

Routinizing School Engagement to **Better Reach Men and Boys**

Initial Challenges With School-Based VMMC Demand Creation

Schools serve as important entry points for Voluntary Medical Male Circumcision (VMMC) programs, offering a unique setting to reach a concentrated group of adolescent boys and young men, particularly those aged 15-19. This age group is crucial for districts that have reached VMMC saturation levels and need to maintain coverage. The Ministry of Health and Child Care (MoHCC) recognizes this demographic as the sustainability age group, meaning that targeting boys within this age range can sustain national VMMC coverage.

Since the inception of Zimbabwe's VMMC program, the program has targeted schools as key venues for reaching adolescent boys and young men, especially now as the program transitions to sustainably maintaining coverage. Initially, the VMMC program engaged schools in an unstructured manner; community health workers would arrive at schools unannounced, leading to uncoordinated visits that did not align with school schedules. These visits resulted in minimal engagement, sometimes limited to just a few minutes during school assemblies. Following the COVID-19 pandemic, schools became even more protective of their instructional time, making it increasingly challenging for health workers to engage with school-aged boys and young men.



Digital Health Program. Zimbabwe, 2021

Stakeholder Feedback on School-Based Demand Programming

The INTEGRATE team conducted a series of qualitative stakeholder interviews to better understand the challenges with conventional school-based demand models. The consultations highlighted several barriers impacting the effectiveness and reception of the VMMC program:

- Schools reported that the program was disruptive and interfered with regular school activities.
- There was a perception that the program did not appreciate the efforts of the school staff.
- Schools felt that boys were not given enough time to understand and assent/consent to the procedure.
- Boys missed school for the procedure and subsequent recovery.
- VMMC was not well integrated into the school health curriculum.
- Headmasters, school health coordinators, and teachers indicated their lack of knowledge on VMMC. School health focal points, responsible for creating demand, mobilizing boys, and monitoring post-procedure recovery, felt ill-prepared for this role. However, school staff were interested in taking on a more significant part in the VMMC program.
- Limited coordination existed between the MoHCC and the Ministry of Primary and Secondary Education (MoPSE).

Developing a More Routinized Model for School-Based VMMC Engagement

In response to these challenges and drawing on lessons from Zimbabwe's Expanded Program on Immunization—which successfully navigated similar obstacles by routinizing engagement with schools—the INTEGRATE team piloted a new model for implementing school-based demand creation. This model aimed to systematize school engagements, ensuring more effective and efficient collaboration.

The team structured the model around a seven-step process focused on collaboration and co-planning with key MoPSE and MoHCC stakeholders, including

district school inspectors, headmasters, health promotion officers, local healthcare facilities, and civil society organizations (see Figure A). The model optimized collaboration between health workers, facilities, and schools and ensured minimal disruption to school activities.

Mapping and Clustering Schools:

The INTEGRATE team convened district school inspectors, headmasters, health promotion officers, healthcare facilities, and civil society organizations to jointly map VMMC coverage by district and school, identifying priorities. The team then clustered schools based on geographic proximity and VMMC coverage to streamline outreach efforts.

Scheduling and Planning:

With clusters established, the team coordinated with MoHCC, MoPSE, school inspectors, and community representatives to schedule VMMC services and educational sessions, aligning them with school schedules to minimize disruptions.

Interpersonal Communication and Education:

Community health workers conducted interpersonal communication (IPC) sessions, including both group and individual educational talks, at each school

according to a pre-agreed schedule. These sessions focused on ensuring students understood the VMMC procedure and emphasized the importance of informed assent and consent.

Consent:

After IPC sessions and ongoing community dialogues, the team distributed consent forms to engage parents and community leaders, ensuring they were fully informed and part of the decision-making process.

Service Delivery:

Following educational outreach, the team conducted service delivery as scheduled. School Health Coordinators, who were trained to deliver VMMC information effectively, played an important role in this step by linking boys to nearby healthcare facilities. They also supported boys during the healing time and ensured their attendance for follow-up care.

Mop-Up Campaigns:

As the final step, the INTEGRATE team coordinated and executed mop-up campaigns during school holidays to reach students missed during the regular term. This step ensured that eligible students were not left out due to absences or scheduling conflicts during the initial outreach.

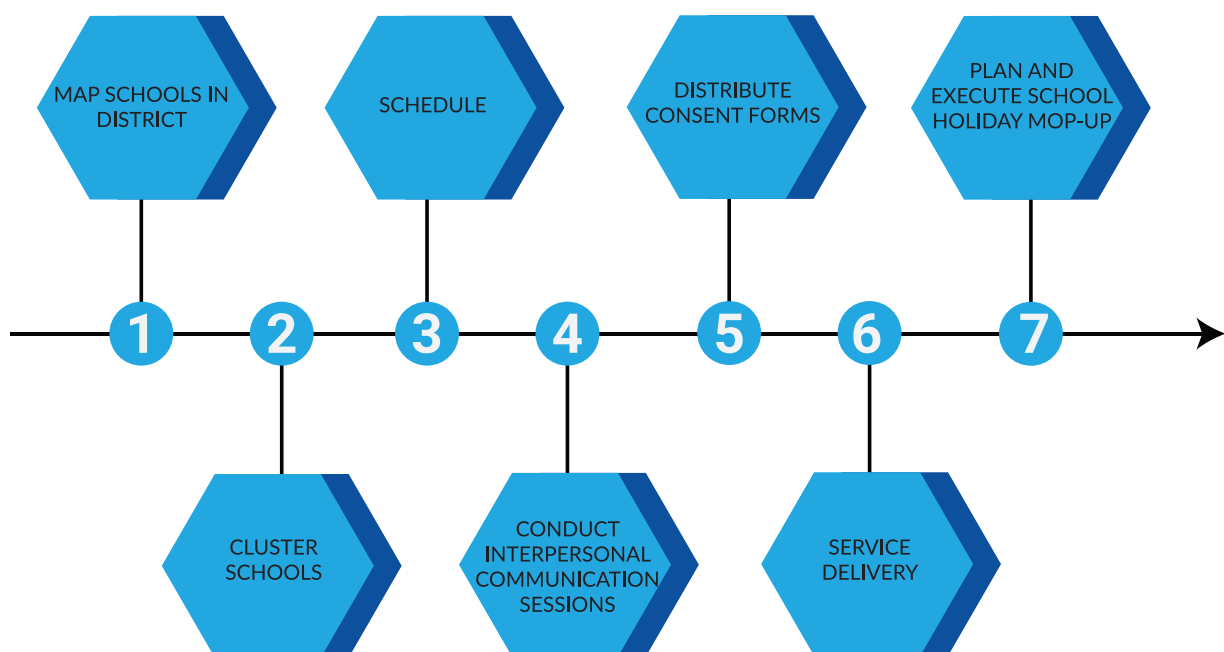


Figure A: Seven Steps in Routinized School-Based Demand

Evaluating the Impact of the Routinized Model

A structured approach to school engagement facilitates a better-organized and less intrusive implementation of health programs, leading to improved cooperation from schools and higher engagement among students. Since implementation resumed following COVID-19 closures, the model achieved 80% and 83% of the monthly VMMC targets for March and November 2022, respectively. In 2023, despite disruptions from national elections and a nationwide cholera outbreak, the model reached 141%, 129%, and 110% of monthly targets in March, July, and November.

The success of the routinized school demand model underscores the importance of understanding and supporting the operational mandates of both schools and health programs. By working collaboratively, aligning health programs with the operational rhythms of schools, prioritizing effective communication, and ensuring informed consent, this model effectively minimizes disruptions while maximizing student participation and program efficacy. The model provides a blueprint for health and educational systems to collaboratively support school-aged children, achieving health and educational objectives simultaneously.

Lessons Learned and Future Directions

The Routinized School Demand Model Offers a Sustainable Approach for Districts That Have Reached Coverage and Aim to Maintain It:

Targeting school settings in a structured and systematic manner helps maintain VMMC coverage for the 15-19 age group. Schools provide a congregate setting for this age group, increasing cost-efficiency and conversion rates.

Targeting and Mapping Support Efficiency, but Baseline Surveys May Be Necessary:

Targeting and mapping schools based on demographic data and VMMC coverage helps prioritize outreach efforts, ensuring resources are directed where they

are most needed. However, not all districts had VMMC coverage data broken down by schools, making it challenging to determine the number of uncircumcised boys in each school. The INTEGRATE team benefited from access to historical program data, which helped identify schools previously involved in VMMC outreach, allowing for informed assumptions about coverage. Future projects, particularly where historical data is not available, could benefit from conducting a baseline assessment to ensure effective mapping and targeting of schools.

Stakeholder Engagement Increases Program Acceptance:

Engaging key stakeholders, including school authorities, community leaders, and health coordinators, from planning through implementation fosters a sense of ownership and collaboration. This engagement is crucial for the smooth running of the program, securing buy-in across key stakeholders, and ensuring its sustainability.

Schools and MoPSE Need to Feel Agency in the Model:

Adopting a structured and systematic approach to demand creation minimizes disruptions to school schedules. Careful planning of activities, such as aligning education sessions and service delivery with school timetables, respects the academic environment while achieving program goals.



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Integration into School Curriculums Promotes Sustainability:

The seven-step process was supported by the existing curriculum in schools. Integrating VMMC into this curriculum allowed students to learn about VMMC within their regular classes, thereby reducing the need for separate educational sessions. Incorporating VMMC information and activities into the school health curriculum increases awareness and acceptance before targeted outreach. This approach maintains high participation rates and supports the program's sustainability.

Regular Training and Sensitization Increase Effectiveness and Sustainability:

Regular training and sensitization for school health coordinators and teachers are crucial to the program's effectiveness. School Health Coordinators received specialized training in HIV and VMMC, equipping them to deliver health sessions confidently with minimal support from program personnel. This continuous professional development helps build their capability to support the program independently. Additionally, broadening the training to include a wider pool of teachers ensures that they are trusted, knowledgeable sources of information. This prevents misinformation and ensures they support the program rather than inadvertently undermining it due to a lack of knowledge.

Community Involvement Supports Wider Acceptance:

Involving parents and the community helps obtain consent and increases support for the program, which strengthens community trust and demand for VMMC.

Addressing Resistance Among Some Community Health Workers: Under the new model, community health workers and school health coordinators shared incentives to promote joint mobilization efforts. However, some community health workers resisted, preferring to work independently in the hope of claiming the full incentive. These community health workers would revert to arriving at schools unannounced. To address this, the project widely promoted the benefits of school collaboration, which could mobilize a larger number of boys more effectively. For those unwilling to participate, the team made agreements with MoPSE and districts to allow these workers to continue community mobilization but restrict their access to schools.

The School Demand Model Needs to Be Complemented by Broader Community Demand Activities:

The school demand model must be supplemented by broader community activities to reach boys not enrolled in participating schools. It is important to continue community outreach, especially during school holidays, to reach boys who are not accessible through the school program. This approach helps ensure comprehensive coverage.



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