

## Expanding Male Circumcision for HIV Prevention

As part of a comprehensive HIV prevention strategy, male circumcision is proven to reduce HIV risk. Yet, a multifaceted intervention is needed to prepare service delivery sites and create an environment for expansion.

*This document is part of a series of briefs for health program managers interested in implementing evidence-based programs. With a special emphasis on underutilized interventions, they present evidence on programs that work and provide guidance and resources for replication.*

### What Works: Clinical Evidence and International Guidance

Three randomized controlled trials completed in South Africa, Kenya and Uganda during 2005 to 2007 demonstrated that male circumcision (MC) performed by trained medical professionals is safe and can reduce men's risk of acquiring HIV through vaginal sex by approximately 60 percent.<sup>1-3</sup> In light of these findings, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) convened a technical consultation in 2007 on MC for HIV prevention. The consultation recommended that geographic areas with high HIV prevalence, driven predominantly by heterosexual sex, and low MC rates immediately integrate MC services as an additional component of existing comprehensive HIV prevention strategies.<sup>4</sup> The international community recommended urgent action because modeling studies revealed that to have an immediate impact on the epidemic, countries would need to increase MC prevalence to 80 percent within five years.<sup>5</sup>

### Why Male Circumcision Is Underutilized

A review of acceptability studies across nine sub-Saharan African countries showed that the most common barriers to MC among men and women are fear of pain, culture and religion, cost and time away from work, and concerns about safety.<sup>6</sup> Yet the review also revealed a number of facilitating factors and that a high proportion of men and women in non-circumcising populations favored MC when associated with a protective effect against HIV. Even if acceptability is likely to be high enough to have a significant impact on the epidemic,<sup>6</sup> health systems barriers must be addressed to meet increased demand for MC services. Barriers to MC at the health systems level include unavailability of trained health staff, lack of instruments and supplies, and inadequate service delivery.<sup>7</sup> Absent or ambiguous health policies and lack of government commitment to adding MC to the existing HIV prevention strategy must also be addressed.

### Where and How Male Circumcision Has Worked

In response to the WHO/UNAIDS recommendations, the government of Kenya launched a national male circumcision campaign in 2008. Recently presented government figures show that by July 2011, government staff and partners had performed over 290,000 circumcisions. Kenya's national plan focused on mobilizing resources to meet the goals of a short-term "catch-up" phase (rapidly providing safe, voluntary MC services to a large number of men), which was reflected in the Rapid Results Initiatives (RRIs). In 2009,

during an RRI in Nyanza Province, where HIV prevalence is high and MC rates are low, approximately 36,000 MCs were performed in just 30 days in 11 districts.<sup>8</sup> An additional RRI conducted in 2010 in Nyanza resulted in 40,000 MCs.

In South Africa, the “Bophelo Pele” project in Orange Farm successfully rolled out MC based on WHO/UNAIDS MC recommendations and guidelines. Orange Farm was the site of one of three randomized clinical trials looking at MC. Data from the Bophelo Pele implementation showed that it is feasible to rapidly expand comprehensive, high-quality MC services according to WHO/UNAIDS guidelines in a low-income African setting that has low MC rates and high HIV prevalence. As of 2009, 14,011 MCs had been performed, representing 39 percent of the clinically uncircumcised men over 15 years of age in Orange Farm.<sup>9</sup> A separate study assessing the impact of MC on the spread of HIV in the Orange Farm community showed that MC conducted by trained medical providers reduced the rate of new HIV infections among circumcised men by 76 percent in three years, demonstrating for the first time that successful promotion of MC can markedly decrease the spread of HIV in endemic communities.<sup>10</sup> Along with the Kenya experience, Bophelo Pele is considered a model for the rollout of MC services.

The successes in Kenya and Orange Farm, South Africa were not solely a result of training providers. In both cases, comprehensive, multifaceted interventions were implemented to ensure the readiness of service delivery sites and to create a political and sociocultural environment that enabled increased uptake. Lessons learned from the MC experiences in Kenya and South Africa, combined with a growing body of MC standards and operational guidance developed by WHO and UNAIDS, can inform the introduction or expansion of MC programs in other priority regions.

Below are features central to the successful introduction and expansion of male circumcision services.

## **LEADERSHIP**

Early and ongoing leadership for the introduction and expansion of MC services needs to be established at national, provincial, district and community levels. On a national level, the government health ministry and national AIDS program, as applicable, must serve as the key government leaders.<sup>11</sup> In Kenya, the involvement of the Kenya Ministries of Health and the National AIDS and STI Control Program (NAS COP) was instrumental to advancing the MC program.<sup>12</sup> The Prime Minister even spoke at local forums and encouraged men to consider MC for HIV prevention. The government also created MC task forces at both national and provincial levels. And in Nyanza province, district-level steering committees were formed to encourage local ownership and leadership of the program.<sup>12, 13</sup>

Engaging community leaders, particularly traditional or religious leaders, to endorse MC and to act as champions is also critical.<sup>11</sup> In Nyanza Province, the Luo Council of Elders was initially resistant to MC because it was typically framed as a cultural practice rather than a medical procedure. After a series of consultations with government officials and MC partners, the Luo Council issued an official statement endorsing MC as a medical intervention for reducing HIV in the community. Not traditionally a circumcising culture, the Luo now accept MC as an additional strategy to prevent HIV, which is instrumental to expanding MC services in Nyanza Province.<sup>12</sup> In South Africa, where Zulu leaders abolished MC a century ago, the Zulu King called for the revival of the practice to help fight the spread of HIV. The King’s approval strongly influenced the uptake of MC among Zulu men.<sup>9</sup>

## **PARTNERSHIPS AND ONGOING STAKEHOLDER ENGAGEMENT**

In addition to strong government and community leadership, a successful MC program needs dynamic partnerships among government agencies and other key stakeholder groups: national and international nongovernmental organizations, civil society groups (including women’s groups), human rights advocates, the private sector, professional associations, training centers, religious groups, the media and funders. Strategic partnerships generate broader support for MC, leverage additional resources and expertise, and ensure that MC advocacy, service delivery, training and research activities are well coordinated and closely aligned with national goals.<sup>11</sup>

In Kenya, organizational partnerships are facilitated and reinforced by the national and provincial MC task forces that meet regularly. The meetings are well attended by government representatives and partner organizations.<sup>14</sup> The task forces also organize annual stakeholders’ meetings in Nyanza Province to maintain community involvement and support. The experience in Kenya also shows that, because MC is a surgical intervention, it is essential to get technical support from medical licensing and medical supply groups.<sup>14</sup> In addition, coordinating the contributions of program partners is essential and requires significant effort (see the section on External Support). In the South Africa Bophelo Pele project, political, traditional, religious, medical and other key stakeholders were engaged as partners from the outset. Select stakeholders also formed a community advisory board (CAB) that reviewed documents and forms related to communication, counseling and outreach.<sup>9</sup> Both the South Africa and Kenya experiences highlight the need for early, continuous and meaningful involvement of stakeholders.

## **KEY POLICY, STRATEGY AND GUIDANCE DOCUMENTS**

Successful introduction and expansion of MC services requires a supportive policy environment. If existing policies and regulations are ambiguous or silent on the provision of MC services, stakeholders should advocate for and guide needed policy revisions. National MC strategies and implementation plans

must be developed, so policy makers and program managers have guides and advocacy tools. Any new national MC strategy should be developed in collaboration with key stakeholders, should complement the existing HIV prevention strategy and should include monitoring and evaluation to track the progress and outcomes of implementation.<sup>11</sup>

In Kenya, key MC-related policy and strategy documents were developed including the following:

- *National Guidance for Voluntary Medical Male Circumcision*
- *Kenya National Strategy for Voluntary Medical Male Circumcision*
- *Communications Strategy on Medical Male Circumcision*

With the support of partners, Kenya also adapted WHO's *Clinical Manual for Male Circumcision under Local Anesthesia*, which provides technical guidance and information on comprehensive male circumcision services. Kenya also developed a plan for the implementation of the national MC strategy. Staff from partner organizations and the Ministry of Health were dedicated full time to the MC program, which was important in developing these documents and promoting their use.<sup>12</sup>

One key policy change was the decision by the Kenya Ministry of Medical Services to permit nurses to be trained in providing MC services. Developed in consultation with the Nursing and Clinical Officers Councils, the new policy authorizes lower level workers to perform the procedure, increasing the number of eligible MC service providers and creating an environment that allows for task shifting and accelerated MC provision.

### **ADVOCACY AND COMMUNICATIONS**

Communications and advocacy planning are critical elements of successful MC programs and should be incorporated into MC programs early.<sup>8</sup> MC messages and materials should be developed in collaboration with stakeholders and geared toward community and district levels as well as the national level. Communications and advocacy efforts must directly address MC myths and misperceptions; target men, women and families; and provide clear, practical and easy-to-understand information on MC.<sup>8,11</sup>

In Kenya, successful high-level political advocacy efforts have transformed public perception of MC. Once viewed as a sociocultural practice, MC is now viewed as a voluntary medical intervention. This transformation was supported by a national MC communications strategy, which involved trainings, workshops and briefings with journalists and the media to help report accurately about MC. MC messages were disseminated nationally, as well as in local languages in Nyanza Province. The media was monitored very closely for accuracy in MC

reporting. The Kenya communications strategy included a communications toolkit, which was developed in collaboration with communications partners.<sup>12</sup> The toolkit, *Voluntary Medical Male Circumcision Communication Toolkit*, includes materials, tools and guiding documents that reinforce the national MC strategy.<sup>15</sup>

### **DEMAND CREATION AND COMMUNITY OUTREACH**

Demand generation is key to promoting the uptake of any new service. MC demand-generation activities need to target both men and women and must be coordinated with capacity-building efforts to ensure health systems are prepared to meet increased demand. Demand creation must also be balanced with education and counseling to promote informed choice and reduce risk behavior.<sup>8</sup> Engaging districts, communities and nongovernmental organizations can help increase demand for MC and its uptake.

In the Bophelo Pele project in South Africa, outreach and communication increased project awareness, MC and HIV knowledge, and drove demand for MC services, which was particularly important as the national-level MC campaign had not yet launched.<sup>9</sup> In Kenya during the successful RRI in Nyanza Province, the provincial government instituted an intensive community awareness campaign via community gatherings and radio, among other forums. MC services were set up at Ministry of Health facilities, hospitals and various outreach and mobile sites.<sup>8</sup> The majority of communications activities to date, however, have been at the national and provincial levels. While these efforts have been successful, there is a strong need for communications and outreach activities focused on the district and community levels.<sup>12</sup>

### **SERVICE DELIVERY – HEALTH SYSTEMS, HUMAN RESOURCES AND COMMODITIES**

In 2008 WHO developed a *Male Circumcision Quality Assurance Guide*, which guides program and facility managers and staff on how to implement safe, quality MC services. The guide includes a uniform set of MC standards for service delivery, which can be adopted as written or tailored to the local context. These standards cover effective management systems; a minimum package of MC services; the medicines, supplies, equipment and environment essential for providing safe, high-quality MC services; provider competencies; client information and education materials or messages; client assessments; evidence-based MC surgical care; infection prevention and control measures; continuity of care; and monitoring and evaluation systems.<sup>16</sup> The standards also refer to the *Clinical Manual for Male Circumcision under Local Anesthesia*, which provides technical guidance and information on comprehensive MC services, including surgical procedures for performing circumcisions for males of all ages.<sup>17</sup>

The Bophelo Pele project in South Africa was implemented according to WHO recommendations. Kenya also adapted

these guidance documents to ensure quality services. Yet as MC implementation progresses, many lessons about effective service delivery have been learned that can supplement WHO guidance. Health systems lessons from Kenya are highlighted below.

- Renovations to facilities may be necessary to scale up program activities. These improvements can be expensive. It is important to identify and prioritize high-volume, high-impact facilities.<sup>14</sup>
- While integrating MC into existing services is ideal in the long run, the rapid rollout of MC often requires investments in vertical (dedicated) services, particularly to meet the goal of increasing MC prevalence to 80 percent. In Nyanza, integrating MC into existing clinics proved challenging. Clients were not willing to wait in long lines for services and preferred services dedicated to MC, rather than waiting at a clinic where many others, including women and children, were being seen.<sup>18</sup>
- To increase access to MC, additional resources are needed to set up outreach\* and mobile service sites at the community level.<sup>8</sup> According to a recent study, all three modes of service delivery — fixed, outreach and mobile — increase access to MC services and may have similar unit costs.<sup>19</sup>
- MC programs must be responsive to variations in demand. Strategies that have been effective in responding to fluctuations in demand include creating a pool of trained staff that can be temporarily hired, dedicating mobile teams to move around to facilities with high demand, implementing client priority schemes, and encouraging MC-dedicated staff to take leave during low-demand periods.<sup>14</sup>
- For the program to be sustainable, staff working at health facilities must be committed to the program and empowered to provide the service. Additional staff need to be trained, the provision of MC services needs to be added to their job descriptions, and potential barriers to service provision need to be understood and addressed.<sup>14</sup> In-service training is insufficient to prepare providers to deliver safe MC services. Efforts must be made to partner with the Ministry of Health and training institutions to integrate MC training in pre-service curricula, and facilitate the development of a national capacity-building and training plan.<sup>12</sup>
- Introducing provider-initiated counseling dramatically increases the number of MC clients getting tested for HIV.<sup>13</sup> Monitoring and maintaining the quality of counseling must also be a priority.

- Task shifting and task sharing among members of MC teams allows for more efficient use of limited human resources.<sup>13</sup> As mentioned, in 2009 the Kenya Ministry of Medical Services authorized nurses to be trained in providing MC services.

## EXTERNAL SUPPORT

Resources dedicated to health are scarce in countries with high HIV prevalence. Introducing and rapidly expanding MC in priority countries will be possible only with sustained financial and technical support. For example, in Kenya, the FHI 360-led Male Circumcision Consortium (MCC) and other partners promoted and facilitated collaboration among the Ministry of Health, NASCOP and other stakeholders; supported the operations of the national and Nyanza provincial task forces; supported the development, adaptation, adoption and implementation of the key strategy, guidance and communication documents; coordinated high-level political advocacy efforts; provided technical support for human capacity development; and helped leverage additional financial resources. NASCOP also posted an MC officer to facilitate the completion of key documents in collaboration with MCC partners.<sup>8</sup> Other partners, PEPFAR partners in particular, supported service delivery. The Kenya experience illustrates that appropriate levels of external funding and staff time must be secured to launch an effective MC program. And at the outset of the program, plans must be in place for eventual transition of the program to local institutions.<sup>8, 12</sup>

## Main Points from Male Circumcision Evidence and Experience

- MC is safe when performed by trained providers and can reduce men's risk of acquiring HIV through vaginal sex by approximately 60 percent.
- Reported MC acceptability is high in many countries in sub-Saharan Africa, and health systems need to be prepared to meet this growing demand.
- Introducing and rapidly expanding MC can only be done with significant financial and technical support.
- Early and ongoing leadership for the introduction and expansion of MC services needs to be established at national, provincial, district and community levels.

\* The key features of "outreach" MC services are 1) a health center or a dispensary in a rural area receives supplemental inputs (staff, equipment, etc.) from a base facility that performs MC; and 2) the health center or dispensary provides minimal or no inputs other than providing space for the MC services.

- A successful MC program needs dynamic partnerships among government agencies and other key stakeholders groups.
- The introduction and expansion of MC services requires a supportive policy environment.
- Communications and advocacy planning are critical elements of successful MC programs and must also be incorporated into MC programs early.
- The Kenya experience highlights numerous service delivery lessons, ranging from task shifting to the importance of vertical programs in the short term.
- Demand generation targeted at both men and women is key to promoting the uptake of MC.

## Expanding Male Circumcision: How to Get Started

The expansion of MC services will not occur spontaneously, regardless of how powerful the evidence is for MC implementation as an HIV prevention strategy. A deliberate, multifaceted strategy is needed to expand MC and replicate the success experienced in other settings. Moreover, each country will require a strategy tailored to local conditions. Guidance is provided below on the initial steps for introducing or expanding MC services.<sup>11,20</sup>

### SITUATIONAL ASSESSMENT

Once the appropriate geographic regions for MC — those with a low proportion of men circumcised and high prevalence of HIV — are identified, conduct a situational assessment with key stakeholders from the Ministry of Health and other relevant institutions. The assessment should address policy and legal framework (including policies that can impede or facilitate task shifting and, as new MC devices are developed, that facilitate the introduction and approval of new devices); culture and religious context; timing and circumstances (e.g. impending political or health systems changes that may affect introduction or scale up of MC services); leadership/coordination capacity; physical facilities and equipment; human resources (both public and private sector); technical skills; training capacity; logistics/supplies; referral systems; supervision systems and quality assurance strategies; presence and capacity of local and international health organizations; existing influential champions or opponents of MC; and health information systems.

As significant financial support is needed to launch or expand an MC program, the assessment should also include a scan of the funding environment. Both external funding sources and opportunities to leverage local resources should be identified.

The *Male Circumcision Situation Analysis Toolkit* provides a framework and tools that can be used to carry out a situation analysis prior to making decisions about how to increase rates of safe male circumcision. The toolkit can be found at: <http://www.malecircumcision.org/programs/documents/MCSituationAnalysisToolkitFINALforprint4O9.pdf>.

### PROGRAM DESIGN

Based on the assessment results and in close collaboration with a team of relevant stakeholders, develop a program strategy to introduce or expand MC services. The program strategy should include the goal and objectives of MC introduction or expansion, the geographic areas in which the MC program will be initiated, the different population groups that will be targeted, how the introduction or expansion will be organized and phased in, how internal and external resources will be mobilized, how to maximize opportunities (such as the presence of groups that already advocate for MC) and minimize constraints (such as impending elections), and how the process and outcomes will be monitored and evaluated. The strategy should be accompanied by a work plan that outlines detailed activities, responsible partners and timelines. As multiple partners will be involved in implementing the strategy, each partner agency should have its own work plan. Review results regularly with the stakeholder team and refine the program as needed for further implementation.

A number of tools are available for those designing and implementing MC programs on the Clearinghouse on Male Circumcision for HIV Prevention website, including *Operational Guidance for Scaling up Male Circumcision Services for HIV Prevention*.

These tools can be found at: [http://www.malecircumcision.org/programs/male\\_circumcision\\_programmes.html#guidance](http://www.malecircumcision.org/programs/male_circumcision_programmes.html#guidance) and [http://www.malecircumcision.org/programs/documents/MC\\_OpGuideFINAL\\_web.pdf](http://www.malecircumcision.org/programs/documents/MC_OpGuideFINAL_web.pdf).

### MONITORING AND EVALUATION

As for all programs, an MC program should have a clear monitoring and evaluation plan. The *Guide to Indicators for Male Circumcision Programmes in the Formal Health Care System* presents indicators that MC programs can use to monitor and evaluate progress toward achieving program objectives. The guide can be found at: [http://www.malecircumcision.org/programs/documents/MC\\_ME\\_final\\_3\\_2010.pdf](http://www.malecircumcision.org/programs/documents/MC_ME_final_3_2010.pdf).

### OTHER RESOURCES

The *Clearinghouse on Male Circumcision for HIV Prevention* maintains a comprehensive inventory of resources for policies and programs, advocacy, training, and research. Visit [www.malecircumcision.org](http://www.malecircumcision.org) for more information.



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