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DMPPT REGIONAL TRAINING REPORT: MEASURING THE COST AND IMPACT OF MALE CIRCUMCISION

April 19–21, 2010
Nairobi, Kenya

AUGUST 2010

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

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The U.S. Agency for International Development provided funding through the Health Policy Initiative, Task Order 1 to support the participation of Steven Forsythe and Lori Bollinger as facilitators of the workshop. Emmanuel Njeuhmeli and Delivette Castor from USAID/Washington also provided indispensable leadership.

EXECUTIVE SUMMARY

The Decision Makers' Program Planning Tool Training was conducted from April 19–21, 2010, in Nairobi, Kenya, to orient participants on the structure of the tool and how to use it. Twelve countries in Eastern and Southern Africa were represented in the training—of which five are currently completing a male circumcision (MC) costing exercise. Those five countries shared their experiences to date.

Participants rated the training overall as a 4 on a scale of 1–5, noting the participatory nature of the workshop, the exchange of ideas, and country experiences as strong aspects. Participants were also satisfied with the structure and curriculum content; however, some expressed the need to refine the impact model component for increased understanding and application. At the workshop's conclusion, country teams discussed initiating, revising, or completing their costing exercise. Participants plan to apply their newly acquired knowledge and skills to better engage policymakers and various stakeholders and to scale up MC programs in their respective countries.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
CAFS	Centre for African Family Studies
DMPPT	Decision Makers' Program Planning Tool
HIV	human immunodeficiency virus
IRB	Institutional Review Board
M&E	monitoring and evaluation
MC	male circumcision
MOH	Ministry of Health
TSF	Technical Support Facilities
UNAIDS	Joint United Nations Program on HIV/AIDS
WHO	World Health Organization

BACKGROUND

Various African countries are currently developing a strategy to scale up male circumcision (MC) services. The World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS), in collaboration with the President's Emergency Plan for AIDS Relief have been providing countries with information and tools to help assess the current situation and develop future plans for male circumcision scale-up. In support of this work, UNAIDS collaborates with the USAID | Health Policy Initiative, Task Order 1 to estimate the potential impact and costs of alternative approaches to scale up medical MC services. The analysis is done using the Male Circumcision Decision Makers' Program Planning Tool (DMPPT).¹ The tool is designed to support policy development and planning and has been applied in several countries in sub-Saharan Africa (Botswana, Swaziland, Lesotho, Uganda, Zambia, and Namibia). The tool addresses the following main areas:

- All male adults, young adults, adolescents, and newborns
- Targets, coverage levels, and rates of scale-up
- Service delivery modes:
 - Mobile, outreaches, fixed sites
 - Public, private, NGO
 - Integrated or standalone clinic
 - Task shifting and task sharing
 - Use of MC Kit or not
 - Use or not of electrocautery
 - Surgical techniques use for MC: Forceps guided, dorsal slit, or sleeve resection

Results from the tool enable analysts and decisionmakers to understand the costs and impacts of strategic options. A “unit cost” is expressed as the cost of performing one male circumcision. Total costs can be based on detailed facility-level inputs on the costs of service provision plus program-level expenditures to determine the cost of training, the supply chain system, communication including community mobilization, demand creation, or assumptions about the average costs per male circumcision performed. Impact is expressed in terms of new HIV infections averted or reductions in incidence or prevalence.

In collaboration with the Health Policy Initiative, Centre for African Family Studies (CAFS), and Technical Support Facilities (TSF) in Southern Africa, UNAIDS designed a training to orient country stakeholders on the structure of the DMPPT and how to use it. The Decision Makers' Program Planning Tool Training was conducted from April 19–21, 2010, in Nairobi, Kenya, for people working on MC costing issues, with strengths in health economics or epidemiology. Participants came from 12 priority focus countries for MC scale-up in Southern and Eastern Africa. The training covered the basics of how the MC tool is set up, how to identify inputs, and how to interpret the results.

OBJECTIVES

The overall objective of the DMPPT training was to orient stakeholders on using the tool to estimate the costs for scaling up MC interventions and the associated impacts, including introducing the facilities data collection form and the nature of the data to be collected from the selected sites. Results of the costing exercise help inform the design of cost-effective and efficient MC scale-up strategies. Experts can estimate both the human and financial resources required to implement MC programs at a local level, as

¹ The Decision Makers' Program Planning Tool was developed by John Stover and Lori Bollinger of Futures Institute under the USAID | Health Policy Initiative, Task Order 1, with technical support from Catherine Hankins of UNAIDS. It is available at <http://www.malecircumcision.org/programs/DMPPT.html>.

well as estimate the costs to scale up MC interventions on a national level. The tool also estimates the associated impact of MC interventions on the HIV epidemic.

PARTICIPANTS AND FACILITATORS

Twenty-four participants from 12 countries attended the three-day training, including Ministry of Health (MOH) staff responsible for working on MC-related issues, as well as TSF/Southern Africa consultants from Kenya and Zambia and Health Policy Initiative consultants from South Africa and Uganda.

Participants gained skills in the DMPPT, as well as the Spectrum System of Policy Models. The training focused particularly on measuring the cost of male circumcision and analyzing the long-term impact of scaling up MC services.

Facilitators included Emmanuel Njeuhmeli and Delivette Castor of the Office of HIV/AIDS of USAID/Washington; Lori Bollinger and Steven Forsythe of the Health Policy Initiative; and Urbanus Kioko of TSF/Southern Africa. Catherine Hankins and Precious Lunga of UNAIDS provided guided implementation of the training. Dr. Hankins followed the training from Geneva and attended the third day via videoconference.

PROCESS

The training was designed so that participants had significant opportunity to gain hands-on experience through case studies and practical exercises. The amount of lecture was limited, allowing for ample discussion and feedback. The training also served as an opportunity for countries at different stages of the MC costing process to share their experiences to date and learn from each other, particularly for those countries that had yet to start the process.

RESULTS AND FOLLOW-UP

The workshop began with introductions and a review of objectives. Dr. Njeuhmeli then presented results from the desk exercise that had been conducted in 14 countries.

Subsequently, the consultants involved in conducting MC costing in five of the countries made presentations on their ongoing activities (Kenya, Zambia, Zimbabwe, Uganda, and South Africa).² These presentations raised a number of questions about the DMPPT process, especially from participants who had not yet begun to conduct an exercise in their own countries. Questions included the following:

- How did the consultants work with the technical working groups on MC?
- How was sample size for the number of sites determined? How should other countries determine their sample size?
- How do countries select geographic areas where data should be collected? How should countries deal with the political pressures of collecting data from certain sites?
- What kind of a protocol was used in each country for data collection?
- How did each country modify its survey instrument? What were the lessons learned?
- What was the ethical review process? How long did this delay the process?
- How were data collectors selected? What skills did they need to have?
- What were the logistics of managing the data collectors?

² The TSF consultant for Zimbabwe, Carl Schutte, was not able to attend the workshop. The presentation on Zimbabwe was made by Gertrude Ncube.

- How does each country define “static,” “outreach,” and “mobile” services?
- How should countries cost “demand creation” and “training”?

The five presenters explained the logistical and technical challenges they encountered and how they addressed them, answered questions raised by the countries that have not yet begun their data collection, and presented the preliminary results of the cost exercise. Finally, the presenters laid out a timeline for completing their work.

Next, Dr. Forsythe presented the costing component of the DMPPT, followed by a case study that permitted participants to break into teams and practice analyzing MC costing data. The teams were then given a chance to present their results and compare their findings with the answer sheet.

Next, Dr. Bollinger presented the impact component of the DMPPT, including an extensive review of the epidemiologic and behavioral data used in the modeling process. Dr. Bollinger then asked the participants to work with a case study on impact modeling and present their results.

Following the two case studies, participants heard a presentation explaining the Spectrum System of Policy Models, including a discussion of the latest revisions and updates to the models. Participants then broke into groups to work through an exercise requiring use of the models.

Dr. Kioko moderated a discussion on the final day, allowing participants to talk about some of the challenges in scaling up MC in their own countries. Participants also discussed their plans for moving forward with the MC costing process and use of the tool.

South Africa noted that the first step in its process is understanding the current situation. In South Africa, there is limited access to comprehensive medical MC services. However, it was noted that the Department of Health does have plans for scaling up MC and the DMPPT costing exercise fits in well with this process. Data have been collected and are in the cleaning process. MC is done mainly for medical indication rather than for HIV prevention. A report on this costing work is forthcoming. It was noted that South Africa’s data collection instrument was significantly modified. Dr. Mahomed also noted that the selection of sites was not random but rather based on ensuring a variety of service delivery venues, including mobile and static sites. Some challenges faced by South Africa included knowing where to collect secondary data, such as the costs of equipment and buildings.

Zimbabwe noted that the data collection process has required careful planning, especially in regard to evaluating sites. The training will help to clarify things that were not initially clear. Dr. Ncube also noted that the process so far has worked well with stakeholders. Support is evident from the WHO, UNAIDS, United Nations Population Fund, and USAID. Dr. Ncube also noted that using data collectors who understand the health sector is essential; and that calculating overhead costs has been somewhat problematic, especially given that many health centers and hospitals were constructed prior to independence. Zimbabwe has also struggled with determining how to properly cost demand creation.

Kenya emphasized that their data collection process has encountered various delays, due in part to making sure the survey instrument was properly modified to the Kenyan context and to delays associated with completing the Institutional Review Board (IRB) process. Despite these delays, the data collection process is now complete, and data from 30 sites have been obtained. A draft report was shared with stakeholders after meeting with the national MC task force for input. Currently, MC is focused mostly on Nyanza, but other provinces are on the horizon. Dr. Kioko noted that it’s particularly important to have data collectors who are familiar both with the health system and the costing process. Dr. Kioko also emphasized that countries should expect delays and be flexible in the design of the costing exercise.

Dr. Tumwesigye presented the results from **Uganda**. He also noted the importance of selecting appropriate data collectors, ensuring sufficient data cleaning and analysis, and conducting the overall process in close collaboration with stakeholders to ensure acceptance of the results. Dr. Tumwesigye particularly noted that the preliminary unit cost estimate for Uganda (US\$19/client) seems somewhat low and that he is going to continue reviewing the data to validate the results.

The results from **Zambia** were presented by Chris Chiwevu. It was noted that Zambia also suffered from some delays, due in part to the IRB approval process. Meetings with stakeholders concluded by the end of 1st quarter 2010, and there is a need to further discuss the strategy. Zambia benefited from the significant involvement of the Ministry of Health, which has taken a lead role in ensuring that the data collection process proceeds smoothly. The exercise process was also noted to be lengthy, thus requiring patience. The largest challenge for Zambia has been that most facilities offering MC services have had poor record keeping and the tracking of MC delivery has been incomplete. With time, the Ministry of Health, with the support of partners, hopes to strengthen existing MC service delivery systems. The data collection was also found to be difficult because it was necessary to go through various layers of authority before final approval could be obtained to conduct face-to-face interviews with those involved in MC and delivery services. Zambia finalized the report in August 2010, despite the delays due to the ethical review process.

Tanzania is on the verge of initiating its own MC costing process. It was noted that Tanzania needs technical assistance and that the process will be limited to a few regions identified as priorities by the government. Tanzania had questions about their needed sample size for each region.

Swaziland is on the verge of an extremely rapid scale-up of MC services, with initial projections suggesting that 80 percent of men could be circumcised within six months. The Swazi team requested additional technical assistance in using the DMPPT, as well as a generic protocol that they could use in conducting the costing and impact analysis.

Rwanda also indicated a desire to use the DMPPT in the next three months and will request additional technical assistance for the application. The Rwanda team received a copy of a generic protocol, along with the data collection instrument being used in Zambia and Kenya. Rwanda is currently implementing MC services within the military sector but hopes to expand delivery.

Mozambique also indicated that it will soon initiate an MC costing process. The team particularly requested assistance in understanding how demand creation could be used to expand the number of men willing to be circumcised in the country. While Mozambique was initially reticent politically to move forward with male circumcision, it now appears that the country is prepared to move forward.

The team from **Malawi** noted that a recently completed situation analysis indicates that only one community is predominantly circumcising. At the time of the training, an MC meeting was planned for later in April 2010 to decide how to proceed with the DMPPT.

Botswana plans to discuss next steps with the technical working group. The DMPPT was not used in the country's previous costing work, so part of the discussion will include determining its utility in the new exercise being rolled out. Catherine Hankins asked about the issue of scaling up for universal equity and whether there can be costing at a few sites to determine cost and scale-up measures. Dr. Hankins also asked about the possibility of neonatal circumcision in Botswana. The representative indicated that infant MC is part of the country's MC plan.

Finally, **Namibia** noted that the country is one of the first to use the DMPPT. However, it was pointed out that data need to be updated, as the initial exercise was based on higher HIV prevalence estimates and significant use of general anesthesia. It was noted that Namibia no longer promotes general anesthesia for

adults (although it is still used for newborns) and that the costing exercise should reflect this. The task force will be briefed to determine whether new variables or different data are needed from those initially used.

Next steps after the training included the following:

- Synthesize data from six countries: **Kenya, Zimbabwe, Tanzania, Uganda, Namibia, and South Africa.**
- Present results from those countries that have completed their data collection in the June Arusha meeting.
- Complete analysis of the data and data cleaning. Review variations in unit cost and cost drivers across countries.
- Share protocols between countries that are further along in their costing and those just initiating data collection.
- Assist countries that wish to include male circumcision in their Round 10 Global Fund proposal.
- Complete country reports by mid-June.

At the training's conclusion, each participant was asked to complete an evaluation (see Appendix D). Fifteen participants completed the evaluation, and the responses showed that they enjoyed the participatory nature of the workshop. The majority (12 of 15) felt it facilitated the exchange of experiences. While most participants did not note the need to eliminate any topics of the curriculum, some participants (7) thought that the impact model component should be refined. Regarding other workshop content, some suggestions were offered, including using an example of a completed DMPPT application and discussing an approach and costing of monitoring and evaluation (M&E) for male circumcision, factors for low MC in specific countries, and the involvement of traditional male circumcisers.

The evaluation also asked participants whether their country's decision on who should participate would have been affected if they had known more about the content of the course. Seven (7) said "no" and five (5) said "yes," with suggestions of appropriate persons including M&E coordinators and health economists in the MOH, epidemiologists who work on MC, and more program managers within the various departments of the respective ministries of health. One participant felt that prior knowledge of the content would have allowed them to carry out country-specific data collection prior to the workshop.

When asked how they planned to apply the knowledge and skills acquired, most participants stated the potential to better engage policy and decisionmakers; also mentioned was the ability to review and scale up existing MC programs, improved monitoring and evaluation of MC, and the ability to use the knowledge in the development of Global Fund Round 10 proposals.

Suggestions for strengthening the training included improving the case study and group discussions, adding more time to better understand the tools, using recent country-specific data, and inviting traditional male circumcisers to the training. Participants rated the training overall as a 4 out of 5, in terms of organization and logistics of the course, structure of the training, extent to which new skills were acquired, usefulness of the tools, and networking.

APPENDIX A: AGENDA

Decision Makers' Program Planning Tool (DMPPT) Training

April 9–21, 2010
Nairobi, Kenya

Monday April 19, 2010

Time	Activity	Facilitator/Presenter
08:30 – 09:00	Arrival and registration	
09:00 – 09:15	Opening remarks	Nicholas Muraguri
09:15 – 09:45	<ul style="list-style-type: none"> • Introductions • Welcome Remarks • Expectations 	Emmanuel Njeuhmeli
09:45 – 10:00	Collecting unit cost data: Progress from Kenya	Urbanus Kioko
10:00 – 10:15	Collecting unit cost data: Progress from Uganda	Nazarius Mbona Tumwesigye
10:15 – 10:30	Collecting unit cost data: Progress from Zimbabwe	Gertrude Ncube
10:30 – 10:45	Collecting unit cost data: Progress from Zambia	Chris Chiwevu
10:45 – 11:00	Collecting unit cost data: Progress from South Africa	Ozayr Mahomed
11:00 – 11:15	Discussion	All
11:15 – 11:45	Refreshment Break	
11:45 – 12:15	Overview of the DMPPT results in Africa	Emmanuel Njeuhmeli
12:15 – 13:15	Lunch	
13:15 – 15:00	Costing component of the DMPPT	Steven Forsythe
15:00 – 15:30	Refreshment Break	
15:00 – 16:30	Case study and country team work: Estimating male circumcision costs	Steven Forsythe
16:30 – 17:00	Discussion of issues arising on costs	All

Tuesday April 20, 2010

Time	Activity	Facilitator/Presenter
09:00 – 09:15	Overview of day	Emmanuel Njeuhmeli (day chair)
09:15 – 10:30	Country report backs	All
10:30 – 11:30	Impact component of the DMPPT	Lori Bollinger
11:30 – 12:00	Refreshment Break	
12:00 – 13:30	Case Study and country team work: Estimating male circumcision benefits	Lori Bollinger

13:30 – 14:30	Lunch Break	
14:30 – 16:00	Country report backs	All
16:00 – 16:30	Refreshment Break	
16:30 – 17:30	Overview of Spectrum and Identification of spectrum data used in DMPPT	Lori Bollinger and Steven Forsythe

Wednesday April 20, 2010

Time	Activity	Facilitator/Presenter
09:00 – 09:15	Overview of day	Lori Bollinger (day chair)
09:15 – 11:00	Country teams entering data to run tool for country application	Urbanus Kioko
11:00 – 11:30	Refreshment Break	
11:30 – 13:00	Country teams report back on progress, challenges, and solutions	All
13:00 – 14:00	Lunch	
14:00 – 15:00	Discussion: Remaining issues in scale-up	All
15:00 – 15:30	Refreshment Break	
15:30 – 17:00	Next Steps	Emmanuel Njeuhmeli, Precious Lunga, Lori Bollinger, Steven Forsythe, Delivette Castor, Catherine Hankins

APPENDIX B: DMPPT PARTICIPANT LIST

Name	Organization	Email
Facilitators		
Lori Bollinger	Vice President, Futures Institute	LBollinger@futuresinstitute.org
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Dr Jonas Mwale	National MC Coordinator, Directorate of Public Health & Research-HIV unit, Ministry of Health	jonascmwale@yahoo.co.uk
Zimbabwe		
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Gertrude Ncube	National HIV Prevention Coordinator	getrudencube@yahoo.co.uk

APPENDIX C: RESOURCE LIST

Male Circumcision Decision Makers' Program Planning Tool—an Excel-based model that estimates the impact and cost of scaling up male circumcision services as an HIV prevention intervention. Available at: <http://www.malecircumcision.org/programs/DMPPT.htm>.

Spectrum—a system of policy models that makes use of a unified set of Windows-based commands that can be used to project the need for family planning/reproductive health, maternal health, and HIV/AIDS services. Available at: <http://www.policyproject.com/software.cfm?page=Software&ID=Spectrum>

APPENDIX D: DMPPT TRAINING EVALUATION

Results Summary

1. What did you like best about the training?

- Participatory nature of workshop and environment (7)
- Learning from other countries (4)
- Impact model presentation (3)
- DMPPT results (1)
- Costing exercises (1)
- Planning tools (1)
- Software (1)

2. If you had to eliminate something from the curriculum, what would you pick?

- Nothing (10)
- Discussion time too long (2)
- No answer (2)
- Optimize time (1)

3. What part of the curriculum most needs strengthening or modification?

- Impact model (5)
- Spectrum models and assumptions (2)
- Case study, country team work and use of real data (1)
- Duration of the timing (1)
- More time for individual work (1)
- Software use/mini manuals (1)
- Time keeping (1)
- No answer (2)

4. What other subjects should have been included in this training?

- Costing and tracking of M&E (3)
- Analysis of data collected and finished DMPPT (2)
- Produce a model to take home (2)
- Highlight factors for low MC (1)
- Approach to costing (1)
- Traditional male circumcisers involvement (1)
- Objectives well met (1)
- No answer (4)

5. To what extent did the training facilitate the exchange of experiences among participants?

NOT AT ALL __0__, SOMEWHAT __3__, QUITE A LOT __12__

How could it have done a better job?

- 5 slide power point for country presentations, no off the cuff remarks (1)
- Rotate participants (1)

- More countries (1)
- Discussion on challenges and how to solve them (1)
- Too short (1)

6. If you had known more about the content of the course one month ago, would it have affected your country's decision about who should participate?

YES 5, NO 7, TO SOME EXTENT 1

Who should have come who did not? (Description or position of person)

- M&E coordinators (2)
- Health economists (1)
- Epidemiologist and health economist working in MOH (1)
- Program managers in MOH (1)
- Not about the attendance but also carrying specific data for our country for use in the exercises (1)

7. How might you apply the knowledge and/or skills acquired in the course? Please give concrete examples:

- Engage/advocacy efforts with policy- and decisionmakers (4)
- Costing (3)
- For scale-up (3)
- Debriefing colleagues (3)
- Review programs (1)
- Piloting (1)
- Assess training needs (1)
- Global fund round 10 proposal development (1)
- Validate assumptions (1)
- M&E (1)

8. What suggestions do you have to improve this training?

- Nothing (4)
- Use recent country specific data (2)
- More time to understand the tool (2)
- Reduce to 2-day workshop (1)
- Improve group discussion on case study (1)
- Less 'down time' and have one 'helper' per table (1)
- Some may need some basic orientation (1)
- Time for shopping (1)
- No answer (2)

9. Any other comments or concerns that you may have regarding the training?

- None (6)
- Well organized (1)
- Terrible hotel and refreshments (teas etc) (1)
- No Answer (9)

10. Prior to the training, please rate your skill with or knowledge of: (circle your answers)

Please rate on a scale of 1 to 5, where 1 is the minimum and 5 is the maximum

• Excel	1 (1)	2 (1)	3 (2)	4 (6)	5 (5)
• Costing	1 (0)	2 (3)	3 (4)	4 (5)	5 (2)
• Epidemiological concepts	1 (0)	2 (2)	3 (4)	4 (5)	5 (1)
• MC programs	1 (0)	2 (1)	3 (4)	4 (8)	5 (1)

Total	1	7	13	24	9
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**Actual number of responses in parentheses*

11. Please rate each of the following: (circle your answers)

Please rate on a scale of 1 to 5, where 1 is the minimum and 5 is the maximum

• Satisfaction with overall organization of the course	1(0)	2(1)	3(2)	4(11)	5(1)
• Satisfaction with logistics of course	1(0)	2(3)	3(3)	4(7)	5(4)
• Satisfaction with accommodations	1(2)	2(1)	3(2)	4(6)	5(3)
• Satisfaction with meals	1(2)	2(0)	3(4)	4(6)	5(3)
• Structure of the training	1(0)	2(1)	3(4)	4(9)	5(1)
• Usefulness of daily reviews	1(1)	2(1)	3(3)	4(6)	5(2)
• Usefulness of tools	1(0)	2(0)	3(1)	4(7)	5(5)
• Extent to which you acquired new skills	1(0)	2(1)	3(2)	4(10)	5(2)
• Extent to which training contributed to networking	1(0)	2(0)	3(4)	4(10)	5(2)
• To what extent do you feel better equipped to undertake costing of MC?	1(0)	2(0)	3(5)	4(7)	5(3)

Total	5	8	30	79	26
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**Actual number of responses in parentheses*

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