

Q&A - Effective Approaches for Increasing Uptake of VMMC Services in the Context of COP20 Guidance

April 2, 2020

COVID-19 and VMMC Programming

Comment: Many thanks for the presentations. Great that we look at how VMMC resources could be used in the context of COVID-19. Two things to consider: using VMMC social mobilizers to disseminate vital public health information about COVID-19; and supporting the continuation of critical HIV services, especially for vulnerable populations like adolescents.

Resource: PEPFAR COVID-19 guidance can be found here:

<https://www.state.gov/pepfar/coronavirus>

VMMC COP20 Technical Priorities

Q. Could you provide examples of where Population-based HIV Impact Assessment (PHIA) data has been used to target high-risk men?

A. *PHIA data may help us identify high-risk clients. Recency testing identifies recent HIV infection, and can be used to locate hot spots, where there may be low prevalence for VMMC. Men in these areas/among these categories should be recruited for VMMC services.*

Q. Was provider competence level one of the main factors for the adverse events such as fistula and injury to the glans?

A. *When it comes to urethrocutaneous fistula, there are several causes, and all cadres are involved. The biggest challenge is that most providers were trained to provide adult MCs (forceps-guided). Then we switched to dorsal slit, in boys <15 years old. Many providers struggled to make the switch, but the biggest challenge was associated with small penises, and likely immature anatomy.*

Q. Could you clarify targeting men 15 years and older in tertiary institutions?

A. *We should be targeting secondary and tertiary institutions. NOT PRIMARY schools.*

Q. Results from the PHIA survey in 2016/17 demonstrated in most countries that targeting adult men 30yrs and above has the most impact on HIV incidence reduction from the VMMC program. How has this been taken care of?

A. *PHIA data showed HIV incidence reduction in ages 15–34, but not 35–59, when circumcised men were compared to uncircumcised men. The numbers were, however small. For this reason and given a higher impact observed in older men,*

we are shifting VMMC services to sexually active men who are at high risk of HIV infection.

Making VMMC Services Attractive to Adult Men: The Tanzania Experience

Q. Can you provide a link to the study on a demand-generation intervention that informed the development of your strategies in Tanzania so that it can be considered by other countries in addition to country contexts?

A. *The study that informed development of the VIP strategy can be found here: "Increasing voluntary medical male circumcision uptake among adult men in Tanzania"*

<https://journals.lww.com/aidsonline/pages/articleviewer.aspx?year=2017&issue=04240&article=00014&type=Fulltext>

Q. For the 19% of clients who were not satisfied by the VIP services, what were the reasons for their dissatisfaction?

A. *Only 3% of respondents were "not satisfied" (81% were "very satisfied," 16% were "moderately satisfied"). We did not have probes in our client satisfaction feedback. An area important to include. However, intel from volunteers who come from the same communities suggests that being treated disrespectfully is the top concern/complaint.*

Q. Was the attraction of people of faith (e.g., pastoralists) only linked to enhanced services, or also to some other specific intervention to attract them to VMMC?

A. *We did not have additional interventions for pastoralists. Sometimes we provide transport, but this is for all clients who come from far away, especially during campaigns. We are now restricted to providing services on health facility premises.*

Q. What are the main challenges to operationalizing the VIP clinic?

A. *Compensating providers for working after hours (e.g., weekends/public holidays) to guarantee options for clients. We ended up paying the equivalent of what the government would pay for extra duty or overtime.*

Q. How did you address lost time at work for men 15 and older? It is one of the main barriers in our program, especially with urban males.

A. *We did not directly address lost wages as it is a structural issue. However, we created incentives (e.g., an option to be fast-tracked or select the time of the MC based on what would disrupt the client's livelihood the least). In two instances, we worked with tea and sugar estates run by multinational companies to have workplace interventions and advocated with management to provide*

compensation. The companies allowed workers to have MCs without fear of layoff or going unpaid.

Increasing Demand for VMMC In Males 15 and Older in Mozambique

Q. How do you conduct door-to-door demand creation? What modality are you are using and what has been your experience with the demand-creation model?

A. *Home-to-home visits are usually best made at the end of the day when the whole family is at home. This works well because the mobilizers are from the same community, are known in the area, and have permission from the community leader to work there. Home visits also facilitate postoperative follow-up.*

Q. Progress using site optimization approaches: How were you able to improve your proportions in older men? Did you use the same or different approaches? What strategies and innovation did you incorporate to ensure >50% among 15–29 year olds? How will you deal with the 36% who you will no longer serve starting in FY21, or now? It also looks like your proportions have stagnated over the past 3 years.

A. *Mobilizers are oriented to work with adult men and are assigned goals with more adults than children. We also have mobilizers whose mission is to mobilize adult men only, and their performance is evaluated accordingly. Also, outreach to secondary school night course sessions helps to reach men 15 and older. For the next COP, we will work with community leaders on this orientation and with the health sector at provincial and district levels to inform the community about this change, so as to avoid misinterpretation. We will also instruct mobilizers to reach out to men 15 and older only.*

Q. The Mozambique team has given a number of interventions. Were all of them effective? Which three would they recommend to the rest of us?

A. *Not all of them are effective. For example, companies only allowed us to conduct a small amount of MCs on their workers because they cannot afford loss of labor, so they dispense workers little by little. The three interventions that have proven most effective in our context, were, in order of effectiveness: 1) secondary school campaigns find many people 15 and older but not many who are over 25 years; 2) door-to-door visits in the evening when the whole family is at home; and 3) prisons because they only have adult men. (This we do through mobile units inside the penitentiary with the permission of the manager. Mobilization is conducted by a prisoner who is appointed by the prison).*

Q. How are you ensuring effective supervision of mobilizers?

A. *We have a site supervisor who monitors daily activities. We hold technical meetings at each site to evaluate the activities of the week and plan for the following week (distribution of mobilization sites by mobilizer). The provincial*

staff makes monthly visits to the sites for technical support to the mobilizers. We have a demand-information record sheet that is shared via WhatsApp.

Q. How were the mobilizers motivated?

A. The mobilizers receive a monthly subsidy and cell phone credit to ensure their communication with the team, candidates and clients. In addition, they receive transportation allowance, because even if they are local, they can be called upon to work far from home and need transport. They are easily identifiable because they wear branded t-shirts, caps, and carrying bags when mobilizing.

Q. What activities were you conducting in secondary schools?

A. Schools have a weekly class meeting for 90 minutes, during which the schools provide time for mobilizers to meet with students. We also identify a mobilizer teacher at the school who registers the student candidates and communicates with the Rumos mobilizer assigned to work at this school. The activities are conducted with the permission from the school director. Mobilization takes place during day and night courses, which have more older students because some are day workers. We also have a counseling corner at the school, where we place our gazebo with social behavior change communication material and a mobilizer to provide information and register candidates.

Delivering VMMC Services for Males 15–49 In Zambia

Q. Most men in occupational areas are so concerned about their production time during the healing period. How did you overcome this?

A. Most of the private companies want VMMC services provided on Fridays so their workers can heal over the weekend. They will allow us to circumcise 10 clients per week (smaller groups) who rest over the weekend and resume light duties on Monday. Most farm owners are flexible and allow our teams to provide services anytime. The key is engagement of management from the start and taking their preferences into account.

Q. Men, like those in higher learning institutions, have serious privacy concerns! Can you talk about how you manage to get them circumcised?

A. Our teams have group discussions with both sexes and provide general messages on the benefits of VMMC. They discuss the process of the whole program from when consent is given up to the 6-week healing phase. General concerns are raised by all, especially females who are curious about the VMMC procedure and mutual benefits for both male and females. At this stage, male clients can be shy to ask about sensitive matters, so the VMMC team separates males from females so that males are free to ask those questions. Our observation over time has been that males open up about their fears and

concerns, which are then addressed promptly. However, providers invite them to call or approach them individually if they have further questions. This has contributed to the overwhelming numbers of men who have come for circumcision.

Q. Is there a VMMC program that has used only devices for circumcision? What was the adult acceptance rate to the device compared to conventional methods?

A. *Yes, Centre for Infectious Disease Research in Zambia (CIDRZ) with funding from CDC, finished active surveillance on Shang Ring and acceptability has been 80-90%, according to reports presented to us at National Technical Working Group meetings.*

Q. How do you handle distance for those willing to accept the service but have to walk more than 15 kms to and from the facility or outreach point, particularly in places that are hard to reach and where you don't offer direct service provision? How are you setting targets in terms of age band?

A. **The issue of distance is a bit challenging. First, if teams are conducting outreach activities, SAFE provides a vehicle that is used to create demand and ferry clients to their destinations, if need be. But this is rare because we try to take the services as close to the people as possible. For static services, clients have to manage such challenges on their own.**

Secondly, general targets are set by USAID, and we do have targets in terms of critical age group (60%). All these issues are discussed with USAID at the beginning of each fiscal year. All of these are also contained in the COP for the country, which is then shared with implementing partners. Therefore, as a program, we now develop strategies to meet such targets. SAFE also communicates with our stakeholders. Together, we discuss the way forward. My team provides guidance on key activities to be implemented frequently.

Q. I would like to know more about your partnership/engagement with private sector clinics to do VMMC. Do you mobilize clients to send to them? Who pays? How was this implemented?

A. *At the moment we have not placed mobilizers under private clinics. However, SAFE has community-based volunteers placed under the ART program who receive a monthly stipend. One of their responsibilities is to link HIV-negative uncircumcised males to VMMC facilities including private clinics. In addition, a minimum of two community volunteers (advocates) who provide interpersonal communication skills to clients link them to public and private facilities that provide VMMC.*

Q. Are there any distal or proximal challenges that you have identified and if so, what actions have you undertaken to overcome them?

A.

Challenges	Solutions
Inadequate transport and fuel (delayed retirement receipts by MOH staff)	Hired vehicles for each district team to conduct outreach/mobile activities. Engaged DHO via the G-G platform on timely retirement of fuel, but it proved difficult (withdrew fuel allocation)
Infection prevention and waste disposal	Teams collect both medical and non-medical waste and dispose it at hospitals
Reviews and 6-week healing/abstinence period	Mostly limited to seasonal workers. Six week abstinence is a topic that must be explained adequately. Some opt out due to this but our teams work to explain the mutual benefits. Critical during discussion when both males and females are present.
Poor infrastructure; inadequate lighting resulting in early closure of MC clinics	Close clinic as early as possible and reschedule the clients for following day
Overwhelming numbers	Ensure booking of clients and increasing tables and logistics
Clients coming late when they hear that a team has come	Reschedule clients for following day
Inadequate supplies and consumables	Work with MOH to ensure adequate consumables and supplies

General Question

Q. It would be interesting to hear if any of the presenters have good tools or approaches for assessing conversion rate. Linking our demand creation/mobilizer data to our service data...

- A. Maende Makokha: The VIP card has a tear-off slip with a serial number. They use this to record referrals in the daily client register. Clients are asked to present their VIP card when they go for services. Providers record the VIP card number on the service form. Hence the same client can be linked via the VIP number. Each month volunteers reconcile their referral registers with facility service forms to indicate if the referred client was served.**
- B. Winfred Kapenda Khondowe: We are in the process of training our mobilizers in human-centered design model, which will result in**

supervision and linkage tools. Currently, we have cards that mobilizers give clients but we mainly use escorted referrals.