VMMC LANDSCAPE IN EASTERN AND SOUTHERN AFRICA: PAST, PRESENT, FUTURE

PRESENTED BY ZEBEDEE MWANDI, USAID
PRESENTATION OVERVIEW

• Where did we come from?
  – Evidence to action

• What progress have we made?
  – Progress toward targets and impact
  – Challenges along the way
  – Lessons learned

• Where are we going?
WHERE DID WE COME FROM?
SCIENTIFIC EVIDENCE

• Biological plausibility: Inner surface of the foreskin highly vulnerable to HIV infection [1]

• Over 50 ecological and observational studies: lack of male circumcision associated with higher HIV in men [2]

• Three RCTs in Kenya, Uganda, South Africa: 60% protection [3,4,5]

• Longer-term (4–5 years) follow-up of the Kenya and Uganda RCT participants: protective effect sustained/increased [6]

• Community-level impact evaluation in South Africa (Orange Farm) demonstrated 76% incidence reduction [7]
MODELING FOR DECISION MAKING

• In 2011, the DMPPT was used to model the impact and cost of VMMC scale-up in 14 high-priority countries in Eastern and Southern Africa with high HIV incidence and low male circumcision (MC) coverage.

• The model estimated that 20.3 million circumcisions would be required to increase circumcision prevalence from 2011 baseline levels to 80% by the end of 2015 in men ages 15–49 years.

• The model predicted that if 80% male circumcision prevalence was then maintained through 2025 (requiring an additional 8.4 million circumcisions over 10 years), a total of 3.36 million HIV infections would be averted over the period 2011–2025.
Neither the elegance of the science nor the strength of the effect predict the ease of implementation

1. PEPFAR-UNAIDS Publications in PLoS Medicine: Signpost the way forward to accelerate the scaling up of VMMC service delivery safely and efficiently to reap individual- and population-level benefits

2. PEPFAR-WHO-UNAIDS-BMGF-World Bank collaboration to launch the WHO-UNAIDS Joint Strategic Action Framework for Acceleration of the Scale-Up of VMMC

3. Purpose of the Framework is to guide key stakeholders to collaborate and cooperate towards common goals: country ownership, expanded coverage, and contribute to getting to '0' infections

www.ploscollections.org/VMMC2011
WHAT PROGRESS HAVE WE MADE?
INCREASE IN NUMBERS OF VMMCs

• The total number of VMMCs performed annually in the 14 priority countries:
  – 2008: 21,000 (programs in only 5 countries)
  – 2012: 1.71 million (programs started in all countries)
  – 2013: 2.66 million
  – 2014: 3.24 million
  – Cumulative total of 9.1 million by end 2014

• The greatest cumulative numbers of VMMCs were performed in Uganda (2.15 million), South Africa (1.86 million), and Tanzania (1.23 million)

• Greatest increase in the number of VMMCs performed occurred in 2013
ANNOUNCEMENT AT ICASA: 10 MILLION MALES CIRCUMCISED

December 2015, Harare
WIDE VARIATION IN PROGRESS AT COUNTRY LEVEL

- Botswana
- Kenya
- Lesotho
- Malawi
- Mozambique
- Namibia
- Rwanda
- South Africa
- Swaziland
- Tanzania
- Uganda
- Zambia
- Zimbabwe

VMMCs through 2014
Target
### MC PREVALENCE BEFORE START OF VMMC PROGRAM (“BASE”) AND MODELED ESTIMATES OF COVERAGE BY THE START OF 2015

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Source: Base from DHS and AIS surveys; coverage from DMPPT 2.1 modeling, Project SOAR
CHALLENGES ALONG THE WAY

• The goals set out in the Joint Strategic Action Framework are highly ambitious (20 million men over 5-year period)
• The decision to circumcise involves deep-seated values and beliefs which vary with cultural identity
• Human resource constraints hinder service capacity
• More difficult to attract males 19+
• Timely matching of supply to demand
• Seasonal preferences for VMMC in some countries
MEETING THE CHALLENGES OF SCALE-UP: LESSONS LEARNED

• Focus on programmatic efficiencies
• Systematically define site capacity and identify underutilization to ensure resources aren’t wasted
• Prioritize sub-populations (by age, geography) to maximize impact
• Partner with private providers to open a significant and not well used number of new VMMC sites and attract older clients
• Proper forecasting and supply planning and pooled procurement will drive commodity prices lower and reduce lead times
• Ongoing support for novel techniques that may alleviate supply and demand side constraints, e.g., devices, HIV self-testing, support for task shifting & task sharing, novel demand creation approaches
LESSONS LEARNED, CONTINUED

• Implementation of Continuous Quality Improvement (CQI) within VMMC services in over 200 sites in 4 countries reveal improvements in:
  – Client safety
  – Infection prevention and control
  – Strengthened country leadership
  – Reduction in client morbidity

• Addressing openly and up front the barriers to uptake, such as fear of pain and concerns about the healing period can help move men from hesitancy to action
WHERE ARE WE GOING?
PEPFAR HIV PREVENTION TARGETS ANNOUNCED
AT UN GENERAL ASSEMBLY, SEPT. 2015

• By the end of 2016, PEPFAR will provide 11 million voluntary medical male circumcisions for HIV prevention, cumulatively.

• By the end of 2017, PEPFAR will provide 13 million voluntary medical male circumcisions for HIV prevention, cumulatively.
PEPFAR TECHNICAL CONSIDERATIONS

• Countries should prioritize age group 15-29 years old (10-29 for Tanzania and 15-34 for South Africa)

• The focus should be to saturate and reach 80% among this age group in a short period of time

• Once a district or province has reached 60% among the 15-29 year age group, the prioritization of 10-14 year olds can progressively increase

• VMMC services should not be denied to any medically eligible men
In some countries, progress has been uneven: certain age groups and districts are reaching saturation before others. Based on the initial targets, these regions will need to start planning for sustainability sooner than originally thought.

Tanzania is an example of this: Iringa and Njombe regions are close to saturation among males 15–24. Now planning for sustainability.
WHAT DOES VMMC SUSTAINABILITY ENTAIL?

• Sustainability of a VMMC program = When local stakeholders maintain high circumcision prevalence after the initial scale-up is reached.

• Generally occurs by incorporating into routine newborn and adolescent service delivery systems:
  – Early infant male circumcision (EIMC)
  – Early adolescent voluntary medical male circumcision (EAVMMC)
  – Or both
EARLY INFANT MALE CIRCUMCISION (EIMC)

Advantages of EIMC:

✓ No sutures (less bleeding)
✓ Reduced costs
✓ Quicker healing
✓ Lower complication rates
✓ Done long before becoming sexually active

Tanzania, Kenya, Lesotho, Botswana, Swaziland, Zimbabwe have introduced EIMC
WHAT ABOUT DEVICES?

Advantages of devices:
✓ Don’t require highly skilled provider
✓ Procedure time is less
✓ Clients can resume normal routine sooner
✓ Don’t require injection of anesthesia or sutures

Questions that remain:
▪ Are they stimulating incremental demand?
▪ Can costs be brought down?
LESSONS LEARNED FROM TRANSITIONS IN OTHER HEALTH PROGRAMS

• Early planning is critical to successful transitions

• Technical and managerial support is often needed to build domestic capacity and ensure the institutionalization of support mechanisms

• A systematic, phased approach to transition planning allows for course corrections and helps ensure that critical elements are considered

• Post-transitional support is important to ensure quality as well as to assess transition effectiveness

• Sustaining the status quo is not a requisite; transition could also involve moving to more efficient and effective service delivery modalities and better targeting
REFERENCES


