

Overview of VMMC Progress in countries

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Outline

- Introduction
- Progress in the seven pillars of the Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in East and Southern Africa: 2012–2016
- Challenges
- Opportunities
- Conclusion and way forward

Introduction

- In 2007 WHO and UNAIDS recommended male circumcision as an additional intervention for HIV prevention - 14 MC priority countries in East and Southern Africa
- Detailed focus will be on VMMC Update Report for 2011 developed in line with 7 pillars of Joint Strategic Framework:
 1. Leadership and Advocacy
 2. Country implementation
 3. Innovations for scale-up
 4. Communication
 5. Resource mobilization
 6. Monitoring and evaluation
 7. Coordination and accountability
- Five years on, essential programme elements in place: leadership, advocacy, funding, , partnerships, normative guidance, policies & strategies, coordination structures, MC plans, communication strategies, procurement & supply management, QA plans, M&E



Pillar 1

Leadership and Advocacy

Global level

- Development of the Joint Strategic Action Framework by key partners led by WHO - UN, PEPFAR, Gates Foundation, WB
- Partners collaborating in implementation and monitoring of framework in support of MoHs

Regional level

- Champions for an HIV-Free Generation continue advocacy for HIV prevention, including MC



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Pillar 1 *contd.*

- Production of MC Song-Champions, Gates Foundation, UNAIDS, three prominent African artists

Country level

- Existence of Ministry of Health
VMMC focal person – 12 countries
- Existence of national advocacy strategy – 10 countries
- Existence of VMMC Champion – 8 countries
- Use of events to promote and support VMMC – 9 countries -
Trade Fairs, World AIDS Days; MC campaigns; Football matches, traditional ceremonies



Pillar 2

Country implementation

- Data received from countries
 - limited age disaggregation
 - inclusion of traditional male circumcisions
- Impact & costing estimates state: scaling up MC in 14 priority countries to 80% coverage among males aged 15-49 years by 2015 would entail:
 - More than 20 million MCs performed by 2015
 - 3.4 million new HIV infections averted by 2025
 - Cost of procedures - \$1.5 billion by 2015
 - Net savings of \$16.5 billion (averted treatment and care costs)

Potential impact and number of male circumcisions performed in the 14 priority countries, 2008–2011

Estimated number of MCs needed to reach 80% prevalence	Potential infections averted by scaling up MC to reach 80% prevalence in five years	Number of MCs carried out per year					% achieved of estimated number of MCs needed to reach 80% prevalence
		2008	2009	2010	2011	Cumulative total	
20,855,905*	3,364,344	21,310	122,988	422,924	884,283	1,451,505	7.0%

Source: Ministries of Health

**Includes figures for 94% coverage in Kenya*

No data available for Lesotho



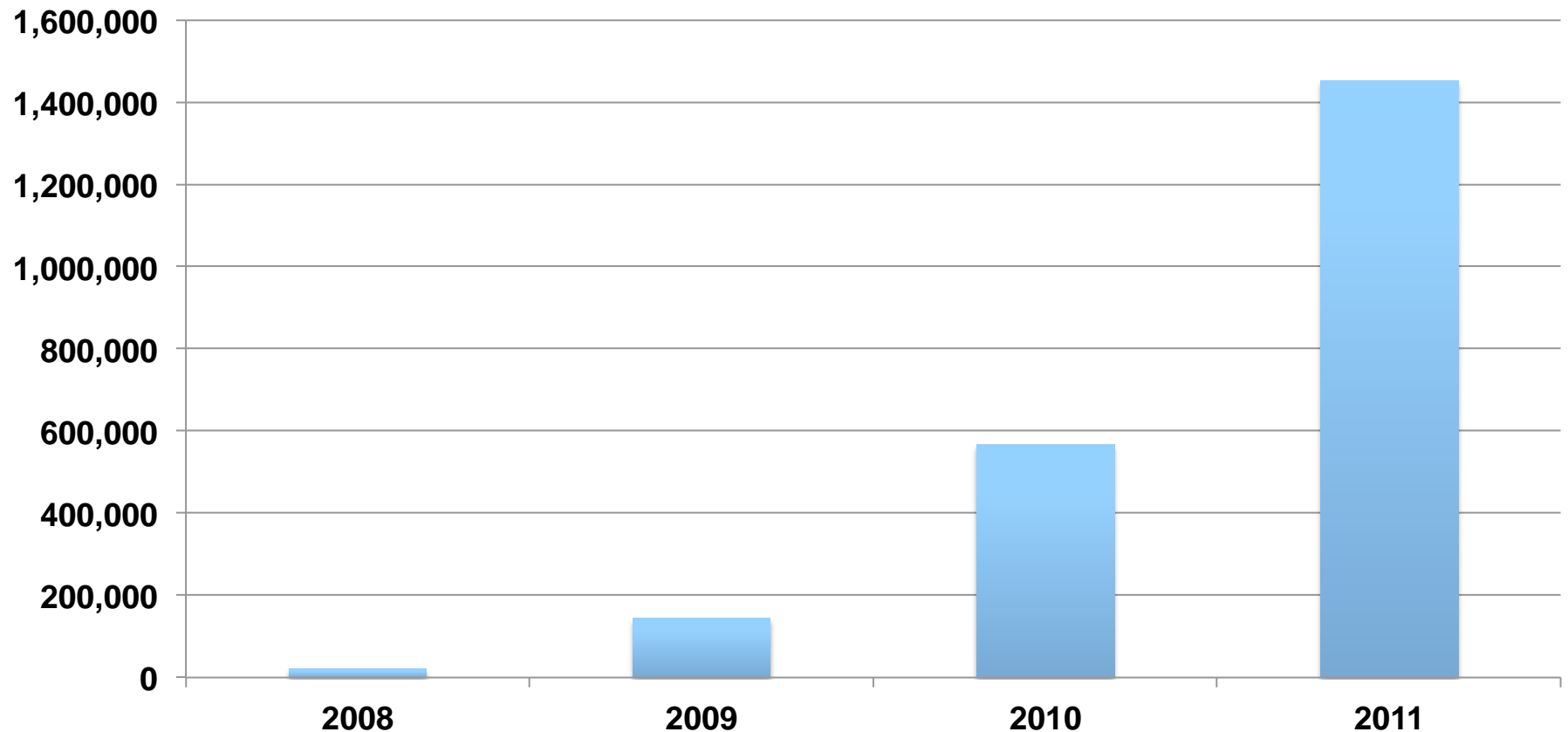
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Number of male circumcisions performed in the 14 priority countries: 2008-2012

Country	Number of MCs carried out per year						% achieved of estimated number of MCs needed to reach 80% prevalence by end of 2011
	2008	2009	2010	2011	2012 (end August)	Total by end of 2011	
Botswana	0	5,424	5,773	14,661	26,423	25,858	7.5
Ethiopia	0	769	2,689	7,542	9,600	11,000	27.5
Kenya	11,663	80,719	139,905	159,196	118,517	391,483	45.5
Lesotho**	No data	No data	No data	No data	5,953	No data	N/A
Malawi	589	1,234	1,296	11,881	No data	15,000	0.7
Mozambique	0	100	7,633	29,592	69,249	37,325	3.5
Namibia	0	224	1,763	6,123	3,607 (July)	8,110	2.5
Rwanda	0	0	1,694	25,000	33,100	26,694	1.5
South Africa	5,190	9,168	131,117	296,726	No data	442,201	10.2
Swaziland	1,110	4,336	18,869	13,791	8,728	38,106	20.8
Tanzania	0	1,033	18,026	120,261	116,673 (July)	139,320	10.1
Uganda	0	0	21,072	77,756	104,721(March)	98,828	2.3
Zambia	2,758	17,180	61,911	85,151	No data	167,000	8.6
Zimbabwe	0	2,801	11,176	36,603	25,700	50,580	2.6
Total	21,310	122,988	422,924	884,283	(522,271)	1,451,505	7.0

Source: Ministries of Health
No data available for Lesotho

Cumulative number of male circumcisions performed from 2008 to 2011



Source: Ministries of Health



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Service delivery approaches

- MC provided as part of minimal package of services:
HTC, Safer sex, STI treatment, condoms, referral for care and treatment
- Integration into:
 - adolescent & youth friendly services – 14 countries
 - infant programmes – 2 countries (Ethiopia, Swaziland)
- Stand-alone sites – 7 countries
- Outreach services – 11 countries
- Mobile services – 9 countries
- Innovative approaches – hard-to-reach men



Procurement and supply management

- Generic standard list of commodities for:
disposable surgical supplies, infection prevention and emergency toolkits
- VMMC kit options and modules developed to meet
countries' needs for quality assured standard kits
- 11 countries experienced challenges related
 - inadequate supplies
 - delayed procurement
 - inadequate funding in 2011
- Kenya, Namibia & Swaziland did not have any challenges

Quality assurance (QA)

- QA processes & mechanisms are needed, esp. as services expand
- QA mechanisms in place - 10 countries
- External QA conducted by PEPFAR to inform quality of services & provide recommendations for improvements



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Capacity building

- Training of service providers with support from partners
 - Categories of health workers trained:
doctors, nurses, midwives, clinical officers, health auxiliaries, counselors, health officers, programme directors, lay counselors, expert clients, licentiates and theatre assistants
- Cascading of training from national to district and lower level health facilities
- Training of cadres in other sectors
 - community health workers
 - private sector



Current VMMC planning in priority countries

Country	Estimated # of MCs needed to reach 80% prevalence	Revised estimated # of MCs needed to reach 80% prevalence	Target group (yrs)	End-year of plan
Botswana	345,244	385,000	13-49**	2016
Ethiopia	40,000	No info	No info	No info
Kenya	860,000	860,000	15-49	2014
Lesotho	376,795	317,215	15-49	2016
Malawi	2,101,566**	875,000**	15-49	2016
Mozambique	1,059,104	2,000,000**	10+**	2016
Namibia	330,218	330,000	15-49	Mar 2016
Rwanda	1,746,052	2,000,000	15-49	Jun 2013
South Africa	4,333,134	5,000,000	15-49	2016
Swaziland	183,450	Under discussion	10-24**	2016
Tanzania	1,373,271	2,800,000**	10-34**	2016
Uganda	4,245,184	4,200,000	14-49	2015
Zambia	1,949,292	1,900,000	15-49	2015
Zimbabwe	1,912,595	1,268,000**	13-29**	2015

Source: Ministries of Health



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Pillar 3

Innovations for scale-up

- **Male circumcision devices** - to be covered later
 - guidance from WHO received on use of MC devices
 - research underway in Kenya, Rwanda, Zimbabwe and Botswana
- **Human resource innovations**
 - > Models for Optimizing Volume and Efficiency (MOVE) which entails sharing tasks and techniques to make surgical technique more efficient
 - > Engaging volunteers e.g. Swaziland
 - > Task shifting status for adult VMMC
 - Existence of task shifting policy – 5 countries
 - *Ethiopia, Kenya, Rwanda, South Africa, Zambia*
 - Implementation of task shifting activities – 10 countries
 - ..*Bots, Les, SA, Zim have not implemented task shifting*
 - ..*Mal, Moz, Nam, Swa, Tan, Uga- no policy but task shifting implemented*



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- Task shifting for aspects of MC procedure implemented – 10 countries

Pillar 4

Communication

- 10 countries had various communication / demand creation strategies
 - main channels for communication:
 - mass media, interpersonal communication
 - community mobilization
 - health education sessions in health facilities
 - variety of materials: brochures, pamphlets, poster
- Involvement of women & young people:
 - Women:** support partners & sons; advocacy, mobilization, participants in couples counselling
 - Young people:** mobilization: school programs; TWGs; peer educators



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Pillar 5

Resource mobilization

- Funds generally available to support MC in most countries
- Sources of funding include:
Governments, partners such as PEPFAR & Gates Foundation, UN system, multilateral partners and private sector
- Funding from the Global Fund was available for VMMC services in 4 countries — Lesotho (R8), Rwanda (NSP), South Africa (R10) and Zambia
- Increased government contributions needed for sustainability phase of MC programme

Pillar 6

Monitoring and evaluation

- M&E systems in early stages of development but becoming stronger in most of the countries.
- Findings for M&E and proceedings of last week's meeting to be covered in the next presentation
- Adverse event** rate reported as less than 2% in most countries

****** *an injury that was caused by medical management and not due to the underlying condition of the patient. An unexpected and undesired incident directly associated with the care or services provided to the patient."*

Pillar 7

Coordination and accountability

- All countries had established multi-sectoral task forces to coordinate partners' inputs with MoH taking the lead
- In some countries, task forces needed strengthening
- Countries had different types of partners:
bilateral agencies, international and national NGOs, private sector, health professional bodies, youth groups and women's groups.
- Partners contributed, financial, human and technical support to MoHs

Challenges

- Limited demand for VMMC services
- Limited increase in number of male circumcisions performed
- Integration into routine services - esp. early infant & adolescent services
- Human resource constraints - need for task shifting
- Inconsistent leadership and coordination across countries
 - *VMMC Focal Points, Champions in-country, partner coordination*
- Sustainable funding – *partner funding, UN, Global Fund. Government to increase domestic funding esp. for sustainability phase*
- Procurement, supplies, equipment, infrastructure, waste disposal
- Weak M&E systems



Opportunities

- Strong political will and leadership at different levels
- Funds and technical support currently available
- Innovations from research on MC devices available soon to inform device use
- Learning from experience in scaling up sound HIV prevention programmes
- Partnerships
- Best/good practices, experiences & operational research

Conclusion and way forward

- Cultivating strong leadership at all levels
- Enhancing demand creation
- Making progress on innovative approaches to service delivery, including potential inclusion of MC devices
- Sustaining & diversifying funding from both govt. & partner sources
- Improving monitoring and evaluation
- Improving procurement and supply management systems
- Establishing infant & adolescent MC services for sustainability
- Conducting well-designed evaluations of the HIV impact, cost-effectiveness and return on investment of VMMC in priority countries

Thank you



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