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VMMC Webinar Series

PEPFAR VMMC 4TH WEBINAR

Priorities for Voluntary Medical Male Circumcision for HIV Prevention Programs:

Safety – Safety – Safety

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MCHIP Maternal and Child Health Integrated Program

CDC Centers for Disease Control and Prevention

Moderator:

Naomi Bock, CDC

Presenters:

- Renee Ridzon, Ahimsa Associates
- Zebedee Mwandi, USAID Malawi
- Jabbin Mulwanda, Jhpiego, an affiliate of Johns Hopkins University
- Anne Thomas, DOD
- Jonathan Grund, CDC
- Dan Rutz, CDC
- Jason Reed, OGAC

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STANDARDIZED AE GUIDE
INFECTION CONTROL
TRAINING
MONITORING/ REPORTING & USE OF LOCAL DATA
EFFECTIVE COMMUNICATION
AE PREVENTION & MANAGEMENT
SAFETY FIRST

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Medical and Surgical Complications of VMMC: Prevention and Management

Renee Ridzon, MD

Ahimsa Associates

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Adverse Events

- Anesthetic toxicity
- Bleeding
- Surgical complications

Three Types of Anesthetic Complications

- Psychogenic or vaso-vagal reaction (fainting) most common reaction with local anaesthetic injection
- Anaphylaxis extremely rare (<1% of adverse reactions to local anaesthetics)
- Toxicity
  - Occurs with excessive levels of anaesthetic through repeated injections or direct injection into a vessel
  - Very difficult to manage; requires ICU; high mortality with cardiotoxicity or seizures

Anesthetic Dosing

	Lidocaine 1.0%	Lidocaine 2.0%	Marcaine 0.25%	Marcaine 0.5%
-----	X	X	X	X
Lidocaine 1.0%			X	X
Lidocaine 2.0%			X	X

Preventing Anesthetic Complications

- Weight based dosing
- Double check dose
- Draw back on syringe before each injection of anesthesia to assure not in vessel
- Never use lidocaine with epinephrine

Bleeding

- Von Willebrand disease
  - Up to 1% of population
- Hemophilia (Factor VIII deficiency)
  - 20 per 100,000 males 10-14 yrs
  - 13 per 100,000 males 15-19 yrs
  - African prevalence 2-6 per 100,000 males
- For mild to moderate bleeding disorders, client is often unaware they have the condition until they undergo a procedure like dental work or even VMMC

Prevention and Management

- Obtain and record medical history
- Early recognition of abnormal bleeding
- Apply pressure
- Get help when needed; referral plan in place
- Management by experienced surgeon with medical back up

Surgical Complications

- Lacerations
- Amputations
- Diathermy burns
- Excess skin removal
- Excessive scarring or keloid formation

Prevention and Management: Injuries

- Good technique and training with use of diathermy needed to avoid burns
- Never cauterize near the frenulum-formation of fistulae
- Always mark the skin prior to foreskin removal
- Management should be by a specialist
- Have a referral plan in place

Overriding Considerations

- Management of serious complications requires advanced medical and surgical training and skill
- Do not manage anything you are not trained to handle
- Get help if you need it
- Always have a referral plan in place

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Adverse Event Action Guide for VMMC

Adverse Event (AE) Guide

- Developed by PSI and CDC
- Guide for both *classification* and *management* of VMMC AEs
- Audience: clinical providers of VMMC surgery , providers of emergency AE services and post-operative reviews
- Endorsed by COSECSA (College of Surgeons, East, Central, Southern Africa)
- Next version will include device-related AEs

Why an AE Guide?

- Standardization across VMMC sites, partners, and programs
- Guidance on AE management in one document
- Emphasis on appropriate clinical management and client safety
- Improved reporting of PEPFAR indicators

AE Guide Contents

- Section 1-Introduction to The Adverse Events Management Guide
  - About the guide
  - How to use this guide
- Section 2-Adverse Event Management
  - Bleeding
  - Infection
  - Wound Disruption
  - Pain
  - Scarring/Disfigurement
  - Torsion of Penis
  - Insufficient Skin Removal
  - Excessive Skin Removal
  - Injury to Penis
  - Excess Swelling
  - Difficulty Urinating
  - Sexual Complications/Undesired Sensory Changes
  - Anesthetic-related Problem
  - Occupational Exposure
- Section 3-Appendicies
  - AE Recording and Reporting
  - AE Classification and Definition: During Surgery and Prior to Discharge from VMMC Clinic
  - AE Classification and Definition: Post-operative Period from Discharge from VMMC Clinic

Color Photo Job Aid

- To aid with correct identification and classification of AEs
- Illustrating AEs of varying
  - Severities
  - Timepoints
- Job aids will be produced in color, in laminated form for wide distribution
- Both AE Guide and job aids will be available on CD

Adverse Event Action Guide

For Voluntary Medical Male Circumcision by Surgery

2013

psi
Zimbabwe

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Infection Prevention and Control in VMMC Settings

Zebedee Mwandi
Biomedical HIV Prevention Advisor, USAID Malawi

PRIORITIES FOR VOLUNTARY MEDICAL MALE CIRCUMCISION FOR HIV PREVENTION PROGRAMS
PEPFAR VMMC Webinar Series

SAFETY – SAFETY – SAFETY , *December 04, 2013*

Outline

- Prevention of wound infections
- Prevention and management of health care worker occupational blood-borne pathogen exposure
- Prevention of community blood-borne pathogen exposure (waste disposal)
- Cross-cutting themes

Protecting Wound infections

- Hand hygiene
  - Correct scrub with flowing water
    - Can alternate with hand sanitizer
  - Correct gloving with sterile, single-use gloves
- Surgical garb
  - Apron at minimum
  - Mask and eye protection – recommended
- Surgical site preparation
- Sterilization of instruments
- No role for prophylactic antibiotics

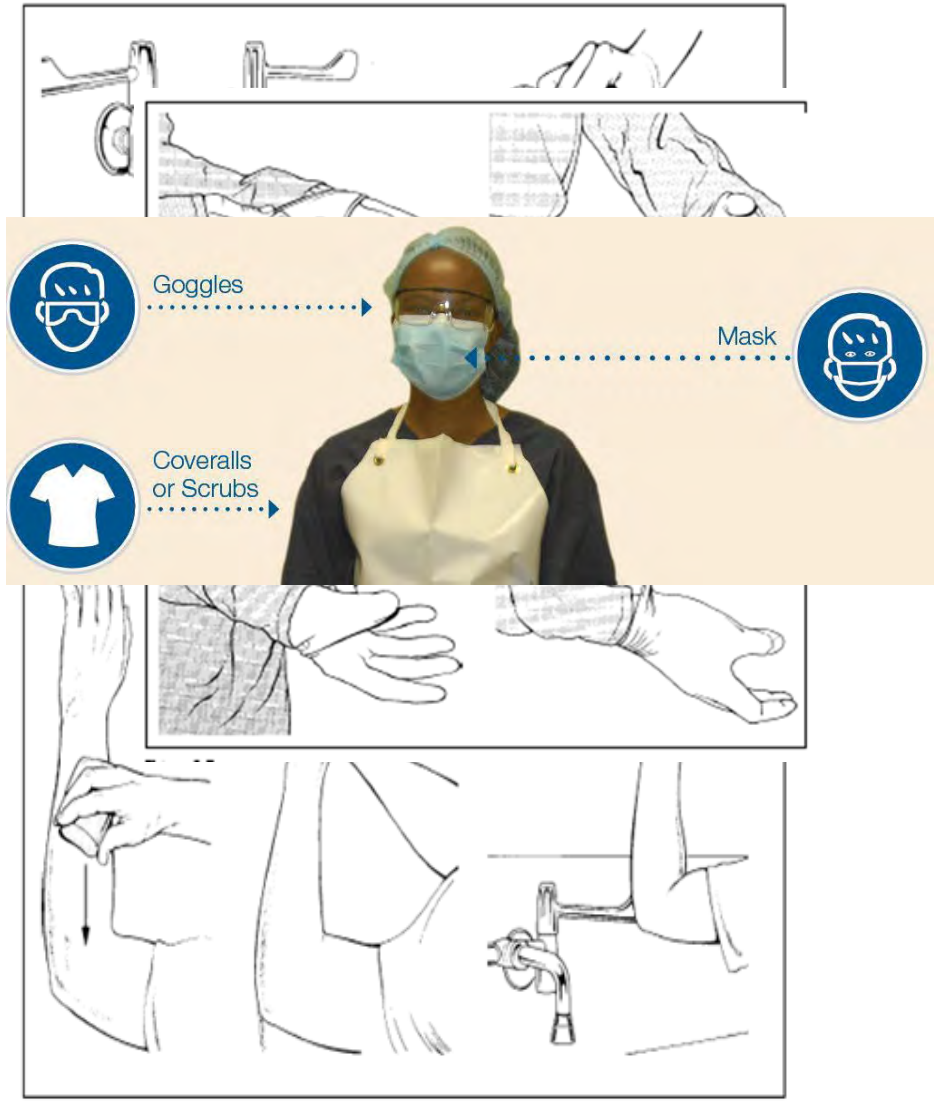


Figure 2.4

Post-Exposure Prophylaxis (PEP): HIV

- PEP should be initiated ASAP, within hours & no later than 72 hours following potential exposure
- Should not be started in those known to be infected with HIV
- Have an SOP for PEP:
  - Wash injured area with Soap and Water
  - Reporting chain
  - Evaluate exposure source and the exposed person's status (HIV test if status unknown)
  - Someone designated to determine need for PEP
  - Where PEP is stored
- For outreach services, recommend PEP starter kit
  - If PEP drugs not on site, a vehicle must be available to transport HCW to source of PEP

Post-Exposure Prophylaxis: HBV

- Gold standard is HBV vaccine for HCW/HCP before they start working

- Currently HBV vaccine not offered in most settings (Managers **MUST** correct this)

- WHO MC manual recommends unvaccinated workers to receive HBV vaccine and HBIG at time of exposure; this practice should be implemented

Waste Disposal

- Differentiate infectious from non-infectious waste; regularly clean containers with disinfectant, water rinse, air-dry.

- Highly Infectious Waste=**Red**

  Non-Infectious Waste =**Black**

  Infectious Waste = **Yellow**

SCMS VMMC HCMW Toolkit

SCMS developed the VMMC Health Care Waste Management Toolkit as a sustainable and cost-effective process for ensuring that VMMC sites properly handle, treat, and/or dispose of HCW, and practice sound environmental hygiene.

The kit consist of key tools on:

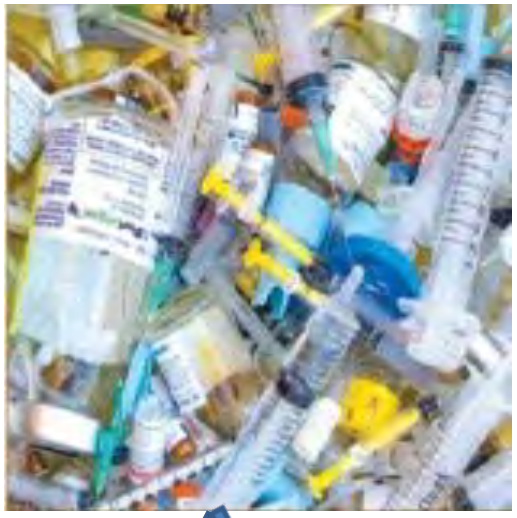
- **Operational Planning**
- **Procurement and Commodity Management,**
- **Point of Generation,**
- **Storage,**
- **Transport / Transfer,**
- **Treatment or Destruction and/or Disposal,**
- **Staffing and Training,**
- **Quality Management and**
- **Environmental Hygiene.**

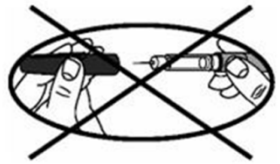
Ref: www.scms.pfscm.org for VMMC guidance document on *Proper Decontamination, Storage, Transport and Disposal of Disposable Non-Sharp Metal Instruments*

Bio-hazardous waste disposal

- Sharps in puncture-resistant container with opening to allow items to be dropped through, but small enough to prevent removal; when ¾ full, dispose.

- Personal level initiative to protect oneself





Cross-cutting Themes

- Training
  - Early
  - Refresher
- Quality assurance
  - Ongoing internal Continuous Quality Improvement team
  - Periodic External Quality Assessment (EQA)
- Program managers must be knowledgeable and provide oversight
  - Including on waste disposal!

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innovating to save lives

Jhpiego

an affiliate of Johns Hopkins University

The Role of Training in Ensuring Client and Provider Safety in VMMC

Jabbin Mulwanda, FCS (ECSA), MMED (Surg.), MBCHB

Jhpiego, an affiliate of Johns Hopkins University

Background

- ESA countries have set ambitious targets for rapid scale up of VMMC and this entails training of large numbers of providers
- Training is essential to ensure safety for both clients and providers
  - poor training can contribute to risks of injury or harm
  - good training can prevent harm

Recognized Best Practices

- Pre-training:
  - Recognition of baseline knowledge and skills of learners
  - Emphasis on proper participant selection
- During training:
  - Evidence based training techniques e.g. simulation based training
- Post-training
  - Transfer of skills from classroom to workplace
  - Post-training support
- Emphasis on safety throughout training process

Pre-Training

- Important to select appropriate
  - Curriculum selection
  - Trainer selection
  - Participant selection
  - Site selection

During Training

- Using evidence based training techniques
- Learners practice skills and experience mistakes before interacting with actual clients

During Training

- When learner has demonstrated competency on a model she is ready for supervised clinical practice
- **Checklists** ensure safety by enforcing adherence to standards

Post-Training Support to the Learner

- Working with supervisors to ensure that newly trained providers have opportunity to use their new skills
- Identifying experienced VMMC staff to provide onsite mentorship
- Linking post-training follow-up to ongoing quality assurance and supportive supervision

Summary

- Training is a process
- Programs should put equal emphasis on what happens before and after training as they do during training
- Training programs should address the selection of the right trainers, learners, training techniques, transfer of learning to lead to safe VMMC services
- QA findings and service delivery data (including AE rates) should be routinely fed back to the training program

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Discussion

Naomi Bock, MD, MS
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Safety, Safety, Safety: Monitoring, Reporting, and Data Use

Anne Goldzier Thomas, Ph.D.
DoD HIV/AIDS Prevention Program

PEPFAR Webinar Series #4

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HOW DO YOU KNOW IF YOUR PROGRAMS ARE “SAFE”?

Data Collection

- Surgery registers
- Client (patient) records
- Adverse event registers
- Adverse event summaries

- Electronic or paper

NGI PEPFAR VMMC Indicators

P5.1D: Number of males circumcised as part of the minimum package of MC for HIV prevention services

- **By Age: <1; 1-9; 10-14; 15-19; 20-24; 25-49; 50+**

H2.3D: Number of healthcare workers who successfully completed an in-service training program

- **By MC Training and Pediatric Treatment Training**

P5.2D: Number of circumcised clients experiencing at least one moderate or severe adverse event (AE) during or following surgery

P5.3D: Number of locations providing MC surgery as part of the minimum package of MC for HIV prevention services

P5.4D: Number of males circumcised who return at least once for post-operative follow-up care (routine or emergent) within 14 days of surgery

Proposed MER Indicators – FY14

- **P5.1.D:** Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program within the reporting period
  - By Age: <1; 1-9; 10-14; 15-19; 20-24; 25-49; 50+
  - By HIV status
  - By technique (surgical vs device)
    - By follow-up status: # males surgically circumcised who returned at least once for follow-up within 14 days

- **P5.2.D:** Number of males circumcised surgically or by medical device that experienced at least one moderate or severe adverse events(s) (AEs)
  - By AE type [surgical intra-operative AE(s), surgical post-operative AE(s), or device-based AE(s)]
  - By severity (moderate or severe)

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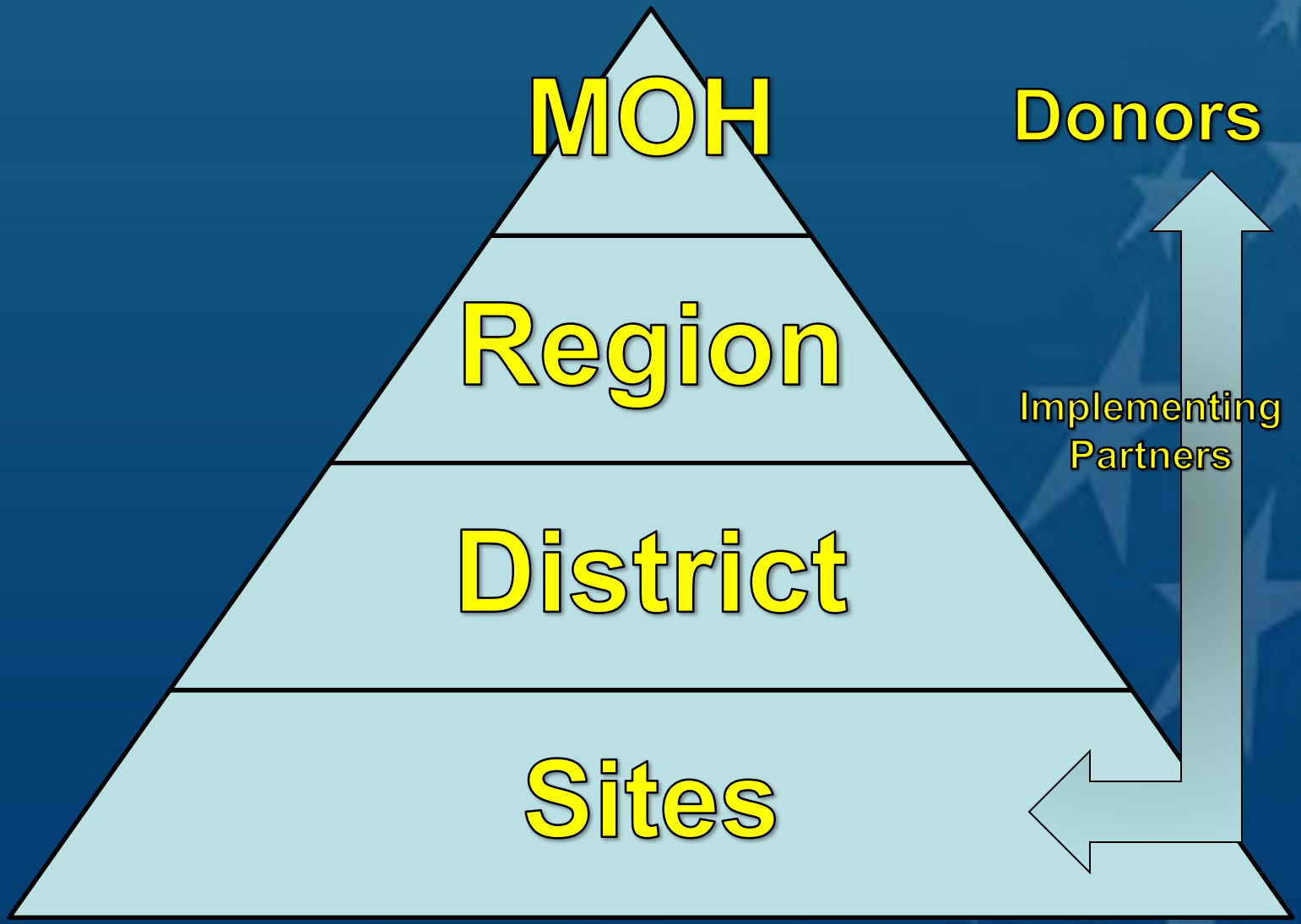

Use of Data

- Site, Implementing partner, government review:
  - Weekly, monthly, quarterly review meeting
  - Are there patterns in the AEs?
  - Is the AE rate higher than expected?
  - Is the follow-up rate reasonable? >80%?
  - Is the management of the AEs sufficient?
  - Are some AEs associated with certain personnel or settings?
  - Is additional training needed?
  - Are there critical deficits that require changes in staffing?

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Thank you!

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What Do the VMMC Adverse Event Data Tell Us?

Jonathan Grund, MA, MPH
CDC

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Published VMMC AE Data

- Published VMMC adverse event (AE) data are limited
- Predominantly from a few countries
- Difficult to compare AE rates across countries due to challenges with:
  - Definitions
  - Diagnosis
  - Documentation
  - Denominator

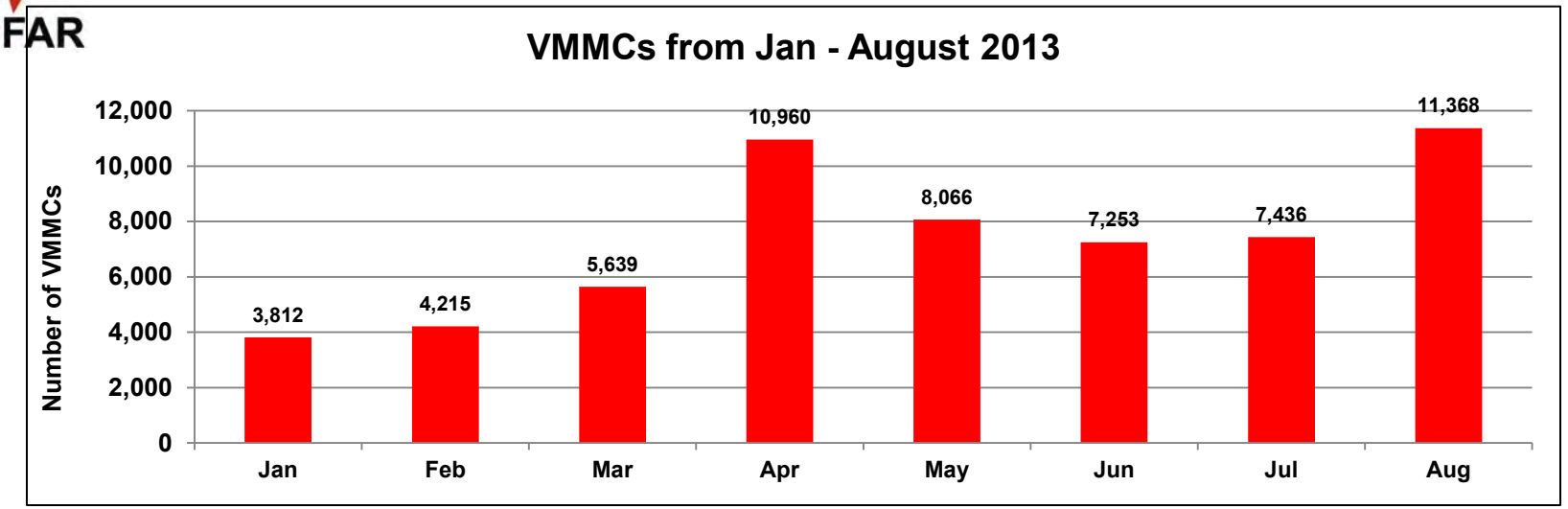
Denominators for Intra- and Post-Operative AEs

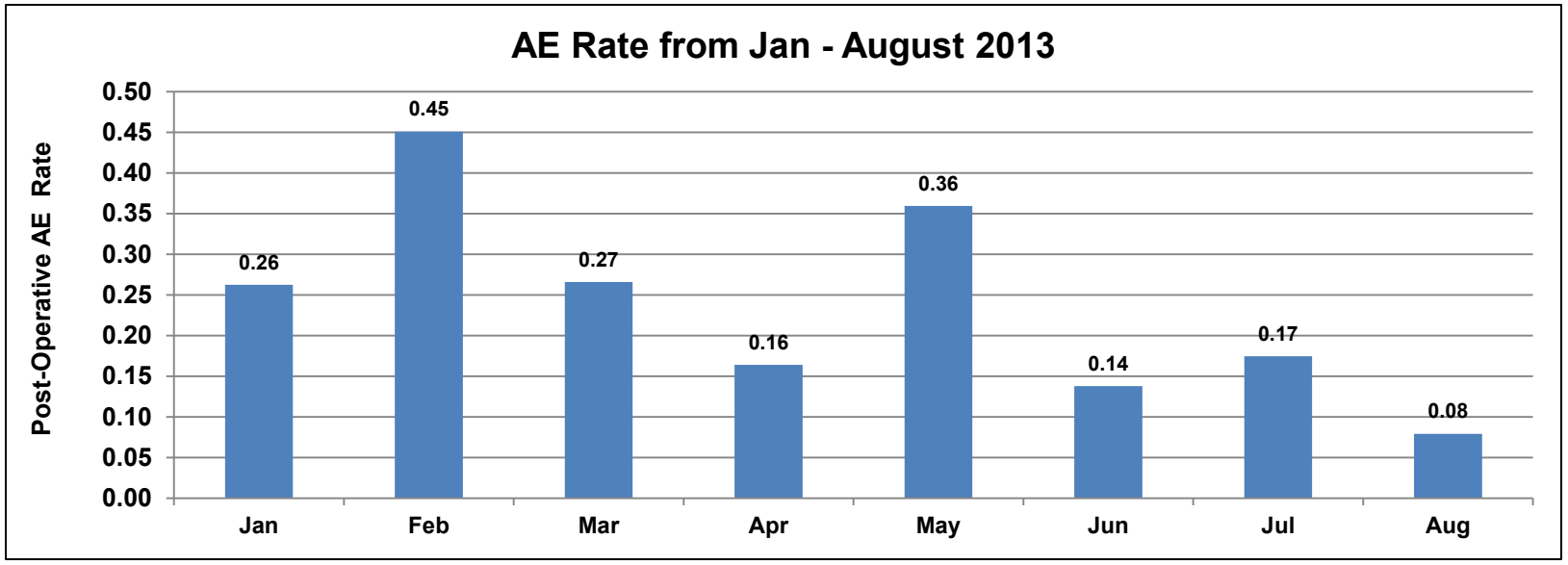
Type of AE	Numerator	Denominator	Rate
Intra-operative	Total number of intra-operative AEs	All VMMCs performed	
Example	*29*	*1,698*	*1.71%*
Post-operative	Total number of post-operative AEs	Total number of VMMC clients who return for at least 1 post-operative visit	
Example	*262*	*11,456*	*2.29%*

Review of Published AE Data

Country	Author	Year	Moderate or Severe Post-Operative AE Rate	Most common Post-Operative AE reported
South Africa	Auvert	2005	3.8%	Pain
Kenya	Bailey	2007	1.7%	Bleeding, Infection
Uganda	Gray	2007	3.6%	--
Kenya	Herman-Roloff	2010	2.7%	Infection
Kenya	Chesang	2013	2.4%	--
Swaziland	Grund (forthcoming)	2013	2.6%	Infection

VMMC and AEs from Zimbabwe, 2013





Bertrand JT, Rech D, Aduda A, Frade S, Loolpapit M, Machaku MD, Mavhu W, Onyango M, Perry L, and Farrell M. Systematic monitoring of the voluntary medical male circumcision scale-up in Eastern and Southern Africa (SYMMACS): Final report of results from Kenya, South Africa, Tanzania and Zimbabwe. April 2013. Baltimore: USAID | Project Search: Research to Prevention.

Do VMMC Clients Lost-to-Follow-up Experience AEs?

- Observational cross-sectional study of VMMC clients aged 13+ years in Nyanza Province, Kenya (n=1,531)
- 51 medium- and high-volume VMMC sites from April – October 2012
- Home-based exam 14 days after surgery vs. chart review abstraction

- Objective: To compare AE rates and types between clients who did vs. did not return for follow-up

Findings from Kenya VMMC AE Study

	Follow-up at VMMC Site (n=703)		Home-Based Assessment (n=828)		Relative Risk (95% CI)
	n	%	n	%	
Participants with ≥1 moderate or severe AE (pain excluded)	22	3.1	56	6.8	2.2 (1.3, 3.5)

Reed J, Grund J, Mwandi Z, et al. *Evaluation of loss-to-follow-up and post-operative adverse events in a voluntary medical male circumcision program in Nyanza Province, Kenya*. Forthcoming.

Conclusions from Kenya VMMC AE Study

- Cannot assume that clients who do not return have no AEs
- Some clients but not all pursue follow-up from alternative sources (27% in this study)
- How to increase follow-up among VMMC clients?

Reed J, Grund J, Mwandi Z, et al. *Evaluation of loss-to-follow-up and post-operative adverse events in a voluntary medical male circumcision program in Nyanza Province, Kenya*. Forthcoming.

What Do the VMMC AE Data Tell Us?

- VMMC AE rates are very low
  - Denominator for intra-operative AEs
    - Total number of VMMCs performed
  - Denominator for post-operative AEs
    - Total number of VMMC clients who have returned for at least one follow-up visit
- Standardizing definitions and reporting requirements can improve quality
- Interventions to reduce lost-to-follow-up should be implemented and evaluated

Thank you.

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Time on Your side

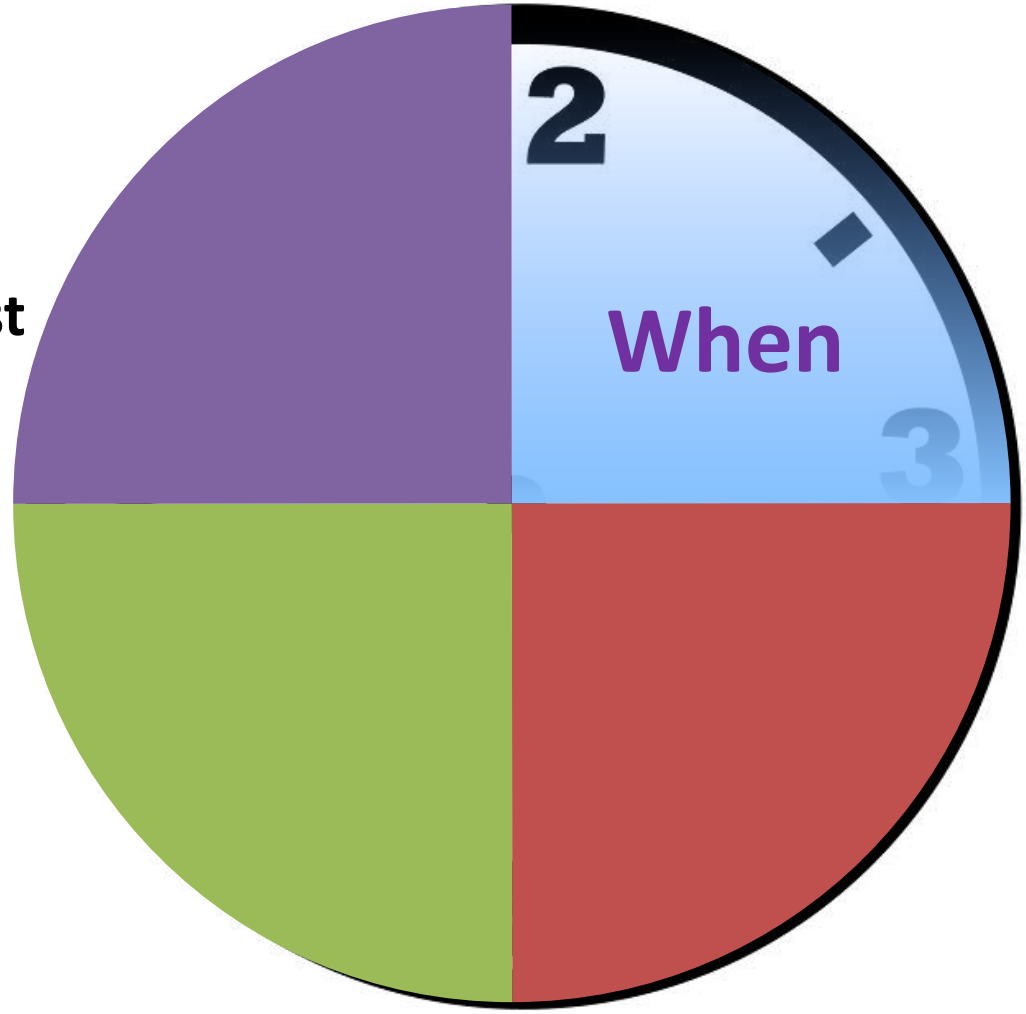
Effective Adverse Event Communication

Daniel C. Rutz, MPH
CDC Division of Global HIV/AIDS
HIV Prevention Branch
PEPFAR Medical Male Circumcision Technical Working Group / Communication Sub Group

Shared Responsibility – Strengthening Results for an AIDS-free Generation

First Things Fast

- Your response starts at first word of adverse event
- Silence sends a message
- Delay is damaging



Facts, Feelings, Follow-up

- **Expect emotions to run high**
  - VMMC Client – fear, sadness, anger
  - Program personnel – guilt, fear, defensiveness
- **Prioritize the response**
  - VMMC Client / family
  - Program personnel (directly involved)
  - Overseers, partners
  - Media (sometimes, but not always)
- **Remain engaged**
  - Respect client needs and issues
  - Assure remedies are completed
  - Assure that “lessons learned” are applied

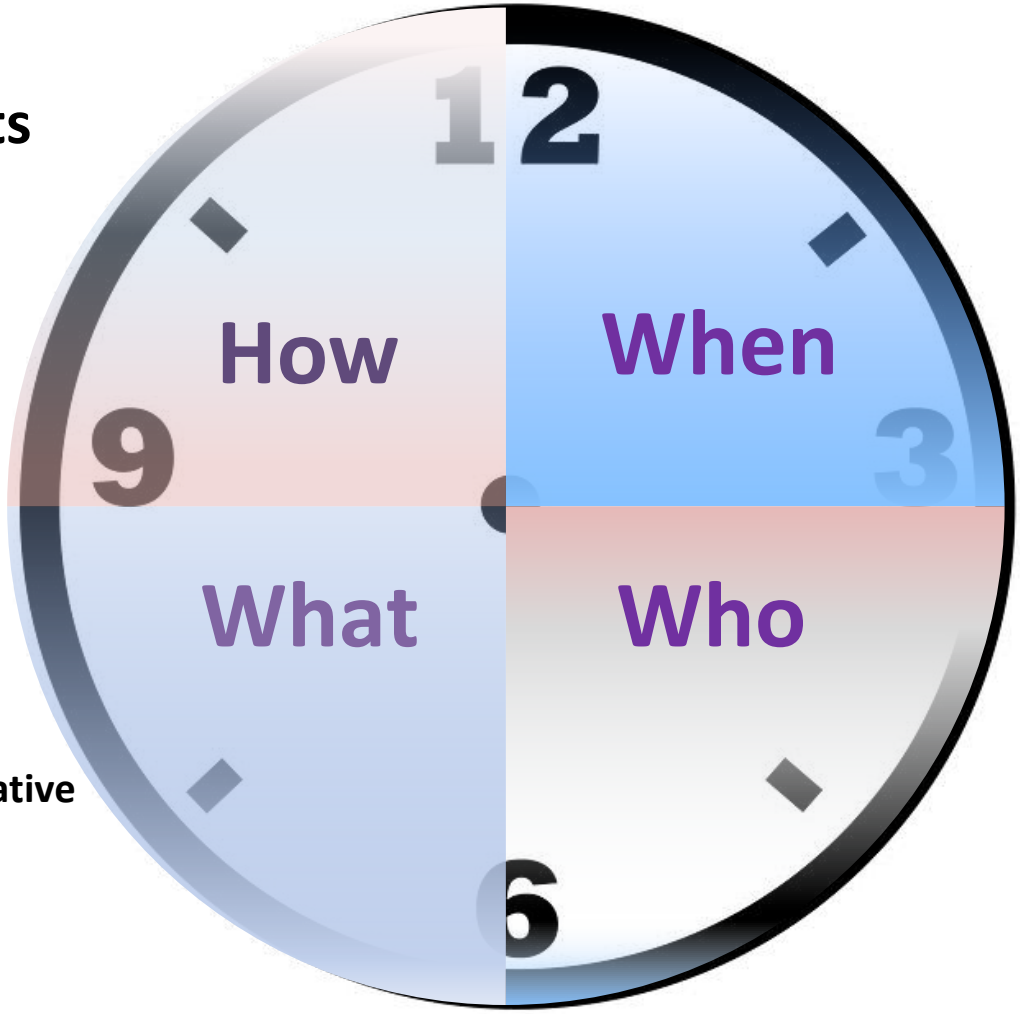
Compassion is King

- **Express empathy**
  - Be genuine
  - Don't minimize
  - Focus on resolution; not blame
- **Media – yes, no, or maybe**
  - Protect client privacy
  - Share process for immediate remedies and long term improvement
- **Communicate with partners**
  - Transparency builds trust
  - Coordinated response shows competence

On Time, In Control

- **Plan ahead for adverse events**
  - Who to call, how to call them
  - Who speaks, to whom, and how
  - Know, follow the law
  - Know what remedies can be tapped
  - Maintain media contact list

- **Be ready for likely issues**
  - Keep promises
  - Answer anger with patience.
  - Don't become defensive or argumentative
  - Expect media to fix blame
  - Be pro-active with "lessons learned "
  - Remember: It's not about you



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PEPFAR HQ Notification of VMMC Client Deaths:

-Review of Reporting Requirement
-Answers to Frequent Questions
-Next Steps

Jason Reed, MD, MPH

OGAC

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Required Reporting

Presented During March 2013 Webinar

1) Implementing partner notifies in-country donor agency technical lead or agency Chief of Party
   - *No later than close of business same day as client death*
2) In-country technical lead notifies agency Chief of Party
   - *Within 24 hours of client death*
3) Chief of Party notifies PEPFAR Coordinator and Agency HQ technical lead
   - *Within 24 hours of client death*
4) PEPFAR Coordinator notifies other in-country agency Chiefs of Party, CSTL, OGAC MC TWG Co-chair
   - *Within 24 hours of client death*
5) OGAC MC TWG Co-chair notifies all MC TWG Co-chairs
   - *Within 24 hours of client death*

Question #1: Since occurrences of death are managed in-country, why do they need to be reported to HQ?

- Regional Oversight: The HQ MC TWG is responsible for remaining aware of and responsive to the experiences of the whole of the regional program (all 14 countries)
- Support: The MC TWG's Communications Subgroup and OGAC Public Affairs can provide support to U.S. Embassy Public Affairs
- Follow-through: Allows OGAC and HQ MC TWG to re-assess each case, after completion of clinical investigations, to identify unresolved matters with family, community, implementing partner, and partner government by way of a report from the PEPFAR Coordinator
- OGAC Front Office requested to be immediately informed of client deaths

Question #2: What does HQ do with the information?

Awareness of the totality, frequency/timing, characteristics, and pattern of events from all countries enables HQ MC TWG to:

- provide appropriate program oversight
- consult with specialists to better understand events and identify potential risks to clients' and staff health/safety
- introduce new or modify existing Policy Guidance
- introduce new or modify existing Technical Considerations
- apprise OGAC and agency leadership of program's needs, preventative and mitigating measures
- provide virtual support for clinical investigations as they occur in-country

Question #3: Why is this subject only an issue for VMMC and not other program areas?

- As a minor surgical procedure, VMMC poses unique health risks, and complications may be severe and occur rapidly. The VMMC program bears the responsibility for ensuring risks are well understood and mitigated through the highest quality services.
- VMMC clients are healthy individuals undergoing an elective procedure; therefore, safety and risks to health are particularly important issues.

Summary

- VMMC programs are safe programs
  - Severe AEs and deaths have been very rare
- Medical and surgical procedures pose some inherent risks
  - Preventing and mitigating such risks is the responsibility of the program and providers
- Understanding the experiences of the overall program allows for safer services through program improvement
  - HQ notification is required to ensure technical resources are brought to bear

Next Steps

- A more detailed notification protocol will be forthcoming
  - Clarifications/definitions of who receives what information by which methods and in what time frames
  - Standardized forms and reports
  - Specified schedule for conference calls between country team and HQ
- All PEPFAR agency field offices, PEPFAR-funded implementing partners, and supported facilities will need to be informed of the new requirements

Thank you!

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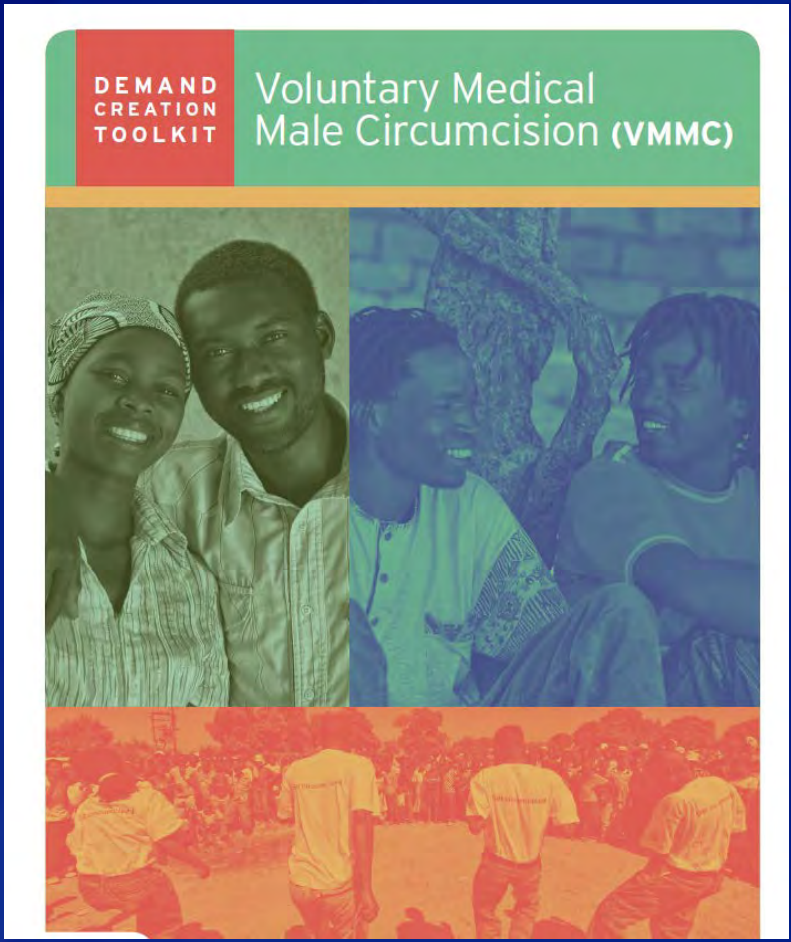
The Demand Creation Toolkit
for
Voluntary Medical Male Circumcision (VMMC)

What – Why – How It can Help

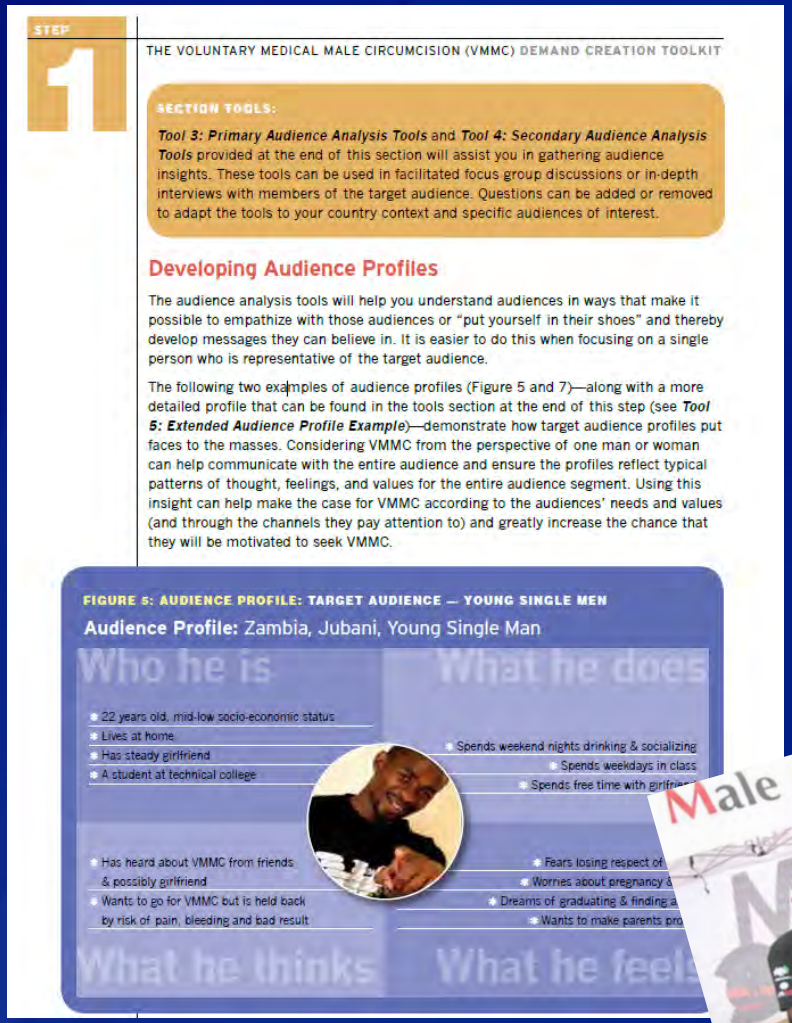
Dan Rutz
Division of Global HIV/AIDS, Center for Global Health
Centers for Disease Control and Prevention

Purpose and Promise



- Assistance for expert and novice communicators
- A “How-to” guide and reference
- Forms, templates, checklists to stream-line demand creation activities

Audience Profiles



STEP 1

THE VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) DEMAND CREATION TOOLKIT

SECTION TOOLS:

Tool 3: Primary Audience Analysis Tools and ***Tool 4: Secondary Audience Analysis Tools*** provided at the end of this section will assist you in gathering audience insights. These tools can be used in facilitated focus group discussions or in-depth interviews with members of the target audience. Questions can be added or removed to adapt the tools to your country context and specific audiences of interest.

Developing Audience Profiles

The audience analysis tools will help you understand audiences in ways that make it possible to empathize with those audiences or "put yourself in their shoes" and thereby develop messages they can believe in. It is easier to do this when focusing on a single person who is representative of the target audience.

The following two examples of audience profiles (Figure 5 and 7)—along with a more detailed profile that can be found in the tools section at the end of this step (see ***Tool 5: Extended Audience Profile Example***)—demonstrate how target audience profiles put faces to the masses. Considering VMMC from the perspective of one man or woman can help communicate with the entire audience and ensure the profiles reflect typical patterns of thought, feelings, and values for the entire audience segment. Using this insight can help make the case for VMMC according to the audiences' needs and values (and through the channels they pay attention to) and greatly increase the chance that they will be motivated to seek VMMC.

FIGURE 5: AUDIENCE PROFILE: TARGET AUDIENCE — YOUNG SINGLE MEN

Audience Profile: Zambia, Jubani, Young Single Man

Who he is

- 22 years old, mid-low socio-economic status
- Lives at home
- Has steady girlfriend
- A student at technical college

What he does

- Spends weekend nights drinking & socializing
- Spends weekdays in class
- Spends free time with girlfri

What he thinks

- Has heard about VMMC from friends & possibly girlfriend
- Wants to go for VMMC but is held back by risk of pain, bleeding and bad result

What he feels

- Fears losing respect of
- Worries about pregnancy &
- Dreams of graduating & finding a
- Wants to make parents pro

- **The person behind the data**
- **Building empathy**
- **Relevant messaging**

Non-Medical Message Themes

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New Resources for VMMC Demand Creation

Documentation of ongoing demand generation initiatives in the field

Paulin Basinga

Bill & Melinda Gates Foundation

BILL & MELINDA GATES *foundation*

Demand creation Website available!

1. **BBC WST documentation website accessible at:**
   - http://www.demandcreationforvmmc.org/
   - The website highlights some of the best examples of demand creation for VMMC currently underway in seven countries in Africa.
   - It is not intended as a comprehensive register of all current activities, but rather designed to support the spread of innovative and effective approaches which drive the uptake of VMMC.
   - Site to be merged with the http://www.malecircumcision.org/

2. **The website has links to:**
   - Zambia April demand Creation brief meeting report
   - Short film on the Zambia meeting
   - Status of the implementation of the impact evaluations of innovative demand generation initiatives being funded (3iE)
   - Other ongoing demand creation activities to be added (ie: market research, ect)
   - You are welcome to submit demand creation activities to be shared in the web.

http://www.demandcreationforvmmc.org/

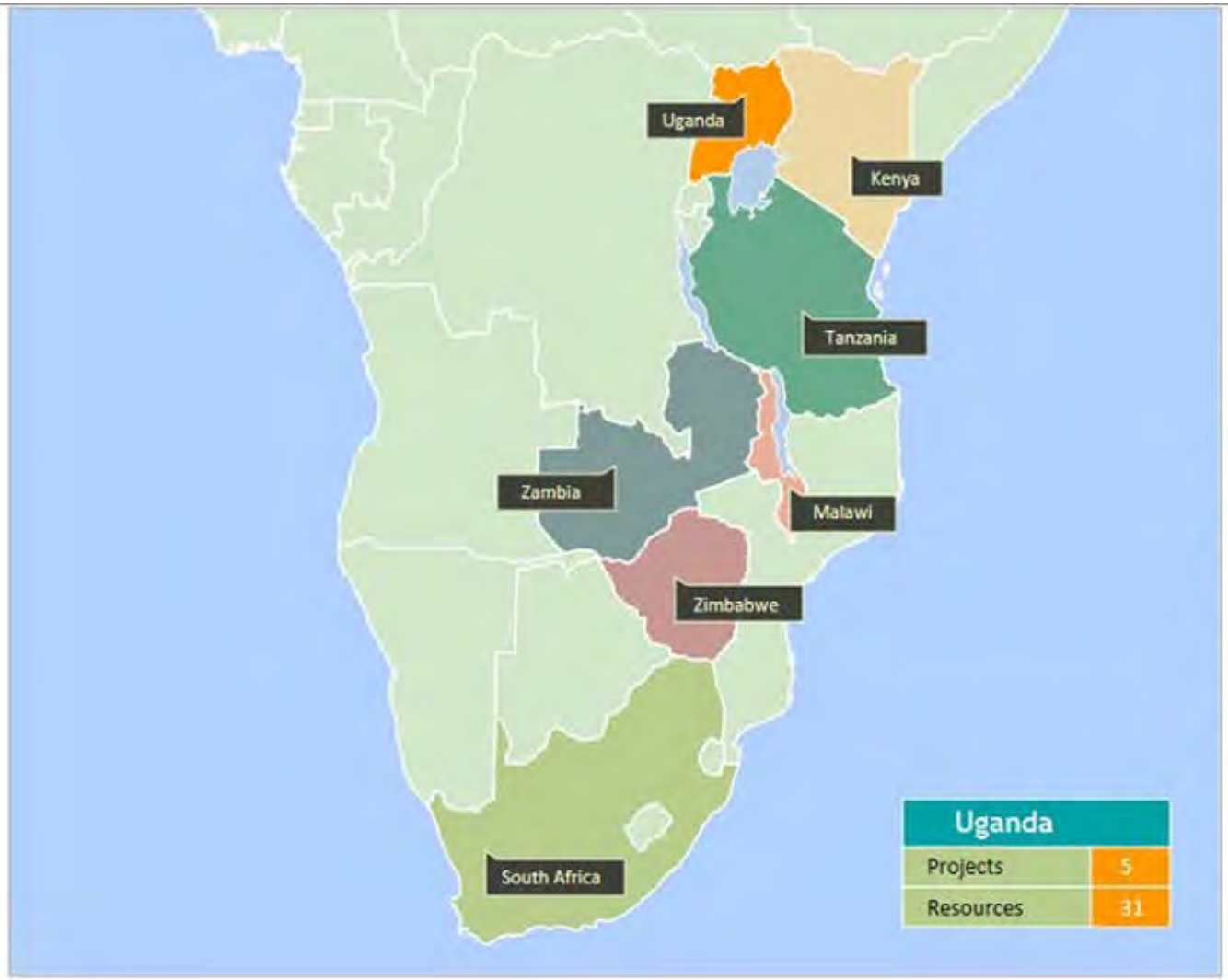
VMMC
CREATING DEMAND FOR VMMC

HOME | ABOUT THIS WEBSITE | PROJECTS | RESOURCES | EVENTS | COMMUNITY | CONTACT US

Creating Demand for Voluntary Male Medical Circumcision

Innovative and effective approaches to demand creation for VMMC

Projects in the websites are organized by country and by categories



- **For questions / suggestions about the website :**

http://www.demandcreationforvmmc.org/contact

- **Thank You!**

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VMMC Webinar Series

Summary of PEPFAR VMMC Webinars I-III

Emmanuel Njeuhmeli
USAID

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MCHIP Maternal and Child Health Integrated Program
CDC Centers for Disease Control and Prevention

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VMMC Webinar Series

PEPFAR VMMC Webinar I: 19 March 2013

- **Monitoring, Reporting, and Quality of Services**
  - Participation:
    - **102 participants** from over 13 countries
    - **78 viewing party participants** from Uganda, Kenya, South Africa, Botswana, Tanzania, Swaziland, Malawi, Zambia
  - Summary:
    - Discussed PEPFAR technical considerations and revised VMMC indicators; data quality assessment and reporting; continuous quality improvement; external quality assessment

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VMMC Webinar Series

PEPFAR VMMC Webinar II: 6 June 2013

- **Moving Communication Forward**
  - Participation:
    - **199 participants** from over 12 countries
    - **77 viewing party participants** from Malawi, Botswana, South Africa, Zimbabwe, Uganda, Ethiopia, Swaziland, Kenya, Zambia
  - Summary:
    - Showcased successful implementation practices from the field and provided the "how" when discussing the use of communications.

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VMMC Webinar Series

PEPFAR VMMC Webinar III: 21 August 2013

- **Devices for Adult Male Circumcision for HIV Prevention: What's the Current Situation? What's Next?**
  - Participation:
    - **180 participants** from over 14 countries
    - **65 viewing party participants** from South Africa, Uganda, Swaziland, Kenya, Uganda, Zambia
  - Summary:
    - Discussed the use of devices as an alternative to surgical male circumcision. It included an overview of available MC devices and their clinical performance, WHO guidance on their use, tips for media engagement, costing information, and an overview of questions for countries to ask in all stages of program implementation.

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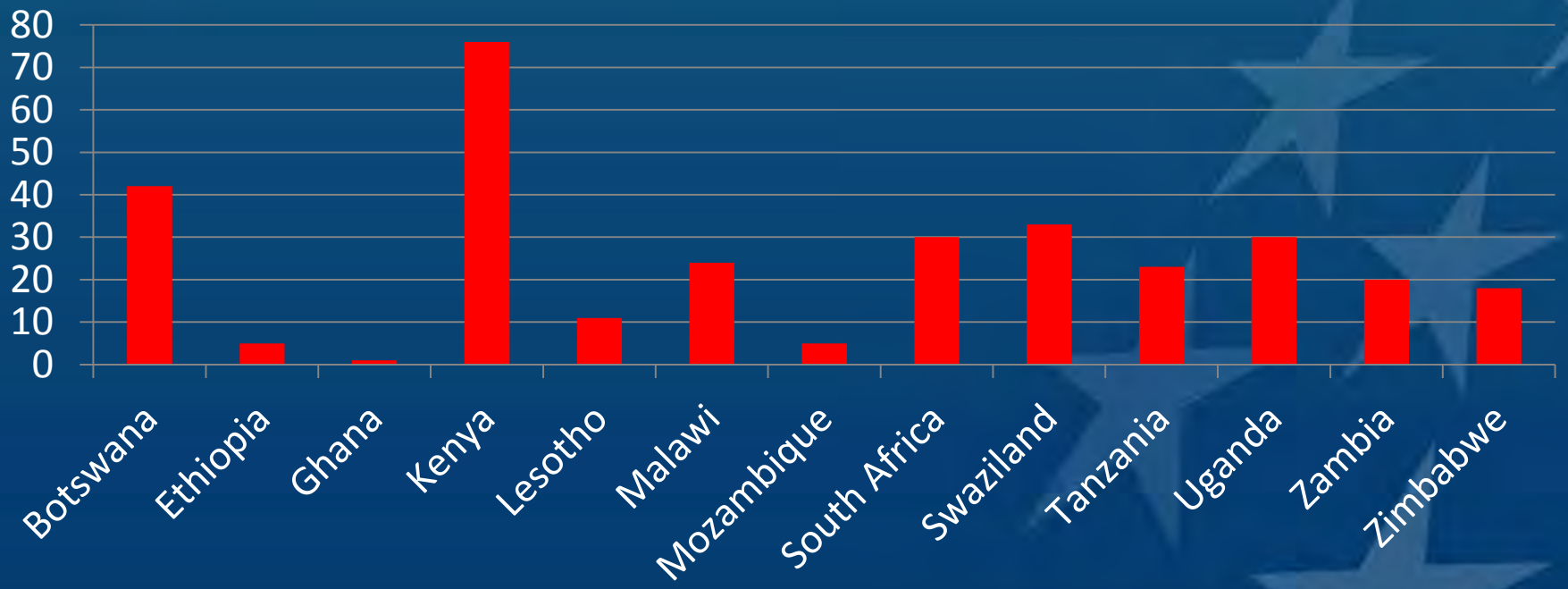
VMMC Webinar Series

Field Participation in Webinars I-III
(Total field participants: 312)



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  - Co-Chairs: Jason Reed, Emmanuel Njeuhmeli, Anne Thomas, Naomi Bock
  - Members: Catey Laube, Funmi Adesanya, Kim Ahanda, Adolfus Muyoti, Dianna Edgil, Delivette Castor, Regine Jean-Francois, Michael Qualls, Dan Rutz, Jonathan Grund, Stephanie Hess, Bruce Porter, Poran Pordell, Reden Sagana, Nida Parks, Stephanie Marie Davis, Jonathan Davitte, Jacob Buehle, and Melanie Bacon

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VMMC Webinar Series

For more information about
the PEPFAR VMMC webinar series, contact:

Emmanuel Njeuhmeli (enjeuhmeli@usaid.gov)

Webinar Resources:
www.malecircumcision.org (Meeting Reports)

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Webinar evaluation:
https://www.surveymonkey.com/s/VMMC4

Next PEPFAR VMMC webinar:
Early Infant Male Circumcision

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