Jackie Sullet: – and a total of five speakers. After each presentation, we will have a brief Q&A session. To ask your questions, there is a box at the bottom of your screen. If you look on your screen, on the webinar environment, there is a Q&A box. You can go ahead and type in your questions, even while the presenters are speaking. If you have a question or a comment, you don't have to wait until the end of the presentation to type in your comments or questions. You go ahead and ask your questions and we have a team of technical people who will assist you if you have any difficulties.

Also, you can tag and it will be done. Only we can see your questions or any difficulties that you have with the connection. We will assist you. We will collect all of your questions and pose them to our panelists and speakers so they can respond to your questions. If we do not have time to respond to all of your questions, this webinar is being recorded, and the questions that are not answered will be shared with all of our speakers. They will provide the answers and will post it on the website and you will be able to have access to it.

If for some reason, you get disconnected, just reconnect. Close your browser, reopen your browser, and reconnect to the Adobe Connect. If you're still having difficulties, do not worry. Like I said, this session is being recorded and it will be posted on the website. We'll send you a message and you will have access to it.

Now, I would like to introduce our speakers. This morning, for our first session, we have Dr. Valerian Kiggundu from USA, Washington D.C. He's the Senior Prevention Advisor for VMMC Services. We also have Dr. Stephanie Davis, who is from the US Center for Disease Control and Prevention. She's from the Voluntary Male Circumcision Team.

Now, I would like to turn over to our presenters, Valerian and Stephanie, to do the first presentation. Valerian, over to you.

Dr. Valerian Kiggundu: Thanks, Jackie. Can you well?

Female Speaker: Yes, we can hear you, Valerian.

Valerian: Thank you very much. Good morning and good afternoon, everyone. Welcome to this webinar. Thank you so much for joining us. During this first part of the presentation, Stephanie and myself are going to talk about preferred best practices for VMCC

site operations, which is the second edition, which would like you to know that it's currently out and available for use.

This presentation basically covers the following topics, as you see on this slide. First and foremost, we'll talk about objectives of PEPFAR's Best Practices Guide, how to access the guide, and structure and organization of the second edition. I have a couple of reference docs and resources and we shall review the 12 chapters included in the second edition. Then, we shall talk about the key changes and then review some case studies that are being included in this guide. And finally, the final packaging of the second edition.

The key objectives of the Site Operations Guide – one is to provide guidance on the processes for establishing and maintaining high-quality VMMC services. Two, is to describe approaches that have been previously used to establish VMMC services successfully in priority countries.

And, to ensure high-quality and safe VMMC services from the outset, we'll focus on minimizing any potential delays that could affect service delivery of the program. And finally, I will cite and share key best practices from the field.

[Omit interruption] [00:04:51]

Valerian: On this slide, basically we have a web link on how to access the guide. It's important we know where the guide is located on the AIDSFree website. We shall talk a little bit about that, but with this web link, you can copy and paste it into your browser and it will take you directly to the guide.

The structure and organization of the second edition, first and foremost, there are 12 chapters, and each of the chapters have been organized into the following subheadings. First, you have the chapter goals, which state the objectives of the chapter. Next, you have what you need to know, which key highlights in the chapter. It summarizes the important information and referenced documents with a link for the online version or directions for the printed version to tools, documents, and resources that you'll want to access.

Next, each chapter has frequently referenced information, which has additional relevant content embedded into the body of the text. And then, there is additional information, if you need to read more about the chapter, followed by tools, instruments, and guidance

documents. And, finally, case studies and references.

This slide shows some of the key documents that have been included in this guide. Important to note is that all of these documents are not basically available in the guide, but they are links, which are hyperlinks, so that's in case you need this guide in an online version. You can read this document, which may be on the other website. For example, on the AIDSFree website, or on the VMMC direct health website, or other websites where these documents are available. So, it is easier to know that these documents are all available so you can read about them from the different websites.

The 12 chapters for PEPFAR's best practices are actually included on this slide. Given we're going to talk through them on the next couple of slides; I will not spend much more time on this.

So, the key changes in the second edition, specifically included on this slide – one, the chapters have been condensed. Some have been combined. This second edition has fewer chapters. This has 12 chapters and the previous edition had 15. There are fewer chapters, but with of course more information. It includes the tetanus risk mitigation information in different chapters and information on the dorsal slit for clients 10-14 or 15-plus with mature penile anatomy.

Key resources and documents, such as the adverse event guide and weight-based anesthetic dosing are included for ease of access. It includes the new information on injection safety. My colleague will talk more about this one. It introduces the VMMC online training we have, which makes the back of the second part of this webinar.

A copy of the draft Informed Consent is included and new demand creation approaches are also discussed. And, of course, cites examples of key best practices from the field.

So, the first chapter is the introduction and background of the second edition, which summarizes what readers can expect throughout the second edition, including the focus of the second edition. So, the main focus of the second edition is optimizing management of existing service locations.

Optimizing management basically as far as renewed attention to quality and safety of VMMC services, technological innovation and efficiency in service delivery techniques, strategies for

reaching the age pivot, and geographical pivot to areas with high HIV burden and low MC prevalence.

It also talks about new PEPFAR policies and guidelines since 2013. It highlights new platforms for accessing the guide, emphasizing web-based and mobile access with point-and-click functionality that is expected to reach a wider audience. The second part of chapter one, which is the background, introduces the reader to evidence of VMMC's efficacy, cautions about risk compensation due to the partial protection of VMMC, current circumcisions conducted and HIV infections expected to be averted from these numbers.

This slide basically shows the message from the US Global AIDS Coordinator. Basically, what we find in this message and the connect of involving men in HIV prevention, care, and treatment, highlighting VMMC as one of the key options, or key entry points for men. So, it's a very good message we can use to address some of the key challenges that we find with VMMC, including the need to reach the men we need to circumcise.

The next couple of slides, we're going to talk about some of the changes that are included in the different chapters. The second chapter, which is service site selection, planning, preparation, and launch, the key goal is select appropriate locations and facilities to serve as VMMC service delivery sites, to prepare sites for launch of VMMC services and three end points reinforce knowledge, attitudes, and skills of new VMMC teams, or refresh experienced teams, and ensure that they have the necessary confidence, skills, and systems that provide quality services.

There are no key changes in this chapter, only that the chapter combines the first four chapters we had in the previous edition.

Chapter three is commodities, procurement, and supply chain considerations. The key goal of this chapter is to understand the discrete steps in the procurement process and the resources to assist site managers completing these steps, and also to remain aware of the steps in the procurement process that are particularly prone to delays due to the reliance of external actors.

There are many key changes in this chapter – one introduces tools to help with planning and forecasting, including managing stock levels. Lists the ten steps in the procurement process, and highlights benefits of pulled procurements, including negotiating lower costs on commodities procured in bulk, improved quality,

and reduced lead times.

Chapter four, which is VMMMC communication at the site level and demand creation, has three goals. One, to provide key audiences in the community with accurate and complete information about VMMC to build demand and enable eligible men to make an informed choice. Communicate essential information on VMMC and HIV prevention clearly and comprehensively at appropriate stages of the client's visit, and provide general information on successful demand creation strategies and considerations.

They main key changes for chapter four are to underscore the need to use the unique opportunity of men seeking VMMC to share key messages on HIV prevention and reproductive health services. It introduces the reader to VMMC In-service Communication: Best Practices Guide, and emphasizes the use of the counseling checklist to ensure the information shared during counseling is consistent and highlights messages to discuss tetanus risk mitigation in VMMC with clients.

Chapter five, which is VMMC skills training, the key goal is to give VMMC service providers the required competencies to provide a full package of VMMC services according to approved standards. It highlights key competencies during staff training, including training in new areas, such as tetanus risk mitigation, new aesthetic dosing charts, use of dorsal slit for 10-14, the table of prequalified VMMC methods, including surgical and device-based methods, discussing advantages and disadvantages and also highlighting key differences.

It highlights the need for training and adequate injection safety techniques and introduces site staff to the VMMC online training hub.

Chapter six, which is providing the VMMC minimum package of services – the key goal for this chapter is to ensure site staff are able to provide clients with all components of the VMMC service package in accordance with approved standards. We are familiar with the minimum package of services, which has six components shown on the right side of the slide.

The key changes for this chapter is an emphasis on the components of the VMMC minimum package, especially areas that have not performed very well in the past, such as linkage and referral of HIV infected clients with HIV testing services and HIV treatment

services. Eligibility assessment for to avoid preventable adverse events such as prolonged bleeding that can actually be caused before clients are circumcised. Ensuring age appropriate VMMC methods, to see if circumcision is appropriate for clients under 15 years. Tetanus risk mitigation, and also underscores the importance of discussing tetanus risk during client consent, before clients undergo VMMC. Of course, it also talks about weight-based anesthetic dosing charts, including starting and maximum doses.

So, I will **[inaudible – interference] [00:16:19]** for now and let my colleague, Stephanie Davis from CDC, talk about the next couple of chapters. I'll come back to talk briefly about **[inaudible]**. Thank you very much.

Dr. Stephanie Davis: Thanks, Valerian. This is Stephanie Davis. Can people let me know if they can hear okay?

Female Speaker: We can hear you perfectly, Stephanie.

Stephanie: Excellent. Thanks. Good morning and afternoon, everybody. Thank you so much for joining. I'm Stephanie Davis on the CDC Voluntary Medical Male Circumcision Team. I'll just briefly discuss the next few chapters, picking up from Valerian.

Chapter seven, as you can see, is managing, monitoring, and reporting VMMC adverse events. This chapter contains the Adverse Event Guide second edition with which hopefully some of you are already familiar. The goals of this chapter are essentially what you might imagine, to ensure that the site level staff are able to screen, diagnose, and document adverse events that are related to VMMC surgery, to ensure that they're able to properly manage those events, make appropriate referrals when necessary for those, and generally be up-to-speed with the tools and equipment that are available to them to remediate those adverse events.

Some key elements of the content, it goes over the rationale – the justification for why programs need to identify these adverse events, as well as how to manage them promptly and efficiently to optimize the outcome for the client. Then, it outlines a general path of adverse event management for a program, which includes starting before the procedure with client education, continues with post-operative monitoring, follow-up visits, and then the program being able to calculate its own adverse event rates. It also explains the recommended classification and grading system for adverse events in order to ensure that every site in the program in a country

is reporting using the same standards, so the country can get an accurate picture.

The key update is that, by means of links, the full Adverse Event Guide second edition that's been updated to include device adverse events is included in this chapter.

I'll move on now to discuss the updates to chapter nine, which is injection safety and healthcare waste management. This topic is very close to my heart. I'll discuss why momentarily. The goals of this chapter are to ensure that site level staff are able to use safe injection practices to prevent the spread of pathogens, especially bloodborne pathogens such as HIV, hepatitis B, hepatitis C, and whatever else is out there that we haven't even discovered yet – to clients or to providers. So, ensuring the safety of both.

And then separately, to properly manage the waste that's generated by VMMC services to protect healthcare workers, the community, and the environment. So, those of you who are familiar with the previous edition of the Best Practices Guide, will know that waste management was covered previously, but injection safety wasn't. This just came out of observations, where it was noted that, in some programs in some places, there were particularly a setting – it's common that anesthetic vials will be reused.

As you all know, they tend to contain more anesthetic than the average client needs. But, when that's the case, it opens the door for the possibility of more sinister practices of reentering that vial with a used needle or syringe and then having the vial used for another client. As you can imagine, that opens the doorway for transmission of bloodborne pathogens.

So, this content was added for that reason, to protect both client and staff safety. It basically outlines the key safe practices to prevent transmission of infections. It discusses the challenges related to what I just described – double dipping – where you reenter a vial with a used needle or syringe. And then, it cites examples of alternative approaches that can be employed to reduce the reuse of needles and syringes – really, to eliminate it.

As we discussed, it cautions against reuse, even in the same client, because we have to remember there's always a risk of bacterial contamination for skin flora, but also certainly between clients because that's where the risk of bloodborne pathogen transmission is introduced. And then, it also emphasizes the dangers of using potentially contaminated vials of anesthetic or other drugs due to

reuse of needles and syringes to reenter those. Then, it discusses the need for proper sharps management.

The next chapter, comprehensive quality assurance and continuous quality improvement. The chapter goals are to ensure that the site staff can provide comprehensive and high quality VMMC services at all sites. Those should be in line with standards that exist on a national level, from WHO, and from PEPFAR supported services standards as well, through quality assurance and continuous quality improvement activities.

This involves prioritizing patient safety, maximizing site level efficiencies, and building the site staff capacity to deliberately implement this quality methodology in a purposeful way.

The content includes outlining the need for internal quality assurance. This is, as you can imagine, a site led process where the staff themselves are monitoring the quality of services delivered. And then it also reviews the benefits of external quality assessment visits, EQAs, where external experts who can be objective about services and have experience in other settings can come and assess the quality of services provided at a site.

So then, it highlights the different objectives of these two types of activities – external quality assurance and continues quality improvement, which is more internal and site led. There is also a case study contained in this chapter that discusses the specifics of how this has been handled in some programs in Uganda and South Africa.

The next chapter, geographic information systems, or GIS. GIS is essentially a computer based systematic approach for capturing, storing, verifying, and displaying data that's related to positions of various types of points of interest on the earth's surface. So, one of the advantages of GIS is that it can support the analysis and display of multiple different data sets and types of data in one place. So, you might have one data set on clinic locations and another data set on schools, if that were relevant to the population you're capturing – or just on community locations.

So, each of these data sets is called a layer, and these layers can be added on top of each other in a GIS display, to show where certain types of areas or points of interest are relative to others. So, this capability enables users to visualize, question, analyze, and interpret data to understand spatial relationships, patterns, and trends.

So, the goal of this chapter is to ensure that implementing partners and site level staff are able to use these GIS technology systems to first, efficiently locate and schedule VMMC services to improve uptake by males in the target communities. And then, also, to adequately match VMMC services to priority geographic areas and priority male populations, to ensure that the supply is being provided in the same place we know we need to raise uptake.

The chapter defines GIS and it also discusses advantages and potential applications of GIS in an attempt to demystify it and make it practically useful in the program. This also contains a case study that describes how this was used to improve VMMC uptake in Tanzania.

Moving on to chapter twelve, which is on the voluntarism and informed consent process. The goals of this chapter are to ensure that site level staffs are able to provide appropriate information to clients, their spouses, guardians, etc. who are seeking VMMC services so these clients can make informed decisions. So, this is the informed element of informed consent, just ensuring that the client has the necessary tools to make the decision that they feel is best for themselves.

And then next, to actually obtain and document the informed consent of the males, or guardians of minors, and to ensure that the clients are aware of, and truly understand, the risks and benefits of VMMC and choose the services voluntarily without coercion.

Key changes are that the information has been expanded. There is a draft consent form that's available and can serve as a template. There is some discussion on reimbursement, and then there is also a more thorough attempt to address the question, what about incentives to clients.

As we know, many programs provide free transportation in order to enable clients to access services, but there is also discussion now about, especially in the form of wage compensation for lost wages – directly providing clients come kind of compensation for their time. Here, it's important to highlight that this is actually an area where the approach and guiding policies differ by agency, so I would encourage those of you who are implementing partners to contact your agency points of contacts for guidance. It's a very agency specific area.

With that, I'll turn it back over to Valerian for the next few slides.

Valerian: Thank you so much, Stephanie. The next few slides basically highlight the key best practices from the field. The next slide is a case study from Namibia, setting up private VMMC clinics, which is under chapter two. This was a work done building baseline assessment of private health facilities for VMMC services in Namibia. As you can see on this slide, in the dark green, these facilities basically were performing quite well before the initiation of VMMC services.

But, the best practice here is to ensure that the sites were assessed before or prior to beginning of VMMC services. So, it's what you need to scale up VMMC services.

The second case study is again from Namibia, about VMMC training of providers, which highlights modified approaches to VMMC training. This is a case study was done some time back, when our providers were trained online and later were brought in one place for a practicum session. It extended the time the providers need to be trained, mostly importantly for this program, as a private provider so they don't have that much time to sit in a class for two weeks.

So, this basically was a training that informed the VMMC online training hub, which we are going to talk about in the next couple of slides.

The next case study for Lesotho is improving active referral and linkages to HIV care and treatment services for HIV infected men identified through VMMC services. From the previous discussion, I mentioned that one of our key weaknesses has been referral and linkages of clients identified as positive to VMMC care and treatment services. As you can see on this slide, a lot of our clients were tested. Some of them undergo VMMC.

We also identified a couple of clients who are HIV positive. As you can see, it is very small for VMMC. What is important is that whoever is identified as positive is referred and we link and confirm that they actually were indicated in the care and treatment at whatever site they have been referred to. That is the importance of this study, which tracked all the client services tested and all the sites in Lesotho.

The next slide, I'll hand it back over to Stephanie to complete this presentation. Thank you so much.

Stephanie: Hi. Thank you. I'm Stephanie again. Now, I'll just briefly discuss another case study in Uganda, which I think some of you are probably familiar with, the Mwami Mulembe, or Stylish Man, Campaign. This was a coordinated social, behavioral change communication campaign that used both mass media and interpersonal communication to increase demand for VMMC services as well as condom use among men in the Rakai District in Uganda.

The clients included particularly high-risk groups, which are especially important to reach with VMMC, such as fishermen and mobile transport workers. It was a one-year pilot launched in early 2014, and it reframed the ideal Ugandan man as a stylish man who cares about pleasing his partner while simultaneously caring for his own health and personal hygiene.
A few of the most striking results and key lessons learned from this – the overall coverage rose from 37 percent to 49 percent of the targeted men in this area, as compared to the previous two years where there had been changes in the neighborhood of 2 percent to 3 percent. So, really a substantial improvement in uptake.

Some of the key lessons included coordination between demand creation and the service delivery teams to improve impact. As you know from experience, this can include coordination of time so that demand creation is out there in advance, obviously coordination of location, and extent of investment demand creation. They used local leadership in designing the strategies, messages, and materials, so it wasn't all international or top down, which improved the relevance and interest to the men.

They also used routine frequent monitoring and feedback, which allowed for immediate changes, to make adjustments during the campaign itself. There was a note that older men in particular really needed to feel specifically invited to participate in events. There couldn't be this sense that if you just present the benefits they will come. It needs to be something more personal.

Also, an important lesson that's carried over into other demand creation work, that there is value in segregating services for younger and older men because older men tend to prefer to be served separately from younger males.

This is our final slide. This is logistically, to make clear, that there are four platforms, or forums, at which this Best Practices Guide is available. One is on USB drive, using digital media. This has direct links to the resources that have been discussed and contains

relevant tools and guidance documents. The second platform is a hard copy, which prints the actual chapters from the PDF document.

The third platform is an electronic PDF, and this is useful because the hyperlinks are active to the tools and guidance documents. And then, finally, there's the online version where it's hosted on the VMMC section of the AIDSFree website as well as on the Male Circumcision Clearinghouse.

As you can see, for people with some connection limitations, each chapter is a standalone and can be downloaded and accessed as a PDF or through its own link.

Just quickly to acknowledge Valerian Kiggundu and Jonathan Grund, who were the lead editors in pulling this together, as well as the VMMC TWG, USAID, OHA, AIDSFree, and the partners, including Project SOAR, URC/ASSIST, GHSC/PSM, HC3, and Jhpiego.

I will now turn the presentation back over to our moderator, **Jackie Sullet [00:34:01]**, for a Q&A. Thank you.

Jackie: Thank you very much, Stephanie and Valerian, for this wonderful presentation on the Site Operations Manual for the VMMC services. As you have heard, it covers a lot of aspects of the VMMC services. It's very comprehensive. Each chapter can be used independently of the others. It covers areas such as how to set up a VMMC site to the surgical procedure, continuous quality improvement, external quality assessments, with management, GIS mapping, obtaining informed consent – it's very comprehensive and it looks at all aspects of the VMMC services.

Before we go to questions from our participants, Valerian and Stephanie, could you talk a little bit about who this is manual targeted to? Who can use it? Is it just people at the level of the ministry? People at the level of the site? Is it geared towards someone who is actually doing the circumcision? A site manager? Who can use this document and how can it benefit them in terms of improving VMMC services in their sites?

Valerian: Thanks very much, Jackie. So, the manual is basically a site document. It is intended for site staff – the providers, the assistants – so they are able to use it to reference all they need at the site level. There are other documents for the above site and it doesn't mean that somebody who is not working at the above site cannot

use it, but it is intended to be used at the site level. Stephanie?

Stephanie: Thanks, Valerian. You covered it. Nothing to add.

Jackie: Thanks, Stephanie and Valerian for that. We have a few questions and we have a question from **[inaudible] [00:36:16]**. It says with the minimum package, we have seen a serious challenge in promotion of safer sex practices and condom, especially with the young – condom education and distribution, especially with the younger age – that would be referring to the 10-14-year-olds. There is a serious ethical and cultural issue that we need innovative ways to overcome these. Does that manual address some of those?

There is also, on waste management, the disposal of used instruments has been very challenging. It is difficult to handle transportation and disposal, which adds serious budgetary constraints. Could you talk about the different packs that we have for VMMC services and the issue of waste management? Does the manual address some of those challenges?

I'll pause here for you to answer these two questions, and we have about three other questions that I will ask.

Valerian: Thank you so much, Jackie. I take the first question and Stephanie will take the second. I think this was a comment from **[inaudible]**. Thank you so much. I think the most similar things about condom distribution, especially for the younger age groups, is about messaging. We have demand creation and communication best practices guides and checklists, which you can actually use. But, it's also important to ensure that – discuss the **[inaudible]** with our clients.

We'll call it mobilizing even though it goes by other names in other countries. You need to be trained to understand the messages that we give our clients. These mobilize as volunteers. They are not paid and they are not trained, so they do not have the right messages to give our clients. They clients receive the first message when they come to the site. So, once you have our mobilizers well trained and understand exactly the same messages that we understand, using some of the key messages in the demand creation and communication chapter, and also using the key documents, the Best Practices Guide for Demand Creation and Communication, I think we can be able to address some of these challenges, be it cultural or social. We are able to address them. Thank you so much.

Stephanie: Thanks, Valerian. I'll touch quickly on the waste management issue and then I'm thinking Valerian may also have thoughts to add on that. I think it's an extremely important question. So, yes, there is some guidance about waste management and approaches to dealing with used disposable instruments in the guide, and there is also a link to an existing document that's dedicated to healthcare waste management.

But, I do want to mention, from a technical perspective, I think that you highlighted one of the major challenges of working with disposable instruments. Different approaches have their advantages and disadvantages, but the fact is, working with disposable instruments generates an enormous mass of waste. For those of you who aren't aware, the PEPFAR annual planning guidance for the past couple of years has promoted the introduction of reusable instruments where possible, largely for this reason.

So, from a technical perspective, the CDC's perspective is that there is a lot of value in making that switch for that reason. There are a handful of programs that have had some success with working with third party companies to create the plan to smelt down and reuse the metal of the used instruments. I don't know if Valerian wants to add anything about whether there are case studies on that available in the guide or not. I'm not sure. But, there are a couple of situations where that's also been tried.

Valerian: Thanks, Stephanie. I want to say that what you use depends on where you are in terms of scaling up your medical services. The disposable kits have been quite helpful during the initial stages of scale up, and until later, we realized we actually needed to dispose of them off, we had opportunities where some companies are using the instruments and used them to develop a recycle program.

In terms of moving forward, for sustainability, I think we don't want to leave governments without anything. It is important that we plan to have the usable instruments and other important things like autoclaves and so on. So, it depends on where you are in terms of your activity and your budget. If you feel that you're moving towards this, it's important to consider that we now need to think about reusable instruments if you are beginning activities and it basically – also, it means that the activity at the site level or the mobile, then you may want to use some disposables until a time when you want to switch.

But, I agree with Stephanie that the waste that is generated after disposable instruments have been used, we've ran out of storage for

the used instruments and it looks like a waste, because they are not going to be used again. So, we would like you to evaluate your programs and decide where you are and what your city would like to bring in terms of moving forward. Thanks so much.

Jackie: Thanks, Valerian and Stephanie. We only have time for one last question. The other questions we will circulate to the panelists and they will respond to the questions and we will post them on the site. So, the last question, before we move on to the next set of presentations, some from Felix in Mozambique and he would like to know if there will be any plans to translate this guide into Portuguese, since most of the people in Mozambique, Portuguese is their language. Although some people speak English, a Portuguese version would be much better.

And, I supposed if we had francophone speaking people on the call, they would be asking if that would be translated in French as well.

Valerian: Thank you so much, Jackie. I think that is a very good question and I would either say that question has been answered by Jackie, or the director. I think it's important to have translation. We didn't have a plan in the initial plan to translate into other languages, but I think let's park that and talk about it off of the webinar and see how we can help our colleagues in Mozambique. There are other documents that are being translated and you will hear in the next presentation about that.

But, I also want to mention that we have a couple of highly important documents here **[inaudible] [00:44:21]** for colleagues that are only in English. But, in terms of Portuguese, Jackie and myself and my colleagues at the offices of HIV, we'll discuss and see how we can help in case translation is possible. Thank you so much.

Jackie: Thank you very much, Valerian and Stephanie. On that last note, Valerian, even for the online training hub, which the presentation that Valerian is going to talk to in a few minutes, we are in the process of translating that into Portuguese. So, we now move on to the next session. We will have a panel of Dr. Zebedee Mwandi, who is the Senior Regional VMMC Advisor for AIDSFree. He will be talking to us on the online training hub.

We also have on that panel Mr. Kusaasira Hope from Uganda, and Miss Andiswa Letsoalo from South Africa. But first, we will start with Zebedee for his presentation.

Zebedee, I hand over to you.

Dr. Zebedee Mwandi: Thank you, Jackie. I believe everybody is able to hear me. I am coming from Jhpiego and I'll take you through the next presentation on the online training hub.

This presentation will cover an introduction to what AIDSFree is and what the deliverables for AIDSFree are. And then, we're going to monitor the online training hub, including goals, objectives, the modules that are within the training hub, and approaches. We'll also speak about what the OTH improvements compares with the conventional VMMC training. And, technology allowing, we'll do a quick demo and finalize with progress on the rollout so far.

For AIDSFree, it's strengthening high impact interventions for an AIDS-free generation is what we're calling on as AIDSFree. It is a PEPFAR funded five-year project that started in 2014 and is funded through the USAID. It is implemented by JSI with several other partners based on their technical expertise. And, in this case, Jhpiego implements VMMC activities and the AIDSFree.

Other technical areas implanted in AIDSFree include PMCT by **[inaudible] [00:47:04]** and their pediatric HIV treatment, HIV prevention, age and gender. The rest of the many partners are indicated on the slide.

Quickly, AIDSFree VMMC activities in brief. We **[inaudible]** activities. All of them get what we're using HIV infection and contributing to the epidemic control. On the left, you have the core-funded activities and on the right we have the country programs, which are funded with **[inaudible] [00:47:48]** from the different countries on there so far.

We have done it in four countries, which are Tanzania, Namibia, Malawi, and Namibia (sic). These are also scaling up for HIV prevention. On the left side of this slide you see besides technical assistance to the field programs, we have activities, one which Valerian and Stephanie have just spoken about, the PEPFAR Best Practices, and then the OTH, which I'll be speaking more about.

[Inaudible] which is what we are calling updated training approach. We know the conventional approaches comprises classroom didactic training for a number of days to cover the content of the VMMC curriculum, which is then followed by a

practicum where you practice simulation and end up dealing with actual plans from direct physician and surgery to assisting and finally being the lead surgeon for several times before being classified for competency.

Now, the next slide is the traditional classroom based training method. We know the curriculum and content are not standardized across all the trainers in 14 countries. We also know that the required to length to complete the training also differs from country to country, thereby bringing issues of quality. And we know that **[inaudible]** local anesthesia about ten years ago, it has been very difficult to share updates and/or policies with providers who we trained earlier.

We also know that it has been difficult to support or mentor or remediate for those who have made up failed courses, or even track those who are trained and need further training and coaching.

In this slide, for instance, we see the duration of training in different countries is not standardized. **[Inaudible – breaking up]** the duration of theory days, and it ranges from three days to 14 days. Also, the practicum periods, which ranges from three to seven days. And the last column shows the number of procedures actually needed to be certified as competent. That ranges from a minimum of five in some countries to a maximum of 20 in much of the countries.

But, the challenges in this scenario include the fact that one-off activity with limited capacity for repeated interaction. The content is not standardized, which also **[inaudible]** over time.

So, I will be talking about what is OTH, or the online training hub, which we will describe as a social landing platform. That provides **[inaudible – breaking up] [00:51:21]** resources and continue to help one advance skills and **[inaudible]** performing VMMCs. It is a deviation from the classroom based didactic training and it is found in the latest published studies of group training techniques **[inaudible]**.

We can therefore say that the VMMC OTH is a mobile training platform for VMMC programs and providers. **[Inaudible]** practicum, and I'll keep on repeating that point. Valerian, **[inaudible]**?

Female Speaker: We can hear you clearly, Zebedee.

Zebedee: Thank you. So, we continue saying the hub is standardized VMMC curriculum content and delivery consistent across the majority of the countries. **[Inaudible – breaking up]** maintaining the curriculum content consistent. It also has a learning malignant system that is **[inaudible]** database and has the ability to cut provider training days and has a **[inaudible]** and even their competency score at the time of training.

The planning system also will allow for subsequent engagement **[inaudible]** information, satisfy ongoing competencies, and remediate witnesses that are not **[inaudible]**. The VMMC Online Training Hub enables trainers and program managers to customize training to staff needs. So, their personal time is directed to subjects relevant to individuals' training needs. For instance, we are **[inaudible]** VMMC. VMMC providers are the comprises and are directed to different modules from the module **[inaudible]** to be trained on.

And trainees would take this course at their pace and in the comfort of their home or offices, and complete their didactic process in advance of a practical training. This practical training will then be done by the existing master trainers in a particular country and will allow some time to focus on simulation practice and other skills, including **[inaudible]** and actual annotation of the surgeries.

Let me establish a better way of training. The new platform enables rabid **[inaudible]** to standard from peer down to provider level. The program **[inaudible]** as well as it is typical of a very fine provider creation of the new information. The system will **[inaudible – breaking up] [00:54:25]** training in specific detail. **[Inaudible]** training was completed and the knowledge area where a particular provider has strengths or weaknesses on.

Now, the goal of the OTH is to increase the provision of safe and high quality VMMC services delivered by competent health providers at all sites, preferably in the 14 **[inaudible]**.

Some of the objectives of the OTH, as I mentioned earlier on, is to standardize training content and the method of delivery and avail this training to as many providers as possible. By so doing, we'll **[inaudible]** efficiencies in VMMC training. Additional objectives are to collect provider level data on training and their progress, as well as when they completed the training, what is scores, their training needs, and their performance.

The OTH will also provide real time remedial training on topics that require reinforcement, which are identified during the training and online testing. And OTH enables repeated contact with previously graduated providers to relay updates to policies and standards of care and verify receipt of new information directly to the provider.

And finally, for most managers and advisors and coordinators, one is able to synthesize training data to improve accountability and **[inaudible]** for future planning for training partners, implementing partners, national programs, and donor agencies.

Let me emphasize OTH regarding the target audience. OTH is not meant to be **[inaudible]** in the medical field, such as medicine, nursing, counseling, lab technicians, etc. It is targeted to clinical staff and counselors who are interested in offering the VMMC services and for the staff **[inaudible]**. For freshly graduated clinical staff and students, they may be able to **[inaudible]**, however this will not make them VMMC providers until they go through a more directed selection and hands-on training during the **[inaudible]** even if they have not been exposed to VMMC procedure before.

As compared to their staff who needs the course. The course has been tailored to different **[inaudible]**, so that's one way staff can take portions of the course. They are the ones who practice and they **[inaudible]**. VMCC providers **[inaudible]** mangers, depending on their previous clinical and **[inaudible]** may not take clinical modules of the course, but can take the rest of the other modules.

So, in summary, the primary users of OTH are clinical staff currently engaged in VMMC studies, clinics, or have been considered for training to work as staff at various points along the VMMC studies provision loop. Currently South Africa, Namibia, Lesotho, Mozambique, Malawi, and Uganda have committed resources to their online training hub and we're working with them on the approaches on how they can use OTH to train or refresh their already existing staff who are engaging in VMMC services.

Now, I'm going to the modules of OTH and the content of the OTH call in organizing the modules that have different topics. Ultimately, we will have eight modules, but for now we have the five basic modules that are already not existing there **[inaudible] [00:58:50]**. These five modules are already complete. On this slide, you'll see on the far right column we have the current

modules as one, four, five, six, and seven. They are complete and live on their websites. They have been configured **[inaudible]**.

This was done in 2017, last year. We have so far used them to train about 140-250 existing VMMC trainers, coordinators, and advisors. It's gone from the ministry of health, the government agencies, and in many clinics from nine countries in east and southern Africa. These countries are Namibia, Lesotho, South Africa, Swaziland, Mozambique, Malawi, Kenya, Uganda, and Tanzania.

The remaining **[inaudible]** use – that is modules two, three, and eight – are not available on their modules for those labs – access to the site. These are completed in terms of the content. Some of them have gone into internal use for both MC and VMMC and other decoders, and we are now configuring two of the modules – that is modules three and eight – into the system. I believe, by the end of this quarter, they will be live on the program.

The only module that is **[inaudible]** is module two on data for decision making. That one, we are working on formatting it within the **[inaudible]** system.

Now, as we went through this process, we had new modules that we projected **[inaudible]** which we are putting them in the parking lot. **[Inaudible]** that we know are key challenges within provision of the VMCC services. Community mobilization and demand creation is something that is a challenge across all countries. We have issues of supply chain for VMMC services especially in infection prevention and control, especially in cleaning, disinfecting, and sterilizing reusable MC instruments, especially in this time of **[inaudible – cuts out] [01:01:46]**.

VMMC basics for program managers and USG staff, and site operations for facility managers are potential module and we are still open for discussion. So, if anybody feels there is anything potentially important for being included in the VMMC training curriculum, we could be able to discuss.

For those who are familiar with **[inaudible]** we can say that the VMMC online training hub is a form of **[inaudible]** and the web based platform hosts the content and can be accessed via online modules. It is delivered by low dose high frequency methods. It is suited for provider learning to maximize evidence based techniques, simulation, and problem solving as one land.

So, if there is a trainee who has been selected by their VMMC trainer, they register through their organization. For example, a training in Lesotho **[inaudible]** self-paced online class on use and moderation of **[inaudible]** and these repetitional small quantities of information as one goes through the classes. And questions not passed at the end of the class are brought back until one completes with a passing grade, which is usually 80 percent.

These questions are scored and one has to advance to the next class only when they score 80 and above. They also have additional reading on questions on topics in the system through links to appropriate resources. Some of them were in Valerian's presentation. At the end of the training, they get a certification. That is given on completing the final exam.

One of the key benefits of OTH is decreasing the time spent to train participants in the theoretical or didactic phase of the VMMC training. We are seeing that with dedication and commitment, one can take the five modules in about 14 hours. These 14 hours would be one end **[inaudible]**, but taken within the normal days.

We also know that OTH has standardized training materials with updated and current information and is likely to result in better or higher quality training than what materials are currently in use. We can say that there's also savings by doing with many partners. There is no need to develop or create materials by themselves.

In brief, we can say that OTH **[inaudible] [01:05:50]** the VMMC world the advantage of having standardized training content and delivering methods. It allows engagement of trainers and trainees so that they can introduce new information relevant to the VMMC provisions. And also, track their post training needs and delivery volumes. **[Inaudible]** OTH does not **[inaudible]** for certification in countries.

Jackie: Excuse me, Zebedee. In the interest of time, could you try to wrap up your presentation in a few minutes? We would really like to hear the experiences from the field from both Kusaasira and Andiswa. Thank you.

Zebedee: I wanted to do a quick demo. Jackie, thank you for that. I'd like to do a quick demo. Maybe you can be able to help me.

Jackie: Zebedee, unfortunately, we do not have time for the demo. We will be posting all of this on the web for all of the participants and we will try to put in a short demo in there for the participants. Could

we just wrap up and then we can get to both Andiswa and Kusaasira?

Zebedee: Okay. So, we will not be able to project the **[inaudible] [01:07:46]**?

Female Speaker: Zebedee, you have to release control.

Zebedee: Okay, I've done that.

[Omit interruption]

Zebedee: We have a learning management system that will allow repeated contacts and tracks rollout performance. I'm looking for in terms of – can I just move the slides?

[Omit interruption]

Zebedee: For the relationship between AIDSFree, MOH, and training IPs, I'd like to say that **[inaudible]**. This can take about 14-20 hours for the online portion. And later there's a four-day program workshop where we train. It's supported by AIDSFree to identify, register, and train cohorts of aspiring VMMC providers, counselors, and agent officers. All want to be able to be refreshed. This will depend on what kind of VMMC staff would need to be trained at a particular time.

Of course, the practicum sessions would need to be arranged as usually happens. So far, we have three cohorts of participants and **[inaudible]**. At the end of the four-day workshop, trainees are issued a certificate of completion of OTH and e-moderators and they are put into a work plan for training VMMC providers in their countries.

So far, we have **[inaudible]** cohorts of VMMC providers in Namibia and South Africa **[inaudible]** in the countries. Post-training, online certificates from the online portal upon graduation **[inaudible]** post new updates and all their policies on the platform for the graduates to be able to access them and continue having access and print their copies.

Finally, the coordination of the OTH practicum by the e-moderators. **[Inaudible]** will continue supporting their different countries as they organize this session. **[Inaudible]** Regarding updated the OTH curriculum. AIDSFree will be doing quarterly reviews with USAID for the team to approve. This will be

incorporated in the OTH module as they become available. **[Inaudible]** which is currently available on the different modules of OTH, but have been missing in the earlier versions.

So, all updates in the system will be through cooperation with VMMC and PEPFAR **[inaudible]** materials and updates of any new content. And looking at the currently existing on OTH, we do updates through the connects platform, which is a social media available in **[inaudible] [01:13:05]** and I was unable to demonstrate that. Thank you.

Jackie: Thank you very much, Zebedee. Unfortunately, we are running out of time, so we won't be able to go through the Q&A. But, we have just enough time to hear only one of our panelists. We will go over to Miss Andiswa Letsoalo from the National Department of Health. Andiswa is an Assistant Director for VMMC Services in the National Department of Health in South Africa.

Andiswa, over to you.

Andiswa Letsoalo: Good evening, everybody. This is Andiswa Letsoalo speaking. I hope everyone can hear me. I've had a lot of connection issues this morning.

Jackie: We can hear you.

Andiswa: Thank you, Jackie. I am going to be presenting on the South African Experience of the online hub. An overview of this presentation is to present the South African training objectives, the OTH usability testing, the training of our OTH moderators, the training of the VMMC providers, and the plants that we have for 2018 in South Africa.

So basically, we have objectives for training in the country. We want to address skills shortages and increase the number of health workers who are equipped to offer safe, voluntary medical male circumcision in the country. We also want to build capacity at all levels of VMMC service delivery.

And our objective is to train and mentor all clinicians involved in the VMMC program nationally. We also want to develop guiding policies and training tools for the country nationwide.

For the rollout in South Africa, we had **[inaudible] [01:15:03]**. So, this is where we would see if the OTH would work in all places throughout the country. We did the testing in generally the 31st

January through the 6th of February in rural and urban settings. For our urban testing, we chose **[inaudible] [01:15:21]** which is very urban, and then for rural we chose Mpumalanga. We had a total of 35 participants from the NDOH and participants from our partner trainers. The partnerships in the country were JPS Africa, CHAPS, ASSIST, and Right to Care, which is assisting us with most of our VMMC training.

The findings of the usability testing – we found out that technology, the classes can be done in 10-15 minutes, and each participant has to have at least 60 megabytes of data for them to be able to download all of the modules and read them. Otherwise, the functionality was good in the rural setting and urban setting. All of our participants were able to use it on their laptops, tablets, and mobile devices.

As you can see in the picture there, we have **[inaudible]** assisting one of our participants in Mpumalanga.

And then, after the accessibility testing, we needed trainers in the country from our amazing partners, and then we trained them as OTH moderators. OTH moderators are the behind the scenes people who will be assisting our participants in how to use or log-in to the system. We had total of 30 participants who registered on the 31st of July and they completed modules one, four, five and six like Zebedee just shared.

So, upon completion of the workshop we had on the 31st of July, the participants were then certified as OTH moderators for the country.

Training of the VMMC providers, in South African we have nine provinces. For the initial phase, we chose to select only two provinces just so that we can see any glitches that might come up. We chose KwaZulu Natal and Mpumalanga. We enrolled 18 participants from KwaZulu Natal and six participants from Mpumalanga with the assistance from our OTH moderators which we had trained.

The participants were trained **[inaudible]** because they are not used to online training. They're used to the five-day training we normally had, so it was noted that our OTH moderators called them on a weekly basis or emailed them to encourage them to go to module two and three. Lastly, the online assistant the OTH moderators to look at how far the participant has gone. So, it was easy for them to motivate and see the progress of each participant.

Within one week of rolling out the online system in Mpumalanga, we had a doctor who successfully completed all the modules within one week. And then, we had another participant who completed in KwaZulu Natal as well. Other participants **[inaudible] [01:19:24]** module five and module six. The contributing factor was because we factored the rollout in November and it was **[inaudible]** so we think there were some of the challenges.

Now, that we've done it again, OTH moderators are going to be experts in encouraging our participants to continue completing their modules and reading their text to complete the online training.

The benefits of the OTH in South Africa is that it has assisted us to standardize training content and the delivery method. We have many provinces and our training was being delivered by various training partners with different training materials. With the OTH, we were able to synchronize all the material and use one training for all the provinces. So, regardless of whether a participant has been trained in Mpumalanga or not, we know they are receiving similar training because it's online and everybody can access it.

We have an easy monitoring of the training data online, like I've shared, where **[inaudible]** are they able to download the module. The system has been very beneficial for us as a country. Plus, it has reduced the cost of training. Our training **[inaudible]** took the participants to a common venue at a hotel. That includes the cost, so now that they can do it online, it reduces the cost for us as a country.

So, it has been beneficial for us in the system. In 2018, our plans are to provide post training mentoring for the current cohort. The current cohort will have a total of 24 doctors, nurses, and clinicians that will be providing mentoring for them. They will be completed, and we will engage with them via email and via phone to encourage them to complete their module.

And then, in February 22, we go to enrolling the system in Gauteng, which is another province, and in Free State. We'll continue monitoring online, how it's going, and glitches, and then we **[inaudible] [01:22:15]** time we reach province number nine, I'm sure that there will be less challenges than we were facing.

So, that is the influence that we've had in the country. Thank you.

Jackie: Thank you very much, Andiswa, for sharing your experience with us. We have just about another ten minutes we can accommodate Mr. Hope Kusaasira, who is the spokesperson for VMMC and key populations at the Gulu Regional Referral Hospital in Northern Uganda.

Mr. Kusaasira, handing over to you.

Mr. Hope Kusaasira: Thank you very much. **[Inaudible]**, Jackie?

Female Speaker: Yes, we can hear you.

Kusaasira: So, I want to say hello to everyone. I would like to talk about the online training hub from **[inaudible]** online for this talk. It has a lot of good, so I'd like to talk about the good. Being online at your own pace, that's what happened to me. I was in one of the hard to reach areas. But, while I was working there, I was able to take this course and **[inaudible]**. It was very easy to understand because the modules were very **[inaudible]** and they were using what everybody can understand.

And also, the information was **[inaudible]**. Then the connect feature of this online training hub is amazing because it gives you an opportunity to feel like you are not alone in this whole thing. The theme of having other people to run with you **[inaudible]** and it comes in handy with a thought like this so other people may consider **[inaudible]**. That's because you have people to help here and there and it becomes easy.

The pretests at the beginning of each module touch on something **[inaudible]** remind me that I actually do not know everything and therefore I needed to pay attention to learn something new. Here, I need to pay more attention as I go through the module. And then, the content was great. **[Inaudible]** I was able to notice that actually the content is great.

And then, the clinical practicum, I did not get the opportunity to experience. But, of course, I understand that that is one of the important parts of the online training hub because it is **[inaudible]** and the theory, it's very good to go ahead and have the clinical practicum. There is an ability to review the finished modules and classes. That's a very big **[inaudible]** because at the time I'd remember that, "Oh, this is something that I did not pick up." I go back and check on it and understand it. It was very good.

And then, there are just a few little things that **[inaudible]** on my part. The Internet – I had **[inaudible]** one of those areas that Internet is very difficult to come by. Therefore, it was not very interesting on that point, especially the financial cost attached because I want to **[inaudible]** so that I can do this course to completion. Though Internet was challenging, it was actually possible.

And then secondly, the certificate date needs to be updated so that each cohort has their own certification date because the certificate that I have right now was given to **[inaudible]** in September. I did the course in November.

I think the **[inaudible]** for me was amazing. My general feeling that the OTH is such a great tool for training and it makes it easier for practitioners to learn and develop their skills. That's why I **[inaudible]** that OTH is appropriate for the current computer age. We live in the computer age. Everything is made much easier with computers and this for VMMC training is very good.

In other countries here in Uganda, we could use this very well, especially for refresher courses. People keep forgetting things, and this would be very good to refresh your mind just like I did. Thank you very much for listening.

Jackie: Thank you very much, Mr. Hope. I would like to take this opportunity to thank all of our panelists and all of you who participated on this important webinar. Like I said, even if we did not have time to field your questions, we will be answering your questions and sharing them with our presenters. They will give written responses to your questions and this will be posted on the web together with a recording of the procedures today. Thank you very much, everyone. Have a good day.

[Omit after end of webinar – recorder left on – 01:27:54 – 01:31:32]

[End of Audio]

Duration: 88 minutes