Leadership and Advocacy for VMMC services scale up

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Vision

- VMMC contributes to ensuring an HIV free generation in Lesotho
- It is part of revitalizing HIV prevention in Lesotho
- VMMC should not be seen are not a standalone program but fit into all combination prevention activities

Approach

- VMMC services to be fully integrated in routine hospital services
- VMMC free of charge
- VMMC offered as a package of services (HTC, STI, condom, health education)
- VMMC as a entry point for male SRH clinics

Background

- Pop: 1.8 M
- HIV prevalence: 23 %
- MC prevalence (Sit. Analysis):
  - 10-15%: medical
  - ~30%: traditional
- Program implemented by MOH through DCD
- Partners: USAID; UN agencies; US-DOD; MCHIP/Jhpiego, PSI

Background

- Program is health facility based and VMMC services are gradually integrated into hospital services
- 2 days for MC clinic per week per facility
- MOH and USAID share cost for equipment, supplies and pharmaceutical
- Data reported through DCD in MOH

Leadership and Advocacy for VMMC services in Lesotho

Background

- Lesotho has a culture of traditional initiation that includes element of MC called *"Lebollo"*
- Lesotho embarked very early in supporting UNAIDS, WHO and PEPFAR effort to scale up VMMC in East and Southern Africa:
  - Participation to early development of regional strategy
  - Participation to the development of manual for MC under local anesthesia

Where are we coming from?

- In 2005-2007: training of initial providers and program managers
- 2008:
  - MC Task Force set up that included traditional sector (through Min of Culture): prepare country for scale up
  - MC situation analysis conducted

Where are we coming from?

- 2008: key documents drafted:
  - Policy drafted that recognizes the role of traditional sector
  - Strategy and operational plan drafted
- 2009: facility assessment conducted in 9 facilities

Challenges

- High volume VMMC considered as cultural violation with risk to destroy Basotho culture (also loss of profit as traditional initiation is paid for): Strong opposition from traditional initiators

- Some reluctant official in MOH (data from DHS 2009)

- Some clinicians not very supportive of high volume MC (MC is an OT procedure)

What was done (traditional initiators)

Identify key stakeholders
(Religious, Local Chiefs)

Engage with key stakeholders

- Discuss openly on MC
- Identify controversial issues
- Agree on potential solutions and way forward

What was done (traditional initiators)

- Local chiefs (custodian of Basotho culture) engaged with traditional initiators and discussed on benefits of MC
- Agreement on key principles:
  - Health facility based model provision
  - Use of Sesotho word “removal of foreskin”

What was done (traditional initiators)

- Agreement on key principles (continued):
  - No mass media and large scale communication: not only high demand but also risk of antagonism with traditional initiators
  - More important: permanent consultation with chiefs and religious

What was done (clinicians and MOH)

- Active leadership from high level in the country
- Engage with clinical services and ensure that requirements for safety are in place
- Discuss evidence (DHS 2009): *"prior status of HIV was not known"*

Key accomplishments (since Feb. 2012)

- High demand for services
- 5 sites (including military hospital)
- MC done (Mar. 12 to mid Sept. 12): **6000** with more than **80%** of clients between 15- 24
- High HIV test uptake: **97%**
- HIV prevalence among MC clients: **3.6%**
- AEs rate: **2%**

What does this mean for Lesotho?

- 80% aged 15-24 get circumcised before higher risk of HIV infection
- DHS 2009: age group 15-19: 2.9% HIV positive; 20-24 (5.9%); 25-29 (18%); 30-34 (40%); 35-39 (35%)
- MC reduces risk before entering into high risk age group

"Success"

- Demand remains high
- MC target in the "100 days" of the new government
- Continuous engagement with various stakeholders (their active support for MC is important)
- Rapid VMMC services scale up (from 0 sites to 6 sites; from 0 MC done to 6000)

Challenges

- Challenging issues that require continuous strong advocacy:
  - Task shifting: Lesotho Nursing Council, Lesotho Nursing Association, Lesotho Medical Council
  - HR: need for doctors
  - Additional resources for VMMC scale up
- Advocacy should keep the guard for potential negative events that may affect program at nascent stage

Moving forward

- Consolidate and build on early success
- Integration of quality MC services in all hospitals (with outreach to health centers as per need)
- Ensure appropriate coordination (health sector, military, associations…)
- Introduce carefully Early Infant Male Circumcision

Adverting new HIV infections through a strong partnership for VMMC scale up