

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

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*; *Operational Guide for Voluntary Medical Male Circumcision Services: A Service Guide for Site Operations* by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

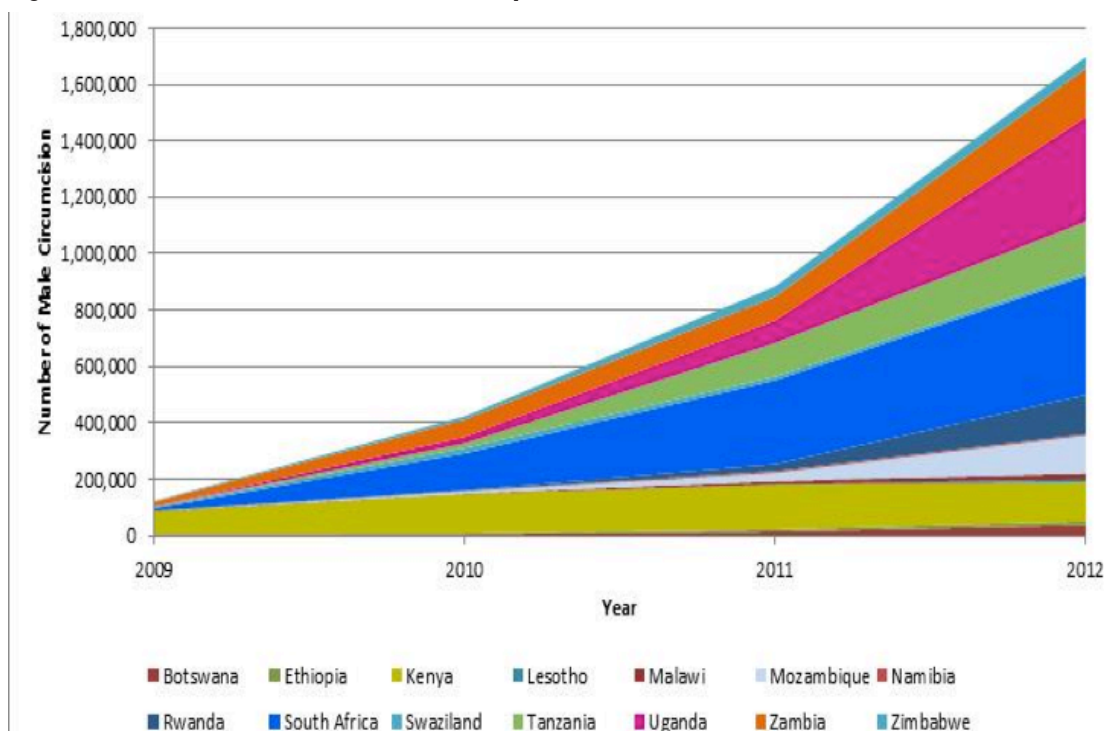
In a quest to bring VMMC to scale, priority countries are learning from one another. In 2012, six countries undertook missions to other countries to exchange experiences in VMMC programming. South-South collaboration built the capacity of priority countries on such issues as preparation for roll-out 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 aspires to achieve 80% VMMC coverage among men aged 15-49 years, requiring approximately 20 million men to be circumcised, and to establish sustainable services for adolescents and /or infants to maintain coverage.

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 circumcisions in selected countries: 2009-2012



Source: UNAIDS GARPR 2013 and Ministries of Health reports to WHO

Large variability occurred across 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 1. With the exception of Swaziland, all other countries also performed more male circumcisions in 2012 than 2011. 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. Swaziland performed 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 only five.

Table 1: 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 Male Circumcisions (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 some, but not all, countries provided age disaggregated data and there was some inconsistency in the age groups reported. For eight countries the proportion of circumcisions among men aged 15 years and older could be computed and ranged from 50% in Swaziland to almost 100% in Ethiopia (Table 2). The weighted average over the eight countries was 85%. In six of these countries, the numbers of circumcised males in the 15-19 year age group were also provided and showed that these age group represented about half of the circumcisions in the age range of 15-49 years.

Table 2: 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	858	1 173	1 082	1 634	53	4 863
Rwanda	714		16 485			121 512		138 711
South Africa				422 009				422 009
Swaziland	7	111	4 818	2 610	1 161	1 223	47	9 977
Tanzania				183 480				183 480
Uganda 0-4 yrs								4 573
Uganda 5-17 yrs								93 899
Uganda >= 18 yrs								270 018
Zambia		67 401				106 591		173 992
Zimbabwe		11 087		12 568	6 916	9 696	488	40 755
TOTAL								1 710 531

Source: Ministries of Health

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 15 to 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 the PrePex™ and ShangRing™. 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. 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 organizations 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 met 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.** 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. Integration of Early Infant Male Circumcision with a routine offer to parents has not been implemented in the majority of countries.
- **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 global and regional partnerships

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SUMMARY REPORT



**World Health
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