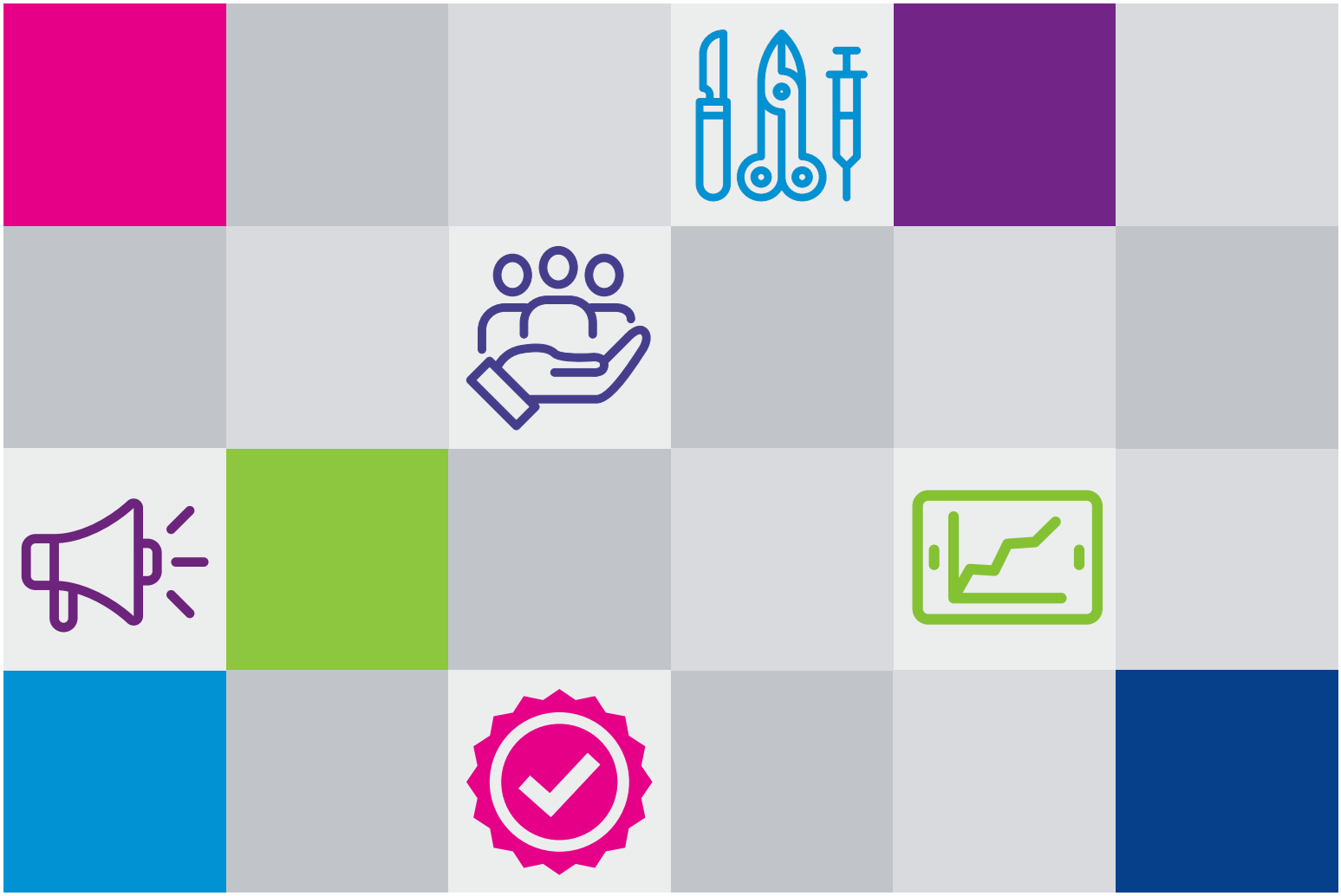

Sustaining Voluntary Medical Male Circumcision (VMMC) to Prevent HIV

A compendium of spotlights of successful VMMC integration in Zimbabwe

PRIMARY HEALTH CARE • A HEALTHY NATION • MINISTRY OF HEALTH AND CHILD CARE ZIMBABWE

UCSF Institute for Global Health Sciences

UWE Bristol University of the West of England

WOMEN'S UNIVERSITY IN AFRICA

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Glossary and Abbreviations

A

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy

B

BCCM	Behavior change communication mobilizers
BCF	Behavior change facilitators

C

CBO	Community based organizations
CHBCG	Community home based caregivers
CHN	Community health nurse
CIR	Client intake record
COVID-19	Coronavirus disease 2019
CQI	Continuous quality improvement
CR	Client register

D

DAAC	District AIDS Action Committee
DAC	District AIDS Coordinator
DDC	District Development Coordinator
DHE	District Health Executive
DHIO	District Health Information Officer
DHIS2	District Health Information System Version 2
DHPO	District Health Promotion Officer
DHSA	District Health Services Administrator
DOMCCP	Diocese of Mutare Community Care Programme
DMO	District Medical Officer
DNO	District Nursing Officer
DPO	District Pharmacy Officer
DQA	Data quality assurance
DSI	District Schools Inspector

E

EHO	Environmental Health Officer
EHR	Electronic health record
EPI	Expanded Programme on Immunization

F

FACT	Family AIDS Caring Trust

G

GMO	Government Medical Officer
GOZ	Government of Zimbabwe

H

HCC	Health centre committee
HIV	Human Immunodeficiency Virus
HPO	Health Promotion Officer

I

IEC	Information, education, and communication
Ilima	Ndebele word meaning community collaboration to help with agricultural work

M

M&E	Monitoring and evaluation
MCs	Male circumcisions
MDH	Maphisa District Hospital
MoHCC	Ministry of Health and Child Care
MOU	Memorandum of understanding
MRF	Monthly return form

N

NAC	National AIDS Council
NCDT	Nyanga Community Development Trust

O

OI	Opportunistic infection
OSDV	On-site data verification
OPTIMISE	Optimizing Stakeholder Operating Models for HIV Prevention

P

PDSA	Plan Do Study Act
PMCHO	Provincial Maternal and Child Health Officer
PMD	Provincial Medical Director
PPCL	Professional Practice in Change Leadership
PVO	Provincial VMMC Officer
PSH	Population Services for Health

R

RHC	Rural health center

S

SHC	School Health Coordinators
STIP	Sustainability Transition Implementation Plan

T

TB	Tuberculosis

V

VFDH	Victoria Falls District Hospital
VHW	Village health workers
VIAC	Visual inspection with acetic acid and cervicography (cervical cancer screening)
VMMC	Voluntary medical male circumcision

W

WHO	World Health Organization
WIT	Work Improvement Team

Z

ZICHIRE	Zimbabwe Community Health Initiative and Research

Spotlights Overview

Lupane

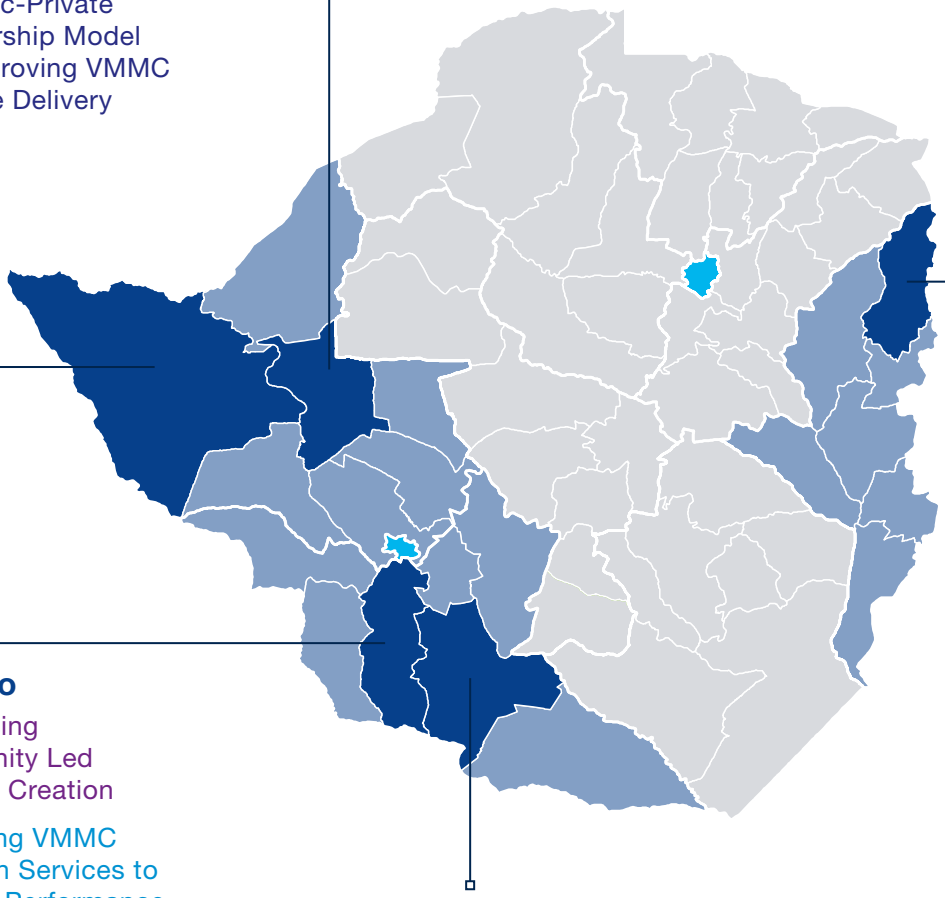
Integrated VMMC Clinical Mentorship and Support

Diversifying Multisectoral Demand Creation for VMMC Integration

Hwange

Doing More with Less

A Public-Private Partnership Model for Improving VMMC Service Delivery



Nyanga

Expanding VMMC Service Capacity through Circumciser Training

A Sustainable Transport Management System for Improved Service Delivery

VMMC Multisectoral Demand Creation

Increasing Engagement of Low Yield Wards in VMMC Services

Decentralization of VMMC Services

Matobo

Revitalising Community Led Demand Creation

Increasing VMMC Outreach Services to Improve Performance

Gwanda

Improving VMMC Data Quality for Decision-making

Increasing VMMC Coverage in Low Performing Facilities

Leadership, Management, and Coordination

Service Delivery

Demand Generation

Quality

Strategic Information

Leadership management and coordination

A Public-Private Partnership Model for Improving VMMC Service Delivery

Leadership, management and coordination

Hwange District | Matabeleland North Province

Improvement area and aim

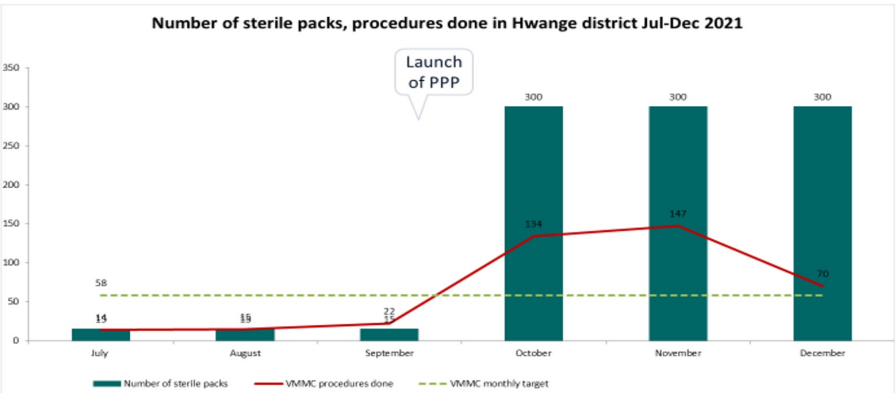
The use of re-usable sterile packs is a sustainable option for ensuring continuous availability of VMMC services. Victoria Falls District Hospital (VFDH) had limited capacity to process sterile packs for the operating theatre, maternity, and outpatient departments, including VMMC. The 24-litre autoclave available only processed 2 packs per cycle. This contributed to the district hospital circumcising only 51 clients between July and September 2021 against a target of 174 clients for the quarter. The aim was to increase the number of clients circumcised at the district hospital through increased availability of VMMC sterile packs.

Description

The District Health Executive (DHE) identified partners who had pre-existing agreements with the hospital and engaged the partners for support in autoclaving hospital sterile packs. A private partner who was utilizing theatre and incineration services from VFDH was engaged to provide complimentary autoclaving services for the hospital. Following the collaboration with the partners and agreements from the meeting, the district hospital was now using sterilized packs autoclaved at the private hospital due to its close proximity to VFDH.

Outcomes

The number of VMMC packs available for use per month increased from 15 in quarter 3 (Q3) to 300 in quarter 4 (Q4) of 2021. This resulted in the total number of circumcisions increasing from 51 in Q3 to 351 in Q4 of 2021. Performance against the quarterly target increased from 29% to 200% over the same period. The extra sterile packs were used during outreach services to support clinics' VMMC service delivery.



Leadership, management and coordination

Steps to implement

1. Analysed monthly VMMC data
2. Data for July to September 2021 showed outputs were below target (51 against 174).
3. Root cause analysis pointed to limited autoclave capacity after introduction of reusable VMMC kits.
4. The DHE identified private partners within the district with pre-existing agreements with the district hospital and autoclaving capacity.
5. Held a collaboration meeting with partners in
6. October 2021.
7. One partner, a private hospital, hospital agreed
8. to autoclave 10 VMMC sterile packs per day.

Recommendations

- Conduct periodic stakeholder coordination meetings updating and involving partners in district plans and activities to strengthen partnership s-leave no one behind to foster community.

Lessons Learned

- Maintaining private-public partnerships is of great importance
- The give and take leadership principle (Stephen Covey's 7 Habits of Highly Effective People)

VFH autoclaving pot

Partner autoclaving machine

Facilitators

1. Preexisting public private partnerships
2. Strong collaboration between the DHE and partners

Barriers & Adaptations

1. Fuel for transporting packs
2. Electricity for autoclaving
3. Fuel for Fueling generator during power cuts

A Sustainable Transport Management System for Improved Service Delivery

Leadership, management and coordination

Nyanga District | Manicaland Province

Improvement area and aim

VMMC in Nyanga District operates using both outreach and static models. More MCs were done through outreach because only 2 of the 30 health facilities could offer VMMC on a walk-in basis. The mobile team from Nyanga District Hospital does VMMC outreach service delivery. However, access to a vehicle for the outreach was a challenge, with the district having a total of 4 vehicles. The vehicles were occupied with routine programmes, such as malaria, COVID-19, and measles vaccination. VMMC outreach was not prioritized. In addition to competing programmes, frequent breakdowns of vehicles, lack of funds for vehicle maintenance, and frequent shortages of fuel led to limited vehicle availability for VMMC (at most 2 days per month).

On average, approximately US$750 is required to service each vehicle after every 10,000 km, requiring a budget of US$3,000 every quarter for the 4 vehicles. The district only had a budget of US$1,500 per quarter for vehicle servicing. Additionally, the district's approximate fuel consumption is 400-600L/week. A 2-day VMMC outreach would be allocated 40 litres per month.

In 2020 the district only managed to do 8% (120/1589) of our annual target. We aimed to have a well-coordinated transport system to support at least 2 VMMC outreach days per week and achieve an annual target of 1097 MCs for 2021.

Description

In February 2021, the DHE, PSH, and other key VMMC stakeholders from within the district were invited to discuss challenges affecting the VMMC programme. The meeting included the Provincial Medical Director (PMD), the District Schools Inspector (DSI), the District AIDS Coordinator (DAC), Chairperson of the Pastors Fraternity Forum, local government, DHE members, PSH representatives and 2 Ministry of Health central office representatives.

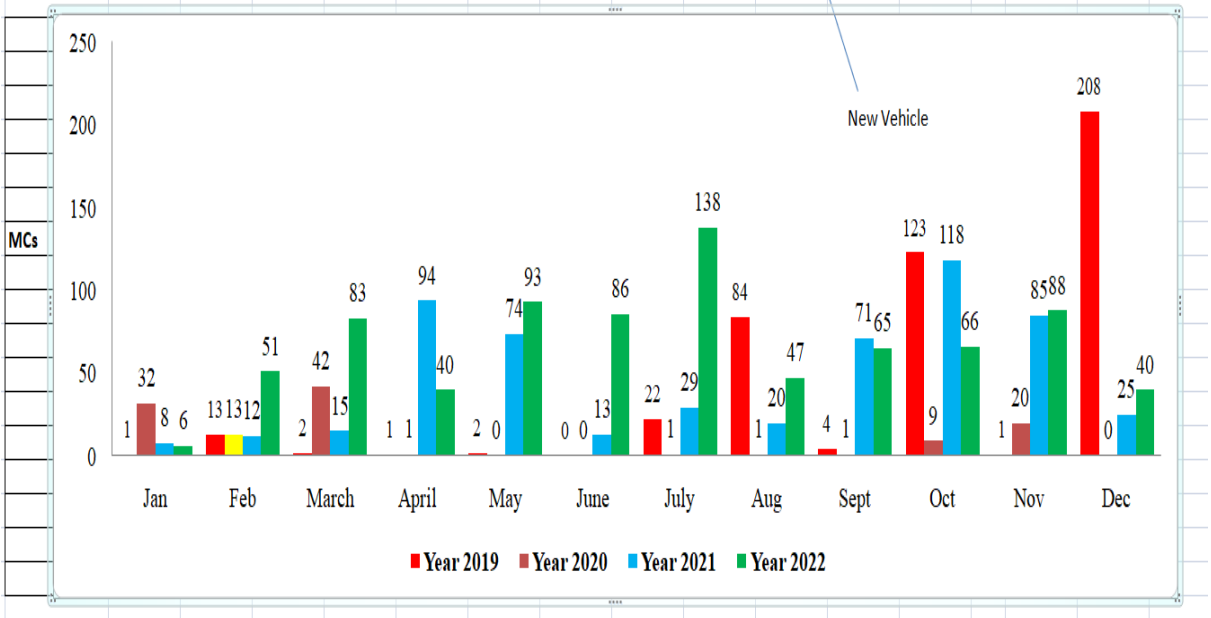
To address transport management, the District Health Services Administrator was tasked with pooling all available funds into a budget for: 1) vehicle servicing and 2) fuel. The team agreed to prioritize vehicle and fuel allocation to VMMC outreach. The VMMC focal person was tasked with sharing outreach plans during monthly DHE meetings. These agreements were put into a work plan with agreed timelines. The plans were shared with all stakeholders and reviewed quarterly. PSH also agreed to partner with Nyanga District in supporting the VMMC programme.

Outcomes

A total of 200 litres were made available weekly for VMMC outreach. Vehicles were now being serviced routinely. Vehicle allocation for VMMC outreach increased from 0-2 days per month to 2-3 days per week. As a result, the number of weekly VMMC outputs increased from 0 MCs to approximately 10 per week, and the annual target achievement increased from 30% to 51% from 2019 to 2021. The VMMC focal person regularly attends 1 DHE meeting per month to share updates and plans. The DHSA prioritizes a vehicle and fuel for the VMMC programme.

Although there was a remarkable improvement in the annual number of MCs, a further Pareto analysis was done to determine factors that led to the failure to reach 100%. The analysis identified several factors, including pressure from competing programmes and a limited number of VMMC trained providers. In October 2021, PSH supported the district with a new programme-specific vehicle. This resulted in new changes to fleet management and a slight decline in performance during the transition. However, this later improved, with a vehicle MOU developed between the MOH and PSH. The new vehicle is now part of the MOH fleet, dedicated full-time to VMMC, but available to cover emergencies, COVID-19, and EPI vaccination campaigns.

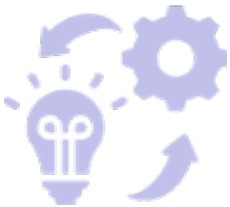
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total MCs	Annual Target	%
Year 2019	1	13	2	1	2	0	22	84	4	123	1	208	461	1554	30%
Year 2020	32	13	42	1	0	0	1	1	1	9	20	0	120	1589	8%
Year 2021	8	12	15	94	74	13	29	20	71	118	85	25	564	1097	51%
Year 2022	6	51	83	40	93	86	138	47	65	66	88	40	803	1037	77%



Leadership, management and coordination

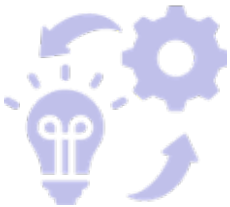
Pre-Implementation

1. Problem identification
2. Generation of solutions
3. Consolidated work plan



Steps to implement

1. Periodic Task Team meetings
2. Capacity building on the use of quality improvement techniques
3. Training of PPCL students on organization development and facilitation skills
4. DHE support, planning, resource allocation, implementation, and programme review
5. District support from PSH with fuel and vehicle maintenance
6. Interim district Task Team meetings
7. Regular DHE review meetings with PSH



Recommendations

- VMMC outputs should be monitored in relation to outreach resources invested.
- The team should develop a quarterly outreach plan and share with the DHE.

Lessons Learned

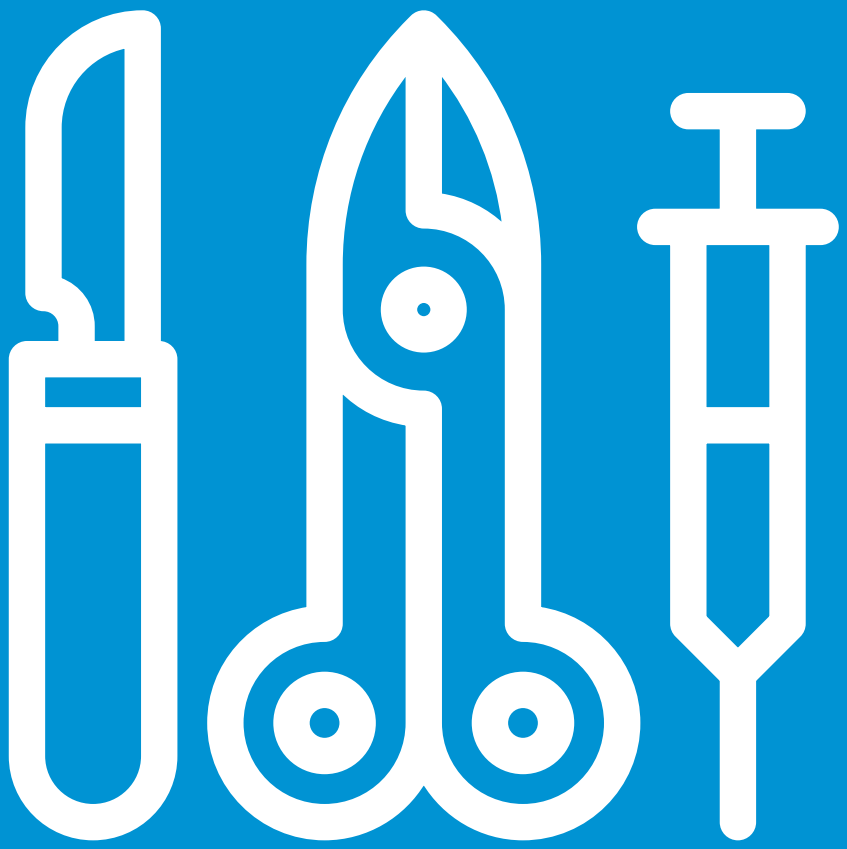
- Increased number of outreach visits does not automatically translate to increased MCs
- Sharing outreach plans at short notice makes it difficult for resource support

Facilitators

1. Periodic Task Team meetings
2. Capacity building on the use of quality improvement techniques
3. Training of PPCL students on organization development and facilitations skills
4. DHE support, planning, resource allocation, implementation, and programme review
5. District support from PSH with fuel and vehicle maintenance
6. Interim district Task Team meetings

Barriers & Adaptations

1. Staff attrition is a major problem.
2. Some trained health workers are transferring to other districts. However, Nyanga has never received any staff who are trained on VMMC.
3. Facility based health workers were not contributing to mobilization, resulting in missed opportunities for clients coming to facilities.



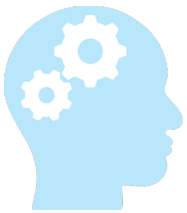
Service Delivery

Doing More with Less

Service Delivery

Hwange District | Matabeleland North Province

Improvement area and aim



Staff attrition in Hwange District from 2nd quarter 2021 led to a decrease in the number of decentralized sites from 14 to 9 facilities. Staff attrition also affected the number of circumcisers available at the district hospital with a reduction from 5 to 2 circumcisers. Geographically, Hwange District health facilities are sparsely distributed with the farthest health facility 185 km from the district hospital. The district had to come up with a cost effective and efficient strategy to ensure continued service delivery without compromising other health services.

Description

Following analysis of the problem, the district was clustered into 4 segments. From these 4 clusters, 7 circumcisers were identified and mentored. These were selected from 27 certified cadres in the district to assist the 25 cadres with basic or conversion training who cannot perform the procedures on their own. Previously the district had 3 mentors who are provincial trainers. The additional 7 were then certified to be additional mentors for a total of 10 mentors. On a monthly basis, facilities without certified circumcisers mobilize clients for service delivery. The decentralized mentors then travel to circumcise the mobilized clients, together with assistants from the health facilities.

Outcomes

With fewer resources, the district has increased clients circumcised and is now achieving targets. The district revived service delivery in facilities that had been affected by staff attrition. The farthest distance mentors had to travel decreased from 185 km (Victoria Falls to Kamativi) to 44 km (Dete to Kamativi), saving fuel and staff time, as only 1 mentor had to do weekly outreach visits. The cost for outreach services also decreased for per diems ($1,630 per month to $865 per month) and fuel ($2,040/mo to $1,020/mo) for an overall reduction in monthly costs of $1,785 or nearly 50% in savings).

Resource	Before Intervention	After Intervention
Staff	2 mentors	1 mentor
Per diem	$1,630 per month	$865 per month
Fuel	$1,200 litres/mo	600 litres/mo
Budget	$3,670/mo	$1,885/mo

Service Delivery

Steps to implement

- Monthly human resource tracking showed a decrease in the number of circumcisers
- District Task Team came up with a strategy of clustering the district into 4
- 7 circumcisers identified, mentored and certified as mentors to support the clusters to add to the pool of 3

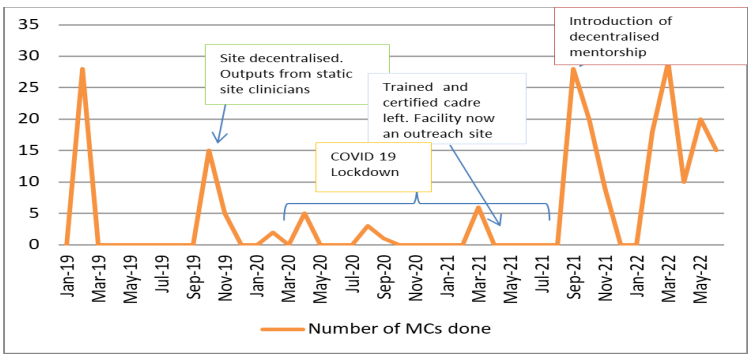
Recommendations

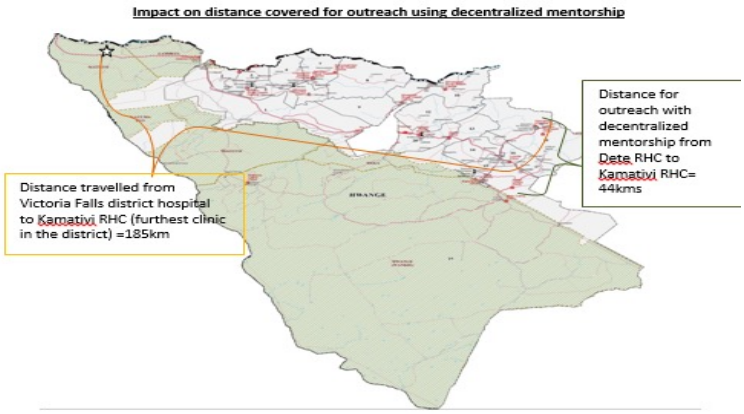
1. There is need to integrate VMMC and other programs
2. There is need for another vehicle to be stationed in Hwange to support the 2 clusters in Hwange East.

Lessons Learned

1. Program ownership by district management is important and sustains gains
2. Horizontal implementation of the VMMC program is possible

Performance effects of staff attrition and impact of decentralized mentorship at Lukunguni Rural Health Centre





Facilitators

- Teamwork and dedication of facility staff and district management
- Availability of certified circumcisers
- Stakeholder support

Barriers & Adaptations

- District has 1 vehicle for VMMC

Increasing VMMC Outreach Services to Improve Performance

Matobo District | Matabeleland South Province

Service Delivery

Improvement area and aim

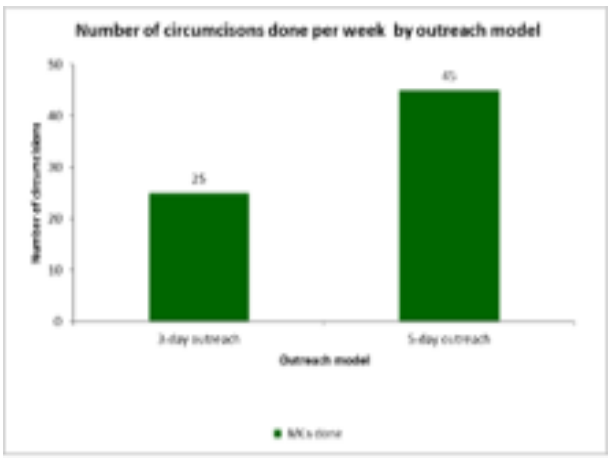
Matobo District has been implementing the VMMC program since 2013. This has mainly depended on partners support and with no clear sustainability strategy or plan. Consequently, the capacity to offer VMMC services in rural health centres was low, with only 2 out of 19 (11%) facilities providing the service onsite, and the remaining 17 relying on the outreach model. This issue has been further exacerbated by high staff attrition of skilled VMMC service providers and the lack of decentralisation of this service to the primary health care level. Hence the number of MCs done per week is suboptimal. The DHE (District Health Executive) aimed to improve access at rural health centres by reallocating human resources in order to maximise the outreach model at the 17 outreach sites.

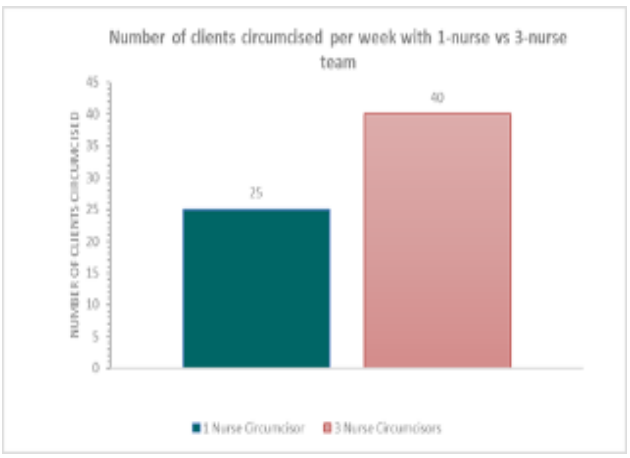
Description

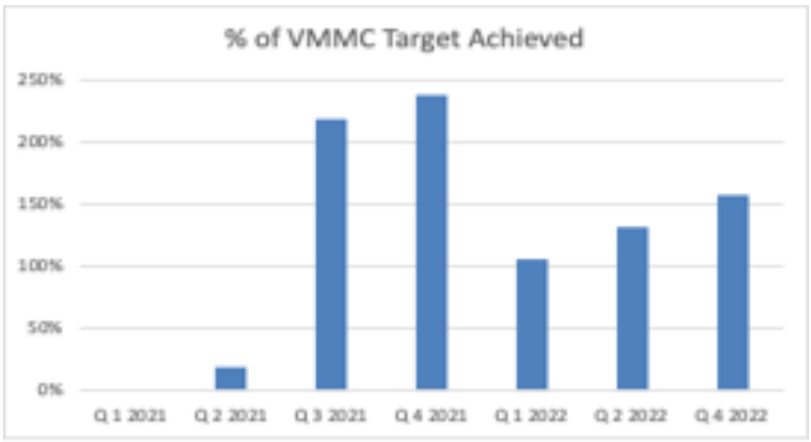
We increased the number of outreach team members from 1 to 3 nurses and the number of VMMC outreach days from 3 to 5 per week to reach more clients in the short term. In the long term, complete decentralisation of the service will be the ultimate goal.

Outcomes

The number of MCs done weekly increased by 60% (from 25 to 40) after improved staffing of the outreach team and a further 20% (from 40 to 45) after increasing the number of days. Overall, we achieved performance improvements by addressing human resources, exceeding our quarterly VMMC targets after implementing these changes.

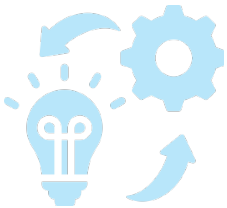






Service Delivery

Steps to implement



1. Formulation of a district plan according to the national Sustainability Transition Implementation Plan Pillars
2. Setting up of a work improvement team to focus on the service delivery pillar. Using root cause analysis and the prioritisation matrix helped determine the best approach to address the problem in peripheral health centres in the short term through effective management and coordination of human resources.
3. Change of team leadership from demand creation officer to a clinician led team.
4. Increased the number of nurses from 1 to 3 and outreach days from 3 to 5 days per week to yield more MCs.
5. Outreach activities, monitoring and evaluation of performance using the Plan Do Study Act (PDSA) cycle.

Team Members

- GMO
- Nurse Circumciser
- Demand Creation Officer
- Data Clerk
- Matron
- DNO
- HPO

Lessons Learned

- VMMC sustainability can be achieved through effective management and coordination of human resources.

Idea Inspiration

- The idea for the sustainability of VMMC services was drawn from the successful roll out of OI/ART services in Zimbabwe, initially through outreach and then decentralisation.

Facilitators

- Training of DHE and Task Team members in planning tools
- Setting up of Work improvement teams.
- Availability of VMMC partner

Barriers & Adaptations

- Staff attrition addressed by maximising usage of all nurses trained and multi-tasking at their work stations
- Competing programmes, effective delegation by managers
- Delays in funding for trainings - on the job training and mentorship
- Reduced VMMC subsidies – top up with GOZ funding allocation
- Donor dependence – 5% of local funding to go towards HIV prevention

Expanding VMMC Service Capacity through Circumciser Training

Service delivery

Nyanga District | Manicaland Province

Improvement area and aim

Nyanga District had a limited number of trained VMMC service providers. A total of 13 certified providers were trained between 2018-2020. Nine of the 13 providers left the district, having retired, resigned, and moved to other districts. The district had 11 providers awaiting certification, but they had not completed enough follow-up procedures to qualify for certification. The district had only 2 out of 30 health facilities offering walk-in VMMC services. The district depended on 3 circumcisers (2 at Nyanga District Hospital and 1 at Regina Coeli Hospital) and 10 assistants. They provided VMMC services as a roving team across the 30 health facilities. This outreach model was expensive and ineffective. A sustainable system is one in which static facilities mobilize and perform procedures daily. VMMC clients should be able to walk into their nearest health facility and get services.

A VMMC procedure is done by 2 trained VMMC providers, 1 of whom should be certified, while the other one can be at any level of VMMC training after completing the basic training. For a health worker to be certified in VMMC, they first go through a 6-day basic training, a 3-day conversion training, and lastly a 1-day certification. After the basic training and the conversion training, the providers are expected to do 15 to 20 supervised follow-up procedures to qualify for certification. Our aim was to ensure that 25% of health facilities in Nyanga district could offer VMMC services by the end of 2021

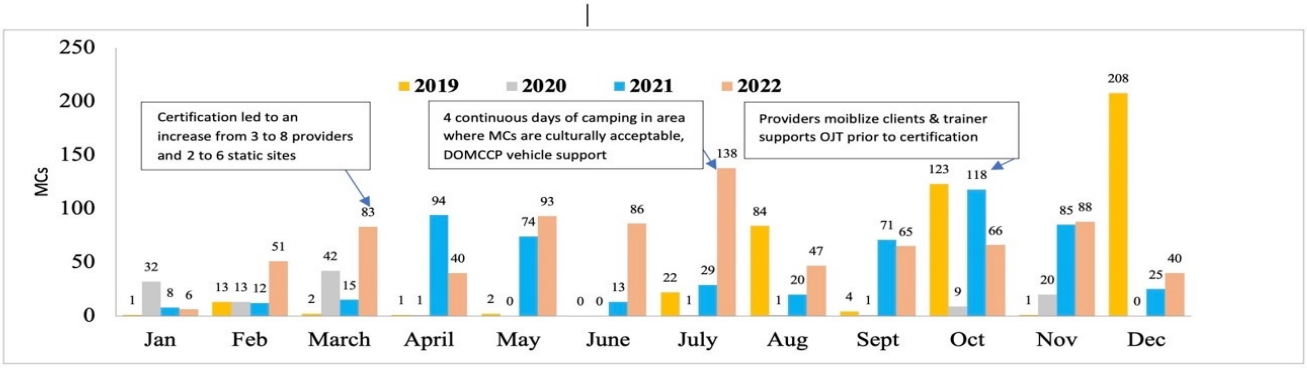
Description

In May 2021, during the 2nd Task Team meeting, a service delivery Work Improvement Team (WIT) was formed. The goal of this WIT was to address the shortage of trained VMMC service providers and the need to increase the number of facilities with the capacity to offer VMMC on a walk-in basis by supporting trainee providers with adequate follow-up procedures. The Provincial VMMC Trainer, who is also a circumciser in Nyanga, led the WIT. The team identified 15 providers who were due for certification and conversion training. They supported them to do adequate follow-up procedures.

Outcomes

Two training sessions were conducted at Regina Coeli Mission Hospital, a 6-day basic training and a 1-day certification. A total of 4 providers were trained in basic VMMC, 5 were certified, and 5 were converted. The total number of static health facilities with a capacity to offer VMMC services increased from 2 to 6 sites. Certified providers increased from 3 to 8 providers. The support of follow-up procedures and the increase in certified providers increased VMMC performance. Overall, the coverage of MCs increased from 2% to 51.4% from 2020 to 2021.

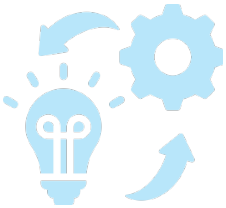
Male Circumcisions by Month from 2019 to 2022



Service delivery

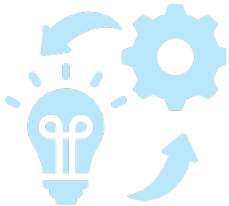
Year	Total MCs	Annual Target	Achievement
2019	461	1554	30%
2020	120	1589	8%
2021	564	1097	51%
2022	803	1037	77%

Pre-Implementation



1. Problem identification
2. Service delivery WIT formation
3. Plan for follow-up procedures
4. Certification and conversion

Steps to implement



1. Provider-initiated demand generation through "bring-a-buddy" technique
2. Facility-based mentorship by the Provincial Trainer
3. 20 follow-up procedures done per provider
4. Follow-up log sheets signed
5. Training conducted

Facilitators

1. The WIT was a strategic engagement and planning platform.
2. The consistency in availability of a vehicle facilitated easy access to all providers.
3. Resident Provincial VMMC Trainer
4. PSH support for training sessions

Lessons Learned

1. Support from the District Nursing Officer (DNO) is key to motivate trained providers for continued service delivery
2. Loss of trained providers to retirement, resignations, transfers etc. is continuous and should be anticipated.
3. The presence of a resident Provincial VMMC trainer is essential for supporting trainee providers with follow-up procedures.

Recommendations

1. Planning meeting for training nurses should include the District Nursing Officer.
2. Training of nurses for VMMC should be a continuous activity in anticipation of attrition.
3. All districts should have at least 1 Provincial trainer to oversee quality and continuous training.

Barriers and Adaptations

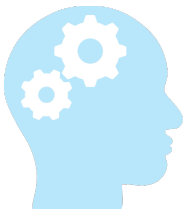
- Poor demand generation support caused a delay in the completion of 20 follow-up procedures per person. Provider initiated demand generation through 'bring-a-buddy' helped to increase clients seeking VMMC.
- High workload at facilities, which sometimes limits VMMC follow-up procedures. The Work Improvement Team resolved to address this through service task-sharing.
- Poor road networks in Bende and Nyafaru affected service delivery to already mobilized clients during the rainy season. The WIT is addressing this by accelerating the establishment of 2 health facilities as static sites offering VMMC services

Decentralization of Voluntary Medical Male Circumcision Services

Service Delivery

Nyanga District | Manicaland Province

Improvement area and aim



Nyanga district VMMC services were mostly delivered through an outreach/mobile team with circumcisers from the district hospital. There was a shortage of staff in rural health facilities, and sometimes the outreach sessions were interrupted by communication breakdowns or poor mobilization. In addition to limited human resources, the low number of VMMC trained providers (3 certified) negatively affected VMMC services. VMMC clients would travel long distances to facilities that offer VMMC. Some clients would wait for many days until their facility got support from the roving district team.

Description

During the first OPTIMISE Task Team meeting, a Service Delivery Work Improvement Team (WIT) was developed. Led by a resident VMMC Provincial Trainer who is also a certified provider, the team generated a VMMC provider training plan for 2021. This list included providers to be trained in basic VMMC and those to be converted and certified. The plan also addressed a gap in supporting 11 providers with follow-up procedures to qualify for the next level of training. The team implemented and frequently reviewed the training plan, sharing regular updates with the District Health Executive (DHE) and the Task Team.

Outcomes

The total number of circumcisers to perform MCs increased by six. Additionally, five assistants were converted, and the number of facilities offering VMMC increased by four. The increased number of certified providers led to more MCs and reduced outreach services.

Training and Service Delivery		Outcome	
		Before	After
Circumcisers		6	12
Assistants	Basic	10	10
	Conversion	0	5
Facilities offering VMMC		2	6

Service Delivery

Pre-Implementation

1. Problem identification
2. Generation of solutions
3. Consolidated work plan

Steps to implement

1. Task Team formation
2. Creation of a service delivery WIT
3. Development of a staff development register
4. Support providers with follow-up procedures to qualify for the next level of training
5. Conduct VMMC trainings: basic, conversion, certification
6. Share VMMC outreach plans and updates
7. Timely vehicle servicing and procurement of fuel through PSH
8. Monitoring of VMMC outputs per outreach visit
9. Revision of the work plan
10. Planning of VMMC camps

Team Members

- DMO
- DHPO
- CHN
- CHN
- DHIO
- DPO
- DHSA
- DSI
- DDC
- DAC
- Pastors Forum
- PVO

Lessons Learned

1. Support from the District Nursing Officer (DNO) is key to motivate trained providers for continued service delivery
2. Training of providers for VMMC should be continuous to cover the gap from attrition.
3. Teams need to plan ahead for service delivery, (e.g., quarterly service delivery plans) in order to meet targets.

Facilitators

1. Periodic Task Team meetings
2. A resident Provincial trainer with capacity
3. Availability of funds to train more cadres
4. DHE support, planning, resources allocation, implementation & program review
5. District support from Population Solutions for Health (PSH) with fuel and periodic vehicle maintenance.
6. Interim District Task Team meetings.

Barriers & Adaptations

1. Staff attrition is a major problem.
2. Some trained health workers are transferring to other districts. However, Nyanga has never received any staff who are trained on VMMC.
3. Facility based health workers were not contributing to mobilization, resulting in missed opportunities for clients coming to facilities.

Increasing VMMC Coverage in Low Performing Facilities

Service Delivery

Gwanda District | Matabeleland South Province

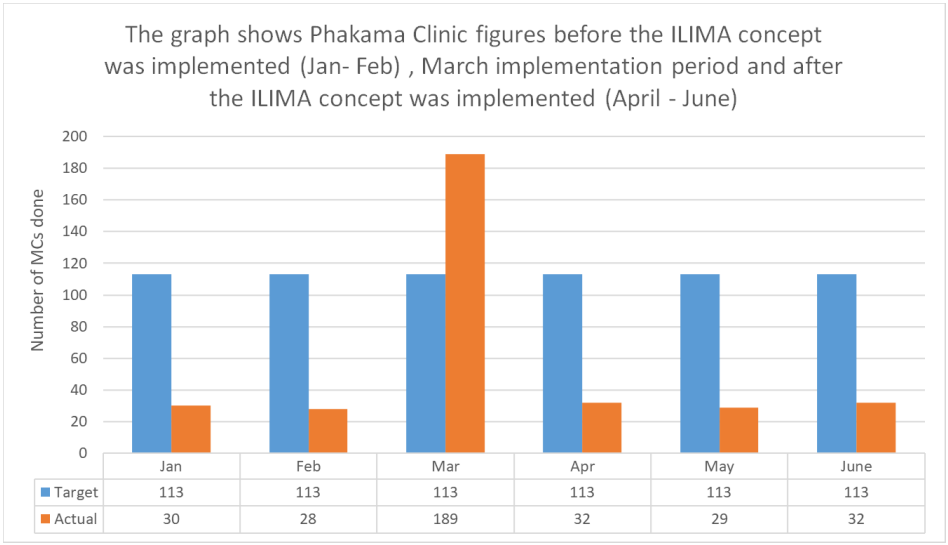
Improvement area and aim

Following the analysis of Q4 2021 VMMC data, some facilities in Gwanda District were consistently achieving their targets, whereas other facilities were not, despite all the facilities having at least one trained nurse and receiving support from the outreach team. This difference was mainly due to the shortage of mobilisers in the affected areas. In view of this, the district adopted a pooled human resources strategy for demand creation to assist the low performing facilities to achieve their targets, using the ilima concept. Our aim was to increase VMMC coverage in low performing health facilities so that they could achieve their targets by the end of Q1 2022

Description

The district adopted the social mobilisation strategy or ilima concept in March 2022. *Ilima* is a traditional practice of working together as a community to help each other to achieve a task within a short period of time. In this instance, Phakama Clinic was the first beneficiary of the concept. Mobilizers from neighbouring villages teamed up to assist with demand creation in the low performing facilities. This was done one day per week for the month of March. Months without *Ilima* show low performance, indicating how effective the strategy was.

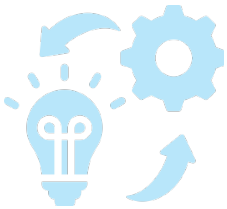
Outcomes



NB: *Ilima* concept was implemented in one facility which is Phakama Clinic. The plan was to cascade implementation of ILIMA to other facilities.

Service Delivery

Steps to implement



1. Map mobilisers from neighbouring facilities
2. Plan dates and areas for mobilisation
3. Communicate plans to mobilsers
4. Transport mobilisers to the facilities where *Ilima* will be done
5. Conduct a 5 day campaign using one on one communication with clients

Team Members

- DMO
- DNO
- Administrator
- District Pharmacy Technician
- DHIO
- District Focal Person
- VMMC Focal Person
- Community Nurse
- District Remedial Tutor
- District AIDS Coordinator
- District VMMC Sustainability Officer
- District Health Promotion Officer

Lessons Learned

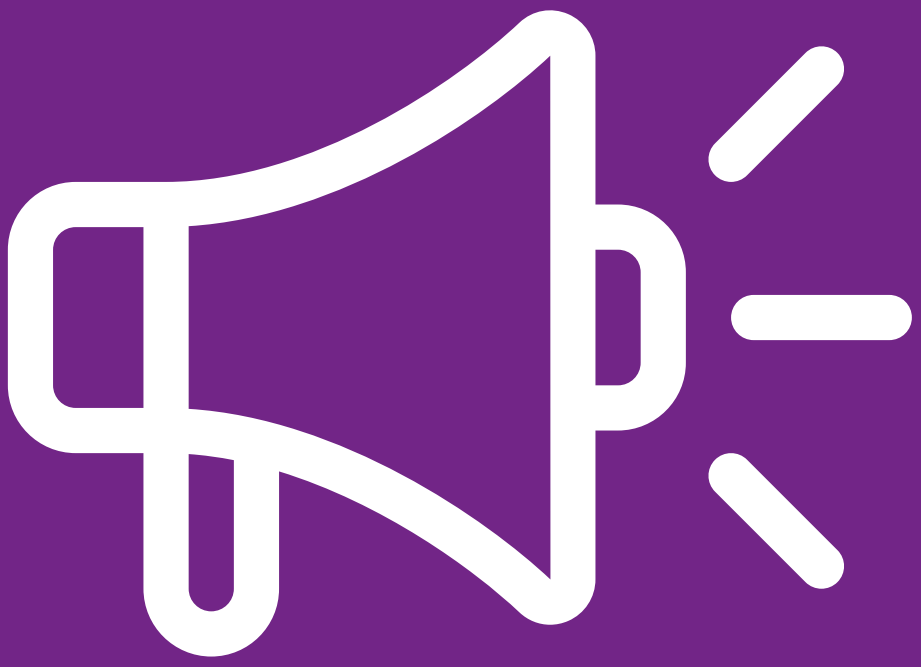
- Team work contributes high outputs.
- Effective demand creation yields high results

Recommendations

- Replicate the Ilima concept for other facilities with low performance.
- Develop local IEC materials appropriate for the target age group (15-29) using available local funds.
- Engage VMMC champions who are closer in age to the target group as peer educators.

Barriers & Adaptations

- Shortage of vehicles for coordinating demand creation activities.
- Shortage of IEC materials appropriate for the target age group (15-29) years.
- The targeted group could not relate well with mobilizers due to age differences.



Demand generation

Revitalising Community Led Demand Creation

Demand Generation

Matobo District | Matabeleland South Province

Improvement area and aim

With the COVID-19 pandemic, the number of clients mobilised and circumcised declined from 639 in March 2020 to zero in December 2020. The major contributing factors were the restrictions imposed on gatherings and travel, which affected demand creation activities. The aim of the District Health Executive was to revitalise demand creation activities by formulating integrated work plans.

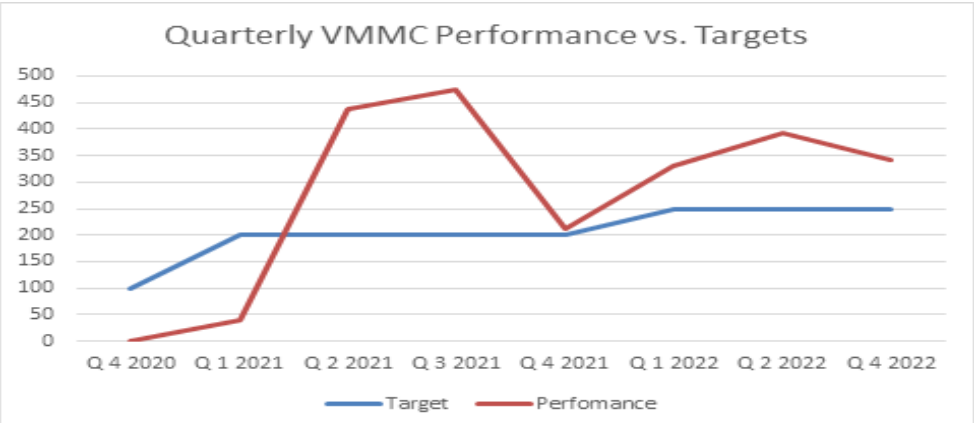
Description

First, the DHE formulated a sustainability and integration work plan. The DHE then set up a Work Improvement Team to focus on demand creation. The Work Improvement Team consisted of the DNO, HIV focal person (Matron) and HPO. The DHE brainstormed on the causes of poor demand creation and ways to sustain demand for health services with particular attention to VMMC. Using a prioritization matrix, demand creation was identified as an area for potential quick wins with minimal effort. This idea was also seen as an opportunity to integrate and sustain demand for all health services across the health system in the district.

Outcomes

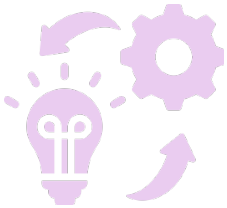
Number of clients mobilised from October 2020 to December 2022:

- Trainings in Q1 2021 resulted in an increase of 0 clients to 39 clients circumcised.
- Refresher training in Q2 2021 resulted in an additional 437 circumcisions.
- Q1 2022 figures increased due to intensified door to door campaigns/mobilisations.



Demand Generation

Steps to implement



1. Formulation of a district sustainability and integration plan, adopting national recommendations to resume VMMC service delivery in the context of COVID-19.
2. Set up a Work Improvement Team focusing on demand creation
3. Integration of demand creation activities with other health care activities: outreach EPI, VIAC, COVID-19 vaccination awareness and sensitisation meetings.
4. Designed strategies to improve demand creation mobilizer trainings for VHWs, ward focal persons, CHBCGs, community dialogue trainings of health workers, introduction of the instant mobiliser reimbursements – supported by ZICHIRE, bring a buddy initiative.
5. Demand creation feedback through a mobiliser WhatsApp group for immediate reporting
6. Reviewed and revised planning for demand creation.

Team Members

- **HPO**
- **Matron**
- DNO
- HPO

Lessons Learned

- The district had to maintain a baseline of 200 people reached with VMMC information monthly. Continuous training and replacement of community mobilisers, VHWs and VMMC champions is also key for sustainability of demand creation.

Idea Inspiration

- The idea for the spotlight was derived from the EPI programme, which is viewed as an essential need at community level. The community leads demand for the services offered though active participation

Facilitators

- Training of DHE and Task Team members in planning tools
- Setting up of demand creation Work Improvement Teams (effective & efficient).
- Availability of VMMC partner- ZICHIRE
- Training of health workers on COVID-19 by WHO
- Other demand creation activities for COVID-19 and TB

Barriers & Adaptations

- Facility based health workers were not contributing to mobilization, resulting in missed opportunities for clients coming to facilities. HPO went for MDL but an EHO seconded to role
- Competing programmes, effective delegation by managers

Diversifying Multisectoral Demand Creation for VMMC Integration

Demand Generation

Lupane District | Matabeleland North Province

Improvement area and aim

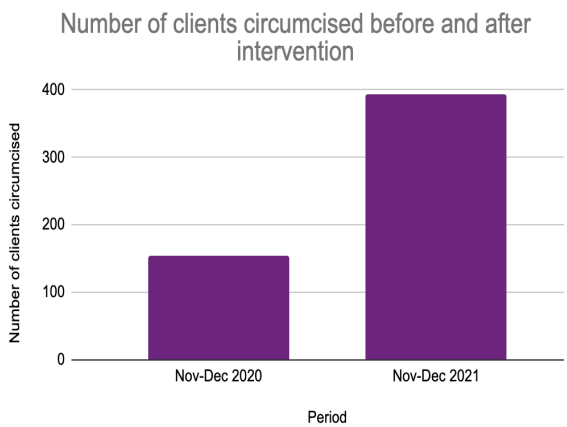
The demand creation model used for VMMC in Lupane district was neither cost-effective nor sustainable and was expensive to operate. Mobilisers supported by some partners were paid US$3 per client mobilised. However, for other partners, mobilization activities were already integrated into their routine work and such cadres were not paid per client mobilised. We aimed to improve efficiency and reduce costs by diversifying and increasing the platforms for demand creation for VMMC.

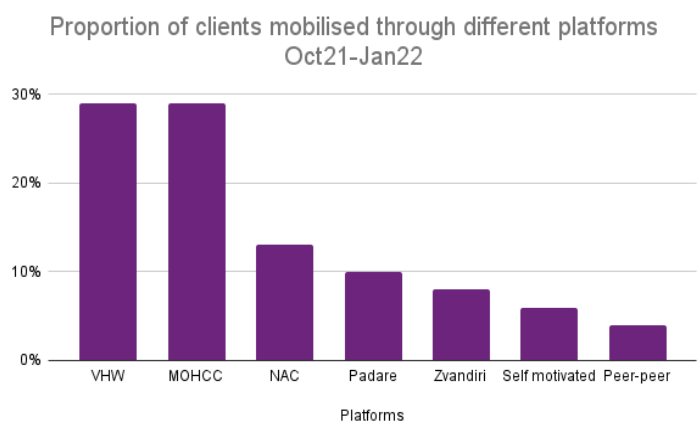
Description

Stakeholder mapping was done to identify the HIV prevention activities each stakeholder was doing throughout the district. An effort versus impact prioritisation tool was used to examine each demand creation activity. The team then engaged other local stakeholders, including Padare, Zvandiri, and the National AIDS Council, to get involved in demand creation activities. This resulted in a wider base of demand creation cadres.

Outcomes

The intervention resulted in 7 platforms being used to create demand for VMMC including VHWs, Padare, Zvandiri, NAC, MOHCC, peer-peer and self-referrals. The number of clients circumcised increased from 155 between Nov-Dec 2020 to 394 during the same period in 2021. VHW and MoHCC channels accounted for more than half of the mobilizations. The use of multiple platforms reduced the overall mobilization costs per month by more than 50%

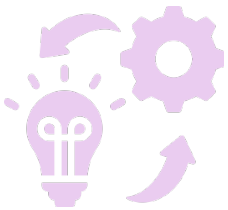




Demand Generation

	Number of clients circumcised	Demand creation cost $	Demand creation unit cost $
Q1 2020	2859	17154	6
Q1 2021	293	879	3

Steps to implement



1. Stakeholders sensitised at various levels.
2. Joint stakeholders planning meeting held.
3. Sensitisation of cadres on the ground with implementation schedules. These are mobilisers, male advocates, BCFs and HCCs.
4. Demand creation activities implemented.
5. Health Promotion Officer daily reporting to service delivery team to track progress.

Team Members

- Nurses
- Health Promotion Officer
- Doctor
- Education Officer
- Health Information Officer
- Driver

Lessons Learned

1. Teamwork improves productivity, leading to cost reductions in implementing a change idea.
2. Standardisation of key messages leads to activity improvement.

Facilitators

1. Buy in and guidance from DHE
2. Continuous feedback from partners
3. Use of local languages which aided in effective communication

Barriers & Adaptations

- Delays in payment of incentives to demand creation cadres.
- Poor coverage of demand creation activities due to limited number of cadres on the ground.

Increasing Engagement of Low Yield Wards in VMMC Services

Demand Generation

Nyanga District | Manicaland Province

Improvement area and aim

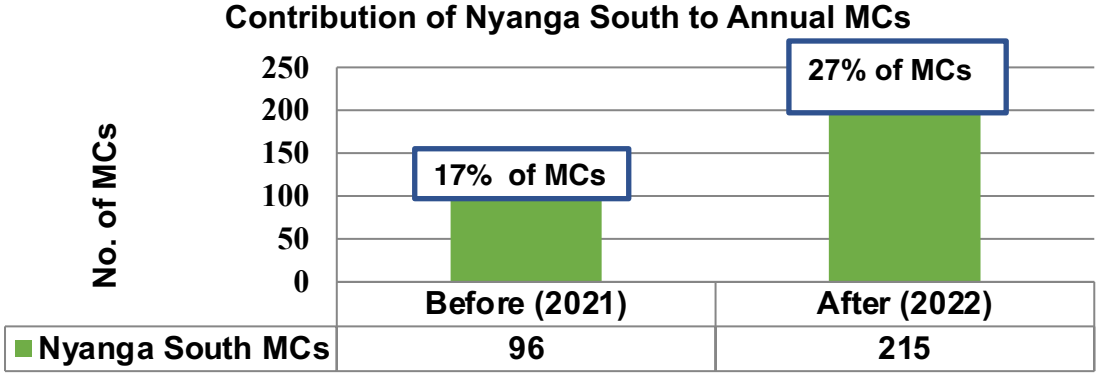
The community in Nyanga South does not practise circumcision as part of their culture, unlike Nyanga North. This explains why there was low VMMC uptake relative to Nyanga South. Moreover, more partners were supporting wards in Nyanga North. Only one partner (Nyanga Community Development Trust (NCDT)) was supporting 6 wards in Nyanga South. Accessibility in Nyanga South is also an issue; approximately 95% of the roads are gravel with difficult terrain, making some areas hard to reach.

Description

The problem was identified and discussed during the Task Team meeting with relevant stakeholders, including the District Development Coordinator's (DDC) office, National AIDS Council (NAC) and the Pastors' Fraternity. The DAAC (District AIDS Action Committee) platform was used to integrate the VMMC program.

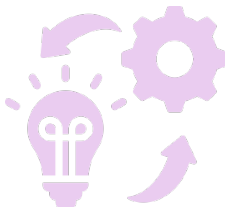
The National AIDS Council sensitized 28 BCCMs (Behaviour Change Communication Officers) with VMMC demand generation training. BCCMs were sensitized from all wards, including the 18 Nyanga South wards. The DDC office shared a list of all partners operating in Nyanga South (Community Technology Development Organization, FACT Organization and Simukai Child Protection Program) for integration of VMMC education during care group trainings, community visits, and Health Centre Committee meetings. The District Pastors' Fraternity relayed information and engaged the special groups from religious objectors who deny medical services. Of particular interest was Nyajezi, Nyafaru, Ruchera, Nyautare and Nyatate. School Health Coordinators from 18 wards in Nyanga South were all trained in interpersonal communication demand generation. During 2022, facilities in Nyanga South have contributed 27% (215/803) of the total annual MCs. This is an increase from the 17% (96/564) contribution in 2021.

Outcomes



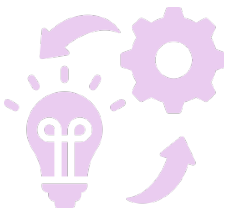
Demand Generation

Pre-Implementation



1. During a Task Team meeting, a challenge was observed that there was low uptake of VMMC services in Nyanga South.
2. The District AIDS Action Committee was identified as the platform to integrate the VMMC program.
3. Stakeholders, partners, and the DHE supported and facilitated program integration and resource mobilization.

Steps to implement



1. One day meeting with District AIDS Action Committee.
2. The provincial trainer conducted mentorship and procedure follow up visits.
3. Activities integrated with local partners.
4. MMC service delivery in Nyanga South wards through Rural Health Centres (RHCs)
5. Sensitization of SHCs and community health workers
6. 2 service providers were certified.

Team Members

- DMO
- DHPO
- CHN
- CHN
- DHIO
- DPO
- DHSA
- DSI
- DDC
- DAC
- Forum
- PVO

Lessons Learned

- Training of providers should be ongoing.
- The Task Team should continuously engag e partners in the district.
- Engagement of stakeholders will increase VMMC coverage.

Facilitators

- Periodic Task Team Meetings
- District Aids Action Committee (DAAC)
- Buy-in and guidance from DDC office and DHE
- The presence of a resident provincial trainer
- Interim district Task Team meetings supported by PSH

Barriers & Adaptations

- Density of religious objectors for medical services
- No VMMC practicing culture in Nyanga South
- Poor road network
- Lack of HIV/AIDS partners in Nyanga South

VMMC Multisectoral Demand Creation

Demand Generation

Nyanga District | Manicaland Province

Improvement area and aim

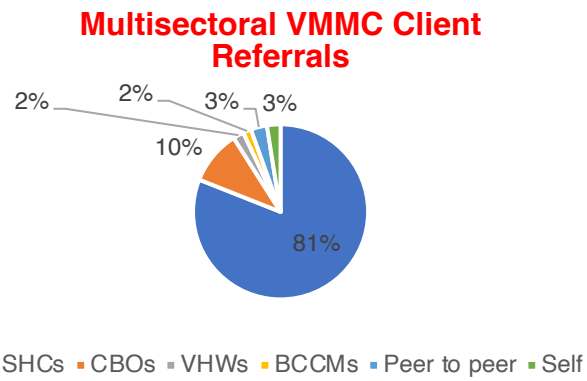
Demand generation usually requires more resources. If demand generation is only done by the MoHCC, outputs are usually low. Supporting demand generation by one stakeholder is not cost effective nor sustainable. The district had no partners to support capacity building of VMMC mobilizers. With the OPTIMISE project, we decided to involve other stakeholders to improve efficiency and reduce costs. This was achieved by diversifying and increasing the platforms for demand creation, particularly for VMMC but also other health programmes.

Description

In early 2021, the Task Team identified a failure to meet the annual targets for 2020 as a problem. Nyanga District only managed to achieve 7% (117/1589) of its annual 2020 targets. In addition to a drop in demand due to COVID-19 restrictions, there was a gap in demand creation. All stakeholders agreed to focus on designing activities to increase demand generation. This included engaging local partners to support demand generation. In the past, only School Health Coordinators (SHCs) had done this. We decided to involve mobilizers, Community Based Organizations (CBOs), and village health workers (VHWs) to help the SHCs.

Outcomes

Item/Activity	Outcome	
	Before	After
Multisectoral approach	None	8 various stakeholders raising awareness
Mobilizers	0	38
Mass media approach	No funding. Only using SHCs, IEC materials	Subgranting funds available to support this
Referrals	SHCs	SHCs, DOMCCP (CBOs), VHWs, BCCMs, peer to peer, self



Demand Generation

Pre-Implementation

1. Stakeholder mapping was done to determine which stakeholder was doing which type of HIV prevention intervention in various geographical location in the district through the District AIDS Action Committee (DAAC)
2. Each stakeholder doing demand generation share plans during routine meetings for integration
3. Engagement of local leadership and community from the grass roots, at village heads' homesteads

Steps to implement

1. Stakeholder sensitization at various levels and opportunities
2. Planning along with other stakeholders
3. Actual sensitization of community cadres on the ground (DOMCCP and PSH) with implementation schedules
4. Sharing of VMMC outreach plans and updates
5. Monitoring VMMC referrals from mobilizers
6. Health Promotion Officer weekly reporting to service delivery team as needed

Team Members

- DMO
- DHPO
- CHN
- CHN
- DHIO
- DPO
- DHSA
- DSI
- DDC
- DAC
- Pastors Forum
- PVO

Lessons Learned

1. Communication improves teamwork spirit and productivity, leading to cost reductions in implementing a change idea
2. Key messages should be standardized nationally
3. With national implementation of VMMC, there is a need to equip demand generation teams with real-time information for dissemination

Facilitators

1. Periodic Task Team meetings
2. Capacity building of mobilizers
3. Availability of funds to train more mobilizers
4. Buy-in and guidance from DHE
5. District support and continuous feedback from Population Solutions for Health (PSH) with fuel and occasional vehicle maintenance.
6. Interim District Task Team meetings

Barriers & Adaptations

- Poor coverage of demand generation activities due to limited number of cadres on the ground
- Some trained cadres failed to refer clients or mobilize, citing different challenges relating to community resistance
- Facility based health workers were not contributing to mobilization, resulting in missed opportunities for clients coming to facilities.

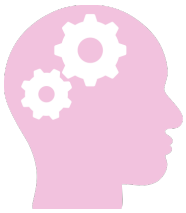
Quality

Integrated VMMC Clinical Mentorship and Support

Quality

Lupane District | Matabeleland North Province

Improvement area and aim



The VMMC mentorship programme had been conducted parallel to the existing district clinical mentorship programme, requiring separate funding, additional time, and placing an increased workload on mentors and mentees. This resulted in inconsistent programme follow up. The parallel mentorship programmes were not sustainable and needed to be integrated. The VMMC mentorship tool was also long and did not follow up on progress.

The aim was to incorporate VMMC mentorship into an existing, integrated facility site support and mentorship programme.

Description

The Task Team identified an opportunity to integrate VMMC mentorship into the existing clinical mentorship programme. The adapted mentorship tool assessed VMMC training needs but did not include "VMMC clinical mentorship and data quality issues". A new page on "VMMC Mentorship" was included in the tool that was then used during integrated clinical mentorship visits.

Outcomes

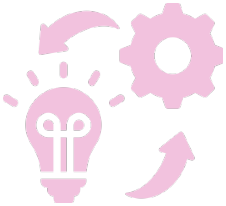
The change reduced mentor to mentee contact from 2 visits by 2 mentorship teams in a quarter to 1 comprehensive integrated visit. Prior to the integrated mentorship programme the District incurred a lot of costs (monetary, human resources, time) from having parallel mentorship visits. Due to the introduction of the Integrated Clinical Mentorship Programme in line with the Sustainability Transition Implementation Plan, all associated costs have been reduced by 50%. The cost reduction did not affect the quality of service delivery.

	No. mentors/team	Unit cost (lunch)	No. of facilities	Annual visits	Number of Teams	Total Cost
Before	5	US $10	13	8	2	US $10,400
After	5	US $10	13	4	1	US $2,600
Total Annual savings for per diems						US $7,800

Generally, above 50% savings were realised on all variable costs, i.e., fuel, human resources, time, task repetition.

Quality

Steps to implement



- Gap identified in how VMMC and facility clinical mentorship programme were conducted.
- Planning meeting for integrated clinical mentorship visits. Tool modified to include VMMC mentorship and data quality.
- Training of mentors in integrated clinical mentorship.
- Actual programme implementation of integrated clinical mentorship visits with new tool used at each facility visited.

Team Members

- Mentors
- Facility staff
- Driver

Lesson Learned

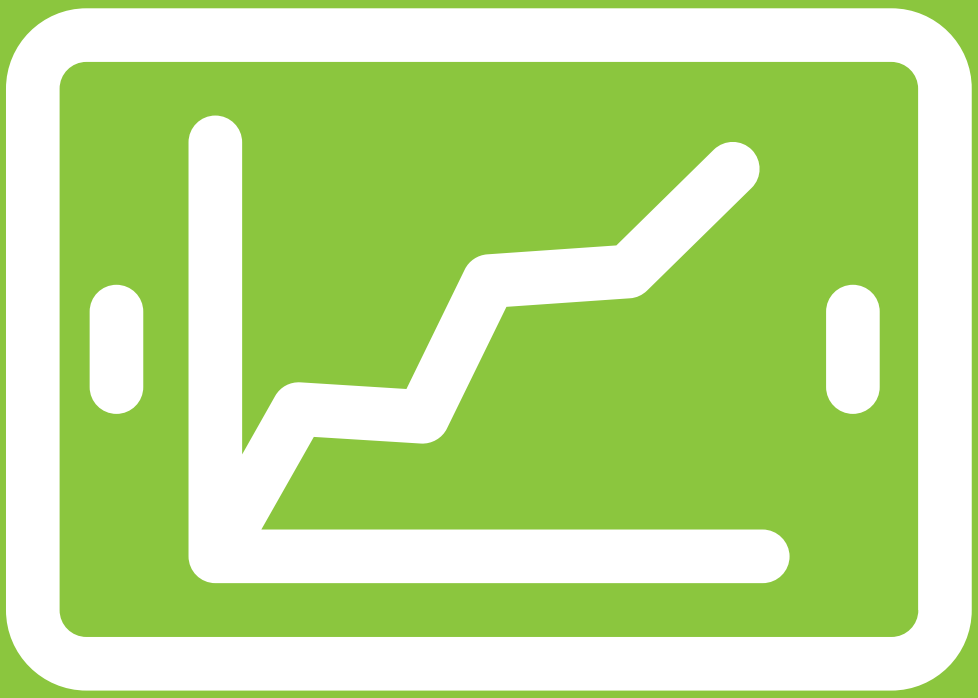
- Teamwork improves productivity, leading to cost reductions from implementing a change idea.
- Standardisation of key messages leads to activity improvement.

Facilitators

- Availability of VMMC trainers and mentors for an integrated clinical mentorship team.
- A committed mentorship vehicle

Barriers & Adaptations

- Staff attrition
- Competing programmes within MoHCC



Strategic information

Improving VMMC Data Quality for Decision-making

Strategic information

Gwanda District | Matabeleland South Province

Improvement area and aim

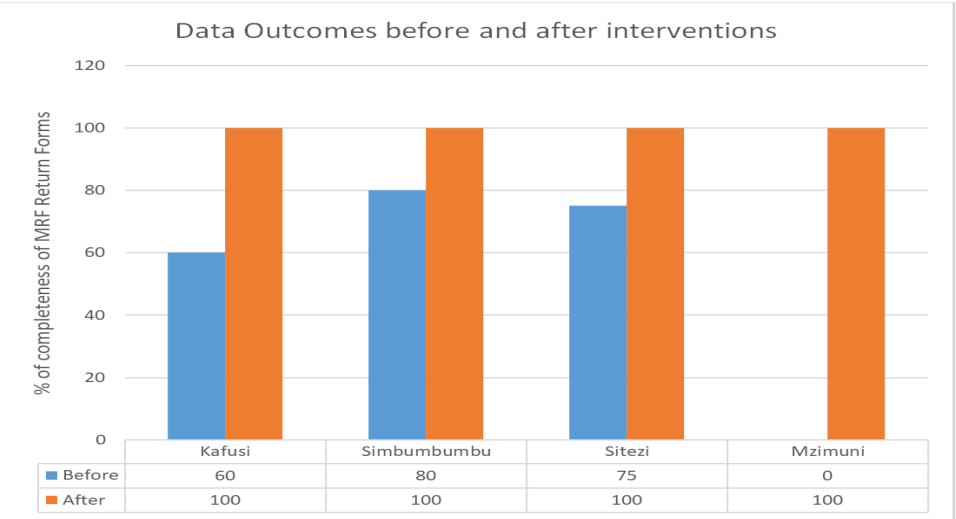
Quality data is important for informing decisions and improvement interventions in healthcare. Health facilities in Gwanda District were experiencing challenges with late reporting rates, incompleteness, and inaccurate reporting. Underlying causes included gaps in skills and knowledge among health workers on how to use the monitoring and evaluation tools for VMMC. We aimed to improve data completeness from 60% in December 2020 to 100% by December 2021 by conducting monitoring, evaluation, and mentoring in strategic information at the facility level.

Description

Following root cause analysis and prioritization of key challenges, the Task Team identified gaps in the quality of data. The team reviewed available data verification and triangulation protocols and selected the Continuous Quality Inventory (CQI) tool for this purpose. A multidisciplinary team was assembled who conducted the triangulation across multiple sources including DHIS2, monthly return forms, Client Intake Register (CIR) forms, and registers at facility level. Gaps in data quality were discussed with the facility team and addressed through onsite mentorship.

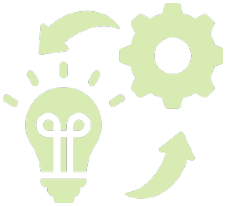
Outcomes

The onsite data verification and mentorship resulted in improved timely reporting rates across the four supported facilities. In addition, data variances between DHIS2, Monthly return forms (MRF) and primary data sources were reduced to acceptable ranges which is 5%.



Strategic information

Steps to implement



- Selection and prioritization of facilities to be engaged
- Validating District Health Information System Version 2 (DHIS2)
- Review of protocol and process for data verification by the Task Team
- On site Data Verification (OSDV): comparing DHIS2, Monthly Return Forms (MRF) , Client Intake Register (CIR) form and registers
- Tabulate findings and share with facility team
- Compare data between partner and DHIS2 for invoicing purposes
- Mentorship of facility team
- Monthly data quality meetings integrating VMMC
- Follow up exercise to validate submitted data
- Update and correct data in DHIS2
- Conduct monitoring and evaluation (M & E) trainings
- Conduct Electronic Health Record (EHR) trainings at selected sites

Next Steps

- Continue support and supervision, mentorship
- Continue onsite data verification
- Continue the rollout and training

Lesson Learned

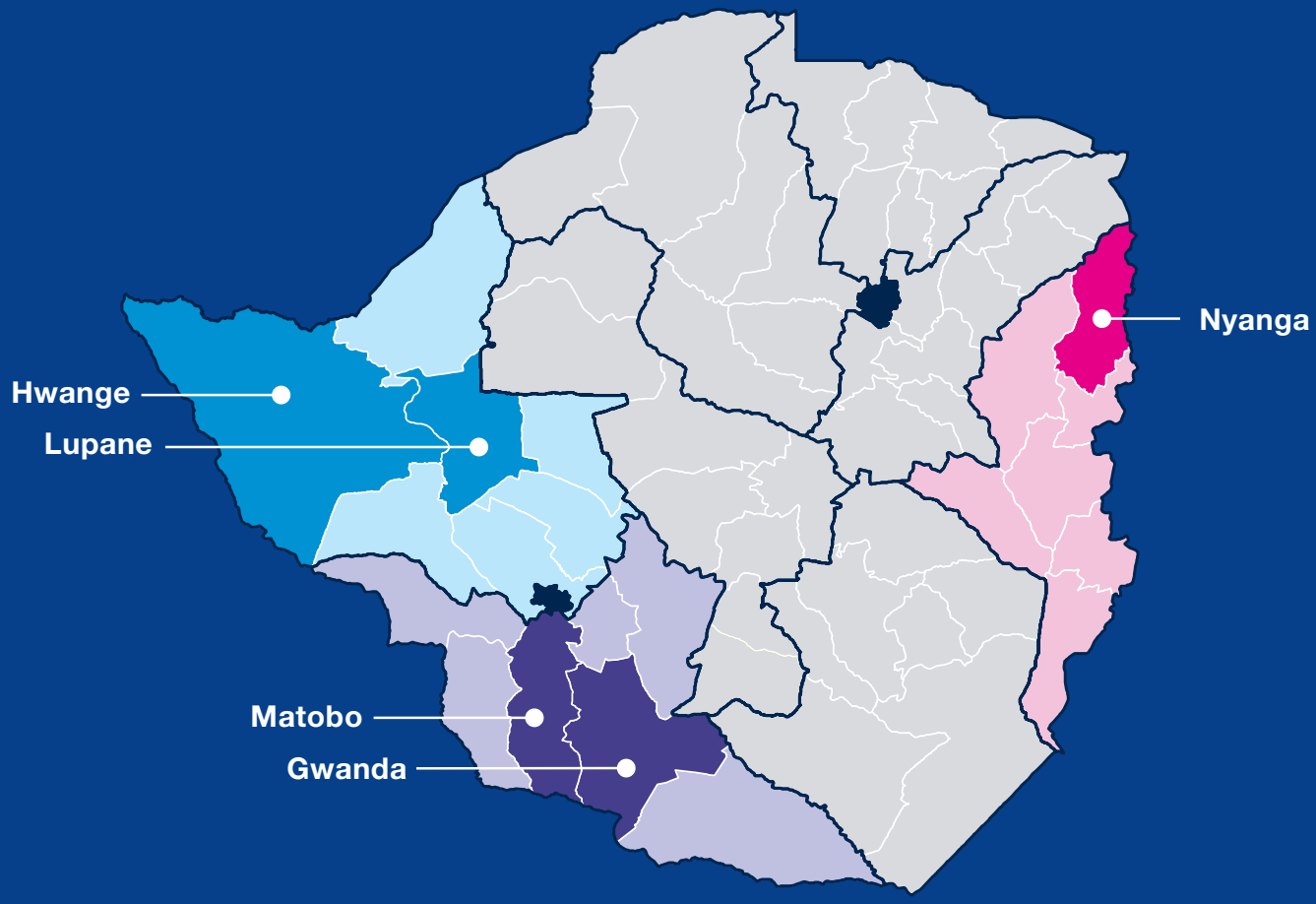
- Regular monitoring and mentorship will identify issues early and result in timely improvements
- Teamwork facilitated the achievement of improving data quality
- Monitoring and evaluation trainings equipped the team with skills to track progress

Facilitators

- Support from the provincial team
- Collaboration with Population Services Health (PSH) and other partners

Barriers & Adaptations

- Covid 19 restrictions limited team data verification meetings
- Limited resources to carry out verifications
- Shortage of staff due to attrition
- Competing programmes



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