



USAID
FROM THE AMERICAN PEOPLE



PEPFAR
U.S. President's Emergency Plan for AIDS Relief

AIDSFree
Strengthening High Impact Interventions
for an AIDS-free Generation

Effective Approaches for Increasing Uptake of VMMC Services in the Context of COP20 Guidance **Thursday, April 2, 2020 | 8:30 AM-10:00 AM ET**

Katie:

Good afternoon, everyone. My name is Katie Cook, and I'm here supporting AIDSFree. We're gonna go ahead and get started with the webinar, and I just wanna ask folks to please make sure to mute your line. So, before we begin, I'd like to do some quick housekeeping and review the Adobe Connect environment for today's webinar.

Within the webinar environment, please make sure to use the chat box, which you'll see on the bottom right side of your screen, to share your thoughts, ask your questions, or ask for help with sound during the presentation. If you're experiencing difficulties, our technical support will respond to your question privately. We will collect your questions for our speakers, and we will save them for our discussion period at the end of the webinar.

It's so great that we're able to connect people from so many places today, but your experience may vary based on your internet connection and computer equipment. Especially with the current COVID-19 environment, we've been experiencing increased technology challenges, so please be sure to chat us your questions if you need any assistance.

I will briefly go over a few troubleshooting steps in case you run into any issues today. Please be sure to mute your phone as well as your computer depending on how your audio is connected. You will not automatically be muted, so you'll need to do that yourself. Please use the chat box to ask AIDSFree tech for assistance. If the troubleshooting steps are not successful, please rest assured that the webinar is being recorded, and you'll receive an email with a link to the recording following today's event. Also, questions that don't get answered during the Q&A session will get answered and sent by email to all participants. So, I'd like to go ahead and turn it over to Liz.



Liz: Hi. Good morning and good afternoon. Welcome to our webinar, “Effective Approaches for Increasing Uptake of VMMC Services in the Context of COP20 Guidance.” My name is Liz Gold. I’m the senior technical advisor, social and behavior change for the AIDSFree project. I’ll be moderating today.

So, this morning, we’re first gonna hear from Alison Cheng, USAID’s biomedical prevention branch chief in the Office of HIV/AIDS. Alison will update us on VMMC programming in the context of COVID-19. Then, we’ll take just a few minutes to answer some specific questions you may have around that topic, so be sure to put your questions into the chat box.

Next, we’ll hear from Dr. Valerian Kiggundu from USAID’s Office of HIV, and then our three country speakers, who will discuss effective approaches that they’ve used in their programs for increasing uptake of VMMC among the older priority age groups. We’ll save time at the end of the webinar to answer any of your questions. Alison, over to you.

Alison: Thanks, Liz. So, we wanted to just acknowledge at the start of this webinar the challenges that the COVID-19 pandemic will bring to our VMMC services, and this is a very difficult time for our global community. I just want to highlight for you some of the guidance coming out from PEPFAR on mitigating the impact of COVID-19 on HIV services. I’m going to highlight the main guidance that has been released so far as of last night, and specifically, just highlighting the VMMC FAQs.

So, the first one is how will VMMC services be affected? New VMMCs may be delayed or paused, as guidance around mass gatherings renders them impractical. Post-op follow-up should continue for circumcisions that have already occurred, with consideration given for telephonic or virtual consultation as an initial screening before an in-person visit. We acknowledge – or, **SGAC** acknowledges that prevention services for men may be impacted by COVID-19.

The other one I would highlight is just an FAQ around the healthcare worker – healthcare workforce. How should PEPFAR-supported healthcare worker staffing be modified to maintain essential HIV services? PEPFAR programs should be prepared to manage that through these challenging times. I’m gonna highlight the second paragraph, which just says that PEPFAR-supported healthcare workers should be prepared to continue to deliver essential HIV services using service delivery teams that may be rapidly and regularly reconfigured in response to staffing shortages.

Staff should be prepared for task-sharing of essential services where allowed and work with MLH and policymakers to allow emergency task-shifting where formal task-shifting policies are not in place. PEPFAR staff,

whose regular services may be paused or delayed, such as VMMC, should be repurposed and redeployed to support essential HIV services. There is also an FAQ around notifiable adverse events in that guidance.

So, this is, again, official guidance on what we have so far from PEPFAR. It is posted on the PEPFAR website at www.state.gov/pepfar/coronavirus. I'm going to put this link in the chat box. PEPFAR is updating their guidance around two times per week, usually on Wednesdays and Fridays by the end of the day, and all that guidance will continue to be posted publicly on the PEPFAR website. It is important to continue checking for new guidance as the pandemic evolves.

That said, we know that VMMC services will be impacted differently in different countries depending on the course of the local epidemic. IP should follow their national guidelines on mitigating the impact of COVID-19. For example, if social distancing guidance is released, VMMC services must comply with that.

As examples, USAID discussed last week with our implementing partners that some countries may need to temporarily pause the VMMC campaign or community mobilization activities. We've also discussed VMMC programs avoiding – as with other services, avoiding group meetings such as group counseling and group education – again, where social distancing guidance cannot be met.

I'm gonna wrap up here, but note that we know that the next few months will be very challenging. We also do expect normal VMMC services and HIV services to resume after the pandemic. This webinar focuses on preparations for COP20 VMMC implementation, which is still six months away. So, again, feel free to drop questions in the chat box during the webinar. We can take one or two now. We may not be able to address all questions today, especially – again – as guidance is still evolving, and we do have a lot of other content to cover in this webinar. However, we will collect these questions and concerns from you and seek clarifications where possible.

Liz: Thank you, Alison. I'll now turn things over to Shira Chandler from USAID, who's gonna facilitate just a short Q&A with Alison, so if you have questions, you can go ahead and put them into the chat box.

Shira: Thank you, Liz. We will try to get to as many questions as we can in the time we have, but we – know that if we don't get to your questions, we're collecting them, and we will respond to each one through email after the event, so if you have any questions, please put them in the chat box now. We see that a few people might be typing in the chat box, so we'll just wait a minute to allow people to get their questions in.

So, we're gonna move on, and if you have questions regarding COVID-19 and VMMC programming, just add them to the chat box, and then we can get them at the end during our Q&A. Back over to you, Liz, to introduce our next speaker.

Liz: Thanks. I'd like to introduce our next speaker, Dr. Valerian Kiggundu, who will talk about PEPFAR COP20 guidance and what that means for our VMMC program. Valerian is senior advisor, biomedical prevention at the USAID Office of HIV/AIDS. He supports the scale-up of VMMC for HIV prevention and provides technical leadership and assistance and programmatic advice to USAID field missions and country programs on VMMC.

In addition, he promotes U.S. government interagency collaboration with international development partners that support HIV prevention. Valerian has more than 15 years of experience in clinical research, HIV prevention, care, and treatment, and global public health. Valerian?

Dr. Kiggundu: Thank you very much, Liz. Good morning and good afternoon, everyone. Can you hear me?

Liz: Yes, we hear you.

Dr. Kiggundu: Okay. I would like to thank everyone for making the time to join our webinar today considering the times. We hope you're keeping safe wherever you are. I'll briefly look – review COP20 technical priorities for VMMC and what this means for VMMC programming and demand creation.

So, this slide basically shows that PEPFAR has supported more than 23 million men for VMMC as of fiscal year 2019. However, a proportion – the big proportion of our circumcisions have come from younger boys 10-14. The priority age group has been 15-29, but eligibility is 10-49, so there has been a bias to get young boys in a lot.

However, last year, PEPFAR instituted a short-term task team that looked at notifying of adverse events, and it showed that 100% glans injuries and almost 90% urethra-cutaneous fistulae were occurring in younger boys under 15 years. The adverse events basically doubled in clients who are under 15 and almost 10-fold in infants who were seeking EIMC. Glans injuries have basically persisted despite changes implemented to prevent them, and the methods to prevent urethro-cutaneous fistulae have been much less clear. Most are related to smaller size of the penis.

On this slide, which details a bit about glans injuries – this slide was

provided by analysis done by CDC. This slide basically shows that 27 glans injuries were reported from 2015-2018 from nine countries. Forceps-guided has been implicated as inappropriate use in the majority of cases. I need to mention that all cadres have been involved – physicians, clinical officers, and nurses – and tissue handling has often been inadequate. Overall, it's very difficult to repair glans injuries once they occur, although attempts have been made to clear them. On this slide, as you can see on the right, the majority of the clients are under 15, most of them coming from younger boys who are 10 years old.

This slide here shows what was happening on the second notify of adverse events that was reported, which is urethro-cutaneous fistula. Thirty-eight cases were reported between 2015 and 2019 from 10 countries, and again, all cadres were involved. Dorsal slit was very much implicated; however, we need to note that we've been transitioning from forceps-guided dorsal slit, so we may not be able to explain the way that dorsal slit is implicated here.

Hemostatic and skin sutures were commonly identified on investigations found within the urethra of young men who reported urethro-cutaneous fistula. The graph on the right shows that apart from the 25-year-old man, all the other cases were identified in clients who were under 15, most of them in the current 10- and 11-year-old clients.

So, last year, towards the end and at the beginning of this year, PEPFAR came up with COP guidance guidelines specifically for VMMC. When it comes to age, the minimum age was raised from 10 to 15. Of course, there are a couple of conditions. In the case of clients who are under 15 to be considered for VMMC, they must be Tanner Stage 3, and clients must be able to understand options and give informed consent. There is an opportunity to explore a Shang ring in under 15; however, there should be approval before [inaudible] [00:15:59] on this age group.

Infant EIMC will not be supported in COP20. I need to note that while the changes officially occur in COP20, programs need to immediately assure that clients under 15 seeking VMMC services and their parents are aware of the increased risk of complications and informed about them as they continue seeking services before this year ends.

And again, we also know that young boys who are under 15 will continue seeking for VMMC services at our facilities coming at the beginning of the next fiscal year. We should be sure to provide other services – for example, sexual risk reduction counseling and sexual avoidance counseling – and this is key in services where boys have found to be at risk when it's appropriate.

This slide demonstrates – shows the Tanner staging, Stage 1 through 5.

Tanner Stage 3 is the one recommended. So, Tanner staging is used to assess sexual maturity for boys and girls. So, for boys here, Tanner Stage 3 was recommended in the case – in the program would like to consider boys who are under 15 years, even if this is going to be using Shang ring.

Additional guidance is basically written to subcutaneous. As I mentioned at the beginning, most of the – some of the investigations revealed that hemostatic and skin sutures were found connecting tissues to the urethra and implicated in some of the urethro-cutaneous fistulas, so a meeting that set in **Haradi** which involved – organized by [inaudible] [00:18:01] involved senior surgeons, urologists, and stakeholders from headquarters recommended that suture materials should be of a small size and needles should be of [inaudible] size.

So, this slide here shows the specifications for those key recommendations, and then, it's recommended that going forward, programs should consider having these supplies on the site to be able to be used in appropriate age groups of smaller boys. However, in the future, we plan to have these materials included within standard kits.

Then, this slide here on additional guidance shows some of the other areas where we may experience difficulties of having safe procedures. The first one is inadequate lighting. We need to ensure that we have enough lighting. The second one is about caseload. We know that in some of the cases that were reported, providers were circumcising in just one day 60 to 100 clients, either one team or one provider with one assistant, and that is too much. When it comes to diathermy, it should not be used in the frenular area, especially when it comes to smaller boys.

We also noted that when a fistula is diagnosed, it hasn't been managed by experienced hands and well-trained staff, so we encourage our providers not to attempt to repair some of these adverse events, but to refer clients to senior surgeons and urologists.

So, what are the key takeaways from this COP guidance in terms of VMMC programming and demand generation? The first one about age – you see that the minimum age has been raised to 15 years – 15 plus – with targets to be lower, and we encourage age targeting so that we're able to reach high-risk men, and we need to avoid primary schools. We should consider tertiary institutions, and then try to scale up what we know that works. The next three presentations are going to describe some of the approaches that have been used in the past that we can scale up.

When it comes to AE prevention and management, we know that safety is most important, so safety first. We must continue to monitor adverse events, even for older clients. We don't want these adverse events in younger boys

to shift to older age groups. Alternative safer methods, such as Shang ring – we need to explore safety and cost, and also make sure that once we think of targets, we get approval. Most of this approval comes from country chairs.

We also understand when it comes to country policy that countries have shortages that have targets for VMMC ranging from either all males, all males 10-plus. It's very important to have country dialogue to discuss these risks at the level of the country so that our colleagues from [inaudible] [00:21:27] are aware that these risks exist and they plan accordingly. We shall not be able to stop them if they decide to circumcise clients under 15 years; however, PEPFAR will not be supporting these procedures.

And then, finally, on sutures and needle size changes, the specifications are included here, but we need to make sure that our providers are well trained and competent, and of course, when it comes to smaller boys who we think will continue coming, even if they are 15 plus, our providers are cautious. We know that providers are trained to manage adult circumcisions, so now, when a young boy or pediatric client comes in, I think it's difficult.

For CQI – we encourage scaling up CQI at all facilities, including in the campaigns. Right now, of course, services are closed, but once we open and are back normally working, we encourage that when we have campaigns or outreaches, CQI goes within the programs to make sure that the programs are safe.

I mentioned that younger boys 10 to 14 will continue seeking services. We encourage that these boys receive messages about risks associated with this age group, but these messages should also be shared with the providers, counselors, and all staff working at the facility. Then, younger boys should receive other services.

We are also working around updating our informed consent documentation so that we've included additional risks so our colleagues, clients, and staff are aware of these increased risks and can communicate them effectively to the clients. So, thank you very much for listening. Back to you, Liz.

Liz:

Thanks so much, Valerian. I'm sure people will have lots of questions for you at the end. I'd now like to introduce our next speaker, Maende Makokha, who will share the Tanzania experience in making VMMC services attractive to the older men. Maende is a social and behavior change communication specialist with 20 years' experience implementing HIV prevention programs. He's the project director of the VMMC activity in Tanzania under the Jhpiego-led RISE Project. Previously, Maende led demand creation and community advocacy for VMMC in Tanzania under AIDSFree. Maende, over to you.

Maende:

Thank you so much, Liz. Good afternoon and good morning, colleagues. I'm delighted to have this opportunity to share with you a promising intervention to attract adult men that we tried out in Tanzania. I will provide a quick background information to set the scene. Jhpiego has been implementing VMMC activities in Tanzania since 2009, when we set up the first center of excellence in the region, and since then, Jhpiego has implemented VMMC activities through several mechanisms, including the AIDSFree project, supporting five out of 17 regions identified by the national AIDS control program as priority regions for VMMC programming.

Jhpiego has contributed over that period to about five percent of VMMCs achieved by the program nationally, and is one of four implementing partners. The other three are serving 12 regions supported by CDC and DOD.

In COP16, as many of us would be aware, PEPFAR highlighted prioritization of men ages 15 to 29 for VMMC as a critical age for clinic control, but here, AIDSFree achieved 84% of target for FY 2017, but again, when we look at the coverage in 25 to 29, we were only able to achieve 15% of target for that year.

Collectively, for the same year, Tanzania VMMC program achieved only 41% in the same age group, which sort of highlighted or signaled the fact that we're lagging behind in a critical age in Tanzania. It's around this time that AIDSFree began discussing different strategies that might be used to try and make up the gap within this age group. We're lucky that at that point in time, we had access to findings from two studies that had been conducted in supported regions looking at motivational incentives for older men, and also looking at different choices that older men might prefer in terms of how they sound.

Also, before how I say how that influenced our decision, a quick – this graphic shows quickly how we've been performing prior to FY '17-18, and the sharp drop that we experienced in 25- to 29-year-olds from FY '17. There was a slight uptick in FY 2018, but then, we're still having ground to cover.

Amongst the areas and strategies that have been proposed, we're looking at how to tailor VMMC sites to ensure that they are friendly to adult men, including looking at the possibility of weekend or extended services, including moonlight or nighttime services that are coupled with something else going on that provides opportunities for older men to use services. Based on this and other discussions that we're having, including from findings of the studies that I mentioned earlier, we're able to begin

considering approaches that will focus at a subset of men who were reporting interest in using VMMC services, but have not used them, and looking at what are the issues for these types of men.

We identified four critical areas: Lack of dedicated services for adult men – so, they are mixed up with other ages, and this creates a barrier. Look at inconvenient service times. Many of the adult men are working or involved in other livelihood activities that prevented them from using services during the clinic hours. Lack of privacy – many of the places are crowded – and then, the predominance of service providers being female is a potential barrier for adult men.

Acknowledging that we – the structural realities that we could not address that beyond the capability of the project, we looked at what specific areas were feasible for us to modify in a cost-efficient way to ensure that routine service delivery facilities were able to attract older men, and from the experience that we had looking at the incent game, we came up with the VIP card.

So, the VIP card was motivated first and foremost by the reach culture within Tanzania where cards are often used for social activities, and often confer an element of status, and in our case, we would tap into that and ensure that there was autonomy that's provided for adult men to choose how they would consume services.

In the card we presented, there were certain interactive features that could be built in with the aim of ensuring that the clients had increased opportunities for more information, for follow-up and assistance during the decision-making process. Here are the circled areas where these features existed, providing phone-in information, places where they could call free of charge or send a text message to get additional information, an area of the card where they provide contact for follow-up.

Predominantly, the options that the card provided lay in the 10 areas, but clients were given an opportunity to choose how they wanted the service to be combined and how they wanted to use it. I will address the actual options a little later.

And so, the card also provided an opportunity for the client to follow up with a volunteer community advocate who would mediate the process and a number that was unique to this individual on the card that could be torn off, and this would remain with them once they provided a referral for them to be able to follow up with the client if need be.

This is a quick timeline. I won't get into the details; I will only point out that it was a long, iterative process that involved so many stakeholders,

including the National AIDS [inaudible] [00:31:47] as well as FHI360 provided the creative content and design for the card. We did a pretest in March of 2019, and immediately after, scaled up the intervention into 71 of the VMMC supported facilities in five regions.

The volunteer community advocates are a key part of the VIP initiative in the way that they actually use local knowledge to target interpersonal communications to individuals who are most likely to benefit from using the services. They help potential clients get through the options that they have and see what is useful for them.

They guide them through the decision-making process over a period through follow-up and repeat contact, and they also provide opportunities for direct support and linkage to healthcare providers by negotiating appointments and escorting clients if they need to have an escort. Often, VCAs would then promote VIP services through satisfied clients, and they would use word of mouth to reach to their peer networks.

On the top right corner is the standard operating procedures that we provided as a framework to guide volunteer community advocates and healthcare providers in providing VIP services, including what sort of compensation they would get. If clients ask for services outside normal service hours, to ensure the choice the client made was guaranteed for them. The bottom part is a form that volunteer community advocates keep that involves referrals, providing information to the clients, and follow up on them after using services.

This table is simply to highlight how the volunteer community advocates and healthcare providers interact in ensuring that clients are able to use the options that they select. So, there are 10 options that are listed there. A client can choose any of those – any combination or one of them – and this is then an immediate discussion between the client and the healthcare providers to ensure that the option they selected is viable within the context in which services are going to be provided.

I'll show some highlights from the results that we saw from the initial implementation of the VIP services. The first main result is that actually, VIP services have an effect on the uptick of services among 25- to 29-year-olds.

You can see this is a historic comparison of two years, the year during which we introduced VIP services and the year before, and you will see that – you will note that from August, when we introduced VIP services at a small scale and when we scaled them up in September, there was a sharp increase in uptick in 25- to 29-year-olds. This is from all modalities that clients chose to use, whether it was routine services, outreach, campaigns, or mobile

services that we also included.

Clients expressed satisfaction with the VIP services they had received – 97% did. A small portion did not. Unfortunately, the way we had asked the questions, we didn't have an opportunity to probe for reasons why the clients were not satisfied with our services, so this is an area which can be improved in the future.

In terms of what services – what options on the VIP card clients who used VIP services reported influenced them to make the decision to use services, you will see that 81% reported three options. That is services being fast-tracked, not having to wait in a crowded area, sense of privacy provided through arranged services with the providers or times that were convenient to them, and then, a question about preferred providers, which was a choice on the sex of the provider they wanted to serve them. As you'll see, the fast track seemed to have been a very strong predictor of clients using services.

We've learned a few things from interviewing with our clients that we think are important for others who consider to replicate the VIP services in their context. The first is the VIP card option and its use in the decision-making process builds trust between the volunteer community advocate and the client, as well as the provider. That triangle that enables our service to come in the way that the client chooses is important, but it has to be matched by respectful services at the facility. If services do not match up to the expectations of clients, the VIP card may not work out as well as it did for us.

Privacy and manner in which the service was provided were two areas that respondents who interviewed that we had liked the most, and yet, they are also the two areas that they said need to be improved. For us, this signals how important for adult clients the two areas are, so we need to focus on improving those two areas and ensuring that they are guaranteed in the way services are provided.

Being fast-tracked appeared to minimize concern about using services during clinic hours, even when those are in crowded or high-volume settings. The fact that an adult client can come and get into the service immediately was something that many clients appeared to prefer.

How providers treat the client was often a more important provider selection criteria than the provider's sex. We imagined in the beginning that the provider's sex would be a critical factor for adult men, but then, we had many situations whereby when the adult client came into contact with a female provider, how they were received and how they were handled, especially if they were respectful, changed their mind on whether they would agree or not to be served by that particular provider. So, we should

look more at the quality and respect granted during the service provision rather than focusing on the sex of the provider.

Finally, VIP services attract several hard-to-reach adult men, especially nomadic pastoralists. We're now in regions where we're encountering a lot of pastoralists, and many of them are on the move, and we find that the VIP service was able to draw them to services, including as well adult men who are itinerant traders and workers on estates.

In conclusion, we would like to recommend VIP services to colleagues in their countries, especially if it's linked to a very strong client satisfaction review process, and hopefully some sort of focus group discussion alternative for interviewing, which will allow for exploring why clients tended to like or not like certain aspects of the options they were given. Thank you so much for listening to me. Back to you, Liz.

Liz: Thank you so much, Maende, for sharing that experience, and we'll take your questions at the end. I'm sure you have some for Maende. Next. I'd like to introduce our next speakers, Maria Tanque and Francisco Zita, to talk about increasing uptake of services among males 15 and above in Mozambique. Maria has worked at Hopkins CCP in Mozambique for 11 years now. She's been coordinating the demand generation activities for VMMC in Manica and Tete provinces since November 2015. Francisco, or "Zita," as we call him, has worked for Jhpiego for five years now, and since May 2016, has been chief of party at AIDSFree VMMC project in Manica and Tete in Mozambique. Maria?

Francisco: All right, good afternoon.

Liz: We can hear you. Thank you.

Francisco: All right. Sorry, good afternoon. Can we start with the presentation?

Liz: Yes, please go ahead. Zita, please start. We can hear you.

Francisco: Good afternoon. Okay, we'll speak here.

Liz: Zita, can you try unmuting your microphone?

Francisco: Good afternoon.

Liz: Yes, we hear you.

Francisco: We'll pass the presentation or start – Maria will start and make the presentation.

Maria: Hello?

Liz: We hear you, Maria. Go ahead.

Maria: My name is Maria from Mozambique CCP, coordinator – can you hear me?

Liz: Yes.

Maria: I want to present to you the experience for demand creation to VMMC in Manica and Tete – oh, okay, in Manica and Tete. First of all, I will talk about our implementation. We have since passed from **H3** to **CHO**. H3 was a USAID-funded project implemented by JHCCP in cooperation with MOH to support VMMC service in Tete and Manica province since November 2015. The call at CVT was to improve demand for VMMC service and service communication targeting a priority age group 15 to 29 years old. Would you pass for another?

Okay. And also, we were focused in some gap we had in the **[inaudible]** **[00:45:54]** September 2015 and the administration assessments in October 2015. We find that there was a lot of complaints in the comprehensive training of counselors, and the post-op counseling needed improvement, and the communication material had gaps that we were not meeting needs of young clients. And, we saw that the demand was poor in most sites. Client where service was most...was men ages 10 to 14 years, and mobilizers were underperforming.

That's why we did the strategy to get men above 15 years. Working in the secondary schools and in the university and professional schools was the responsibility of the coordinator of this section. We were also working in the formal and informal markets and the churches and workplaces with the managers of the enterprise. We also worked in large social gatherings with the people who organized the social events.

Also, we worked in the prisons by the permission of the manager of the prisons. We have there the mobile unit, and we have mobilizers, but one mobilizer is the prison people who helped another prisoner to get the VMMC service. We worked also in the bus stops where we distribute the SVCC material, and we put in there the card that speak about VMMC. We went in the community door to door, where we go at the homes of the people and do the mobilization.

Also, we worked with the women in the prenatal consultation – the health unit, also in the fountain where the women go to get water to motivate their partners to go to the VMMC service. We tailored the key message about the advantage of the VMMC for the women.

And then, what we do when we go to mobilization and what we do to improve the skills of our mobilizers: We supervise and support them to improve their skills. We train mobilizers in effective interpersonal communication (IPC), and we assign mobilizers according to their education and skill levels as appropriate to schools. We divided the mobilizers – some organizers go to the organization in their school, another one in their community, another one to conference in the university – based on their skills.

And then, we meet clients' transportation needs because some clients don't like to get transport in the [inaudible] [00:51:32] with the younger clients, and sometimes they'll say, "You will catch me in another point," and they will recommend this need or wish. And, they allow clients to enter through the VMMC unit side door because some clients don't like to enter in the same door with the young clients.

And, we include the mobilizer's contact number on invitations for the adult clients where we put the number of the VMMC unit in the literature, and we put the time that the unit works, and we put also the number of the mobilizers because this helps them to contact the mobilizer in another time to book appointments or to get more information if preferred.

Also, we use the video testimonial to share the experience of the clients that say to us of the service, and also, we have debates on the community radio with testimonials sharing their experience, and we have a WhatsApp group for the mobilizers to check the reach of the priority age group daily and reinforce the guidance.

To improve the in-service communication of the providers, we train all the providers in the message that they have to give to their clients in each VMMC stage, and we monitor the performance and share the information such as daily data on VMMC provided by age group and ways to improve performance and overcome challenges. We share this information with the mobilizers. This is the supervision to see what we did yesterday and what we have to do to improve our performance. And, this approach is where – it's good for us because we work with the H3 project, Jhpiego, and the big coordination with these partners.

Francisco:

Thank you. As Maria was mentioning, the intrinsic element of implementation with the VMMC project in Mozambique – it's because we have a demanding creating partner – that is JHU CCP and Rumos – that is implementing that component. And then, we have the service supply on conducting the VMMC procedure at the clinic.

So, as Maria mentioned in the previous slide, the teams coordinate on a weekly basis. We also engage the DPS. What we would like to highlight is

coordination key. We plan together according to our targets. The resources we allocate to the districts, meaning the staff, the people, aid the mobilizers, as she was mentioning. The number of mobilizers that Rumos allocated to the district are in accordance to the capacity that we have in the health facility.

So, in terms of the communities where we do all the demand creation, we involve interaction between Rumos and Jhpiego. We have involved all the team members from the coordination or leadership until the person at the implementation and the ground. They know in terms of targets, in terms of what are the activities that they have to – in terms of planning, everybody is engaged.

There is this tool that we call site capacity and productivity. This tool that is the optimization and planning that helps for policing the personnel helps the delivery of services, and then, the demand creation side because this tool tells us that if you have a facility with two beds, for example, some days, you just have to bring 30 clients, not more than that, assuming that all of them will be eligible. So, the direction of target is also focused. Let's say because we know that we have to bring 15-year-old people for circumcision, what we do is focus the demand creation to bring people of that age. The number of people that have to come, but related to the target that we have.

The same is in relation to outreach in the specific districts because we have the static site and also outreach site, so when we plan, we do the outreach planning as well so that we can compensate for that target that we have for that district.

So, as you can see, since 2016 that the project transitioned into Jhpiego, this is the target that we had. October – this was from May, but if you see the second where target is in blue, and then the conducted VMMC in red, you will see that in the first year, from October '15 to September '16, we took over in the middle – in May of '16 – so after four months, it was low, but in the following year, from October '16 to September '17, you will see the target was 95,296, so we reached 106% in terms of target because of coordination of the strategies that the demand-creating partner used.

Then, in the following year, in COP17, our target was 120,000. We reached 89%. This was due to other reasons, but we were close to the target. In the previous COP18, we reached 100% of our target.

So, this is the proportion of the age group. You can see that our focus from 15 years was always above 50%. In COP16, for example, with 61%, COP17 was 61%, and COP18 was 60%. During this period, we were targeting adults – all the different age groups from 10 onwards, not specifically from 15 onward. We're starting from 10, but you can see that the priority age

group from 15 is the majority in terms of number and percentage.

So, this age group, you can see is the same as the previous slide. We're showing by age group. You will see that by age group in this period of H3 implementation, where 60% from 15 to 29 years, and then, four percent from 30 years onward, and 36% from 10 to 14 years, which means that from 15 years onwards, it's where we have the biggest number of clients that received our services.

So, in terms of lessons to strengthen mobilization, training of mobilizers, providing supervision of mobilizers, support and motivate them – as Maria mentioned in her previous presentation, and she gave the example – is key as we capture the lesson. Then, there's a need to permanently to pay attention to how the strategy of demand creation is working and adjust whenever is necessary. And then, we do it in a weekly basis because in a daily basis, we have the number of circumcisions that we conducted, as Maria mentioned. Also, in a daily basis, we have the number of people that were taken to receive services, so this is very important.

We also use data for decision making. It's very important to use – as I mentioned – the daily data to analyze what's happening, and also the site capacity and productivity tool to manage, to adjust, and to track our targets on a daily basis. We do it not as separate entities. Interestingly, we have given WhatsApp groups for coordination. We have WhatsApp groups that Maria and her team from JHUCCP, Rumos, that we have together with Jhpiego team that we take some decision, we mention what we have to change to adjust to this implementation.

As Maria mentioned, we have service centered to clients. Of our clients, as she mentioned, some do not like to go in the transport that we provide with the younger clients, so we organize service picking-up points or times like Saturdays that we have to pick up the clients. And then, we mentioned about accessing the service in a daily basis, and then follow up and motivate the mobilizers to reach the people from 15 years old.

So, follow-up of clients post-operation is very important, not only to provide services, because 1). It's to make sure that the client – is the wound healed and is happy with the circumcision, and 2). To have his feedback on the service that we provide, and then we use that information to adjust our service. Thank you for your attention.

Liz:

Thanks so much, Zita and Maria. That was great. I'd now like to introduce our last presenter, Winfred Khondowe, to talk about effective demand creation for achieving the age pivot in Zambia through the JSI SAFE project. Winfred is senior VMMC advisor for the USAID-funded Supporting an AIDS-Free Era program. Before joining JSI, he served as

deputy program manager at Project Concern International, regional manager for PSI, and more than 12 years as health center in charge. Winfred, over to you.

Winfred:

Good afternoon. Thank you so much for that introduction. The VMMC program with the SAFE project is basically just one of the paths for this treatment program. So, we started in 2018, providing male circumcision, and we are supporting basically three provinces within Zambia: Copperbelt, Central, and North-Western. So, basically, Zambia started doing VMMC way back in 2007, and by end of December 2019, we have circumcised 1.9 million males, and USAID has contributed to that 8.7% in the last two and a half years that we have worked in the VMMC space.

We have a number of static sites. Of course, when we started, our static sites – those sites which are providing routine services – were quite few, but now we have a total of 104, and that includes about 10% which are privately owned, and the rest are government owned. Then, we also achieved 95% of staff conducting MCs are Ministry of Health staff, meaning are members of staff that were trained in VMMC that we built capacity – we trained them VMMC in a government-to-government kind of arrangement.

So, mostly, our facilities [inaudible] [01:09:13] VMMCs are provided for by Ministry of Health. Mainly, the [inaudible] is campaign-based, so for us in the USAID space, every month is a campaign, meaning that even in between campaigns, we want also to utilize those [inaudible]. So, our facilities that we are supporting, they do understand that they're supposed to provide VMMCs all year round.

As I said, we are effectively working through Ministry of Health structures. They are the structures that have been provided, starting with the national level down to the community level, so we are working within those structures. So, as a project, we are contributing to what the government is actually doing. In terms of funding for consumables, for providing stipends for the providers, it's mainly with the support from the donors, for over 90% of our programs in Zambia are donor-supported.

The strategy that we are using, as we said, is basically 1). We are participating in the VMMC campaign during school holiday campaign, and then, we have also – we are also providing services in the higher institutions of learning, and also, we have identified some hard-to-reach areas where we know that VMMC has not been utilized to a greater extent, so those are some of the areas that we are going to, and then, providing the service. Basically, we have the static services, and then, we also have the outreach and mobile activities that we are doing. Basically, when we go to higher institutions of learning, we are targeting the above-15 – those are the ones who are in the colleges, they invest –

[Crosstalk]

Winfred: Hello?

Male Speaker: **[Inaudible] [01:11:34]**

Winfred: I can't – you are saying something? All right. So, for the project that we are using, it is utilizing the private-sector platform and the farm blocks to provide the service, and then, also, as I said earlier, we are increasing on the static sites so that these facilities can provide routine services all year round. So, for this fiscal year, we are saying that as a country, we have a target of circumcising 382,000 MCs, and SAFE, the target has been 85,000-plus, and then, we are supposed also to achieve 60% of those in the critical age group, 15 to 29.

In terms of community mobilization approaches, we do have community meetings, especially have traditional leaders, so what we do here – we meet them in the community as well as organize meetings with the key traditional leaders, engagement meetings where we talk to them about VMMC. This is because some of the communities are non-circumcising, so we are trying to get them to buy into the program by explaining the benefits that accrue to this program – other than HIV prevention, of course. That is the chief one.

And then, we are also using the healthcare workers and mobilizers who go into the community to just provide information, as I said, through the neighborhood health committees. The neighborhood health committees – these are community members that have been picked from different zones within the villages by that particular facility services, and through them, we tell them that this is a program and this is how the schedule is for the facility – for example, if the facility provides VMMC on Wednesdays every week, so we sell that idea through them so that they're able to go and tell the community or inform the community on the schedules that the facility has chosen.

Then, we have mobilizers for each facility who provide the personal communication kind of skills so that they're able to clarify some of the specific concerns that people may have. So, these – mainly, they move from one community to the other. They try to provide information on VMMC and when it'll be provided. Also, they go to schools, they engage with school authorities if they want to go there to provide some mobile activities.

Then, in some areas, we have used the female mobilizers or we are using the female mobilizers to create demand. This is because some of our communities here – the females have more power than the males, so once the female agrees or sees the benefit of VMMC, then they are able to explain

to their spouses, for example, and we are able also to provide information through the women's groups, like in churches and the community, so we use the females themselves as they are conducting – at activities like cervical cancer screening and so on so they can talk about VMMC and encourage their spouses, who are not sometimes there, but they can talk to them at home so that they come for the service.

So, traditional leadership and faith-based organization engagement – so, this is done mainly quarterly. We have a structured program where before the launch of school holiday campaign, we call the traditional leaders, and then we provide the necessary information for them to be able to also engage their headmen and those who are under them so that they know that this time, the government policies that we are providing this service, and then they can allow the community to participate. So, basically, these meetings are just to get their buy-in, and some of the strategies that we can use to reach more masses.

And then, we have separate sessions to promote men's clinic in their chiefdoms, and then, as I said, advocacy and just trying to explain the policy to them in regard to VMMC. Then, the Ministry of Health also writes letters to churches informing them about VMMC program. Basically, these letters are written from the district health offices, and then given to individual facilities. So, you identify the churches that are there, and then you are able to provide that information.

And then, we also have another strategy of outreach: Going to some remote areas. We have a number of remote or hard-to-reach areas, like the fishing camps in this case. I can see the team there that's handling going to one of the fishing camps within Central Province, and these teams – they go to these places, and the arrangement of the fishing camps – we see a lot of trading happening there, and we see a lot of men and women coming to the fishing camps to procure fish and other things.

So, when they are there, our teams will go there and provide, first of all, the information, and as we are seeing, most of the time, the entry point is HIV testing, so we talk about HIV, and we provide the testing services, and those who are negative, we link them to prevention services, like VMMC in this case. So, basically, in those fishing camps, we have older men and those who are doing business, so mainly, we get more of the older age as opposed to the younger ones.

The other strategy that we have used is going to the farm blocks. Again, this is basically the outreach activities as well as mobile sometimes. So, for the farm blocks, we have a number of farms that maybe are owned by one farmer, and then we engage the farm manager to say, "This program that we have – apart from this program, we also have HIV testing, we have

[inaudible] [01:18:53], and so on and so forth.” So, we try to provide a holistic kind of approach, and then, we tell them about VMMC and the importance of VMMC, the importance of having a workforce that is healthy and how VMMC actually has proven scientifically that it can provide significant protection against HIV.

So, once they understand the importance of all this, then we are able to schedule when we can go there and provide the service, so we basically share the schedule with them, and then the farm managers and other supervisors talk to the men that on this particular day, there’s a team coming from the district health office, and then, when they go there, then we provide more information to them so that at the end of the day, they choose actually to come for VMMC, they are circumcised, and we have that good will from the managers so that we are able to give them some days off so that they are able to heal.

Basically, VMMC is an essential service, and then, SAFE is able to help the Ministry of Health to increase uptick of VMMC through this particular strategy.

Then, the other strategy that we have used which has really proven to be very, very effective and has given us very good numbers is reaching males in the higher institutions of learning. In this case, first of all, we engage the management of the schools, the colleges, and universities through the academic office, and then, we are able to do a presentation to them. Then, they understand, they are buying in, and they give us a date when we can come and engage the students.

So, basically, for the past few months and years, we have been engaging the first-year students so that through the already-established health groupings within the colleges, we are able to come, engage them, provide the information, provide the clarification, and then we are able to provide the service right to them. If there is a nearby clinic – like, in one of the colleges, we have a clinic just nearby – we now – after talking to them, we lead them to that facility, where we begin circumcising them.

As I said, we also identify a local point person to just register the students, so through those groupings that they have – the health clubs – we are able to identify somebody who can just help us to recruit as many clients as possible.

Then, just a few months ago, again, we introduced the men’s health – basically, with this strategy, we are able to engage companies, especially companies in this case – big mining companies, big government companies, like those who are provided worker quality, whatever company it is. So, we engage them, and then, through their management, they allow us to provide

information to the workers, and we have a particular day that they choose themselves – for example, on Fridays, I think you can be coming, or maybe two days or three days in a month. So, we adhere to those schedules that we make with them.

So, the approach here basically is to provide the holistic kind of service, and among the services is the VMMC that we also look at because this is one of the strategies that we are seeing to be – men have liked this strategy because it's one of the strategies that emphasizes on them being protected from contracting HIV. So, we try to integrate these services as much as possible, and then we make sure that within that place, we are able to identify the nearby facilities whereby if somebody tested positive in this case, we are quickly able to link them to HIV services, and those who are negative, we encourage them to take up the prevention services, like VMMC.

So, how does SAFE engage the companies? This is one of the strategies that we are seeing to be working really well. So, we meet with senior management and present the services that we are providing, access the Ministry of Health, and then, there are some memorandum of understanding that we are signing with these companies which explains our responsibilities and also their responsibilities.

In this case, for the companies and private clinics, what we have told them or what we are providing is that we are using government-approved data tools, and then, SAFE is also – through Ministry of Health – able to provide the consumables free of charge, and then we ask them now to reduce the cost of doing VMMC – providing VMMC to their clients, and in this case, SAFE is providing all the medicine, we are providing all the consumables, we allow them now to just charge a consultation fee, like in this case.

So, most of the clinics that we are working with now just take up that responsibility, especially if they have already provided, but if they don't have, then through the district health office, we are able to organize a team within the district to approach or to be conducting these mobile services to the private clinics with agreed schedules. And then, I will explain in terms of commodities and Ministry of Health that conduct the mobile services for those who don't have providers.

So, in terms of numbers from the time that we started in 2018, we have seen – so, the blue bar there is just telling us VMMCs that we have done below 15 and the red that we have done above 15 years old. So, from time and again, we have tried to emphasize that using various methods or modalities in reaching men is quite important because during the school holiday campaigns, what we see is the younger age group coming for VMMC.

As you can see, over the years, I think we have tried to reach the critical age

group. Of course, the first year, we didn't reach the 60% of the 15-to-29, but over the – in 2019, we reached that target, and you can see also Quarter 1 of Fiscal Year 3, we have also done about 75% of those above 15 years, which is quite good.

So, this graph is just telling us comparison to all the MCs that we have done so far. From the time that we started, we have done 165,000-plus, and the red dotted line is just showing us the 15-to-29 – the number that we have contributed towards reaching those numbers.

The lessons that we have learned: 1). Engagement meetings with senior management, especially to solicit their buying in of the activity, has been very, very rewarding, and also, traditional leaders, just to make them understand that though they are not circumcising a tribe or community, but when you explain the benefits that they are able to get when one is circumcised, most of the traditional leaders are now changing their stance, and also, they are giving the support to the program.

Then, of course, partnering with Ministry of Health to support the farm blocks and the private clinic intervention that I explained – we have formed teams that are responsible for conducting mobile and outreach services have been very good – so far, so good. Then, the integration of other services with VMMC – although this is more or less like a new intervention, so to speak, maybe that's over about six months old.

We are seeing that – I think this is the way to go if we are able to get the older age group, especially those who are working – the working class. So, this has proven to be very good, although the numbers are not as much as we are getting from the other intervention, but I think it is promising that this can be very good intervention.

Using mobile units to reach the hard-to-reach areas – this is basically bringing the services as close to the people as possible, which is the government's goal. I think this has been very good, although it's an expensive venture because you need to have vehicles going for outreach, and then you need to have Ministry of Health employees or staff going for a number of weeks, sometimes one week to two weeks, just conducting VMMC in those areas, so it's a bit expensive, but it's giving us very good numbers.

And then, the issue of having routine VMMC services – yeah, I'm winding up – this is very good because depending on – if we depend on the school holiday campaigns, that is not giving us very good numbers, but when we have routine services being offered year round, the people know the schedule, they understand that VMMC is provided in this facility, and so on and so forth. That is giving us very good numbers, especially the older age

group.

Then, recruiting satisfied clients and women as mobilizers – we cannot overemphasize that point. It's very critical for us, especially for older age groups, because they have issues, they have questions that they may want to be clarified, and these satisfied clients are able to advocate for VMMC, and the influence, of course, of women cannot be overemphasized.

Otherwise, I think that's the lead-through that I wanted to – the strategies that I wanted to share with the team out there, that doing things the same way may not give us the desired result, especially, for example, as we are aware, VMMC services are provided during the school holiday campaign. That may not help the project, but having other innovations around creating demand and reaching people that somehow have not been reached for many years – I think that has proved to be very effective. Thank you so much.

Liz: Thanks so much, Winfred, for that great information. I realize that time is up, but for those who are able to stick around, I think our presenters are willing to hang around and take a few questions, and I see some were already responded to in the box, and don't worry – we'll also be sending out by email responses to the questions. Before we turn it over to Shira for questions, I just quickly wanted to draw your attention to that little box at the bottom of your screen that says "AIDSFree resources." You can click on those, and they can be found on the website. Okay, I'm gonna turn it over quickly to Shira to take a few of the questions.

Shira: Hi. Maende, this is a question for you. What are some of the main challenges you face in the operationalization of the VIP clinic?

Maende: Thank you for that question. The main challenge first was around compensating healthcare providers for services they provided after hours or over weekends, when VIP clients requested for these options. Mainly, this was around – because in our standard operating procedures, we had provided them with a provision for about \$4.50 if their clients were served over the weekend. This would be the equivalent of one extra duty for healthcare providers.

But then, it conflicted, I think, with the amount they were actually being paid by the government when they do extra duty or overtime, so in the beginning, this created problems for us, and we had to adjust to pay the equivalent of what the government would for extra duty or overtime. But, that was the main challenge with us in the beginning.

Shira: Thank you so much. And, we have one more question for you. How did you address the issue of lost time at work for this age group – the primary age group, 15-plus? It is one of the main barriers in our program, especially with

urban males.

Maende: Thank you. So, we didn't, in a sense, with the VIP intervention, address directly the question of lost time at work or lost wages. It's one of those structural issues or realities that we thought were beyond the project. Nevertheless, what we created as an incentive for concern about lost time and lost wages was the fact that they had an option to be fast-tracked and to select a time that was convenient to them that would not impact too much on their livelihood or their ability to be able to work.

And, in two cases – two examples – we've worked directly with companies. One is a sugar factory to have workplace intervention. We sort of advocated with the management to provide compensation instead of the project providing compensation – so, allowing their workers to actually have VMMC and not lay them off or not pay them for the days that they were out healing. So, that was the other way we went about it.

Shira: Thank you so much. Maria and Zita, this question is for you all. Overall, the Mozambique team has a great number of interventions, and they're wondering what three interventions are the most effective that you all would recommend to the rest of the program. So, what are those top three interventions? **[Audio feedback]** I think you're having some sound issues.

Maria: The most effective is **[inaudible]** **[01:36:03]**. That is most effective...because the –

Shira: Maria, we have a follow-up question, but the sound is not –

[Crosstalk]

Maria: – too much number in the short time, but then, the school – the secondary schools – they don't experience – people give us the numbers.

Shira: Okay, thank you. We're gonna take a question for Winifred. Maria and Zita, if you could mute your line, and then we'll follow up with you in writing for the questions.

Francisco: I don't know if you received that from Maria. Was it clear? Hello?

Shira: We're gonna jump to a question for Winifred now.

Winifred: Waiting.

Shira: Okay. Most men in occupational areas are concerned of their production time during healing periods. How did you overcome this? This is similar to the last question about lost wages and focusing on production times during

the healing period regarding work. So, how did you, as a program, work on this?

Winfred: So, that one, what we do – so, when we have those engagement meetings, we talk about especially the 48 hours, which is a critical period, where we engage management to allow those who are circumcised not to report for duty until we remove the bandage, and then they can report for lighter duties.

So, in most of the cases, date in the farm blocks, date in the professional health places, management has given us that leeway because they do understand also – we make them understand that having a productive workforce is actually very keen for their production, so most of the time, some of the private companies, what they have told us – they would want us to provide the service on Friday so that Saturday, Sunday, Monday, their workers can report for duty, so it just depends on the willingness of management to provide more days, to give us a flexible schedule that will also not impede on their production.

For the farm block, most of them, actually, they have told us we can go there any time we make a schedule with them, so for them, they are not a problem, but for companies, they like the Fridays, and they don't want us to circumcise, for example, all of them at once. They will give us, for example, maybe just 10 for this particular Friday, then we go there and circumcise the 10, then they give us again another group maybe after two weeks. So, it just depends with the way we arrange with management.

Shira: Thank you. Another question for you: Adult men such as those in higher learning institutions have serious privacy concerns. Can you share the ways in which you've managed to get them involved with VMMC programs and get them circumcised even when there are privacy concerns?

Winfred: So, when we engage the first-year students, the first engagement, we have the men and the ladies, so they are present, and we have noticed, as we are saying, a lot of shyness, especially among the males, but the females are able to come out and ask questions within the grouping. And so, what we do is after we have given the general information, then we separate the groupings. We maybe take out the ladies, then we sit with the men.

So, when the men remain on their own, at least they are able to come out and ask those statement – questions about masturbation, about periods, the long period for them to heal, and so on and so forth. So, there are a lot of questions that come up, and then, we try to provide as much information as possible, but for those who have very private questions, very sensitive questions. We allow them again to see us whenever they are free, so they can see us on one to one, and they can ask us questions on pain or whatever

it is. So, basically, we try to provide as much information as possible, and we try to separate, and we try also to provide that privacy for those who have shy kinds of questions.

Shira: Thank you so much. I think that is all the time we have questions for today, but we will be following up by email with the remainder of the answers to these questions. Back to you, Liz.

Liz: Thanks so much. Thank you to all of our presenters today for giving us their time and their expertise. We apologize for any technical difficulties, but with everybody working from home, we had a few challenges, but I think we got through it. Thanks so much. Everybody please stay safe and healthy. Thank you.

[End of Audio]

Duration: 103 minutes