Transitioning to sustainability in Kenya – an overview

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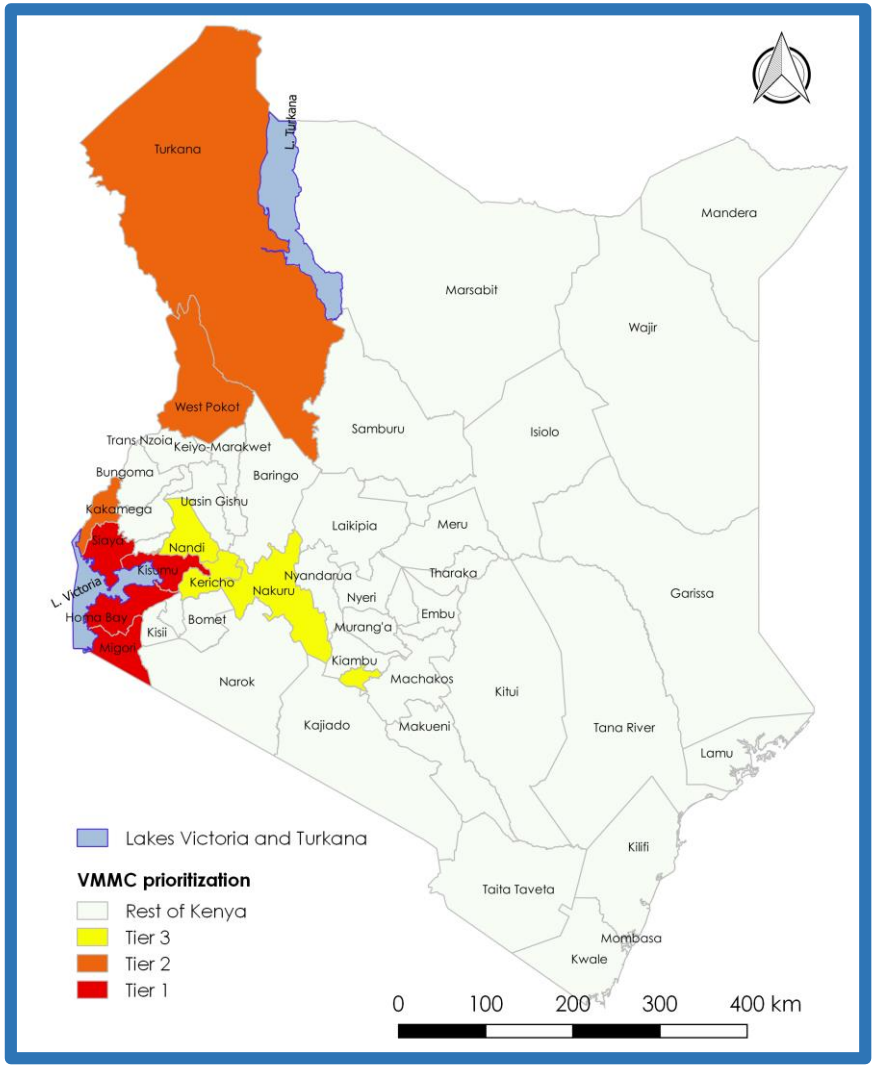
Outline

- Background
- Sustainability policy
- Program evaluation: Identifying Sustainable Service Delivery Models To Maintain Medical Male Circumcision Coverage in Western Kenya
- Key takeaways

Background

- HIV prevalence among uncircumcised males aged 15-64 years is estimated to be more than five times higher than circumcised men, at 16.9% and 3.1%, respectively.
- In 2008- 09, Kenya adopted VMMC as one of the key strategy for HIV prevention.
- 11 counties are prioritized for VMMC. These counties are traditionally non circumcising and have high HIV prevalence



Sustainability as defined by WHO key informant interviews

- The capacity of VMMC services to continue to function effectively for the foreseeable future and maintain high VMMC coverage
- VMMC services being integrated into the routine systems and services
- Strong country ownership and leadership through a co-produced approach with community participation, and sub national, national, regional and global support
- Resource mobilization, both domestic and external funding, coordinated through the government.

VMMC Program in Kenya: Phased Approach

Catch-up phase (2008–2014)

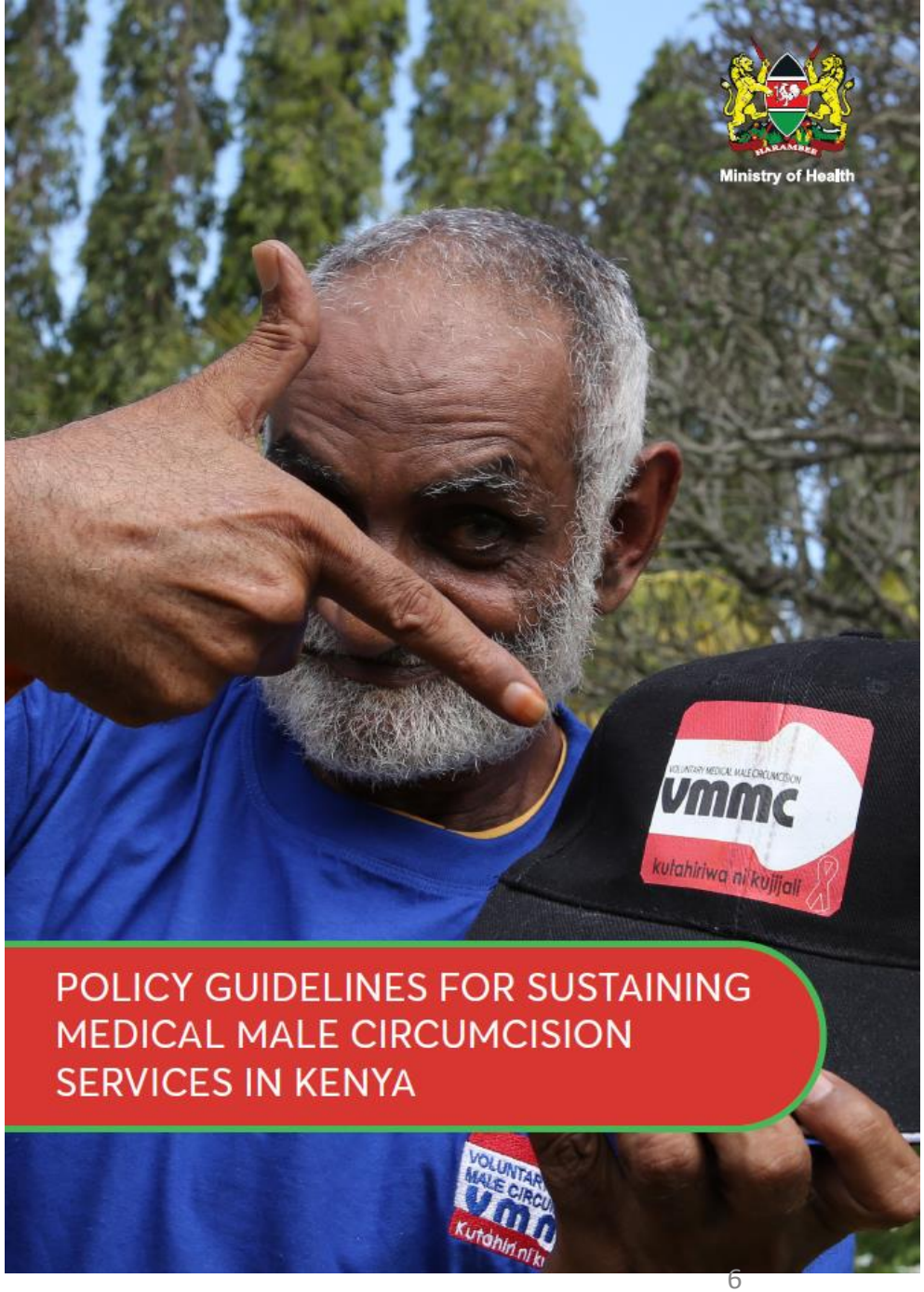
- Create an enabling environment for implementation of VMMC through community ownership and leadership
- Mobilise programme funding to scale up
- Increase demand for VMMC
- Increase uptake of VMMC
- Build government led partnership and coordination mechanism with donors and implementing partners

Integration and sustainability phase (2014–2019)

- Maintain high coverage> 80% and saturation
- Develop sustainability strategies and pilot them
- Integrate VMMC into health systems and maintain coverage
- Strengthen county leadership and ownership
- Mobilise domestic and necessary external resources to implement the agenda

Policy

- **Mission**: To facilitate provision of safe, accessible, equitable and sustainable MMC services that maintain high coverage and contribute to the reduction of new HIV infection in Kenya
- **Goal**: To sustain MMC through integration into the health system
  - Routinize MMC as part of essential health services package
  - Strengthen health work force capacity in MoH facilities
  - Integrate MMC records with the HMIS
  - Strengthen national- and county-level MMC leadership and coordination
  - Integrate supplies and equipment with the medical supply chain
  - Enhance community engagement
  - Mobilize financial support



*Awaiting approval

Identifying Sustainable Service Delivery Models To Maintain Medical Male Circumcision Coverage in Western Kenya

Year 1 Findings

Improving Quality VMMC

Evaluation partners

- NASCOP – Principal Investigator
- Migori County AIDS/STI Coordinating office – county oversight
- Siaya County AIDS/STI Coordinating office – county oversight
- University of Maryland School of Medicine, Kenya Programs – Migori service delivery
- Centre for Health Solutions, Shinda project – Siaya service delivery
- CDC – Financial and technical support
- Jhpiego – Lead evaluation; technical support

Goal

To determine if three distinct VMMC service delivery models for 10-14 year olds, designed for different geographic areas, can maintain adolescent client demand/acceptability, minimize costs and health system burden, optimize program and HIV/AIDS indicator data availability, and facilitate government ownership.

Why evaluate adolescent-focused models of service delivery?

- Kenya has been a leader in VMMC scale-up and has many areas approaching 80% coverage or higher among males 15-29 years
- Once achieved, service delivery can shift to a maintenance approach. Whether adolescents or infants or both are primarily targeted, adolescent programs (10-14) will be needed at least 10-15 years.
- Possible important differences from existing ones
  - Lower, more predictable annual volume and geographic distribution
  - Availability of venues where males are highly concentrated
- Long-term need to develop these programs in forms that are fully affordable and managed by the MoH
  - Kenya's per capita annual health expenditure, 2014: $78 (World Bank)
  - PEPFAR VMMC unit expenditure, Kenya, 2016: $49

Evaluation questions

1. Can this model deliver high-quality VMMC services that are sufficient in volume to maintain over 80% coverage among 10-14 year olds?

2. Can this model be sustainably implemented by the Government of Kenya using its own financial, human, and management/oversight resources?

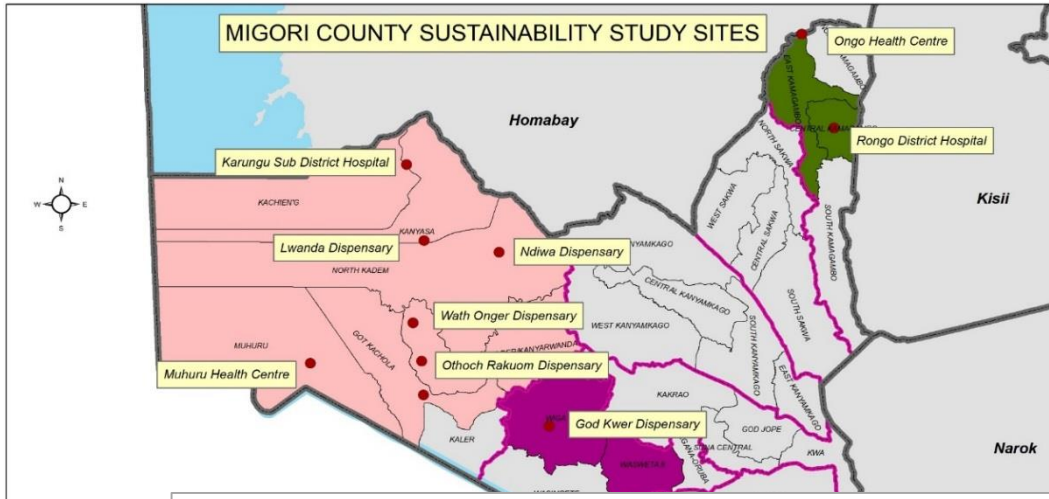
3. What are the areas of weakness that need to be improved in order to maximize the models' sustainability?

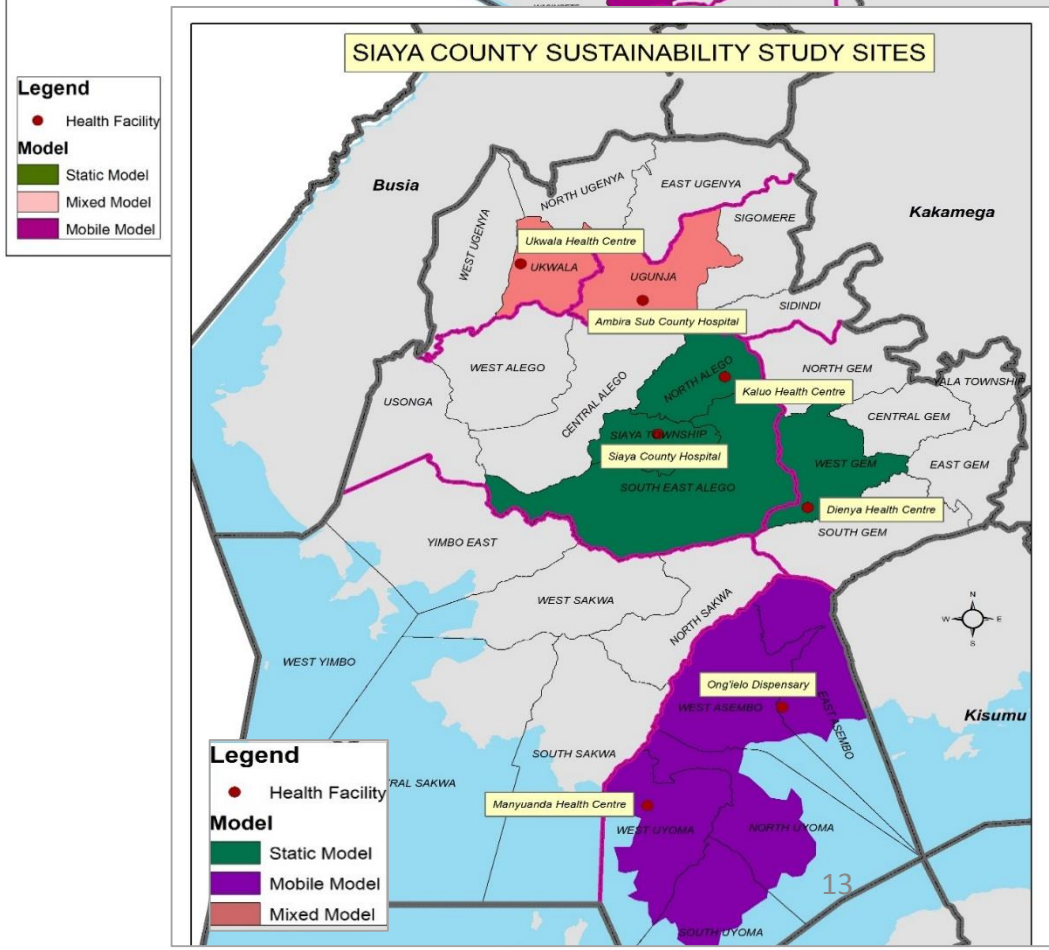
Evaluation design

1. Monthly monitoring of quantitative indicators of VMMC services
    - Number of VMMCs performed disaggregated by age
    - Number of moderate and severe adverse events
    - Number of referrals to STI clinic, HIV care and treatment
2. Serial in-depth qualitative key informant surveys mapped to PEPFAR sustainability index and dashboard (SID)
3. Quantitative assessment of annual productivity and costs (recurrent expenditure and investment spending)

Implementation models

- Static – general clinicians stationed in health facilities offer VMMC to clients who present at facility.
- Mixed – providers offer a mix of year-round static services with periodic rapid results initiative (RRI)-type demand creation and services at opportune times in the school year.
- Mobile – a single dedicated VMMC team is responsible for maintaining VMMC coverage in a large area.
- Targets were set for each model, by county

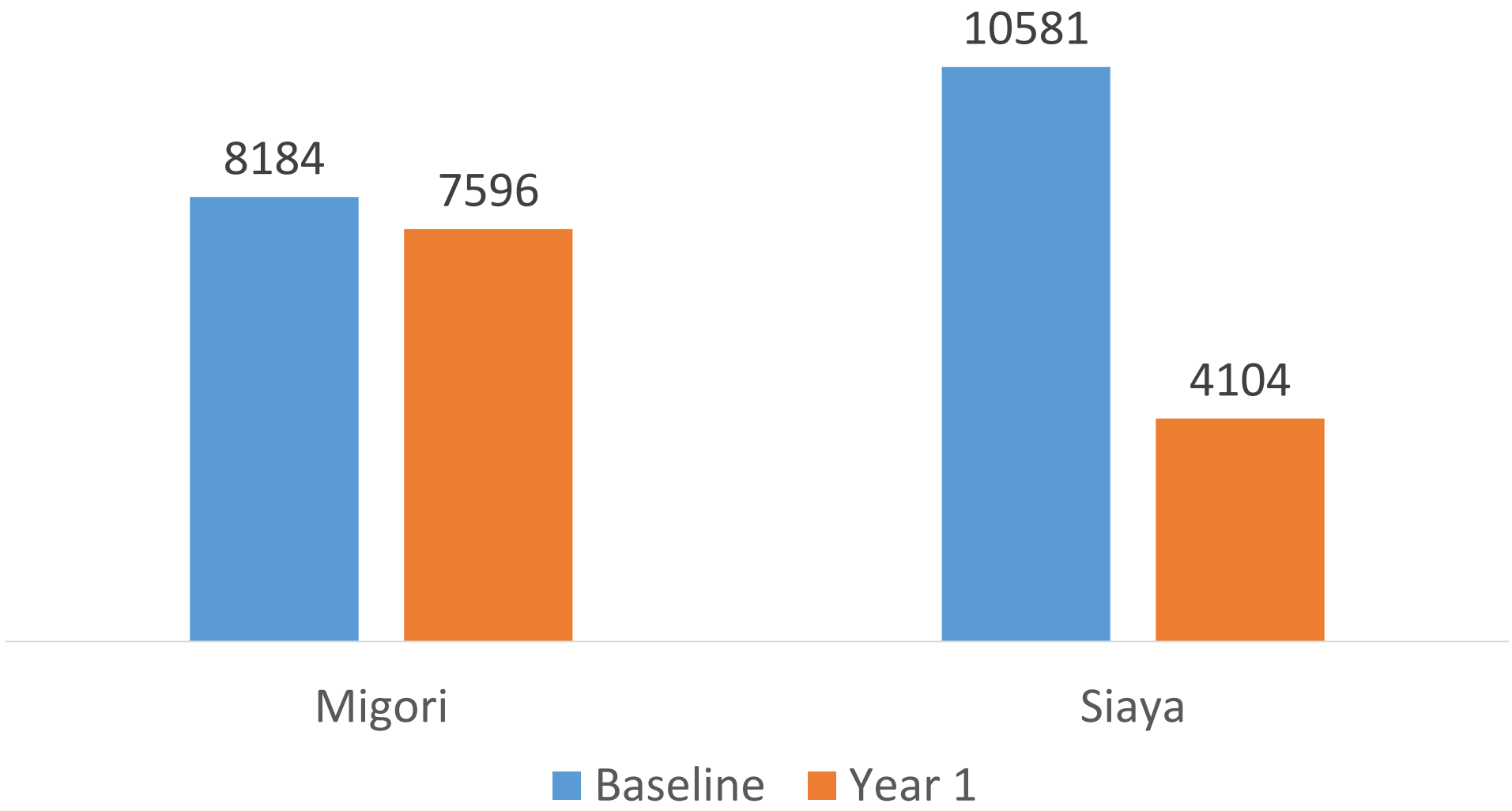




Evaluation Question 1:

Can this model deliver high-quality VMMC services that are sufficient in volume to maintain over 80% coverage among 10-14 year olds?

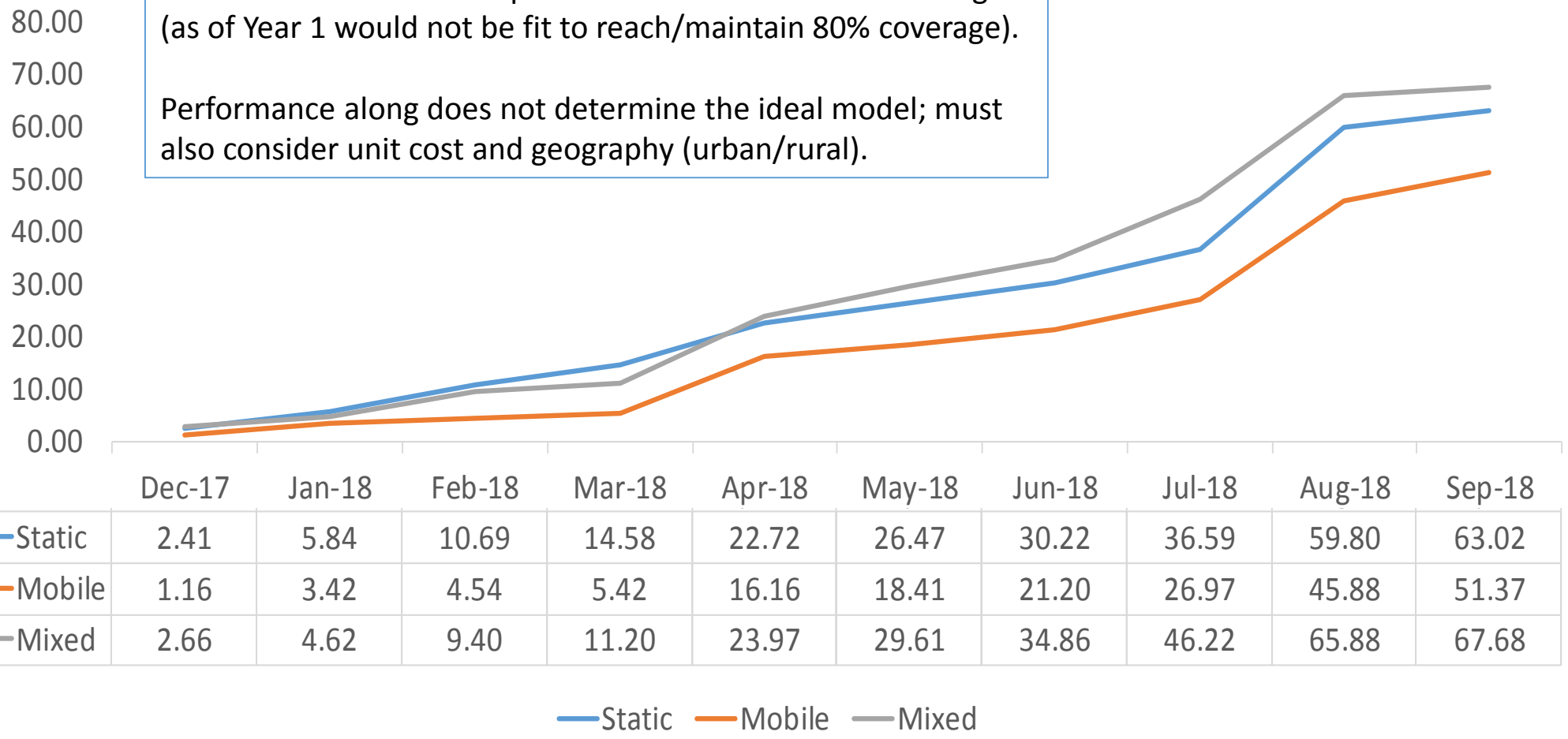
Baseline and Year 1 Cumulative VMMC Uptake



Siaya Cumulative Monthly VMMC Uptake (% of Target) Among Resident 10-14 Year Olds, by Model

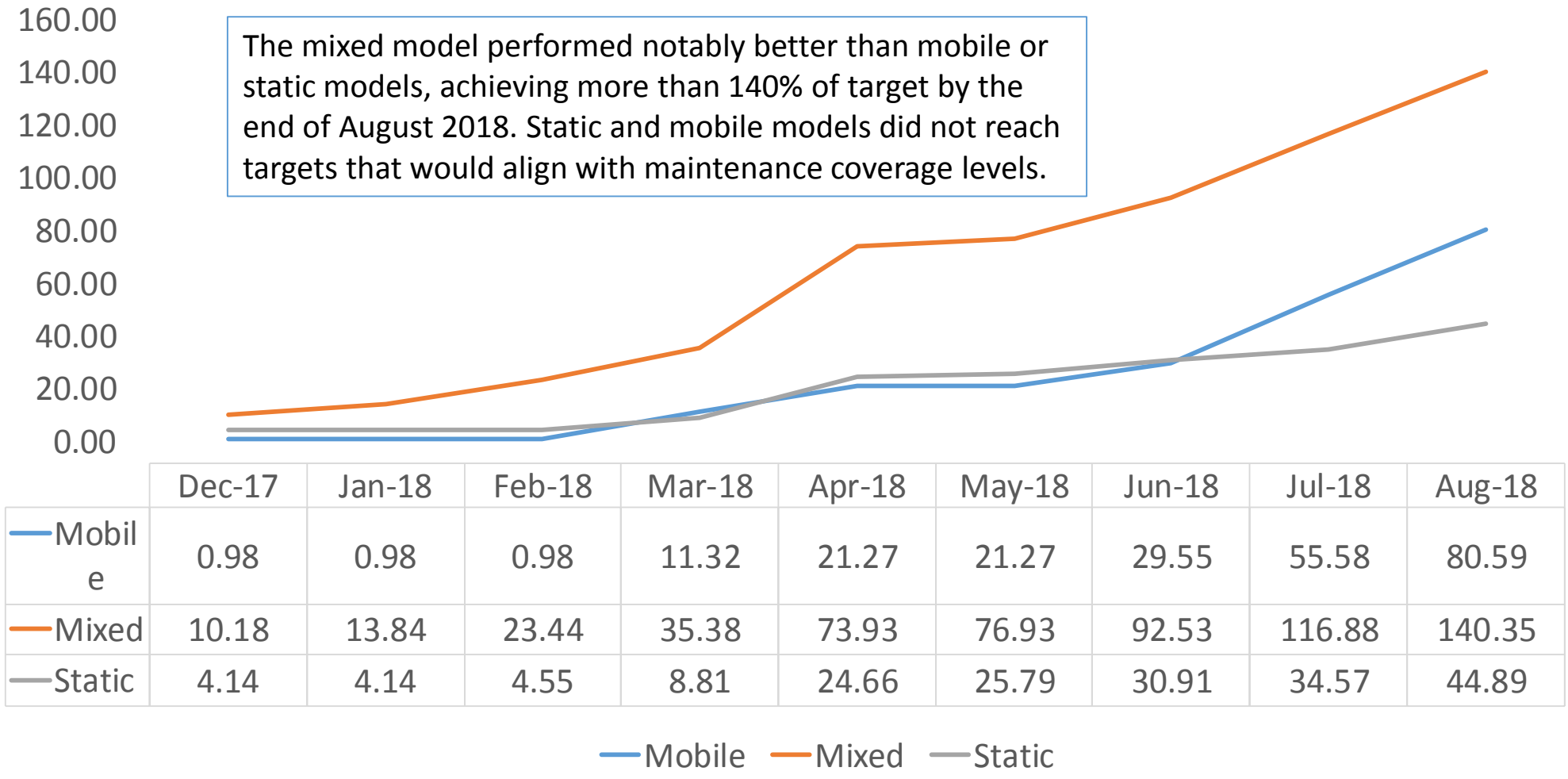
Each of the three models performed less than 80% of its target (as of Year 1 would not be fit to reach/maintain 80% coverage).

Performance along does not determine the ideal model; must also consider unit cost and geography (urban/rural).



	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Static	2.41	5.84	10.69	14.58	22.72	26.47	30.22	36.59	59.80	63.02
Mobile	1.16	3.42	4.54	5.42	16.16	18.41	21.20	26.97	45.88	51.37
Mixed	2.66	4.62	9.40	11.20	23.97	29.61	34.86	46.22	65.88	67.68

Migori Cumulative Monthly VMMC Uptake (% of Target) Among Resident 10-14 Year Olds, by Model



	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Mobile	0.98	0.98	0.98	11.32	21.27	21.27	29.55	55.58	80.59
Mixed	10.18	13.84	23.44	35.38	73.93	76.93	92.53	116.88	140.35
Static	4.14	4.14	4.55	8.81	24.66	25.79	30.91	34.57	44.89

Evaluation Question 2:

Can this model be sustainably implemented by the Government of Kenya using its own financial, human, and management/oversight resources?

Baseline recurrent expenditure responsibility by county/partner

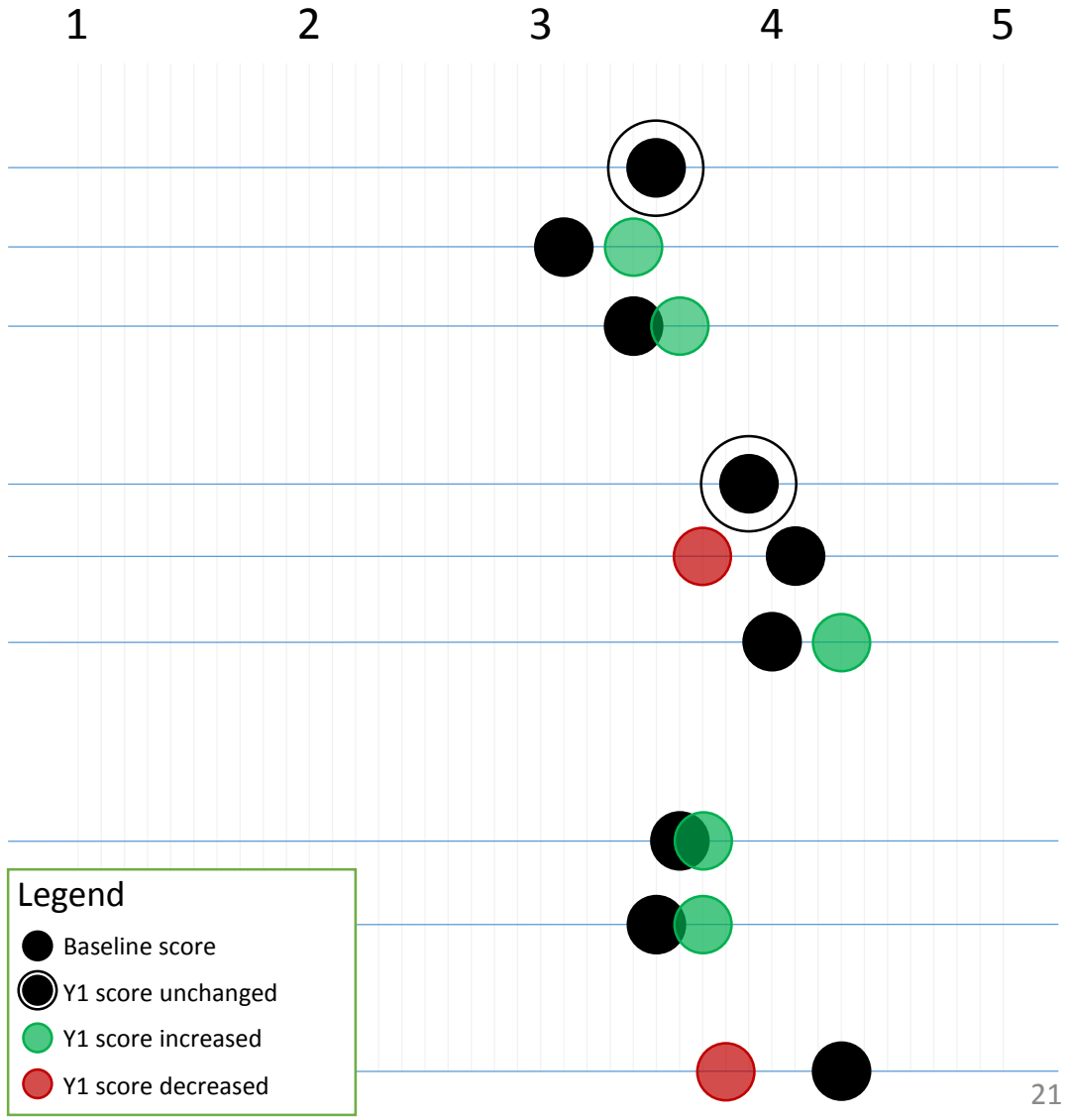
	Siaya County (CHS)	**Migori County (UMB)**
HRH - Routine	100%	85%
HRH – TA/QA	100%	66%
Commodities	100%	100%
Facility operation and transport	91%	100%
Demand creation	0%	100%
Unit expenditure/VMMC* *10-14 years only*	Kshs 6,801 ($68.01)	Kshs 7,252 ($72.50)

Evaluation Question 3:

What are the areas of weakness that need to be improved in order to maximize the models' sustainability?

Baseline and Year 1 qualitative survey feedback by sustainability domain

Governance, leadership and Accountability
Planning and Coordination (P&C)
Civil Society Management (CSM)
Transparency (T)
National Health System and Service Delivery
Domestic Service Delivery (DSD)
Supply Chain (SC)
Quality Management (QM)
Strategic Investments, Efficiency and Sustainable Financing
Domestic Resource Mobilization (DRM)
Technical and Allocative Efficiencies (TAE)
Strategic Information
Performance Data (PD)



Key takeaways

- Sustainable VMMC implementation models in Kenya may be extremely context-specific
- In determining sustainable implementation models, we must balance implementation efficiency vs. implementation cost
- Progress towards sustainability may advance more rapidly in some domains than others; in some cases, the trajectory towards sustainability may not be unidirectional

Acknowledgments

- Ministry of Health, Kenya
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- Migori County AIDS/STI Coordinating office
- Siaya County AIDS/STI Coordinating office
- Jhpiego
- University of Maryland School of Medicine, Kenya Programs
- Centre for Health Solutions, Shinda Project
- U.S. Centers for Disease Control and Prevention
- Kenya Technical Support Unit (TSU)
- Bill & Melinda Gates Foundation