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GUIDE ON HIGH-IMPACT PRACTICES TO CREATE DEMAND FOR VOLUNTARY MEDICAL MALE CIRCUMCISION SERVICES

DECEMBER 2019

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This publication is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID) under the terms of Cooperative Agreement AID-OAA-14-00046. The contents are the responsibility of AIDSFree and do not necessarily reflect the views of USAID, PEPFAR, or the U.S. Government.

Recommended Citation

Gold, Elizabeth, Maria Carrasco, Jackie Sallet, Chiwawa Njhoma, Adrian Musiige, Aleisha Rozario, Maende Makokha, and Skye Grove. 2019. *Guide on High-Impact Practices to Create Demand for Voluntary Medical Male Circumcision Services*. Arlington, VA: Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project.

Acknowledgments

The high impact practices (HIPs) included in this document were selected based on USAID's past 8 years of experience implementing VMMC programs in VMMC priority countries. The following VMMC experts co-wrote the document: Elizabeth Gold (JSI/AIDSFree), Maria Carrasco (USAID), Jackie Sallet (JSI/AIDSFree), Chiwawa Nkhoma (PSI Malawi), Adrian Musiige (Jhpiego/AIDSFree Malawi), Aleisha Rozario (Jhpiego Lesotho), Maende Makokha (Jhpiego/AIDSFree Tanzania), Skye Grove (Right to Care). We would also like to acknowledge the inputs and consultation from the following people: Francisco Zita, Jhpiego/AIDSFree Mozambique, Dineo Pereko, Abt Associates/AIDSFree Namibia, Maria Tanque, JHCCP/Rumos Mozambique, Margot Harrington, JSI/AIDSFree, and Alexandra Coombes, JSI/AIDSFree. We would like to express our appreciation to the Knowledge Management Team at AIDSFree for their support with editing, design, and making this document come to life.

AIDSFree

The Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project is a five-year cooperative agreement funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) with the United States Agency for International Development (USAID) under Cooperative Agreement AID-OAA-A-14-00046. AIDSFree is implemented by JSI Research & Training Institute, Inc. with partners Abt Associates Inc., Elizabeth Glaser Pediatric AIDS Foundation, EnCompass LLC, IMA World Health, the International HIV/AIDS Alliance, Jhpiego Corporation, and PATH.

CONTENTS

ACRONYMS

ART	antiretroviral therapy
ARV	antiretroviral
CM	community mobilizer
FY	fiscal year
IPC	interpersonal communication
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
SBCC	social and behavior change communication
RTC	Right to Care
STI	sexually transmitted infection
TA	technical assistance
TMI	traditional male initiation
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VMMC	voluntary medical male circumcision

INTRODUCTION

Scaling up evidence-based HIV prevention, such as voluntary medical male circumcision (VMMC) in VMMC priority countries, is a critical component of countries' efforts to achieve epidemic control (World Health Organization 2018). To date, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has supported nearly 19 million VMMCs to protect men and boys in east and southern Africa. However, offering high-quality services is only part of the equation. Ongoing, effective demand creation is essential to motivate adolescent boys and men to access services, which has proven to be a significant challenge (UNAIDS 2017). Over the past few years, VMMC programs have gained valuable experience in generating demand for VMMC and matching supply with demand. Based on significant implementation experience, several approaches have proven to lead to considerable increases in service uptake. As countries begin to transition toward more locally managed and sustainable VMMC services, this experience and the lessons learned can inform their efforts to generate and sustain demand for VMMC.

The specific objectives of the guide are to:

1. Share high-impact practices for creating demand for VMMC, illustrated by specific country program examples.
2. Disseminate resources and tools that can support VMMC demand creation efforts.
3. Document lessons learned from VMMC demand creation that can be applied to engaging men in other HIV and health services.
4. Serve as a reference guide for those who may be new to VMMC, as well as the more experienced practitioners.

Intended users of this guide include ministries of health, implementing partners, local nongovernmental organizations, VMMC program managers, and site managers.

THE ABCs OF VMMC DEMAND CREATION

What is Demand Creation?

Demand creation increases awareness of and demand for health products or services among a particular intended audience through social and behavior change communication (SBCC) and social marketing techniques (Johns Hopkins University 2019).

How Is It Done?

Using multiple approaches and a combination of channels to generate demand will increase the effect, with each approach serving a different purpose at various points along the potential client's long and complex decision-making process. Mass media and outdoor media (such as billboards and taxi branding) are best for raising awareness of VMMC and service locations and times. Information and computer technology and social media allow for interactive discussions in real time. Interpersonal communication (with community mobilizers [CMs], satisfied clients, and providers) is best for dispelling myths, addressing obstacles and fears men may have, and facilitating the decision to move forward. Engaging community leaders who then facilitate dialogue in their own communities is the best approach for creating a supportive environment. All of these approaches work together and are mutually reinforcing, but the level of time and resources one decides to invest in each will vary, and should be adjusted over time depending on VMMC prevalence, the level of awareness, the priority age group, and the available budget, among other factors.

In addition to the multiple approaches outlined above, the quality of the VMMC services also plays an important role in demand creation. A happy customer is the best marketing asset. It is well-established that peer support and peer referrals significantly influence men's decision-making around VMMC. One client's bad experience the day he goes for VMMC—be it the long time he had to wait in the heat or a provider's unpleasant attitude—will be talked about among his peers and may discourage some from accessing VMMC services. Conversely, a client's good experience may influence others to access services. To successfully attract clients, VMMC services need to be client-centered, which entails ensuring that the services address clients' needs and concerns.

Understanding and Addressing Behavioral Determinants

A number of barriers at the individual, health system, and sociocultural levels have been identified in the research and literature as central to the uptake of VMMC (Carrasco et al. 2019). While each context is unique, some of the common barriers include: fear of pain (both during the procedure and after), fear of complications leading to poor sexual performance or infertility, concerns about losing time from work, a belief that VMMC is not part of one's culture, and reluctance to abstain from sex during the healing period after surgery. Based on the research, we know that some of the barriers for adult men—such as time lost from work and the required abstinence period—are less of an issue for the younger adolescents who can access VMMC during school holidays and, in many cases, are not yet sexually active (Hatzold, Mayhu, and Jasi 2014). Some common motivators include improved hygiene, enhanced sex appeal, peer and partner support, preventing HIV and sexually transmitted infections (STIs), and preventing cervical cancer in women.

Communication that merely states the benefits of VMMC and fails to address the barriers and motivators in the local context will not be effective in creating demand for services. It is important to understand the unique barriers and motivators in the local context so they can be effectively addressed in both communication with potential clients and in services being offered.

WHAT EXPERIENCE TELLS US WORKS BEST IN VMMC DEMAND CREATION

Strengthening Community Mobilization

From 2015 to 2017, the United States Agency for International Development (USAID) conducted VMMC demand creation assessments in Eswatini, Lesotho, Malawi, Mozambique, and South Africa as countries were struggling to meet targets, particularly in terms of reaching the older priority age group. While each country context is unique, certain challenges or gaps proved to be common to demand creation efforts in all five countries, including inadequate support of the CMs, insufficiently tailoring communication to address men's fears and troubleshoot barriers, and not leveraging satisfied clients for advocacy and peer referrals. By addressing these challenges, VMMC programs showed significant improvements (Musiige et al. 2019).

Community mobilizers play a critical role in generating demand for VMMC and helping to move men along their decision-making journey. They are known in the community, making it easier for community members to trust what mobilizers communicate. As community members, mobilizers are also readily available in the community and able to provide detailed, personalized information to prospective clients through multiple contacts. As members of the community, they understand the people of the community better than other VMMC staff.

Site-level client data from Malawi, Lesotho, and other countries show that the majority of clients name CMs as their primary source of information and referral on VMMC, yet assessments in five countries revealed that this was an under-resourced area relative to its importance for program success (Gold and Seifert-Ahanda n.d.). From group discussions with CMs, it was clear that they lacked the training, supervision, compensation, and tools to do their job effectively. Strengthening community mobilization has proven effective in significantly increasing uptake of VMMC services, particularly among the priority age groups.

Below are a few recommendations for strengthening community mobilization for VMMC.

Strengthening Recruitment, Management, Support, and Motivation of Mobilizers

- When recruiting new mobilizers, search for those who have a secondary level of education, as they are more skilled in recording monitoring and evaluation data and are able to more quickly grasp complex concepts at mobilizer trainings.
- Engage satisfied VMMC clients as mobilizers. Potential clients want to hear from a man who has been through the experience and can dispel myths and address concerns.

- Equip mobilizers with branded t-shirts, hats, and identification badges to lend them credibility in the community.
- Equip mobilizers with job aids and SBCC materials to address myths and frequently asked questions and enhance communication.
- Ensure supervisors regularly observe and monitor mobilizers' performance and provide on-the-job mentoring and support.
- Provide mobilizers with monthly mobile phone credit to follow up with potential clients, and transportation to facilitate covering wide distances to reach clients (e.g., bicycles for rural areas).
- Train mobilizers using an evidence-informed curriculum that includes interpersonal communication skills, the basic science of VMMC, responding to men's questions, and what to expect from the procedure. On-the-job mentoring may be more effective than refresher trainings.
- Provide mobilizers with fixed monthly stipend plus a group performance-based bonus to motivate them to perform.
- Set weekly targets for each mobilizer, keeping records of their daily productivity.
- Facilitate collaboration between mobilizers and clinic staff in order to reach daily and weekly clinic targets. Having clear clinic targets helps to keep mobilizers motivated.

Lessons from Malawi's Successful Community Mobilization Approach

In 2018, USAID was supporting two organizations to provide VMMC services in Malawi: PSI and Jhpiego through AIDSFree. PSI has been implementing VMMC services since 2013 in four districts in Southern Malawi—Blantyre, Chiradzulu, Mulanje, and Phalombe. Since 2017, AIDSFree has been implementing VMMC in Zomba, Thoyolo, and Chikwawa districts. Both organizations saw their targets rapidly increasing and faced the added challenge of reaching the priority age group of older men. Changing their approach to community mobilization and investing more effort and resources into strengthening this key component of demand creation led to significant increases in service uptake in FY 2018 for both PSI and AIDSFree.

Interpersonal communication (IPC) is one of the main approaches used in VMMC mobilization. It requires CMs to conduct one-on-one discussions with potential clients addressing men's barriers to VMMC. As an approach, IPC has several advantages compared to mass media. Through IPC, mobilizers can determine what stage the potential client is at in the journey and provide tailored messages that will take the client to the next stage of the stages of behavior change. It is also easier to address the barriers to VMMC through IPC because there is face-to-face interaction and the client has the opportunity to ask questions.

Initially, PSI worked with CMs on short-term, temporary arrangements, identifying and recruiting them two weeks prior to service delivery and then orienting them on basic VMMC information

as well as IPC skills. This approach worked well in the initial stages of implementation when the "early adopters" were accessing VMMC. However, as time went by, the approach became less effective since many men (particularly older men) had unique individual barriers to VMMC that needed to be addressed, requiring more skilled mobilizers. As a result, PSI began to recruit and train long-term mobilizers from within respective communities who were put on six-month contracts, renewable based on performance, allowing for building the capacity of the mobilizers over time.

PSI mapped out health facility clusters to ensure mobilizers were strategically deployed, and advertised VMMC in health facilities and within communities. Health facility personnel were involved in the interviews conducted at health facilities. Mobilizer supervisors were identified from the pool of applicants. All applicants were required to hold at least a Junior Certificate of Education, and satisfied VMMC clients had an added advantage. New mobilizers attended a two-and-a-half day training focusing on IPC skills, VMMC basic knowledge, understanding the target audience, stages of behavior change, and making referrals, as well as data collection.

Monitoring and mentorship of mobilizers proved critical to ensuring strong performance. Mobilizer supervisors were responsible for day-to-day supervision while demand creation officers conducted spot checks based on mobilizer work plans. Demand creation officers also conducted periodic supervision (at least one visit/mobilizer/month) and provided constructive feedback for improvement. Data collection tools were revised to enable demand creation officers and mobilizer supervisors to provide effective supervision. For PSI, this change in mobilization strategy led to the achievement of 55,922 MCs in FY 2018 representing 103 percent against target (see Figure 1).

In late 2017, AIDSFree Malawi recruited 80 CMs to support seven VMMC sites. Prior to their deployment, the project trained the CMs on interpersonal communication (IPC) for VMMC demand creation, and equipped them with identification cards and branded t-shirts to give them credibility within the community as trusted sources of information on VMMC. Each CM received a bicycle to facilitate easy movement within his/her catchment area. The CMs were also given SBCC materials and job aids for reference while talking to prospective clients. These materials enhanced the communication, addressing the common myths, misconceptions, and frequently asked questions about VMMC. Each VMMC site had at least ten CMs, supervised by a community mobilization and communication assistant who conducted regular supportive supervision visits to support CMs and to monitor the quality of CMs' communications with community members on VMMC.

AIDSFree used a combination of two payment schemes to compensate CMs. Each CM received a fixed monthly individual pay. In addition, each CM belonged to a work group consisting of two to three CMs from the same catchment area. At the end of every two weeks, the group received a pay amount based on number of clients the group successfully referred for VMMC in those two weeks. Group members would share this payment equally. This pay system ensured that each CM had a minimum monthly income, and could earn additional income based on the number of clients his/her group referred. This arrangement of compensation motivated CMs to work hard.

By focusing most demand creation resources to strengthening IPC using well-trained and well-equipped CMs, many of whom were satisfied VMMC clients, AIDSFree Malawi significantly increased uptake of VMMC in its focus districts overall, and specifically among the priority 15–29-year-olds.

At the end of FY 2018, the first year of implementing this approach, Chikwawa district, which had the highest target but lowest past uptake of VMMC, reached 18,173 clients (91 percent of its target) with 71.3 percent of them aged 15–29 years. AIDSFree Malawi met 100 and 108 percent of its combined target for the three districts in FY 2018 and FY 2019 respectively (Musiige et al. 2019).

For both VMMC partners, PSI and AIDSFree, strengthening their community mobilization efforts proved to be a winning strategy.

Figure 1. Impact of Strengthened Approach (VMMC Uptake by Age Group Before And After Strengthened Mobilization Strategies) (Source: PSI Malawi)

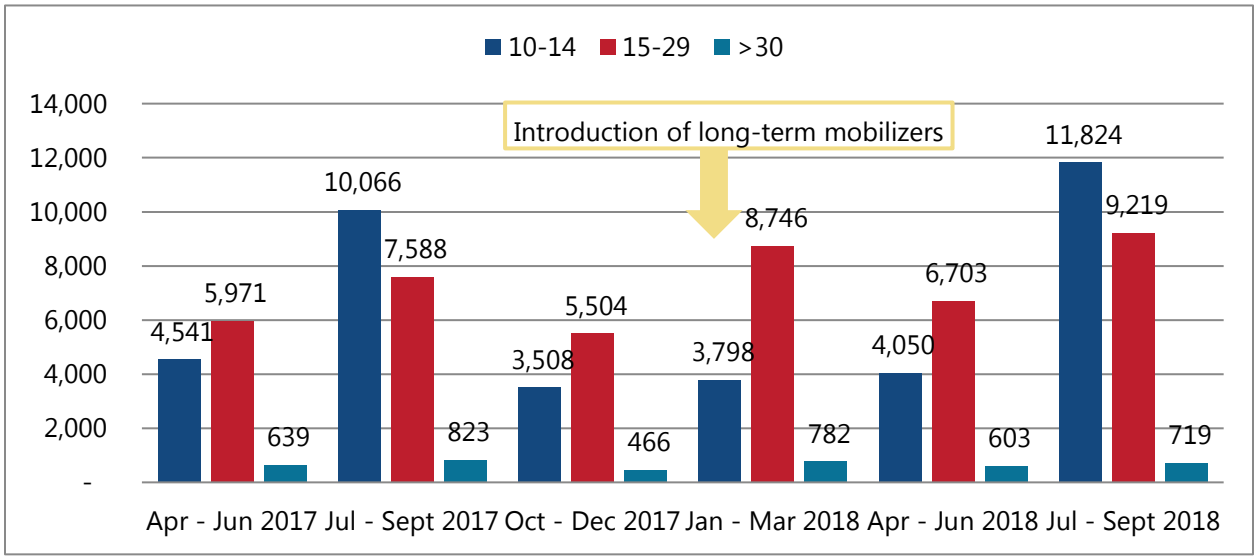


Figure 1 demonstrates the increase in VMMC uptake among 15–29-year-old males. This could be attributed to mobilizers having acquired skills to tackle individual barriers.

Making Services Accessible and Attractive to Older Men

Mobilizing men 25 years and older to access VMMC requires tailored approaches that differ from those used for mobilizing younger men. For example, experience indicates that older men prefer not to be transported in vehicles with young adolescents when accessing VMMC, as they don't want to be perceived as accessing a service that is for younger boys. Additionally, older men typically have jobs and more responsibilities that limit their availability and resources to access services. Older men also have significant concerns about confidentiality and privacy when accessing services. These specific needs should be addressed to make sure older men access VMMC services.

Transport

Experience indicates that older men do not like to be transported to services with young adolescents, as this makes them feel that they are accessing services intended for youth. Additionally, older men prefer to keep their access to VMMC services confidential and, thus, they do not want to be seen boarding branded vehicles that transport clients to VMMC services. Offering transport catering to older men only or transport reimbursement has proven successful in many countries, such as in Malawi.

Mobile

Offering transport may still not help some older men who live far away from health facilities, or are busy working. For them, bringing the services closer to where they are has worked well. Bringing mobile VMMC units to busy marketplaces and to workplaces can help increase service uptake among the older, working men. In Lesotho, for example, the TSEPO program has engaged workplaces around the urban areas in Maseru offering services to employees and their family members onsite at factories, construction sites, and security companies using mobile units.

Service Hours

Older men typically work during the day and are unable to take time off to access VMMC services during regular working hours. Offering and promoting extended service hours in the evenings and weekends helps attract older men.

VIP Services for Older Men

A strategy that has worked well in Tanzania is to offer older men VMMC services that are tailored to their needs. This tailoring allows potential VMMC clients to feel welcomed by the service and ensure that possible barriers to uptake are overcome.

The VIP Card: A Human-Centered Design Initiative Improves Men's Use of VMMC Services in Tanzania

VMMC uptake in older men aged 25–29 years declined in the AIDSFree Project in Tanzania from 113 percent in FY 2016 to 15 percent in FY 2017 and then increased to 26 percent in FY 2018. Data provided by PEPFAR showed the overall national achievement in this age for FY 2017 was 41 percent. PEPFAR urged implementing partners to devise new strategies to target this priority population with VMMC services more effectively.

AIDSFree identified ten supply and demand barriers frequently associated with men who continued to express interest in VMMC services while withholding use. AIDSFree drew on findings from recent studies supported by Jhpiego to increase uptake of VMMC services in older men in AIDSFree-supported regions as well as community insights from local volunteers supporting demand creation activities in their communities (Bazant et al. 2016; Wambura et al. 2017). The project omitted barriers linked to infrastructure in rural settings beyond its control and scope, such as long distances, poor road network, limited transport, and facilities not qualified to offer VMMC services. Its overall assumption was that removing these barriers and providing clients with a menu of options would improve on existing service uptake.

AIDSFree collaborated with the Tanzania National AIDS Control Program and USAID Tulonge Afya Project implemented by FHI 360 to develop a client invitation card in Swahili. This card offered potential clients a menu of ten adult-friendly service options, such as choosing day and time for service, preference for male or female provider, and others. AIDSFree promoted the initiative as "VIP services" to emphasize older men's special status as a priority population in HIV prevention and that VMMC services under this initiative were tailor-made for them. The VIP card prototype was pretested in March 2019 with 58 men in the target age group, who reviewed it positively. AIDSFree also pretested the card with 106 volunteers and providers, and revised content with the National AIDS Control Plan and USAID Tulonge Afya before printing.

VIP services launched at scale in August 2019 at all 70 health facilities delivering VMMC services in five AIDSFree-supported regions. During the first month of implementing VIP services, 873 clients ages 25–29 years used the services, compared to 261 clients the previous month, a 335 percent increase. Of these, 784 clients (90 percent) were recruited through the VIP card. In a client satisfaction survey of 160 VIPs from August conducted by AIDSFree in September, 97 percent said they were satisfied with services (81 percent very satisfied and 16 percent moderately satisfied) while 97 percent said they would recommend VIP services to their friends and peers. The top three reasons that VIPs said influenced their decision to use services were "privacy of service provided" (34 percent), "how you were served" (30 percent) and "assistance to access services" (19 percent).

Although it has not been implemented for long, the VIP card has also spurred interest from men younger and older than ages 25–29 years. The project plans to conduct monthly client satisfaction surveys and group discussions every quarter to unpack key findings and consider making VIP services available to ages 20 years and older starting in FY 2020.

Daily Coordination between Service Delivery and Demand Teams

For demand creation efforts to succeed in increasing uptake of services, collaboration, effective coordination, and sharing of key information between service delivery and demand creation teams are essential. The example from Mozambique below illustrates how performance improves after demand and supply teams invest in a collaborative approach, including creation of joint plans and targets, data sharing, and tracking of combined results.

Coordinating and Balancing Demand and Supply to Achieve VMMC Targets: The Mozambique Experience

The AIDSFree VMMC program in Mozambique implements VMMC services within the public health sector in Manica and Tete provinces. Over the past three years, AIDSFree has used the USAID Site Capacity/Utilization tool to balance supply and demand to achieve their targets, while maintaining service quality and achieving economies of scale.

The close collaboration and coordination between AIDSFree as the service delivery partner, the Ministry of Health at all levels, and Rumos as the demand creation partner has been one of the main drivers in balancing both aspects of the program. First, AIDSFree used the USAID Site Capacity/Utilization Tool to estimate the capacity of each of the VMMC sites with respect to the targets set by USAID and negotiated with the Ministry of Health (MOH) on the staffing levels and space within the facilities. The tool enables users to monitor the performance of sites against their optimal output. The number of beds and staffing required to achieve the targets for each of the sites were calculated and utilized to develop a site-specific plan for each VMMC site. This plan included daily, weekly, and monthly targets per site, as well as quality assurance indicators.

AIDSFree shared these site-specific plans with Rumos, their demand creation partner, and together they developed a comprehensive plan detailing how they would achieve these targets. This plan included the number of outreach and mobile sites; the placement of personnel that should be used to support each static site; and the number of demand creation personnel and activities per site/district and province. The number of mobilizers recruited and assigned to each site was determined by monthly and daily service delivery targets. Each plan was submitted to the MOH for review.

Joint planning was done first on an annual basis to prepare for the coming financial year. During these planning sessions, the partners shared ideal approaches for implementation. Together, they conducted weekly and monthly reviews of performance per site and adjusted the plan based on the site performance using the site-specific plan. During these joint review sessions, the service delivery and demand creation partners discussed the performance in terms of

reaching the priority age group (15–29 years old) and developed strategies to address performance gaps. In addition to in-person meetings, the demand creation teams and service delivery teams created Skype and WhatsApp groups for daily communication and coordination.

Monitoring performance and sharing information through weekly technical meetings, site visits, and review of daily data on VMMCs enabled both partners to take steps to improve or maintain performance, and overcome any challenges. This included supportive supervision, training events for personnel, and periodic quality improvement of the program.

The two organizations jointly managed transportation of clients (availability, routes, and number of clients needing transportation) which was critical to addressing transport barriers. The demand creation partner also assisted with the follow-up of clients post-procedure through reminders to clients for their follow-up appointments.

Lessons Learned

- Joint training of those doing demand creation with the VMMC service providers is key to success. This leads to better understanding of the program by both parties.
- Strong strategic planning is in the best interest of the client and joint ownership of the program.
- Sharing of data and joint reviews of the performance of each site results in data-driven planning, which in turn leads to better outcomes for the clients and optimal site-level performance.
- To ensure program quality, key elements include targeted selection of staff, comprehensive training, and supportive supervision of all cadres.
- The engagement of the provincial and district health directorate is key, as it facilitates the entry of teams into new implementation zones.
- The experience in Manica and Tete provinces demonstrates that effective coordination between supply and demand, informed by data and deliberate collaboration, enables an increase in VMMC uptake, particularly among males aged 15 to 29 years.

Using Multiple Channels

Using a blend of multiple channels—including mass media, community dialogue, and interpersonal channels—increases an audience's exposure to messages. It also increases repetition of the message, reinforcing the message through multiple sources. Repeat exposure improves the likelihood that a message will be understood, accepted, and acted upon. Efforts should also focus on channels that foster dialogue and allow for follow-up with potential clients.

Experience with generating demand for VMMC has shown that maximizing the use of channels that foster dialogue and address men's individual needs, questions, and concerns will be most effective, particularly with the older priority age group. These channels are listed below.

Interpersonal Communication

Individualized interpersonal communication can facilitate a man's transition from intention to get circumcised to actual uptake of services. IPC is therefore a critical component of an effective strategy. To ensure mobilizers effectively use IPC to address men's fears and concerns, VMMC programs need to carefully select and train mobilizers, equipping them with tools and job aids that help the mobilizer nurture dialogue and respond effectively to questions and concerns (Health Communication Capacity Collaborative 2016).

Two-Way, Longer Format Radio Programming

While airing radio spots can help create awareness of VMMC and promote service hours and locations, two-way, longer format programs allow for dialogue and addressing men's questions. These include panel discussions, call-in shows, and testimonials from satisfied clients. Featured guests on radio programs can include providers, counselors, satisfied VMMC clients, community leaders, and others with the background and training to promote VMMC.

Call Centers or Toll-Free Hotline Numbers

Toll-free hotline numbers and call centers provide another way of responding to men's questions and concerns, and provides men with an avenue for individual and more anonymous follow-up after a group event (where he may be reluctant to ask questions). This number should appear on all posters, leaflets, radio programs, and other materials.

WhatsApp and Messaging Platforms

Online messaging platforms and social media can be used to support individualized communication responding to a man's specific needs. For program planners, this can offer a less costly option than a call center or hotline, yet still allow for follow-up and dialogue. The WhatsApp number should be promoted on all communication materials. Short videos that address specific barriers, such as fear of pain, can be shared on this channel.

Engaging Local Leaders

Experience in generating demand for VMMC services has shown the importance of engaging local community and traditional leaders who can enable entry into a new community. People in the community will be more receptive to VMMC if their trusted leaders are speaking about it

and facilitating community dialogue around the topic during village and community meetings. Engaging leaders can help to dispel fears and myths that may be posing barriers to VMMC for men in their communities.

In Thyolo, Malawi, for example, one senior chief has used his village meetings to advocate for men to go for VMMC. With his backing as the senior chief, the VMMC mobilization team has gained entry to meet with other local leaders.

Source: Wezzie Mhango, Jhpiego

A traditional chief addressing his subjects on VMMC in Malawi's Thyolo district.

Strategies to Engage Leadership

- Set up meetings with local leaders and other influential people in a community
- Book a day to hold a village meeting
- Engage leaders to be mobilizers, or ask them to identify people from their community to mobilize (in advance of outreach)
- Train leaders on key messages and on use of communication materials designed for leaders
- Invite leaders to participate in radio panel discussions
- Equip them with branded t-shirts and hats to identify them and encourage them.

Partnering with the Traditional Sector—The South African Experience

When WHO and UNAIDS recommended VMMC as an additional important HIV prevention strategy in 2007, they stipulated that the sociocultural context of each country, region, or community should inform the implementation of specific VMMC programs. They recommended that, "VMMC should be promoted and delivered in a culturally appropriate manner that minimizes the stigma associated with circumcision status."

Male circumcision is practiced as a significant part of the rite of passage from boyhood to manhood in several cultures in sub-Saharan Africa. Initiation in traditional circumcising populations is considered an important social mechanism for managing the turbulent adolescent period. The education and preparation provided at initiation schools are intended to facilitate the shift from childhood behavior to the more responsible conduct required in adulthood. Although initiation schools are regarded in traditional circumcising communities as cultural institutions where initiates are taught essential values necessary for adult life in the community, injuries and deaths of initiates due to complications secondary to traditional circumcisions are a cause for concern.

Right to Care (RTC) pioneered the provision of culturally appropriate medical assistance to the traditional male initiation (TMI) process in 2016 in Mpumalanga, South Africa. RTC's integration approach to TMI and VMMC is aimed at improving the safety of the TMI practice while not conflicting with the cultural values and rituals of a community. The core of the integration approach is the buy-in and ownership by all structures and hierarchies of traditional leadership. This included high-level advocacy and support from the AmaNdebele King and local traditional leaders as well as employing male health care workers and nurses who are all graduates from traditional AmaNdebele initiation.

RTC's novel integration approach, termed medically assisted traditional male initiation (MATMI) significantly reduced the morbidity and mortality associated with traditional circumcision. Since the start of MATMI in 2016, no severe adverse event or death in any of the traditional initiation schools that RTC supported was reported. As part of its USAID VMMC program in South Africa, RTC has safely circumcised more than 40,000 young AmaNdebele men as part of their traditional rite of passage.

RTC's culturally led integration of TMI and VMMC is implemented year-round to keep the practice of MATMI in the public consciousness. Advocacy and awareness campaigns about safe initiation engage the whole community: would-be initiates through school and college outreach programs; all strata of traditional leaders through working groups; parents and guardians through public dialogues; and health stakeholders through workshops.

RTC's MATMI model focuses on technical assistance (TA) as well as direct service delivery. TA entails training traditional leaders and nurses in World Health Organization standards of infection control and VMMC protocols; developing training curricula that take local legislation, culture and VMMC protocols into account; assisting district traditional leaders with MATMI microplanning; and developing monitoring and evaluation tools that meet PEPFAR/USAID and WHO guidelines.

Direct service delivery involves:

- Community mapping through the identification of stakeholders engaged in the MATMI program
- Establishment or revival of local traditional circumcision forums; demand creation, advocacy, and community awareness of MATMI and its benefits
- Increasing the support for safe culturally led health services; the provision of commodities to ensure compliance to infection prevention and control inside the initiation school
- Pre-screening for HIV, TB, STI and noncommunicable diseases that may be contradictory for prospective initiates to undergo circumcision in a traditional setting/non-health facility
- The circumcision procedure in the initiation school, performed in accordance with a cultural framework as well as the WHO VMMC safety standards.

Partnering with the Traditional Sector—The Lesotho Experience

In Lesotho, traditional initiation is a barrier to VMMC uptake by males 15 years and older. The Jhpiego-implemented USAID TSEPO program has made deliberate efforts to engage traditional initiation schools in outreach services and differentiate "traditional initiation" from VMMC. In 2013, the USAID-funded Maternal and Child Health Integrated Project worked to mitigate any perception of encroachment of VMMC on traditional practices within initiation schools. Jhpiego and the MOH worked together to design a VMMC brand and media campaign called "Rola Katiba" ('Remove your hat')—to correct misconceptions equate VMMC to traditional initiation and reassure community leaders that the two initiatives could operate simultaneously. In partnership with the MOH, Jhpiego supported a cascade of advocacy and engagement activities with the principals of traditional initiation schools, chiefs, and local civil society organizations to forge partnerships and seek guidance and partnerships with traditionally initiated communities.

Activities included:

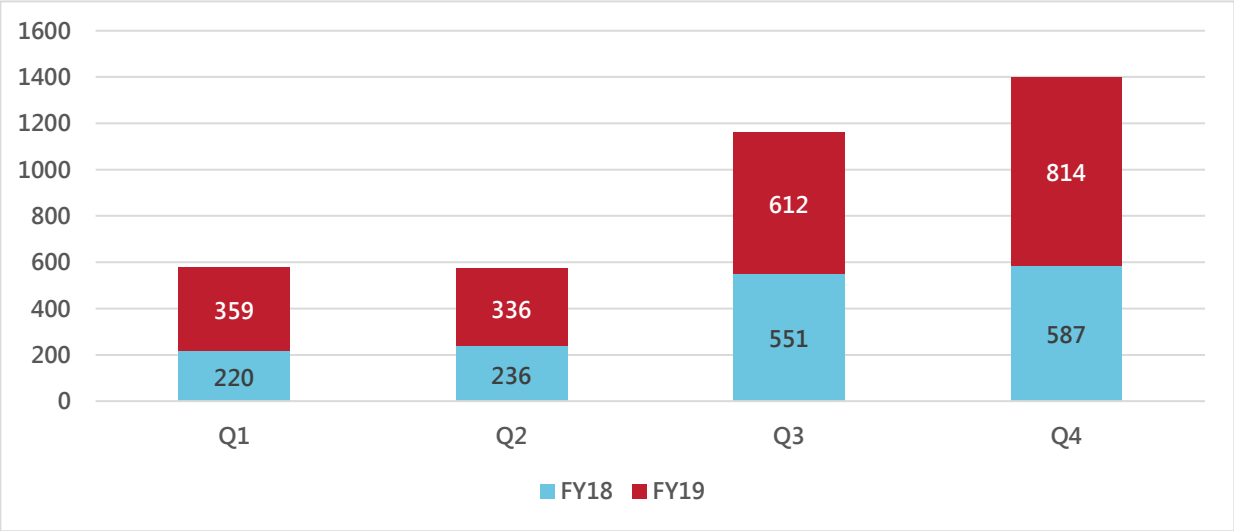
- Engagement of a traditionally circumcised male as a consultant to map the traditional initiation schools and contact traditional initiation leaders.
- Identification and training of traditionally initiated service providers—using nurses, HIV testing services counselors, and mobilizers to support and provide services for the traditionally initiated communities.
- Provision of combination prevention services to traditional initiation school, including HIV testing, TB screening, hypertension, and diabetes screening to destigmatize VMMC as a stand-alone service.
- Engagement of organizations that work with traditionally initiates for mobilization activities and seasonal service provision launches to provide VMMC services.
- Recruitment of traditional initiates as volunteer mobilizers to enhance peer-to-peer demand creation.
- Provision of differentiated services for traditional initiates, including "moonlight services," discrete services (unbranded), and male-only service provision teams.

Jhpiego started collecting data on traditional initiated men who receive VMMC services[1]. While progress has been made in reaching traditionally initiated men, there are mixed results. Given that Lesotho has circumcised many 10–14-year-old males, most traditional initiates attending initiation school have already been circumcised. The figure below shows that traditionally initiated males are more likely to seek VMMC services during winter.

[1] **Experts do not recommend using the phrase "traditional circumcision" to refer to VMMC in Lesotho, as this term tends to discourage men from accessing VMMC services.**

However, there are district-level differences in reaching traditional initiated communities and preferences in the timing of accessing services. In Berea and Maseru districts, which are more urban and VMMC saturation is higher, there is less seasonal variation in reaching traditional initiates. However, this is not the case for Mohale's Hoek and Mafeteng, which are rural areas with strong cultural traditions.

Figure 2. Traditional Initiates Receiving VMMC in Lesotho, FY 2018–2019



Engaging Private Providers to Expand Access to VMMC Services

Many private providers in East and Southern Africa offer male circumcision services, but as a low-volume service with patients paying out-of-pocket. Partnering with private providers helps expand accessible VMMC services. Often located in central areas with good access to transport, private providers tend to attract an older clientele who may be challenging to reach through public services. The perception among men that private services are of higher quality than those offered in the public facilities, along with some men's desire for privacy, makes them particularly attractive to older clients (Health Communication Compatibility Collaborative).

In Namibia, where 70 percent of doctors are in private practice, Abt Associates has been partnering with private providers to provide VMMC services since late 2014; initially through the SHOPS Project before transitioning to AIDSFree in 2015. AIDSFree has engaged a network of 32 private health facilities in Windhoek. Previously, these service providers were only providing VMMC services to clients with health insurance or those who could afford to pay out-of-pocket. To increase VMMC coverage in Windhoek, AIDSFree partnered with the Khomas VMMC regional team to pilot and introduce free VMMC services for uninsured males at private health facilities. The free services were introduced in October 2016, with USAID funding. A service-level agreement was reached to reimburse facilities for providing the VMMC service package. Additionally, facilities were supported with VMMC kits recordkeeping tools, and reporting equipment.

The Khomas regional VMMC team and AIDSFree worked together on conducting demand creation activities to encourage clients to access the private providers' VMMC services. Between October 2016 and September 2017, Khomas region conducted 8,846 circumcisions, with 81 percent of these done in private facilities (Pereko et al. 2018).

Private providers in Namibia were willing to provide transport for clients and bear the expense of engaging their own mobilizers to create demand for services. Their ability to offer Saturday and evening hours appeals to an older, working clientele. In addition, private providers have been able to tap into their existing client base, cross-promoting their services using videos and other SBCC materials in office waiting rooms, and sending SMS messages to clients to raise awareness of their VMMC services.

MAKING DEMAND CREATION SUSTAINABLE

As VMMC coverage has increased, reaching 80 percent or more coverage in some areas, countries will move from a phase of rapid scale-up to the phase of maintaining VMMC coverage. This will require implementing strategies to ensure that VMMC demand creation is sustainable. While the shape and form VMMC sustainability takes will vary by country, a key sustainability consideration across countries will be how to maximize limited resources to ensure VMMC continuity. One important strategy, as exemplified below, is ensuring VMMC mobilizers are local. Another strategy could include enhancing VMMC integration in the health system. Finally, another important strategy could entail working with community organizations on VMMC demand creation. To date, experience making demand creation sustainable has been limited. This area requires further exploration and emphasis.

Next-Door Expert: Local Volunteers Unlock Opportunities for Sustainable VMMC Demand Creation—The Tanzania Experience

The community calls them doctors—a sign of how highly regarded the local volunteers AIDSFree recruited to promote VMMC and early infant male circumcision services are in their communities. One criteria for selection was prior volunteer experience in promoting health and development work, for which most AIDSFree volunteers were already renowned in their community. Many were born here, or have lived here for decades. They know members of the community by name, family, or clan, and have no plans to leave.

At project inception in October 2014, AIDSFree inherited a demand creation team of employed non-local professionals from preceding VMMC projects implemented by Jhpiego. A study in AIDSFree-supported regions reporting preliminary results later that year found that that communities were ready to talk about VMMC with local promoters, including female promoters targeting women as partners of potential clients (Wambura et al. 2017). These findings informed planning of the VMMC sustainability phase per PEPFAR, which two AIDSFree-supported regions entered from October 2016, incorporating use of local volunteers to engage clients in place of employed non-locals.

From April to September 2016, AIDSFree recruited 91 volunteers to field test the intervention, scaling up to 167 volunteers in October 2016. AIDSFree has deployed over 1,500 volunteers through life of project. Local volunteers enabled the project to adapt a person-centered approach with older men. The intimate knowledge and relationships volunteers have with potential clients and existing providers allowed them to support adult clients in navigating

barriers, and serve as a bridge between community and facility by arranging appointments and escorting clients.

In 2017, AIDSFree performed a retrospective review of volunteers' impact on VMMC uptake since their introduction. It showed a five-fold increase at routine services compared to the period of non-local professionals and helped the project reach twice as many clients in the first full year of using volunteers (FY 2017) for a unit cost per procedure that was US$11 lower than the previous year (Makokha et al. 2014; Strengthening High Impact Interventions for an AIDS-free Generation Project 2009). Programmatic insights highlighted four factors that made local volunteers key to unlocking opportunities for sustainable demand creation. Local volunteers had *credibility* in their community, *familiarity* with the geographical area, *availability* through personal activities and networks, and *accessibility* to people and places as insiders. Successful volunteers used their proximity and interaction with clients, partners, friends, and providers through multiple settings to maximize uptake.

An emerging area around VMMC demand creation and sustainability is monetary payments to clients to access VMMC services. While paying clients to access VMMC services may appear to help enhance VMMC uptake per recent research, it is not included here as a high-impact practice. This is because of two factors: first, as other health services do not pay clients to access services, such payments may pose significant challenges to the integration of VMMC services into the health system. Second, paying clients to access VMMC services makes demand creation more costly, undermining sustainability. Organizations considering paying clients to access VMMC services should ensure that such payments are in line with local policies and MOH priorities as well as the policies of donor organizations. Additionally, while such payments may help to increase uptake in the short-term and reach ambitious targets, it will be important to carefully weigh the possible long-term consequences of such payments for both VMMC demand creation sustainability and the health system at large.

LEARNING FROM VMMC: LESSONS FOR ENGAGING MEN IN OTHER HIV AND HEALTH SERVICES

By 2017, 18.6 million men had accessed VMMC since its scale-up in priority countries in sub-Saharan Africa, averting an estimated 230,000 new HIV infections (WHO 2017). This has happened while other HIV services struggle to engage men in HIV services (UNAIDS 2018). Based on the experiences of engaging men in VMMC services presented above, key lessons to promote uptake of HIV services among men are:

- Meet men where they are (live, work, congregate)
- Understand behavioral determinants to address barriers to accessing services
- Engage community leaders, including traditional leaders
- Use multiple channels of communication to reinforce key messages
- Make personal contact through interpersonal communication with a trusted person
- Offer a service that addresses men's needs and concerns and is truly client-centered
- Provide high-quality services
- Utilize data to continually assess efforts and update the demand creation strategy and service model as needed to ensure it remains high-quality and client-centered

These key points reflect experience in engaging men in other health areas, such as family planning and maternal health. The main contribution of VMMC in engaging men is that the service is explicitly built for men. However, VMMC services still had to go through a process of learning to be client-centered to attract men and address their needs and concerns. The best practices shared in this guide provide a snapshot of this work to date. Future work in VMMC will require building and expanding on the rich experience to date.

RESOURCES AND TOOLS

- Tools to Strengthen VMMC Demand Creation
  - Creating Demand for Voluntary Medical Male Circumcision: A Training for Community Mobilizers
  - VMMC Demand Creation Assessment Tool
  - Training for Community Mobilization for VMMC
- Increasing Uptake of VMMC: Lessons from AIDSFree Malawi
- Systematically Coordinating VMMC Demand and Supply in Mozambique
- Educating Men and Their Families About the Importance of Voluntary Medical Male Circumcision
- Leveraging Local Intelligence: Use of Volunteer Community Advocates Leads to A Five-Fold Increase in Number of VMMCs in Routine Services in Tanzania
- A Public-Private Partnership Approach to Expand VMMC Uptake in Khomas Region, Namibia

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