TOO LITTLE TOO SLOW

Results from civil society monitoring of male circumcision for HIV prevention in Uganda

June 2012

Richard Hasunira, Sylvia Nakasi, Prima Kazoora,
Marion Natukunda & Allen Kuteesa

Foreword

THE Ministry of Health launched the Safe Male Circumcision Policy toward the end of 2010. This was a whole four years since research found that medically performed male circumcision reduces the risk of HIV infection in men by an average of 60 percent. It was a long, long wait for a policy to take forward such a highly potent intervention in a country where hundreds of infections take place daily.

And yet, the policy did not come with the much-needed urgency in implementation. As this report demonstrates, the roll-out of safe male circumcision (SMC) in Uganda has so far been driven by PEPFAR, and not the Ministry of Health and Government of Uganda as it should.

The lack of Government leadership in the implementation of SMC – as has largely been the case with the national response to the HIV epidemic – is the reason we have an uninspiring mix of well-facilitated SMC initiatives with poorly resourced ones.

The National HIV and AIDS Strategic Plan (NSP) 2007/08-2011/12 recognises modelling results that revealed that the incidence rate of new HIV infections could be reduced by up to 40 percent with male circumcision as one of the HIV prevention interventions, compared with a decrease of 25 percent without male circumcision.

Consequently, the National HIV and AIDS Prevention Strategy 2011-15 adopted "combination HIV prevention" as the strategy to reverse the country's HIV incidence with SMC as part of the prevention package.

This commitment needs to be followed with concrete action. The UNAIDS/PEPFAR five-year Framework to Accelerate the Scale-up of SMC for HIV Prevention in Eastern and Southern Africa and its ambitious targets should be embraced as an opportunity to catch up on lost time.

By highlighting the good practices, key lessons and gaps in the implementation of SMC so far at national, local government, community and service-point levels, this report is an invaluable resource for accelerated, effective and ethical implementation of potentially one of the most powerful HIV prevention interventions.

Rosette Mutambi
Executive Director
HEPS-Uganda

Acknowledgements

MANY individuals and institutions have made this work possible and, on behalf of our partners in this work, HEPS-Uganda is grateful to them all. District health officers Dr Christine Wanzige (Budaka) and Dr David Okoth (Pallisa) welcomed this project and actively supported service monitoring at safe male circumcision (SMC) sites in the two districts. Special thanks also go to site coordinators: Mr Dauda Kiuluka, Budaka Health Centre IV; Leonard Rotich, Butebo Health Centre IV; and Mr Abdul Kadir Pande, Pallisa Hospital.

The district health officer of Kayunga District was a key informant in this survey. The key circumcision site of Kayunga Hospital generously allowed a tour of the site by members of the Uganda Civil Society HIV Prevention Group and staff of Uganda Network of Civil Society Organizations (UNASO). Makerere University Walter Reed Project (MUWRP), which spear-headed the Kayunga SMC project, provided invaluable support to this work by granting interviews and access to the circumcision site at Kayunga Hospital.

HEPS-Uganda is also grateful to the different people who provided information, guidance and input into the different components of this work: Dr Alex Opio and Mr Sam Eginyu, both of Ministry of Health; Cindra Feuer, Angelo Kaggwa and Emily Bass at AVAC; Denis Kibira at HEPS-Uganda; Milly Katana, WHiPT Uganda Team Leader; and Bharam Namanya at UNASO.

HEPS-Uganda and partners are also grateful to AVAC (Global Advocacy for HIV Prevention) for the financial and technical support and coordination of the different components of this work.

Richard Hasunira
Coordinator, Uganda Civil Society HIV Prevention Working Group
HIV/AIDS Advisor, HEPS-Uganda

Table of Contents

Abbreviations

ART	Antiretroviral therapy
DHO	District Health Officer
DHTs	District health teams
GBV	Gender-based violence
HAG	Health Rights Action Group
HC	Health centre
HCPU	Health Communication Partnership Uganda
HEPS	Coalition for Health Promotion and Social Development
IEC	Information, education and communication
MMC	Medical male circumcision
MoH	Ministry of Health
MUWRP	Makerere University Walter Reed Project
NMS	National Medical Stores
NSP	National HIV and AIDS Strategic Plan
PEPFAR	US President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PNFP	Private-not-for-profit
RHSP	Rakai Health Sciences Programme
SMC	Safe male circumcision
STAR-E	Strengthening TB and AIDS Responses in Eastern Uganda
STIs	Sexually transmitted infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASO	Uganda Network of AIDS Service Organisations
VMMC	Voluntary medical male circumcision
WHiPT	Women HIV Prevention Tracking
WHO	World Health Organisation

Executive Summary

Context

This report summarises results from the work of a consortium of civil society organisations (CSOs) that followed, documented and engaged with the process of rolling-out of safe male circumcision (SMC) services for HIV prevention in different parts of Uganda. The partners were Coalition for Health Promotion and Social Development (HEPS-Uganda); Uganda Network of AIDS Service Organisations (UNASO); Health Rights Action Group (HAG); and Mama's Club.

Approach

This work took an advocacy-and-documentation approach. Over the course of 2010 and 2011, partner organisations monitored the roll-out of SMC under different advocacy projects based on a common evidence-based advocacy theme.

Uganda's SMC policy framework

Key finding: Uganda does not have a costed work plan for the roll-out of SMC. There has not been a systematic costing of the intervention, nor a written-out fundraising plan. As of December 2012, there was no operational plan for the crucial year of 2012, either. The SMC Strategic Plan was yet to be finalised.

Recommendation: Expedite the finalisation of the SMC Strategic Plan, annual operational plan, costed work plan, and fundraising plan as a matter of priority.

SMC implementation structures

Key finding: The National SMC Taskforce does not have regularly scheduled meetings to discuss progress, address challenges and guide the rollout of the intervention.

Recommendation: Re-activate the National SMC Taskforce with civil society representation, and clear terms of reference and work plan, including a schedule of meetings and other key coordination activities.

SMC funding in Uganda

Key finding: Male circumcision for HIV prevention is largely funded by donors. This work did not find information on specific government allocations for SMC but it was clear that any such investment was minimal.

Recommendation: Develop a costed male circumcision national action plan for the country that specifies Ugandan and donor commitments, identifying funding gaps and opportunities for resource mobilisation.

SMC infrastructure and logistics

Key finding: Uganda's SMC programme is a cocktail of best practices and poorly-planned initiatives that represent a waste of precious financial, human and material resources.

Recommendation: Develop an infrastructure development plan to expand theatres to accommodate SMC alongside emergency services. The budget for medical supplies should be expanded at NMS to cater for SMC commodities.

SMC service coverage and access situation

Key finding: There is high, unmet demand for SMC throughout the country. Some service providers are using innovative ways to deal with the high demand.

Recommendation: The district leadership should monitor and ensure that SMC service sites are supported to attend to all the people seeking the service.

Human resources for SMC

Key finding: There is a critical shortage of human resources for SMC, which is competing for health workers with general clinical work.

Recommendation: Meeting the demand for SMC will require task-shifting, innovative outreach and tailored service models and clear goals.

Communication and messaging

Key finding: The key messages have tended to revolve around partial efficacy of SMC and the need to continue with ABC (abstinence, faithfulness and condoms) and other prevention strategies but have not necessarily been uniform across implementers.

Recommendation: Ministry of Health and HCP should develop a set of simplified and translated key messages and circulate them widely to service providers and other audiences.

Gender issues in the rollout of SMC

Key finding: Women's involvement in male circumcision remains limited.

Recommendation: Messaging should emphasize the lack of a direct HIV risk-reduction benefit for women with circumcised partners.

Human rights issues in SMC implementation

Key finding: The initial stages of the roll-out of SMC gave only limited consideration for safeguarding human rights of clients, including informed consent, confidentiality and others.

Recommendation: Make human rights the cornerstone of SMC roll-out, particularly the right of all people to access the service, as well as the right to written, informed consent

Management of negative attitudes, myths and misconceptions

Key finding: There are widespread fears, myths and misconceptions at different levels that are negatively impacting on the roll-out of SMC.

Recommendation: The Ministry of Health, together with HCP and implementing partners, should develop a system of quickly identifying wrong information circulating in communities and swiftly developing and widely communicating clarifications.

1. Context

SMC clients in their queue for the service. MOH/HCP photo

CLINICAL studies conducted in Uganda (Rakai), Kenya (Kisumu) and South Africa (Orange Farm) showed that male circumcision performed by well-trained and equipped medical providers is safe and reduces the risk of heterosexual acquisition of HIV infection among men by about 60 percent (Gray, et. al 2007; Dickson KE, et. al 2011). Male circumcision also has a protective effect against urinary tract infections, syphilis, gonorrhoea, and other sexually transmitted infections (STIs) in men. Male circumcision is also associated with a lower risk of penile and prostate cancers.

In 2007, World Health Organisation (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommended that specific countries with high HIV prevalence, low rates of male circumcision and an epidemic driven by sexual transmission adopt adult voluntary medical male circumcision (VMMC) as one of their HIV prevention interventions. Uganda and a dozen other countries in eastern and southern Africa were accordingly identified as high-priority countries for the implementation and rapid scale-up VMMC.

Over the course of 2010 and 2011, a consortium of civil society organisations (CSOs) followed and engaged with the process of rolling-out of SMC services for HIV prevention in different parts of Uganda, and documented perceptions and experiences at service delivery points, as well as at community, local government and national levels. This report summarises a civil society perspective of Uganda's experience with the implementation of VMMC – known officially in Uganda as safe male circumcision (SMC) – for HIV prevention.

2. Approach

Members of the civil society listen to MUWRP's Dr Fred Magala at the MUWRP field office in Kayunga

THIS work took an advocacy-and-documentation approach. Partner organisations monitored the roll-out of SMC under different advocacy projects based on a common evidence-based advocacy theme. They identified good practices, key lessons and gaps in the implementation of SMC at national, local government, community and service-point levels in order to inform advocacy for accelerated, effective and ethical implementation of potentially one of the most powerful HIV prevention interventions.

In Kayunga district (central Uganda), the Uganda Network of AIDS Service Organisations (UNASO) documented lessons and good practices relating to human resources, financing and messaging in one of the country's earliest SMC projects. This component was undertaken as an AVAC HIV prevention research advocacy fellowship project hosted at UNASO and implemented through 2011.

In Kapchorwa district (eastern Uganda), where female genital mutilation as well as male circumcision are traditionally practiced, and the capital Kampala , Health Rights Action Group (HAG) and Mama's Club – both working under the AVAC-sponsored Women HIV Prevention Tracking (WHiPT) project – engaged communities around the implementation of SMC and documented women perceptions. A report for the first phase of this component, implemented over the course of 2010, has been published separately.[1]

In Budaka and Pallisa districts in eastern Uganda, the Coalition for Health Promotion and Social Development (HEPS-Uganda), engaged district-level SMC stakeholders and SMC service centres and mobilised communities for SMC. This component was implemented in the second half of 2011.

At the national level, HEPS-Uganda, UNASO, HAG and Mama's Club, working with other civil society partners under the Uganda Civil Society HIV Prevention Working Group[2], engaged the National SMC Taskforce, parliament and other national stakeholders over the course of 2011, to advocate for the expedited and effective implementation of SMC in Uganda.

[1] Available at http://www.avac.org/ht/a/GetDocumentAction/i/31646

[2] The Uganda Civil Society HIV Prevention Working Group is a coalition that brings together Ugandan advocates and advocacy groups working to promote access to proven HIV prevention approaches and to accelerate ethical biomedical research into new options that are safe and effective. See http://health.groups.yahoo.com/group/preventionadvocacy/

3. Circumcision situation in Uganda

IN Uganda, male circumcision is traditionally practiced largely for religious and cultural reasons by a section of the population. The Ministry of Health (2006) estimates that one quarter of Ugandan men aged 15-59 years were circumcised by 2005. The prevalence of male circumcision however, varied widely, from 55 percent among men in the eastern region to less than 10 percent of men in north central, north east and south western regions. And across faiths, male circumcision was highest among Muslim men (97%) and lowest among Catholics (10%).

However, research conducted in Uganda and other countries had showed that men reporting circumcision have, on visual inspection, either not undergone any removal of the foreskin but only a ritual cut or have had a smaller or larger portion of the foreskin than would constitute circumcision in the medical definition of the term (Thomas, et al., 2011). Hence, these data on the status of male circumcision in Uganda may not necessarily give a true picture of actual circumcision prevalence in country.

A study by the Uganda Ministry of Health and HCPU (2009) revealed that 44 percent of uncircumcised males intend to get circumcised. Three out four of these intend to circumcise principally to reduce chances of HIV infection (HCP 2010).

A cartoon in The New Vision of 12 December 2011

4. The UNAIDS/PEPFAR plan to scale up male circumcision: Implications for Uganda

UNAIDS and the US President's Emergency Plan for AIDS Relief (PEPFAR) jointly launched "The Framework to Accelerate the Scale-up of SMC for HIV Prevention in Eastern and Southern Africa (2012-2016)" early December 2011. The framework, to which Bill and Melinda Gates Foundation (BMGF), the World Bank, and ministries of health in the target countries are party, seeks to accelerate the scale up of SMC for HIV prevention, and guide key stakeholders to collaborate and coordinate efforts for promoting country ownership and expanding coverage of make circumcision as a component of "combination HIV prevention".

The framework is guided by the vision that: "**VMMC is established as an HIV-prevention social norm for neonates, adolescents and adults and acts in synergy with other HIV prevention, and reproductive health strategies, to move towards zero infections in countries with generalised epidemics where the MC prevalence is low."**

The framework targets to achieve circumcision prevalence of at least 80 percent among 15-49 year old males (20 million males) in the target countries in eastern and southern Africa, including Uganda, and establish a sustainable national programme that provides SMC/VMMC services to all infants (up to 2 months old), and at least 80 percent of male adolescents. This is expected to avert 3.4 million new infections by 2025. This is expected to cost US$1.5 billion and then save US$16.5 billion by 2025 in averted treatment costs.

In the case of Uganda, the UNAIDS/PEPFAR framework means that the country should circumcise an average of 840,000 men annually for the next five years, to top 4.2 million circumcisions in five years. The plan suggests circumcising 1.2 million men in 2012 alone, to kick-start the five-year drive that should eventually avert a projected 340,000 new HIV infections by 2025.

Dr Alex Opio, National SMC Taskforce Chair at the launch of the clinical guidelines and educational materials December 14, 2011

5. Uganda's SMC policy framework

KEY FINDING

Uganda has published an SMC policy as well as the SMC Communication Strategy. However, the country does not have a costed work plan for the roll-out of SMC. There has not been a systematic costing of the intervention, nor a written-out fundraising plan. As of December 2012, there was no operational plan for the crucial year of 2012, either. The SMC Strategic Plan was yet to be finalised.

RECOMMENDATION

Expedite the finalisation of the SMC Strategic Plan showing how the country will achieve the needed 4.2 million circumcisions over the next five years; as well as an annual operational plan to clarify the different activities planned and stakeholder roles and contributions. A costed work plan covering the next five years and a clear plan to raise the needed funding should be published as a matter of priority.

UGANDA has recognised male circumcision as a key intervention within the broader framework of male reproductive and sexual health that should contribute to a marked reduction in new HIV infections in Uganda. The National HIV and AIDS Strategic Plan (NSP) 2007/08-2011/12 particularly makes note of modelling results that revealed that the incidence rate of new HIV infections could be reduced by up to 40 percent with male circumcision as one of the HIV prevention interventions, compared with a decrease of 25 percent without male circumcision. The National HIV Prevention Strategy 2011-2015 targets to increase the proportion of adult males that are circumcised to 80 percent, from an estimated 25 percent in 2005.

The Ministry of Health launched the Safe Male Circumcision Policy in September 2010, to provide a framework for increasing access and use of safe, and sustainable male circumcision services as an integral part of the HIV prevention strategy. The SMC Communications Strategy was also launched on the same occasion.

However, the rest of the development of the other necessary policy-related documents has been slow. The clinical guidelines and educational materials were only launched about a year later, on December 14, 2011. But by the end of the year, the SMC Strategic Plan was still in draft form. A work plan for the planning period, a budget, fundraising strategy, as well as an operational plan for 2012, when the country is expected to circumcise the biggest number of the males in the five-year planning period, were yet to be drafted.

The ongoing revision of the NSP; national proposal drafting process for Round 11 (Transitional Funding Mechanism) of the Global Fund; the negotiation of a working framework with PEPFAR for the next five years; and the 2012/13 national budget formulation, among other ongoing and upcoming policy and planning processes, provide excellent opportunities to fill the gaps so far identified in this and other monitoring processes.

6. SMC implementation structures

KEY FINDING

The National SMC Taskforce, which is supposed to drive the intervention, does not have regularly scheduled meetings to discuss progress, address challenges and guide the rollout of the intervention. Different partners are providing SMC services, but services are not coordinated from the top. Public referral-level facilities were expected to start offering SMC services free-of-charge following the launch of the SMC policy, but there was neither clear communication to them of the commencement of service delivery nor additional resources for it.

RECOMMENDATION

Re-activate the National SMC Taskforce with civil society representation, and clear terms of reference and work plan, including a schedule of meetings and other key coordination activities. The Ministry of Health and the National SMC Taskforce should publish guidelines for the different implementing partners and a common reporting format to ease monitoring at the national level. A monitoring and accountability system for tracking numbers of male circumcisions performed by trained government staff and at government facilities should be put in place.

THE rollout of SMC is spearheaded by the Ministry of Health through the 15-member National SMC Taskforce, and SMC services delivered at public referral-level health facilities (Health Centre IV and hospitals) are free-of-charge. SMC services are also being provided by private and private-not-for-profit (PNFP) health facilities. Private facilities charge for the service, while services in PNFP facilities are either subsidised or free, thanks to different donors.

Following the launch of the SMC policy in September 2010, public health facilities with the required capacity were expected and encouraged to start providing SMC services free of charge. There was no clear, formal communication from the Ministry of Health to the health facilities on the commencement of the service. In Pallisa and Budaka districts, a PEPFAR-funded project known as Strengthening TB and AIDS Responses in Eastern Uganda (STAR-E), together with the district health offices and health facilities identified and trained sets of health staff in the delivery of SMC services.

After the training, delivered by Makerere University Walter Reed Project (MUWRP) in Kayunga district, the service was deemed to have started at the relevant health facilities. The budgets for the health facilities, including supplies and staff remained the same; and the Health Management Information System (HMIS) did not provide for SMC as a separate service.

The SMC rollout effort has not been effectively coordinated. It is not clear whether the meetings of either the National SMC Taskforce or the technical working group were actually taking place.

After noting gaps, the team participating in this work followed up with the taskforce to share the findings of the WHiPT project; to invite the taskforce members to participate in ongoing community dialogues; and request a closer working relationship, including exploring the possibility of civil society representation on the taskforce/technical working group. On

"Many (stakeholders) are providing circumcision services but I have no single figure of those circumcised... We are not coordinating our work; data is not being shared." - SMC National Taskforce chairperson, 14 December 2011

multiple occasions over a period of five months, the team was not successful. There was no schedule for the taskforce meetings, and even a meeting was finally scheduled, it was called off at the last moment.

In December 2011, members of this project team were invited "to share their experience with the SMC campaign" at the National SMC Taskforce meeting scheduled for December 14, 2011. As it turned out later, however, it was not a taskforce meeting, but a rather large stakeholder meeting during which educational materials, clinical guidelines and public awareness materials were launched.

Currently, SMC is a stand-alone intervention, and is perceived by some stakeholders to be provided independent of other HIV prevention or even reproductive health services. Stakeholders raised concerns about "parallel planning" by STAR-E, accusing the intervention's major sponsor of diverting health workers from other health service delivery interventions that need the same health workers.

Even at the local government/district level, SMC implementation was not effectively coordinated. Over the course of 2011, HEPS-Uganda's intervention in the two districts concentrated on assessing the situation; facilitating stakeholder dialogue around the existing gaps and challenges; and mobilising communities to understand and access SMC services. Stakeholder dialogues in Budaka and Pallisa districts clarified roles and created a sense of responsibility among the different players.

For instance, the office of the district administrative officer took steps to address the problem of a non-functional electricity generator at Butebo Health Centre IV; the medical superintended of Pallisa Hospital authorised the SMC coordinator to ensure supplies for SMC are included in the hospital's requisitions to the National Medical Stores (NMS); while the district health office was negotiating more appropriate space for SMC surgeries in the hospital. These processes contributed to the marked improvement in service delivery and access that was observed in the two districts by the end of 2011.

This work found that there was no written plan to respond to major adverse events and other service emergencies, to minimise or avoid damage to the entire intervention in case something ever went wrong.

7. SMC funding in Uganda

KEY FINDING

Male circumcision for HIV prevention is largely funded by donors. This work did not find information on specific government allocations for SMC but it was clear that any such investment was minimal. To achieve the target 80 percent SMC coverage in the next five years, the country needs to circumcise 3-6 million male adults, children and infants. This could cost US$ 120-200 million, at an average of US$35 per circumcision (USAID, 2009).

RECOMMENDATION

Develop a costed male circumcision national action plan for the country that specifies Ugandan and donor commitments, identifying funding gaps and opportunities for resource mobilisation.

AS of the end of 2011, ownership and financial commitment from the government to SMC was virtually non-existent. The different SMC implementation initiatives that were taking place in different parts of the country, were all donor funded and driven by non-government partners. Even where SMC was provided in public health facilities, as the case was in Budaka, Pallisa and Kayunga districts, staff training, supplies and staff motivation were being provided by donor projects, most of them funded by PEPFAR.

The rollout of SMC in eastern Uganda is being funded by PEPFAR through the STAR-E project. It is one of the several PEPFAR-funded projects that are supporting SMC service delivery in the different regions of the country. The project funded the training of SMC staff in Budaka and Pallisa districts; mobilisation for circumcision camps (outreaches); pays allowances of SMC staff during circumcision camps; and provides equipment and consumables. The five-year project started in March 2009 to provide HIV prevention interventions and entered its fourth year in October 2011.

Members of District Health Teams (DHTs) expressed concerns that a new service had been introduced without additional resources to health services being increased and warned that providing more services on the same resources was likely to affect the quality of services. Neither the central government nor the district administrations have allocated resources for SMC.

In Kayunga district, as is the case with other districts, the Primary Health Care (PHC) grants from government which are dwindling and very limited and largely fund health education and sensitisations at community level.

8. SMC infrastructure and logistics

KEY FINDING

Uganda's male circumcision programme is a cocktail of best practices and poorly-planned initiatives that represent a waste of precious financial, human and material resources. There is no space in some theatres for SMC, and no provision for SMC commodities at NMS

RECOMMENDATION

Develop an infrastructure development plan to expand theatres so that SMC does not compete for space in theatres with life-saving, emergency cases. The budget for medical supplies should be expanded at NMS to cater for SMC commodities and close gaps in the supply chain for necessary commodities.

THERE are examples in Kayunga district, Rakai district and elsewhere of programmes that are appropriately staffed, with adequate theatres, counselling space, supplies and a commitment to providing SMC services in the context of comprehensive prevention and community mobilisation. On the other hand, are also examples of initiatives where staff trained with donor funds are unable (due to lack of logistical supplies, etc) or unwilling (due to heavy work load) to perform male circumcision. There is wastage of resources when staff, many of

ONE PROGRAMME, TWO FACES: The bushy, littered compound of a circumcision site in Pallisa district; versus a state-of-the-art mobile circumcision unit at Mukono Health Centre IV near Kampala

whom are stationed at government facilities, are trained and not supported to provide the service.

Stakeholders participating in district-level dialogues organised by HEPS-Uganda in Pallisa and Budaka learnt that there was no provision from the Ministry of Health to cater for SMC at the health units. SMC sites reported intermittent supply of consumables such as gloves, cotton wool, bandages and switchers from STAR-E.

The SMC site coordinator at Pallisa Hospital reported during a stakeholder dialogue that the SMC team were allowed to requisition for only a limited quantity of supplies for SMC from NMS, which they even never got to use by then as they were diverted to emergency surgeries. It was however, agreed during the dialogue that henceforth SMC units access the supplies as NMS delivers them and then store them separately. The Pallisa Hospital SMC team reported in December 2011 that they were doing this.

Pain killers are basic but essential supplies for SMC. However, some sites reported a challenge accessing them

9. SMC service coverage and access situation

KEY FINDING

There is high, unmet demand for male circumcision in communities throughout the country. Some service providers are using innovative ways, such as outreach camps and mobile circumcision van, to deal with the high demand, while others are just turning them away

RECOMMENDATION

The district leadership should monitor and ensure that SMC service sites are supported to attend to all the people seeking the service. The model of outreach camps as has been used in Budaka and Pallisa districts to mop-up excess demand, and that of a mobile circumcision van as has been used by MUWRP to reach underserved areas in Kayunga and Mukono districts should be adopted for the rest of the country to meet the overwhelming demand for services

COMMUNITIES in different parts of the country report high demand for safe male circumcision and service providers are unable to meet this demand. Donor-funded SMC outreaches have failed to meet the demand and government health centres are turning them away because of lack of capacity or logistics to provide the service. Kampala providers reported

PEPFAR-supported SMC service sites by December 2011

Region	USG Partner	# Districts	# facilities
Northern Uganda	NUMAT, (AMREF-1)	15	24
Central	AMREF, IDI	8	25
Eastern	STAR-E	11	16
East-Central	STAR-EC	9	15
South-Western	STAR-SW	13	24
Kayunga/Mukono	MUWRP	2	5
Central	Rakai Health services	4	4
Countrywide	HIPS	19	67 (34 Kla)
Selected districts	IRCU		19
Selected regions	Baylor (West Nile Region)	7	21
Total		**58 (84)**	**109 (216)**

Source: Ministry of Health

feeling “totally overwhelmed” by demand. There were reports of staff focusing exclusively on male circumcision and neglecting their other duties given the high demand.

There is overwhelming demand for SMC across the Pallisa and Budaka districts, which the existing three sites have no capacity to handle. The circumcision camp approach was adopted to mop up excess demand, but service providers were not able to circumcise all the people that turned up. Clients given appointments for the routine service were unable to access the service on the appointed dates mainly because of shortage of logistics.

The service is targeted at males aged 15 years and above. However, SMC sites reported high numbers of children clearly below the age limit turning up at circumcision outreach camps claiming to be 15 and demanding to be circumcised. Stakeholders attending the dialogue meetings in Budaka and Pallisa districts expressed fears that the entire intervention might be perceived negatively in the community or even opposed if children continued to escape from school and to return home to shock their parents with circumcision wounds.

Stakeholders discuss SMC implementation in Budaka 28 November 2011

10. Human resources for SMC

KEY FINDING

There is a critical shortage of human resources for SMC. Staff participating in SMC training programmes are drawn from the mainstream clinical work, which has placed extra pressure on health facilities. This work noted discontent in the diversion of human resources from general clinical services as well as controversy around motivation of SMC staff, who are paid by SMC projects.

RECOMMENDATION

Meeting the demand for SMC will require task-shifting, innovative outreach and tailored service models and clear goals. Ugandans recognise the benefits of SMC and should have access to it as part of their right to health.

There are two service providers for training of SMC service providers – MUWRP and Rakai Health Sciences Programme (RHSP) – that provide health workers from the mainstream health system with circumcision skills. This has heightened the shortage of staff as no new ones have been recruited to fill the gaps the SMC implementation is creating.

An SMC surgeon with Makerere University Walter Reed Project. People of his calibre are in short supply in Uganda

The health workers highlighted the interruptions in SMC as the surgeons have to keep running between the theatre and out-patients to carry out clinical work. At one facility, a clinician working at an HC IV who had been trained by a donor-funded initiative now refuses to carry out the procedure claiming that he is overworked and does not have time to add the surgery to his other responsibilities. The only other capable person is the District Health Officer (DHO) who does not have time to do clinical work.

One DHO expressed concerns that the introduction of SMC was hurting other services as health workers have been diverted to SMC. Budaka DHO expressed particular opposition to staff diverted to provide SMC services at circumcision outreach camps in neighbouring Pallisa. "*SMC has become a liability to the delivery of health services,*" said the official.

Project payments to SMC staff has been a source of controversy and caused friction at some health facilities. STAR-E for examples, gives a daily allowance of Ushs 30,000 to health workers providing SMC services during circumcision outreach camps. While health workers attending the stakeholder dialogue in Budaka complained that the amount was too little, other stakeholders said it was responsible for diverting staff from other services. There were also concerns that the allowances were likely to create differences between health workers involved in SMC and the rest of the health workers who consider themselves not equally favoured even as they carry a bigger workload when colleagues are away during SMC outreaches.

At the time of this work, there were only two community mobilisers that are supported by STAR-E to mobilise in the two districts and service providers reported that the mobilisers are too few to reach some parts of the two districts. This prompted some service providers to divert valuable time to get involved in mobilising potential clients to take up the service.

At one health facility, in spite of a donor-trained team in place, they had arranged for a private doctor to come once a week and perform the surgery at a cost. These are some of the examples of how financial resources committed to training are going to waste because the government and partners do not have a well-organised strategy for implementation.

11. Communication and messaging

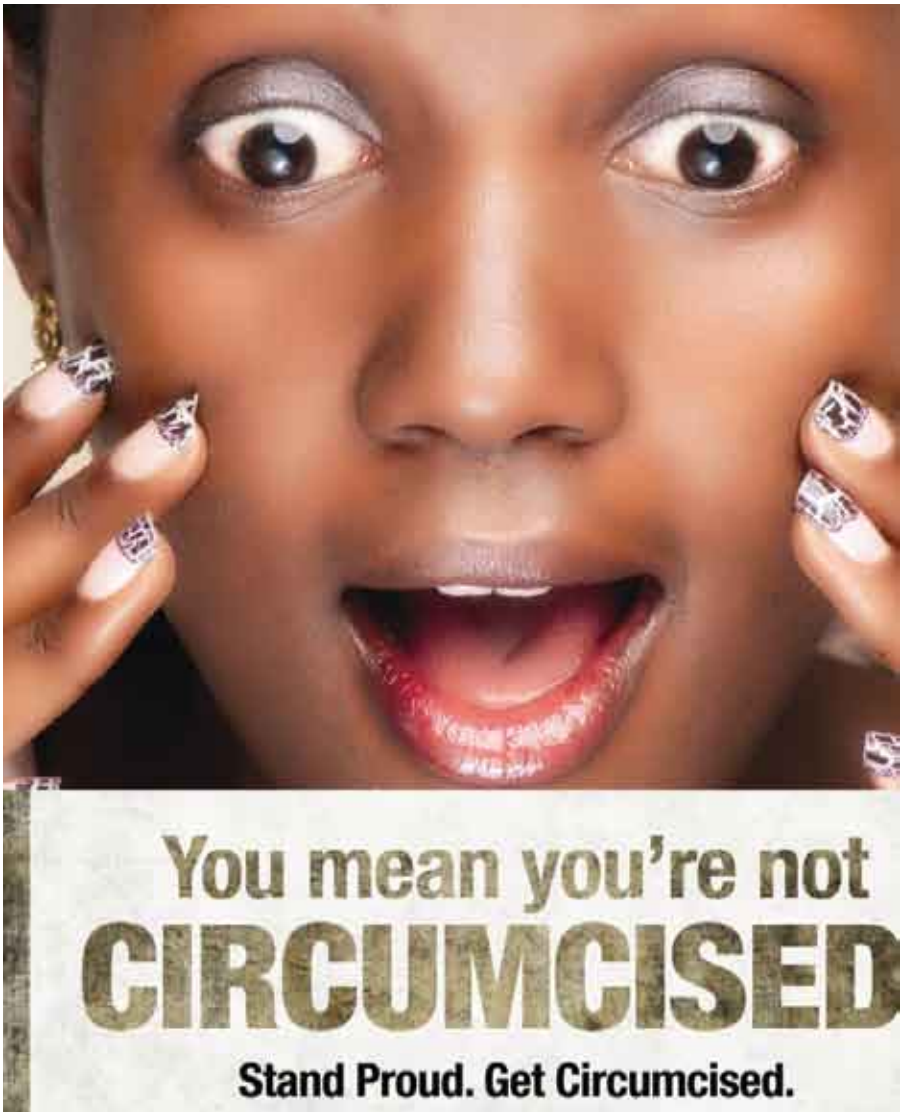
KEY FINDING

Different partners were implementing SMC in different parts of the country prior to the MOH's communication policy (September 2010) and SMC information, education and communication (IEC) materials (December 2011), and therefore there has not been a common communication strategy or plan. The key messages have tended to revolve around partial efficacy of SMC and the need to continue with ABC (abstinence, faithfulness and condoms) and other prevention strategies but have not necessarily been uniform across implementers.

RECOMMENDATION

Ministry of Health and HCP should develop a set of simplified and translated key messages and responses to frequently asked questions (FAQs) on SMC, and circulate them widely to service providers and other audiences

THE FACE OF SMC: There was a deliberate effort to give circumcision a female face on publicity materials. Below is the sign for service sites



"Medical circumcision is done for all men, if we only circumcise HIV negative men, it will cause stigma, and even those who have been circumcised, might use circumcision as proof of their HIV negative status in the community even when they could have contracted HIV after the circumcision", said a surgeon at Kayunga site.

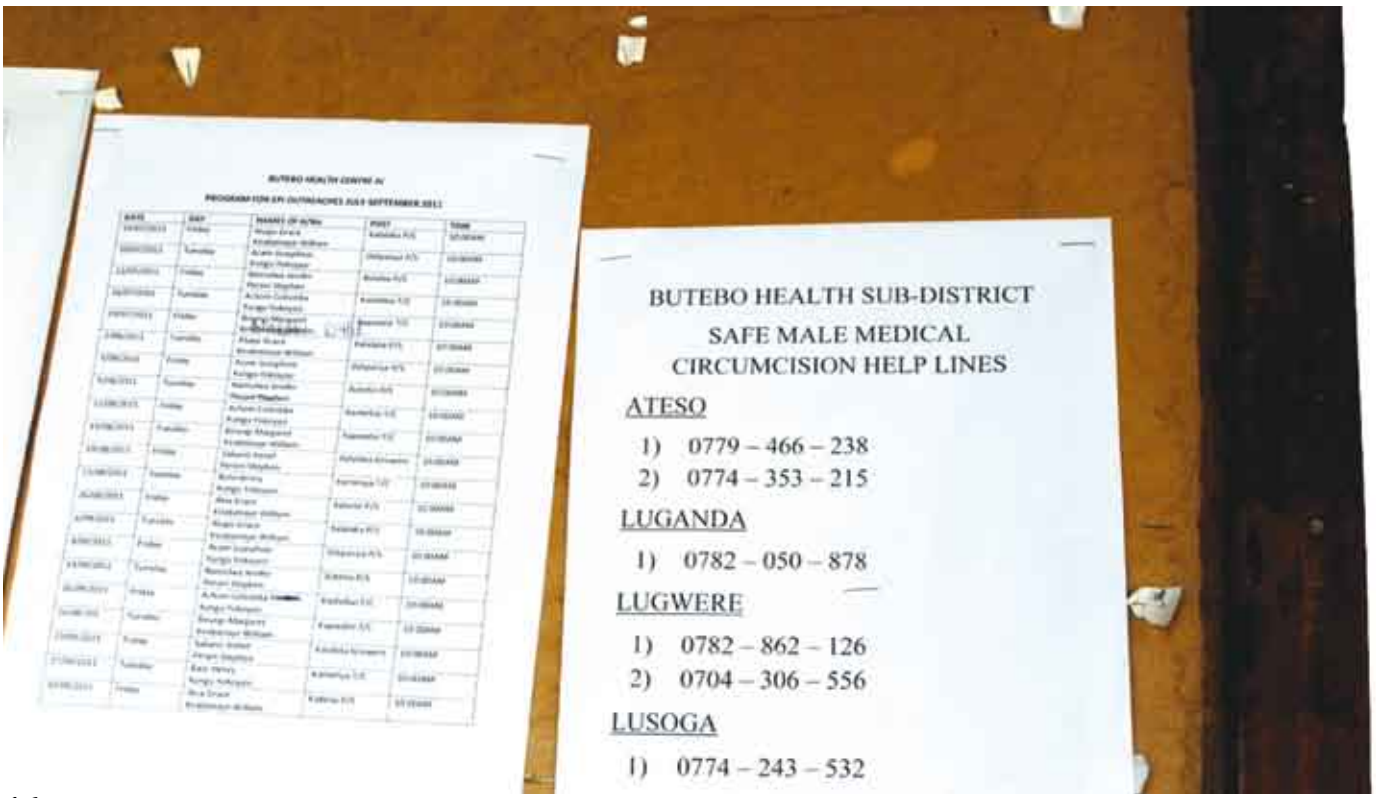
A National SMC Communication Policy was launched in September 2010, followed by SMC information, education and communication (IEC) materials in December 2011. These resources came in place after some partners had already started providing SMC for HIV prevention. That means that what started as "medical male circumcision" (MMC) when RHSP and MUWRP started offering it in 2008 and 2009 respectively, ended up being "safe male circumcision" upon the launch of the policy.

When MUWRP for instance launched the circumcision programme in Kayunga, there was no standard way of initiating the service and the project had to develop its own strategies for communication, approaches to community mobilisation and key messages. They engaged political, religious and cultural leaders; dealt with questions about an alleged Islamisation agenda; and other fears and myths.

Mobilisation was done through radio, bill boards, posters, community mobilisers and peer educators. One innovation was the use of a "youth centre", an HIV care facility purposely built to serve the youth, by providing facilities for entertainment, and indoor and outdoor games, alongside health education, HIV counselling and testing as well as antiretroviral therapy (ART). The centre has successfully been used to mobilise the youth for SMC. During the one year pilot phase, 600 men were screened for HIV and 513 circumcised. By mid this 2011, an average of 35 men were circumcised daily at the Kayunga Hospital site. The number of men circumcised was reported to be just over 10,000 since MUWRP started in 2009.

Key messages communicated were about where the service is being offered, the partial efficacy of SMC as an HIV prevention strategy, eligibility for circumcision, and that the service was free of charge. Men who tested HIV positive but were otherwise in good health were circumcised. However, those with opportunistic infections were referred to the ART clinic for treatment.

Butebo Health Centre IV (Pallisa district) noticeboard 20 July 2011



12. Gender issues in the rollout of SMC

KEY FINDING

Women's involvement in male circumcision remains limited, as does men's compliance with recommendations regarding abstinence for the entire duration of wound healing.

RECOMMENDATION

As SMC is rolled out, advocates, grassroots women's groups, implementers and government must provide clear and correct messages to men and women and train the media with factual information, highlighting risks and benefits of SMC for HIV prevention overall and the implications for women. Correct messaging should emphasize the lack of a direct HIV risk-reduction benefit for women with circumcised partners. SMC messages especially on post circumcision should target women as well in order to increase support and adherence to the recommended six weeks of abstinence during wound healing.

THERE is no conclusive evidence that male circumcision has a direct effect on women's risk of HIV infection. Observational studies have suggested an overall 20% lower HIV incidence in female partners of circumcised men, compared with partners of uncircumcised men (Weiss H, et. al. 2009). Other benefits of male circumcision to female partners of circumcised men have less risk of cervical cancer and some STIs, such as Chlamydia, genital herpes, chancroid and syphilis.

Women engaged in Kapchorwa, where female genital mutilation is a cultural practice and in Kampala, are generally supportive of the implementation of SMC as an HIV prevention strategy in their communities. However, there was wrong information in the communities about the benefits of SMC, which if not addressed will pose a danger to entire intervention. Nearly half of the women interviewed believed that SMC is protective for them directly. Nearly two-thirds believed SMC would change ideas around HIV risk.

These perceptions ranged from concerns that men would increase behaviour risks and possibly lead to an increase in gender-based violence (GBV) and heightened stigma for women living with HIV. This could be a result of circumcised men's misperception that circumcision confers permanent HIV-negative status and/or that they cannot transmit the virus. There were fears that, in such situations, safer sex could be less negotiable than before circumcision, putting women at greater risk for GBV.

In Kayunga, women involvement by their spouses before circumcision was minimal despite, the programme emphasizing its importance to the men during the health education sessions. Up to half of the men interviewed reported that their decisions to get circumcised were influenced by their peers, which suggested that they probably never consulted their spouses. A few men participating in the focused group discussions in Kayunga feared their spouses might discourage them from getting circumcised. Only one in 10 men who had undergone circumcision reported to have fully adhered to recommended minimum six weeks before resuming sexual activity, indicating an elevated risk of HIV transmission to their female partners.

Women who participated in community dialogue and focused group discussions were generally supportive of the idea of their male partners getting circumcised. What is needed is to ensure women across the country are reached with clear messages on SMC to help them understand and dispel fears, myths and misconceptions.

13. Human rights issues in SMC implementation

KEY FINDING

The initial stages of the roll-out of SMC gave only limited consideration for safeguarding human rights of clients, including the right to information, informed consent, confidentiality and the right of minors to access health services, including their right to participate in decision making

RECOMMENDATION

Make human rights the cornerstone of SMC roll-out, particularly the right of all people to access the service; the right to full and correct information on SMC, including the benefits and risks; as well as the right to written, informed consent

ACCORDING to WHO/UNAIDS (2007), countries should ensure that male circumcision is provided with full adherence to medical ethics and human rights principles, including informed consent, confidentiality, and absence of coercion. The age of consent in Uganda is 18 years. This means that a client of 18 or older can make the decision to be circumcised himself. For the age of 17 years or younger, a parent or legal guardian's signed consent is required. SMC counselling must be provided to the parent or guardian to ensure their consent, on behalf of the minor, is informed.

The Minimum Standards of Procedures for Safe Male Circumcision (MoH, 2011) require the following steps for obtaining informed consent from clients:

- Administer signed client consent for any client 18 years old and above.
- Administer signed parental or guardian consent for newborns and children from birth to 17 years old.
- Administer signed client consent for the underage 18 who report that they do not have a parent or guardian to provide consent and there is proof from the local council (LC) that they are functional adults or emancipated minors.

It emerged during the community dialogues and focused group discussions that the issue of informed consent was particularly not being taken seriously at SMC sites, which raises ethical questions for the roll-out of the service. Health workers reported that some clients consented verbally, while others put their consent in writing but such records were not well kept. At the time of this work, SMC sites in Budaka and Pallisa neither had standard procedures for obtaining informed consent, nor standard forms/formats for clients' consent due partly to overwhelming demand. So it is possible that decisions to get circumcision may have been based on wrong information, which can disastrous for the HIV prevention response.

It was also observed that minors were falsifying their age in an attempt to access SMC services. While the national SMC policy provides for SMC for minors, and the chairperson of the National SMC Taskforce maintains that minors should be offered the service, the guidelines for SMC projects supported by PEPFAR, the biggest supporter for SMC implementation in Uganda, requires a minimum age of 15 years. Therefore, at PEPFAR-supported sites, minors of 14 years and below are turned away. Some sites reported attending to minors only when the numbers of adults were low.

14. Management of negative attitudes, myths and misconceptions

KEY FINDING

There are widespread fears, myths and misconceptions at different levels that are negatively impacting on the roll-out of SMC.

RECOMMENDATION

The Ministry of Health, together with HCP and implementing partners, should develop a system of quickly identifying wrong information circulating in communities and swiftly developing and widely communicating clarifications, including responses to frequently asked questions

THIS work found attitudes, fears, myths, misconceptions and untruths at individual, community, professional and policy levels that may not favour the speedy roll-out of SMC as an HIV prevention strategy in Uganda. In spite of the clear messaging that SMC is conducted medically for health reasons, stakeholders felt common talk in the communities continue to

LET'S TALK ABOUT THIS: A circumcision counsellor during a session at Kayunga Hospital.

link the service to a hidden agenda to Islamise them. Among programme managers and district administrators, the need to resource the roll-out of SMC and to promptly provide the service to those seeking it is not felt, arguing that "circumcision is not an emergency". Programme managers and health workers generally felt that SMC is not an emergency!

"*If the health centre has to incur a cost on the generator, it will be to save a life not an operation like SMC which is not an emergency,"* said one DHO

One of the respondent peer mobiliser in Kayunga reported that despite having mobilised many young men for SMC in his community, he was still sceptical to do it himself because he had heard that circumcision reduces one's sexual urge. At a community dialogue in Kampala, a few participants strongly believed circumcision adds to sexual performance, and others that sex was more pleasurable with a circumcised man. In a situation where there is a shortage of staff to provide adequate counselling to large numbers of clients seeking the service, such misinformation could lead to an upsurge in risky behaviour among circumcised men and among women seeking "more pleasurable" sex. This is a definite danger to the HIV prevention effort, given that work in Kayunga also suggested that most men were not abstaining from sex for the required six weeks healing window after surgery.

In the communities in Pallisa and Budaka, there were rumours, spread by a prominent religious leader, that the United States was promoting SMC in Uganda and other African countries in order to collect foreskins to make expensive cosmetics, and that the service providers were selling each at UGX4 million (about US$2000).

Some people are reluctant to embrace SMC because of fears that it may be part of a hidden agenda to convert them to Islam, for whom circumcision is a religious practice. In communities neighbouring those that traditionally circumcise, some traditionalists/elders do not favour circumcision as it makes them feel inferior or that their neighbours' (often rival ethnic group) has triumphed. In Kapchorwa district, where male circumcision and female genital mutilation (FGM) are cultural practices, some people have promoted the idea of "SMC for men and FGM for women".

Myths around male circumcision differ from one community to another. It is advisable to put in place some form of "feedback" mechanism that quickly picks up the myths in the community, tries to understand them and their source before promptly responding with clear messages.

"Stimulating him is now faster, just a mere touch he is ready, oral sex is now very fine because he is clean" said a female respondent FGD Spouses of circumcised men.

One of the respondent said that because the SMC mobiliser in his village is married to a Muslim man, he therefore has fears of Islamisation if he got circumcised.

15. Conclusion

MALE circumcision has been recognised by stakeholders at the global level (UNAIDS, WHO, PEPFAR, BMGF, World Bank, etc) as an intervention that has the potential to turn round the rising HIV infection rates. They have accordingly published a framework for its scale up, with Uganda as one of the target beneficiary countries. The country's SMC roll-out programme has been a cocktail of vertical as well as integrated service delivery. The UNAIDS/ PEPFAR framework offers an opportunity that Uganda should seize to streamline SMC roll-out, including enhancing ownership as well as urgency so as to strengthen the national HIV prevention response that has faltered over the recent years. The ongoing revision of the NSP, the Round 11 (transitional funding mechanism) Global Fund national proposal drafting process, the negotiation of a working framework with PEPFAR for the next five years, and the 2012/13 national budget formulation, among other ongoing and upcoming policy and planning processes provide excellent opportunities to fill the gaps so far identified in this and other monitoring processes.

References

Dickson K.E., et al. (2011). Voluntary Medical Male Circumcision: A Framework Analysis of Policy and Program Implementation in Eastern and Southern Africa. *PLoS Medicine* 8(11): e1001133. doi:10.1371/journal.pmed.1001133

Gray R.H., et al. (2007). Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. *Lancet* 369: 657–666.

Ministry of Health (2006). Uganda HIV/AIDS Sero-Behavioural Survey 2004-2005. Calverton, Maryland, USA: Ministry of Health and Macro.

Ministry of Health and HCP-Uganda (2009). Mapping medical male circumcision services in Uganda.

Ministry of Health (2011). Minimum Standards of Procedures for Safe Male Circumcision

Thomas, A.G., et al. (2011). Voluntary Medical Male Circumcision: A Cross-Sectional Study Comparing Circumcision Self-Report and Physical Examination Findings in Lesotho. *PLoSOne*. *http://www.plosone.org/article/info:doi%2F10.1371%2Fjournal.pone.0027561*

Tobian A, et al. (2009). Male circumcision for the prevention of HSV-2 and HPV infections and syphilis. *New England Journal of Medicine*, 13: 1298–1309.

USAID/Health Policy Initiative (2009). The Potential Cost and Impact of Expanding Male Circumcision in Uganda.

Weiss H, et al. (2009). Male circumcision and risk of HIV infection in women: a systematic review and meta-analysis. Lancet Infect Dis 9: 669–677.

WHO and UNAIDS (2008). Operational guidance for scaling up male circumcision services for HIV prevention. Geneva: World Health Organisation.

HEPS-UGANDA

Coalition for Health Promotion & Social Dev't
Plot 351A, Balintuma Road, Namirembe
P.O. Box 2426, Kampala, Uganda
Tel: +256-414-270970
info@heps.or.ug
Web: www.heps.or.ug