwives as circumcisers.

The Ministry of Health should establish regional SMC training centres to be able to reach many health workers.

The Ministry of Health should also target nurses that are unemployed in communities and use them during SMC campaigns, during school holidays and weekends when the peak is high which will attract a small remuneration from the Ministry of Health.

The Ministry of Health should reconsider training health workers in forceps guided technique after gaining proficiency in dorsal slit technique to increase skilled human resource in techniques that deliver high outputs.

²² The National HIV Strategic Plan 2011-15

²³ Ministry of Health Annual Sector Review report 2009/10

3.4 Finance

3.4.1 District Health Funding

Kayunga district health budget is supported by the Government through the Primary Health Care Grant (PHCG), which has been thinning every financial year. Compared to the district health budget needs, this funding is very small. However, there are some partners like MUWRP that supplement this gap and provide health related services in the district. The district through MUWRP has programmes on HIV and AIDS care and prevention through PEPFAR.

Majority of the partners fund HIV related programmes; so the district had to see how other activities can ride on to the HIV wagon given that the funding from government is very limited and a significant proportion of it is on payment of salaries, leaving a small percentage to service delivery.

The Kayunga SMC programme is funded by PEPFAR through MUWRP. The initial programme cost to start SMC in Kayunga catered for capacity building of staff, purchase of supplies, staff salaries, community mobilization and communication. The minor theater at the Kayunga hospital was remodeled and equipped with the necessary equipment and human resource.

3.4.2 National HIV and AIDS Funding

In support of efforts to scale up safe male circumcision (SMC) in PEPFAR programs, readily available data have been applied to estimate the potential cost and impact of scaling up medical MC services in Uganda to reach 80 percent of adult (ages 15–49) and newborn males by 2015. Key conclusions are that scaling up the program would result in averting 428,000 adult HIV infections over the time period from 2009 to 2025, would result in cumulative net savings of almost US\$2 billion over the same time period, and would require approximately 2.4 million MCs to be performed in the peak year (2012)²⁴.

For Uganda, we need to circumcise 3-6 million men to hit the 80% target in five years that is set in the National HIV Strategic Plan 2011-15 and this will cost us 120-200 million US\$, at a cost of US\$35 per SMC²⁵ .

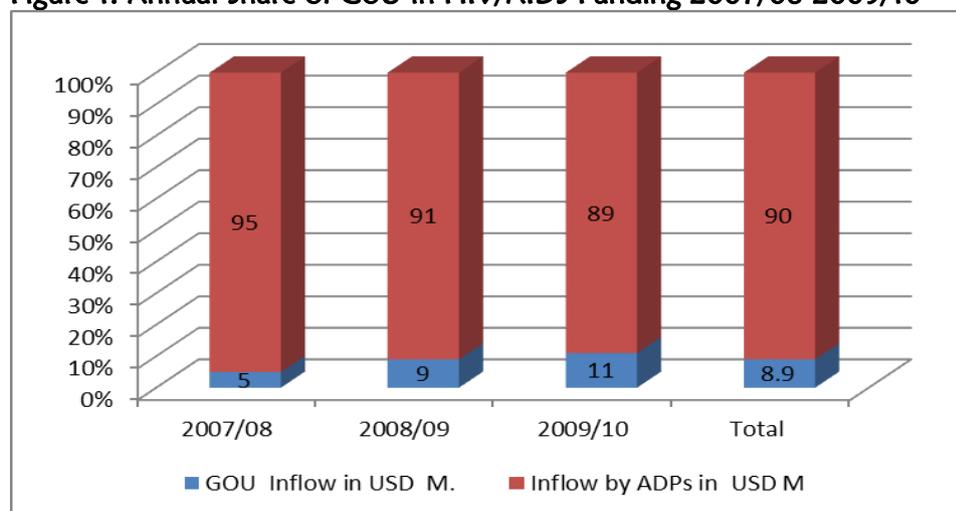
Although, the Government of Uganda contribution towards the national HIV response is shown to have grown from about US \$ 13.9million in 2007/08 to US \$ 36.3m in 2009/10, accounting for 161% percent growth, it is evident that the annual target of increasing Government of Uganda funding to at least 16% of the total funding is yet to be attained. The recent Joint Annual and Mid Term Review of the NSP 2007-12 report showed that the annual share of the Government of Uganda in the total HIV and AIDS funding grew from 5% in 2007/08 to 9% in 2008/09 and

²⁴ USAID/Health Policy Initiative: The Potential Cost and Impact of Expanding Male Circumcision in Uganda, 2009

²⁵ Njeuhmeli et al. 2010a

11% in 2009/10, indicating a total of 8.9% contribution from government and a 90% contribution from the donor community in the 3 year period²⁶.

Figure 1: Annual Share of GoU in HIV/AIDS Funding 2007/08-2009/10



Source: UAC – JAR 2008; UNGASS, 2010 & GFTAM Gap Analysis 2009 and 2010.

In 2010, there was a 10 percent reduction in funding from donor governments for the AIDS response in low- and middle-income countries from the previous year's levels²⁷. With the increasing economic challenges in the developed countries dependency on donor funding is not sustainable.

Inadequate funding for HIV prevention interventions especially SMC from the government has contributed to the slow scale up of SMC in the country despite communities showing a lot of interest in male circumcision.

The Kayunga SMC programme has plans to scale up SMC to the 2 HC IVs. The DHO emphasized the need to scale up SMC to realize any meaningful impact in HIV prevention. In Uganda to avert 1 HIV infection we need to have done 19 circumcisions in a community.

“We definitely have to scale up for SMC to be effective as a prevention strategy, big numbers of circumcised men are needed to be able to avert a single HIV infection in Uganda. You can’t do that with one hospital and one mobile van” said the DHO.

3.4.2 SMC Commodities and Supplies

SMC should be performed in an appropriate facility with proper equipment and supplies. Surgical instruments wear out with use and with repeated disinfection and

²⁶ Joint Annual AIDS Review And Mid-Term Review of the National HIV & AIDS Strategic Plan 2007/08 – 2011/12

²⁷ <http://www.voanews.com/policy/editorials/>

sterilization; hence periodic review of surgical instruments is also important²⁸. In Kayunga, dorsal slit and forceps guided surgical techniques are used and they each vary in the quantity of supplies to be used and in the amount of time taken.



Items and materials used for SMC surgery at the theatre

Photo by: Sylvia Nakasi

Lesson learnt: A successful SMC service delivery depends on a good supply chain system where there is good forecasting, procurement, distribution, storage, stock in hand and disposal management.

3.4.3 Efficient use of facility space

Depending on the number of service recipients, the facility space could either be used in a conventional fixed surgical setup or apply the MOVE principal to maximize efficiency of resources. In the conventional surgical approach (below), typically one surgeon/circumcision provider, assisted by one nurse, performs all steps of the MC procedure for one client. One surgeon/circumcision provider working with one assistant only allows an average of eight to 10 MCs per day. The conventional surgical setup is appropriate when the demand for SMC is low, however, when demand is high the MOVE principle is recommended in the same facility space. Task sharing and shifting, choice of surgical method and scheduling and flow of clients also enhance efficiency in SMC service provision. It's important to do segment or individual booking for clients, provide easy access and exit to the facility, provide pre and post counseling area and recovery area.

Lesson learned: SMC scale up requires significant investment in material, financial and human resources.

Different service delivery models; the conventional fixed and the mobile are necessary to scale SMC.

Some of the factors that impact on efficiency and productivity of SMC are; clinical and surgical techniques used, demand creation, counseling and testing, efficient use of staff and training, efficient use of facility space, client scheduling and flow, commodities and supply chain management and cost efficiency²⁹.

²⁸ WHO/UNAIDS/JHPIEGO, Manual for Male Circumcision under Local Anesthesia, 2008

²⁹ WHO/UNAIDS/JHPIEGO, Manual for Male Circumcision under Local Anesthesia, 2008

Recommendations:

There is need for government to increase its investment in HIV programmes especially prevention programmes like SMC to supplement donor funding that is dwindling due to hard economic times.

The Ministry of Health should develop a costed SMC national action plan that specifies Ugandan and donor commitments, identifying funding gaps and opportunities for resource mobilisation

SMC should be embraced in all HIV programmes by government, civil society organizations and donors, through community mobilization, monitor implementation and advocate for its scale up.

The Ministry of Health and the Uganda AIDS Commission must take lead in rolling out, mobilizing resources, monitor and coordinating SMC implementing partners to ensure quality service delivery.

4.0 Conclusion

Implementation of the SMC programme in Kayunga district is a key learning experience to other districts and partners that are to implement SMC in the country. Given that SMC is more easily acceptable in the communities having a national costed SMC action plan will be a guiding factor to many stakeholders in resource planning and scaling up of SMC in Uganda.

The SMC programme is an entry point for men to access other reproductive health services. Partnerships and proper investments in skilled human resource, supplies and infrastructure are essential.

Implementation of such a comprehensive programme requires adequate funding which cannot be provided for in the Primary Health Care Grant that is allocated to districts and this renders donor funding key in rolling out SMC in districts at the moment, as government lays strategies to raise funds domestically as stated in the National HIV Strategic Plan 2011-15.

Uganda will reach the 80% target in male circumcision by 2015 and benefit from reducing new HIV infection if the Ministry of Health and Uganda AIDS Commission takes lead in SMC rollout by coordinating, monitoring implementing partners to ensure a standard package of SMC programmes are implemented in the communities.

Above all civil society organizations should advocate, monitor, mobilize communities and implement SMC for HIV prevention.

5.0 General Recommendations

Uganda set a target of circumcising 80% of adolescents and men by 2015 in the National HIV Strategic Plan 2011-15. In order to achieve this target, the Ministry of Health needs to develop a strategic plan that clearly indicates roles of different stakeholders with clear strategies in achieving the targets set.

Engagement of national and district political, cultural and religious leadership is very crucial in the scale up of SMC in communities right from the initiation of the programme.

Effective coordination and collaboration with partners at the national and district levels is key to ensure close monitoring and learning in the SMC programme.

Civil society organizations should programme, mobilize communities, monitor and advocate for SMC scale up in their communities.

Demand control for SMC service is crucial in the success of the programme. Mobilization and communication of SMC in the community should be done in the targeted area only, to avoid mistrust and frustrations in the community due to constant turning away of service recipients due to the limited capacity to deliver the service

Women involvement in SMC right from the start of the programme is very important in mobilization of more men and also in supporting their spouses in adhering to abstinence during the 6 weeks after surgery.

SMC programmes should be targeted in populations with a high HIV incidence like lake shores, landing sites, men who have sex with men communities so as to have a big impact to the HIV incidence.

For Uganda, scaling up the SMC program would result in averting 428,000 adult HIV infections over the time period from 2009 to 2025, would result in cumulative net savings of almost US\$2 billion over the same time period³⁰. The high dependency on donor funding is not sustainable because funds from developed countries are scaling down due to the hard economic times thus calling for innovative ways of raising revenue domestically to fund HIV programmes like SMC.

³⁰ USAID/Health Policy Initiative: The Potential Cost and Impact of Expanding Male Circumcision in Uganda, 2009

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