


Technical Considerations for Demand Generation for Voluntary Medical Male Circumcision in the Context of the Age Pivot



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Acknowledgments

This document stemmed from a Demand Creation Summit held in Arlington, Virginia, in January 2016, where several implementing partners shared their recent experiences in generating demand for voluntary medical male circumcision (VMMC) among the 15- to 29-year-old age group, followed by a series of working groups among the social and behavior change communication (SBCC) advisors: Kim Seifert-Ahanda, Maria Carrasco and Liz Gold (co-authors of this document).

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Contents

Introduction

In alignment with U.S. Presidents Emergency Fund for AIDS Relief's (PEPFAR) approach to do the right thing, at the right time and place for the right people in order to achieve greater effectiveness and efficiencies, the COP16 technical considerations highlight the importance of voluntary medical male circumcision (VMMC) for a more focused target audience. The focus on men ages 15 to 29 as a primary audience is termed "the Age Pivot."

What Is the Age Pivot?

According to the PEPFAR COP17 technical considerations:

- Countries should continue to prioritize clients aged 15-29 years for immediate impact.
- As prioritized areas approach saturation in this population group (i.e., 80 percent or more men in select geographic areas are circumcised), they are urged to extend the prevention benefit to adolescent boys 10-14 years of age.
- Given the low rates of HIV infection among males who have not yet had sexual debut, programs should consider offering HIV counseling and testing to this group only on request and not offer this routinely.
- Services should not be denied to any medically eligible male for VMMC.

What Do We Know about the 15 to 29 Year Olds?

Most clients accessing VMMC services to date have been adolescents 10 to 19 years of age. Several factors make this age group relatively more receptive to VMMC than older age groups. In many traditionally circumcising communities, for example, male circumcision has been part of rites of passage for adolescents into manhood.[1] Therefore, while culturally acceptable for adolescents, VMMC may be viewed by adult men as culturally inappropriate for their stage in life.

In addition, based on the research, we know that some of the barriers to VMMC for adult men – such as time lost from work and required abstinence during the healing 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.[2] Research and programmatic experience tells us clearly there are differences in barriers and motivators by age group. To effectively address the age pivot, it is important to understand these differences so they can inform demand generation strategies.

So what do we know about men aged 15 to 29 years old?

Age-Specific Barriers and Motivators to VMMC Uptake

From the research and literature, we have compiled a list of age-specific barriers and motivators to VMMC uptake below. For full references and further reading, please see the list of references provided in the Resources section of this document on page 10.

Age-Specific Barriers to VMMC Uptake from the Research and Literature

- Fear of pain (associated with procedure and local anesthesia)
- Fear of HIV test (belief that test is mandatory)

[1] Westercamp N, Bailey RC. Acceptability of male circumcision for prevention of HIV/AIDS in sub-Saharan Africa: a review. *AIDS Behav.* 2007;11:341–355.

[2] Hatzold K, Mavhu W, Jasi P, et al. Barriers and motivators to voluntary medical male circumcision uptake among different age groups of men in Zimbabwe: results from a mixed methods study. *PLoS One.* 9(5):e85051.

- Fear of complications from procedure leading to infertility or decreased sexual performance
- Reluctance to abstain from sex during the healing period (for the sexually active)
- Older males reluctant/embarrassed to mix with younger boys (in transport and services)
- Perception that health facilities are for women
- Lack of partner support
- Low risk perception
- Inconvenient days and times of services
- Female providers (context-specific)
- Taking time off from work and lost wages

Age-Specific Motivators from the Research and Literature

- Improved hygiene
- Enhanced sex appeal, preferred by women
- Improved sexual performance
- Prevent HIV/sexually transmitted infections (STIs)
- Peer support
- Partner support
- Be a role model (set good example for the community)

Anecdotal

- Other health services for men offered at VMMC site: weight, blood pressure and STI treatment

Demand creation activation in South Africa.

Program Experience: Gaps and Promising Practices

Gaps in Current Approach

While each country context is different, assessments of demand generation interventions conducted in several countries have revealed some common constraints to increased uptake by older men.

These constraints include:

- Current communication not consistently addressing critical barriers and motivators (e.g., pain and/or fear of testing)
- Reliance on old formative research that may not be in line with the current landscape (remaining, uncircumcised men, current context)
- Mobilizers need refresher training/reorientation to address age pivot (strengthen interpersonal communication or IPC)
- Mobilizers poorly compensated, ill equipped and not recognized for their contribution.
- Lack of understanding of site capacity by partners and site managers
- Lack of understanding of coverage gaps among various age groups within a subnational unit
- Site-level data to inform demand creation not being regularly collected/analyzed
- Lack of coordination between service delivery and communication partner (or units within the same partner)
- HIV testing services (HTS) not systematically referring HIV-negative men to VMMC
- No clear tracking of which approaches are working/not working.

Promising Practices

From program experience to date in addressing the age pivot, a number of promising practices have emerged. Implementing partners have shared these experiences during discussions, the demand creation summit held in January and during country visits.

Several key approaches in Manica and Tete provinces of Mozambique are increasing uptake of VMMC among the older priority age group. See the case study on page 16 to learn more.

Soccer tournaments in Zimbabwe help attract groups of males in priority age group.

Structural Interventions

Several country programs have found that if they address men's concerns about mixing with the younger boys and taking time off from work with a few adaptations to the services – making them more "friendly" and accessible to adult, working men – uptake among the 15 to 29 year olds increases.

Promising structural approaches include:

- Separate waiting and group education areas at VMMC sites
- Special extended hours/days for older male services (*Saturdays)

- Separate transport for older clients (or reimbursement for transport)
- Mobile services at workplaces and marketplaces – to bring services to the men
- Reduced waiting time
  - » VMMC by appointment
  - » Strategic use of low season

Communication Interventions

In addition to the structural interventions mentioned above, several country programs have found communication interventions that effectively address the age-specific behavioral barriers and motivating factors, and use channels that foster dialogue, also help generate demand among the 15- to 29-year-old age group.

These promising communication interventions include:

- Individualized IPC (through outreach): Listening to men and addressing their specific concerns and needs; reassuring men that those in the VMMC program care about their well-being (starting with the mobilizer).
  - » Requires different skills set (implications for mobilizer selection and training)
  - » Requires different tools to work effectively (for example, a list of frequently asked questions and a short video on a mobile device to address individual yet common concerns with consistent, proven communication)
- Two-way radio formats: Providing mass dialogue around/answers to common concerns (call-in shows, panel discussion, man-on-the-street interviews and testimonials from satisfied clients)
- Promotion of non-HIV benefits through the various communication interventions
  - » Personal hygiene
  - » Enhances sex appeal
  - » Reduces risk of cervical cancer for partner
  - » Benefits to the relationship
- Mobilization in secondary schools and tertiary institutions
  - » Engage teachers for their buy-in on male circumcision
  - » Recruit circumcised students as champions

Waiting area of private provider's office in Johannesburg, South Africa.

Working with Private Providers

Many private providers in Eastern and Southern Africa offer male circumcision services, but as a low-volume service with patients paying out-of-pocket. Partnering with private providers, who are often located in central areas with good access to transport, contributes to the expansion of accessible VMMC services. In addition, private providers tend to attract an older clientele. Currently, USAID-funded VMMC programs in South Africa, Swaziland, Namibia and Lesotho are working with private providers to offer VMMC services.

Demand generation approaches with private providers include:

- Visit private companies to form relationships with management (or tap into existing relationships) and lead group discussions with workers
- Leverage existing pool of clients for VMMC promotion: use of existing client database (promotional SMS), waiting room promotion, short videos on WhatsApp (See the Resources section for sample materials)

The benefits of working with private providers include:

- Private providers reaching an older clientele and clientele who may be hard to reach through public services
- Quality of service (perception of high quality service): Clinic locations, leveraging existing client base, perception of high quality, desire for privacy could help explain why men come (need further analysis)
- Assured continuum of care (one stop shop)
- Collaboration between service and demand generation (including data analysis)

Program Monitoring: Implementation and Outcome

Now more than ever, it is critical that we carefully monitor all demand generation activities, including which age segments are being reached (15 to 19 years; 20 to 25 years; 25 to 29 years) and how we are reaching them so we inform and adapt approaches on an ongoing basis.

Promising practices in the area of program monitoring include:

- Improved coordination and data sharing among service delivery and communication partners (including mobilizers and community-level resources)
- Data collection instruments
- Daily available human resources at site (providers, counselors, etc.)
- Number of men reached
- Number of men who received the service
- Source of information and motivation about male circumcision (two key questions at the service site)
- Monitoring calls to hot lines and to radio programs
- Review data with mobilizers
- Monthly analysis of site capacity/site utilization data
- Quarterly analysis with age and modality disaggregation

Data for Decision Making

It is critical for VMMC program managers and implementers to have the necessary data to make decisions aimed at achieving the age pivot. This section presents a package of online tools that can provide data to enhance planning and monitoring of VMMC programs. These tools include: the Decision Makers' Program Planning Tool (DMPPT) 2.0 online, the Site Capacity and Productivity Assessment (SCPA) Tool, and the VMMC Geographic Information System (GIS) Dashboard. Taken together, they provide implementers with all the data they need to achieve the age pivot.

Decision Makers' Program Planning Tool

The first iteration of the DMPPT was developed and used extensively for advocacy, providing data for setting global VMMC targets for the UNAIDS-WHO Joint Strategic Action Framework for Acceleration of VMMC Scale-Up: 2012 to 2016. However, as countries launched and began implementing national VMMC programs, new questions began to emerge: "Which age groups might have the greatest impact on the HIV epidemic?" "Should we prioritize certain regions of the country?" "What are the current coverage and targets by client age and district, based on program progress to date?" Answering these questions required a revision of the tool.

So, the DMPPT 2 was developed. It was used in 2013-2015 to examine the impact, cost, and cost-effectiveness of circumcising specific age groups and focusing the program on sub-national units. It has been applied in nine priority countries (Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania and Uganda). Data was collected and validated through intensive, bottom-up country engagement and produced context specific country models.

Figure 1

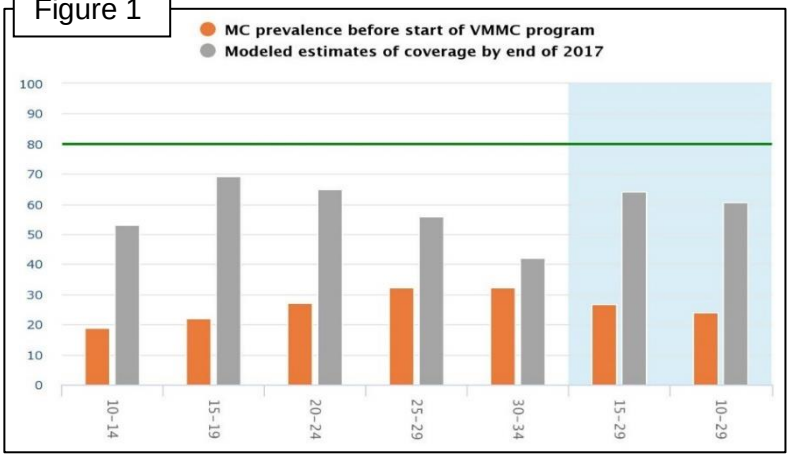
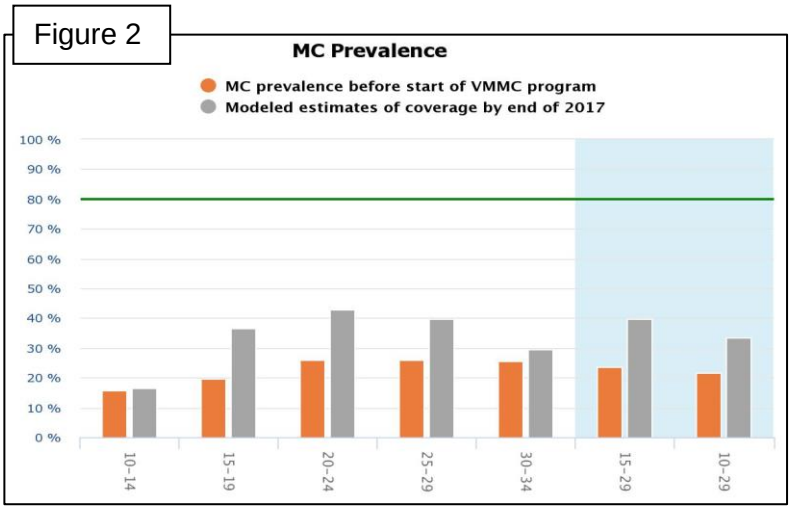


Figure 2



The DMPPT 2 has now been put online to offer a user-friendly interface for country teams to answer fundamental program questions regarding target setting, coverage, and impact across age groups and sub-national geographic units. Figure 1, presents data from Mozambique taken from the DMPPT 2 Online Tool. The orange bar represents progress made in VMMC coverage before the start of the national program, and the gray bar, coverage at the end of 2017 (assuming 2017 targets are met). Prior to the VMMC program, the largest proportion of circumcised men were in the older age categories, ages 20-24 years. After the start if the program, there were greater numbers of adolescents and young men being circumcised, which has contributed to increased coverage in the 15-29-year age groups and moving Mozambique closer to achieving the age pivot.

Contrast this with Figure 2, which presents similar data for Namibia, also taken from the DMPPT 2 online tool. Here we see that there has been a downward trend in the number of program circumcisions among males aged 15-29 years. The reason for this can be observed by the fact that the numbers of younger age groups (i.e. 10-14

years) being circumcised is minimal. Without younger boys aging into the 15-29-year-old age cohort already being circumcised, it is unlikely that the program in Namibia will achieve the age pivot. The same would be true in any other country context.

For example, the scenarios presented in Figures 3, 4 & 5. Using data from Lesotho, the DMPPT 2 online tool considers the historical circumcisions that have been done and projects the VMMCs needed to achieve set targets. Figure 3 illustrates a scenario where VMMC coverage targets for 15-29-year-olds are set at 80 percent, and no program circumcision coverage planned for younger boys. Under this strategy, saturation among 15-19-year-olds by the target year (2020), is not effectively achieved, and in each subsequent year a certain level of circumcision among the 15-19-year-olds will be required.

Figure 3

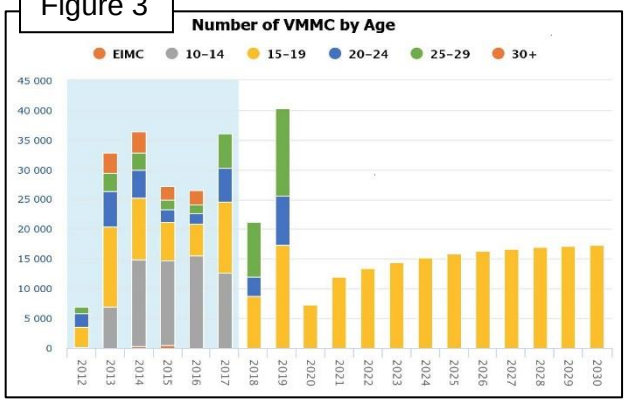


Figure 4

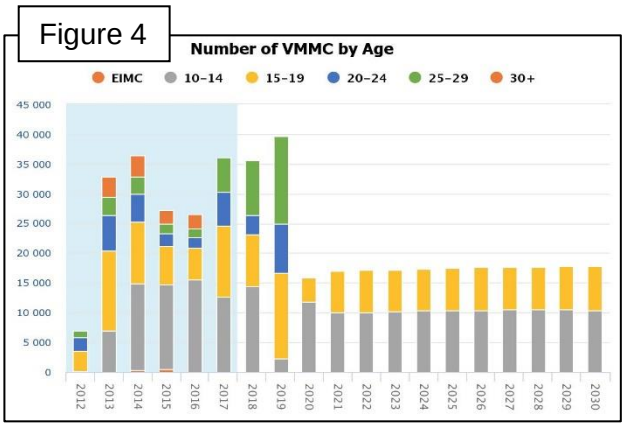
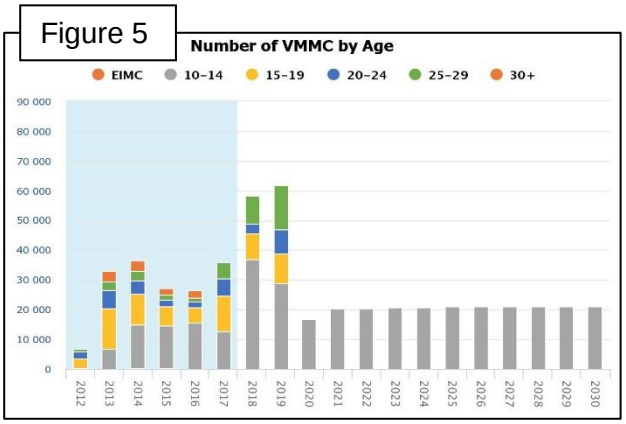


Figure 5



Even if Lesotho were to set a modest coverage target of 40 percent for 10-14-year-old boys, as in Figure 4, the program would still not achieve saturation among 15-19-year-olds, and would have to continue to circumcising a certain percentage of 15-19-year-olds annually to meet set targets. Only by setting a commensurate coverage target of 80 percent for 10-14-year-olds, as in Figure 5, will the VMMC program in Lesotho achieve the age pivot by saturating 15-19-year-olds.

In addition to providing insights into age prioritization strategies, the DMPPT 2 online tool can identify potential geographical disparities in program achievement among various age groups. Figure 6 below, using results for Mozambique, presents coverage levels for each age group by district. In the table, or "heat map," green indicates coverage levels above 70 percent; yellow indicates coverage between 50 percent and 70 percent; and red represents more limited coverage levels below 50 percent. Reasons for such disparity may be numerous, including lack of demand, poor site productivity, among others, and the DMPPT 2 online tool can alert program managers to these potential problems.

Figure 6

	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	15-29	10-29
National	53	69	65	56	42	38	39	37	37	46	64	61
Province: Gaza	92	90	62	42	30	26	26	25	25	24	67	74
Province: Manica	27	41	38	29	16	13	12	11	10	10	37	34
Province: Maputo City	89	101	102	93	76	68	68	65	64	155	99	96
Province: Maputo	72	85	80	76	66	63	66	64	64	63	81	78
Province: Sofala	66	96	85	62	35	27	24	22	20	19	83	78
Province: Tete	16	21	18	13	6	5	4	3	3	3	18	17
Province: Zambezia	54	77	78	73	60	56	58	57	56	55	76	69

Site Capacity Productivity Assessment Tool

The Site Capacity Productivity Assessment (SCPA) Tool was developed out of the External Quality Assessment (EQA) and Continuous Quality Improvement (CQI) processes for VMMC programs. It enables users to monitor the performance of VMMC sites against their optimal output. A site's capacity, established by three fixed variables (number of beds, number of surgeons, number of assistants), should produce a theoretically pre-determined optimal number of circumcisions it can perform per day. This data is important for managing or improving site performance to meet set targets, including the age pivot.

Figure 7

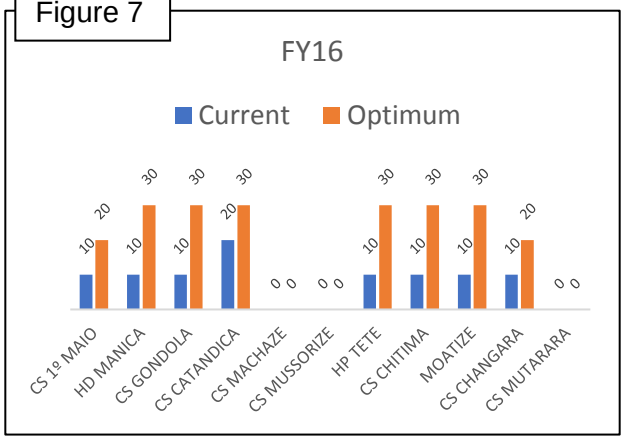
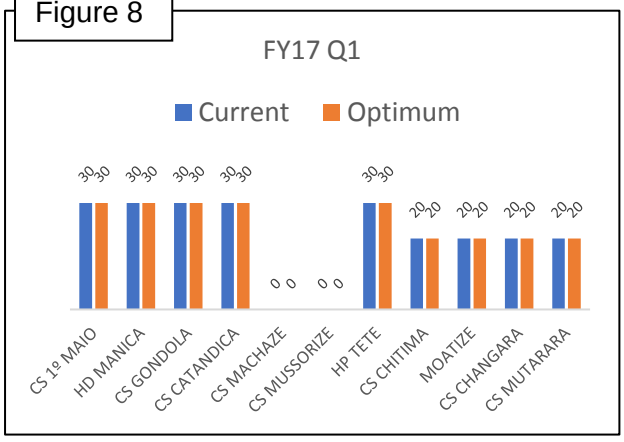
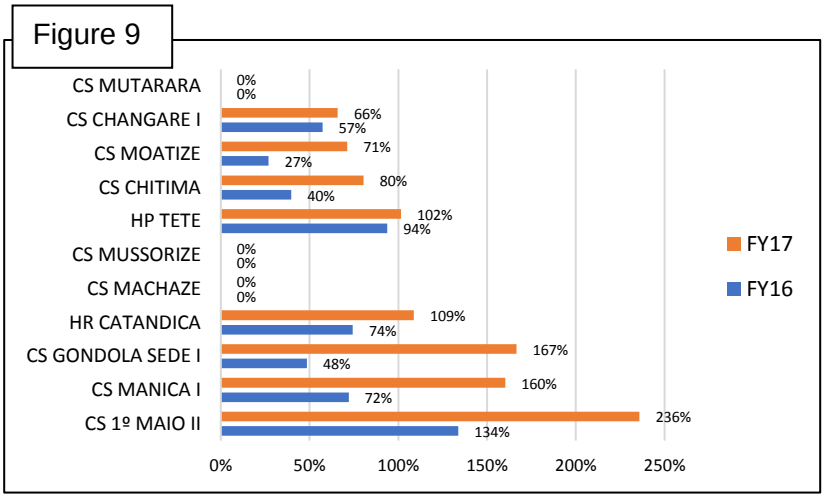


Figure 8



For example, in Figure 7 and 8 present the current daily optimal capacity for each of the PEPFAR supported sites in Mozambique. In Figure 7, the current operating capacity of each site is compared to the optimal capacity for FY16. The SCPA Tool shows that all sites were running below optimal capacity. After corrective interventions (e.g. extra staff or beds) all sites were at optimal capacity by the first quarter of FY17, as seen in Figure 8. Figure 9 presents the utilization rate of all PEPFAR supported sites in Mozambique for FY16 as compared to the

Figure 9



first quarter of FY17. The site utilization rate is calculated as a ratio of the number of VMMC performed daily at any particular site to the daily capacity at that particular site. This is important for planning and achieving the age pivot.

VMMC Geographic Information System Dashboard

The Geographic Information System (GIS) Dashboard was developed and piloted in South Africa in 2016. This mapping and visualization tool presents key health-related and other data critical for strategic decision-making. The Dashboard is linked to the DMPPT 2 Online and SCPA Tool to automatically display their results geographically. Depending on data availability, the Dashboard can include facility-level data, population estimates, HIV prevalence and incidence, country VMMC targets, and health facility staffing, among others. By linking and visualizing disparate available data sources, users will be better able to use data for VMMC program planning. The dashboard will be especially helpful for demand creation efforts where it can present nearby schools, road networks and other useful geographic or socio-cultural characteristics that may pose challenges to service delivery and the achievement of the age pivot.

Figure 10 presents a map of South Africa with each province categorized by their respective percentage of circumcision coverage. This Dashboard visualization can be useful in determining where in the country the VMMC program is achieving greater levels of success and where more effort may be needed.

Figure 10

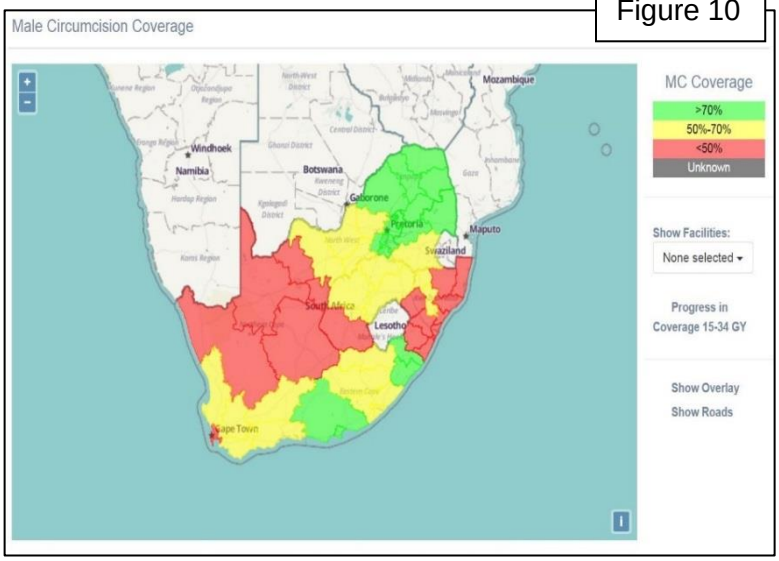
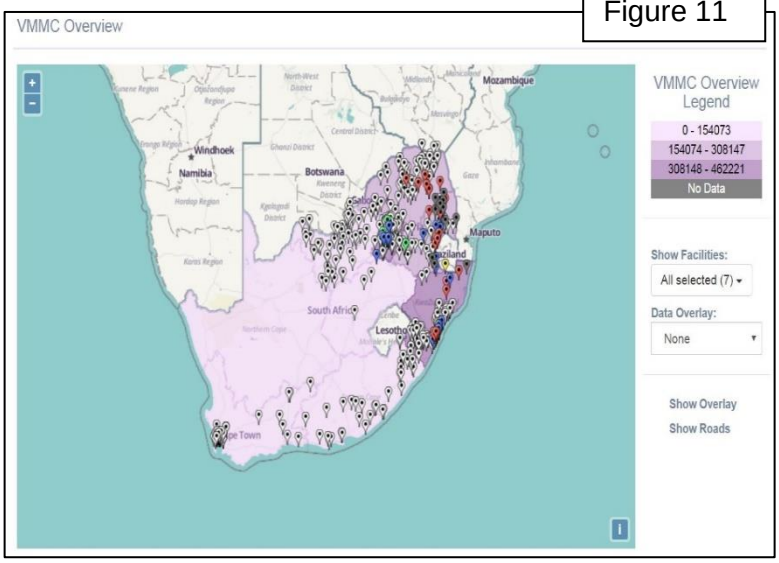


Figure 11 shows the health facilities throughout the country offering VMMC services on a map with shading that categorizes the level of service provision, with the darker areas performing a higher number of circumcisions. Clicking on a facility shows the number of circumcisions performed during the selected period, which can be compared with information on the site's capacity. This allows users to match supply of VMMC services with demand.

Figure 11



Key Takeaways on Data

- Program planning and policy development can be greatly enhanced by using data.
- The DMPPT 2 online tool provides program planners and managers with age and geographically disaggregated data for program target setting aimed at achieving the greatest impact and reach the age pivot.
- The SCPA Tool monitors site performance and provides data to maximize VMMC site level performance.
- The GIS Dashboard presents data from various sources on a series of country maps and provides a way to relate program planning and performance to the geographic context of the country.

Recommendations

Demand creation for VMMC is not a one-size-fits-all approach as different countries, and even regions within countries, are at various stages of VMMC scale-up. Each context is unique, influenced by dynamic socio-cultural underpinnings as well as the history of the local VMMC program that requires its own clearly defined communication and demand creation strategy, informed by research and an in-depth situational analysis.

Nevertheless, from the existing research and program experience, we can identify recurrent issues and themes across countries, and recommend a number of steps to help increase demand for services among the 15- to 29-year-old age group. As programs continue to try new approaches and gain more experience in demand generation among this age segment, particularly the older age group, we will continue to build on the list of lessons learned and recommendations and facilitate an ongoing learning and sharing process. The following is a summary of our recommendations to date.

Mobilizing at a workplace in Mozambique.

Recommendations for Demand Generation to Address the Age Pivot

- **Understand and Address Age-Specific VMMC Barriers and Motivators in Your Local Context**
  Although the age pivot targets 15 to 29 year olds at large, there are different sub-groups among this population who share similar behavioral determinants (barriers and motivating factors) related to VMMC uptake. For effective demand creation, it is critical each program develops a tailored strategy by meaningful population segments. An important, initial segmenting may be conducted by age band as these bands represent different periods in a life cycle – for example, communication that primarily targets 15-to-19-year-olds and 20-to-29-year-olds separately. For some countries, development of these strategies may require additional research. Others may have the information, but need to tailor demand creation efforts more strategically, addressing age-specific barriers and motivating factors more explicitly in the program's communication and interventions. All programs must ensure demand creation strategies reflect the age pivot (if they have not done so already).

- **Ensure Services Are "Friendly" to Older Males**
  As explained in previous sections, simple structural changes can make VMMC services more appealing and accessible to the 15 to 29 year olds, such as evening and weekend hours for greater accessibility outside work hours, mobile services that bring VMMC to the men, separate waiting areas and separate transport for older men, etc. Be sure you know the age-specific factors that impede and encourage men's use of VMMC services in your local contexts. Collaborate with service partners, as needed, to render services more inviting to the 15 to 29 year olds based on these insights.

- **Address Key Questions and Known Information Gaps Pro-Actively, Early On**

  » **Be Open about Pain and Address Concerns Early On**
  The research has consistently pointed to fear of pain as a key barrier to service uptake, yet most VMMC programs have failed to honestly address the issue. It is important to address men's fears around pain early on so it does not prevent them from accessing the service, and to prepare mobilizers to effectively respond to questions and concerns around pain. We have learned it is critical to acknowledge that pain exists and simultaneously reassure the men that it will be carefully managed during the procedure and afterwards through medicines he will take home.

  » **Clarify Up Front that an HIV Test is Strongly Recommended though Not Mandatory**
  Similar to the obstacle of pain, the misconception that HIV testing is mandatory has been proven again and again to be a significant barrier to the uptake of VMMC services. It is important to communicate early on that HIV testing is part of the VMMC package of services and strongly recommended optional and important though not required for VMMC. Outreach and individualized

communication and counseling should emphasize the benefits of knowing one's status while making it known that HIV testing is ultimately the man's choice. (Legal and political barriers to optional HIV testing must be addressed upfront.)

- **Recruit Satisfied Clients and Train as Mobilizers**
  Potential clients want to hear from a male who has been through the experience. Mobilizers who have been through the VMMC experience themselves are best positioned to dispel myths and misconceptions.

- **Actively Promote Multiple Benefits of VMMC, including Non-HIV Advantages, Most Relevant to 15 to 29 Year Olds**
  Research and experience has demonstrated the importance of non-HIV motivating factors in demand generation for VMMC among 15 to 29 year olds. Advantages to the men and to their partners include good hygiene, enhanced sex appeal and prevention of cervical cancer in the men's female partner(s).

- **Maximize Use of Channels that Foster Dialogue and Address Older Males' Individual Needs, Questions and Concerns**

  » Recent experience demonstrates the importance of individualized interpersonal communication and counseling (IPC/C) to facilitate a man's transition from intention to get circumcised to actual uptake of VMMC services. IPC/C is therefore a critical component of an effective strategy for reaching the age pivot, not only at the clinic level but essentially during mobilization as well. To ensure mobilizers can effectively use IPC/C to address males' individual-level fears and concerns, programs will need to rethink how they select and train mobilizers and may need to develop new tools and job aids (such as frequently asked question guides) that help the mobilizer nurture dialogue, and raise and respond to men's individual questions and concerns.

  » Other examples:

  – Two-way, longer format radio programming allows for dialogue and addressing men's questions and concerns. These include panel discussions, call-in shows, testimonials from satisfied clients and man-on- the-street interviews.

  – Call centers or call-in numbers provide another way of responding to men's questions and concerns.

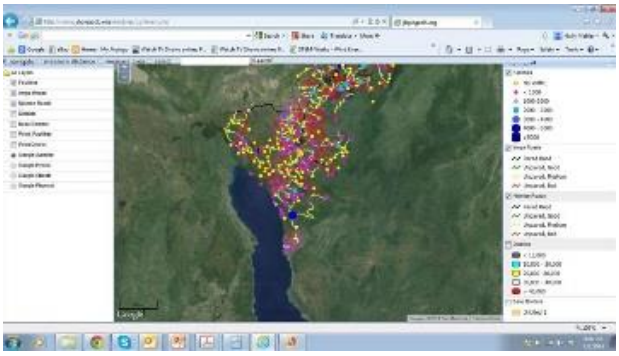
  – WhatsApp and SMS text messaging has been used to support individualized communication responding to a man's specific needs. Short videos responding to key concerns and frequently asked questions have been used to disseminate consistent information in an engaging manner.

- **Involve Community and Traditional Leaders**
  While we know the influence of local leaders and they have been involved in VMMC promotion efforts generally in the past, it is unclear whether programs have informed them about the importance of circumcision among the older age groups, addressed their questions and concerns, and involved them in demand generation around the age pivot priority age groups. Advocacy and communication strategies should ensure we are using to full potential the role of the community and traditional leaders in demand creation around the age pivot.

- **Consider Time-Bound Triggers to Help Move Men to Action**
  We know from the research that too much time to ponder the VMMC decision brings anxiety and reportedly a state of "dissonance" (where males have the intention to undergo VMMC but do not act). Consider using time- bound triggers such as a special occasions like an 18th or 21st birthday or other time-bound triggers to create a sense of urgency and help move men to action.

- **Increase Use of Data for Decision Making through the Use of the VMMC DMPPT, Site Capacity-Utilization and GIS Mapping Tools to Allow Site-level Planning and Monitoring of Progress**

  GIS mapping has been used to depict where and with whom VMMC has been conducted by geographical area. This mapping supports the monitoring of interventions and can also be used to underscore the remaining men eligible for VMMC. Demand creation efforts can be more finely tuned and targeted when armed with specific information about the location, numbers and age-disaggregated data on men in need of service.



GIS mapping can be used to support demand creation efforts.

- **Strengthen Monitoring and Use of Data to Inform Demand Generation Interventions**

  Ensure the collection and assessment of standardized information on demand generation interventions including the monitoring of planned interventions (what, when, with whom and how often) as well as two critical pieces of information at the service level:

  » How did the client hear about VMMC?

  » What prompted him to seek services today?

  *Make certain the demand generation partner(s) are using this information, paired with service use data, to monitor the effectiveness of interventions and inform future programming.

- **Ensure System for Active Referrals and Validation of Service Uptake**

  To answer the "so what?" question (results beyond reach), demand generation partners must have a system to monitor "active referrals," including a means to document (and ideally track) service uptake among those referred for VMMC. This can be done through paper referrals and counter-referrals, or through electronic tracking.

- **Ensure/Formalize Demand Generation-Service Delivery Coordination and Collaboration**

  Collaboration and the sharing of key information between service delivery (supply) and demand generation (demand) partners are essential for successful demand generation. Where different partners (or units among the same partner) are responsible for demand generation and service delivery, clear terms of reference and procedures should be established to ensure the necessary balance of supply and demand, mutual access to key information for planning and monitoring, as well as timely troubleshooting of issues related to service uptake. Coordination roles and responsibilities should be stipulated in new agreements, or can be outlined in a memorandum of understanding or partnership agreement between demand generation and service partners. Regular donor-facilitated meetings between demand generation and service delivery partners can also strengthen collaboration and coordination across the partners.

Resources

Group education session in Mozambique (HC3)

A: Case Study

Increasing Uptake of VMMC among Priority Age Groups: The Mozambique Experience

Tobias, a 21-year-old shopkeeper, lives with his wife and two young daughters in Tete city in Mozambique. He first heard about male circumcision on the radio, but assumed it was not for him since word on the street was that this was something children did. He had heard that, for adult men, circumcision could be painful and even cause infertility. But then an "activista" (mobilizer) talked to Tobias about the advantages of circumcision, in fact he came back to see him twice, "and he also explained to me that to do circumcision the technicians apply anesthesia to prevent pain; I thought a lot.... really a lot and I asked help from my wife and she understood that diseases can be avoided such as HIV, and my wife accepted, and one day the activist passed by my shop again and I decided to get in the car that had other young people and we went to Matambo Health Center where I got circumcised."

For Tobias, deciding to go for VMMC involved a complex and extended decision-making process, as it does for most men in the 15-to-29-year age group where barriers, such as the fear of pain, and motivators, such as HIV prevention, are contemplated. Over the past year, HC3 has identified several key approaches to capitalize on facilitators and address barriers to VMMC access. These approaches are proving to be effective in significantly increasing uptake of VMMC services among this priority age group in the Manica and Tete provinces of Mozambique. The approaches include:

- **Fine-Tuning and Personalizing the Community Mobilization—How Was It Done?**
  - » Mobilizers distributed personal invitations to men attending mobilizations sessions. Invitations included the national hot line number, as well as the mobilizer's personal contact phone number to facilitate follow-up and bookings.
  - » Mobilizers assigned and trained to target specific groups (i.e., schools, companies).
  - » Mobilizers also received tablets in order to access and use a frequently asked questions (FAQ) tool and share short videos with potential clients to address specific barriers?

- **Strengthening Recruitment, Management, Support and Motivation of Community Mobilizers—How Was It Done?**
  - When hiring new mobilizers, favored those who are well educated (with a secondary level of education), and, in the case of males, favored those who had been circumcised. Potential clients want to hear from a male who has been through the experience. Mobilizers who have been through the VMMC experience themselves are best positioned to dispel myths and misconceptions. Mobilizers who are well educated can more easily relay the information about the benefits of circumcision.
  - Supervisors performed quarterly evaluations of mobilizers' performance, based on knowledge of key messages and ability to meet monthly targets, and replaced those who lacked ability to mobilize and performed poorly.
  - Supervisors attend community mobilization sessions regularly to observe performance.
  - Regular refresher trainings and on-the-job-training were given for mobilizers; trained in effective use of SBCC materials.

Community mobilizer talks to men at a bus stop in Mozambique (HC3)

  - Improved the subsidies that mobilizers receive (25 percent), and the more active ones also received phone credit for client follow-up (based on phone records). Dismiss those with low productivity.
  - Equipped mobilizers with branded t-shirts, briefcases and caps to better identify them in the community and help lend them credibility when approaching leaders.
  - It's important to properly orient the mobilizers on the program priorities and goals, as well as the rationale behind age prioritization.
  - Mobilizers should understand that while demand creation efforts are focused on the older age group, they should not discourage the 10 to 14 year olds from accessing services.
  - Set monthly targets for each mobilizer, and keep weekly records of daily productivity of each mobilizer.
- **Coordinated, Site-level Planning**
  - Site-specific action plans were developed and implemented.
  - Recruitment and training of providers and mobilizers to match optimal site capacity for achieving the daily target
  - Monthly monitoring of progress was done using the USAID VMMC site capacity-utilization tool.
- **Ensuring Appropriate Number of Mobilizers to Reach Monthly Targets—How Was It Done?**
  - In Manica and Tete provinces of Mozambique, a country with 63 percent VMMC prevalence nationally (varies by province), the following averages have worked:
  - 314 was the average number of men (potential clients) reached per mobilizer in the three- month period of April – June 2017 (Quarter 3).
  - 189 was the average number of men reached who then accessed the VMMC service per mobilizer in the same three-month period (April – June 2017)
  - On average, a mobilizer has to reach 10 men in order for 6 to actually access the VMMC service
  - While the average mobilizer can typically reach 200-300 men during the three-month period, the highest performers can reach 600-900 men in a three-month period.

» It is important to note that there is often a lag or delay of about 2 or 3 months between the time when a mobilizer talks to a potential client and the time they access the service. The numbers above are for general illustration purposes. Plans to ensure having enough mobilizers during a 3- month period to reach VMMC targets should take into consideration this "lag."

- **Leveraging Satisfied Client Testimonials via Multiple Channels—How Was it Done?**
  - » Satisfied clients share experiences through:
  - » Public events
  - » Interactive community radio discussions (with call in)
  - » Brief videos in local languages, played during mobilizations sessions and on TVs in health units
  - » Videos shared on mobilizers' tablets and WhatsApp
  - » Videos shared on Facebook

Mobilizing at marketplace in Mozambique (HC3)

- **Mobilizing in Secondary Schools, Vocational Training institutes, Universities—How Was It Done?**
  - » Identified two teachers per school as mobilizers to facilitate meetings with school directors, prepare calendar of lectures, organize and mobilize students, help organize process of transporting students to VMMC sites, in coordination with HC3 mobilizers.
  - » The mobilizing teacher received a small monthly stipend to purchase credit for the phone, as they communicate frequently with mobilizers and for transportation.
- **Mobilizing During Public Events, Concerts, and Festivals with Individual Follow Up —How Was It Done?**
  - » Took advantage of festivals, health fairs, sporting events where priority age group congregates
  - » Displayed and distributed SBCC materials about VMMC benefits and the procedure
  - » Distributed personal invitations (with mobilizers' contact number)
  - » Led discussions about VMMC services at public events and dispelled any myths or misconceptions around VMMC
  - » Registered interested people with their contact info.
  - » Mobilizers followed up by phone with potential clients.
- **Implementing mobile Brigades (Outreach)—How Was It Done?**
  - » Mobile brigades helped reach men living far away from the fixed sites.
  - » Community leaders facilitated entry into the community, and helped identify members of community as local mobilizers in advance of the mobile brigade's arrival.
  - » Radios provided to community leaders to follow community radio programs
  - » Community radio informed the community about the arrival and departure of the mobile brigade
  - » Temporarily moved a mobilizer from the fixed site to the community to help empower the local mobilizers.

- **Actively Engaging Community Leaders—How Was It Done?**
  - » Community leaders help mobilize the community to raise awareness.
  - » They mobilize in the community and draw up a list of stakeholders. They get in touch with the mobilizers to make transportation available to the circumcision unit.
  - » They help identify potential mobilizers for VMMC.
  - » The leaders involved in the project, are equipped with T-shirts and caps, as a way to identify and encourage them.
  - » Radios provided to community leaders to follow community radio programs

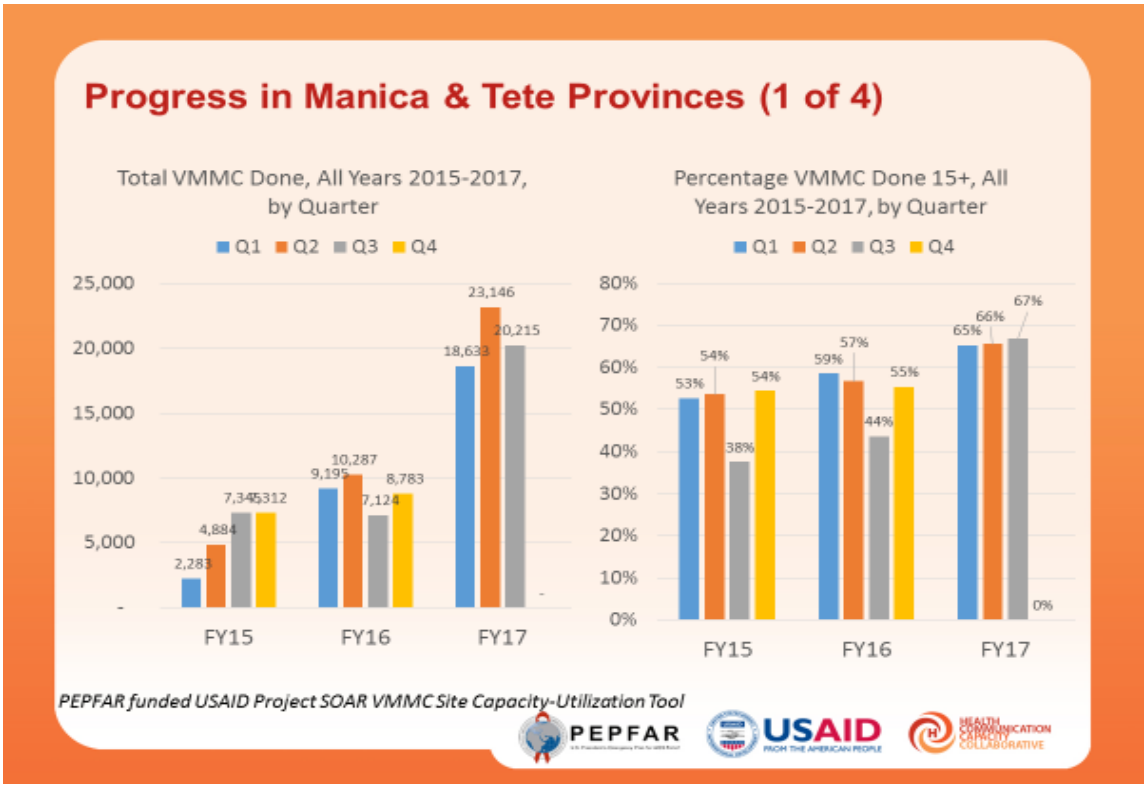
Key Lessons Learned:

- » Recent site-level data shows that while clients report having received information on VMMC from several sources, such as radio, TV, and friends, the majority of clients in the 15 to 29-year age group (80 percent) reported having received information about the VMMC service from activistas/mobilizers, indicating that this is an effective approach to promote uptake.
- » Strong recruitment, management/supervision, support, and motivation of community mobilizers is key to reach targets.
- » Mobilization works better when the mobilizers are divided according to their abilities and background, and assigned specific groups. For example, there are mobilizers who work only with schools, others who focus on workplace/companies, and others who work in the community.
- » Including the mobilizer's contact number on invitations has allowed men to ask follow-up questions and book their appointments in a more private way, following group mobilization sessions.
- » Close collaboration with school directors and active involvement of teachers was critical to success in mobilizing students.
- » Providing transport for students from school to health facility was also key to success.
- » Events that happen at night attract more males in our priority age group; so important to mobilize at night.
- » During events, register the contact of the interested party for follow-up, and provide invitations with personal contact of mobilizer so interested men can also follow up. It is the strong follow-up after the event that results in service uptake.
- » It is important to meet with community leaders so they can facilitate proper entry into the community and identify members of their communities who can best help to mobilize locally.
- » Advanced and close coordination between the communication partner and the clinical partner(s) contributed to success of mobile brigades (outreach). Even when the same partner is responsible for both service delivery and demand creation, close coordination between the two teams or units responsible for these two areas is critical.

What Does the Data Tell Us?

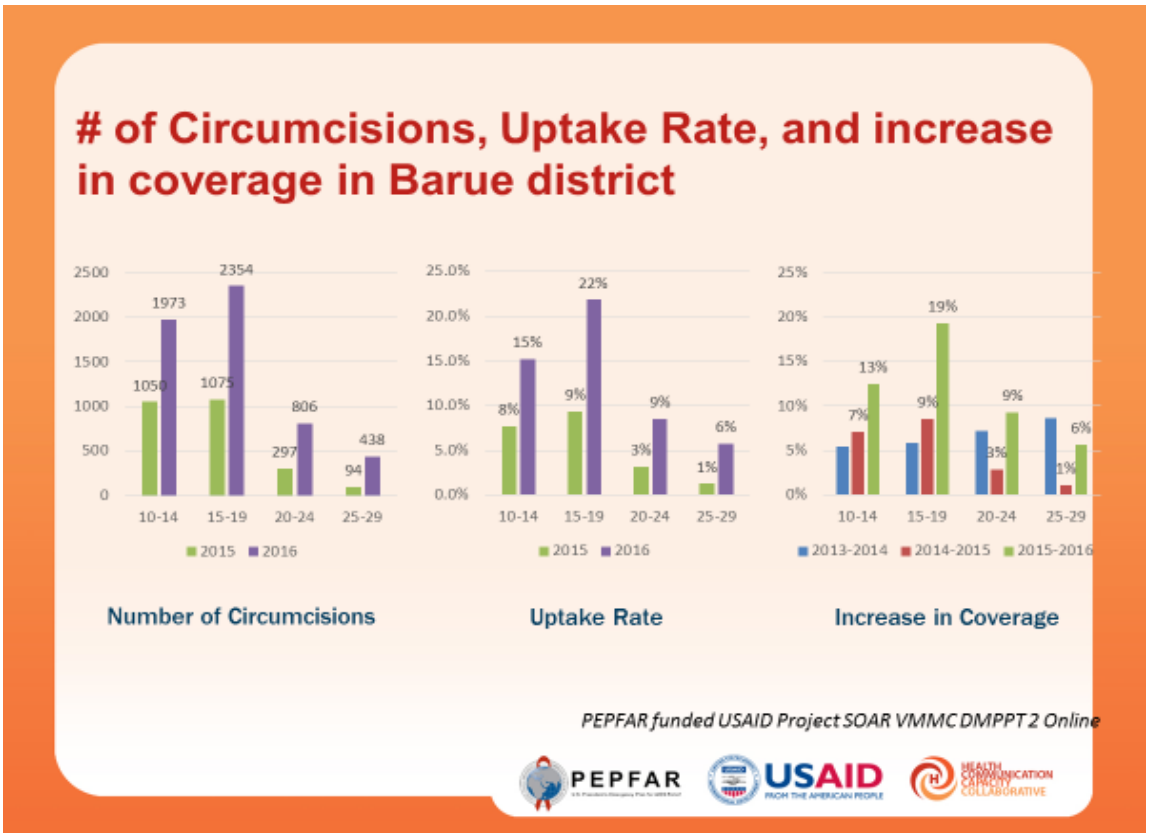
HC3 project started its intervention in November, 2015:

- » The first graph below (on left) illustrates that the impact on the overall number has been big and the number of total VMMC is now reaching the desired targets—almost doubling from one year to the next.
- » The second graph (on right) shows that there is a significant increase of 15-29 year olds. Close to 70 percent are now in the 15 and above.



At the district level, looking at Barue district in the figure below:

Left – comparing the number of VMMCs done in each age group, in each year. We see that there's an increase from 2015 to 2016 among all age groups, including 10-14. Even though the program is targeted to 15-29, their program is accommodating to all men seeking services, so they get 10-to-14-year-olds as well. Uptake rate and coverage both increased significantly as well.



B: Technical Support Available

For Technical Support in Achieving the Age Pivot:

Technical support is available on age and geographic targeting to address the pivot from Project SOAR (at no additional cost to you).

Please contact: Peter Stegman, Senior Economist, Avenir Health

PStegman@avenirhealth.org

Technical assistance for GIS mapping is available from The Palladium Group.

Please contact: Liz Nerad

Liz.Nerad@thepalladiumgroup.com

Technical assistance for site capacity/site utilization analysis is available from ASSIST.

Please contact: Michel Tchuenche

JMTchuenche@avenirhealth.orgJ@urc-sa.com

Support is also available to ensure demand creation strategies are effectively addressing the age pivot from communication experts Kim Seifert-Ahanda, Maria Carrasco and Liz Gold.

Please contact: Maria Carrasco, Senior Behavior Change Advisor, USAID Office of HIV/AIDS

mcarrasco@usaid.gov

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