Chat Room Discussion
VMMC and Sustainability PEPFAR Webinar
July 9, 2015

Liz Gold: Good morning, All

lisa Mulenga: Morning everyone!

Belinda Awiti: Hi every one

Lani Marquez: Are the coverage figures total population coverage or target coverage?

Tigi: Lani, I believe this is target coverage

Hawa Mziray: Hi everyone

Abebe Shume: It is better to re-check the data that 70% 10-14y coverage of Ethiopia

Katharine Kripke: the coverage figures are estimated coverage by the end of 2015

Katharine Kripke: based on PEPFAR 2015 targets, adjusting for non-PEPFAR circs

Katharine Kripke: so non-PEPFAR circs are included

Kelly Curran, Jhpiego and AIDSFree: Katharine, can you explain the numbers that are over 100%?

Kelly Curran, Jhpiego and AIDSFree: Was the original target too low/based on an underestimate of the population?

Katharine Kripke: probably the client ages in the program data were not correct

Katharine Kripke: that is what we heard from the implementers that we consulted with

samuelsonj: It may be that the denominator is based on the original numbers to achieve 80% coverage

Katharine Kripke: the denominator is based on the population size estimate from Spectrum

Kelly Curran, Jhpiego and AIDSFree: Looking at these data that Emmanuel presented I am so proud of what everyone has achieved as a VMMC community. Even countries whose overall scale-up has been challenging have great coverage in adolescents. I can't wait to see the incidence reductions as a result of all this hard work.

Omega: I would like to find out if the slides will be shared

Elizabeth Mallalieu: Yes, all slides will be shared after the webinar on the HC3 website. www.healthcommcapacity.org

Omega:Thank you

eugene rugwizangoga: Demand among 10-14 is high but priority is for group age 15 yrs and above

Guest: Thank you for sharing the website for the presentation Elizabeth

Elizabeth Mallalieu: Can the viewing parties that are logged in please let us know how many people you have watching? Thank you

Scott: Is sustainability realistic give the impact of structural adjustments on the ability of health systems and ministries to develop capacity?

karin hatzold 2: PSI Zimbabwe and partners 10 participants

Felisberto Massingue: JHUCCP and JHPiego Mozambique. Hearing Sound in good condition. Total 6 participants

Abebe Shume: Ethiopia 3 participants

Guest: JHPiego Kenya homabay 5 participants

Cornel: Jhpiego Kenya Busia County a single participant but determined to continue

Martin Mtika: 3 participants for Malawi.

Khumbulani Moyo: Right to Care South Africa is represented

Omega: Zambia single participant

Simba Mabaya: itech zimbabwe 2 participants

Tiruneh Z.Mengesha: Tirngo Fantahun from Ethiopia is also participating

newayg@gmail.com: Pretoria/RHAP 1 participant

Scott: Scott Barnhart- I-TECH / ZAZIC.

Amon Marwiro: Jhpiego Botswana 2 participants and expecting more to join

Martin: Question: Is there any pattern of transitioning between governance, service delivery and or financing transition???

Tigi: I think this 'macro' level framework and processes is good and almost intuitive. While all variables are important some variables are obviously more important than others. Can you go a bit granular and help VMMC prioritize what to focus on?

Belinda Awiti: Jhpiego Kenya one participant from MOH has joined

Geoffrey Menego: Evening/Morning everyone. We are 5 participants from Kenya. We are listening from Turkana County Northern region of Kenya while on an EQA exercise: Geoffrey Menego-Jhpiego, Mathews Onyango- Consultant NASCOP, George Otieno- NRHS, Stephen Odima-IMPACT RDO, Mr Kirui IMPACT RDO.

Jason Reed: Thank you for the presentation, Marelize. In the examples of GAVI and USAID (or in your opinion), is the transition process led from within Ministries or are there key external organizations that help facilitate/coordinate the process?

Martin: Question: For programs which have been transitioned when at saturation, what does the presenter advise such programs to handle the abruptness??

Khumbulani Moyo: What is an assistant medical officer?

Abebe Shume: How about the attrition?

Abebe Shume: Sorry, attrition of trained staff

Alice Christensen: For the slide on the human resources requirement assume that drs are cross trained in EIMC and VMMC.

Marelize: Answer to the question from Jason Reed: Whilst I have not been involved in GAVI or the USAID family planning transition approaches implementation, my understanding from speaking with stakeholders who have been, is that GAVI sets the percentages for gradual scale-down of funding over a 5-year period, and this is communicated to countries upfront. How countries then respond to the reduction in funding, is the countries' decision (they have to present transition plans to GAVI). Technical assistance for this is available. So, it is a partnership between the countries and the funders.

Marelize: Funders provide support for transition planning -- as the Global Fund will do too (transition planning committees have been set up in some cases, such as in Macedonia, for example).

samuelsonj: Is the assumption that all nurses available would be trained?

Katharine Kripke: @samsonj: I believe she is looking at the number of currently trained doctors and nurses

Jason Reed: Thank you, Marelize. So, it was the initial donor that articulated the financial transition plan. This is further complicated with PEPFAR, given the recent push to "transition" even adult services in some areas without notice.

karin hatzold 2:Why would we include anesthetists?

Kelly Curran, Jhpiego and AIDSFree: One question I have about the transition to sustainability concerns management of SAEs. While severe adverse events are rare they can be very costly to

manage if the client/patient needs to be hospitalized or needs follow up surgery. Are these costs being taken into account in some way? We need to ensure that clients who experience an SAE are able to afford care.

samuelsonj: Is there a way to account for different service delivery models in the different scenarios?

karin hatzold 2:Note also that for the data from our study in Zimbabwe commodities costs were based on a specific device the accucirc device

Hawa Mziray: Was the modality of implementation for EIMC and VMMC similar? E.g. standalone program over integration program

Jason Reed: Given sustainability is a speculative endeavor (for most countries still), think we could also look at purely nurse-based models, i.e. optimized device-based models that largely won't require doctors or surgical theaters.

Martin: Totally in agreement with Jason Reed's concern, its a push to "transition". How is governance transition brought in here given the fact that it is more a push to execute service delivery transition?

eugene rugwizangoga: Thanks kelly to raise issue of SAE cost

Katharine Kripke: please keep in mind that what Rachel is presenting is a very preliminary analysis. It would be good to do a more in-depth analysis, looking for example at different implementation models, as suggested by samulsonj. She really had very limited data to work with to prepare for this presentation.

Rajab with Lesotho viewing party: Jhpeigo Lesotho viewing party, 10 participants with 1 colleague from MOH.

Tiruneh Z.Mengesha: Staff turn over problem is among the challenges to sustain the program in Ethiopia

Valerian Kiggundu: It has been demonstrated that governments allow less than 10% of the National budget for Health. Can National governments really match the level of funding and sometimes coordination?

Dan: Is there significant public bias against the public sector health system; that is, do people widely assume the private sector is much better? If so, what messaging can we develop to change this perception?

Martin: Does the Namibian private sector have sufficient HR to make this big push? I think in many SSA countries, the private sector has an HRH challenge.

Geoffrey Menego: How do you maintain quality in the private sector and is there mechanisms to ensure VMMC is provided as a package of services as recommended?

Valerian Kiggundu: In many countries, PEPFAR funds are used indirectly to fund other services such as laboratory that generally handle requests beyond HIV Care and treatment. Has transition or sustainability plans put these into consideration?

Peter Wanga: human resource is always the concern in private sector

Laurie Krieger: With targets, is that using all the male population, even in countries with significant numbers of members of ethnic or religious groups that have always circumcised or are programs assuming that all religious and ethnic groups should use medical providers?

Abebe Shume: In most all private sectors do not implement the minimum package

Martin: There is usually high turn over of human resources in private sector. How has Namibia handled this issue?

Charles Ndinya: The private sector may not also be willing to offer VMMC services free of charge!

Geoffrey Menego: How about demand creation costs. Do we include this when analyzing costs?

Lani Marquez: We heard in the VMMC CQI webinar on Tuesday from Dr. Shephard Maphisa, private provider in Johannesburg, how investing in CQI has helped to stimulate demand for other services, contributing to his practice's profitability

karin hatzold 3: How do we ensure entire package of VMMC in the private sector especially the very labor and time consuming counseling part?

Marelize: Response to Martin's question about transition planning: "For programs which have been transitioned when at saturation, what does the presenter advise such programs to handle the abruptness??" This is indeed a challenge, as transition planning has not been considered early on in all contexts and some programs can abruptly transition. The diagnostic tool that we have developed, helps countries to prioritize which transition issues are 'mission critical' ones that need to be accommodated first. I think the key is to agree that transitions need to be planned systematically, irrespective of the timing of transition. Early and systematic planning, and gradual handover – where possible -- has shown to work well to not disrupt service provision.

Martin: Charles, at the beginning of her presentation she alluded to Namibia having a government insurance as the largest player...

Marelize: On the question of accommodating the costs of SAEs, I think that we would all agree that these costs and the service delivery links, referrals and mechanisms need to be incorporated into transition planning.

eugene rugwizangoga: This presentation will help us to advocate for MC coverage by insurance industry in Rwanda

Charles Ndinya: Could this be supported or replicated in Kenya?

Amon Marwiro:How much is paid by medical insurance for MC in Namibia?

Moses Mera -EGPAF: What measures were put in places to retain trained human resources? Since most private health facilities in Uganda have challenges in retaining their Health workers

Tadele Bogale: Missed most of the presentation of the last presenter on private sector: how to ensure the provision of the comprehensive package will be an issue

Abebe Shume: In Ethiopia, without starting EIMC & under 15 y, how can we ensure sustainability?

Amarachi Obinna-Nnadi: One participant from Nigeria

Martin: I mean, which one comes first????

Katharine Kripke: @Laurie Krieger - the targets and coverage estimates assume that the traditional circumcisions and other circumcisions that were happening outside the VMMC program continue at the same rate, so the VMMC program is additive to the background rate of circumcision. For some countries, the background rate is adjusted to account for incomplete traditional circumcisions, where data are available.

Martin: or is there any order in which they come??

Martin: Thanks your response suffices

nelsiwe cindzi: What is pepfar's commitment towards funding and supporting EIMC given the recent focus on the older age groups?

Marelize: @ Valerian Kiggundu: Question: “In many countries, PEPFAR funds are used indirectly to fund other services such as laboratory that generally handle requests beyond HIV Care and treatment. Has transition or sustainability plans put these into consideration?” Answer: Whereas we have not been involved in these transition planning efforts, it would be important that VMMC transition planning efforts should be seen in the broader context of HIV response and health system sustainability and transition planning and that these broader investments should be considered in such planning efforts.

Marelize: On the question of accommodating the costs of SAEs, I think that we would all agree that these costs and the service delivery links, referrals and mechanisms need to be incorporated into transition planning. Funding for SAEs is important, but service delivery links are essential too.

Laurie Krieger: Thank you, Katherine.

Belinda Awiti: Despite government having the largest insurance people still prefer private insurance providers in Namibia this is an opportunity for Namibia to scale up VMMC services

Amon Marwiro: 6 participants from Jhpiego Botswana found the presentation interesting

Martin: Yes that response answers the HR question Dawn.

Liz Gold: I think there were a few questions, Dawn, about how you can ensure quality and the minimum package with private providers

Jason Reed: Emmanuel, can you describe the role of CQI with the private provider strategy in Namibia?

Sheila Kyobutungi: How do we restructure a VMMC program that was not initially set up with "sustainability" in mind to focus on sustainability when it's already in the scale up phase. For Uganda VMMC was introduced almost as a parallel program to the existing Government Health Programs with PEPFAR funding over 98% of the country's VMMC program.

Tadele Bogale: Please move the microphone a bit away

Emmanuel Njeuhmeli: Lani: could you please describe the role of CQI to support private providers in Namibia and please provide details of the lessons learned from support private clinics in South Africa

Martin: Sheila points to a challenge being experienced in Uganda, where a vertical program is now being steered to transition. How can governance transition be achieved in such a case?

Dawn Pereko: Regarding comprehensive package by private providers - we have a network and being part of the network means you receive training on the VMMC package. Part of the on-going coaching and support re-enforces the comprehensive package. In reporting, we request the providers not only to report on VMMC but on other components of the package as w

Sheila Kyobutungi: Dawn how have you insured a standard quality VMMC program in the private sector? Did you use any specific QI approaches?

Tich Mangono: The case of private financing in Namibia is quite instructive. Can we get access to the detailed business case that SHOPS made as they pitched this PPP to the insurance companies and providers?

Martin: Lija, 14.7% of health workers being trained is unique given such an achievement? which strategies beyond static services has the country employed??

Katharine Kripke: For those asking about how parallel programs can be switched to sustainability - keep in mind that the sustainability phase will not look the same as the scale-up phase. It will involved many fewer circumcisions annually, and will be focused on adolescents, infants, or both. So it is a very different kind of program.

Omega: Who supports EIMC programs since these are not supported by PEPFAR?

Emmanuel Njeuhmeli: PEPFAR do support EIMC however, EIMC is part of the second pronged approach of PEPFAR support for VMMC coming when we reach high coverage for high risk men age 15-49 years old.

I-TECH Malawi: Oliver: I have trying to connect, having problems now totally off

Emmanuel Njeuhmeli: The first pronged approach is to support catch up to reach high coverage among men 15-49 years old

Omega: Is it possible to start building up the EIMC program while transitioning out the adult program?

Abebe Shume: Emmanuel, I read a guideline that EIMC devices can't be procured using PEPFAR funding.

Sheila Kyobutungi: Emmanuel and Katharine please provide further clarification on what sustainability means for VMMC is it a combination of countries reaching saturation and country ownership and funding of the program it was a little unclear in the opening remarks....or maybe I just missed it.

Emmanuel Njeuhmeli: PEPFAR can be use to procure only devices pre-qualified by WHO

Cornel: What proportion is the 2,500 EIMCs conducted within the said period in the 2 regions? Looks interesting out put.

Katharine Kripke: @sheila your description sounds right to me

Emmanuel Njeuhmeli: Sheila, I will provide clarification during the next Q&A session

Abebe Shume: I mean devices Mogen and the likes.....that was why we were not able to train the providers on EIMC. And the current focus of PEPFAR is 15-29 years.

samuelsonj: The WHO Prequalification programme covers devices for adolescent and adults. WHO reviews only the clinical efficacy and safety data and disseminates the conclusions.

Laurie Krieger: When you refer to "mop up", as we do in immunization, how do you ensure the 'voluntary' in VMMC?

Martin: How has Kenya found this transition from being heavily donor based to engaging county governments to own it within the overall health service delivery?

Geoffrey Menego: Clarify the issue of considering boys aged 61 days to 9 years

samuelsonj: Which programmes are actively engaged from the Kenya MOH in order to integrate?

Charles Ndinya: With the problems we are experiencing with the County Health management, how sure are we in Kenya that the County governments will support sustainability of VMMC services?

Kelly Curran, Jhpiego and AIDSFree: Hi Geoffrey, I understood that they are trying to make a

provision for boys to receive VMMC as soon as they turn 10, if they and their families are interested.

Kelly Curran, Jhpiego and AIDSFree: One of the key things about the transition is that we need to help our communities understand that this service will still be available when their boys turn 10, so that they don't try to circumcise boys of the wrong age (between 2 months and 9+ years)

Dawn Pereko: Clarification on HR for private sector: With the exception of nurses, the majority of private providers in Namibia are self-employed. They own their own practices. What we referred to as consulting rooms are their own private consulting rooms. They are not employed by a private hospital. They run their won businesses. This should address the question of turn-over and retention.....and yes they would not offer VMMC for free

Geoffrey Menego: Pre service training is an excellent strategy to deal with personnel challenges.

Marelize: @ Sheila Kyobutungi: “How do we restructure a VMMC program that was not initially set up with "sustainability" in mind to focus on sustainability when it’s already in the scale up phase. For Uganda VMMC was introduced almost as a parallel program to the existing Government Health Programs with PEPFAR funding over 98% of the country’s VMMC program.” A very pertinent question and the case in many PEPFAR programmes – Malawi has been in the same boat. A detailed and government-led transition planning process is needed to diagnose which areas of the program can be transitioned to the Government over which timeframe, and to plan how, in a gradual and phased way, such institutional, service delivery and financing transitions can be made (financing transitions should be aligned to governments’ budgeting cycles). The WB’s HIV transition planning tool, or other sustainability planning / change management tools, might be useful here.

Lani Marquez: Very encouraged to hear that the VMMC training has been integrated into pre-service training in Kenya

Rosalia Rodriguez-Garcia: agreed this is an achievement as changing pre-service training is difficult.

Martin: Curriculum development gurus are one of the biggest hurdles to pre-service integration

Moses Mera -EGPAF: Thank Dawn

Tadele Bogale: Is there any country who did task analysis of potential VMMC providing health cadre at pre-service training to make the service routinely provided at health facilities?

Amon Marwiro: interesting presentations from both presenters; Lija and Benson.. Even though Botswana is not close to reaching saturation, we also have plans for sustainable VMMC services. Consultations have begun to integrate VMMC with Cervical Cancer screening services. The idea is to have offer services for both males and females so they support each other to access health services. Even though the Sustainability in VMMC Approach is about incorporating EIMC and adolescent circumcision, could this approach of other female targeted services such as Cervical cancer screening be considered?

Rachel Sanders: Responding to the question about whether the human resource analysis included adverse events: It did, where that information was available (i.e. the % of clients experiencing adverse events, and the provider time and materials required to address those events), however, this information was more available for adolescent/adult VMMC than EIMC.

Abebe Shume: Kim just said that EIMC & adolescent circumcision is critical for VMMC sustainability, but I am not quite sure why PEPFAR's current focus is shifted to 15-29?
Dan: Kim, the "ideal" showing preference for MC in childhood bodes well for sustainability. This is an excellent inclusion in your presentation.

Lani Marquez: Responding to the question about piloting and scale up of CQI, there has been a lot of experience with this in the Uganda and South Africa VMMC programs, where piloting of CQI methodology was conducted prior to scaling up on a larger scale

Amon Marwiro: Given the shift foreign funding has had on the need for government support in funding VMMC service, what has been the experience in integrating EIMC services in SRH

Lani Marquez: For further reference for experience of the private sector of CQI, an in depth discussion was held on the CQI webinar 2 days ago, by a well-known private practitioner in SA who has embraced CQI totally. The link to this discussion can be found at https://www.usaidassist.org/content/webinar-rolling-out-continuous-quality-improvement-voluntary-medical-male-circumcision

Francis Ndwiga Benson: The transition plan from donor funding is what is in the process of county level engagement initiate to support VMMC services. The National task and county member are to take lead to advocate and lobby financial support

Lawrence: CQI Model for Namibia Private sector; A baseline assessment is done looking at various indicators, gaps and site readiness for VMMC noted. Feedback and coaching provided to the sites, an agreed upon time line of bridging the gaps, follow up visit to support and review progress towards agreed targets.. The private providers are capacitated to monitor their own quality, and the private practitioners have an interest in quality improvement as they are held accountable-both legally and professionally for all their patient outcomes

Katharine Kripke: @amon Marwiro, Botswana is close to reaching saturation among 10-19 year olds, so now is the time to start planning for transition to sustainability.

Moses Mera -EGPAF: Thank you Kim

Martin: Does age specific saturation replace all ages saturation, can a country make a decision for transition based on one age????

Guest: @ isaiah Thank you Kim

Abebe Shume: Good question Martin.

Katharine Kripke: @Martin, I think the answer will depend on the country - each country will need to explore whether it is feasible to achieve saturation in the higher age groups and what it

will take. But in countries like Botswana that have achieved saturation in among adolescents, they must initiate sustainability planning immediately.

Guest: What do you mean under barriers when you talk about newborn windows?

Katharine Kripke: To continue my previous comment, I mean putting in place long-term sustainable programs at the same time as finishing the "mop up" or whatever you want to call it among the higher age groups.

Martin: Katharine, achieving saturation among 10-14 year olds surely should not be a strong basis. The starting point of this VMMC program was targeting sexually active men who were more at risk. Now such a shift may cause loss of sight of the initial purpose

Kelly Curran, Jhpiego and AIDSFree: Abebe...I think Gambella, Ethiopia needs to be considered in the same category as Kenya and Tanzania and start planning for the transition to sustainability. For countries still early on in the catch-up they should focus their PEPFAR funds on 15-29.

Cornel: Considering staff shortage and their attitude of viewing VMMC as a non-emergency health service, how is the government of Kenya responding to this even as it plans to implement the 2nd strategy

Katharine Kripke: @Martin, if you look at the experience in Tanzania, sustainability planning is something that takes time, and they have been thrust into it before they are ready. So countries that are approaching saturation do need to go ahead and start sustainability planning now, even while they are continuing to scale up VMMC among men in the higher age groups. In addition, many countries are finding that it is not possible to attract men above age 35 and in some cases above age 25, so the initial target of circumcising 80% of men ages 15-49 may not actually be feasible. It will be necessary, as I said, for countries to explore the feasibility of attracting the older men to VMMC services.

Kim Ahanda: @Guest: the newborn window barrier refers to the time or age parents/guardians cited as the ideal time to circumcise their young infant. In most contexts they preferred to do so at an age older than the recommended window of 24 hours to 60 days.

Kelly Curran, Jhpiego and AIDSFree: Martin--our colleagues in Zambia have done a great deal of work integrating VMMC into pre-service education, at least for clinical officers. I can put you in touch with them offline if you would like.

samuelsonj: Thanks to all the presenters. WHO is beginning to work on a new 'strategic action framework', your inputs from the webinar have been helpful; we will be requesting additional inputs in the near future.

Abebe Shume: Kelly, our intention this year was to include EIMC & adolescent circumcision.

Jason Reed: Thank you to all of the presenters

Jason Reed: Great webinar

Greg Smiley: Well done everyone

Dawn Pereko: Thanks Jason!

Yvette Moore: Thank you to all the presenters. This was a great presentation.

Martin: This has been a great webinar with a lot on insights for learning

Geoffrey Menego: This was great.

Abebe Shume: Thanks!

Charles Ndinya: Thanks a lot, you presenters

Marelize: Thank you to PEPFAR for the invitation -- this was very interesting!

lisa Mulenga: Thank you for the interesting presentations!

Rosalia Rodriguez-Garcia: This was very-very useful for WB work on VMMC. Many thanks.

efison: Thank you!

Lani Marquez: Thanks everyone!

Amarachi Obinna-Nnadi: Thank you

MELUSI NDHLALAMBI: Thank you all.

Francis Ndwiga Benson: Thanks very much for the opportunity.

Guest: @ Isaiah Thank you all the presenters and the organizers of this it was great

Belinda Awiti: THANK YOU ALL

Francis Ndwiga Benson: Thank you very much for the opportunity. Thank you ALL

Kelly Curran, Jhpiego and AIDSFree: Laurie Krieger--I am not sure whether anyone responded to your question about ensuring voluntarism in the "mop-up" phase but as far as we are concerned voluntarism is the V in VMMC no matter the service delivery modality. In the program that we support in Tanzania "mop-up" refers to mobile teams who are dispatched to reach men/boys in very remote areas who may not have been able to access VMMC at fixed sites or during previous campaigns. So mop-up is in a way an equity strategy, it is about reaching the last kilometer. But it is always voluntary no matter how far the mobile team has traveled.

Emmanuel Njeuhmeli: THANK YOU VERY MUCH EVERYONE