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PROVIDER EXPERIENCES AND OPINIONS ON COUNSELING ADOLESCENTS UNDERGOING VOLUNTARY MEDICAL MALE CIRCUMCISION IN WESTERN KENYA
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ABSTRACT

Objectives: **Voluntary medical male circumcision (VMMC) remains an important component of comprehensive HIV prevention package. Kenya and other key countries are focusing increased attention on achieving large proportions of adolescent circumcisions. Because little is known about the impact of adolescent VMMC counseling, we sought to capture the experiences and opinions of VMMC providers regarding effective adolescent VMMC counseling.**

Design and Setting: **We purposively selected six VMMC sites: three each in Siaya and Kisumu Counties. From each site, we administered key informant interviews to two VMMC providers at a place of their choice for privacy and confidentiality. Outcomes of the study were participant responses to questions regarding their adolescent counseling practices, prior training, and opinions for improvement of counseling practices.**

Results: **Three providers (25%) reported having been trained on adolescent-specific VMMC counseling. Compared to adults, adolescents receive less information during VMMC counseling. There was lack of consistency in counseling procedures, with counselors making subjective judgments as to what content to include, depending on their perception of the sexual experience of the client. Providers recommended greater engagement of parents in the VMMC process, limiting numbers of clients per day to ensure quality of counseling, and allocation of space to facilitate confidentiality.**

Conclusions: **All providers counseling adolescent VMMC clients should receive adolescent-specific counseling training, and adhere to national VMMC guidelines. Measures to assure confidentiality should be taken, and numbers of clients per day limited to ensure quality of counseling services.**

INTRODUCTION

Voluntary medical male circumcision (VMMC) is a key human immunodeficiency virus (HIV) prevention intervention implemented in high-priority settings in eastern and southern Africa [1]. The World Health Organization (WHO) and the US President's Emergency Plan for AIDS Relief (PEPFAR) recommend that all VMMC patients, regardless of age, receive counseling that explains the link between VMMC and reduced risks of HIV acquisition, emphasizes the need to abstain from sexual intercourse and/or masturbation during the healing period, and encourages increased knowledge on how to further protect oneself from HIV post-VMMC [1–3].

Delivering VMMC to adolescents under-16 years of age has the advantage of higher social acceptance of circumcision [4,5], with fewer barriers to sexual abstinence during the post-operative healing period [3]. Adolescent circumcision maximizes overall population incidence protection by providing protection from new infections before sexual debut and extending risk reduction throughout their sexually active years [3]. Compared to early infant male circumcision (EIMC), adolescent circumcision is culturally more acceptable, with less waiting time between circumcision and exposure of the male to risk of HIV acquisition. Therefore, the impact on the epidemic is faster than with EIMC. Moreover, adolescent circumcision is more efficient due to mortality of boys between birth and adolescence, causing "wasted" circumcisions.

The 2nd National VMMC Strategy for Kenya [6] is to introduce EIMC with the goal of achieving 40% coverage among infant boys born in health facilities, and scale-up adolescent VMMC with the goal of achieving 90% coverage. After 10-12 years, those receiving EIMC will reach adolescence and the burden to sustain 90% coverage in perpetuity will be reduced. Although relatively few EIMCs have been performed to date in Kenya, current practice is otherwise consistent with these strategic goals, in that 82% of males circumcised under the PEPFAR program in 2017 were under age 16 years.

Little is known about the content of counseling that adolescents are exposed to as part of VMMC service delivery. Previous research in Tanzania, South Africa, and Zimbabwe [1] showed that the counseling content during the adolescent VMMC process lacked many crucial elements. Those studies demonstrated that not only were counselors not meeting the guidelines for counseling in the context of VMMC programs, but also there were lost opportunities to enhance knowledge of adolescents about post-operative wound care and HIV risk reduction behaviours [7,8].

We sought to assess provider experiences on counseling adolescents undergoing VMMC, to learn about their training, and to hear their opinions about effective strategies for counseling adolescents compared to adults in two counties in Western Kenya.

MATERIALS AND METHODS

This was a purposive multi-stage cluster sampling study at six sites in Siaya and Kisumu Counties, western Kenya. We selected twelve VMMC providers from six pre-selected VMMC sites in the two counties. Sites were selected on the basis of expected high volume of VMMC clients during the study period. In Siaya we interviewed two VMMC providers each at Malanga Health Center, Bondo sub-County Hospital and Siaya County Referral Hospital. In Kisumu, we interviewed two providers each at Kisumu County Hospital, UNIM Research and Training Center and Ahero sub-County Hospital.

All twelve counselors agreed to participate, provided informed consent and were

interviewed in places of their choice to ensure privacy. Interviews were conducted in English. Each interview lasted approximately twenty minutes.

The interview guide included questions regarding the respondents' usual practice on counseling adolescents, whether previous sexual experience influences counseling practice, adolescent counseling specific training, confidence in own ability to counsel adolescents, and recommendations for improvement of current practice, including additional training. The interviewer took nearly verbatim notes which were typed directly into a Word document. Saturation (minimal new information garnered with each additional interview) was achieved after the tenth interview, indicating that additional study subjects were not necessary to achieve external validity.

Data analysis: Transcriptions were initially framed by the domains included in the interview guides. Themes within and across the domains were identified and codes assigned to reflect relevant themes and salient emerging concepts. Coding was organized around the central concept of content and future intentions of HIV counseling programs in Kenya. Direct quotes were included to illustrate important themes as well as variation in responses.

Ethical Approval: All participants provided signed informed consent. The study was approved by Maseno University Ethics Review Committee and University of Illinois at Chicago Institutional Review Board.

RESULTS

Twelve key informant interviews were conducted: six each from VMMC providers in Kisumu and Siaya Counties. Six respondents were male and six were female.

When asked if they provide group counseling to adolescents, all the providers answered yes. Majority said that they provide group counseling mostly when many adolescents come for VMMC services at the same time.

"I normally engage in group counseling when the workload is huge. It then helps to shorten the procedure, since it makes it possible to cut down on time."

"Whenever I have a group consisting of ages 10 to 11 years, I normally do group education due to the work load. This is because they comprise the biggest group that normally would show up for counseling. They are equally not sexually active and therefore there is always no need for HIV testing.

One counselor added that she normally considers group counseling only when the adolescents all come from the same area because they tend to have similar experiences and are more likely to share their experiences freely.

Group counseling was unanimously reported to be important for two reasons: First, to save time; and second, to allow individual adolescents, who would otherwise be shy during individual counseling, to feel free and open up during group counseling. Ten respondents also said that they conduct individual counseling.

Asked whether they ask boys about their sexual experience during counseling, most of the respondents answered yes, but for some, it depended on the age or appearance of the adolescent.

"It depends with the age; and those who appear to be sexually active are the ones I ask about their sexual experience."

"Those between 10 to 14 years are not asked about their sexual experience because they normally don't have a clear answer to the sex question. However, those aged between 13 to 16 years are asked about their sexual experience since most of them would normally be able to have answers."

When asked about their opinion on whether a boy's previous sexual experience influences the information they provide to the adolescents and how, eleven respondents said yes. Those not yet exposed to sex are

introduced to HIV and STI risks and prevention measures, but there will always be a difference in the depth of the discussion compared to counseling older boys.

"It is important to talk to those who are sexually active because they need more information on risk reduction, condom use and provision and other general information about HIV and its prevention and the benefits of circumcision."

"If I found out that he is exposed to risk, I must put more emphasis on behaviour change and risk reduction strategies for counseling. We also need to test them for HIV."

"For those who have engaged in sex, I explore more during counseling on the impact of sex during adolescence and what they need to do to help them on matters HIV.

Asked how they approach the topic of HIV testing to boys aged 10 to 16 years, the respondents gave a variety of explanations:

"As we inform them about the importance of circumcision, we also tell them of the importance of knowing their HIV status. We also tell them that circumcision is not 100% in preventing HIV. We therefore test based on eligibility based on probing and weighing the responses."

"I start by introducing more about HIV, the benefits of HIV testing and then I explain the procedure of HIV testing and always obtain the assent from the adolescent in addition to the previously obtained consent from the parent.

"First of all, I have to test their knowledge on HIV. I will need to know their past history of testing for HIV and then I introduce the topic of testing."

When asked if they have received training specifically to prepare them for counseling boys ages 10 – 16 years, only three respondents answered yes.

When asked the difference between how they counsel adolescents compared to adults, most of the respondents indicated that they provide a lot more information to adults and they tend to be more careful when handling adolescents.

"There is a lot we talk to an adult about as opposed to what I tell an adolescent. For example, when I talk to adolescents, I don't talk to them about marriage."

"I always employ lots of flexibility in terms of ensuring they open up and participate in the session as a way of eliciting as much information from them as possible. I do not do condom demonstration unless they are sexually active. Adults end up with lots of information as compared to adolescents."

"I strictly offer individual counseling to the adults as opposed to the adolescents where I offer group counseling."

"I always have to be very sensitive with the information I give when handling adolescents, for example, giving condoms would not be appropriate to most of the adolescents unless they have previously engaged in sexual intercourse."

Participants were asked if they felt confident to provide counseling to adolescents on sexual and reproductive health topics. All the providers said that they were confident, despite indicating that they face various challenges doing so.

"This is because of the long experience I have had with the adolescents since the year 2008. Secondly, the majority of the clients that we cut are adolescents. This means we engage with them most of the time."

"Since I am a young person, I feel like I am handling my age groups and more often than not, we get along very well."

The two most prevalent themes that emerged regarding how to improve counseling for adolescents were: development of standard guidelines for adolescent-specific counseling including adolescent specific standard operating procedures, and specific training on adolescent counseling in the context of VMMC.

Participants mentioned that condom demonstrations should be included in the guidelines, as well as limitations on the number of clients to be counseled in a day, since adolescent clients often come in large numbers, putting stress on counselors and compromising counseling quality.

"There should be a specific SOP for the adolescents as well as there is need to take counselors for adolescent specific training."
"There is need to train the service providers on adolescent counseling. There is a critical need to come up with a curriculum that would help to address all these issues in a more consistent and exhaustive manner."
"Condom demonstration would be an important aspect of adolescent counseling. This is currently not the practice."
"Adolescents should be given more time as opposed to the current practice. The target should be reduced in terms of numbers to improve the quality of counseling. Currently, there are no targets in terms of how many a counselor should handle in a day."

Another theme that emerged was the desire of counselors to increase engagement of parents in the consenting and counseling of their adolescent sons.

"The consenting procedure should ideally be done at the VMMC site as it is usually not possible to confirm that the right person is the one who consented for the adolescent to be circumcised.
One case in point is where I tested an adolescent who turned out to be HIV positive and when I requested for the parent to come over, only to realize that the person who consented was not the real parent but a class teacher."
"Involvement of the adolescent's parents during the counseling sessions since we normally give a lot of information that I suspect may end up confusing them. Having their parents would be an opportunity of providing information to both of them at the same time as well as mobilizing the parents to bring in more of their sons for the same. Lastly, it would be useful in combining forces toward proper care of the wound."

Other recommendations that the providers offered included increasing privacy during counseling, designing a questionnaire that the boys could fill to inform the counselor about the boy's experience and needs, and more involvement of the Ministry of Health in adolescent sex and risk education.

"There is need for a lot of privacy when handling adolescents. Especially when there is congestion at the facility and privacy is compromised. Also, to ensure condom dispensers are within the VMMC site itself for ease of access since some adolescents tend to shy off from picking freely."
"There is need for the Ministry of Health to begin to interact with the adolescents online in terms of providing a specific site where the adolescents can get more information on HIV and VMMC online as a way of promoting knowledge access even before coming for VMMC."

DISCUSSION

As priority countries near saturation - 80% coverage of VMMC for those aged 15–49 years - prioritization of younger men becomes critical to VMMC sustainability, and the benefits of circumcising males aged 10-16 years are being increasingly recognized (9, 10). With this in mind, recent studies have examined how well adolescents are reached with WHO's minimum package for comprehensive HIV prevention [1, 11, 12, 13].

In this study of VMMC counselors' experiences and opinions regarding counseling adolescents undergoing VMMC in western Kenya, we found that VMMC providers are inconsistent in the approaches they use and information they provide, especially to younger boys and boys they perceive as not sexually active. Few of the counselors have been trained in adolescent-specific counseling as provided for in WHO and PEPFAR guidelines (12), and most respondents said that they would welcome further training and job aides.

Our findings are consistent with those reported from studies in Tanzania, South Africa and Zimbabwe. In Tanzania, opportunities to provide individual counseling were curtailed due to space or high volume of clients (13). Many of our respondents expressed the same pressure to prioritize group counseling sessions due to

large numbers of clients, although some also felt that group counseling was more appropriate for younger adolescents who may be shy or reticent to talk in a one-on-one setting.

Also similar to our findings, in Tanzania counselor training and the materials that counselors used as job aides contained the same content for all clients, meaning that there were differences in message delivery based on counselors' comfort level and individual judgment in communicating information that they perceived as age-sensitive (13).

Some of our respondents indicated that they do not ask younger boys about their sexual experience either because they perceive it as too sensitive or they assume that a boy so young would not have had his sexual debut. So, contrary to WHO and PEPFAR guidelines on VMMC counseling (12, 14), providers are making their own judgments about what messages to deliver based on appearance. Thus, some young adolescents are not getting tested for HIV and not being counseled on condom use or other prevention measures.

A multi-site study of providers in Tanzania, Zimbabwe and South Africa found remarkably consistent provider practices and opinions in keeping with our results [7]. Providers expressed hesitation in communicating complete sexual health information—including HIV testing, HIV prevention, proper condom usage, importance of knowing a partner's HIV status, and abstinence from sex or masturbation during wound healing—with younger males and/or those assumed to be sexually inexperienced [7]. Adolescents prefer to receive information on sexual and reproductive health from health care workers, and view this information as more credible than that which they receive from their parents [7, 15–17]. This suggests an especially important role for education and counseling on sexual and reproductive health along with HIV prevention messages within VMMC services [18]. VMMC may be the first contact beyond early childhood that a young male has with the health care system. If providers are not well-equipped or confident in their ability to address the needs of adolescents in age-appropriate ways, a critical opportunity may be lost to engage positively in ongoing sexual and reproductive healthcare to educate and build confidence.

The providers themselves recognized the need for further training. Only 25% of respondents reported receiving any adolescent-specific counseling training. Consistent with other studies (13) almost all providers reported that they would feel more confident and comfortable when working with adolescents if they had more thorough and in-depth training. Some respondents expressed the desire for standardized age-appropriate messages and job aides.

There is need for staff to be trained on how to properly assess the client's sexual activity level, to frame counseling around the individual client's needs, and to ensure that counseling is comprehensive for each adolescent, regardless of their age or sexual experience.

The study findings on privacy and confidentiality were similar to those of a previous study conducted in Nairobi and its environs, (18) where issues of privacy and confidentiality were captured as key deterrents to better adolescent counseling outcomes. Respondents in this study indicated that privacy is compromised by the close proximity of the waiting bay to the VMMC counseling rooms. This could be addressed during health management team facility assessments with recommendations for changes in locations of counseling sessions. For example, in some locations, temporary tents are erected where counseling can be conducted privately.

This study has some limitations. Qualitative data are not generalizable beyond the included participants, although we did reach saturation after ten interviews, suggesting that the information we collected may be generalizable to counselors throughout the region where the study was conducted. Participants were selected from sites with relatively high volumes of circumcisions and the nature and quality of counseling may be different in smaller volume sites. Also, the counseling approaches used and the experiences of providers might differ between the organizations managing the sites, although our participants came from four different organizations representing most of the VMMC implementing partners in western Kenya.

CONCLUSION

Majority of VMMC counselors do not have the requisite training to effectively provide age-appropriate adolescent VMMC counseling. VMMC providers are inconsistent in the approaches they use and the information they provide, especially to younger boys and boys they subjectively perceive as not sexually active. Privacy and confidentiality, as well as high daily counselor workloads are key areas to be addressed. Increased parental engagement may improve wound care and parent-son communications regarding risk sexual behavior.

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