Male Circumcision in Zambia: National Operational Plan for Scale-up

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National MC Coordinator
Zambia’s high HIV prevalence (14.3%) and low MC adoption rates (13%) make it an environment where VMMC can have a significant public health impact.

Ministry of Health (MoH) adopted VMMC as one of the key prevention interventions of it’s comprehensive HIV prevention strategy in June 2009.

In 2011, Zambia revised its target to reaching universal coverage of adult males 15-49 by 2015.

In order to achieve this aggressive target, we realized that we needed an operational plan to which all stakeholders could align.
MC in Zambia – Baseline

**HIV %**

(Numbers in parentheses indicate the MC %)

- 15.2% (40.2%)
- 14.5% (4.4%)
- 20.8% (10.2%)
- 17.5% (5.7%)
- 17.0% (14.4%)
- 6.9% (71.0%)
- 6.8% (3.3%)
- 13.2% (9.9%)

**Source:** ZDHS 2007 GRZ Tables 13.12 and 14.5

**Target**
To achieve universal coverage by reaching 1.949M HIV-negative adult males by 2015

**Impact**
This is expected to avert 339,632 HIV infections (29.9%) and create a net savings of USD 1.7 billion (2011-2025)
Target Setting Methodology

Target setting - Example

- **Total Adult Male population**
- **Eligible population**

![Diagram showing the relationship between total adult male population, eligible population, HIV+ population, and circumcised population.]

- **HIV + Circumcised population**

**Province A**

- **Target (80% of eligible population)**

- This implies that while HIV-positive men may receive VMMC, they are not included in the 80% target.
Provincial Targets (2012-2015)

Eligible Population and Targets by Province
Men Aged 15-49 Years (2012-2015)

- Non-eligible males (HIV+)
- Non-eligible males (Circumcised)
- Eligible males
- MC Targets (80% of eligible males)
Developing Annual Targets

Provincial and district targets are broken down into annual targets based on an exponential scale-up curve.

Improved human resource capacity, programme efficiency, community awareness, and resource mobilization are expected to lead to an exponential scale-up curve.

- **Historical volumes**
  - 2011: 84,604
  - 2012: 198,511
  - 2013: 270,528
  - 2014: 526,818
  - 2015: 868,538
  - 2016: 126,463

- **Catch-up phase**
  - Annual VMMCs decrease in 2016
Assessing Annual Targets

- Annual national targets can now be compared to the donor-funded targets of implementing partners.

- This has uncovered a significant gap in the annual resources required to achieve 5 year targets.

- Quantifying this gap on an annual basis improves our ability to advocate for resources during annual MOH and donor budgeting processes.
When the National VMMC Program was launched in 2009, the service delivery landscape was already crowded by:

- Multiple donors; funding
- 5 implementing partners; to achieve
- Disparate targets; through
- Different service delivery models
Strategic Direction – Where we are

Country Operational Plan for the scale-up of Voluntary Medical Male Circumcision in Zambia, 2012-2015

- Includes annual targets at the district level


- Provides key VMMC messages for each target group
Country Operational Plan – 8 Pillars

Pillar 1: Leadership & advocacy
Pillar 2: Governance & coordination
Pillar 3: Service delivery of VMMC
Pillar 4: Communication & demand generation
Pillar 5: Monitoring & evaluation
Pillar 6: Implementation science
Pillar 7: Resource mobilization/Costing VMMC scale-up
Pillar 8: Early infant male circumcision (EIMC)

Developing the Operational Plan directly supports Pillars 1&2.
Governance structure of VMMC in Zambia – National level

- National MC TWG
  - Partners
  - NAC
  - Private Sector
  - Other Gov’t Stakeholders

- National MC Coordinator
  - MC Program Officer – Northern Region
  - MC Program Officer – Southern Region
  - Monitoring and Evaluation Coordinator

- Director of Public Health and Research
  - Deputy Director of Public Health and Research - EDC
The National Operational Plan:

- Categorizes facilities into one of four levels (A-D) based on availability of resources required for MC; and
- Defines efficient service delivery models for each level

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level A</td>
<td>Facilities able to provide dedicated VMMC service days without supplementary staff or equipment</td>
</tr>
<tr>
<td>Level B</td>
<td>Facilities requiring outreach staff and mobile equipment to provide dedicated VMMC service days</td>
</tr>
<tr>
<td>Level C</td>
<td>Facilities requiring outreach staff and mobile equipment to provide dedicated VMMC service days</td>
</tr>
<tr>
<td>Level D</td>
<td>Facilities requiring outreach staff and mobile equipment to provide dedicated VMMC service days</td>
</tr>
</tbody>
</table>
Zambian model for optimizing the volume and efficiency of VMMC services...

- **Efficient mix of models**: Unique combination of higher and lower volume service delivery models in order to align supply and demand.

- **Accessible service locations**: Within walking distance of as many beneficiaries as possible.

- **Dedicated service days**: Scheduled for specific days when multiple clients can be attended to by a dedicated team of providers.

- **Efficient activity scheduling**: The frequency of VMMC service days will be determined according to facility capacity.

- **Mobile services**: Routine outreach services will be needed to supplement facility capacity and to improve access.

- **Efficient client flow**: Maximize provider time and productivity of dedicated VMMC service days.

- **VMMC commodity efficiency**: Pre-packaged VMMC consumable kits and re-useable equipment sets should be used.

- **Procedural efficiency**: Wherever possible, electrocautery, homeostasis during surgery or the use of approved VMMC devices should be incorporated.

- **Task-shifting**: VMMC will be offered by nurses and clinical officers. Where appropriate, HIV counseling and testing and other non-clinical tasks should be undertaken by qualified non-clinical personnel.
## Operational Plan – Costing

<table>
<thead>
<tr>
<th>Area</th>
<th>Total Cost (2012-2015), USD Million</th>
<th>Unit cost per MC, USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area</td>
<td>2012</td>
<td>2013</td>
</tr>
<tr>
<td>Service Delivery</td>
<td>$23.3</td>
<td>$18.4</td>
</tr>
<tr>
<td>Governance &amp; Coordination</td>
<td>$4.2</td>
<td>$4.0</td>
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<tr>
<td>Advocacy &amp; Demand Generation</td>
<td>$2.8</td>
<td>$2.3</td>
</tr>
<tr>
<td>M&amp;E/Implementation Science</td>
<td>$1.6</td>
<td>$1.0</td>
</tr>
<tr>
<td>Total</td>
<td>$31.9</td>
<td>$25.6</td>
</tr>
</tbody>
</table>
## Operational Plan – Costing

### Operational plan resource envelope, USD million

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required resources</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$</td>
<td>$31.9</td>
<td>$25.6</td>
<td>$54.2</td>
<td>$84.5</td>
<td>$196.4</td>
</tr>
<tr>
<td><strong>Available resources</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>GRZ</td>
<td>$3.9</td>
<td>$4.8</td>
<td>$8.2</td>
<td>$13.0</td>
<td>$29.9</td>
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<tr>
<td>USG</td>
<td>$5.0</td>
<td>$16.0</td>
<td>$16.0</td>
<td>$16.0</td>
<td>$53.0</td>
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<tr>
<td>Global Fund</td>
<td>$0.8</td>
<td>$0.8</td>
<td>$0.8</td>
<td>$0.8</td>
<td>$3.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$9.7</td>
<td>$21.6</td>
<td>$25.0</td>
<td>$29.8</td>
<td>$85.9</td>
</tr>
<tr>
<td><strong>Funding Gap</strong></td>
<td>$22.2</td>
<td>$4.0</td>
<td>$29.2</td>
<td>$54.7</td>
<td>$110.5</td>
</tr>
</tbody>
</table>
Operational Plan – Unit Costing

Unit cost of Service Delivery - $86.25

- Personnel, $46.03
- Partner operating costs, $7.66
- Kits consumables, $12.67
- Vehicles, $8.20
- Capital and infrastructure, $5.60
- Running costs, $6.09
The Hon. Minister of Health launched the August campaign on National TV with the target of 30,000 VMMCs.

The PS sent official letters to all provinces requesting that MoH staff support partners and make providers available.

MoH and partners shared costs to support a national media campaign.

As of August 31st, over 45,000 MCs had been completed!
What worked?

• **Strong MoH leadership** – Launch by Hon. Minister, Official letter announcing campaign to Provinces and Districts.

• **Media Involvement** – Media Launch held to sensitize TV and Radio personalities.

• **Coordination and between MoH and partners** – MC TWG planning sub-committee, Cost sharing for mass media, and demand generation.
What Zambia is still working on...

• **Resource mobilization**
  - The financial gap in Operational Plan funding will need to be addressed through a combination of increased resources and improved program efficiency.

• **Develop a National Workplan**
  - We need to develop an Annual National Workplan which integrates the activities of all stakeholders and is aligned to the National Operational Plan.

• **Implementation of National M&E System**
  - National M&E tools have been developed, and a revised version of the National HMIS which includes MC indicators is being rolled out.
Zikomo!
Thank-you!