JOINT PEPFAR-WHO MEETING ON ACCELERATING THE SCALE-UP OF VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) FOR HIV PREVENTION IN EAST AND SOUTHERN AFRICA
25-28 SEPTEMBER 2012

VMMC Implementation strategies, successes and challenges: Malawi

Presenter: Amon Nkhata
(National STI/VMMC officer)
Presentation outline

• Background
• Implementation approach
• Key interventions and processes
• Successes & Challenges
• Recommendations
Background

- Population: 14.1 million

- National HIV prevalence: 10.6% (urban 17.4%) and rural 8.9%.

- 21% circumcised male population MC situation analysis 2010.

- Prevalence is highest in Southern Region at 14.5% against 7.6% for Central and 6.6% for Northern region

- National VMMC target: 2.1 million over 5yrs
MC by HIV Prev. by Region

North
- HIV Prevalence: 6.6%
- MC Prevalence: 5.0%

Centre
- HIV Prevalence: 7.6%
- MC Prevalence: 12.2%

South
- HIV Prevalence: 14.5%
- MC Prevalence: 33.0%
HIV Prevalence by Region

Northern
6.6%

Central
7.6%

Southern
14.5%

Proportion of HIV positive men and women aged 15-49
Implementation approach

• Phased approach
  – Started with 9 pilot districts out of 28 with 2 model sites
  – Task shifting (Nurses & Clinicians)
  – Districts prioritised for saturation, based on impact assessment study
  – VMMC social mobilization campaigns
  – Efficiency models
Other Considerations

- HIV and MC prevalence in the area
- Expected demand for medical MC services
- Facility type/level
- Existing infrastructure and equipment
- Availability of skilled human resources
- Adequacy of emergency services in case of severe adverse events
- Level of interest of the concerned managers and service providers, etc.
Key interventions/processes

• Accreditation of District Hospitals and Community Rural Hospitals
• All sites utilized MOVE principles;
  – disposable kits used at outreach sites and reusable kits at hospitals (courtesy of BLM).
  – Diathermy utilization
• Provision of VMMC based on minimum package
Key interventions/processes cont’d

• Community Mobilization led by Health Education Unit (HEU), PSI and BRIDGE II. Additional demand creation activities in week 2 by Jhpiego
  – Drama Groups and HEU band (led by HEU)
  – Open days and video van shows (led by PSI)
  – Mobile video van shows (led by BRIDGE II)
  – Extended IPC outreach at village level; school talks (Jhpiego)
Results

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td># MCs</td>
<td>4236</td>
</tr>
<tr>
<td># HIV tested</td>
<td>4219</td>
</tr>
<tr>
<td># 48 hours post-op</td>
<td>2726</td>
</tr>
<tr>
<td># 7 days post-op</td>
<td>1385</td>
</tr>
<tr>
<td># HIV+</td>
<td>99</td>
</tr>
<tr>
<td># AEs</td>
<td>21</td>
</tr>
</tbody>
</table>

- 99.6% passed
- 64.4% passed (48 hours post-op)
- 32.7% passed (7 days post-op)
- 2.3% failed (48 hours post-op)
- 0.5% failed (7 days post-op)
Results by week

Demand Creation stopped
successes/lessons learnt

• MOVE principles fully embraced by week 2 of campaign
  – Surgical efficiencies mastered
  – Immediate recognition that HTC/screening can be the biggest bottleneck to client flow; team readjusted and began client intake earlier.

• Daily site debriefings, review of results, and adjustments for next day made
Successes cont’d

- Although slow to start, effective communication at community level
  - Hard to reach areas learning about VMMC for the first time; demand for services grew resulting in decision to open a outreach site

- Although target not reached, lessons learned are invaluable
Challenges

• Short time for MCHIP to plan the campaign (4 months)

• Lengthy lead time for procurement of supplies (at least a 6 months)
  – 90% of essential supplies/equipment procured outside Malawi

• Need to transport clients to sites
  – Trucks were hired to transport clients on high volume days, however logistics and liability were major concerns
  – Some clients were unhappy due to long waiting times with no provision for lunch.
Most of the respondents to the services were youth almost 98%

No campaign exit strategy

Although good partnership between communication partners established, activities not centrally coordinated
  - Confusion over partner coverage
  - Communication not ideal
Recommendations (1)

• Focus on outreach/mobile sites that are closer to the community to achieve higher impact

• Conduct HTC and booking of clients at community level up to 1-2 weeks in advance to reduce bottlenecks at facility

• Make provision to rapidly shift from one site to another based on demand
• If unable to have mobile sites, consider transporting clients to sites, however:
  – Consider other logistics carefully
    • Lunch to all clients?
    • Provision of transport late at night?
    • keeping clients overnight (Day can end ~8pm)?
• If mobile sites is an option, consider how to manage 48hr and 7 day post op clients
• Demand creation activities should be led by one partner to ensure accountability
• All partners involved in communication should participate in daily team debriefs and weekly management debriefs with DHMT
• Small teams of IPC extension workers have most impact and should start at least 2 weeks prior to campaign
• Inter-space large events (open days, band, drama)
• A deliberate effort should be made to accommodate needs of adults

• An exit strategy should be drawn for campaigns to mop up laggards and allow enough time for follow up to six weeks
Acknowledgements

• National AIDS commission,
• Ministry of Local government and Rural Development
• Pilot and Model sites (Dedza & Mulanje DHOs)
• WHO (Country office Malawi)
• USAID
• MCHIP Jhipeigo
• Banja Lamtsogolo (Marie Stoppes Intl.)
• Bridge II Project
• PSI
I THANK YOU FOR YOUR ATTENTION