Perceptions of a Soccer-Based Intervention to Increase Voluntary Medical Male Circumcision (VMMC) Uptake in Zimbabwe: A Qualitative Study

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BACKGROUND

Three randomised controlled trials have shown that voluntary medical male circumcision (VMMC) reduces female-to-male transmission of HIV by 50-60% and has other important health benefits. Zimbabwe has a target to reach 80% VMMC coverage among HIV-negative 15-29 year-old men by 2015. This is a central strategy in the nation's HIV response. Despite considerable recent investment, VMMC uptake has been slower than hoped. Demand creation, particularly among adult men, presents a critical challenge to increasing VMMC coverage.

In this context, Grassroot Soccer (GRS) developed "Make the Cut" (MTC), a short, scalable intervention facilitated by circumcised "coaches" and delivered to men over 18 years on professional and social soccer teams. MTC represents the first interpersonal VMMC promotion strategy in Africa using soccer as an entry-point to generate demand for VMMC.

A cluster-randomised trial was carried out in Bulawayo, Zimbabwe, from November 2012 through April 2013 to assess the effectiveness of MTC at increasing VMMC uptake over three to six months. Teams were randomised into one of three groups: 1) MTC delivered by local professional soccer players trained as facilitators, 2) MTC delivered by non-professional soccer players trained as facilitators, and 3) control. A qualitative sub-study was conducted to explore reasons for uptake or non-uptake among the three sub-groups.

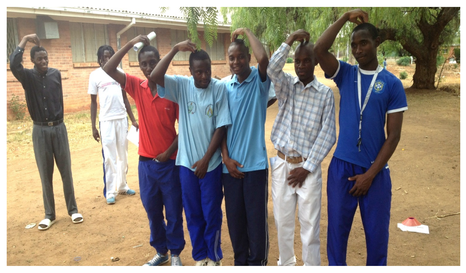
METHODS

In-depth interviews (IDIs) were conducted with MTC coaches (n=10), participants circumcised within 45 days post-intervention as determined using clinic records (n=3), and participants who remained uncircumcised following the intervention (n=6), purposively selected to match the age, sex, and team of circumcised participants. IDIs covered perceptions and acceptability of the MTC intervention, perceptions of VMMC, influential factors in deciding whether to go for VMMC, and suggestions for MTC improvement.

Two focus group discussions (FGDs) were conducted with coaches (n=7 and n=8 respectively) facilitating MTC interventions to learn how coaches viewed the different intervention components. IDIs and FGDs were carried out in English and Ndebele. Those conducted in Ndebele were translated into English by fluent local speakers and transcribed. A four-person team generated a codebook and carried out thematic analysis using NVIVO software. Observations were conducted at the training of coaches, interventions (n=29), and VMMC clinics.

INTERVENTION OVERVIEW

Make the Cut (MTC) was developed by GRS, a non-profit organization that trains community role models to deliver soccer-themed HIV prevention and life skills interventions to youth. MTC consists of a 60-minute soccer-based interpersonal education session. It features "Cut & Cover," a GRS activity that uses soccer metaphors to visually demonstrate the benefits of circumcision and correct condom usage to avoid HIV (see Figures 1 and 2). The activity that has been shown through a randomized controlled trial (GOAL) to increase knowledge on VMMC.



Figures 1 and 2: GRS' "Cut and Cover" activity

Figure 3: MTC coach delivering his Coach's Story

The curriculum also features a "Coach's Story" (see Figure 3), during which circumcised coaches share their experience with VMMC and address perceived barriers such as mandatory HIV testing, pain, and changes in sexual performance. Coaches answer participants' questions in the larger group and individually.

Participants further received information, education, and communications (IEC) materials, specifically: 1) a soccer- themed poster that reinforced messages from the session and provided contact information of local VMMC services (see Figure 4); 2) 23 SMSs delivered during a four-month period following the intervention to reinforce key messages, promote adherence to post-operative healing instructions, and encourage safe sexual behaviors; and 3) referral cards to cut the queue at either of two local VMMC clinics.

Prior to the start of intervention delivery, coaches took part in a required one-day MTC training workshop facilitated by GRS and Population Services International (PSI).

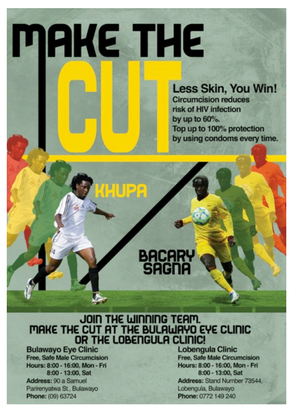


Figure 4: MTC poster, developed with input from MTC coaches and participants

RESULTS

1. Perceived Benefits

Coaches and participants spoke positively about the MTC intervention and its role in influencing VMMC uptake. They suggested that the intervention led to more comprehensive HIV knowledge, highlighting the role of the Coach's Story as an essential component:

> **"[The coaches] explained the me what goes on [during the procedure] and the fear that I had disappeared and the stories about the pain and everything were not true. The way they told us about circumcision was encouraging and I thought I should try it."**
>
> *-Circumcised participant*

Some evidence suggests that MTC had a greater peer effect on VMMC than was detected in the clinic records. Coaches reported informally motivating friends and neighbors to undergo circumcision:

> **"It gives me confidence…I managed to convince about four guys that I know that went to make the cut. And that's powerful."**
>
> *-MTC coach*

Findings were mixed on differences between delivery by professional and non-professional coaches. Certain responses from coaches and participants suggest that experience and facilitation skill are more important factors than being a professional soccer player.

2. Motivators and Barriers to VMMC Uptake

Decreased HIV risk was the most commonly cited motivator for circumcision. The most commonly cited barriers include: 1) HIV testing as a requirement in Zimbabwe prior to VMMC, and 2) fear of pain. Coaches discussed the difficulty of convincing men to take up not one but two health practices: circumcision and testing:

> **"[Participants were] afraid not of being circumcised but being tested."**
>
> *-MTC coach*

Most questions coaches received from players concerned the degree of pain caused by the operation, given a perception highlighted by numerous interviewees that "circumcision hurts" (MTC coach). Further barriers cited include the six-week post-operative abstinence period, opportunity cost in the form of time away from soccer and foregone wages, and a lack of knowledge about VMMC:

> **"The ones that get circumcised are the breadwinners. So how can they get circumcised if they have to stay home? Who will be working and putting the food on their table?"**
>
> *-MTC coach*

3. Delivery Challenges and Recommendations

Coaches highlighted challenges in delivering the intervention to older participants (over 30 years) and to social as compared with professional teams (typically, older participants played for social teams):

> **"[Some men were] maybe ten to fifteen years older. It can be difficult for them to understand…They say, 'What can you tell us?'"**
>
> *-MTC coach*

Older men perceived little benefit from undergoing HIV testing or VMMC at their age. Timing of delivery during the months of November and December posed a further challenge: participants were reluctant to uptake mid-soccer season or immediately prior to the holidays, given the six-week post-operative abstinence period.

Coaches and participants alike indicated that home-based follow-up and small incentives could play a role in improving VMMC uptake.

CONCLUSION

Qualitative findings suggest that the MTC intervention offers a feasible and innovative approach towards VMMC promotion. Participants found MTC (in particular the Coach's Story) persuasive because the MTC coaches had been circumcised and could discuss the procedure. The intervention was perceived to be more effective with participants under age 30. Findings also highlight fear of HIV testing as a major barrier to VMMC uptake in Zimbabwe. Future implementation should incorporate home-based follow-up and small incentives while avoiding delivery during the holidays and mid-season for professional soccer players.

NEXT STEPS

Based on the encouraging findings and lessons learned from the trial and qualitative sub-study, GRS has developed a modified version of MTC. Make the Cut + (MTC+) will be delivered by trained coaches to 15-19 year-old male students in secondary schools in Bulawayo. GRS, the London School of Hygiene and Tropical Medicine (LSHTM), the National University of Science and Technology (NUST), and PSI will run a second randomised trial and qualitative sub-study, MCUTS II, to explore the effects of MTC+ on VMMC uptake among this younger population. The trial will be funded by the International Initiative for Impact Evaluation (3ie) and will begin in November 2013. GRS is further exploring development of a VMMC uptake intervention targeting a broader audience of Zimbabwean men, ages 18-35.

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