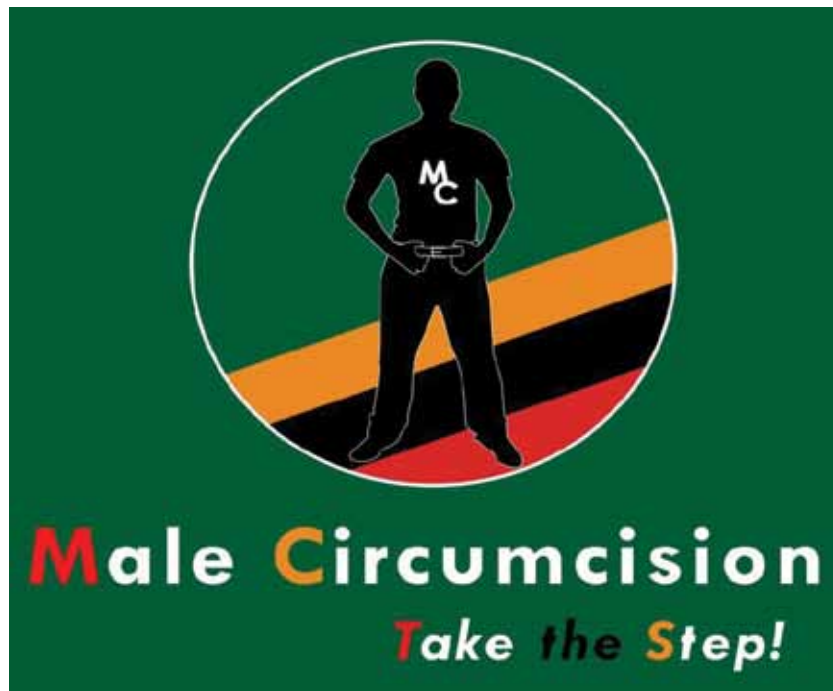




REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH



NATIONAL OPERATIONAL PLAN FOR THE SCALE-UP
OF VOLUNTARY MEDICAL MALE CIRCUMCISION
(VMMC) IN ZAMBIA (2016-2020)

June 2016

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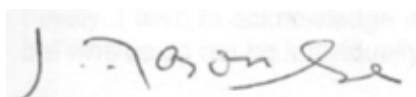


FOREWORD

The Ministry of Health (MoH), in collaboration with cooperating partners, has developed this operational plan to assist in the efficient and effective implementation of the Voluntary Medical Male Circumcision (VMMC) program in Zambia. This program was initiated in 2007 and subsequently scaled up in order to reduce the incidence and prevalence of HIV in Zambia. The Ministry hopes to continue with this effort by capitalizing on lessons learnt in the past years of implementation and leveraging renewed energy and support from partners. The goal for this phase of implementation is to circumcise 1,985,083 million males by

2020, which represents **90%** coverage of males between the ages of 10 – 49 with a focus on those between 15 – 29 years. This is in line with the UNAIDS 90-90-90 strategy to combat the HIV/AIDS pandemic.

The MoH encourages all stakeholders to continue to strengthen their commitment to the implementation of Zambia’s national VMMC program over the next five years as part of the greater effort to address Zambia’s HIV and AIDS epidemic.



Honorable Dr. Joseph Kasonde
Minister of Health



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The program further recognizes and thanks the Bill and Melinda Gates Foundation for their financial contribution towards the development and dissemination of this national document.

The implementation of the VMMC operational plan will contribute to saving the lives of men in Zambia and in turn save the lives of all members of the Zambian community.



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ACRONYMS

AE	Adverse Events
ANC	Antenatal Care
BCC	Behaviour Change Communication
CBO	Community Based Organizations
CCDS	Clinical Care and Diagnostic Services
CDC	Centre for Disease Control
CDE	Classified Daily Employee
CIDRZ	Centre for Infectious Disease Research in Zambia
CHAZ	Churches Health Association of Zambia
CHAI	Clinton Health Access Initiative
CSO	Civil Society Organization
DTC	District Technical Committees
DHIO	District Health Information Officer
DHIS	District Health Information System
DJ	Disc Jockey
DMO	District Medical Officer
DSA	Daily Subsistence Allowance
DSCR	Disease Surveillance, Control and Research
DQA	Data Quality Audit
EDC	Epidemiology and Disease Control
EDQA	External Data Quality Audits
eLMIS	Electronic Logistics Management Systems
EMLIP	Essential Medicines Logistics Improvement Program
F&Q	Forecasting and Quantification
FP	Family Planning
GNC	General Nursing Counsel
HCW	Health Care Worker
HIA	Health Information Aggregation
HTC	HIV Testing and Counselling
HPCZ	Health Professions Council of Zambia
HMIS	Health Management Information System
IEC	Information Education and Communication
IP	Implementing Partners
IPC	Inter-personal Communication
IDQA	Internal Data Quality Audits
IS	Implementation Science
LMU	Logistics Management Unit
MCDMCH	Ministry of Community Development Mother and Child Health



MCH	Mother and Child Health
MNCH	Maternal, New-born and Child Health
MOCTA	Ministry of Chiefs and Traditional Affairs
MOE	Ministry of Education
MOF	Ministry of Finance
MoH	Ministry of Health
M&E	Monitoring and Evaluation
MSL	Medical Stores Limited
MTEF	Mid-Term Expenditure Framework
NAC	National AIDS Council
NASF	National AIDS Strategic Framework
NGO	Non-Governmental Organization
NHC	Neighbourhood Health Committees
NHSP	National Health Strategic Plan
PANC	Post Antenatal Care
PEPFAR	President's Emergency Plan for AIDS Relief
PHE	Public Health Education
PMO	Provincial Medical Officer
PPP	Public-Private Partnership
PRS	Partner Reporting System
QAQI	Quality Assurance and Quality Improvement
RM	Resource Mobilization
RMMS	Report for Essential Medicines and Medical Supplies
RDQA	Routine Data Quality Audit
SBCC	Social Behavioural Change Communication
SCMS	Supply Chain Management System
SMAG	Safe Motherhood Action Groups
SRH	Sexual and Reproductive Health
SSZ	Surgical Society of Zambia
SFH	Society for Family Health
TaT	Turnaround Time
TMC	Traditional Male Circumcision
TOR	Terms Of Reference
ToT	Trainer of Trainers
TSS	Technical Support Services
TWG	Technical Working Group
U5	Under 5
USAID	United States Agency for International Development
UTH	University Teaching Hospital
UNAIDS	United Nations Programme on HIV/AIDS



VCT Voluntary Counselling and Testing
VMMC Voluntary Medical Male Circumcision



A. EXECUTIVE SUMMARY

In 2005 and 2006, three randomized clinical trials in Kenya¹, South Africa², and Uganda³ showed that Voluntary Medical Male Circumcision (VMMC) can reduce female-to-male sexual transmission of HIV by roughly 60%. In 2007, WHO and UNAIDS issued joint recommendations to include VMMC as part of comprehensive HIV prevention and treatment programs especially in settings with high HIV prevalence and low VMMC prevalence.

As one of the fourteen (14) sub-Saharan African countries selected for VMMC, Zambia began providing VMMC services as a method of HIV prevention in 2007. Two years later, in 2009, the national VMMC program was formally launched and VMMC was incorporated in all key national health policy and strategy documents⁴, elevating the intervention to a core component of Zambia's national HIV prevention strategy. To guide the significant program scale-up required, the first operational plan⁵ for VMMC was developed for the period 2012-2015 aiming to reach VMMC coverage of

80% among HIV-negative adult men aged 15-49 years by 2015. This implied ambitious numerical targets of 1,864,396 VMMCs for 2012-2015.

Although the program scaled up significantly in the first half of the operational plan period, it decelerated in the second half due to significant capacity and funding challenges that led to a 30%⁶ decrease in outputs from 2014 to 2015. As a result, Zambia managed to circumcise **1,005,424** men out of **1,864,396** during 2012-2015, thus achieving a national VMMC coverage of **54%**, which is 26 percentage points shy of the **80%** target. This new operational plan for 2016-2020 (The Plan) will build on the existing momentum to reach a new ambitious target of 90% coverage of 10-49 year olds, with a focus on the core age groups of 15-29 i.e. **1,985,083** VMMCs by 2020.

¹ Bailey RC, Moses S, Parker CB, et al. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial. *Lancet* 2007;(369):643-656

² Auvert B, Taljaard D, Lagarde E, et al. 2005 Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 trial. *PLoS Med* 2005; 2(11): e298. doi:10.1371/journal.pmed.0020298

³ Gray RH, Kigozi G, Serwadda D, et al. Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. *Lancet* 2007; (369): 657-666

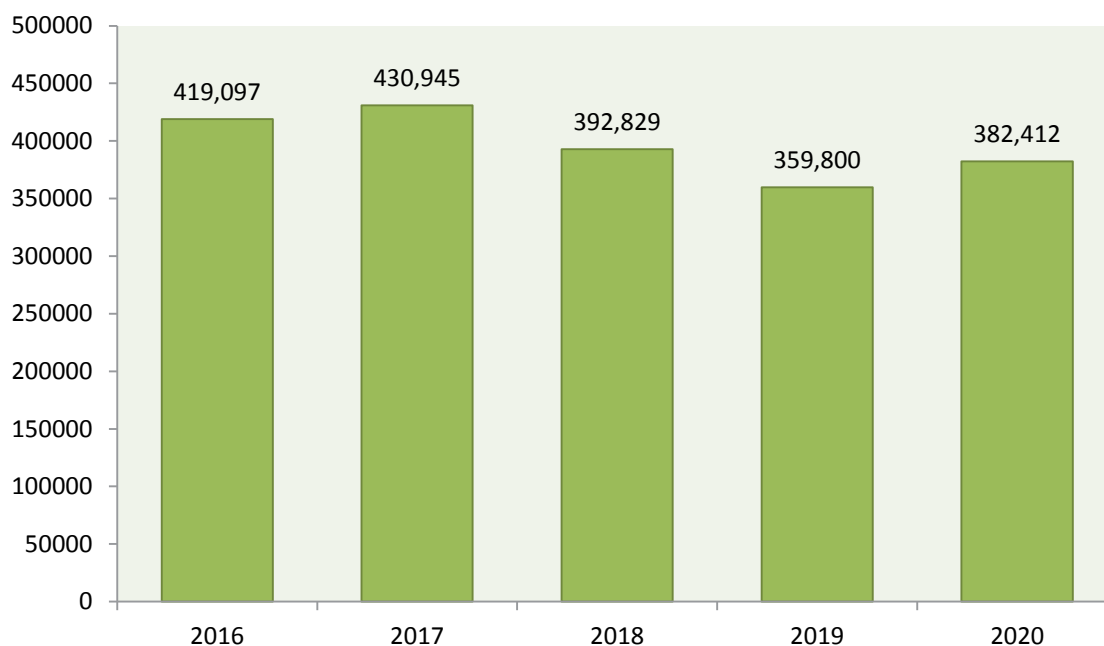
⁴ National Male Circumcision Strategy and Implementation Plan for 2010-2020, National AIDS Strategic Framework 2011-2015, Country Operational Plan for the Scale-Up of VMMC in Zambia, 2012-2015

⁵ Country Operational Plan for the Scale-Up of Voluntary Medical Male Circumcision in Zambia, 2012-2015

⁶ CHAI service delivery efficiency and effectiveness analysis, 2015



Figure 1: Annual VMMCs required for 90% target by 2020



These annual targets represent a significant increase over current annual VMMC volumes, and thus will require a significant increase in funding and a similar augmentation in service delivery capacity. This is especially important given the decreasing international VMMC resource envelope and local economic challenges which affect both global and local funding. Sustained leadership and advocacy, a stronger sub-national level management and coordination structure and targeted demand generation will bring the program closer to the client while maintaining the required momentum and oversight at national level. Centralization and integration are also

highlighted in this plan. Centralizing the supply chain system will allow the program to better coordinate and standardize commodity procurement in a multi-implementer environment while leveraging the Partner Reporting System to strengthen the HMIS data system will enable complete, accurate and timely data capture for monitoring and evaluation (M&E) purposes. Implementation Science will continue to inform the program on the most effective and efficient activities. A detailed transition and sustainability plan will be developed by end of 2017 to guide the program in integrating several aspects of VMMC towards sustainability.



B. INTRODUCTION

Since the release of global guidance in 2007, recommending countries with generalized HIV epidemic and low rates of circumcision to adopt VMMC as an HIV prevention intervention, Zambia has scaled up its VMMC program significantly. During 2012-2015 scale-up, the program reached more than **54%** of its clients, about **26%** shy of the national target of **80%**. However, due to the time-limit on VMMC as well as an ever-changing demographic and epidemiologic landscape, VMMC targets are a dynamic. Thus, the Zambia VMMC program revised the targets for this Operational Plan to be aligned with new global guidance and targets; specifically UNAIDS 90-90-90 campaign that was launched in 2015.

With this plan, Zambia intends to circumcise **1,985,083** HIV negative males between the ages of 10-49, by the year 2020, with a focus on those between 15-29 years. This way, the country will reach **90%** coverage rates amongst the most effective age groups for the most immediate, significant impact in terms of number of HIV infections averted. These new targets were determined using the Decision Makers Policy Planning Tool v.2.1 (DMPPPT 2.1).

In order to reach this target, the Zambia VMMC program will implement the strategies outlined in this plan through a collaboration of MoH and partners. The

success of this plan is hinged on the program's ability to mobilize sufficient resources to cover the **US \$85 million** gap over the next 5 years. This will fund targeted demand generation and increase service delivery capacity to match this demand scale-up. Monitoring and evaluation, Implementation Science will serve to identify programmatic gaps and suggest corresponding solutions to address them. An augmented VMMC management team at national and subnational level will coordinate the program and use the appropriate channels for leadership and advocacy both to set policy and to maintain program visibility and priority within and outside the MoH. Long-term sustainability is also a major consideration for which a separate transition plan will be required.

Based on a robust situation analysis presented to, and ratified by, the VMMC national TWG, this plan provides the major strategies through which it will achieve the objectives by pillar and ultimately its reach the stated targets. A detailed work plan is also included at the end of this document to guide the planning and execution of these strategies at both national and subnational level. The launch of this plan will inform subsequent subnational launches where districts and provinces will develop their own work plans aligned to this document and the attached national work plan.



C. SITUATION ANALYSIS

Despite political shifts that led to changes in VMMC leadership and advocacy structures in 2012, the program has now successfully transitioned back to MOH as its umbrella ministry. This transition also affected the effectiveness of VMMC governance and coordination. While the national and subnational coordination structures are currently well-organized and closely linked, just like leadership and advocacy, governance and coordination was also impacted by organizational changes that led to changes in MoH departmental structures in 2012. Thus VMMC was under the management of the Ministry of Community Development, Mother and Child Health (MCDMCH) for the duration of the previous operational plan. The program has now successfully transitioned back to MoH and there is a need to reengage key VMMC champions, add technical capacity at national level and focus on funding capacity and implementation at subnational level.

For service delivery, Zambia has circumcised close to **1.2 million** males since 2007, but the exit of some partners and funding uncertainties led to 30% decline in 2015 outputs. The program is generally efficient given the configuration of service delivery and VMMC provider compensation modalities. However, ambitious targets call for increased capacity, HR and efficiency; a well-integrated service delivery platform; a centralized supply chain; standardized

quality assurance and proper planning and identification of priorities.

The program currently employs a mix of methods such as mass-media, mid-media, community radio, neighbourhood health committees (NHC) and inter-personal communication (IPC) to generate demand. Recent market research approaches have stratified clients based on their unique characteristics and path to adoption of VMMC. This plan encourages the use of these results to target clients i.e. to inform VMMC demand generation and successfully appeal to each client segment. Increased collaboration and joint-funding are needed to close this gap on targeted demand generation, dissemination of communications strategy and other activities.

For Monitoring & Evaluation, there are currently several sub-optimal processes at facility and district health office level that result in discrepancies between HMIS (DHIS2) and Partner Reporting System (PRS). An initial data quality audit and training exercise reduced data discrepancies from 37% to 7% in one year. The program is committed to reducing and maintaining discrepancies below 5% in the medium term. Long term, all stakeholders have committed to making the HMIS system the main M&E system for VMMC by the end of 2017.



Implementation Science is important for continuous improvement of the program. It will inform program efficiency, cost, and impact. Currently, the program has conducted research on Shang Ring and PrePex with the hope of introducing device-based circumcision in 2017.

As mentioned before, the Zambia VMMC program has thus far utilized its funding resources quite efficiently. However, the new targets to 2020 will require a renewed commitment from the both the MoH, and funding and implementing partners in order to mobilize the resources required to meet targets. The total funding required for the next five years is **US \$136 million**. With **US**

\$51 million projected funding; the program will need to raise enough funding to cover the **US \$85 million gap**

Finally, although EIMC has already been introduced to Zambia, there is currently a gap in resource mobilization as well as service delivery capacity for it. This is because EIMC has less immediate impact relative to adult and adolescent VMMC hence donors' reluctance to fund it. Consequently, this calls for integration of EIMC into existing maternal and child health services and a robust, evidence-based transition and sustainability plan for VMMC in general.



Zambia's VMMC Program Goal

“To contribute to the reduction of HIV incidence by scaling up VMMC to reach 90% of HIV negative men between the ages of 10-49, with a focus on those between 15-29 years, by 2020.”

VMMC Objectives by Pillar

PILLAR	OBJECTIVE
Pillar 1: Leadership & Advocacy	To increase and sustain program visibility and priority at both national and subnational level and garner multi-sectoral support from key stakeholders
Pillar 2: Governance & Coordination	To build sufficient technical and strategic capacity to coordinate and manage a growing VMMC program with strong linkages between the national and subnational levels
Pillar 3: Service Delivery	To offer a comprehensive VMMC package of service in an efficient, effective and increasingly integrated manner while ensuring the highest quality of services
Pillar 4: Communication & Demand Generation	To increase demand and meet the targets for VMMC in the most effective (core) age groups through a targeted, market/client-based approach
Pillar 5: Monitoring & Evaluation	To reduce data discrepancies between HMIS and PRS from 37% to below 5% and develop HMIS/DHIS2 system into a self-sufficient, reliable sources of VMMC M&E data by the end of 2017
Pillar 6: Implementation Science	To conduct operations research studies to fill the most critical VMMC information gaps and provide implementable recommendations for VMMC policy and practice
PILLAR 7: Resource Mobilization	To mobilize sufficient financial resources to cover the programmatic funding gap while also ensuring efficient and effective use of existing resources
Pillar 8: Sustainability & EIMC	To develop and implement a robust plan for VMMC program transition and integration in the sustainability and maintenance phase, once scale-up targets have been met

Table 1 : VMMC Objectives by Pillar



D. STRATEGY AND OPERATIONAL PLAN BY PILLAR (2016-2020)



PILLAR 1: LEADERSHIP AND ADVOCACY



Objective

To increase and sustain program visibility and priority at both national and subnational level and garner multi-sectoral support from key stakeholders

Strategies

- I. Increase program visibility and priority within the health portfolio and at all levels of the health care system
- II. Re-engage the key actors in VMMC advocacy for the new Operational Plan (2016-2020) including Parliament, Traditional and Religious leaders
- III. Prepare the program's advocacy and leadership for any potential changes as a result of organizational and political shifts
- IV. Strategically disseminate critical information to key stakeholders within the program, including regular campaigns and launch of this Operational Plan

During 2012-2015, the Zambia VMMC program successfully created supporting structures and conducted activities for sustained leadership and advocacy of the program, led by the Ministry of Health, with the participation of government and civil society stakeholders. The VMMC program enjoyed high visibility and engagement within the MoH at national level through the placement of the VMMC National Coordinator as the national focal person. The coordinator is under the supervision of

Director of Disease Surveillance, Control and Research (DSCR) and Deputy Director (Epidemiology and Disease Control), who all operate under the authority of the Permanent Secretary, and the Minister of Health. Outside of the MoH, prioritization of VMMC in Parliament and the activity of the inter-ministerial committee on HIV of the NAC have elevated the program. At sub-national (Province) level, leadership and advocacy is led by the Provincial Coordinators and/or focal persons under



the direction of the Provincial Medical Officer (PMO) while local (district and facility) leadership and advocacy falls under the facility in-charge and focal persons with the supervision of the District Medical officer (DMO). At this local level, community groups with influential social standing such as traditional/religious leaders, VMMC Champions and neighbourhood health committees are also a critical component of the advocacy strategy and should be continually engaged.

However, there were three major challenges that slowed down the leadership and advocacy component during the period of the previous operational plan (2012-2015). These were: (i) the switch in ministries which moved VMMC from MoH to MCDMCH in 2012; (ii) the attrition and changes in the role of VMMC national coordinator (the program has seen a total of five coordinators to date) and (iii) the delay in replacing the VMMC coordinator which led to a 6-month leadership gap in the first half of 2015. In order to address these three issues while building on the existing structures and the previous plan's success in leadership and advocacy, this plan will increase current visibility and priority of VMMC, re-engage key actors, take pre-emptive measures to sustain the program through political and organizational changes and strategically disseminate important information.

I. Increase program visibility and priority within the health portfolio and at all levels of the health care system

Advocacy efforts for VMMC will identify and engage individuals at the national, provincial, district, and community levels. These efforts will include stakeholders from the highest levels of national government to traditional, community and religious leaders. While each stakeholder group will play a different role, the advocacy and outreach efforts of all will be important for national VMMC scale-up.

To improve and strengthen political leadership, Programme Coordinators have been identified at national, provincial and district levels with focal persons at facility level. The MoH will be responsible for leading and driving the VMMC agenda forward through these cadres and the strategies outlined in this plan.

National level

At the national level, VMMC champions will be identified from within the broader community, including political, traditional and religious leaders, and other popular (male and female) community figures such as musicians, fashion models, sports personalities and radio disc jockeys (DJs). These VMMC champions will commit to a minimum number of national media appearances, as well as a minimum number of community appearances each year⁷.

⁷The National Male Circumcision communication strategy 2012 includes detailed strategies on messaging and key themes on



Furthermore, to ensure that VMMC has the cross-cutting support necessary for wide-scale roll-out, collaboration will be sought between the MoH and other line ministries, as well as across branches of the MoH (e.g., Maternal and Child Health (MCH)). The VMMC agenda should be highlighted and prioritized by the existing inter-ministerial committee on HIV of the National AIDS Council (NAC), which will serve as a platform for advocacy.

Provincial and District levels

The Provincial and District Medical Officers will provide leadership for the VMMC program at the provincial and district levels respectively. Advocacy activities will feed into those that occur or already exist at both levels. Provincial Medical Officers (PMOs) will distribute information to key constituencies and ensure that VMMC a key component of the overall health program in their districts. This entails emphasizing the integration with other health services including those that reach women (e.g. MCH, Cervical Cancer Screening).

This plan will also be officially launched in each of Zambia's provinces; guidance for launch dates and program content will be provided at the national level. VMMC advocates will participate in provincial planning meetings as well as the launch. Sensitization workshops with key provincial opinion leaders will be held. Two provincial and two district health promoters will undergo training on communicating about

VMMC with both males and females. Information on VMMC will flow through normal MoH channels for health-related information materials, and will be disseminated by PMOs through DMOs to the facility level. Each district will appoint an individual to coordinate VMMC communication efforts; this individual will advocate for the acceptance of the comprehensive VMMC service among chiefs, local headmen, key community opinion leaders, and key community based organizations (CBOs), including women's groups. This person will be responsible for identifying, engaging and coordinating the efforts of community groups. At the district level, advocacy will be largely grassroots; much of the information to be disseminated will also flow through the existing health committees. Emphasis will be placed on generating community-owned leadership in driving a gender-sensitive VMMC agenda.

In addition to playing a leadership and advocacy role within the country, Zambia's VMMC decision-makers will also advocate for VMMC scale-up at the global level, by disseminating evidence based publications at key conferences.

II. Re-engage the key actors in VMMC advocacy for the new Operational Plan (2016-2020) including Parliament, Traditional and Religious leaders

To complement structures within the MoH, the VMMC program will also re-engage key advocates such as the President's office as

VMMC. These will also be included in the upcoming VMMC Communication strategy that will replace it.



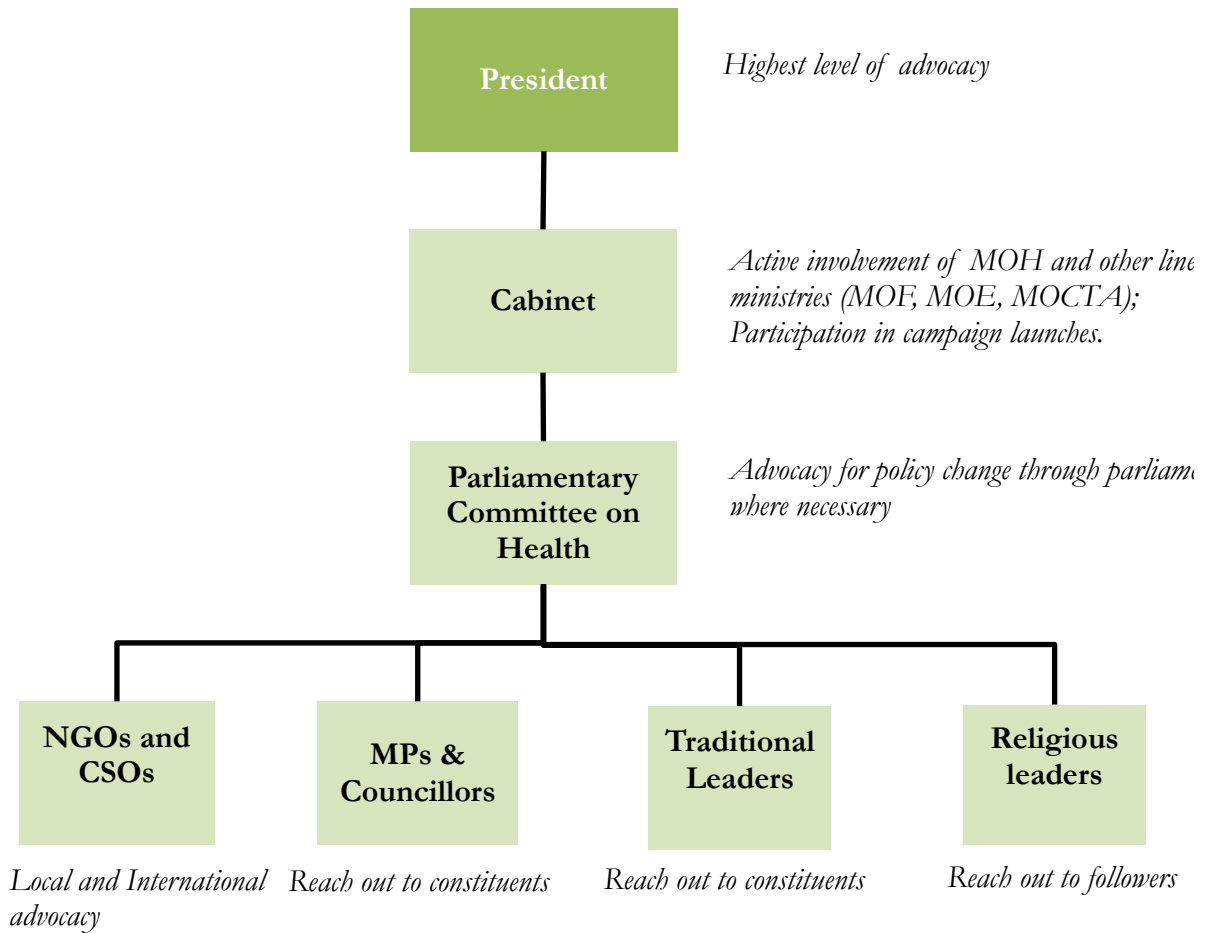
and when appropriate (through the MoH Permanent Secretary and Minister's offices). Cabinet (other line ministries such as Ministry of Chiefs and Traditional Healers Association (MOCTA), Ministry of Education (MOE) and Ministry of Finance (MOF) will be engaged for collaborative advocacy on demand generation, service delivery and funding, respectively. It will be critical that representatives from these ministries are present at all high profile VMMC events, including campaigns. The Parliamentary Committee on Health will be apprised of all important VMMC activities, especially where policy changes and

advocacy requires the participation of the legislature. Non-profits, NGOs, traditional, local government and religious leaders will be equipped with targeted information for their followers, constituents and congregants.

The momentum with traditional leaders and chiefs on advocacy and demand generation has dampened since 2012. The VMMC Communications TWG will engage and plan joint advocacy events with MOCTA (Ministry of Chiefs and Traditional Affairs) to get buy-in and political goodwill to revitalize this relationship.



Figure 2 : National Organogram for Advocacy



III. Prepare the program’s advocacy and leadership for any potential changes as a result of organizational and political shifts

In 2012, unforeseen organizational changes resulted in the VMMC program falling under MCDMCH, a new line ministry that was created then. This had a significant impact on the leadership and advocacy, particularly at national level where it necessitated the re-engagement of leadership on VMMC priorities and the sudden changes in reporting structures slowed down some administrative processes.

Furthermore, attrition of the VMMC National Coordinator post during the 3 years of the Operational Plan (2012-2015) presented challenges to advocacy in the form of nascent relationships and inevitable loss of institutional knowledge. The program also had to operate without a national coordinator for the first half of 2015 which further slowed down advocacy efforts and program scale-up. However, by the end of 2015, VMMC and other health programs transitioned from MCDMCH back to MoH, a welcome move which revamped familiar relationships and organizational systems for continued MOH and partner collaboration on VMMC.



Political and organizational changes have a huge impact on leadership and advocacy, thus the program should take any steps required to prepare for eventualities and unforeseen disruptions that may come with 2016 general elections and other political events. This includes strengthening the TWG (and implementing partner participation) as an independent body that will be able to sustain its activity despite political and MoH organizational changes. The program should also be ready to conduct refresher activity and re-engage all the governing bodies that are relevant for advocacy after these changes occur.

IV. Strategically disseminate critical information to key stakeholders within the program, including regular campaigns and launch of this Operational Plan

The development and dissemination of this new Operational Plan (2016-2020) is also a major tool for leadership and advocacy since the strategies in this document are designed to outlive any one partner, organization or employee. Thus, a national launch of this

plan will enable the widest coverage of the message and access to the document by as many key audiences and stakeholders as possible. This is crucial for national, regional and international advocacy.

The official launch of national VMMC guidance documents will be planned and attended by key stakeholders and high-level opinion leaders. A VMMC advocacy toolkit containing informational materials, to support the dissemination of targeted, audience-appropriate VMMC messages will be developed and distributed. Materials tailored specifically for female audiences will be included in the advocacy toolkit in order to address the role women play in demand generation (i.e., in infant, adolescent and adult VMMC decision-making), and because it is vital that women themselves accurately understand the benefits of VMMC and its partial effectiveness for men. National-level advocacy meetings designed to inform and sensitize key opinion leaders will be held including members of parliament, members of underlying ministries, traditional leaders, women's groups, religious leaders, and business leaders. Advocacy efforts directed at national media, including heads of news media agencies, will be prioritized.





PILLAR 2: GOVERNANCE AND COORDINATION



Objective

To build sufficient technical and strategic capacity to coordinate and manage a growing VMMC program with strong linkages between the national and subnational levels

Strategies

- I. Increase technical capacity at national level and improve the TWG to enable quick decision-making and resolution of existing and future VMMC policy discrepancies
- II. Support the provincial level through secondment, joint-planning and direct budget support for VMMC activities depending on the provincial needs
- III. Revamp the District Technical Committees to enable routine program management and partner collaboration at this level

Governance and coordination is necessary for planning, monitoring of progress and execution of programmatic decisions that ensure efficient and effective resources utilization to meet the national targets. Governance and coordination at national, provincial and district level is not only instrumental in achieving the targets, but also in ensuring accountability. Like the previous plan, implementation of VMMC will continue to be closely aligned with the existing MoH structures so as to encourage an integrated approach to public health. This will boost ownership and ensure program continuity beyond implementing partner support.

The sudden transition of VMMC to MCDMCH in 2012 and the absence of a

national coordinator for the first half of 2015 had adverse consequences for governance and coordination. However, this decision was reversed at the end of 2015, and the VMMC program is now fully transitioned back to MoH. In order to function well, this new governance and coordination structure needs sufficient capacity and technical skill at all the levels of care, and it must be integrated into existing government structures with input and support from implementing and funding partners through effective decision-making bodies such as the TWG. The TWG in turn requires clear Terms of Reference so as to be responsive and ready to make programmatic and strategic decisions and recommendations.



I. Increase technical capacity at national level and improve the TWG to enable quick decision-making and resolution of existing and future VMMC policy discrepancies

Strengthening national level capacity

The priority at the national level will be to strengthen coordination, reorganize service delivery, and improve the management of the national program in line with this operational plan.

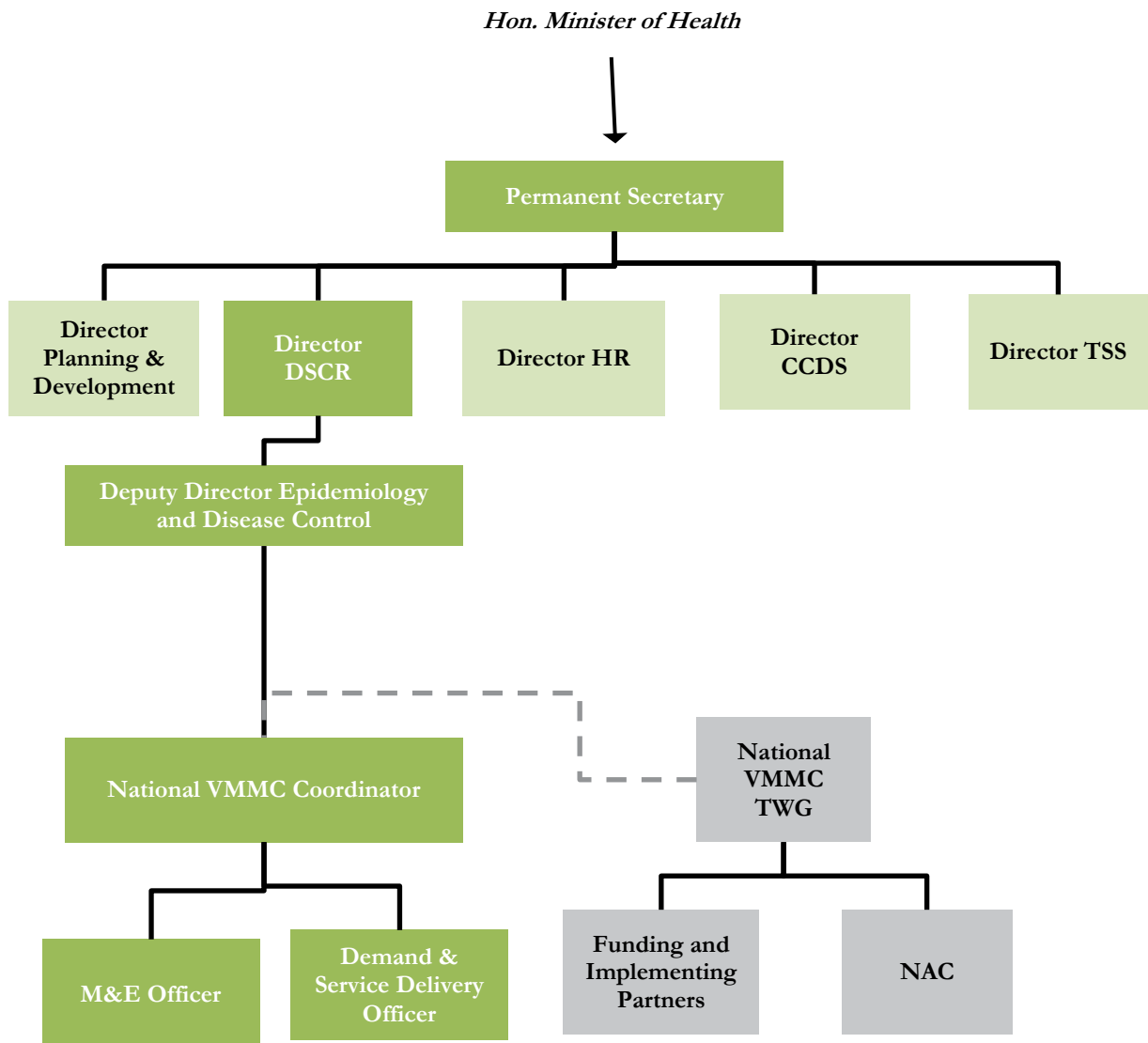
At the national level, the core technical team will consist of the National VMMC Coordinator, a Monitoring and Evaluation (M&E) Officer and a VMMC Program Officer. This team will report to the Deputy Director (Epidemiology and Disease Control) who in turn reports to the Director Disease Surveillance, Control and Research (DS-CR). The M&E Officer will provide support to all provinces and will be responsible for supporting data collection, analysis and management while the Program Officer will be responsible for coordination of specific implementation activities spanning both service delivery (human and infrastructural capacity, training schedules and any other ad-hoc supply concerns etc.);

demand generation (VMMC Communications Strategy, Market-monitoring etc.); and program administrative duties. The National Coordinator will provide technical and tactical leadership to the national team and the TWG, while serving as the program focal person linking the national and subnational levels. The Director (DSCR) and Deputy Director (Epidemiology and Disease Control) will continue to provide political, strategic and administrative leadership. Any matters requiring policy changes and official communication will go through the Permanent Secretary, and all the way up to the Minister if required.

Major activities for the national team will include supporting provincial teams in implementing this operational plan and aligning partner support to new national VMMC strategy and targets. The MoH team will collect and analyze financial and program performance data to monitor progress towards targets, identify implementation challenges and reprogram activities to address these challenges. Coordination at national level will set the pace at which districts and provinces will implement VMMC activities.



Figure 3 : National Level Governance & Coordination structure for VMMC in Zambia



Streamlining the (Technical Working Group) TWG mandate and activities

The VMMC National Coordinator will assume day-to-day administrative functions related to VMMC programming in Zambia, executing decisions on behalf of the MoH. All major decisions regarding VMMC will be made by the MoH in consultation with

the national VMMC Technical Working Group (TWG).

Partner organizations will engage in VMMC programming through the national TWG, which will be called and chaired by the Department of Disease Surveillance, Research and Control. The national TWG will comprise of four sub-committees: (i)



Funding & Resource Mobilization; (ii) M&E and Research (iii) Service Delivery, Quality Assurance & Training; and (iv) Communication and Demand Generation. These subcommittees will deliberate on technical aspects, provide guidance and make recommendations on the scale-up of VMMC services, thus informing the main TWG's decision-making process.

All major VMMC decisions will be made by the MoH in consultation with the national VMMC Technical Working Group (TWG). The MoH shall be the chair for the TWG, while (Clinton Health Access Initiative (CHAI) will be the secretariat. The membership for the TWG will comprise all key VMMC partners and stakeholders.

Although the TWG membership was very active during 2012-2015, it needs to be augmented in terms of the organizational diversity while streamlining the actual representatives in attendance from these organizations. In addition to existing TWG members, the TWG will also include Surgical Society of Zambia (SSZ), other private sector medical/health organizations, MoH cadres with VMMC institutional memory (e.g. previous coordinators), Health Professions Council of Zambia (HPCZ), and MSL to lead the logistics and supply chain discussion.

Effective January 2016, the TWG will develop a fixed monthly schedule for TWG meetings at the beginning of each year, and any ad-hoc meetings will be announced at least 2 weeks in advance. The first TWG

meeting of each year will discuss progress towards program objectives set in the previous year, set/confirm annual targets, new objectives and develop a national workplan (aligned to the Operational Plan 2016-2020) to guide the program. Any revisions to TWG structure and ToRs must be finalized in monthly TWG meetings and approved by Senior MoH leadership. As TWG Chair, the MOH makes the final decisions and ensures clear documentation and prompt communication of resolutions to all stakeholders and senior ministry officials at both national and sub-national level as appropriate.

Finally, to allow smooth scale-up of VMMC services, the program must revise national policies and directives to address the following discrepancies:

- (i) Lack of transparency and/or formal documentation for allocation of sites/districts
- (ii) The difference in the age of consent for HIV testing (16+) and that for VMMC procedure (18+). Eventually, these two policies should be harmonized
- (iii) Out-dated HIV/AIDS workplace policies which do not include VMMC



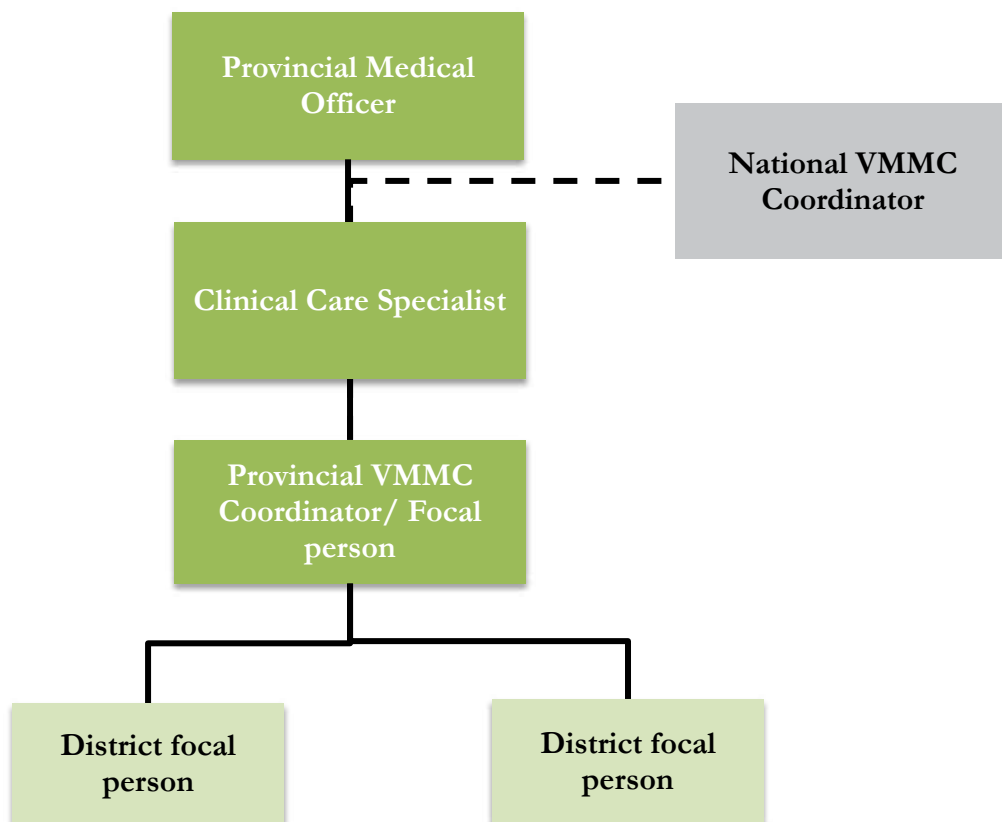
II. Support the provincial level through secondment, joint-planning and direct budget support for VMMC activities depending on the provincial needs

Provincial level

At the provincial level, the PMO oversees the program while the provincial VMMC coordinator provides hands-on coordination and serves as the link between the national and the district coordination structures.

S/he will coordinate the planning and implementation scale-up at the province, providing technical supervision to districts within their respective provinces and carrying out other duties as outlined in the terms of reference. Implementing partners will align targets to the MoH provincial and district targets within this plan and will liaise with the PMO through regular provincial stakeholder meeting/forum and will be accountable to the PMO for any issues needing resolution.

Figure 4: Provincial Level Governance & Coordination structure for VMMC in Zambia



The situation analysis⁸ revealed that, as planned for in the previous Operational Plan, all provinces have a focal person taking on the role of provincial VMMC Coordinator. However, the amount of time dedicated to VMMC depends on the provincial needs. While, Northern, Muchinga, Luapula and Eastern Provinces have full time dedicated Provincial MC Coordinators, Central, Lusaka, Southern and Western have delegated Provincial MC Coordinators with dual roles within HIV. In Copperbelt and North-Western provinces, the Clinical Care Specialists double up as Provincial MC Coordinators. In terms of human resources, this model will largely remain the same. With respect to funding, more resources should be dedicated to the subnational level according to the budgeted activities. Thus, provincial support will be a mix of secondment, joint-planning and direct budget support for VMMC activities depending on the provincial needs.

structure has been working well but there is an urgent need to revamp the District Technical Committees to ensure that all partners are aligned to MoH district level targets in liaison with the DMO as well as ensure data review and monitoring of progress at this level. All partners implementing VMMC activities will be accountable to the DMO and will actively participate in the district technical committee meeting. The district technical committee will report to the DMO for final decisions on implementation and the DMO will be accountable to the province for all VMMC activities implemented in their district.

III. Revamp the District Technical Committees to enable routine program management and partner collaboration at this level

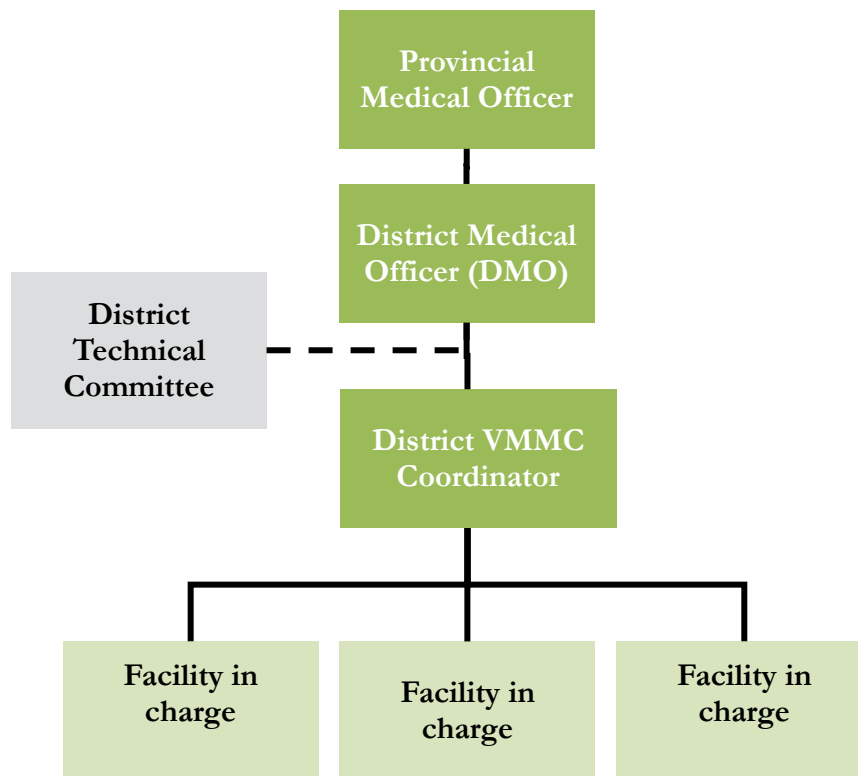
District level

At district level, the coordination is done by delegated VMMC Coordinators who work with implementing partners and facility in-charges under the leadership of the DMO. At facility, the in-charges coordinate the activities of the VMMC providers. This

⁸ Situation Analysis of Zambia's Voluntary Medical Male Circumcision, presented and ratified at a Special TWG Workshop in Lusaka, April 13th 2016



Figure 5 : District Level Governaces & Coordination Structures for VMMC in Zambia





PILLAR 3: SERVICE DELIVERY



Objective

To offer a comprehensive VMMC package of service in an efficient, effective and increasingly integrated manner while ensuring the highest quality of services

Strategies

- I. Expand existing capacity to provide comprehensive VMMC services by introducing pre-service training, eliminating missed opportunities for service delivery and efficiently deploying innovative methods such as devices for service delivery
- II. Ensure adequate infrastructural resources (equipment and waste management) while maintaining the quality of VMMC during scale-up by standardizing QA/QI guidelines, materials and activities
- III. Facilitate the integration of VMMC services with other health programs at all levels of care and centralize VMMC commodity management into the existing Supply Chain System
- IV. Conduct annual planning, geographic prioritization and officially document the allocation of geographies and/or facilities to partners

Zambia VMMC service delivery

Service delivery in Zambia is conducted at all levels of care and in various types of facilities. Both static and outreach service delivery continue to contribute significantly to VMMC scale-up. Service delivery is primarily coordinated at the district level. Strong coordination of human resources and supplies at this level is critical to ensuring a complete and comprehensive service VMMC package that meets the established guidelines, even in remote settings.

The VMMC Focal Person will be assigned by the DMO at each District Health Office to oversee all scheduling and logistics for service delivery. Public health facilities offering the standard VMMC package will be categorized into four service levels (Level A, Level B, Level C, and Level D) according to the facility type, availability of human resources, and the amount of support needed. See Table 2 : VMMC Service Delivery Models.

Where mobile units are used to provide VMMC services in locations that have



limited health care facilities and in catchment areas that have little or no existing infrastructure the following must be taken into account:

- The size and density of the catchment population and prevalence of HIV and male circumcision in the catchment area
- Potential physical space that can be dedicated (temporarily or permanently) to VMMC services
- Existing infrastructure and equipment, availability of skilled human resources
- Level of support of managers and service providers
- Accessibility of sites/facilities to the target population
- Service linkage and referral between VMMC and other services such as care and treatment, post-operative care, and support/AE management may include:
 - HIV care and treatment sites for those who test HIV-positive
 - Clinics able to perform post-operative care
 - Regional, tertiary hospitals—AE management

For immediate impact, VMMC services will concentrate on the ages 15-29. However, this does not preclude the provision of services to other age groups if they come in for circumcision. Each district will develop a localized workplan and budget that aligns with this national operational plan, outlining detailed steps for implementation.



	Level A	Level B	Level C	Level D
Type	<ul style="list-style-type: none"> District or general hospital equivalent 	<ul style="list-style-type: none"> Zonal health centre equivalent 	<ul style="list-style-type: none"> Health centre equivalent 	<ul style="list-style-type: none"> Health post equivalent
Scope of Service	<ul style="list-style-type: none"> fully responsible for all seven core VMMC responsibilities⁹ provide additional support to surrounding lower-level clinics through outreach serve as clinical training hubs for the district 	<ul style="list-style-type: none"> fully responsible for all seven core VMMC responsibilities⁹ 	<ul style="list-style-type: none"> partially relies on external assistance from Level A or B facilities may not be able to take on all seven core VMMC responsibilities⁹ initially But should at least handle local demand generation 	<ul style="list-style-type: none"> Entirely relies on external assistance from Level A, B or C facilities to offer dedicated VMMC services on specific days.
Frequency of Service	<ul style="list-style-type: none"> Provides dedicated VMMC services several days of the week 	<ul style="list-style-type: none"> Provides dedicated VMMC services between 1-12 days per month 	<ul style="list-style-type: none"> Varies according to needs of catchment population (weekly, monthly, quarterly or bi-annually) 	<ul style="list-style-type: none"> “mini-campaigns” conducted a few times per year or during special occasions. Last for several consecutive days and will offer dedicated services to large numbers of clients at a time
Resources	<ul style="list-style-type: none"> 2-3 table operating team with an in-house medical officer 	<ul style="list-style-type: none"> Ideally using 1-3 table operating teams 	<ul style="list-style-type: none"> Sufficient for minimum package of services (outreach) Involve any available health care providers from the facility during VMMC outreach service days 	<ul style="list-style-type: none"> Insufficient human resources and infrastructure f Requires medical tents and other temporary structures
Other	<ul style="list-style-type: none"> serve as a referral hub for any adverse events requiring specialized attention 	<ul style="list-style-type: none"> also serve as a referral hub for any adverse events requiring specialized attention 	<ul style="list-style-type: none"> May use medical tents or other temporary structures to increase capacity where infrastructure is lacking 	<ul style="list-style-type: none"> N/A

Table 2 : VMMC Service Delivery Models

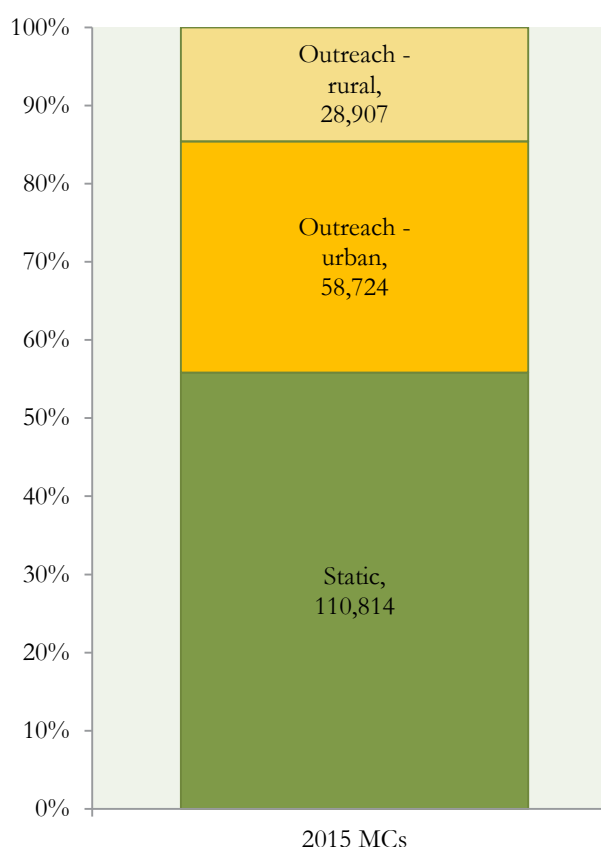
⁹ The seven core VMMC responsibilities are as follows: 1) community-level demand generation, 2) clinical service provision, 3) infection prevention, 4) behavioural counselling, 5) quality assurance, 6) data management, and 7) supply-chain management.



Opportunities for Efficiency by service delivery model

In terms of composition, 56% of Zambia's 2015 MMCs¹⁰ were from static service models while 44% was from outreach (30% urban outreach and 14% rural outreach). See Figure 6 : 2015 VMMC Outputs by service delivery model below.

Figure 6 : 2015 VMMC Outputs by service delivery model



Static site service delivery presents limited opportunities for driving facility-level efficiencies since service delivery is already efficient due to an increasingly integrated approach which takes advantage of economies of scale afforded by existing

government resources. Compensation is also based on performance (400 Kwacha per team¹¹ per 10 MMCs) thus decreasing the cost per VMMC would entail reducing or halting the compensation, which is already very low by regional standards.

Similarly, urban outreach is already quite efficient at facility-level because teams only go out when clients are booked, matching supply to demand. Additionally, travel costs are minimized by only doing short distance, one-day outreach and pegging provider compensations to their performance (based on number of MMCs as opposed to number of days).

Thus, only the rural outreach model presents some opportunity for facility-level efficiency, but it represents only 14% of the program. Alternatively, the program should consider looking at above-facility level costs and in order to increase efficiency and reduce cost per VMMC.

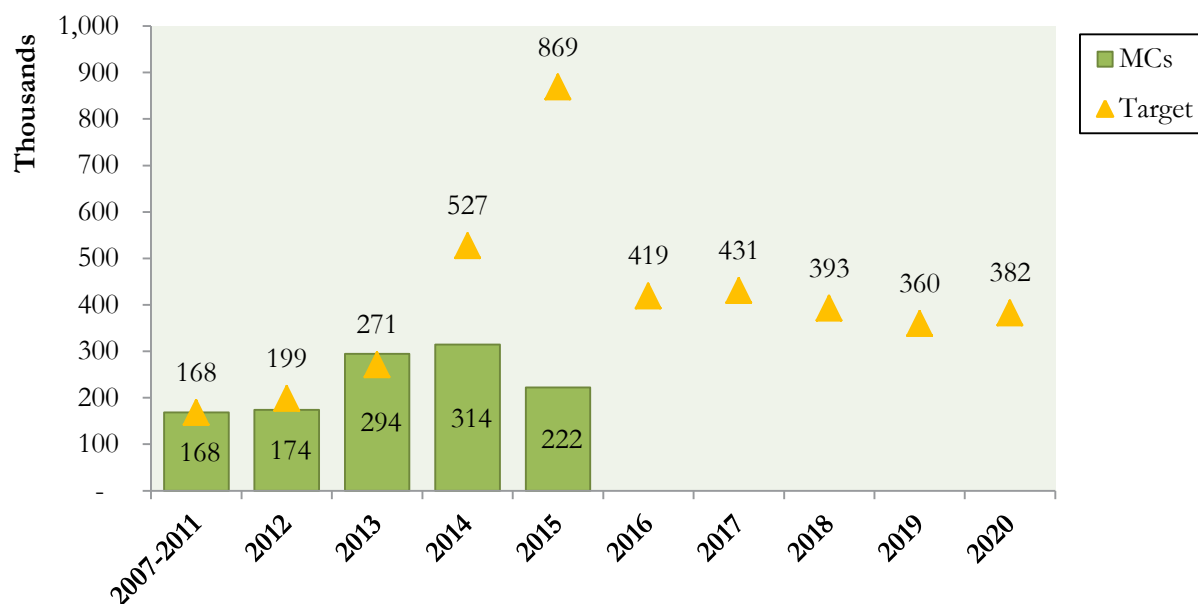
¹⁰ Data source was disaggregated VMMC numbers from implementing partners. It is close to, but does not exactly match the national VMMC totals.

¹¹ A team is considered to consist of: 1 Surgeon provider, 1 Assistant, 1 counselor and 1 CDE (Hygiene Assistant –for instrument processing).



Progress to date and 2016-2020 National and Provincial and District Targets

Figure 7 : Progress against old targets, setting new targets (2016-2020)

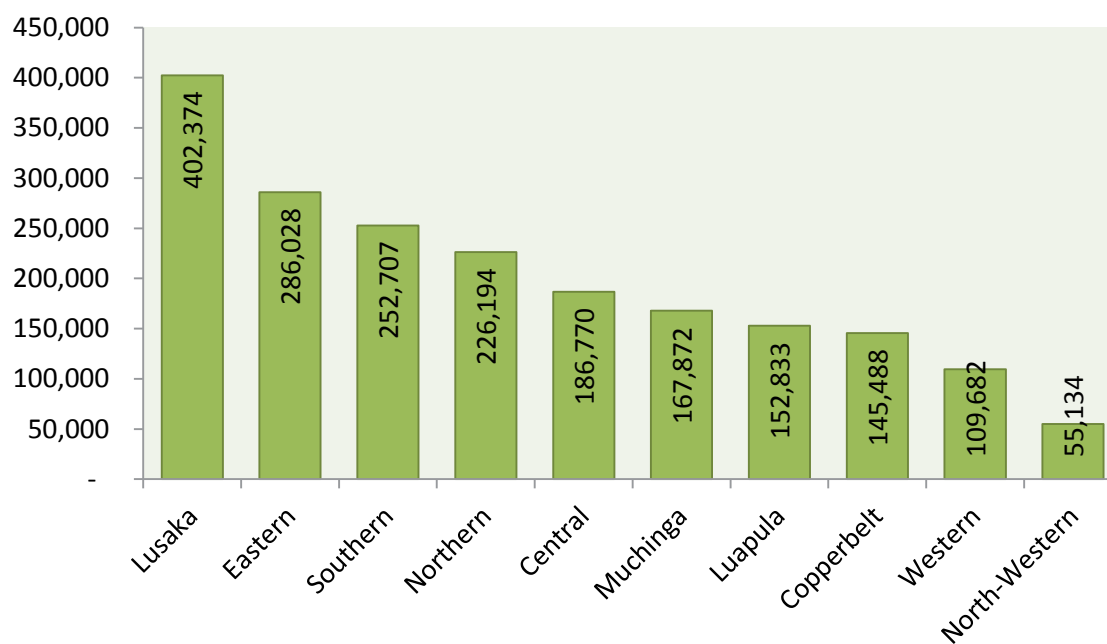


In 2007, the WHO and UNAIDS announced¹² recommendations for countries with high HIV prevalence and low VMMC coverage to incorporate VMMC in their HIV program response. Since then, Zambia has circumcised **1,173,860** males. During 2007-2011 conducted a total of **168,436** which included pilot and mini-scale up of services. The most significant scale-up to date occurred during the previous operational plan period (2012-2015). However, despite successful scale-up until 2014, there was a 30% decrease in total outputs in 2015. This was caused by the exit of some partners in 2014 as well as reduced funding which disrupted service delivery for major implementing partners in the second half of 2014 and early 2015.

¹² <http://www.who.int/mediacentre/news/releases/2007/pr10/en/>



Figure 8: Provincial Targets Chart (2016-2020)



Steady scale-up targets by province by year

Province	2016	2017	2018	2019	2020	TOTAL
<i>Central</i>	39,431	40,546	36,960	33,852	35,980	186,770
<i>Copperbelt</i>	30,716	31,584	28,791	26,370	28,027	145,488
<i>Eastern</i>	60,387	62,094	56,602	51,843	55,101	286,028
<i>Luapula</i>	32,267	33,179	30,244	27,701	29,442	152,833
<i>Lusaka</i>	84,950	87,352	79,626	72,931	77,515	402,374
<i>Muchinga</i>	35,442	36,444	33,220	30,427	32,339	167,872
<i>Northern</i>	47,755	49,105	44,762	40,998	43,575	226,194
<i>North-Western</i>	11,640	11,969	10,911	9,993	10,621	55,134
<i>Southern</i>	53,352	54,860	50,008	45,804	48,682	252,707
<i>Western</i>	23,156	23,811	21,705	19,880	21,129	109,682
TOTAL	419,097	430,945	392,829	359,800	382,412	1,985,083

Table 3 :Provincial target by year



I. Expand existing capacity to provide comprehensive VMMC services by introducing pre-service training, eliminating missed opportunities for service delivery and efficiently deploying innovative methods such as devices for service delivery

For this Operational Plan (2016-2020), Zambia aims to circumcise **1,985,083** males between 10-49 years old, representing 90% coverage for the core age groups of 15-29 by 2020. Scaling up and optimizing service delivery implies increasing the service delivery capacity and avoiding missed opportunities for service delivery. While the former can be partially achieved by improving efficiency of service delivery, for Zambia mobilizing resources required to reach these target is more important. The latter requires an unprecedented level of planning and collaboration among implementing partners within the TWG in order to capture all service delivery opportunities.

Human resource requirements

Although Zambia does not require a surgeon to perform VMMC, there is still concern about the strain that scale-up of VMMC could have on the health system. With a goal of almost **419,097** in 2016, reaching these targets will only be possible if human resources are sufficient and optimally deployed.

Two or more tables are recommended for optimizing HR efficiency using the dorsal slit surgical method of VMMC. With three VMMC tables at one site, one HCW can be assigned to physically examine clients on other tables while the trained VMMC

provider and oriented HCW attend to one table together. Classified employees are used to assist with non-patient contact related tasks such as autoclaving the surgical instruments and preparing the room. Increasing the number of beds available to the team, using electro cautery and introducing devices are some of the ways to augment the program's service delivery capacity. The VMMC team structure comprises 4 cadres, two providers, one lead and the other supporting, one Hygiene Assistant and one Counsellor.

Human Resources are the biggest challenge for VMMC as there are often shortages, especially at lower level facilities (Level C, D). Unfortunately, there is currently no visibility on service delivery and training at national level. This will be one of the roles of the new cadre on the national team, the VMMC Program Officer. This lack of program details on the personnel and capacity situation is exacerbated by the fact that the training methods and packages are not standardized since different partners have different follow slightly different specifications. Furthermore, retention of providers is generally poor due to career mobility, general inactivity, disinterest and the MoH staff rotation that occurs every two years, leaving some providers in areas with no VMMC capacity.

Training requirements

VMMC provider training will remain a key component of the pre-service Clinical Officers and Medical Licentiate curricula as it is a sustainable and more efficient strategy for building VMMC provider competency in the long term. The incorporation of the pre-service VMMC in teaching curricular should



be extended to the nursing schools and this will be achieved through use of an addendum for VMMC surgical components of the clinical components of the curricula. In the interim, in-service training of existing HCWs will be used to meet other training demands and new developments in the program e.g. devices. Where feasible, decentralized training of trainers at provincial and/or district levels and provision of mentorship training packages to service delivery points is required.

Due to the human resource challenges of attrition, inactivity and the need to meet an increasing number of procedures in the catch-up phase, many areas do not have enough providers to meet the demand. The number of additional VMMC service providers to be trained will be based on the existing service delivery models and district level calculations of need. The program will need to train Counsellors, hygiene assistants, and mobilizers with emphasizing areas with poor coverage rates to improve equity of service.

Matching Supply and Demand and eliminating missed opportunities

Matching demand generated to service delivery is a priority. For outreach, this is optimized when staff utilization is maximized i.e. if teams are only deployed once the level of demand at outreach posts has reached a predetermined number. It is also wise to continue to minimize long distance outreach to avoid high DSA and travel allowances.

It is also important to capitalize on all opportunities for service delivery, and eliminate missed opportunities. For

example, if a partner cannot provide service at designated facilities due to funding delays, they must immediately notify the MoH through the TWG in order to identify other partners who can temporarily deliver service. In addition, a simple campaign monitoring tool has been developed; it will be used to monitor the outputs during campaign season to make sure that high-volume sites maintain their productive status by identifying uncharacteristic drops in output. This tool will be deployed and used in every province, and will be the responsibility of the VMMC provincial coordinator.

As for the district, given that district targets vary significantly, careful planning will be used to ensure that resources made available to each district correspond to the district's level of demand. During dissemination and roll-out of this operational plan, each district will develop its own costed implementation plan tailored to its demographic characteristics.

Devices

Device-based VMMC has been shown to result in incremental demand and also provide opportunities for additional efficiencies. Zambia is currently looking at both PrePex and Shang Ring as options for device-based VMMC. Active and Passive surveillance will be conducted for each device by the end of 2016. Swift introduction and roll-out of devices will begin in 2017. This will also require communication strategies tailored to educate clients on, and generate demand for the device(s).



II. Ensure adequate infrastructural resources while maintaining the quality of VMMC during scale-up by standardizing QA/QI guidelines, materials and activities

Equipment management

The Zambia VMMC program adopted, and predominantly uses re-useable surgical instruments. As result, all implementing partners need to adhere to national standards of instrument management. Therefore, the responsibility for instrument decontamination should be assigned to qualified individuals who have demonstrated competence this area. Decontamination is achieved by pre-soaking and manually cleaning disposable non-sharp metal instruments in a sodium hypochlorite solution to disinfect the items, rendering them safe for handling or disposal. After decontamination, the instruments must be thoroughly rinsed and dried before undergoing sterilization or transport.

For sites that do not have an autoclave, reusable instrument sets will need to be sent to an external facility, usually a district or higher-level hospital, with an autoclave. This process will also typically require additional supplies and personnel to manage storage and logistics for the newly sterile equipment.

Facilities and districts with limited autoclaving capacity will be supplied with additional instrument sets in order to ensure that this does not create a barrier to facility service delivery or meeting the demand for VMMC during outreach activities.

Waste management

Voluntary Medical Male Circumcision (VMMC) is an activity that generates health care waste, which is composed of both non-hazardous and hazardous elements. If not managed correctly health care waste carries a risk of infection and / or injury for health care professionals and patients.


To avoid negative impacts on public health and the environment, it is essential to develop safe and reliable methods for the handling and treatment of health care risk waste (HCRW) including Disposable Non-Sharp Metal Instruments. Service providers must have clear Standard Operating Procedures on the segregation, handling, storage, transport, treatment and disposal of Non-sharp Metal Instruments as well as other types of HCRW to cater for each step of the cycle¹³.

¹³ Ackerson S. and Pahl, N. 2013, Voluntary Medical Male Circumcision Guidance Document; Submitted to the US Agency for International Development by the Supply Chain Management System (SCMS)




Figure 9: Decontamination Process for Disposable VMMC Kits¹⁴

Decontamination Process for Disposable Voluntary Medical Male Circumcision Kits




1 Put on required Personal Protective Equipment (PPE), including: reusable safety goggles, apron, rubber gloves, hair net, and face protection (goggles or full-length face shield).




2 Determine the percentage of active sodium hypochlorite by reading the active ingredients on the label of the bottle. Strong sodium hypochlorite concentrations will vary from approximately 1% to 11%.

Sodium Hypochlorite Concentration (5-6%)					Sodium Hypochlorite Concentration (10-11%)				
Total Volume of Bucket/Container	Amount of Water to Add (L)	Amount of Sodium Hypochlorite to Add (ML)	Amount of Sodium Hypochlorite to Add (L)	Amount of Sodium Hypochlorite to Add (ML)	Total Volume of Bucket/Container	Amount of Water to Add (L)	Amount of Sodium Hypochlorite to Add (ML)	Amount of Sodium Hypochlorite to Add (L)	Amount of Sodium Hypochlorite to Add (ML)
1	3.1	190	0.19	190	1	99	990	0.99	990
2	3.2	170	0.17	170	2	97	970	0.97	970
3	3.3	150	0.15	150	3	95	950	0.95	950
4	3.4	130	0.13	130	4	93	930	0.93	930
5	3.5	110	0.11	110	5	91	910	0.91	910
6	3.6	90	0.09	90	6	89	890	0.89	890
7	3.7	70	0.07	70	7	87	870	0.87	870
8	3.8	50	0.05	50	8	85	850	0.85	850
9	3.9	30	0.03	30	9	83	830	0.83	830
10	4.0	10	0.01	10	10	81	810	0.81	810


3 Using the table above, determine the correct amount of sodium hypochlorite and water required to make the decontamination solution (TABLE).




4 Measure the appropriate volume of sodium hypochlorite solution found in table number 3.




5 Carefully pour measured amount of sodium hypochlorite solution into a bucket.




6 Measure the corresponding amount of water as indicated in table number 3.




7 Carefully pour the water into the same bucket as the sodium hypochlorite solution. Use caution to avoid splashes.




8 Use a stainless steel mixing spoon to gently mix the solution. Avoid any process to create a foam or decontamination solution in a separate bucket.




9 Place non-sharp metal instruments in one of the prepared decontamination solutions for 30 minutes to pre-soak the instruments.




10 Fill a third stainless steel bucket ¾ full of cleanroom temperature water to create a water bath.




11 To soak the instruments, place the three buckets next to each other. 1 bucket with pre-soaked instruments, 1 bucket of fresh decontamination solution, and 1 bucket of clean water for the water bath.




12 Remove half of the instruments from the pre-soak solution and place them into the second bucket of fresh decontamination solution. Use the tongs. Soak the instruments thoroughly with a spray nozzle brush while all signs of contaminants have been removed.



13 Place the soiled instrument into the water bath for rinsing. Repeat this process until all (soiled) metal instruments have been sanitized and are placed in the water bath.



14 Rinse instruments from water bath and place them on a clean, dry towel. After the instruments are dry, inspect the site prepared for transport. Items for rest or residual contamination. If a bucket is left with water and the debris of the contents.



15 Place properly decontaminated single use instruments in separate storage containers with appropriate caution signage for temporary storage.

The effective management of HCRW is considered a basic element of waste minimization, identification and proper segregation of the waste. Segregation is the responsibility of the generator of the waste at the point of generation. Segregation is the process of separating different types of waste at the point of generation and keeping them isolated from each other. To improve segregation efficiency, the correct use of containers, proper placement and labelling of containers must be carefully determined and followed.

¹⁴ Source: Ministry of Health, Zambia



Figure 10: VMMC Health Care Waste¹⁵ Streams



Disposal of biomedical waste must be performed according to existing guidelines. In the event that a facility does not have a functioning incinerator, waste will be brought to the nearest health facility where an incinerator is available. Disposal of other materials such as used gauze will follow the same procedure. During QA/QI, the VMMC teams must ensure that sites selected for implementation of device-based VMMC are ready to dispose of the resulting waste as per waste management guidelines.

¹⁵ Source: PEPFAR, SCMS VMMC Waste Management Guidelines, as adopted by MoH Zambia



Quality assurance

QA is a totality of actions that will provide confidence that a product or service will satisfy given requirements for quality (National Guideline 2012). The key principles include: orientation towards meeting the needs and expectation of client's and community, focus on systems and process, use of data to analyze service delivery processes and encourages a collaborative team approach to problem solving and quality improvement. Improving the documentation and reporting of AEs in the VMMC program will require adopting the performance improvement approach through use of M&E data.

In March 2015, a report was produced following a WHO consultative meeting providing guidance on tetanus risk mitigation approaches and surveillance for VMMC country programs. Zambia has adopted the 'clean care' approach at facility and individual level, comprising rigorous surgical skin preparation for all circumcisions, including device methods, and good personal wound care education, as its tetanus risk mitigation strategy¹⁶.

As the VMMC program scales up, enhancing safe and quality VMMC services through standardization and monitoring of Quality Assurance/Quality Improvement (QA/QI) characteristics will become even more important. There is need to strengthen adoption of the national Quality improvement guidelines conceptual

framework¹⁷ at each level of service delivery. Using the Performance Improvement Approach (PIA) in each service delivery point will strengthen AE reporting. Adopting the PIA framework will require joint collaboration of all VMMC stakeholders, as well as other experts outside the TWG (e.g. Health Profession Council of Zambia (HPCZ)). The program will work with the QA/QI unit at MoH to develop core VMMC quality indicators to be added to the present comprehensive national quality indicators. This approach for QA/QI will leverage on existing processes set up for Quality improvement committee/teams, data review meetings and supportive supervision. Concurrently, supportive supervision will not be confined to the national level supervisors, but it will also be decentralized to the subnational level through a series of Training of Trainers (ToT) sessions. In particular, supportive supervision visits should be decentralized to the province.

¹⁶ Zambia Country Operational Plan (COP) 2016 Strategic Direction Summary, *PEPFAR April 14, 2016*

¹⁷ (See page 17 & 18: The first edition of 2012 Guideline on Quality improvement for Health Care Workers in Zambia)



III. Facilitate the integration of VMMC services with other health programs at all levels of care and centralize VMMC commodity management into the existing Supply Chain System

Integration of VMMC service delivery

Zambia's VMMC program is now mature and increasingly moving towards routine, integrated service delivery to take full advantage of the economies of scale that result from using existing government structures and resources to provide time-limited VMMC services. In order to do further accelerate integration, this Plan proposes to adopt the following strategies:

1. **Integration** of VMMC services with other health programs at the health facility (FH, MCH, ANC, and SRH), strengthening referral/follow-up systems and investing in infrastructure and refurbishment of facilities to accommodate VMMC services in the long term
2. **Prioritization** of areas based on HR and capacity gaps
3. **Streamlining** of operations to focus on the most productive sites with threshold for MCs per year or per month or per day
4. **Routinization** of service delivery by increasing focus on static site productivity and conducting outreach on guaranteed high-demand days or during 'mini-campaigns'
5. **Phasing/Site-graduation** – implementing partners continually facilitating sites from partner-dependence to become independent, fully-MoH VMMC sites. Partners assist facilities within each district to take ownership of the seven core VMMC-specific service delivery responsibilities: 1) community-level demand generation, 2) clinical service provision, 3) infection prevention, 4) behavioural counselling, 5) quality assurance, 6) data management, and 7) supply-chain management.
6. **Direct budget, Results-focused funding** – identify and fund high-volume sites/districts that need minimal booster funding to activate their team and resources for VMMC
7. **VMMC compensation/incentive** structure must be standardized, officially documented and published in the short-term. This will avoid differential payments which can impact the program negatively. In the long term over the next five years) will be gradually reduced and restructured over time. Restructuring compensation will follow principles of results-based models aimed at system strengthening rather than individual compensation



Integration of procurement of VMMC into central Supply Chain Management System

The MoH and implementing partners will collaborate to centralize VMMC procurement into the existing Supply Chain System. Currently, procurement is partner-driven and not centralized. This leads to low visibility and accountability for commodities, reliance of the national quantification exercise on inaccurate service data for procurement, and existence of parallel/vertical supply systems run by IPs, resulting in reduced country ownership of the process.

Centralization of the currently fragmented VMMC supply pipeline and standardization of supply chain management guidelines will avoid the frequent shortages and commodities supply interruptions at facility level. Joint national forecasting, quantification, and real-time eLMIS will allow 4-week turnarounds to deliver 4 months of stock. This will cater for seasonal demand and avoid long turnaround time (TAT). The following are key attributes of Zambia's planned VMMC supply chain management system:

Product Selection

A standard product list will be developed which will be adhered to across the country for the VMMC programme. This will be driven by factors that will take into consideration quality, effectiveness, safety and cost effectiveness. This will be reviewed every other year to cater for changes within the programme.

Quantification

The MoH and partners will collaborate to quantify national need at annual forecasting meetings which will include supply and procurement planning. The forecasts will be reviewed during periodic review meetings. National pipeline monitoring and management will be the responsibility of the MoH. The MoH will take leadership in the Forecasting and Quantification (F&Q) for the national need of the program. Program managers, procurement specialists, monitoring and evaluation (M&E) officers, relevant information specialists, warehouse managers, service providers, donor agencies, implementing partners, and technical experts will be involved in quantification. The F&Q will be based on logistics, service statistics, and morbidity/demographic forecasts with the results feeding into the national procurement plan.

Procurement

The program will allow for procurement of commodities through the government and different cooperating partners based on the national need determined by the F&Q process. Procurement coordination and national pipeline monitoring will be led by the MoH and supported by partners to ensure the correct products are available in-country and are ready for distribution when needed.

Distribution

As the program transitions to the sustainability phase, it is expected that MOH will take-up the role of coordinating the supply chain and commodity security issues with implementing partners and Medical Stores Limited (MSL). MSL, which manages the central warehouse and delivery

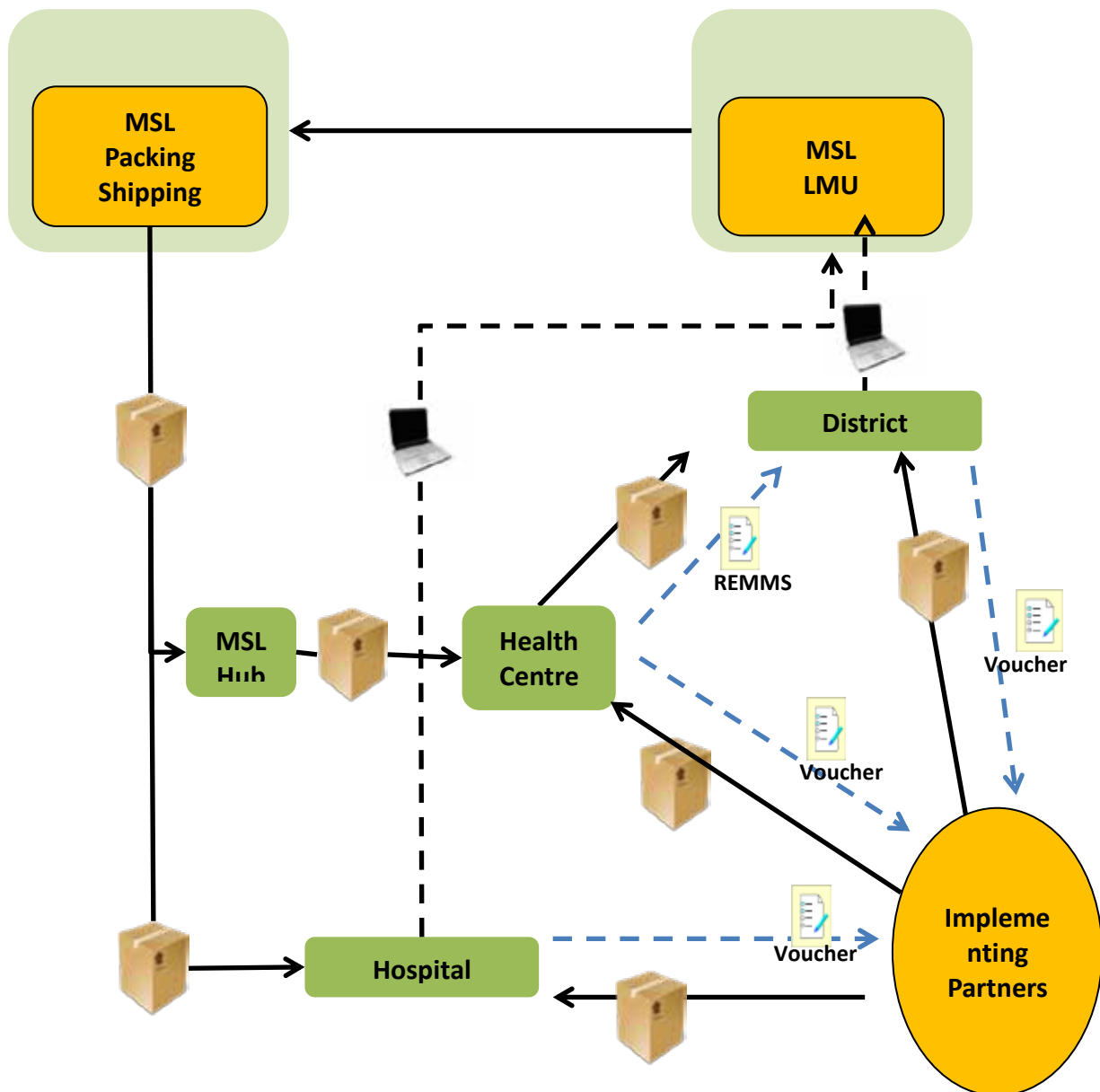


systems for medicines, laboratory and other general supplies that are distributed through the government health system, will take up the role for VMMC commodities in like manner up to the last mile based on the

facilities orders. In the interim, the implementing partners (IPs) may procure buffer stock/commodities which can be used to 'top-up' facilities to meet the gap unfulfilled by MSL

The model is shown in the diagram¹⁸ below.

Figure 11 : Flow Chart for new Supply Chain Management System



¹⁸ Source: VMMC Logistics System Design, GRZ



Reporting and Ordering of VMMC Commodities

All VMMC service delivery points will report for and order commodities through one national supply chain with Medical Stores Limited (MSL). The VMMC commodities will be managed through the Essential Medicines Logistics Improvement Programme (EMLIP), the national logistics management system for essential medicines and medical supplies.

The VMMC in-country supply chain will utilize an electronic logistics management information system (eLMIS) which will enhance the visibility, accountability and accuracy of logistics data in the programme. Logistics data will be collected and available in a national repository for the MoH and partners to use for procurement and other logistics decisions.

The PMO will play a supervisory role for VMMC commodity logistics management, addressing essential medicines logistics reporting and distribution issues. The health facility will complete and send a Report for Essential Medicines and Medical Supplies (REMMS) to the district which the district will enter into the eLMIS and send an electronic copy to Medical Stores Limited (MSL) logistics management unit (LMU) on a monthly basis. MSL will pack orders in sealed packages for each facility and either deliver commodities directly to the health facilities in districts serviced by an MSL hub,

or deliver to the district which will then deliver to the facilities where an MSL hub does not exist.

IV. Conduct annual planning, geographic prioritization and officially document the allocation of geographies and/or facilities to partners

Annual Planning and prioritization at national level

The Zambia VMMC landscape is a multi-implementing partner environment, and thus requires official documentation of geographical focus and facility allocation by partner. This facility map will be updated at least once a year to inform progress and capacity discussions.

District-level planning

This Plan proposes that detailed work plans and budgets at district level should be developed with this document as a guideline. The district coordinating team will determine the combination of service levels most appropriate for generating demand and delivering VMMC in each district and assess the availability of resources (both facilities and staff) in their area to carry out dedicated VMMC clinics. Using district-level VMMC targets over the five years from 2016-2020, MoH staff in each district will make decisions regarding service delivery and demand creation.





PILLAR 4: COMMUNICATION AND DEMAND GENERATION



Objective

To increase demand and meet the targets for VMMC in the most effective (core) age groups through a targeted, market/client-based approach.

Strategies

- I. Provide a national demand generation roadmap by finalizing and launching the National VMMC Advocacy and Communications Strategy (2016-2020), and outlining how to take advantage of referral networks and client follow-up
- II. Generate higher demand by implementing novel, market-based and client-centric methods of demand generation through high-yield targeted communication channels
- III. Integrate market research findings and plan for capacity to carefully monitor demand across market segments
- IV. Improve program effectiveness by focusing the majority of demand generation activities on the core age groups (15-29)
- V. Supplement funding for demand generation activities through joint-funding of specific activities

A well-coordinated, targeted demand generation strategy that accounts for the distinct informational needs and behavioural change triggers of males and females is an indispensable tool for Zambia's national VMMC scale-up plan. The strategy should appeal to both the primary and secondary target audiences and convince them to seek VMMC services; otherwise, investments in VMMC infrastructure and human resources to date will have less impact than intended. Thus communication and demand generation is a key priority for both the short and long term.

The VMMC program currently employs a mix of methods to generate demand including Mass Media (Primarily Community Radio), Neighbourhood Health Committees (NHCs), Inter-Personal Communication (IPC) and others.

I. Provide national demand generation roadmap by finalizing and launching the National VMMC Advocacy and Communications Strategy (2016-2020)

The National VMMC Advocacy and Communication Strategy has already been developed and awaits finalization after the



launch of this Operational Plan. This document will offer specific guidelines for conducting Social Behavioural Change Communication (SBCC) activities in all places and circumstances and especially to particular types/segments of clients.

The Advocacy and Communication Strategy was thoroughly reviewed by the communications subcommittee of the VMMC TWG to address inequality in relationships and women's distinct needs. It also outlines and specifies the appropriate channels of communication. SBCC messages contained therein must be medically accurate, evidence-based, and consider the cultural sensitivities of the local population. Finally, it will meet the information needs for all target audiences about the benefits, importance and limits of VMMC; condom use and VCT. The messaging for target segments will be based on IPSOS findings on VMMC demand creation.

The strategy will be launched in the third quarter of 2016 just after the Operational Plan, but before August campaign.

II. Generate higher demand by implementing novel, market-based and client-centric methods of demand generation through high-yield targeted communication channels

Communication and demand generation increase the uptake of VMMC services and continuously influence positive behavioural change, contributing to the reduction of new HIV incidence. The SBCC will use

comprehensive approaches which will include; targeted advocacy, mass-media, mid-media and IPC strategies that have been articulated in the National VMMC Advocacy and Communications Strategy 2016-2020

Market-segmentation Approach

The VMMC Communications subcommittee already drafted a National VMMC Advocacy and Communications Strategy (2016-2020) which incorporates the client-centric, market segmented approach. This new approach targets segments of the population, tailoring the message and using appropriate, preferably high-yield communication channels to engage the client as follows:

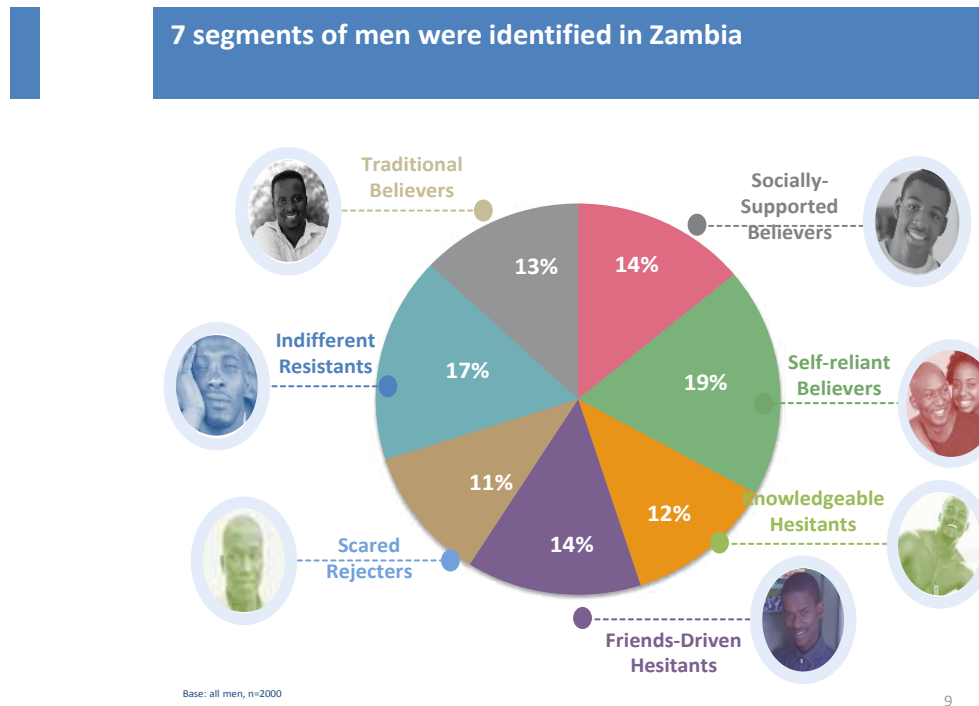
- ***Segmentation and Targeting:*** Identify and segment target audiences and tailor key VMMC messages to address barriers and increase VMMC uptake
- ***Tailored, informative Messaging:*** should be medically accurate, evidence-based, and consider the cultural sensitivities of the local population. It should also meet the information needs for all target audiences; specifying the benefits, importance and limits of VMMC and integrating condom use and VCT in the SBCC materials. Messaging and target segmentation will use the IPSOS findings on VMMC demand generation.
- ***Proper Communication Channels:*** outline specific channels that are appropriate for communication.



Seven segment types of VMMC clients

In line with the IPSOS findings in 2015, this strategy will target the audiences as segmented below:

Figure 12 : Seven Segments of VMMC Clients in Zambia (VMMC Market Research)








While efforts will be made to drive volumes in every segment, more focus will be given to the *Friends-Driven Hesitants*, *Scared Rejecters* and *Indifferent Resistant* to give the right kind of information that would turn them into VMMC believers and ultimately choose to undergo the procedure.



Recommendations by client segment

Figure 13 : Demand Generation Recommendations for each Client Segment

Recommendations Overview						
Segment	Key Messages	Mass Media	IPCs	Advocates	Devices	
 Friends-driven Hesitants	VMMC becoming social norm – be part of norm; more emotional benefits; detailed info on procedure & healing process.	Full and personalized benefits; sense of accomplishment; address uncertainty on risks	VMMC becoming norm, how to manage healing time, clarify pain during procedure, address uncertainty about service quality and availability; reasons for pride	Provide community network of advocate support – VMMC as social norm	PrePex as an additional option	
 Socially-supported Believers	Address uncertainty on healing process and pain during healing and procedure	Not a target	Address uncertainty on healing and pain; identify non-circumcised friends to go together for the VMMC	Engage as advocates	PrePex as an additional option	
 Self-reliant Believers	Address their questions about pain during procedure and healing process	Not a target	Address uncertainty on healing and pain; identify non-circumcised friends to go together for the VMMC	Engage as advocates	PrePex as an additional option	
 Scared Rejecters	Safety of procedure and low risk of complications; Pain management during healing; Emphasize protection benefits	Not a target	Communicate safety – credible info about low risk of complications, expert service; pain is real, but certainly manageable	Use advocates to allay fears, share experience, accompany them	PrePex as a non-surgical option	
 Knowledgeable Hesitants	Assurance in protection benefits, added benefit of VMMC with condom use; Safety of procedure and low risk of complications; Pain management	Not a target	Address uncertainty in safety; low risk of negative consequences (esp. for sexual life); address questions about pain; expert service; involve partners	Use advocates to allay fears, share experience	Not particularly applicable	
 Indifferent Rejecters	Full info on benefits & risks + general HIV/ STIs protection info; clarify safety of procedure; address myths believed, where to get info; service	Full benefits, process, pain exists – how to manage it; sense of accomplishment	Communicate full info on benefits and risks; acceptance of VMMC by wider community and advocacy from leaders; dispel myths	Need a lot of advocates around, communicating pride in VMMC and allay fears	PrePex as an additional option	
 Traditional Believers	Information on benefits and risks; where to get info; service	Not a target	No need in additional motivation, but will benefit from short communication on benefits and risks; info about service/ clinics	No need in advocates	No need in devices	

** Identify in clinics and emphasize the need to use condoms after VMMC

Campaign Planning and Modalities

The VMMC program has continued to benefit from successful campaign launches since 2012. Despite novel methods, VMMC campaigns will still remain a pivotal platform for demand generation. Pre-arranged, timely and innovative campaign modalities will enhance the effectiveness of targeted demand generation, taking advantage of referral networks both during and outside campaigns. So, campaigns will emphasize the following areas:

- Campaign Planning shall begin 3 weeks before each campaign to allow for timely launches and employ new ideas for campaigns timing/frequency (e.g. mini-

campaigns, sustained service delivery etc.)

- Special focus shall be placed on resuscitating the December campaign through early planning, early execution and special messaging
- Anticipation of demand and supply disruptions: the program will preempt any campaign disturbances resulting from political or other competing/disrupting activity through mini-campaigns and reorganizing the timing of demand generation



- Referral networks: pay attention to the effectiveness of referral networks and follow up

Coordinating Demand generation

At national level, a new cadre with dual demand generation and service delivery roles (VMMC Program Officer) will lead the coordination of all national-level activities, including campaigns and TWGs. They will work closely together with the VMMC provincial coordinator on all demand generation issues. At the facility, the VMMC focal point person at district level will be appointed to coordinate activities such as training, and monitoring of IPC agents in VMMC facilities.

National Level Demand Generation

At National-level, VMMC media coverage will continue addressing key behavioural determinants to increase overall demand for VMMC through the following key activities;

- Press conferences and media briefs sensitizing media personnel on the objective of the national VMMC program;
- Radio and TV spots addressing key determinants of VMMC uptake;
- Phone-in shows, talk shows and interviews to create a platform for informed national dialogue on VMMC
- Featuring VMMC champions and ambassadors such as traditional and civic leaders
- Press releases, news and features articles on VMMC
- Use of the existing 990 Health Talk line for VMMC

- Development and distribution of IEC, BCC and promotional materials on VMMC; such as booklets, flipcharts, posters, fliers, brochures and T-shirts etc.
- Utilization of social media channels, such as Facebook, Twitter, Whatsapp and Instagram, to provide accurate information on VMMC services

Provincial Level Demand generation

The provincial health office will liaise with the subnational VMMC technical working group to coordinate and supervise all demand generation activities which will include:

- Identifying local VMMC champions to promote the service at both the provincial and district levels
- Developing and implementing gender inclusive campaigns;
- Utilizing community radio stations as a platform for dissemination of VMMC messages through: Pre-recorded and live VMMC client testimonials, interviews and radio drama; live phone-in programs led by local DJs to discuss VMMC and provide a forum for the panel to interact and provide correct information to the community.

District Level Demand Generation

At District level, the VMMC focal point person, in collaboration with community-level advocates, traditional leaders, identifies activities that will influence a positive SBCC. These activities will include;

- presentations, to the target audience in places such as learning



institutions, churches and work places

- Community level informative and interactive activities such as drama, Mobile Video Unit, public address systems and soccer tournaments. During these activities, VMMC champions and satisfied clients will be given the platform to share their experiences.

III. Integrate market research findings and plan for capacity to carefully monitor of demand across market segments

Market Research to Monitor Demand

Once novel demand generation methods have been implemented, it is also important to continuously monitor the demographics and shifting demand generation dynamics. The respective VMMC focal persons shall be responsible administering and analysing the tracking tools to monitor the market research work and measure the changes in the country's demand generation profile based on client segments that were identified and modelled by Ipsos¹⁹. These activities will also require full partner collaboration. Initial findings have already been adopted into the upcoming Advocacy and Communication Strategy (2016-2010), and a pilot study to help the Ministry and stakeholders determine how to integrate and implement segmentation in the most useful way.

At national level, this includes revising the main messages and communication

channels (mass-media and campaigns). At local level, Facility in-charges will ensure that the IPC agents and the NHC have up-to-date materials and tools. Regular supervision will inspire adherence to standard program guidelines and quality IPC session procedures. District coordinators are also required to conduct regular field supervision to identify the gaps and inform bi-annual refresher trainings for demand generation.

Sustainability of demand generation

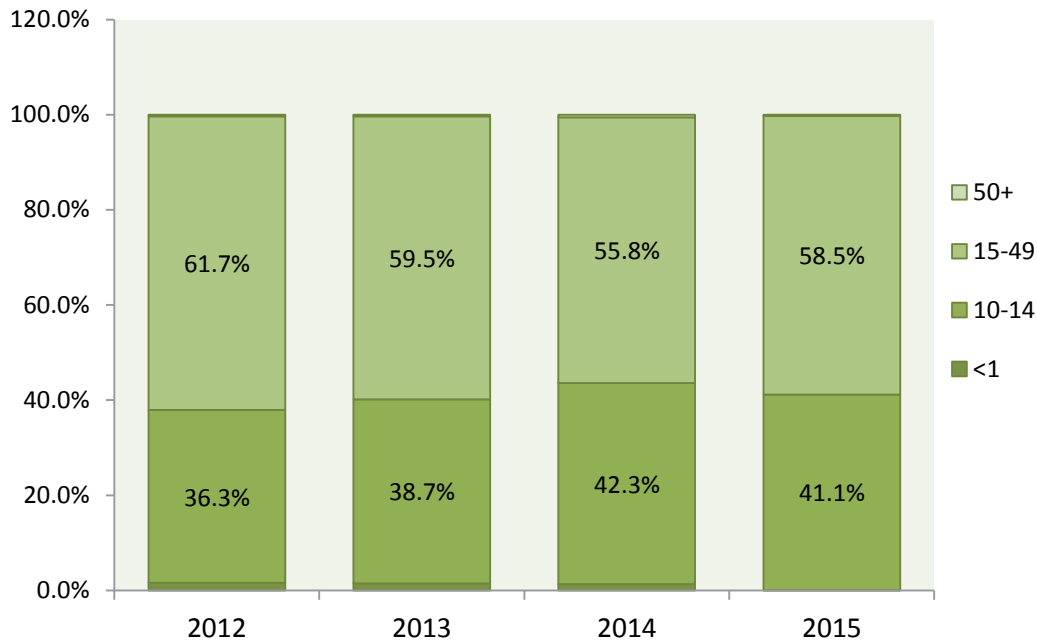
A successful, sustainable demand generation structure for VMMC requires the following;

- A high level of political will and organic community ownership
- Integration of VMMC demand generation with other interventions at implementation level
- Continuous and timely training for Health Promoters and IPC staff
- Up-to-date guidelines/ protocol
- Stakeholder networking and collaboration
- Systems strengthening
- Advocacy for resource mobilization

¹⁹ Implementing the segmented approach to VMMC demand generation, Next Steps 2016



Figure 14 : Age proportions of total VMMC



IV. Improve program effectiveness by focusing the majority of demand generation activities on the core age-groups (15-29 years)

Age-targeting and Effectiveness

In Zambia, modelling data in 2013 showed that targeting specific age groups (15-29) increases the program effectiveness in terms of the number of HIV Infections Averted (HIA) and the immediacy of this impact. In 2015, only 58.5% of VMMCs fell within the proxy²⁰ core age-group of 15-49, showing annually decreasing trend. This was in part due to high MC coverage (‘near-saturation’) rates and a high frequency of adolescent traditional MC (‘adolescent TMC’) in some high-volume provinces which presented a

barrier to increasing this proportion of core VMMCs.

The non-core group (10-14) has been trending upwards since 2012. Going forward, the plan is to reverse this effect where feasible. Zambia has a universal access policy when it comes to health so non-core age-groups will not be tuned away. VMMC donors support measures to disincentivize MCs in this non-core age group, but it will be challenging to reverse the trend since about half of the non-core MCs are from nearly saturated and/or high adolescent TMC provinces where the trend is going in the opposite direction.

²⁰ Zambia’s HMIS does not yet track 15-29 age-group so 15-49 was chosen as a proxy.



The operational plan revision process has redefined target age-groups and strategies to emphasize core age-groups (15-29) and de-emphasize non-core age groups (10-14). Once allocated to the district level, these targets will organically result in a geographically prioritized age strategy based on current MC coverage/saturation rates. Finally, on-going analysis on effectiveness, including synthesis and dissemination of best-practices through the TWG will be required to measure progress towards effectiveness

V. Supplement funding for demand generation through joint-funding of specific activities

Despite successful campaigns every year, the departure and scaling down of some prime demand generation partners has left a visible gap in demand generation funding and activity. Thus, partner collaboration through the VMMC Communications TWG will become increasingly important to fund and sustain demand generation for scale up. Implementing partners will contribute collectively to a national level demand generation pool, organized for specific universally beneficial activities such as campaign launches, dissemination of Advocacy and Communications policy (2016-2020), marketing tools and segmentation research etc.





PILLAR 5: MONITORING AND EVALUATION



Objective

To reduce data discrepancies between HMIS and PRS from 37% to below 5% and develop HMIS/DHIS2 system into a self-sufficient, reliable sources of VMMC

Strategies

- I. Improve data capture, quality and accuracy at subnational level through consistent monitoring of progress and evaluation of data to identify and solve programmatic challenges
- II. Harmonize HMIS and PRS tools and processes to reduce the data discrepancies
- III. Transition fully from PRS (Partner Reporting System) to HMIS for M&E

The M&E framework for VMMC plays the role of reporting on key achievements and evaluating the effectiveness of the VMMC program as part of Zambia's overall HIV prevention strategy. Standardized VMMC data collection and reporting tools (MC client Intake Form, Register, Adverse Event Form, Review Form, etc.) will inform national level summary indicators compiled by the new VMMC M&E Officer once hired. These broad national summary indicators will be tracked through HMIS: i) coverage of VMMC - number of males who have been circumcised; ii) HIV status - number of circumcised males who are HIV positive, HIV negative and unknown status; iii) adverse Events (AE) - proportion of moderate AE and severe AE among circumcised males; iv) follow-up - proportion of circumcised males with at least one post circumcision visit v) method

of VMMC - proportion of male circumcisions conducted using devices

- I. Improve data capture, quality and accuracy at subnational level through consistent M&E activities to gauge progress and evaluation of data to identify and solve programmatic challenges*

Monitoring

Monitoring will done by the government through HMIS with the support of cooperating partners. The VMMC national technical working group's M&E sub-committee, led by the VMMC M&E Officer, shall report on VMMC progress based on routine service data collected at the facility level and processed through the HMIS. The following specific tasks will be



prioritized within the monitoring aspect of M&E.

- **Incorporation of revised M&E tools and indicators in HMIS:** The national M&E framework, indicators, and updated tools will be incorporated in the revised national HMIS summary.
- **Strengthen the use of newly developed M&E tools (registers, client intake forms and HIA 2):** used in all facilities by MoH and partners.
- **Dissemination of the M&E framework and revised tools:** the new national M&E framework will be disseminated and staff trained on revised tools
- **Conducting data audit visits to health facilities:** conduct bi-annually data audits at national level and begin monthly data audit visits at district level, focusing on facilities reporting inconsistently or irregularly to improve data quality. During the data audits, VMMC District focal point persons and DHIOs should interrogate the data on a monthly basis.

Evaluation

Evaluation is critical to inform advocacy, policy development, strategic planning, programmatic and donor reporting. It provides insight into what activities are working and what, if any, changes are required for VMMC interventions. To institute routine review of strategic information, the following meetings will be held each year:

- **Quarterly district level performance reviews:** Each district health office will hold quarterly status review of VMMC program implementation where MC providers, Health Centre in-charges and district coordinators will attend to review their performance.
- **Quarterly provincial level performance reviews:** Each provincial health office will hold quarterly status review of VMMC program implementation where all coordinators will attend to review their performance.
- **Quarterly national VMMC program performance review:** The MoH in collaboration with the VMMC TWG will review data quarterly to target follow-up with provinces throughout the year accordingly.
- **Annual national VMMC program performance review:** MoH in collaboration with all partners will facilitate a national meeting at end of the year to review program performance and share best practices. All provincial health offices will be represented and all scientific as well as operational research findings will be discussed.

II. Harmonize HMIS and PRS tools and processes to reduce the data discrepancies

In 2014 VMMC data discrepancies surfaced during a comparative data audit²¹ conducted

²¹ Zambia VMMC M&E Audit Report, September 2015



in April 2015. The audit showed a deviation of up to 37% between Health Management & Information System (HMIS) and the Partner Reporting System (PRS), with the former showing higher numbers. While the M&E progress and contribution made by the PRS to date is noteworthy, the MoH and all VMMC partners are committed to work towards strengthening the HMIS system as the sole official source for VMMC data by end of 2017. In order to achieve this, the VMMC program will implement the following summary recommendations to address the following M&E challenges.



Summary M&E Recommendations

Figure 15 : M&E challenges and solutions

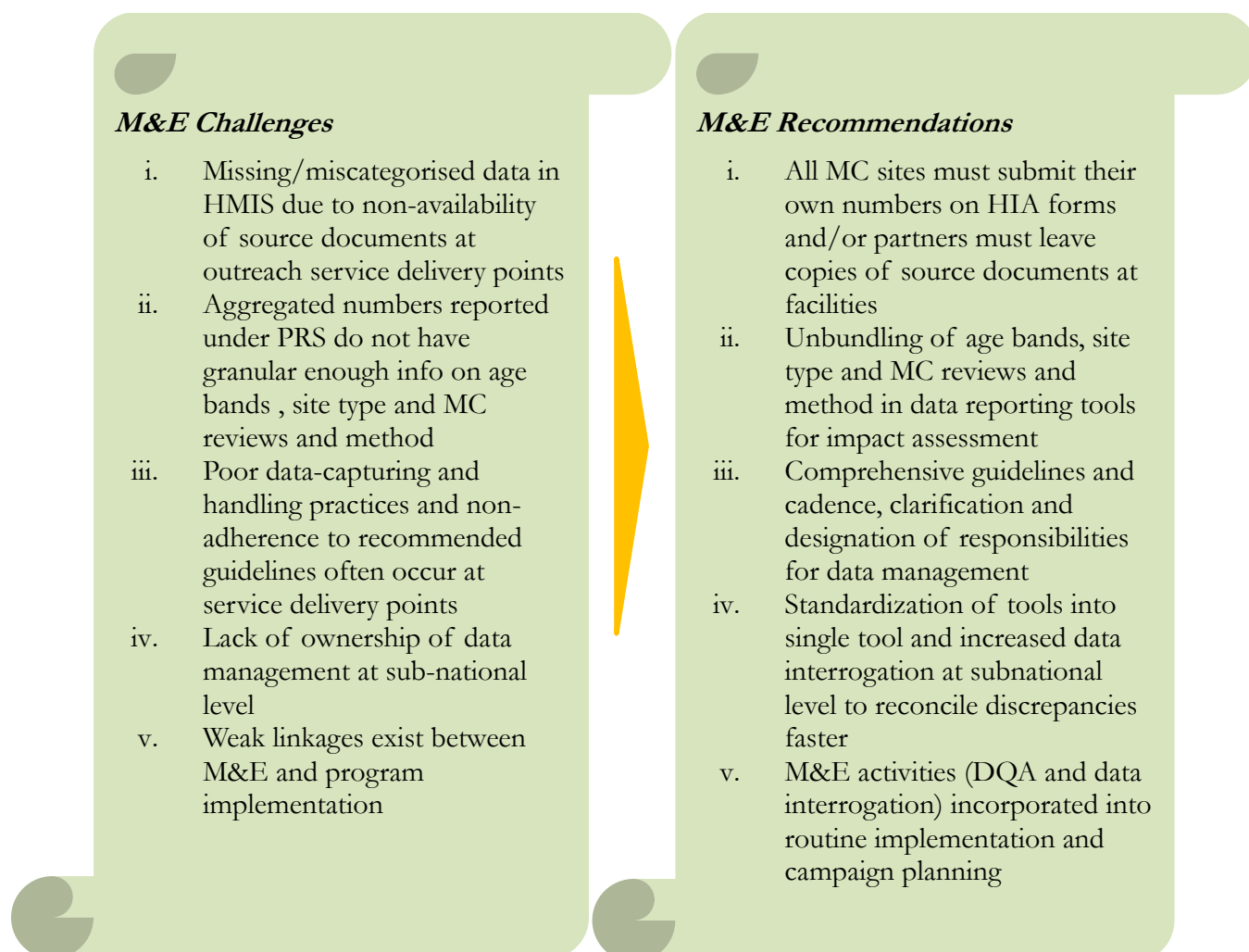


Table 4, below, is an expanded list of these recommendations categorized and customized by individual stakeholders/actors. This highlights the level of responsibility and the different roles that each type of stakeholder will play in revising the HMIS M&E system and harmonizing it with the PRS; this process will require a massive collaborative, consultative approach.



Detailed M&E Recommendations (Activities by stakeholder and level of care)

Level of Health Care	Findings	Recommended Activities
Service Delivery Point (Health facility/hospital)		
<i>Human Resources/Other Support</i>	Lack of clear ownership of specific data capture activities (MC register)	Delegate duty for MC register to specific cadre/officer
	Weak linkage between M&E and program data	Data review meetings , data comparison and interrogation at all levels
<i>Tools/Systems</i>	Different client intake forms	Standardized client intake form
	Lack of data capture tools	Request for data capture tools well in advance from the central level (District/Provinces)
	Inadequate indicators for program	Introduce new indicators to HIA form
<i>Processes</i>	Missing forms, data	Record client intake per case
	Incomplete register	Record in register daily
	Late, incomplete, missing facility data	Fill and submit HIA form monthly
District Health Office		
<i>Human Resources/Other Support</i>	Lack of comparative data analysis at district level	<ol style="list-style-type: none"> 1. Support the enhancement of data analysis and interrogation at district level on a monthly basis to inform accurate data capture. 2. Increase technical capabilities of the DHIO to conduct comparative analysis of PRS (partner summaries) and HIA2 forms before entry into DHIS2
	Irregular district data review causing a mismatch between partner and district data	<ol style="list-style-type: none"> 1. Build capacity for data interrogation and verification by -DHIOs and VMMC District Coordinators to capture accurate data 2. Hold data review meetings frequently
<i>Tools/Systems</i>	Lack of data capturing tools at facility level	District coordinators and Information officers to ensure that facilities have data capturing tools at all times
	Underreporting in DHIS due to lack of source documents at outreach sites	<ol style="list-style-type: none"> 1. Communicate with district coordinators to ensure all numbers reported at facility level are reported to the district on a monthly basis 2. Delegated, DHIS trained hospital staff to verify and report MC data monthly



<i>Processes</i>	Lack of data verification by senior management at district level	<ol style="list-style-type: none"> 1. District Medical Officers to send a memo informing VMMC parent facilities to send monthly summary reports of VMMC data from respective outreach and static sites. 2. DHIOs to expect receipt of summary reports from parent facilities and follow up when summary report is not received. 3. District Medical Officers to verify and sign VMMC summary data from parent facilities and partner reports.
Provincial Health Office		
<i>Human Resources/Other Support</i>	Lack of data comparative analysis at provincial level	<ol style="list-style-type: none"> 1. Support monthly data comparative analyses at provincial level 2. Increase technical capabilities of the DHIO to conduct comparative analysis of PRS (partner summaries) and HIA2 forms before entry into DHIS2
<i>Tools/Systems</i>	Lack of VMMC data review and interrogation at provincial level	Support Provincial Health Information Officers and Provincial Coordinators to conduct data review meetings for VMMC
<i>Processes</i>	Lack of data quality audits at provincial level	Enhance data quality through quarterly provincial audits during campaign monitoring
VMMC National Coordinating Office		
<i>Human Resources/Other Support</i>	Lack of dedicated staff to interrogate data frequently	Hire a new M&E officer to interrogate VMMC data at national level on a monthly basis
	Lack of regular check-up and supply of MC client intake forms and registers	Delegate M&E officer to respond to requests for data tools
<i>Tools/Systems</i>	Excel based partner data aggregation tool contains wide age bandwidth	Revise partner template into more granular age bands
	Lack of program impact analysis	Revise MC register, HIA tool, HMIS to granular age bands
	Numerous client intake forms	Standardise the client intake form as government document for VMMC client capture data
<i>Processes</i>	HMIS data comparison with PRS undertaken once since inception of VMMC data elements in HMIS	Monthly interrogation of national VMMC data



	Lack of RDQA tool	Incorporate RDQA with supportive supervision at national and provincial level
Implementing Partners		
<i>Human Resources/Other Support</i>	Lack of resources for data quality audits and M&E capacity building	Participation in DQAs, IQAs and EQAs periodically and before a campaign period
<i>Tools/Systems</i>	Excel based data aggregation tool contains large age bandwidth	Revise partner template into more granular age bands
	Miscategorisation of MC outputs (by site type, level and geography)	Provide granular data through PRS, by site type (outreach and static), level (clinic, hospital) and relevant geographical area (district)
<i>Processes</i>	Data not shared at service deliver points	Data is to be left at respective facility, e.g. copies of client intake forms
	Lack of follow up on data capture at facility	Follow up on data capture at facility especially MC register

Table 4 : Detailed M&E recommendations by stakeholder and level of care



III. Transition fully from PRS (Partner Reporting System) to HMIS for M&E

Stage I: Current System has 37% data discrepancy

The previous section outlined detailed solutions to address currently known gaps and provided a basis for elevating the HMIS system to be the sole official VMMC data source.

The flow diagrams in this section illustrate the 3 stages of transition and the characteristics defining each system at each stage of transition. Figure 16, below shows the currently suboptimal structure for VMMC M&E.

Figure 16 : M&E Transition Stage I (Current Situation)

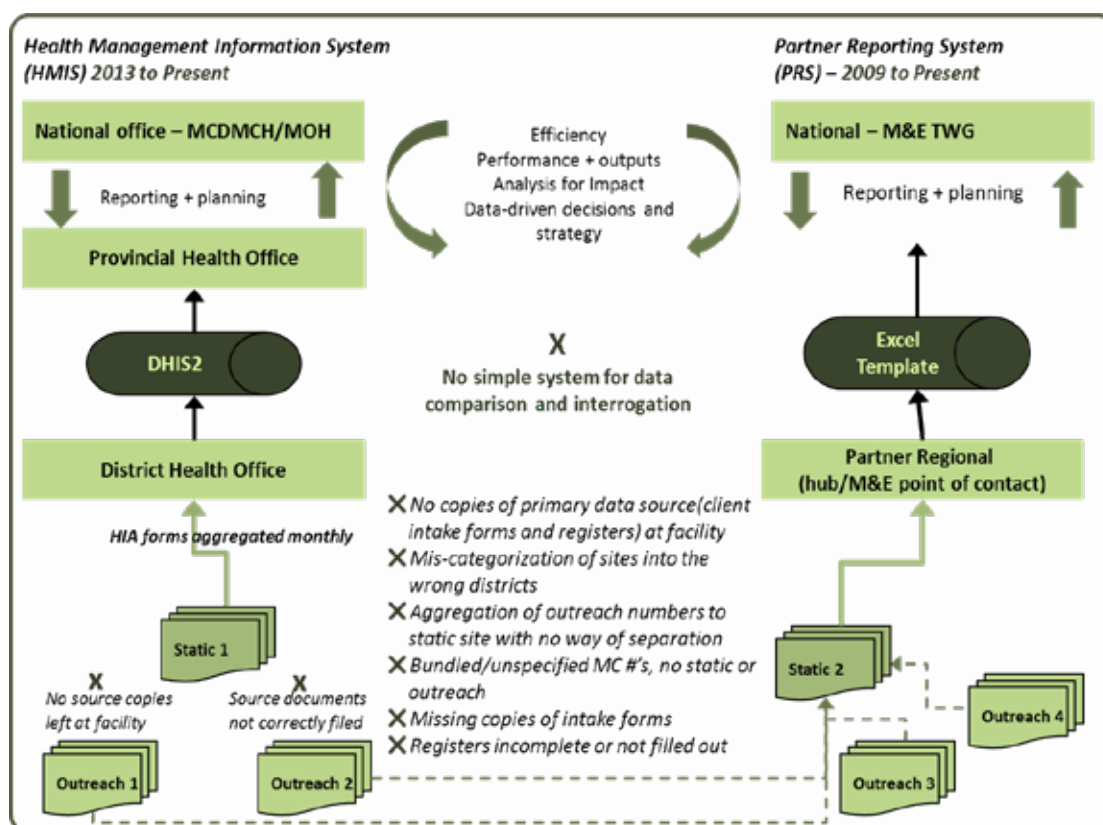
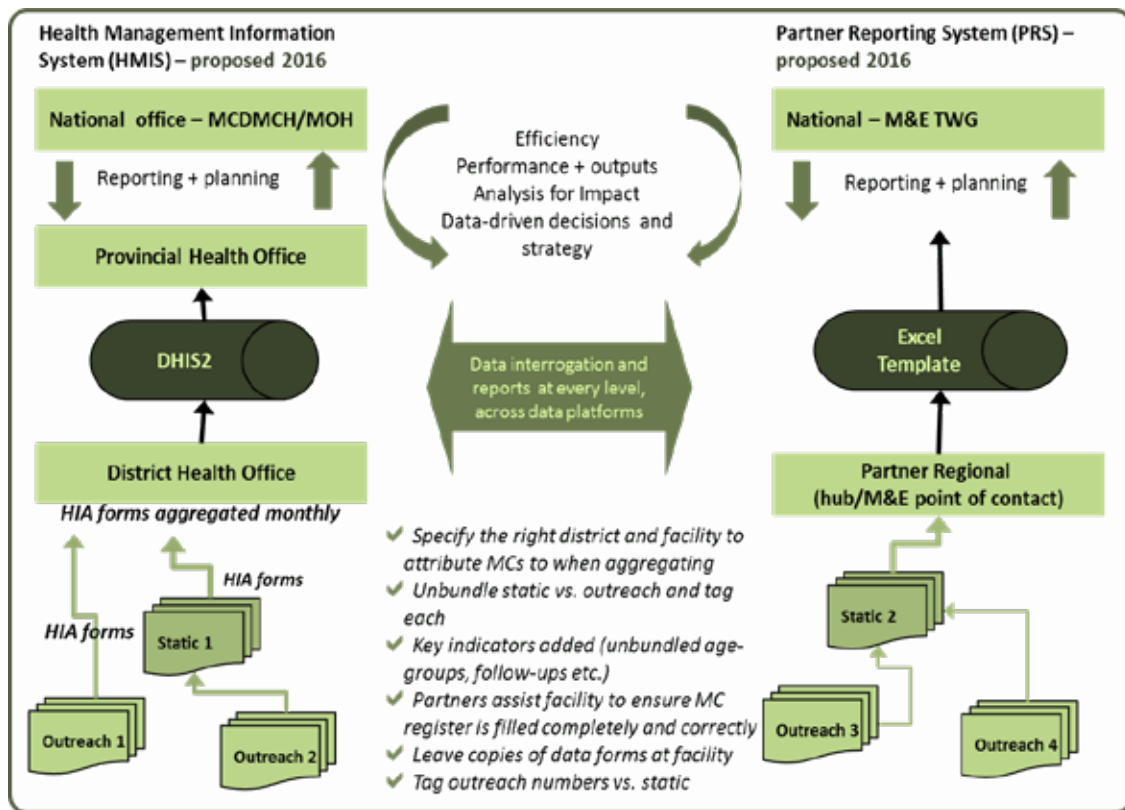


Figure 17 : M&E Transition Stage II (Intermediate)

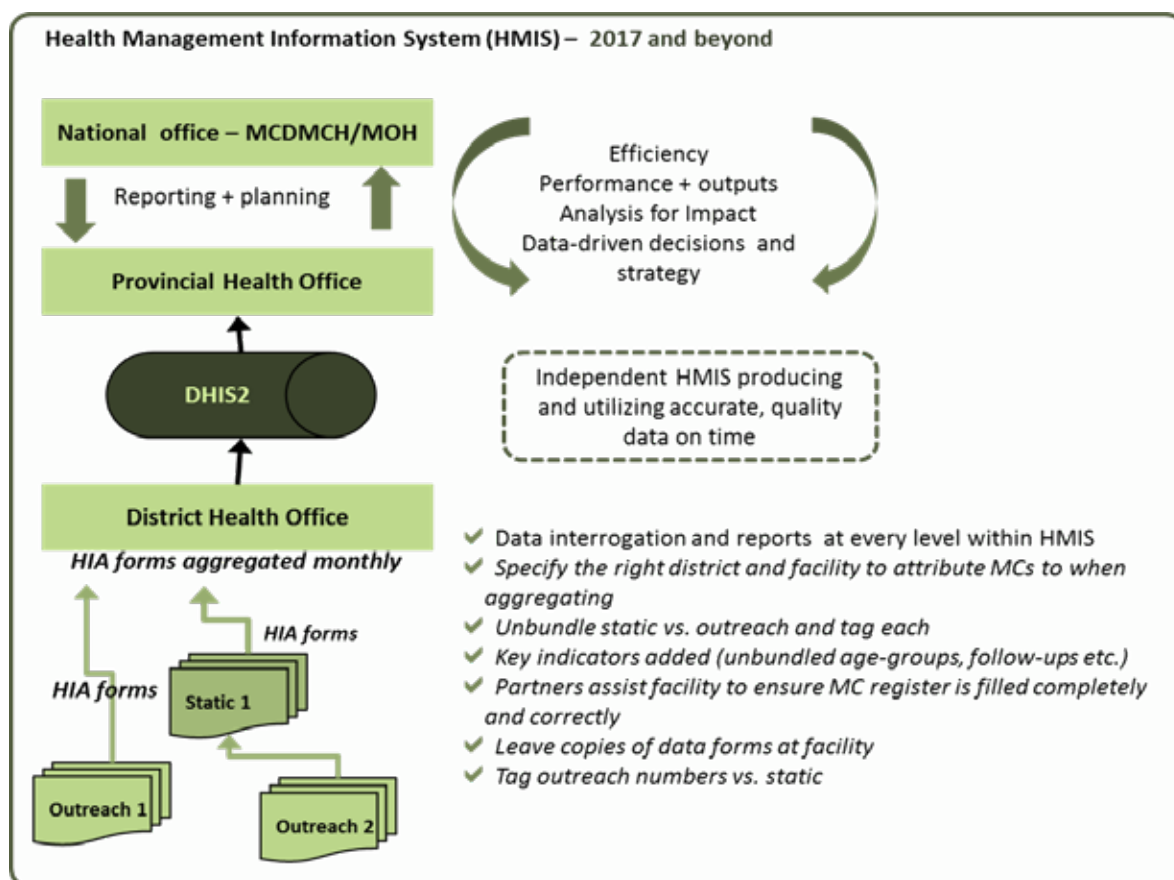


Stage II: Complementary System aims for <5% discrepancy, 2016

These two systems should live side-by-side, as shown in Figure 17, while the HMIS is strengthened through increased data interrogation/comparison as well as best practice sharing across the two platforms. The national M&E TWG subcommittee shall be responsible for reviewing these findings and drawing up a feasible plan of action implemented during 2016 and 2017.



Figure 18 : M&E Transition Stage III (Fully transitioned, well functioning)



Stage III: Sustainable HMIS system for VMMC ~0% discrepancy, 2017+

This third and final stage (Figure 18) will only be possible through the provision of complete and accurate source data collection tools/forms, clarification and emphasis of M&E guidelines to improve data collection practices, better categorization and disaggregation of indicators and more effective, integrated data interrogation at subnational levels. This cross-cutting effort requires the buy-in and concerted effort from all government and non-governmental stakeholders in the VMMC space. By December 2017, the HMIS should be in final stage 3 where misalignments in the data flow structures between the PRS and HMIS no longer exist and the HMIS is a fully independent and effective source of VMMC M&E data.





PILLAR 6: IMPLEMENTATION SCIENCE



Objective

To conduct operations research studies to fill the most critical VMMC information gaps and provide implementable recommendations for VMMC policy and practice

Strategies

- I. Facilitate stakeholder participation in IS activities and develop and maintain a live database of implementation science projects/studies
- II. Ensure wide dissemination of study findings and facilitate the adoption of these findings to improve program implementation

Implementation science (IS) is the study of methods to promote the integration of research findings and evidence into healthcare policy or practice. This improves execution of programs by translating research findings and evidence into practice at scale. It will also inform MoH and partner organizations about best practices in service delivery, resource utilization, demand generation, behavioural change and utilization of technological solutions. IS has four component areas that can be utilized either individually and/or jointly to inform the VMMC program:

- i. Utilization of monitoring and evaluation data
- ii. Operations research
- iii. Impact evaluation
- iv. Cost-effectiveness estimation

The use of these methodological tools will provide a rigorous evidence base to inform national policies and procedures in order to improve VMMC program performance and

outcomes. Implementing partners and the MoH will work together to set a research agenda that best fits the program.

I. Facilitate stakeholder participation in IS activities and develop and maintain a live database of implementation science projects/studies

Research prioritization

For the Zambian program to efficiently use limited resources and to improve outcome effectiveness, research priorities which can contribute significantly to the success of the program must be identified. The focus should be on areas representing potential bottle necks or barriers to reaching national targets for providing safe and effective VMMC services. This includes optimal methods for improving program efficiency and quality, effective demand generation models, models of services integration that



reinforce VMMC outcomes, supply chain management tools and methods for reducing costs and program impact assessments. Table 5 provides a general overview of priority areas, specific examples of research and evaluation topics, as well as

a prioritization of needs based on the Zambian program context. Also, Table 5 indicates whether the source of information regarding best practices is mostly likely to be found in studies and practices in the region or within Zambia.

Table 5: Implementation science prioritization

Area	Example topics	Prioritization	Information Source
Surgical Efficiency	VMMC Surgical methods, VMMC devices, task shifting, task sharing, provider retention	High	Regional, Zambia
Demand creation	Community based, IPC models, referral systems, reaching out to women	High	Zambia, Regional
Quality	Adverse events, client satisfaction, client follow-up, CT rates, counselling services, client and female partner understanding of VMMC's effects	High	Zambia, Regional
Service integration & Sustainability	VMMC linkages with RH, FP and HIV services, Sustainable models for VMMC routinization and integration into MoH structures	High	Regional, Zambia,
Commodities and supplies	Human resources, VMMC kits, VMMC devices	High	Zambia, Regional
Impact	HIV incidence, health systems, economic productivity, behavioural	Moderate	Regional, Zambia

Obtaining information for evidence-based decision making

MoH will collaborate with implementing partners to frame research and evaluation priorities and ensure the incorporation of evidence into program practice. Research projects and impact evaluations that require longer time lines and more rigorous study designs will be unlikely to inform program scale-up in the immediate-term. This is due

to the longer timeline generally required for complex study designs, including protocol development, ethical review, study implementation, analysis and dissemination of key findings. Therefore other approaches for collecting evidence, as well as IS tools should be utilized in conjunction with evidence generated from more complex research and evaluation projects.



Operations research

Below is a selection of operations research topics that have particular relevance and importance for the Zambia VMCC program. The topics reflect the current needs of the program: to reach national targets, increase efficiency and safety and to assure the long-term effectiveness of the VMCC intervention. The following list is indicative, but by no means exhaustive.

- **VMMC Devices:** According to the studies that were conducted in Zambia on the acceptability, safety, efficacy, of the Shang Ring™ and Prepex™ devices, both devices showed strong indication that the VMMC device can potentially bring about improvements in service efficiency, increased safety, decrease cost, and encourage greater demand for VMMC services. Considering that most of the devices have received WHO pre-qualification, the program will endeavour to scale up the use of devices in routine VMMC service provision, alongside the current surgical methods. The scale up process will be preceded by active surveillance phase in select public sector facilities, to be followed by full scale up.
- **Methods for improving efficiency of services:** Priorities have to be determined and set regarding best practices for surgery and services to promote efficiency and lower per-MC costs. The Zambia country program will determine and implement its own approach for high-volume, high-quality service provision.
- **Increasing demand for VMMC services using referrals to VMMC:** Given the broad strategy for VMMC demand generation, IS will be used to understand the relative impact of communication strategies (e.g., media campaigns compared to interpersonal communication), to ensure resources are used most effectively. IS research will also be used to increase the use and efficiency of family planning, reproductive health and HIV prevention and treatment services as a referral for VMMC services. Assessments of effective referral and client follow-up, as well as potential client incentives will be evaluated.
- **Risk compensation:** Risk compensation is characterized as the increase in sexual risk behaviour due to a belief that VMCC significantly reduces or eliminates one's risk of acquiring HIV. Well-designed prospective evaluations are expected to be key sources of information to assure that risk compensation does not offset the benefits of VMMC on HIV in Zambia. Further, interventions that maximize positive behaviour change should be assessed and will be integrated into the VMCC program to maximize the beneficial impact on the epidemic.
- **Sustainability:** Given the declining global VMMC resource envelope and the inevitable reduction in implementing partner participation in VMMC in the long run, what models of transition and integration



are most sustainable for the MoH to continue VMMC services with limited partner support?

Synthesizing existing research and evaluation: IS research and evaluation on VMMC programs to date has been conducted regionally and within Zambia. Applicable and practical recommendations from such studies will be systematically analysed, synthesized, disseminated, and utilized in program decision making.

Examples of program issues for which data can be synthesized and applied include:

- VMMC Devices – evaluation of device safety from field studies and regional studies;
- Effective counselling and informed consent procedures – evaluations of best practices;
- Improving VCT testing rates – impact evaluations of specific interventions to improve uptake; and
- Market-based segmentation of clients to inform demand generation continuously

Collating and analysing M&E data: M&E data is collated from public health facilities and partner organizations to inform the VMMC program (see pillar 5: Monitoring & Evaluation).

This allows the program to track progress towards targets and improve the efficiency and quality of services. Examples of specific topics where M&E systems can inform programs:

- Adverse events – tracking AEs by facility type, provider, and client characteristics;
- Behavioural data – assess risk factors of VMMC clients and relationship to VCT uptake;
- Service uptake tracking – adjusting communication models given demand seasonality; and
- Impact of VMCC on health systems – assessing impact of VMCC on provision of other services.

Routine data analysis/reviews: Program Information and data that may be available will be used to answer some relevant questions related to VMMC. Examples of routine data reviews are

- Community-based interviews to assess acceptability of VMMC devices (mystery client surveys & satisfied client surveys)
- Trends in the acceptability and demand for VMMC among sub-populations;

Process evaluation and documentation of practices: The successes and failures of program implementation will be systemically gathered, analysed and used to produce recommendations for mid-course corrections and program adaptations. Key quantitative process indicators will be incorporated in the M&E system and utilized to summarize program development and progress. Emphasis should be placed on process narratives that focus on prioritized research areas and topics (Table 5: implementation science prioritization).



Examples of process evaluation objectives include:

- Narratives of program evolution;
- Documentation of program failures and reasons target objectives were missed;
- Delineate program performance scores to quantify success; and
- Documentation of program investments and costs.

II. Ensure wide dissemination of study findings and facilitate the adoption of these findings to improve program implementation

Dissemination and utilization of IS evidence

For IS to be effective, evidence needs to be disseminated to ministry, partners and stakeholders and utilized for program decision making. The VMMC TWG, as well as the M&E sub-committee of the TWG are

platforms for the prioritization of implementation science topics and for providing updates on assessments and evaluations. In addition, bi-annual implementation science dissemination meetings should be held to inform program development during the critical scale-up phases. The bi-annual meeting should be coordinated by the MoH, and be focused on evidence to improve program practice and outcomes with representation from national, provincial and district level officials. To ensure evidence becomes practice, the MoH is committed to using it to inform policy and to facilitate standardization of practices and while monitoring progress on programmatic changes. Donors and partners are expected to play a significant role in providing resources and support for IS in key priority areas by supporting IS dissemination meetings, cooperating with the MoH in collecting information and aligning their operations to national policy.





PILLAR 7: RESOURCE MOBILIZATION



Objective

To mobilize sufficient financial resources to cover the programmatic funding gap while also ensuring efficient and effective use of existing resources

Strategies

- I. Mobilize sufficient resources for continued scale-up through a new, intensive TWG sub-committee (Resource Mobilization) while maintaining efficient utilization of existing funding
- II. Maintain and document an accurate understanding of the VMMC resource environment and programmatic funding gaps at all times

The goal of this operational plan is to achieve 90% coverage of VMMC for uncircumcised, HIV-negative men within the core age-group by 2020. While the service delivery models and scale-up plans outlined in this document are expected to improve the efficiency of resources directed towards VMMC, significant additional resources will be required to meet the stated targets.

I. Mobilize sufficient resources for continued scale-up through a new, intensive TWG sub-committee (Resource Mobilization) while maintaining efficient utilization of existing funding

Over the years, Zambia has managed to maintain relatively efficient operations in terms of VMMC costs since 2012. This was

due to continued integration of service delivery, output/performance based compensation at reasonable cost, as well as matching of demand and supply during outreach, minimizing long distance outreach and adopting reusable commodities. Despite this relatively efficient resource utilization, Zambia needs an intensive resource mobilization drive for this new Operational Plan (2016-2020) in order to meet the new targets which are ambitious and will require a strong focus on raising more funding to reach these targets.

Some of the current hindrances to resource mobilization and utilization are:

- Intermittent funding disruptions and disbursement delays
- Lack of private sector health insurance to fund VMMC, limiting the flexibility of VMMC funding



- While the government provides critical infrastructural resources for the program, only a relatively small amount of monetary funding is available. The program would benefit greatly from increased MoH budget allocations
- The compensation and reimbursement model is not eternally sustainable

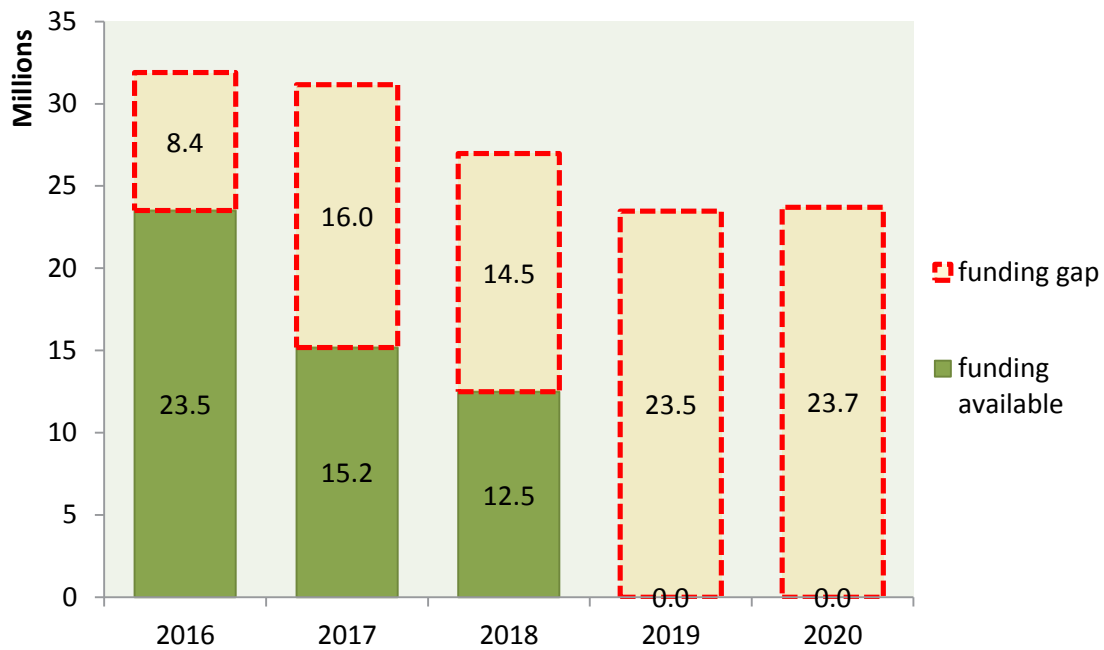
2020 the VMMC program will require a total of **US \$136 million** over the next 5 years. Currently, the projected funding available is **US \$51 million** which leaves a funding gap of **US \$85 million**.

The resources required to implement the operational plan were estimated based on an analysis of the previous year’s average funding per VMMC, as proxy for the actual cost.

Required resources

In order to reach **90%** VMMC within the core-age group, a target of **1,985,083** by

Figure 19 : Resource mobilization – Projected Funding gap chart



Government resources

In addition to supplying the infrastructure and human resources, the government is committed to mobilizing the resources necessary to make the program a success and to achieve positive public health impact.

Of the total costs, it is expected that the government will also contribute to the program monetarily.



Funding gap and resource mobilization TWG Subcommittee

Given a total cost of **US \$136 million** over the next five years, an additional **US \$85 million** in funding will be required to fund the operational plan. Major contributions for funding so far have come from the United States Government, through PEPFAR and Global Fund. The finalization of this operational plan will facilitate a dialogue between the government and partners which will mobilize additional resources to close current funding and future gaps.

The TWG will form a subcommittee to conduct intensive resource mobilization from the government, existing donors and even through public-private partnerships (PPP) and other non-traditional donors. The RM TWG will be active for at least the first

3 years of the Operational plan. They will identify, target and engage all potential sources of funding for the VMMC program with the goal of raising the full amount required to fund the program until 2020. They will write and submit VMMC applications for funding and investment cases.

II. Maintain and document an accurate understanding of the VMMC resource environment and programmatic funding gaps at all times

Every year, the RM TWG will conduct an annual resource assessment to continually assess and prioritize the program's resource needs through regular resource/funding gap analysis based on the remaining program targets and needs by geography.





PILLAR 8: SUSTAINABILITY AND EARLY INFANT MALE CIRCUMCISION (EIMC)



Objective

To develop and implement a robust plan for program transition and integration of VMMC services in the sustainability and maintenance phase, once scale-up targets are met

Strategies

- I. Develop a comprehensive, evidence-based transition and sustainability plan covering all pillars of program
- II. Maintain existing services for Early Infant Male Circumcision (EIMC) while mobilizing resources and evidence for program implementation in sustainability phase

I. Develop a comprehensive, evidence-based transition and sustainability plan covering all pillars of program

As sustainability nears, the program will need to understand how to move towards a sustainable phase of VMMC. Inter-ministerial and interdepartmental meetings will become crucial in building a broad stakeholder base for discussions on the best way to transition roles and responsibilities for VMMC as well as implement integrated service delivery like all other health interventions. Ultimately, an evidence-based evaluation will be required to develop a sustainability and transition plan. The country will likely adopt a phased approach to VMMC sustainability where regions with high MC rates become the testing ground for sustainability until it can be rolled out nationally.

II. Maintain existing services for Early Infant Male Circumcision (EIMC) while mobilizing resources and evidence for program implementation in a sustainability phase

Zambia introduced Early Infant male circumcision (EIMC) with the launch of a Public Health Evaluation (PHE) in the beginning of 2008. This evaluation was undertaken by Centre for Infectious Disease Research in Zambia (CIDRZ) and University of Zambia Medical School, with all procedures conducted at the University Teaching Hospital (UTH) in Lusaka, and two local clinics (Matero Ref and Kanyama). The study concluded in March 2011 with 600 Neonates (0-28 days) circumcised.



Following the conclusion of this evaluation, USG funding was provided to CIDRZ through CDC to spearhead the scale-up of EIMC. In Zambia, EIMC focuses on infants 0-60 days. More than **10,420** infants had been circumcised by September 2014 prior to CIRDZ transitioning EIMC to GRZ on 1st October 2014. The implementation to date has demonstrated the feasibility²² of EIMC in Zambia, yet the scale-up of the program has been slower than anticipated. As the country embarks on increasing uptake of EIMC there is need to increase awareness among parents and guardians about the existence and benefits of EIMC.

Governance & coordination

Leadership and coordination for EIMC will be done by Government. All trainings will be coordinated through government-led TWG. Integrating EIMC into existing Maternal, New-born and child health services, with enhanced government leadership will be a pre-requisite for sustainability. By 2015 EIMC services were offered in 23 sites; in Western, Copperbelt, Eastern and Lusaka provinces. Trained providers include doctors, medical licentiates, nurses (general nurses and midwives), and clinical officers. Other trained staff include: counsellors, mobilizers hygiene assistants (CE).

Service delivery

EIMC will be implemented in all 10 provinces during the strategic plan period at all levels of care which have a trained provider. EIMC is performed using a surgical instrument kit and a single-use

consumables pack. However, the process is different from adult VMMC since it requires a device called a Mogen clamp to complete the procedure. A detailed list of surgical instruments, consumables and other supplies required for EIMC is included in Appendix section. Supply chain management, including forecasting, procurement, distribution, and storage will be coordinated through Government structures.

Advocacy & demand generation

While there will be a range of national demand generation efforts similar to that of adult VMMC, some are specific to EIMC since it will occur at the community and facility level while integrating with MNCH (ANC, PANC, U5, FP). EIMC program implementation demonstrates that the immediate postnatal period is too late to introduce the subject to mothers/parents. Parents need sufficient time to discuss the issue among themselves and with their families before they are ready to authorize consent. While the MNCH platform will continue to strive to involve male partners, MOH will expand its reach to all men by enhancing community engagement, expanding, and strengthening male-to-male community based interventions that reach men where they work, live, and socialize

Transition and sustainability

Political will and government leadership is critical as we scale up EIMC services in the country involvement of PMOs, DMOs and the community is key in initial stages of scale up. Lessons learnt are that community engagement through its established

²² To date, there are no robust cost studies on the cost of EIMC in Zambian settings.



structures before service delivery is initiated is a must. Before EIMC can scale up, the following activities should be undertaken in a realistic, sustainable manner:

- *Training* – a pool of trainer of trainers in each province and trained providers EIMC counsellors and mobilizers up to the level of ZONE (or wherever there is a trained provider is found) and mobilize training and IEC materials
- *Supply Chain Management:* Strengthen the existing national Central Medical Stores supply chain management system to meet the increased requirements of EIMC scale up (appendix 3)
- *Resource mobilization:* EIMC has to be incorporated into comprehensive

HIV prevention strategies and integrated into other national frame works including MNCH strategies

- *Demand Generation:* Increase ownership of EIMC services by engaging public facility providers as part of a comprehensive MNCH demand generation package, and sensitizing influential community leaders like traditional, religious and civic leaders

Monitoring & Evaluation/Implementation science

Additional indicators will need to be added to M&E registers for EIMC in advance of national roll-out of 0-60 days.



E. VMMC NATIONAL WORKPLAN (2016-2020)

PILLAR	KEY STRATEGY	DETAIL	ACTIVITIES	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018	2019	2020
1	I. Increase program visibility and priority within the health portfolio and at all levels of the health care system	<i>visibility and priority</i>	Official launch of national VMMC guidance documents will be planned and attended by key stakeholders and high-level opinion leaders Develop advocacy toolkit containing informational materials, frameworks, and other tools for demand generation (targeted at specific audiences) Disseminate (ongoing) advocacy toolkit, informational materials, frameworks Highlight VMMC and share priority areas at Annual Planning Launch (MTEF)		x	x	x	x	x	x	x			
	II. Re-engage the key actors in VMMC advocacy for the new Operational Plan (2016-2020) including Parliament, Traditional and Religious leaders	<i>Re-engage the key actors</i>	National-level advocacy meetings designed to inform and sensitize key opinion leaders will be held including members of parliament (engage new parliament health portfolio) National-level advocacy meetings (in partnership with NAC) designed to inform and sensitize key opinion leaders will be held including members of underlying ministries (MoE, MoF, Min of Gender and Women Affairs etc.) National-level advocacy meetings designed to inform and sensitize key opinion leaders will be held with MOCTA and traditional leaders					x						

PILLAR #1: LEADERSHIP & ADVOCACY - To increase and sustain program visibility and priority at both national and subnational level and garner multi-sectoral support from key stakeholders



PILLAR	KEY STRATEGY	DETAIL	ACTIVITIES	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018	2019	2020
			National-level advocacy meetings designed to inform and sensitize key opinion leaders will be held with women's groups, religious leaders, and business leaders at national and subnational level											
			Identify key VMMC spoke persons and champions like musicians, footballers, parliamentarians, religious leaders and traditional leaders (input through TWG)											
			Increase VMMC visibility at national events and traditional ceremonies.											
			Ongoing engagement with district level traditional leaders											
	III. Prepare the program's advocacy and leadership for any potential changes as a result of organizational and political shifts	Prepare for potential changes political shifts	Semi-annual review of the VMMC program by the TWG taking into account all potential changes											
	IV. Strategically disseminate critical information to key stakeholders within the program, including regular campaigns and	Strategically disseminate critical information	Mid-term review of the Operational plan											
			National and provincial launch of strategic documents like the Operational Plan											
			National and provincial launch of strategic documents Communication strategy.											
			National VMMC campaign launches and mini provincial campaign launches targeted to specific provinces											



PILLAR	KEY STRATEGY	DETAIL	ACTIVITIES	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018	2019	2020		
	launch of this Operational Plan															
PILLAR #2: GOVERNANCE & COORDINATION - To build sufficient technical and strategic capacity to coordinate and manage a growing VMCC program with strong linkages between the national and subnational levels																
2	I. Increase technical capacity at national level and improve the TWG to enable quick decision-making and resolution of existing and future VMCC policy discrepancies	Increase technical capacity at national level <i>streamline TWG fix policy discrepancies</i>	Lobby for the position of M&E officers at national level		x	x										
			Lobby for the position of social mobilisation/ service delivery officers at national level		x	x										
			Interview and hire staff (once approved)			x	x									
			On-board and train staff			x	x									
			Finalize TWG schedule and Ratify ToRs		x					x			x		x	
			Reach out and re-engage new TWG members (Surgical Society of Zambia, HPCZ, private sector representatives etc.)							x			x		x	
			Engage NAC, Ministry of Legal Affairs on age of consent harmonization							x	x	x				
			Update and disseminate site mapping						x				x		x	
			Engage NAC on updating and disseminating HIV/AIDS workplace policy					x								
			Review/Amend ToRs on the issues of chair, vice chair, and secretariat				x									
		Annual ToR review as needed														



PILLAR	KEY STRATEGY	DETAIL	ACTIVITIES	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018	2019	2020
	II. Support the provincial level through secondment, joint-planning and direct budget support for VMMC activities depending on the provincial needs	<i>Provincial secondment, joint-planning and direct budget</i>	Review annual plans for provincial needs (capacity and budget)		x				x			x	x	x
	III. Revamp the District Technical Committees to enable routine program management and partner collaboration at this level	<i>Revamp the District Technical Committees</i>	Include these activities during MTEF (provincial work plans and budgets) Communicate message to PMO and DMO to reactivate DTC			x								
			DMO to develop activities and schedule for data review for the DTC and include in budget			x				x				
PILLAR #3: SERVICE DELIVERY OF VMMC - To offer a comprehensive VMMC package of service in an efficient, effective and increasingly integrated manner while ensuring the highest quality of services														
3	I. Expand existing capacity to provide comprehensive VMMC services by	<i>Comprehensive VMMC, training, equipment and waste management</i>	Conduct provider trainings as required to meet VMMC client demand											



PILLAR	KEY STRATEGY	DETAIL	ACTIVITIES	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018	2019	2020			
introducing pre-service training, eliminating missed opportunities for service delivery and efficiently deploying innovative methods such as devices for service delivery	<p><i>Monitor campaigns</i></p> <p><i>Coordinate partners through TWG to temporarily take over service delivery</i></p> <p><i>Pre-service training and in-service training</i></p>	<p>Provide quality, efficient VMMC service offering a comprehensive package of services</p> <p>Ensure proper management of equipment at the facility level</p> <p>Determine any waste management needs and ensure waste management guidelines are implemented</p> <p>Roll-out simple monitoring tool to all high-volume sites</p> <p>Discuss campaign preparation in pre and post campaign meeting</p> <p>Conduct joint campaign monitoring, along with QA/QI or supervisory visit</p> <p>Develop and distribute job aides, pocket booklets and tools for AE classification</p> <p>IPs share information available to other partners at national level (move out, move in)</p> <p>Consult districts (DMO) to allocate/reallocate sites</p> <p>Finalize the curriculum for CO for VMMC</p> <p>Chainama/UNZA introduces and implements the curriculum (first graduates in 2019)</p> <p>Engage partners who can sponsor top-up training for Cos</p> <p>Ensure full practicing Clinical officers, follow up on the first intake</p>	x	x	x	x	x	x	x	x	x	x	x	x			
			x	x	x	x	x	x	x	x	x	x	x	x	x	x	
			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x



PILLAR	KEY STRATEGY	DETAIL	ACTIVITIES	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018	2019	2020		
II. Ensure adequate infrastructural resources while maintaining the quality of VMMC during scale-up by standardizing QAQI guidelines, materials and	Standardize QAQI	Innovative methods, devices	Contract and agree on school curriculum			x	x									
			Roll-out of training curriculum to other schools - private schools				x	x								
			Engage and advocate with the general nursing counsel for inclusion of VMMC in nurse curriculum													
			Training (including TOT) and procurement for active surveillance		x	x	x	x	x							
			Active surveillance for PrePex and Shang Ring		x											
			Active surveillance report review							x						
			Passive Surveillance							x						
			Passive surveillance report review and decision on device of choice/methods													
			Training for scale-up													
			Roll-out and scale-up of devices													
			Finalize draft document for QAQI				x									
			Print and disseminate						x							
			Ministry with IPS with roll-out													
			Conduct QAQI along with supervision visit													



PILLAR	KEY STRATEGY	DETAIL	ACTIVITIES	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018	2019	2020			
III. Facilitate the integration of VMCM services with other health programs at all levels of care and centralize VMCM commodity management into the existing Supply Chain System	activities	<p><i>Decentralize supportive supervision and/or QA/QI</i></p> <p><i>Integrate/centralize Supply Chain</i></p>	Finalize guidance materials for QA/QI		X												
			Training of provincial ToT (provinces to choose cadre)			X											
			Provincial cadres will train facilities staff on QA/QI standards and requirements						X								
			Conduct Quarterly QA/QI and Supportive supervision (together with partners where necessary)						X	X	X	X	X	X	X	X	X
			Final revision and harmonizing standard kits, packages and consumables (including PrePex)			X					X			X	X	X	X
			Quantification process and timelines			X					X			X	X	X	X
			Formally inform MSL of commitment			X					X			X	X	X	X
			Procurement			X					X			X	X	X	X
			Integrated outreach program's (mobile ART, cervical cancer screening)					X	X	X	X	X	X	X	X	X	X
			Implement men's clinic concept at appropriate facilities					X	X	X	X	X	X	X	X	X	X
			STI, Family Planning					X	X	X	X	X	X	X	X	X	X
			HMIS/PRS Data collection, mapping and analysis				X							X	X	X	X
			Dissemination of results to stakeholders				X							X	X	X	X
			Annual planning and performance review				X					X			X	X	X
Pre and post-campaign review meetings				X	X	X	X	X	X	X	X	X	X	X			
MoH national to send memo and guidance for						X				X		X	X	X			
IV. Conduct annual planning, geographic prioritization and officially document the allocation of																	



PILLAR	KEY STRATEGY	DETAIL	ACTIVITIES	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018	2019	2020		
	geographies and/or facilities to partners	<i>geographies and/or facilities</i>	allocation Updating the existing site mapping at all levels			x				x		x	x	x		
PILLAR #4: COMMUNICATION & DEMAND GENERATION - To increase demand and meet the targets for VMCC in the most effective (core) age groups through a targeted, market/client-based approach.																
4	I. Provide a national demand generation roadmap by finalizing and launching the National VMCC Advocacy and Communications Strategy (2016-2020), and outlining how to take advantage of referral networks and client follow-up	<i>Launch the National VMCC Advocacy and Communications Strategy (2016-2020)</i>	Review and revise the expired communication strategy based research findings (IPSOs, Implementation research) (May 16)	x												
			Incorporate innovative methods from research	x												
			Present revised strategy to main TWG (May 16)	x												
			Incorporate input from main TWG and finalise the document (June 16)	x												
			Presentation for validation with stakeholders (Communication experts and VMCC implementers) (June 16)	x												
			Incorporate comments from validation, finalise (June 16)	x												
			Proof reading, design and print (July 16)		x											
			Launch the National VMCC Advocacy and Communications Strategy (July 16)		x											
			Dissemination at provincial level						x	x						
			start reviewing the 2016-2020 National communication and advocacy strategy													
Review existing demand creation referral forms							x									
Developing a standard operating procedure for referrals							x									



PILLAR	KEY STRATEGY	DETAIL	ACTIVITIES	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018	2019	2020				
II. Generate higher demand by implementing novel, market-based and client-centric methods of demand generation through high-yield targeted communications channels	Novel methods of demand generation	Develop booking forms/referral cards Share both SOP and booking forms/referral cards Review existing and develop novel demand creation tools and materials Pre-test novel demand creation tools and materials incorporate input from pre-test and finalize Produce the novel demand creation tool Dissemination at provincial level Implement use of novel demand creation tools	Develop booking forms/referral cards Share both SOP and booking forms/referral cards Review existing and develop novel demand creation tools and materials Pre-test novel demand creation tools and materials incorporate input from pre-test and finalize Produce the novel demand creation tool Dissemination at provincial level Implement use of novel demand creation tools															
	Innovative/Flexible campaign	Develop a campaign calendar mentioning frequency and timing Review existing events launch checklist from partner Develop event launch checklist Share the checklist with main TWG for approval Incorporate comments from main TWG	Develop a campaign calendar mentioning frequency and timing Review existing events launch checklist from partner Develop event launch checklist Share the checklist with main TWG for approval Incorporate comments from main TWG	Develop a campaign calendar mentioning frequency and timing Review existing events launch checklist from partner Develop event launch checklist Share the checklist with main TWG for approval Incorporate comments from main TWG														
III. Integrate market research findings and plan for capacity to carefully monitor demand across	Integrate and monitor market research findings Review market research findings and incorporate into identified structures and process Develop tools necessary to measure effectiveness of demand generation channels Pre-test the tools with technocrats	Integrate and monitor market research findings Review market research findings and incorporate into identified structures and process Develop tools necessary to measure effectiveness of demand generation channels Pre-test the tools with technocrats	Integrate and monitor market research findings Review market research findings and incorporate into identified structures and process Develop tools necessary to measure effectiveness of demand generation channels Pre-test the tools with technocrats															



PILLAR	KEY STRATEGY	DETAIL	ACTIVITIES	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018	2019	2020
	market segments		Implement use of tool with marketing component Develop a standard training tool/module for IPC gents Orient communication groups in the use of developed tools						x					
	IV. Improve program effectiveness by focusing the majority of demand generation activities on the core age-group (15-29 years)	<i>Ensure a focus on the core, 15-29 year age-group for all demand generation activities</i>	Identify innovative communication channels Develop messages, tools and materials focusing on 15-29 age group Pre-testing of messages Make changes and finalise	x	x	x	x	x	x	x	x	x	x	x
	V. Supplement funding for demand generation activities through joint-funding of specific demand generation	<i>VI. Facilitate MOH/Partner collaboration, joint-funding of specific demand generation activities and re-engage traditional leaders</i>	Share for implementation at national level Prepare a national demand creation budget Share budget with MOH/other partners			x								
			Re-engage traditional leaders where applicable						x	x	x	x	x	x
PILLAR #5: MONITORING & EVALUATION - To develop HMIS and DHIS2 into self-sufficient, reliable sources of VMMC M&E data by the end of 2017														



PILLAR	KEY STRATEGY	DETAIL	ACTIVITIES	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018	2019	2020			
5	I. Improve data capture, quality and accuracy at subnational level through consistent M&E activities to gauge progress and evaluation of data to identify to solve programmatic challenges	<i>Improve data capture, quality and accuracy at subnational level</i>	Conduct training of staff (DHIO's, MC coordinators, facility information officers) on comparative data analysis			x	x										
			Hold data review meetings and comparative data analysis at all levels and incorporate RDQA activity with supportive supervision			x	x									x	
			Develop comprehensive guidelines and cadence, clarification and designation of responsibilities for data management, including how and when copies of source documents must remain at the facility level		x												
	II. Harmonize HMIS and PRS tools and processes to reduce the data discrepancies	<i>Revise M&E indicators, and tools</i>	Incorporate RDQA with supportive supervision		x											x	
			Disseminate M&E Audit Findings memo to all stakeholders		x												
			Revise HMIS M&E Tools to include more granular age-groups, outreach v. static, surgical v. device etc.		x												
			Standardization of client intake forms		x												
			Print and distribute M&E data tools		x												
			Revise partner reporting tools to include granular age bands		x												
	III. Transition fully from PRS (Partner Reporting System) to HMIS for M&E	<i>Revise partner reporting tools</i>	Adopt and use new PRS tools within partner reporting systems					x									
			Conduct annual national comparative data analysis (PRS vs. HMIS)						x								
			Encourage all implementing partners, facilities to submit accurate and complete data in a timely manner														



PILLAR	KEY STRATEGY	DETAIL	ACTIVITIES	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018	2019	2020	
			Consolidate all data into HMIS and national data collection tools and discontinue PRS as a source for national data						x	x	x				
PILLAR #6: IMPLEMENTATION SCIENCE - To conduct operations research to fill the most critical VMMC information gaps and continually use available data to improve all aspects of the program															
6	I. Facilitate stakeholder participation in IS activities and develop and maintain a live database of implementation science projects/studies	<i>Database of implementation science projects/studies</i>	Develop database of research and studies (historical and ongoing) describing the objectives, timelines and participants												
			Regularly collect new information on ongoing studies and update the database	x	x	x	x	x	x	x	x	x	x	x	x
			Facilitate stakeholders participation and support of the data collection and research process												
	II. Ensure wide dissemination of study findings and facilitate the adoption of these findings to improve program implementation	<i>Dissemination of study findings,</i>	Disseminate all study and research findings locally - TWG and subcommittee meetings (national and subnational)		x	x	x	x	x	x	x	x	x	x	x
			Disseminate study and research findings internationally - international conferences and meetings, where appropriate		x	x	x	x	x	x	x	x	x	x	x
		<i>Adoption to improve program implementation</i>	Incorporate study findings and recommendations into national policy and strategy documents		x	x	x	x	x	x	x	x	x	x	x
			Develop clear plan for implementation of findings and recommendations (what, where, how, who and when?)	x	x	x	x	x	x	x	x	x	x	x	



PILLAR	KEY STRATEGY	DETAIL	ACTIVITIES											
			PILLAR #7: RESOURCE MOBILIZATION - To mobilize sufficient financial resources to cover the programmatic funding gap while also ensuring efficient and effective use of existing resources											
			2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018	2019	2020	
7	I. Mobilize sufficient resources for continued scale-up through a new, intensive TWG sub-committee (Resource Mobilization) while maintaining efficient utilization of existing funding	<i>Efficient resource utilization through service delivery integration and/or routinization, performance-based funding and reusable commodities</i>			x									
		<i>New sub-committee for resource mobilization</i>			x									
		<i>Mobilize resources from private sector (PPP)</i>			x	x	x	x	x	x	x			
		Ensure that VMMC is prioritized in the MTEF, NHSP and NASF 2016 -2021												
		Develop sustainable national plan for eliminating VMMC compensation/ reimbursement						x						
		PMO/DMO and facility levels should develop ministry approved VMMC schedule				x								
		TWG members to develop ToRs and schedule for RM subcommittee			x									
		TWG to meet and identify subcommittee members			x									
		RM subcommittee develop an investment case to be used for lobbying for resources, based on Ops plan			x	x								
		Government and partners to negotiate with insurance association to Include VMMC in standard/minimum health insurance package			x	x	x	x	x					
		Stakeholders to decide on standard price across different types of service delivery points			x	x	x	x	x					
		Engage health insurance (Insurance Association of Zambia) on a cost-sharing format for VMMC which is partially reimbursed (commodities and			x	x	x	x	x					



PILLAR	KEY STRATEGY	DETAIL	ACTIVITIES	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018	2019	2020
			consumables offered etc.)											
	II. Maintain and document an accurate understanding of the VMCC resource environment and programmatic funding gaps at all times	<i>Resource assessment to continually assess and prioritize resource needs</i>	Engage private clinics for service delivery Conduct bi annual gap analysis		x		x	x	x	x	x	x	x	x
PILLAR #8: SUSTAINABILITY & EIMC - To develop and implement a robust plan for VMCC program transition and integration in the sustainability and maintenance phase, once scale-up targets have been met														
8	I. Develop a comprehensive, evidence-based transition and sustainability plan covering all pillars of program	<i>Develop a comprehensive transition and sustainability plan</i>	Ensure that EIMC is prioritized in the MTEF, NHSP and NASF 2016 -2021 EIMC Site assessment and mapping Level 1,2,3 Review and update current SOPs, training manual and guidelines Conduct Evaluation and develop sustainability and transition plan, including EIMC TWG to decide on the cadre to conduct VMCC (midwife or nurse?)	x		x	x	x	x	x	x	x	x	x
	II. Maintain	<i>EIMC Training</i>												



PILLAR	KEY STRATEGY	DETAIL	ACTIVITIES	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018	2019	2020		
	existing services for Early Infant Male Circumcision (EIMC) while mobilizing resources and evidence for program implementation in a sustainability phase		Advocate for EIMC to be included in the pre service curriculum through GNC (General Nursing Council)													
			Conduct Provincial 'ToT' country wide for EIMC skills													
			Train mobilizers(national or subnational level, ministry or partner-led)													
		<i>EIMC Supply Chain Management(a ppendix 3)</i>	EIMC logistics to be included in the national SCMS													
			Ongoing procurement of EIMC commodities													
			Government advocacy to partners to prioritize EIMC													
		<i>EIMC Resource mobilization strategies</i>	Provincial and district annual plans to include EIMC													
			National Level Budget to include EIMC funding													
			Engage MNCH and its partners for joint planning and funding with the aim to integrate													
		<i>EIMC Demand creation</i>	Meetings with all community stakeholders, NHC, SMAG													
			Engage and sensitize would-be parents and spouses (communication through midwives, ANC etc.)													
			Produce IEC materials													



Appendix 1: ANNUAL VMMC TARGETS BY DISTRICT

Province	District	2016	2017	2018	2019	2020	TOTAL	
Central		39,431	40,546	36,960	33,852	35,980	186,770	
	Kapiri-Mposhi	6,823	7,016	6,395	5,858	6,226	32,318	
	Chibombo	5,885	6,052	5,516	5,052	5,370	27,875	
	Mumbwa	4,999	5,140	4,685	4,291	4,561	23,677	
	Kabwe	4,991	5,132	4,678	4,285	4,554	23,642	
	Mkushi	3,926	4,037	3,680	3,370	3,582	18,596	
	Serenje	3,287	3,380	3,081	2,822	3,000	15,571	
	Chisamba	2,902	2,984	2,720	2,491	2,648	13,743	
	Chitambo	2,865	2,946	2,685	2,460	2,614	13,570	
	Itezhi-tezhi	2,325	2,391	2,179	1,996	2,122	11,014	
	Luano	932	959	874	800	851	4,417	
	Ngabwe	496	510	465	426	452	2,348	
	Copperbelt		30,716	31,584	28,791	26,370	28,027	145,488
	Kitwe	8,020	8,247	7,517	6,885	7,318	37,987	
Ndola	6,549	6,734	6,139	5,623	5,976	31,021		
Chingola	3,264	3,356	3,060	2,802	2,978	15,461		
Mufulira	2,523	2,595	2,365	2,166	2,302	11,951		
Luanshya	2,306	2,371	2,161	1,980	2,104	10,921		
Mpongwe	1,747	1,797	1,638	1,500	1,594	8,276		
Masaiti	1,693	1,741	1,587	1,454	1,545	8,020		
Kalulushi	1,664	1,711	1,560	1,429	1,518	7,882		
Chililabombwe	1,590	1,634	1,490	1,365	1,450	7,529		
Lufwanyama	1,359	1,398	1,274	1,167	1,240	6,438		

Note: Minor discrepancies in totals are due to rounding of targets at the district level.



Province	District	2016	2017	2018	2019	2020	TOTAL
Eastern		60,387	62,094	56,602	51,843	55,101	286,028
	Chipata	15,387	15,822	14,423	13,210	14,040	72,882
	Lundazi	12,566	12,921	11,778	10,788	11,466	59,519
	Petauke	9,408	9,674	8,818	8,077	8,584	44,561
	Katete	6,542	6,727	6,132	5,617	5,970	30,989
	Sinda	5,848	6,014	5,482	5,021	5,337	27,702
	Nyimba	3,337	3,432	3,128	2,865	3,045	15,807
	Chadiza	3,312	3,406	3,105	2,844	3,022	15,688
	Mambwe	2,995	3,080	2,808	2,572	2,733	14,188
	Vubwi	990	1,018	928	850	904	4,691
Luapula		32,267	33,179	30,244	27,701	29,442	152,833
	Mansa	6,347	6,527	5,949	5,449	5,792	30,064
	Samfya	5,739	5,901	5,379	4,927	5,237	27,184
	Nchelenge	5,134	5,280	4,813	4,408	4,685	24,320
	Chiengi	3,884	3,994	3,640	3,334	3,544	18,396
	Kawambwa	2,966	3,050	2,780	2,546	2,706	14,047
	Mwense	2,640	2,714	2,474	2,266	2,409	12,503
	Milenge	1,553	1,597	1,455	1,333	1,417	7,354
	Mwansabombwe	1,457	1,498	1,366	1,251	1,330	6,902
	Chipili	1,101	1,132	1,032	945	1,005	5,216
	Chembe	944	970	885	810	861	4,470
	Lunga	502	516	470	431	458	2,377



Province	District	2016	2017	2018	2019	2020	TOTAL
Lusaka		84,950	87,352	79,626	72,931	77,515	402,374
	Lusaka	65,708	67,566	61,590	56,411	59,957	311,232
	Chongwe	5,041	5,183	4,725	4,328	4,600	23,877
	Kafue	4,381	4,505	4,107	3,761	3,998	20,752
	Chilanga	3,842	3,951	3,601	3,299	3,506	18,199
	Rufunsa	1,783	1,833	1,671	1,530	1,627	8,443
	Chirundu	1,705	1,753	1,598	1,463	1,555	8,074
	Shibuyunji	1,660	1,707	1,556	1,425	1,515	7,863
	Luangwa	831	854	779	713	758	3,934
Muchinga		35,442	36,444	33,220	30,427	32,339	167,872
	Mpika	9,893	10,173	9,273	8,493	9,027	46,859
	Nakonde	6,197	6,372	5,808	5,320	5,654	29,352
	Chama	5,177	5,323	4,852	4,444	4,724	24,520
	Mafinga	3,786	3,893	3,549	3,251	3,455	17,934
	Chinsali	3,637	3,740	3,409	3,123	3,319	17,228
	Isoka	3,577	3,678	3,353	3,071	3,264	16,943
	Shiwangandu	3,174	3,264	2,975	2,725	2,896	15,035



Province	District	2016	2017	2018	2019	2020	TOTAL
Northern		47,755	49,105	44,762	40,998	43,575	226,194
	Kasama	9,566	9,837	8,967	8,213	8,729	45,312
	Mbala	8,714	8,960	8,167	7,481	7,951	41,272
	Mungwi	6,580	6,766	6,168	5,649	6,004	31,166
	Luwingu	5,690	5,851	5,334	4,885	5,192	26,952
	Kaputa	5,285	5,435	4,954	4,537	4,823	25,034
	Mporokoso	4,378	4,502	4,104	3,759	3,995	20,737
	Mpulungu	4,182	4,300	3,920	3,590	3,816	19,809
	Chilubi	3,359	3,454	3,149	2,884	3,065	15,911
	Nsama ²³	-	-	-	-	-	-
North Western		11,640	11,969	10,911	9,993	10,621	55,134
	Solwezi	5,806	5,971	5,442	4,985	5,298	27,502
	Mwinilunga	1,467	1,508	1,375	1,259	1,339	6,948
	Kabompo	1,118	1,149	1,048	960	1,020	5,294
	Zambezi	928	955	870	797	847	4,397
	Kasempa	866	890	811	743	790	4,101
	Mufumbwe	715	735	670	614	652	3,385
	Chavuma	389	400	364	334	355	1,841
	Ikelenge	352	362	330	302	321	1,665
	Manyinga ²⁴	-	-	-	-	-	-

²³ Nsama district population numbers are included in Kaputa district.

²⁴ Manyinga district population numbers are included in Kabompo district.



Province	District	2016	2017	2018	2019	2020	TOTAL
Southern		53,352	54,860	50,008	45,804	48,682	252,707
	Kalomo	7,638	7,853	7,159	6,557	6,969	36,176
	Monze	6,471	6,654	6,066	5,556	5,905	30,651
	Choma	6,382	6,562	5,982	5,479	5,823	30,228
	Mazabuka	5,441	5,595	5,100	4,671	4,965	25,772
	Livingstone	4,523	4,651	4,240	3,883	4,127	21,424
	Kazungula	4,143	4,260	3,883	3,557	3,780	19,623
	Namwala	3,991	4,104	3,741	3,427	3,642	18,905
	Sinazongwe	3,980	4,093	3,731	3,417	3,632	18,853
	Zimba	2,558	2,630	2,397	2,196	2,334	12,114
	Gwembe	2,343	2,409	2,196	2,012	2,138	11,099
	Pemba	2,153	2,213	2,018	1,848	1,964	10,196
	Chikankata	1,950	2,005	1,828	1,674	1,780	9,238
	Siavonga	1,780	1,830	1,668	1,528	1,624	8,430
Western		23,156	23,811	21,705	19,880	21,129	109,682
	Mongu	3,143	3,232	2,946	2,698	2,868	14,886
	Kaoma	3,011	3,096	2,822	2,585	2,748	14,263
	Kalabo	2,154	2,215	2,019	1,849	1,966	10,203
	Senanga	1,851	1,904	1,735	1,589	1,689	8,769
	Lukulu	1,600	1,646	1,500	1,374	1,460	7,581
	Nalolo	1,406	1,446	1,318	1,207	1,283	6,660
	Shangombo	1,389	1,429	1,302	1,193	1,268	6,580
	Sioma	1,374	1,413	1,288	1,180	1,254	6,508
	Sesheke	1,067	1,098	1,001	916	974	5,056
	Luampa	1,045	1,074	979	897	953	4,948
	Sikongo	998	1,026	936	857	911	4,728
	Limulunga	979	1,007	918	840	893	4,637
	Nkeyema	962	989	901	825	877	4,554



Province	District	2016	2017	2018	2019	2020	TOTAL
	Mulobezi	901	927	845	774	822	4,269
	Mitete	701	721	657	602	639	3,319
	Mwandi	574	591	538	493	524	2,721



Appendix 2: VMMC EQUIPMENT SET AND CONSUMABLE KIT CONTENTS

Surgical instruments set content for dorsal slit

Product	Description	#
Autoclave storage box	Estimated dimensions approximately: 5"W x 10"L x 2"H	1
Dissection scissors	13-15 cm	1
Combination needle-holder/suture scissors	13-15 cm, working surface approximately 20mm	1
Needle-holder/ driver	Needle-holder (12-14 cm, working surface 20mm)	1
Suture scissors	Suture scissor (12-15 cm)	1
Toothed tissue forceps	Total length 13 cm, working surface 15 mm serrated	1
Mosquito straight clamp	Total length 12-14 cm	4
Mosquito clamp curve	Total length 12-14 cm, working surface 20-30 mm	1
Haemostatic clamps	Total length 13-15 cm, working surface 40 mm	2
Source:	SCMS MC core list, October	2011
http://scms.pfscm.org/scms/docs/papers/MC_Handout_13_OCT_2011.pdf		

Consumables kit contents

Product	Description	#
Multipurpose container tray	Stable plastic recycle tray to conduct procedure, minimum 700 micron virgin plastic, with 3 compartments (Compartment 1 = 13X26, compartment 2 = 5X8, compartment 3 = 5X5, compartment 4 = 5X13 and the total size of the Tray is 26X18).	1
O-drape	Disposable 100 cm X 75 cm (one side absorbable and one side Impermeable. The two different sides are fused together and not lint applied.)	1
Scalpel blade w/handle	Disposable, retractable and lockable; blade type 23; total length 11cm	1
Gauze, plain	Gauze swabs 100X100mm (12ply)	20
Gauze, petroleum jelly impregnated	Paranet gauze 10cmX10cm (1 ply)	1
Syringe	Syringe 10 ml	1
Injection needles	One each of 21g and 23g, 1.5 inch	2
Suture, 3/0 Braided/absorbable	Polyglycolic acid suture, 75 cm, on reverse cutting needle 26 mm	2
surgical gloves	Sterile, one each of size 8 and 7 1/2	2
Apron, disposable	Plastic, trash bag quality	2



Alcohol swabs	1 1/4" x 2 1/2", isopropyl alcohol 70%	2
Surgical paper tape	Micropore 12 mm, 1-3 meter in Length	1
Sterile prep gloves	Examination glove large	1
Source:	SCMS MC core list, October	2011
(http://scms.pfscm.org/scms/docs/papers/MC_Handout_13_OCT_2011.pdf)		

Other items needed for VMMC

Product	Description	#
Lidocaine HCl 1%, injection	Single 20 ml vial	1
Gloves, size 8	Sterile surgical, latex, powdered, size 8, 50 pairs	1
Gloves, size 7	Sterile surgical, latex, powdered, size 7.5, 50 pairs	1
Suture	75cm, absorbable, coated, braided undyed, 3/0, 26mm, 3/8 circle reverse cutting needle, 12 pcs	1
Compression bandage sterile gauze	Box of 50, 4.5 meters long x 5 cm	1
Gauze pads	Sterile, 4 x 4 in 12-ply, 100 pcs	1



Appendix 3: EIMC EQUIPMENT SET AND CONSUMABLE KIT CONTENTS

EIMC Surgical Instrument Set Contents

Product	Description	#
Autoclave storage box	Estimated dimensions approximately: 5"W x 10"L x 2"H	1
Mogen Clamp	Multiple use EIMC device	1
Straight artery forceps	Small size	2
Curved artery forceps	Small size	2
Probe		1
Scissors		1
Surgical blade holder		1
Rectangular Tray		1
Gallipot		2

Source: CIDRZ

EIMC Consumables Kit Contents

Product	Description	#
O-Drape	Disposable 40cm x40cm	1
Scalpel Blade		1
Gauze, Plain	Gauze Swabs 100X100mm (12ply)	5
Gauze, Petroleum Jelly Impregnated	Paraffin Gauze 10cmX10cm (1 ply)	1
Syringe	Syringe 1 ml (Insulin syringe) or Syringe 2 ml	1
Injection Needles	One each of 21g, 23g, 27g	2
Surgical Gloves	Sterile, one each of size 8 and 7 1/2	2
Glucose tablet	Single wrapped tablet, 1g	1

Source: CIDRZ

Other Items Needed for EIMC

Product	Description	#
Lignocaine 1% (no epinephrine), injection	Single 20 ml vial	1
Povidone iodine	50ml bottle	1
Suture	Vicril rapid 4.0	1
Disposable baby nappy	Size dependent on size of baby, size 1 or 2	1
Lifebuoy soap	25g bar for patient to carry	1
Vaseline	2g Single-use plastic/foil packet for patient to carry	1

