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Demand landscaping for voluntary medical male circumcision in South Africa

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Acronyms

ACSM	Advocacy, communication and social mobilisation
BMGF	Bill and Melinda Gates Foundation
CCG	Community caregiver
CCI	Centre for Communication Impact
CDC	Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CHAPS	Centre for HIV and AIDS Prevention Studies
CHW	Community health worker
CMT	Community Media Trust
CW	CareWorks
DHIS	District Health Information System
DOH	Department of Health
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
GP	General practitioner
HTS	HIV testing services
IEC	Information, education and communication
KII	Key informant interview
LAC	Local AIDS council
M&E	Monitoring and evaluation
PEPFAR	US President's Emergency Plan for AIDS Relief
PSA	Public service announcement
RTC	Right to Care
SACTWU	Southern African Clothing and Textile Workers' Union
SFH	Society for Family Health
STI	Sexually transmitted infection
USAID	United States Agency for International Development
VMMC	Voluntary medical male circumcision
WBOT	Ward-based outreach team

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EXECUTIVE SUMMARY

BACKGROUND

South Africa aimed to circumcise 4.3 million men by the end of 2016 and had circumcised 2.86 million by March 2016. The country has been successful in reaching early adopters and in future it needs to win the support of harder to reach men. Seasonality – that is, a strong preference for undergoing circumcision in winter – leads to high numbers of circumcisions in June and July and lower demand in the remainder of the year.

Genesis Analytics was contracted by the Bill and Melinda Gates Foundation (BMGF) on behalf of the Department of Health (DOH) to undertake a landscaping exercise to understand what demand-creation activities for voluntary medical male circumcision (VMMC) have been undertaken in South Africa, what has been effective, and what new and innovative practices might exist. The results of this review will be used initially to inform the DOH's short-term rapid scale-up plan for VMMC and a revised demand creation strategy for South Africa. They may also be used by donors and implementing partners as they consider approaches to demand creation going forward.

METHODS

This landscaping of VMMC demand creation was undertaken in two phases. Phase one comprised a document review and interviews with national-level key informants at VMMC partner organisations of the Centers for Disease Control and Prevention (CDC) and the United States Agency for International Development (USAID), and a sample of general practitioners (GPs).

Phase two comprised visits to 19 districts in three provinces: Gauteng, KwaZulu-Natal, and Mpumalanga, where HIV infection rates and the number of uncircumcised men are high. Interviews were undertaken with various stakeholders involved in demand creation for VMMC including: provincial and district HIV, STI and TB (HAST) managers, advocacy, communication and social mobilisation (ACSM) unit members, community mobilisers, facility managers, service delivery partners and GPs. Data were analysed using thematic content analysis. Initial findings were presented to the DOH and BMGF and recommendations were then discussed with them and incorporated.

FINDINGS

There was a difference in level of understanding of social and behaviour change communication theory among those interviewed. This was more evident at district level. No standard theoretical framework was used across partners and there were variations in the degree to which behaviour change theories were applied in practice. This contributes to an uncoordinated approach to demand creation.

A few partners utilise broadcast mass media for the promotion of VMMC. Most partners use small media and social mobilisation to create demand for VMMC. Small media usually take the form of pamphlets focused mainly on providing information about the benefits of VMMC. Social

mobilisation involves mobilisers approaching men where they gather, for example at taxi ranks and workplaces, and going door to door, encouraging them to get circumcised.

While mass media are important for creating awareness and an environment supportive of VMMC, this landscaping study revealed that social mobilisation is the most effective way to convince men to take up circumcision services. However, it is clear that the selection, contracting, and training of social mobilisers, as well as the exact social mobilisation approach they use, differ among partners and districts. While social mobilisation must address the local cultural context, standardised approaches and training would ensure that each mobiliser is equipped with essential skills and an understanding of how to apply best practices within the local environment.

Factors that partners considered when determining where mobilisation should take place included: the number of men in the area, the size of the catchment area, HIV prevalence, and levels of risky sexual behaviour. Few partners mentioned using formative research to inform decisions on which men they should be prioritising. As a result, partner organisations and health districts employ an inefficient blanket approach where they "target" any man perceived to fit the priority age group.

There was a lack of consistency even with regard to age groups targeted. Although most service delivery partners mentioned the age pivot[1], they differed in terms of their grasp of what this entails and what the DOH target age group is. This lack of clarity contributes to an inability to meet DOH and PEPFAR goals and to a situation where clinics feel unsupported.

Various themes have been addressed in demand-creation materials, including the benefits of VMMC, the fact that the procedure is both free and safe, masculinity and aspirations to be responsible men. Some materials contained inaccurate information – for example, describing medical circumcision as pain-free. The quality of materials differs among partners and there is limited innovation with respect to format and the use of storytelling and case studies. Pamphlets and posters tend to get lost among other similar materials.

There are several persistent barriers to uptake of VMMC. These include a fear of pain, anxiety about getting tested for HIV, the period of sexual abstinence after circumcision, and the idea that healing is easier in winter. Partners provided examples of how they addressed these barriers but there did not appear to be standard training for social mobilisers on how to approach each barrier.

There is a gap in systematic understanding of both barriers to VMMC and factors that might motivate individuals to undergo circumcision, how these vary by segment within the target group, and how far individuals have progressed in the decision-making process on VMMC. There is a corresponding lack of guidance on how to approach men at different stages of decision making.

Call centres serve as a way of generating leads on men who are interested in VMMC. The quality of the staff who follow up on such leads and "close the deal" is critical: they need to provide appropriate support to the caller to ensure he makes an appointment for circumcision and keeps this appointment.

[1] In alignment with US President's 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 aged 15 to 34 in South Africa as a primary audience is termed "the age pivot".

There is also a critical gap in knowledge of how many men need to be approached in order to result in a single circumcision. Few partners could provide information on their conversion rates.

Monitoring and evaluation (M&E) of demand-creation activities seemed to be challenging. Over-arching VMMC targets are not well understood and partners do not always grasp how their targets contribute to the overall target. With a few notable exceptions, conversion rates are not in place. A limited number of formative studies or impact evaluations of demand-creation activities have been undertaken to determine what approaches are most effective. Although a technical working group is in place, there is no clear sharing of approaches by partners.

Despite the challenges mentioned above, there are some strong demand-creation practices and innovative programmes. These are discussed some detail in this report. Many promising practices have been identified and these are featured in callout boxes in the report.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Theoretical foundation

Not all partners have a theory underpinning their demand-creation activities and it is unclear the degree to which theory is applied by those partners that have a theoretical framework. Approaches that are based on theory are more likely to be effective as they incorporate an understanding of behaviour change.

Communication interventions

The main communication approaches are use of small media, mainly aimed at providing information, and social mobilisation. The latter is reported to be the most significant activity in persuading men to get circumcised. The role of social mobilisers is critical but training, approach, and materials used differ across partners.

The overall opinion of partners is that future efforts should focus on addressing and overcoming ideational and practical barriers to VMMC.

Target audience

There is inconsistency among partners in the use of formative research to inform the selection of the target population. Without an understanding of the target population, it is not possible to address barriers and harness motivational factors for VMMC properly.

There is an implicit understanding that “older men” (in their 20s and early 30s) are to be targeted and the reasons for this. But in practice there is no consistency in actual age groups targeted. Districts, in particular, struggle with engaging older men. In order for targets to be met, it is critical to establish universal clarity about who should be targeted and how this should be done.

Messaging on VMMC

Materials differ in terms of creative execution but, in general, there is limited innovation. While artwork and campaign themes may have changed, the core content has not been refreshed to

retell the VMMC story in a way that may reach the target audience more effectively. Ensuring truthful information from all service providers is crucial to ensure there is an accurate and positive perception of VMMC.

Tackling barriers

It is critical that partners address barriers to VMMC more effectively. Presently they appear to approach these in different ways and it is unclear whether mobilisers receive standardised training on how to counteract each barrier. When mobilisers are ill-equipped to deal with barriers, prospective clients can be lost.

Seasonality remains a key barrier to consistent uptake of VMMC and this affects both the efficiency of services as well as achievement of targets. Despite the fact that this challenge is widely experienced, there has not been a concerted initiative to overcome seasonal fluctuations in demand.

Building on intent

A considerable effort is made to contact and follow up with men who show interest in VMMC. However, the success rate varies and is influenced by available resources – for example, personnel, telephones, and transport.

Call centres are a useful way to generate leads, but the quality of the staff who need to "close the deal" is critical in order to provide interested men with the quality information and support they need in order to go through with the procedure.

M&E

In order for all partners to understand overarching VMMC targets and their role in achieving these, improved transparency is needed. Staff at clinic level need to appreciate how targets are established and what their significance is to the national HIV effort. In addition, service providers need support on ways to reach these targets.

There is monitoring of demand creation but it remains a challenge. It is unclear how effective demand creation is as there are no fit-for-purpose indicators of programme performance for routine evaluation – for example, conversion targets and performance against these. Formative research has been limited, as have impact evaluations.

There is no clear sharing of approaches among partners which has inhibited the growth of a common understanding of what approaches are successful and how they can be scaled up for South Africa to reach its targets. There is also no coordination. Partners continue to work in silos and this limits the overall success of the VMMC programme.

Recommendations

Enhancing government ownership of the VMMC programme

A single, strong VMMC programme is needed, led by the DOH and supported by partners. This is particularly important for demand-creation activities. As the VMMC programme is presently structured, health districts are highly dependent on the partners operating in their areas.

In addition, systems and structures should be put in place at various levels to give effect to DOH ownership of the programme. For example, the technical working group should be strengthened and support provided to provincial and district structures to enable them to coordinate implementation.

Developing a systematic approach to knowing the client

Enhanced government ownership could facilitate a more sophisticated appreciation of the VMMC client which is shared by all service providers. A deep and nuanced understanding of concrete and ideational barriers is required in order to tailor the right interventions for various segments of the target group. Building on this stronger client segmentation, the application of behavioural economics could help create approaches that are effective in nudging clients towards VMMC.

Creating a supportive environment using mass media

Once the target audience is understood and segmented, targeted messages can be aimed at specific segments. Every year, at least one large mass media campaign on VMMC should be conducted in order to maintain high knowledge levels, promote a positive attitude towards VMMC, and establish VMMC as a socially accepted – or even desirable – practice.

There should be a smaller summer campaign that would specifically promote uptake of circumcision services during this time of year. It should address the misconception about wounds healing poorly in summer.

Improving the social mobilisation component of demand creation

Selection of social mobilisers

The selection of social mobilisers is crucial to their effectiveness in the field. Social mobilisers should have certain characteristics that position them to be more successful in the field, such as: sales or marketing background, ability to relate to the target age group of 15 – 34 years, and personal experience of circumcision.

Training of social mobilisers

There should be standardised training for social moblisers which emphasises an evidence-informed approach to mobilisation, targeted key messages and, a thorough understanding of specific barriers to medical circumcision and how to address them.

Social mobilisers should be trained in best practices and training should ensure standard operating procedures are followed and that the information given to clients is factually correct and consistent.

As they gain experience, social mobilisers should develop the confidence to modify best practices to suit their local context without compromising on quality of practice.

Materials development

Materials used by the social mobilisers to guide conversations, as well those distributed by mobilisers to prospective clients, must contain consistent messaging and link to the current or

most recent mass media campaign. To ensure this, an agreed-on message brief should be developed for all partners and followed by them. The creative execution of small media will continue to vary from partner to partner as this ensures freshness and local appropriateness.

Monitoring and evaluating for better impact

A structured M&E framework should be developed. It should be structured to measure the attainment of specific goals and key indicators (such as conversion rates) should be defined accordingly. The aim is to be able to measure effectiveness and efficiency of various channels of information and engagement – and to use the results to continuously inform programming. Success is a process and indicators should be chosen to measure intermediate achievements towards major goals.

PURPOSE OF THIS REPORT

South Africa has one of the world's most severe HIV epidemics, with an estimated 300 000 new infections a year. Just a few years after VMMC was conclusively demonstrated to reduce the probability of a man being infected with HIV, South Africa set the ambitious target of circumcising 4.3 million men by the end of 2016. While there was initially rapid uptake of VMMC services, this has slowed considerably over the last 12 months, mainly due to lower demand.

Various stakeholders in the country have undertaken VMMC demand-creation activities, some of which have taken advantage of South Africa's sophisticated media environment. However, new and innovative demand-creation approaches are required if South Africa is to reach 80% of uncircumcised men between the ages of 15 and 49. Interventions with stronger motivational power are clearly needed.

Genesis Analytics was contracted by BMGF to support the DOH by undertaking a landscaping exercise to understand the nature of past and present demand-creation activities and to explore which of these have been effective and what opportunities for innovation might exist.

The results of this review will be used initially to inform the DOH's short-term rapid scale-up plan for VMMC, and subsequently the revised demand creation strategy for South Africa. It may also be used by donors and implementing partners as they consider approaches to demand creation going forward.

METHODS

Phase one of the demand-creation landscaping comprised a document review and interviews with national-level key informants in October and November 2016. Phase two comprised field visits in 19 districts situated in Gauteng, KwaZulu-Natal and Mpumalanga, provinces where HIV infection rates and the number of uncircumcised men are both high.

PHASE 1A: LITERATURE AND DOCUMENT REVIEW

A literature and document review was conducted using a PubMed search for published articles on demand creation for VMMC, reviewing relevant documents from the Clearing House for Male Circumcision (https://www.malecircumcision.org), and evaluating presentations made at 2016 HIV Research for Prevention Conference (HIV R4P).

South African VMMC implementing partners provided relevant documentation, including evaluations of their programmes. Literature on VMMC demand creation in Kenya, Namibia, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe was reviewed in order to identify promising practices for the scale-up of demand creation.

PHASE 1B: NATIONAL KEY INFORMANT INTERVIEWS

Tool development

Semi-structured interview guides were developed for the different types of interviewees: service delivery partners, demand-creation partners and GPs. See Appendix 1.

Data collection

Ten interviews were conducted with key informants from CDC and USAID partners (Table 1) and three randomly selected GPs were also interviewed.

Table 1: National partner key informants

	CDC	**USAID**
Demand creation partner	CareWorks and Community Media Trust (CMT)	Centre for Communication Impact (CCI)
Service delivery partner	The Aurum Institute, JPS Africa, Southern African Clothing and Textile Workers Union (SACTWU), Society for Family Health (SFH), and TB/HIV Care	Centre for HIV and AIDS Prevention Studies (CHAPS) and Right to Care (RTC)

Data analysis

Thematic content analysis was undertaken. An initial presentation of the findings from the national partner key informants was delivered to DOH on 11 November 2016 when findings and recommendations were discussed and validated.

PHASE 2: DISTRICT INTERVIEWS

Tool development

Using the national-level interview guides as a foundation, semi-structured interview guides were developed for the following interviewees: provincial managers of HAST and VMMC programmes, provincial managers of ACSM units, district HAST managers, general practitioners (GPs), community mobilisers, facility managers, and those responsible for demand creation at service-delivery partners (NGOs providing VMMC).

Data collection

A total of 135 interviews were conducted in 19 districts over the course of four weeks in November 2016. DOH provided a signed letter from the HAST cluster manager that was sent to his counterparts in the three provinces, indicating DOH's support and the importance of these interviews. Five field teams comprising two interviewers spent five days in each district, travelling to clinics and facilities that performed VMMC. The head office of each provincial health department was visited on the first day in the field to formally obtain access and subsequently the district office was the first contact point for the interview team in each district.

Table 2: Total number of interviews by category

Clinics/NGO partners	98
Private GPs	6
Health district officials	22
Provincial officials	9
TOTAL	135

BACKGROUND

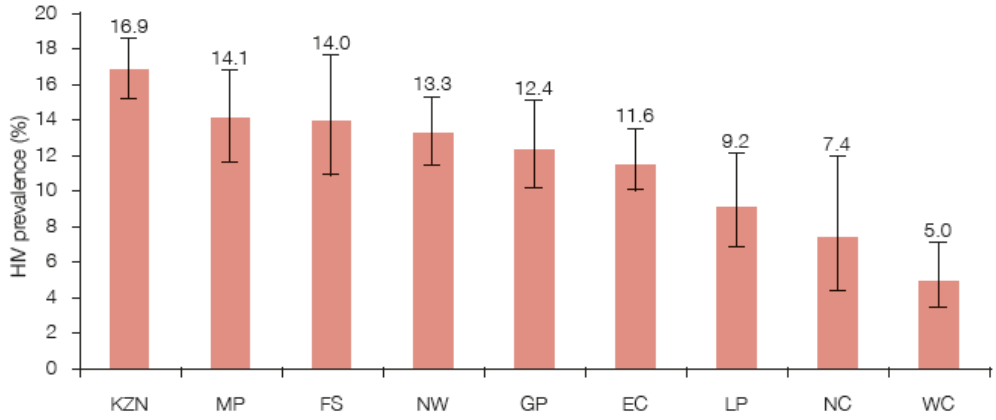
VMMC AND HIV IN SOUTH AFRICA

VMMC has become one of the cornerstones of the HIV prevention response. This is as a result of three randomised controlled trials which showed 60%[2], 53%[3], and 51%[4] reductions in HIV incidence in the circumcision arm compared with control arm in participants from South Africa, Kenya, and Uganda respectively.

Mathematical models estimated that quickly reaching a large number of uncircumcised men with VMMC in strategically chosen populations may dramatically reduce community-level HIV incidence and save billions of dollars in HIV care and treatment costs.

In South Africa, it has been suggested that one new HIV infection may be prevented for every 10 male circumcisions[5]. This is important because South Africa has the largest HIV epidemic in the world with approximately 12.2% of the population (6.4 million persons) HIV-positive in 2012[6]. HIV prevalence differs substantially by province (Figure 1).

Figure 1: HIV prevalence by province, South Africa 2012



Source: Shisana et al, 2014

[2] Auvert B, Taljaard D, Lagarde E, et al. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 trial. PLoS Med.2005;2:e298.
[3] Bailey RC, Moses S, Parker CB, et al. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial. Lancet. 2007;369:643–656
[4] Gray RH, Kigozi G, Serwadda D, et al. Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. Lancet. 2007;369:657–666.
[5] UNAIDS/WHO/SACEMA Expert Group on Modelling the Impact and Cost of Male Circumcision for HIV Prevention Male circumcision for HIV prevention in high HIV prevalence settings: what can mathematical modeling contribute to informed decision making? PLoS Med. 2009;6:e1000109. doi:10.1371/journal.pmed.1000109.
[6] Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.

VMMC PROGRAMMING IN SOUTH AFRICA

In 2007, WHO and UNAIDS issued recommendations to implement VMMC in settings with high HIV prevalence and low prevalence of male circumcision. Thirteen countries, including South Africa, were identified for scale-up of VMMC by UNAIDS and WHO.

South Africa began providing VMMC as an HIV-prevention strategy in 2010. The DOH leads the programme and while coordination and financial and technical support are provided through PEPFAR and the Global Fund. Organisations such as WHO, UNAIDS, and BMGF provide ongoing technical support.

Implementing partners

The DOH facilitates VMMC services nationally, and DOH community mobilisers have traditionally provided support for demand creation. To assist the scale-up of VMMC, several non-governmental implementing organisations (NGOs) have been contracted by CDC and USAID to create demand for circumcision and to provide VMMC services. In addition, general practitioners (GPs) have been contracted to perform VMMC.

CDC funded implementing partners

CDC enters into individual cooperative agreements with implementing partners which specify the funds to be disbursed and VMMC targets. Although CDC monitors total VMMC volumes and the cost per circumcision, its funding is not explicitly tied to the number of circumcisions performed.

CDC has provided funding under two awards. Under the initial award, the following organisations received VMMC funding from CDC: JHPiego (now known as JPS Africa), SACTWU, SFH, Aurum, the Centre for AIDS Prevention Research in South Africa (Caprisa), the Catholic Medical Mission Board (CMMB), TB/HIV Care, St Mary's Hospital and McCord Hospital. Under the new award, there are two prime partners, Aurum and TB/HIV Care. Sub-awards have been made to CareWorks, CMT, JPS Africa, SACTWU and SFH.

USAID funded implementing partners

USAID utilises a fixed-price model to fund a consortium of providers. The fixed-price contract covers a range of activities:

- Community mobilisation and client recruitment.
- VMMC service delivery and follow-up care (in collaboration with DOH teams and practitioners in private practice).
- Management and reporting of adverse events.
- Continuous quality improvement.
- Data quality management.
- Monitoring and reporting to DOH and PEPFAR.

USAID explicitly ties reimbursement of implementing partners to the number of circumcisions performed. Under the current award, that started in September 2013 and ends on 31 March 2017, Right to Care is the prime partner and the other implementing partners (CHAPS and Maternal, Adolescent and Child Health [MatCH]) are sub-contractors.

Distribution of implementing partners

Various health districts in South Africa have been designated for VMMC service provision by either CDC- or USAID-funded partners. Table 3 indicates where the various implementing partners provide services.

Table 3: Districts where PEPFAR-supported VMMC services operate

Province	District
Eastern Cape	O R Tambo
Eastern Cape	Chris Hani
Eastern Cape	Buffalo City
Eastern Cape	Amatole
Eastern Cape	Alfred Nzo
Free State	Lejweleputswa
Free State	Thabo Mofutsanyane
Gauteng	City of Johannesburg
Gauteng	Ekurhuleni
Gauteng	City of Tshwane
Gauteng	Sedibeng
KwaZulu-Natal	eThekwini
KwaZulu-Natal	Umgungundlovu
KwaZulu-Natal	Zululand
KwaZulu-Natal	uThungulu
KwaZulu-Natal	Ugu
KwaZulu-Natal	Uthukela
KwaZulu-Natal	Harry Gwala
KwaZulu-Natal	Umkhanyakude
Limpopo	Mopani
Limpopo	Capricorn
Mpumalanga	Ehlanzeni
Mpumalanga	Gert Sibande
Mpumalanga	Nkangala
North West	Bojanala Platinum
North West	Dr Kenneth Kaunda
North West	Ngaka Modiri Molema
Western Cape	City of Cape Town

General practitioners

GPs are contracted to expand service options and increase access to VMMC for men who prefer private-sector care. GPs are either contracted through implementing partners, like CHAPS, or by the DOH and are reimbursed for each eligible VMMC performed. In addition, USAID has developed a service model with the medical scheme, Metropolitan Health. This provides insurance cover for VMMC, using a standardised tariff which incorporates the cost of the procedure as well as services such as counselling, education and post-operative care.

Other partners

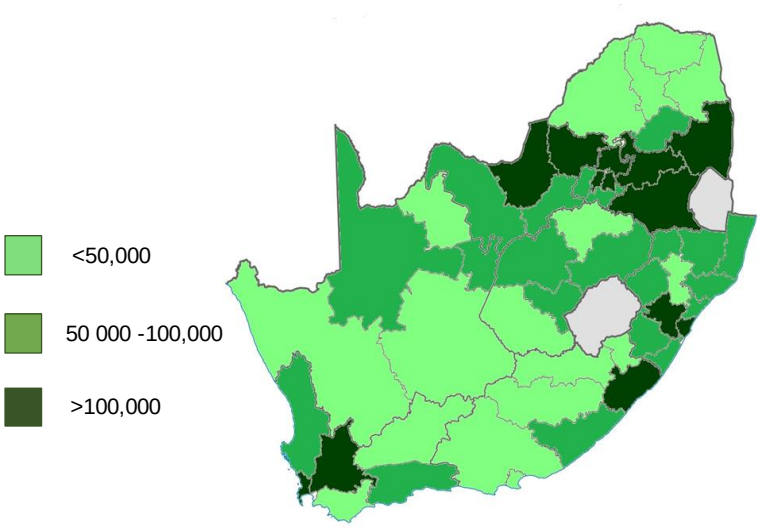
There are several NGOs which have not been formally contracted to undertake demand creation for VMMC but have done so as part of their HIV programming. For example, the Soul City Institute for Social Justice covered male circumcision and HIV prevention in series 11 of its TV show, *Soul City*.

Historically the VMMC programme has largely been funded by PEPFAR and delivered through its implementing partners. As part of its new strategy, PEPFAR is transitioning its support for the VMMC programme in South Africa, focusing more on districts with the highest HIV prevalence. DOH is taking on a larger role both in demand generation and service delivery.

VMMC targets and progress

It is estimated that South Africa has about 5.4 million men aged 15 - 49 years who are uncircumcised and HIV-negative[7]. Figure 2 shows the number of men eligible for VMMC by district. Most districts with large numbers of uncircumcised, HIV-negative men are in the north of the country.

Figure 2: Number of uncircumcised, HIV-negative males by district



Source: Adapted from CHAI, 2016

[7] CHAI,2016.

Table 4 shows HIV prevalence and the number of uncircumcised HIV-negative men in each district of Gauteng, KwaZulu-Natal, and Mpumalanga.

Table 4: Estimate of uncircumcised, HIV-negative men by district

Province	District	Uncircumcised HIV-negative men
Gauteng	City of Johannesburg	469 462
	City of Tshwane	342 649
	Ekurhuleni	348 800
	Sedibeng	91 541
	West Rand	76 837
KwaZulu-Natal	Amajuba	58 353
	eThekwini	498 707
	Harry Gwala	53 302
	iLembe	78 016
	Ugu	73 528
	uMgungundlovu	132 857
	Umkhanyakude	74 661
	Umzinyathi	45 715
	Uthukela	84 094
	Uthunjulu	95 077
	Zululand	100 318
Mpumalanga	Ehlanzeni	123 772
	Gert Sibande	104 770
	Nkangala	112 059

Source: CHAI, 2016

VMMC targets

South Africa aimed to perform medical circumcision on 80% of uncircumcised men between the ages of 15 and 49 years by the end of 2016. This amounts to 4.3 million men and the target was established in 2009 as a contribution to meeting the broader goal of circumcising 20 million men in the 14 countries prioritised by PEPFAR.

The age pivot

In countries where PEPFAR supports VMMC scale-up, men aged 15 - 29 years have been prioritised. In practice, most clients accessing VMMC services have been adolescents in the age-range 10 to 14 years. VMMC may be viewed by adult men as culturally inappropriate for their stage in life as they are already sexually active. The priority age range in South Africa has been modified, on the basis of modelling outcomes, to include boys and men aged 15 - 34 years[8]. This shift is known as the “age pivot” and the focus is on reaching and providing

[8] Health Communication Capacity Collaborative. (2016). Technical Considerations for Demand Generation for Voluntary Medical Male Circumcision in the Context of the Age Pivot

saturation services to 80% of this age group in a short period. However, VMMC services should not be denied to any medically eligible male. The DOH's priority target group is men aged 20-34 years.

Donor targets

PEPFAR's 2016 Country Operational Plan (COP 2016) states that nine of 27 focus districts were expected to reach 80% coverage VMMC among males aged 15 - 34 years by September 2016. An additional 17 districts and one district in the DREAMS programme are expected to reach 80% coverage by September 2017. PEPFAR programmes will continue in some districts with a high burden of HIV even when they reach 80% VMMC coverage in order to maintain the level of VMMC achieved.

Table 5 shows the 2017 VMMC targets for districts and the PEPFAR programme.

Table 5: 2017 VMMC targets for health districts and PEPFAR-supported services

Province	District	Circumcisions per district (15 - 34 years)	Circumcisions by PEPFAR partners (15 - 34 years)
Eastern Cape	Alfred Nzo District Municipality	0	0
Eastern Cape	Amathole District Municipality	21 219	0
Eastern Cape	Buffalo City Metropolitan Municipality	13 262	0
Eastern Cape	Cacadu District Municipality	4 369	0
Eastern Cape	Chris Hani District Municipality	17 417	0
Eastern Cape	Joe Gqabi District Municipality	6 785	0
Eastern Cape	Nelson Mandela Bay Municipality	10 334	0
Eastern Cape	Oliver Tambo District Municipality	5 430	0
Free State	Fezile Dabi District Municipality	26 025	0
Free State	Lejweleputswa District Municipality	29 664	4 892
Free State	Mangaung Metropolitan Municipality	31 551	0
Free State	Thabo Mofutsanyane District Municipality	45 449	11 120
Free State	Xhariep District Municipality	11 409	0
Gauteng	City of Joburg Metropolitan Municipality	172 934	24 800
Gauteng	City of Tshwane Metropolitan Municipality	101 292	14 854
Gauteng	Ekurhuleni Metropolitan Municipality	93 843	12 775
Gauteng	Sedibeng District Municipality	29 772	3 241
Gauteng	West Rand District Municipality	19 380	0
KwaZulu-Natal	Amajuba District Municipality	37 970	0
KwaZulu-Natal	eThekwini Metropolitan Municipality	214 527	83 083
KwaZulu-Natal	Harry Gwala District Municipality	32 401	7 192
KwaZulu-Natal	iLembe District Municipality	48 956	0
KwaZulu-Natal	Ugu District Municipality	34 758	2 274
KwaZulu-Natal	uMgungundlovu District Municipality	66 158	18 724
KwaZulu-Natal	Umkhanyakude District Municipality	37 274	26 292
KwaZulu-Natal	Umzinyathi District Municipality	33 532	0
KwaZulu-Natal	Uthukela District Municipality	47 316	4 355

Province	District	Circumcisions per district (15 - 34 years)	Circumcisions by PEPFAR partners (15 - 34 years)
KwaZulu-Natal	Uthungulu District Municipality	33 634	7 226
KwaZulu-Natal	Zululand District Municipality	44 150	8 251
Limpopo	Capricorn District Municipality	0	0
Limpopo	Mopani District Municipality	2 862	0
Limpopo	Sekhukhune District Municipality	12 517	0
Limpopo	Vhembe District Municipality	13 027	0
Limpopo	Waterberg District Municipality	0	0
Mpumalanga	Ehlanzeni District Municipality	41 839	0
Mpumalanga	Gert Sibande District Municipality	33 917	0
Mpumalanga	Nkangala District Municipality	16 944	0
Northern Cape	Frances Baard District Municipality	22 632	0
Mpumalanga	John Taolo Gaetsewe District Municipality	6 610	0
Mpumalanga	Namakwa District Municipality	11 770	0
Mpumalanga	Pixley ka Seme District Municipality	22 744	0
Mpumalanga	Zwelentlanga Fatman Mgcawu District Municipality	28 658	0
North West	Bojanala Platinum District Municipality	74 155	23 285
North West	Dr Kenneth Kaunda District Municipality	21 417	11 934
North West	Dr Ruth Segomotsi Mompati District Municipality	30 971	0
North West	Ngaka Modiri Molema District Municipality	59 735	30 554
Western Cape	Cape Winelands District Municipality	58 545	0
Western Cape	Central Karoo District Municipality	4 799	0
Western Cape	City of Cape Town Metropolitan Municipality	57 226	25 496
Western Cape	Eden District Municipality	32 497	0
Western Cape	Overberg District Municipality	15 960	0
Western Cape	West Coast District Municipality	22 578	0

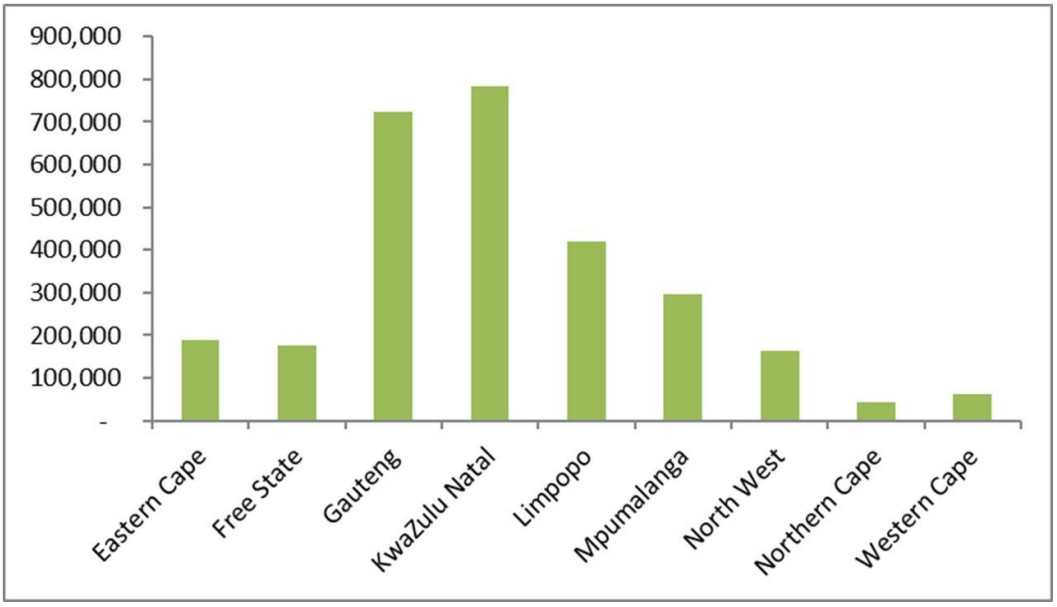
Source: DOH

VMMC progress

Between 2010 and March 2016 a total of 2.86 million men had been circumcised nationally[9]. There is considerable variation among provinces in the number of male circumcisions conducted (Figure 3). However, it should be noted that the number of uncircumcised men and coverage of VMMC services differ by province.

Figure 3: Number of male circumcisions by province, 2010 to March 2016

[9] National Department of Health, 2016.



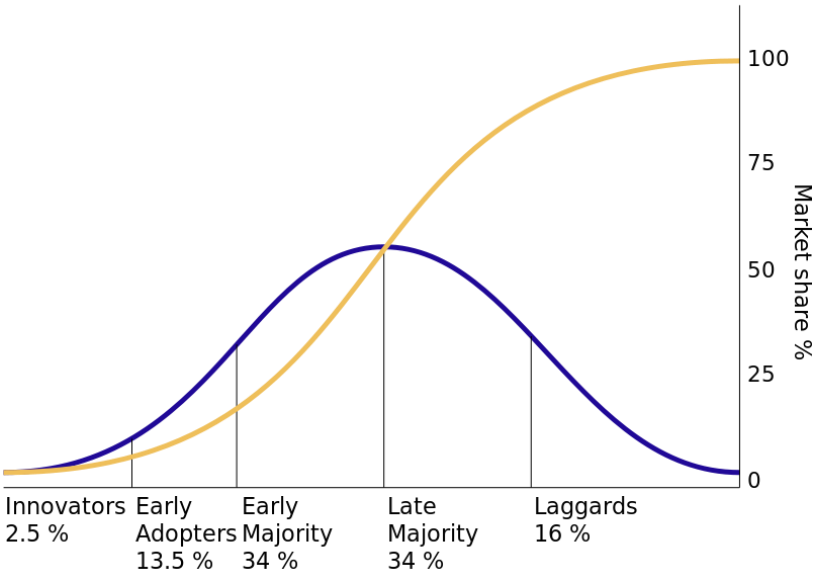
Source: DOH, 2016

DEMAND CREATION MODELS AND APPROACHES

Diffusion of innovation

Like other products or services, VMMC follows the diffusion of innovation curve (Figure 4).

Figure 4: Diffusion of innovation curve



Source: Rogers, 1962

This suggests that as successive groups of consumers adopt the new technology, its market share will eventually reach saturation level[10]. If South Africa is to reach its VMMC target, new and innovative demand-creation approaches will be needed to reach the harder-to-convince “late majority” and “laggards”.

The late majority are among the last to adopt an innovation. These individuals may be deeply sceptical about innovation and tend to have low opinion leadership. They generally have below average social status and are in contact both with the early majority and others in the late majority. Laggards are the last to adopt an innovation. These individuals show little or no opinion leadership and typically have an aversion to change agents. Laggards tend to be focused on "traditions" and constitute the oldest group, only in contact with family and close friends.

Demand creation aims to educate male and female consumers about their need for the service and is especially effective when the service is unknown. When VMMC was first introduced in South Africa, men needed to know that the service was available and what the benefits were. Early adopters who understood the benefits of VMMC responded well to this factual type of messaging.

Initial demand-creation campaigns, generally using mass media, sought to convince the early majority that medical circumcision was widely accepted and was the right thing to do. However, VMMC is unlike most consumer products as it is a surgical procedure and very personal. Therefore, later demand-creation tactics must utilise a variety of communication channels, particularly person-to-person dialogue. Demand-creation tactics should also reinforce an idea in the consumer’s mind, which is where mass media such as television and radio play a part in sustaining awareness.

All VMMC providers are responsible for creating demand for the service, that is, for informing and convincing consumers that men should be circumcised and then reinforcing this idea.

Approaches

Communicators have a choice of approaches, and their interventions are most likely to succeed when multiple coordinated approaches are used. The exact mix of approaches is determined by communication theory.

Whatever the combination, messages need to be consistent and of high-quality. They may be relayed through a variety of channels, such as mass media, peer networks, and service providers, and produced in various forms, including printed materials and broadcast format. They may be purely informative or entertaining as well.[11]

Some key approaches are described in Table 6. It is important to note that these approaches often overlap.

[10] Rogers, Everett M. (1962). Diffusion of innovations (1st ed.). New York: Free Press of Glencoe.
[11] Storey D, Seifert-Ahanda K, Andaluz A, Tsoi B, Matsuki JM, Cutler B. What is health communication and how does it affect the HIV/AIDS continuum of care? A brief primer and case study from New York City. Journal of acquired immune deficiency syndromes (1999). 2014 Aug 15;66 Suppl 3:S241-9. PubMed PMID: 25007193. Epub 2014/07/10. eng.

Table 6: Communication approaches

Approach	Explanation
Mass media	Mass media comprise TV, radio, billboards, newspapers, online media and social media. All of these can be used to raise awareness and knowledge of health issues and to promote healthy practices and health-seeking behaviour. Mass media use includes adverts which are sometimes broadcast as public service announcements and edutainment which involves weaving health and social issues into dramas, talk shows, and reality shows.
Advocacy	Advocacy is a strategic process of communication which targets decision-makers in order to influence policies, legislation, social programmes, and resource allocation.
Social mobilisation	Social mobilisation is a planned but decentralised process. It brings together a wide range of parties with a shared interest in order to raise awareness of issues through dialogue and create pressure in support of a development objective. At its best, it is an empowering process. Examples of social mobilisation are: the work of the Treatment Action Campaign, where participants are mobilised and empowered to take control of their own health; and community dialogues, where participants develop action plans that they will oversee and carry through. Community outreach can be a component of social mobilisation.
Social marketing	Social marketing is the non-profit application of commercial marketing concepts and techniques to influence the behaviour of a target group in order to benefit this group and/or society more broadly.
Interpersonal communication	Interpersonal communication is any interaction that includes the sharing of information, perceptions and feelings between individuals.

FINDINGS

DEMAND-CREATION THEORIES

Most national-level partners reported basing their demand-creation activities on some behavioural theory. However, the degree to which the theory is used in practice appears to differ. Partners who did not report using specific theories mentioned that they drew on their personal experience and discretion. None of the GPs interviewed based their demand-creation activities on any theory.

Interviews undertaken in phase two of the landscaping showed limited understanding of theoretical models among health district interviewees. None of these revealed an underlying theory behind demand-creation initiatives.

Table 7: Theories underpinning demand creation for VMMC Partners

Partner	Demand creation theory in place	Name of theory	Approach
Aurum	√		Mass media: community engagement through radio and TV programmes. Interpersonal engagement: community engagement officers oversee outreach workers who manage recruiters. This activity is supported by a call centre to convert interested men into clients with intent to undergo VMMC.
CareWorks	√	Stages of Change, a trans-theoretical model	Social mobilisation: a “sales force” approach that is peer-led and dedicated to VMMC. Media: use of CMT’s small media.
CCI	√	Social learning theory which involves social modelling	Campaigns: use of Brothers for Life, a national campaign aimed at men. Mass media: messaging to address barriers relayed by high-profile role models/spokespersons. Production of videos containing messaging designed to lead discussion during face-to-face engagement.
CHAPS	x	-	Mass media: leverage existing mass media campaigns. Public events: use of banners and branded merchandise at events. Community outreach: door-to-door relationship building with communities through social mobilisers.
CMT	√	Media strategy	Creates mass media campaigns paired with on-the-ground mobilisation. Mobilisers use IEC materials to link people with VMMC services.
JPS AFRICA	≈	Five-point strategy	Not a standardised theory but a strategy to engage all five senses: smell and taste (mini braais), touch (branded incentives such as soccer

Partner	Demand creation theory in place	Name of theory	Approach
			games), sight (banners), and sound (loud hailers).
RTC	√	Stages of Change, a trans-theoretical model	Media: use of Brothers for Life mass media products and small media. Social mobilisation: focus is on environmental factors, tailoring the approach by geographic area and associated demographics.
SACTWU	X	Fogg Model of Behaviour	Mass media: use of newspapers and radio in conjunction with direct response (please call me) numbers. Materials: posters and pamphlets. Interpersonal: door-to-door visits, word of mouth, public events and outreach focused on workplaces in the clothing and textile industry. Piloted use of USSD (a cell phone to computer technology) so that men can immediately schedule a confidential appointment from their phones. Social mobilisers use tablets to ensure information communicated to the call centre is not lost.
SFH	√	Model used by parent body, Population Services International: Opportunity, Ability and Motivation	Mass media: none Interpersonal communication and social mobilisation.
TB/HIV Care	X	-	Mass media: use of local media with content tailored for specific communities. Interpersonal communication: peer-to-peer mobilisation, IEC and social media.

For more information about these theories, see Appendix 2.

APPROACHES

To create demand for VMMC, partners use a combination of mass media, social mobilisation, and interpersonal communication. Mass media are used to build awareness and social mobilisation through person-to-person communication is used to “close the sale”.

Because demand creation is such a critical part of reaching VMMC targets, it is discussed by NGO partners in a funder-based consortium. This allows for better collaboration and sharing of expertise among partners as well as more efficient use of funds by avoiding duplication of work. In terms of CDC’s cooperative agreements, CMT and CareWorks are demand-creation partners for all service-delivery partners. All consortium partners share a demand-creation strategy and materials.

USAID-funded CCI, RTC and CHAPS utilise the CCI's Brothers for Life campaign. This provides consistent messaging and brand recognition for potential clients. Although GPs and partners leverage the mass media campaigns, most produce their own collateral in terms of posters, leaflets and banners or mobile sign-boards at public events. Materials and banners should extend the branding used in the mass media to maintain a lasting effect on prospective clients and must contain accurate information about VMMC. Although JPS Africa is not USAID-funded it also uses Brothers for Life materials, reasoning that there is no need to "recreate the wheel" when there is a cost-efficient option that promotes consistency in messaging.

CMT creates its own campaigns and tests the messaging and collateral used by its social mobilisers. CareWorks is responsible for social mobilisation only and does not create materials. It leverages materials from CMT as well as other partners, including those supported by other funders. For example, CareWorks social mobilisers use a Brothers for Life flipchart to review facts about VMMC.

Although there is overlap in the way partners approach demand creation, there is still value in the exchange of best practices among partners. A technical working group for VMMC demand creation is in place, but interviewees said little sharing of information on demand creation took place. One interviewee remarked:

"There should be a forum where partners can share lessons learned around VMMC. There is no sharing of strategies. This should not be voluntary but mandatory. Partners are cautious and don't want to share what they are doing."

The mass media approach is to display messages encouraging VMMC in areas where uncircumcised men congregate and broadcast them on the channels/stations men are most likely to watch and listen to. In terms of television, VMMC adverts run on SABC channels, as these are free-to-air and widely accessible. When it comes to radio, local radio stations are used to broadcast adverts or discussions and local languages are used to ensure comprehension of messages. Out-of-home advertising, using channels such as billboards, posters and taxi TV, is focused on high-traffic spaces like taxi ranks, taverns, and malls.

Messaging about VMMC across the board has been fact-based. In South Africa, there is now high awareness among men and women of the health benefits of VMMC, including its role in reducing the risk of HIV and other STIs. One demand-creation partner indicated there might be slight messaging fatigue with respect to the clinical benefits of VMMC among men. While understanding and awareness is high, this does not result in men undergoing circumcision.

There have been new approaches to messaging that include "aspirational" appeals which position VMMC as the choice of a "responsible man" who does the right thing for his family.

Women are also seen as key influencers on men who are considering VMMC. Romantic partners in particular can be a strong force for encouraging circumcision.

Women have been the focus of some tongue-in-cheek, playful messaging about sexual performance and their preference for a circumcised penis. Examples are the Aurum lollipop campaign and CCI's Zing television campaign. These are currently being evaluated for audience response and impact.

Districts rely on small media or materials, such as pamphlets and posters, for recruitment and instruction on post-procedure care. These are provided either by the DOH, the provincial health department or partners. Districts indicate that they have no dedicated budget for demand creation. Pamphlets and clinical forms for intake and follow-up are provided by the

province and meet province-specific requirements. DOH materials relate to campaigns, such as the airtime pilot (see Appendix 3), and are not distributed at clinic level. Many clinics photocopy pamphlets once they have run out of supplies and provide prospective clients with low-quality materials that are hard to read.

There appears to be a contradiction in clinic staffs' attitudes to radio advertising. While they would like the DOH to develop and run radio adverts supporting VMMC, they were critical of the VMMC radio content currently on air and felt that adverts they had heard were not aligned with their clinics' VMMC efforts.

Interviewees expressed a need for better communication with both the national and provincial health departments. They envisaged that this would help clinics understand what recruitment assistance is available as many clinics felt they had no support.

Social mobilisation

All partners and GPs agreed that social mobilisation is key for converting men's intention to undergo circumcision into the actions of making an appointment and utilising the circumcision service.

A partner interviewee suggested that mass media achieve a 1% direct conversion rate – for example, when a man reported that his wife saw the Zing TV advert, appealed to him to be circumcised, and he promptly went to have the procedure. Social mobilisation was said to yield a much higher result. A partner interviewee said that when clients were asked why that had decided to come in for VMMC, they were much more likely to select the answer "interaction with social mobiliser" than other options such as the influence of family and friends or an institution like the church.

Social mobiliser selection

Partners have different criteria for selecting social mobilisers. RTC asks for a minimum grade 12 education and preferably some health experience. In addition, being a "natural salesperson" is seen as an important attribute. CHAPS said it had seen some indications that less educated individuals make better mobilisers. All partners agree that salesmanship is an intrinsic skill that cannot be fully taught, but can be honed and improved.

Most partners use male and female mobilisers. The ability to promote or sell was valued above the gender of the mobiliser. There was no consensus as to whether male mobilisers should be required to be circumcised in order to build credibility. Where districts recruited their own mobilisers, some indicated a preference for older male mobilisers as some older men do not wish to speak to a young man or to a woman about VMMC. There was no mention of sales skills or minimum educational requirements, but a knowledge of the geographic area was considered critical.

In all three provinces, social mobilisation is undertaken by any staff who are available. Clinic nurses were mentioned as doing a substantial amount of outreach particularly in schools and at public gatherings. Ward-based outreach teams (WBOT), community caregivers (CCGs), community healthcare workers (CHWs), and local AIDS council (LAC) members are all utilised as mobilisers for VMMC. This activity is in addition to their existing duties, which typically include HIV/TB testing, family planning, and promoting condom use. While there are synergies with VMMC, VMMC is not considered the priority and adds to the existing workload. There is anecdotal evidence from a district in KwaZulu-Natal that a specialised VMMC mobiliser is

much more effective in recruiting men for circumcision than a CCG operating in the same district.

Social mobiliser training

Social mobilisers require consistent training in order to present accurate VMMC messages and be effective in persuading men to get circumcised. Proper training helps mobilisers understand the barriers men face and how to address these so that prospective clients are more likely to commit to getting circumcised.

Findings of the landscaping exercise are that training is inconsistent among partners and districts. Most managers of VMMC partners have not been trained in demand creation. Mobilisers are trained by the partners but the content and extent of the training differs.

GPs were not formally trained in demand creation but mentioned that their mobilisers had undergone training. These mobilisers were either trained by the GPs themselves or by the contracted VMMC partners.

Table 8 sets out some information about the social mobiliser training for those partners who described this in detail. Other partners offer shorter training or induction.

Table 8: Partner training programmes

Partner	Formal programme?	Curriculum	Length	Strengths	Weaknesses
CHAPS	Yes	- Clinical knowledge - Selling skills - Storytelling - Field day	Five days	Applied learning in additional to theoretical knowledge	M&E not included
CareWorks	Yes	- Clinical benefits of VMMC - Sales techniques	Three days	Focused on marketing and closing the sale	
SACTWU	No	- Why circumcise - Circumcision process - Consent - Mobilising tactics	Not disclosed	Provides educational background on VMMC	Not a formalised program for all SACTWU mobilisers

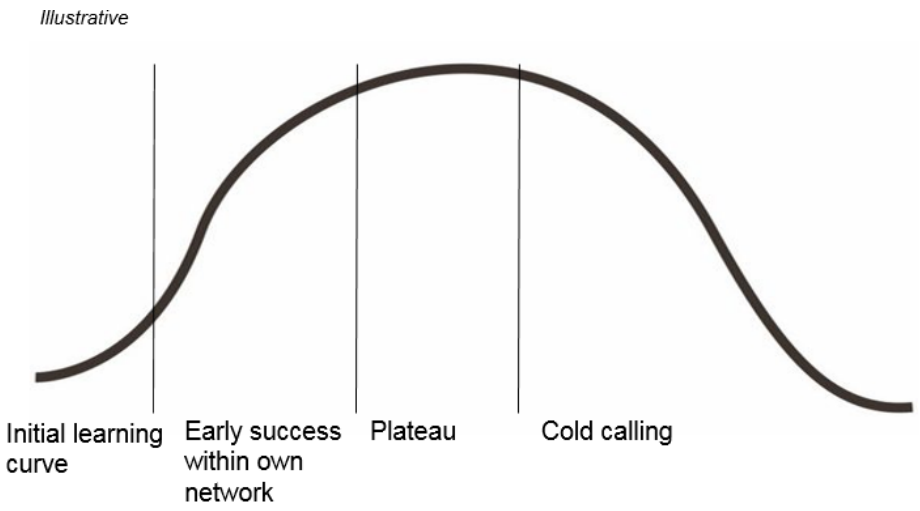
Partners modify their training programmes according to issues that mobilisers encounter in the field. Partners provide supplementary training workshops monthly or bi-monthly. These serve as a forum for mobilisers to discuss successes and challenges and develop new techniques. For example, Aurum trains on a continuous basis and does so primarily through team building.

Social mobiliser incentives

Both CHAPS and RTC initially hired full-time mobilisers, but are moving away from this model in favour of hiring mobilisers on a contract basis. This is a response to CHAPS' observation that effectiveness in recruiting drops the longer the mobiliser has been in employment.

Figure 5 illustrates the CHAPS experience that a mobiliser's ability to recruit is often finite. At first he or she experiences challenges in converting individuals. As the mobiliser adjusts to the job, conversion rates improve. Early success is found within the mobiliser's own network where individuals trust him or her. The mobiliser then reaches plateau where s/he is running out of people known personally and conversions no longer increase. S/he then begins cold calling individuals with whom there is no previous relationship and converting these individuals is more difficult. At this point, the mobiliser may no longer be effective.

Figure 5: VMMC mobiliser success curve



Presently CHAPS and RTC mobilisers are provided a fixed salary plus bonuses for additional recruits. Mobilisers have a monthly target that they must meet. Mobilisers can often earn a reasonable income, particularly when compared to other workers with a similar level of education. If monthly targets are missed consecutively the mobiliser is likely to receive coaching, rather than a reprimand. However, the partner has the right of dismissal if a mobiliser underperforms consistently.

The short-term social mobilisation (STSM) programme presented by CHAPS may help mitigate the risk of diminishing conversion. This programme would see mobilisers hired on short, fixed contracts to maximise the recruiter's potential for early success and the contract would conclude around the time the mobiliser has reached his or her plateau.

Few partners disclosed their demand-creation budgets. However, Aurum stated that 10 - 16% of its VMMC budget was allocated to demand creation and this may be indicative of the practice in other organisations. In addition to salaries the demand-creation budget must usually provide for mobilisers' on-the-job transport, meals and airtime.

At the district level the lack of consistency in recruiting, training, and incentivising mobilisers is a crucial issue. In Gauteng and Mpumalanga, there is no specific provincial budget for VMMC demand creation. Gauteng has an ACSM unit but it appears this unit provides very limited support to the VMMC programme as it has to contribute to many other health programmes. There is also no understanding of how the ACSM demand-creation budget is allocated.

Mpumalanga also has an ACSM unit. It occupies the same office space as the VMMC team, which creates a good working relationship between the two. The VMMC team makes ad hoc

requests to the ACSM team for support, especially for printing of collateral. There are provincial social mobilisers working in a few sub-districts who have been trained by RTC. It is unclear how these sub-districts were selected.

In KwaZulu-Natal, there is a conditional grant which outlines what can and cannot be purchased for demand creation. However, this budget appears to be quickly depleted as it is used for printed materials as well as salaries of mobilisers. Mobilisers are hired on one-year renewable contracts. There is no indication of performance-based incentives for mobilisers, nor of formal training.

South Africa has some strong, promising practices in the area of VMMC demand creation. Certain partners have developed robust training for social mobilisers, and are re-thinking their approaches to reaching and converting prospective clients in the older target group who are more difficult to engage.

Promising practices

CCI and Right to Care: social media

- Take a retail sales approach to VMMC, treating circumcision like any product or service you would buy.
- Have piloted "special offers" in target urban regions via Facebook. For example, offers might include free transport or skipping the service queue.
- Special offers last for a finite time. They are designed to spur create a sense of urgency among those considering VMMC as well as offering added convenience.
- Results of this approach were pending at the time of writing this report.
- The approach aims to segment the target market to overcome barriers to VMMC among prospective clients.
- Residents of large cities can be harder to reach through social mobilisation because there may be an absence of clearly defined communities. Social media have better penetration in cities and could offer an alternative to face-to-face engagement.

CareWorks: social mobilisation

- Dedicated VMMC social mobilisers constitute a "sales force".
- Careworks recruits mobilisers who have a background in sales and/or marketing. They do not require a background in HIV work.
- New mobilisers undergo a three-day training programme.
- Mobilisers operate where men gather – for example, at taxi ranks and taverns.
- Often they do not approach the group immediately but watch and determine who the alpha male in the group is. Then they approach the group and try and get the alpha male on board.
- They use tailored messages, for example, for different age groups.
- The approach is data driven.

Aurum Institute: electronic tracking

- Aurum has developed an electronic system to track lead generation.
- Other partners still use paper-based systems that result in loss of leads and make follow-up more difficult.

CHAPS: quality training

- RTC and GPs send their mobilisers to be trained by CHAPS whose training may be considered a gold standard it includes theoretical and applied learning.
- CHAPS is finalising a research paper on the characteristics and skills required to be a successful VMMC mobiliser.

Promising practices from sub-Saharan Africa

JHPIEGO Tanzania: GIS mapping[12]

- An estimated 20% of the total VMMC budget is allocated to demand creation.
- JHPIEGO utilises an experiential media agency to help engage audiences in high traffic areas by performing skits and conducting quiz shows.
- It has pioneered a GIS mapping project in order to represent variation in VMMC uptake among regions and decide where to focus outreach and campaign activities. This uses Quantum GIS which is open source and therefore free to use.

Game changer in South Africa

Right to Care: GIS mapping and data visualisation

- The organisation is piloting a GIS mapping and data visualisation system using patient data captured through RightMax.
- This plots on a map aggregate patient data for questions such as “How did you hear about VMMC?”, “What made you decide to come in VMMC today?”, and “Who influenced your decision to get circumcised?”
- It helps the mobilisation team understand the aspects of VMMC they should focus on in particular areas and the best people to use in various locations to nudge prospective clients toward commitment.

[12] Promising Practice Tanzania: JHPIEGO Tanzania, Community Mobilisation for “Older Men” and use of SMS and GIS technology

Game changer in South Africa

SACTWU Worker Health Programme (SWHP)

- SACTWU has introduced USSD for mobile booking, with instructions available in English, isiZulu, Sesotho and Afrikaans.
- This has been piloted in nine districts in KwaZulu-Natal, the Free State and the Western Cape.
- SWHP achieved a total of 41 000 USSD sessions in two months.
- It also recorded a 30% increase in circumcisions during November 2016 compared to November 2015 .
- The project is focused on people power, the realisation that “I can easily, privately control my appointment”.
- Mobilisers, using tablets to capture details of men with intent, connect directly to a call centre for folllow-up, eliminating the need for transfer information from paper and possible loss of leads.

TARGET AUDIENCE

Partners were asked how they targeted men for VMMC demand creation. Some of the factors mentioned were: the number of men in the area, the size of the catchment area, HIV prevalence, risky sexual behaviour, and the number of partners working in an area.

According to informants in various health districts in Gauteng, Mpumalanga and KwaZulu-Natal, the highest uptake of VMMC services has been among adolescents aged 10 - 14 years. Several factors make this age group more receptive to VMMC than older age groups. Circumcision is viewed as a symbol of manhood. Parents are involved in making health decisions for their children. It is possible to reach large groups of adolescents via schools and peer influence often helps convert interest into action.

GPs did not appear to have a good understanding of the age pivot. They indicated that their contracting partners had communicated the VMMC target group as men aged 15 - 49 years. Despite this, interviewees reported targeting all males and in some instances performing circumcision on infants. They said that men outside of the age range of 15 - 49 years were not actively recruited but were not denied the service if they were interested.

Although all interviewees mentioned that they took the age pivot into account when targeting, there did not seem to be a clear understanding of what the age pivot was. Partners mentioned “15 - 29 years”, 20 - 34 years”, “25 - 35 years” and “15 - 49 years”.

At the district level, there is a similar lack of consensus on a target age group. Some clinics reported they had received a directive to circumcise adolescents because they are not yet sexually active. It is almost universally agreed that younger boys are easier to convert, though at times there is difficulty getting parental consent for the procedure. At the clinic level, there was not an explicit mention of the age pivot. However, interviewees stated that they faced difficulties in recruiting older men, indicating an awareness that they should be doing so.

MESSAGES

Several messaging themes have been tested and used in South Africa both in mass media campaigns and during social mobilisation. It is important to note that, in a world of multimedia communication, messages may be conveyed by the written and spoken word as well as by images and non-verbal sounds. Some of the key message themes are:

- **Fact-based**. These emphasise the benefits of medical circumcision in terms of reducing the risk of HIV and other STIs, and general hygiene. This type of messaging prepared the ground for open discussion about VMMC without embarrassment or shame. The use of facts about the health benefits of VMMC remains an important aspect of messaging. However, facts alone will not persuade the later majority and laggard population and others who experience particular barriers to circumcision.

- **Free and safe**. Many partners focus on VMMC being a free and safe procedure. This messaging helps to address the possible barrier of cost. It also counteracts the perception that circumcision is unsafe which may arise from some traditional circumcision practices which have resulted in serious infection and even loss of life. Safety is a message likely to appeal to those of traditional mindset as well as those who are unclear about what the procedure involves.

- **Reframing masculinity**. Many materials feature images that reflect the target market. Men are often presented in groups, and this serves both to normalise VMMC and to encourage individuals to envisage themselves as belonging to a group of responsible men. Context is also used to frame the models – for example, a soccer stadium or workplace – which may assist audiences to identify with the messages. Both celebrities and everyday role models are used to provide testimonials and support for VMMC. Celebrity testimonials may be effective in encouraging the younger half of the target age group as conformity may still play a part in their decision making. For older men, a focus on being a positive role model for future generations may be more effective.

- **Engaging women**. Aurum ran the slightly provocative “lollipop” campaign which proposed that women preferred circumcised men. The message was that men would be more desirable to women if they were circumcised. It is important to note that this campaign was implemented only in an environment where VMMC could be discussed openly. Brothers for Life, created by CCI, launched the “Zing” TV advertising campaign in 2015. This features a group of women in a beauty salon chatting about their man getting an “upgrade”. The advert outlines health benefits of VMMC for women, highlights the six-week healing period, promotes the use of condoms, and expresses women’s preference for a circumcised penis. The advert prompted women to discuss circumcision among themselves and to encourage their partners to get the upgrade.

- **Aspirational appeal and challenge**. Beyond facts about health benefits, campaigns have aimed to engage men’s notions of being a responsible man, doing the right thing, and thinking about the future. By calling VMMC the “upgrade” or suggesting that the next generation can be HIV-free, these messages appeal to a sense of duty and pride within members of the target group. Other messaging challenges individuals and

addresses the barrier of fear indirectly by asking men if they are "tough enough" for VMMC[13].

In practice, those mobilising at the district level primarily use fact-based messaging. Aspects such as safety are used to address questions about VMMC versus traditional circumcision. Few district or clinic-based mobilisers have shifted towards aspirational or challenge-based messaging. Some districts have engaged women as mobilisers, however others have avoided doing so, stating that men want to hear about VMMC from other men. There is little mention among health district staff of bringing female partners into the discussion to help influence men to undergo VMMC.

ADDRESSING BARRIERS

Identifying barriers and addressing them effectively are critical elements of interventions designed to convert VMMC interest into VMMC uptake. While prospective clients may understand the benefits of circumcision, their concerns may prevent them taking action to get circumcised. In national and district interviews, three main obstacles were mentioned: concern about having to abstain from sex for six weeks; fear of pain related to the procedure; and fear of getting tested for HIV.

Mobilisers countered the concern about post-operative sexual abstention by explaining its necessity – that is, to reduce the risk of complications. But partners flagged abstention as a particularly difficult barrier to overcome. An interviewee explained: *"Abstinence is playing a negative role, because when you mention the six-week period it's like six years for men."*

Interviewees reported addressing fear of pain by sharing with men facts about the level of pain they were likely to experience. However, a small number of materials incorrectly said that the procedure was "pain free". CCI has produced videos in which men who have been circumcised discuss the pain they experienced, and describe how they dealt with it. These materials have not yet been formally evaluated.

There appears to be a perception among men that HIV testing is mandatory during VMMC and that if men test HIV-positive their status will be reported. Partners indicated they addressed this barrier by explaining to men considering VMMC the benefits of knowing one's HIV status. However, nobody who was interviewed said that they addressed the fundamental misconception – that HIV testing is mandatory during VMMC – by telling prospective clients that it is *not* mandatory to undergo testing. CCI and RTC are planning a focused communication campaign to highlight the fact that HIV testing is optional when undergoing VMMC.

Interviewees at district level said that the traditional belief that wound healing is faster in the winter is still pervasive. Numbers remain low in the summer months when both government and partner clinics struggle to meet their monthly targets. Some have tried to use the shorter waiting times during the summer months as a way to encourage prospective clients with time constraints but there is, as yet, little evidence of the success of this approach.

[13] Wilson *et al*. Advertising for Demand Creation for Voluntary Medial Male Circumcision. J Acquir Defic Syndr 2016;72:S293-S296

Table 9 summarises a range of barriers identified and ways in which the partners have tried to address these. It is important to note that not all partners identified the same barriers and that ways of addressing barriers varied.

Table 9: Barriers among men considering VMMC and ways partners address these

Barrier	Ways in which partners address barrier
Post-procedure sexual abstinence	Explain benefits of abstaining: lower risk of complications.
Fear of pain	Explain facts about level and type of pain to be expected.
Anxiety about HIV testing	Explain benefits of knowing one's status, for example, accessing treatment if needed.
Perception of poor service delivery	Ensure provision of quality services.
Seasonal demand for VMMC	Point out that that people have operations throughout the year and they heal well.
Cultural and religious beliefs	Explain that while some things were true in the past modern medicine has changed many things.

In the literature additional barriers for older men have been identified[14] and these include: getting time off work for VMMC and loss of wages, concerns about disposal of the foreskin (for example, suspicion about it being sold), anxiety about the response of family, friends, colleagues and others, perceptions that health facilities are for women, lack of partner support, low risk perception, inconvenient service hours and female service providers.

The fact that interviewees did not mention these is not necessarily an indication that these barriers do not exist in South Africa. However, they may be less common or staff may not feel able to address these barriers.

National interviewees have found that the best way to address the barriers that prevent men from moving from intention to uptake of circumcision services was to speak to them directly. An interviewee at a partner organisation said:

"We find that direct contact with clients is the most effective. Speaking to people you can find the barriers and address those barriers. With VMMC it is a big ask, as it is for prevention, but addressing the barriers gets us there. It takes time."

A barrier particularly related to the age pivot is that older men are uncomfortable waiting in the same room as younger boys and women. Aurum has successfully introduced a separate waiting area for older men (see box) and others have tried to allow older men to skip the queue, which has the added benefit of cutting down on waiting time. Some clinics offer late hours and weekend services to accommodate working men.

Promising practice

Aurum's exclusive older men's clubs

The Aurum Institute
To Seek, To Find, To Share, To Care

[14] Compiled from interviews and from Health Communication Capacity Collaborative. (2016). Technical Considerations for Demand Generation for Voluntary Medical Male Circumcision in the Context of the Age Pivot

- Older men (over 25 years) feel embarrassed to access the service in the presence of younger men and boys who are often accompanied by their mothers.
- Aurum divided the Winnie Mandela Clinic into sections for minors and older men respectively in an attempt to meet the differing needs of the two age groups.

In addition, Aurum has introduced the non-surgical PrePex method for workers and students because this facilitates a quicker return to work and school.

Taking time off work and consequent loss of wages constitute a barrier for older men. This is also an issue for employers and a reason for resistance to VMMC mobilisation or mobile clinics at some workplaces in male-dominated industries like mines and factories. A pilot programme in Kenya attempted to address the issue of loss of wages and its initial findings gave rise to a similar project in South Africa.

Promising practice

Kenya: economic compensation and male circumcision demand[15]

For older men, a critical barrier to VMMC can be loss of wages due to taking time off work for the procedure. This is particularly likely to affect married men who are often conscious of their role as the breadwinner of the family. A randomised controlled trial conducted in Kenya divided its male participants into four groups who were offered different amounts of compensation if they underwent circumcision. They would receive compensation only after the procedure.

One group received $8.75 US in food vouchers (equivalent to one or two days' wages and costs of transportation). The second received $15.00 US in vouchers (equivalent to three or four days' wages and costs of transportation). The third group received only enough to cover the costs of transport while the fourth got no compensation.

Within two months, VMMC uptake in the two groups receiving wage-related compensation was 6.6% and 9.0% respectively, substantially higher than the uptake of 1.9% and 1.6% in the groups receiving only transport costs and no compensation respectively.

Many of those who declined to be circumcised said they were worried about factors such as pain that could not be addressed by economic compensation. Others felt that the compensation level was too low. It is important to note that economic compensation was not viewed as coercion, but as a nudge for those already considering VMMC.

Game changer in South Africa

Orange Farm method for VMMC demand creation among adults[16]

In a random sample of 981 Orange Farm households, 512 men aged 18 - 49 years were identified. Of these, 226 men were uncircumcised and 212 agreed to enroll in the study.

A personal adviser on male circumcision, trained in interpersonal communication skills, was assigned to each participant. The advisers were trained to explain the risks and benefits of VMMC and to discuss 24 possible reasons given by men for not being circumcised. Each participant had a maximum of three motivational interviews at home over the course of nine weeks.

Participants who decided to get circumcised within the nine-week intervention period received financial compensation for their time. This was equivalent to 2.5 days of work at the minimum South African salary rate.

[15] Evens *et al.* Use of economic compensation to increase demand for voluntary medical male circumcision in Kenya: Qualitative Interview With Male Participants in a Randomized Controlled Trial and Their Partners. J Acquir Immune Defic Syndr 2016;72:S316-S320.

[16] Auvert, B. *et al.* Obtaining a male circumcision uptake of 80% among adults in a short time: a prospective intervention study among a random sample of men living in Orange Farm township of South Africa. 2016

Eventually, 129 of the men who joined the study were circumcised. This represented a 69.8% conversion rate. The prevalence of male circumcision among study households sampled was 56.9% at the start of the intervention and rose to 81.4% as a result of the circumcisions performed during the study. Reported reasons for accepting circumcision were motivational interviews with the adviser (mentioned by 83.0% of those circumcised) and compensation for time (40.0%).

High VMMC uptake can be obtained in a short time among adult men but it requires an intense intervention centred on engaging uncircumcised men at an individual level and providing monetary compensation for time invested.

Marketing VMMC in South Africa: main findings from the McCann Report

McCann Health was contracted by PEPFAR South Africa to develop a marketing strategy and approach to promote VMMC in South Africa. McCann in turn contracted Bateleur Brand Planning to conduct quantitative and qualitative background research to inform this strategy.

This research was conducted in late 2014 and early 2015. The quantitative component comprised of 2 000 interviews in nine provinces, and included males (n = 1 202), female partners (n = 400), guardians (n = 199), medical providers (n = 99), and opinion leaders (n = 100). The key results are summarised below.

- The benefits of VMMC were fairly widely understood, with over 50% of respondents mentioning better hygiene, better overall health and HIV prevention as benefits of VMMC.
- Achieving manhood or maturity, and enjoying pride and self-respect were also important perceived benefits. Improved sexual pleasure, increased respect and respect for one's culture formed a second tier of benefits. Men who are circumcised were perceived to be responsible, reliable and trustworthy, as well as clean and healthy.
- Almost half (46%) of uncircumcised men intended to get circumcised in the next year, and over 80% of these men planned to get a medical circumcision.
- The most important reasons why these men had not yet been circumcised were fear of pain (over half), followed by fear of infection, long healing process, fear of bleeding, and fear of injections (all just over a third of men).
- Almost half the men who did not intend to get circumcised said that it was because their culture did not support VMMC, while 20% mentioned pain as the reason.
- The preference for winter circumcisions seems to be due mainly to the perception that wounds heal faster in winter (over 50%), although some respondents mentioned cultural preferences and school holidays.
- Although perceptions of health services were generally positive, knowledge of the availability of VMMC services was limited. In more rural communities there were concerns about the availability and quality of health services.
- Most men (about 70%) were uncertain about getting time off work for VMMC or thought it unlikely. This is despite the fact that employers generally gave their employees time off to attend health services, and encouraged workers to get tested for HIV.

Lessons of this research, in terms of demand-creation activities, are:

- Mass media interventions should continue to emphasise the benefits of VMMC and position it in an aspirational way for men.
- Mass media products should also emphasise the availability of services.
- In areas where traditional circumcision is more common or in more traditional areas, communication needs to be sensitive to cultural practices, but still encourage VMMC as an acceptable, modern way to improve health, especially among younger men.
- Community mobilisers need to be trained on messages concerning barriers, and to

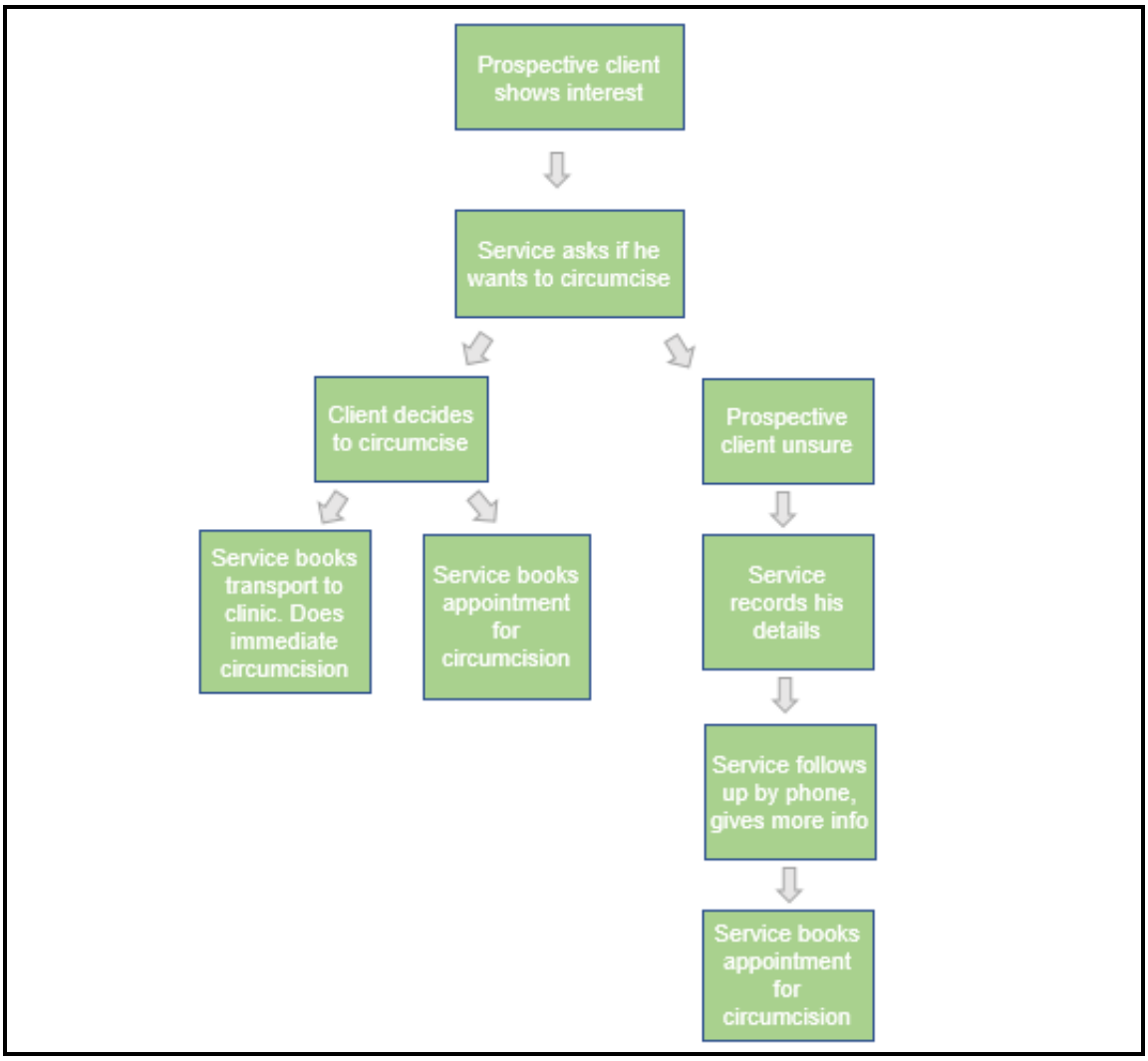
probe for barriers that may prevent men from seeking circumcision. Ways to address these barriers should be explored in an honest but reassuring way.

- Workplace demand-creation programmes are important and employers need to be encouraged to give men time off work to be circumcised.

MOVING MEN FROM INTENTION TO ACTION

Partners were asked what they did when they identified someone who wanted to be circumcised. Processes seemed to differ among partners but most followed the steps shown in Figure 6.

Figure 6: Converting intention to circumcision



The use of a booking system and follow-ups was seen as important, although not without its challenges. For example, one interviewee said:

"I personally don't think it is something you can say to someone 'would you like to get circumcised?' and they agree to get circumcised on that day. I think it takes time to make

decision. There is a need for men to be booked into a system so I think this is a good option. I do think this is a good system but every system has its challenges and the challenges are around getting adequate information."

Another interviewee observed that the messaging they use with men who intend to circumcise does not appear to be working:

"We are losing a lot of men because once again in the messaging there is something missing. We often call and men make excuses and then they end up opting out."

Several respondents said they referred potential clients to CareWorks or indicated that the CareWorks system seemed to be working well. CareWorks confirmed that it converts about 35% of those who display an interest.

There seemed to be limited sharing of information about successful techniques. For example, an interviewee indicated that CareWorks had a good approach but was unable to articulate what that approach entailed:

"I heard CareWorks has a very structured period of contact with different messages at each stage. Ours is quite haphazard."

Call centres

RTC, CareWorks and Aurum have their own call centres which provide additional information about VMMC with the aim of conversion. Call centrees are structured in various ways (Table 10).

Table 10: Comparison of partner call centres and their functions

	Right to Care	CareWorks BRIDGE	Aurum
Lead intake	• Call centre is responsive to "please call me" number listed on VMMC media.	• Mobiliser records details of individuals with intent to circumcise on intake form. Some men will only have indicated interest while others will have completed the booking section of the form. • Intake form is scanned manually by the mobiliser. It is sent to head office and entered into the document management system.	• Leads are entered into recruiter's tablet. • Contact information is provided to the call centre.
Booking	• Men who call this number want, at least, to learn more about VMMC. They may not have encountered a social mobiliser in their community. • Call centre provides information and sends individual's contact details (including address) to the central booking agent. • Booking agent determines which clinic to refer to and provides support through to post-operative period.	• If individual is not yet ready to book, call centre agent supplies more information.	• Call centre then books client for circumcision on a day selected by the client. • Call centre will confidentially confirm if client has been tested for HIV and his status. If client is HIV-positive, he is asked to bring CD4 count on day of appointment. • Process enhances confidentiality because client will not have to disclose HIV status in front of anyone at the facility.
Follow-up approach	• Required to respond to SMS within two hours.	• Call centre relies on social mobilisers to lay the ground work so that call centre is responsible more for "post-booking support" than primary demand creation.	• Clients is reminded of his appointment either by phone call or SMS.

Call centre personnel and mobiliser characteristics		• Call centre agents are multilingual. • Building on learning from HIV testing model, agents are proactive and schedule appointments for individuals with intent to circumcise. • Mobiliser is responsible for pitching the "sale" and call centre is responsible for "closing" the deal. • Call centre agents are trained but little detail was given. They are provided with a basic call script.	
Volume	• RTC reports 50 calls a day at peak and estimates 55% - 60% conversion rate.		
Other	• The call centre originated as post-operative call service and is staffed 24 hours a day with trained nurses. • Since February 2016 it has been used as a demand-creation tool. • Social mobilisers *do not refer* anyone to the call centre. RTC believes that one-to-one relationships will result in higher conversion rates and mobilisers must maintain a relationship throughout the decision process.		

Government clinics also try to follow up with those who have made appointments or show interest in circumcision. However, their systems are not as integrated or robust as those described in the table. Clinics mentioned faulty landlines as an issue and a lack of funding to use cell phones to call prospective clients.

Follow-through

Once clients have made their appointments, possible logistical barriers come into play. Most partners have private, branded transportation available. However, this is not the case at government facilities. Feedback at clinic level suggests that some men do not like entering a branded vehicle as this makes it known they are going for VMMC. A few clinics indicated that transport sometimes returns at a very late hour, causing concern for parents of younger boys. Lack of transportation is often a sore point for clinics, particularly in rural areas. If clients cannot reach the clinics they will forego the procedure.

MONITORING AND EVALUATION

Monitoring

Partners explained that CDC and USAID set their VMMC targets and require that they report performance against these targets at prescribed intervals. Although all partners could tell us what their VMMC targets were, they were not able to articulate how many men they would need to reach with demand-creation activities in order to attain their service delivery targets. Demand-creation partners reported reaching targets but they did not seem to have conversion targets in place. For example, one partner said:

"We are a demand-creation partner thus we do not have a VMMC target. We develop a target for the number of people we want to reach with demand-creation services in our workplan."

GPs did not appear to have specific targets. Those interviewed indicated that they reported their numbers to partners that had contracted them, such as CHAPS and DOH. One of the GPs reported setting his own target of 10 men per day or 200 men per month.

All partners reported having M&E systems in place but the quality and usefulness of the data gathered seemed to differ. One service-delivery partner indicated its demand-creation programmes were "haphazard". As it did not always have budget for demand creation, the organisation did not really monitor or evaluate these activities. Some challenges mentioned in relation to M&E of demand-creation activities were:

- Numbers getting lost during the transfer of data from paper to electronic records.
- The absence of an established M&E unit.
- A lack of indicators in the District Health Information System (DHIS) to capture demand-creation activities.

The issue of conversion rates came up several times. Partners indicated that they reported on the number of men reached through demand-creation activities as well as referrals but expressed concern that these numbers *"don't reflect the number of men that actually went on to get cut".* This gap in feedback prevents partners understanding how many men they need to target with demand-creation messaging in order to meet their VMMC targets.

A system which appears to work well is the allocation of unique codes to different campaigns and media interventions. Prospective clients using the "please call me" facility send a unique number to the CareWorks call centre and this enables the organisation to determine which media interventions are having an impact. An interviewee explained:

"Each campaign is assigned a unique code so we are able to see if it is successful. For example, if CMT is running a public service announcement (PSA) there will a specific 'please call me', so CareWorks is able to determine whether this PSA is effective or not."

Promising practice

Monitoring of social mobilisation

- CareWorks assign each of their social mobilisers a unique code.
- This allows CareWorks to calculate a lead and conversion rate per mobiliser.
- Each mobiliser has specified targets according to where he or she is mobilising. It is easier to mobilise in urban areas so targets in rural areas are lower than in urban areas.
- This monitoring system is used for performance management of mobilisers.

Some partners reported achieving their targets while others indicated that they had not. A common theme which emerged was service-delivery partners blaming demand-creation partners for failing to create sufficient demand for their services and causing them to fall short of their targets. For example, a partner interviewee said:

"[Name of partner] was totally dependent on the mobilising partner. We would just sit and wait for them to go and mobilise and give us the (VMMC) camps and number of expected clients only to find that when we go to those camps the turnout is bad. This was making us not to make the target."

Evaluation

Formative evaluation

In terms of formative evaluation, a partner interviewee mentioned having undertaken a survey to inform the organisation's demand-creation activities. This survey found that eligible men were not easily accessible in communities as they were at work during the day. This led to a decision to expand their demand-creation activities to workplaces and other venues where men could be accessed.

Impact evaluation

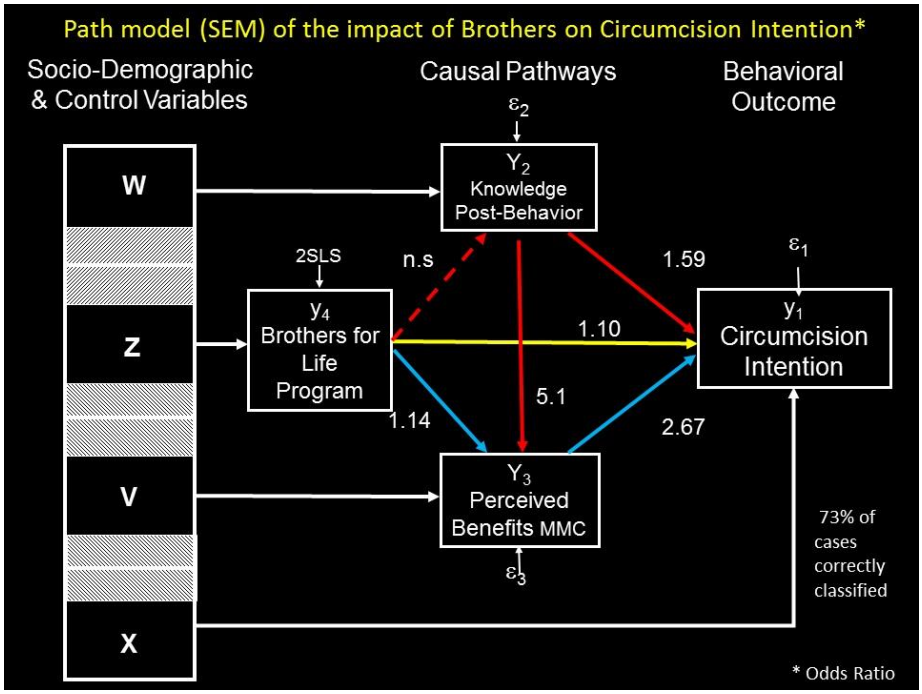
Only three of the partners interviewed said that their demand-creation activities had been formally evaluated. In one of these instances, the interviewee was referring to continuous quality improvement as opposed to an impact evaluation. Another partner mentioned having undertaken an assessment to ascertain what forms of mobilisation work, but did not share this report.

CCI has undertaken various evaluations of the impact of Brothers for Life on VMMC. A survey undertaken by Ipsos for CCI found a positive correlation between exposure to the campaign

and having undergone VMMC in the past three years. However, no analysis that controlled for the influence of other factors was undertaken[17].

A separate impact evaluation that used rigorous evaluation techniques found that exposure to Brothers for Life had both a direct and indirect impact on intention to circumcise. Figure 7 shows that, controlling for other factors, those exposed to the campaign were 1.14 times more likely to perceive the benefits of VMMC. In turn, those who perceived the benefits were 2.67 times more intent on getting circumcised. Those exposed to Brothers for Life were also 1.1 times more likely to intend to undergo circumcision.

Figure 7: Impact of Brothers for Life on intention to circumcise



Promising practice

CCI's impact evaluations

CCI conducts rigorous evaluations of its communications campaigns.

In 2015 they contracted Ipsos to evaluate the impact of the Zazi and Brothers for Life campaigns on a range of ideational and behavioural outcomes. These included outcomes related to VMMC.

By using an existing national representative survey, they could measure the changes that occurred in response to their campaigns. They have demonstrated a dramatic increase in public knowledge of the benefits of VMMC, as well as in intention to undergo VMMC.

One partner suggested a standard evaluation approach for all partners would be helpful:

[17] Ipsos Public Affairs. The Impact of Communication Programmes on the uptake of Medical Male Circumcision and Dual Protection: Brothers for Life and Zazi Khayabus W2 2015.

"*Partners would benefit if there's a structured assessment that CDC or consultants could produce with key parameters for quality, efficacy, efficiency in messaging, so that there is a standard.*"

Clinics and districts report their circumcision numbers on a weekly basis to the district and province respectively. Some districts hold a weekly meeting with all clinics in their catchment area for status updates and discuss strategies to improve communication interventions and services. This type of initiative is highly dependent on the motivation of the district staff, but could be implemented across the board with the right leadership. However, there was no formal evaluation of demand-creation activities. Respondents sometimes alluded to an evaluation of a partner's activities, but not their own.

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Theories

Not all partners have a theory underpinning their demand-creation activities and it is not clear how well theories are applied by those partners who do have a theoretical framework. Approaches that are based in theory – and the associated social science – are more likely to be effective in achieving the required behaviour change among prospective clients.

Most partner interviewees indicated that they had not been trained in demand-creation activities and had developed and implemented their approaches based on their field experience. This experience was also the foundation of the training that they provided to their social mobilisers.

Approaches

Aside from a few mass media campaigns, the main communication activities seem to be the development and use of small media, mainly aimed at providing information, and social mobilisation. The latter is reported to be the most effective approach to persuading men to get circumcised. Social mobilisers are therefore critical to the success of VMMC programmes but there is considerable variation among partners in the training of mobilisers, the approaches they use, and materials they have at their disposal.

There is a general sense that mass media campaigns have increased public knowledge of the benefits of VMMC and what the procedure involves. However, the present status and scale of mass media campaigns to support VMMC is unclear.

The overall opinion of partners, including demand-creation partners, is that there needs to be a concerted effort to address and overcome the barriers to VMMC, which are both ideational and practical in nature.

Target audience

There is inconsistency among partners in the conduct and use of formative research to guide the selection of target population. Some awareness of the McCann report exists (see page 27 for a summary) together with an understanding of the report's findings of the ideation related to VMMC. But it is unclear how partners have acted to incorporate this into their work. The bottom line is that an understanding of the target population is crucial in order to address barriers to and motivators for VMMC effectively and achieve higher uptake.

All partners mentioned the age pivot but there was no consistency in actual age groups targeted by partners and GPs in their day-to-day work. Most districts know they should be trying to target men aged 20 - 34 years but they struggle with how to engage this group effectively. Universal clarity about who to target and how to do so is critical for meeting targets.

Messaging

The creative execution of materials differs among organisations but overall there is limited innovation. While cosmetic changes are made through new artwork and campaign themes, the content has not been refreshed to retell the VMMC story in a way that may reach the target

population more effectively. Materials produced by partners are generally of a high quality and factually accurate. But some of the materials do not seem to be pitched at the target audience recommended by DOH (20 - 34 years) and instead are appealing to younger boys. Ensuring truthful information from all providers of VMMC is crucial to ensure there is an accurate and positive perception of VMMC.

Barriers

There are several barriers to VMMC which must be addressed with deeper sensitivity, honesty and conviction, particularly if the programme is to succeed in attracting older men. Presently partners appear to address these in different ways and it is unclear whether mobilisers receive standardised training on how to counteract each barrier. When mobilisers are ill-equipped to respond in a manner that resonates with men in their 20s and early 30s, it is probable that prospective clients will be lost.

In addition, seasonality remains a key barrier to consistent uptake of VMMC over the course of the year, affecting both efficiencies and targets. Yet, there is not currently a proactive effort to overcome seasonal fluctuations in demand.

Intent

There is a concerted effort to track and follow-up with men who show interest in VMMC, however the success rate varies in accordance with the resources available for follow-up. Both human resources and facilities such as phones and transport play a critical role in this regard. Call centres are a useful way to generate leads, but the quality of the staff who “close the deal” remains critical. The ability of these staff members to provide accurate information in a relevant manner and to relate supportively to prospective clients ensures that bookings are made and appointments for VMMC are kept.

M&E

Staff members at partner organisations do not always understand how overarching VMMC targets are set and how their individual targets contribute to a bigger vision. Improved transparency on the establishment of high-level targets would help field staff understand the importance of meeting their targets. This should be coupled with better support to partners on ways to reach these targets.

Monitoring of demand creation is taking place but it is a challenge. As a result, it is unclear how effective demand creation is. There are no fit-for-purpose indicators of demand-creation performance (for example, conversion targets) for use in routine programme evaluation. There have been limited formative or impact evaluations related to demand creation.

There is no clear mechanism for coordination among partners and sharing of demand-creation approaches in order to understand what practices are successful and how they can be scaled up to help South Africa achieve its VMMC targets. Partners continue to work in silos and this limits the overall success of the VMMC programme.

RECOMMENDATIONS

The following recommendations focus mainly on enabling partners and DOH clinics to provide VMMC more effectively to the target age group. The recommendations may benefit GPs and the traditional sector but are less directly applicable to them. The support requirements of GPs and traditional practitioners are important and should be explored further.

Enhancing government ownership of the VMMC programme

There was a perception among partners and some government officials that the VMMC programme is primarily driven by outside funders, and that the programme would benefit from stronger guidance by the DOH. Government clinics and district offices state that they are reliant on partners. The main consequence of this dependence, is that the programme feels uncoordinated and sometimes disjointed, since funders operate slightly differently. DOH leadership would serve to weld various initiatives into a single, strong national VMMC programme, supported by all the partners.

To improve uptake of VMMC, demand-creation activities should focus on urban metros where there are large, concentrated populations of uncircumcised men and HIV prevalence is high. Concentrating on these areas is likely to make the highest impact on South Africa's HIV epidemic. Partners should focus on reaching men aged 20 - 34 years, in accordance with DOH recommendations. They should ensure that all clinics have a clear understanding of what age group to focus on and receive guidance through new strategies that are developed specifically to reach this more difficult target.

The DOH is uniquely placed to make a very important contribution to increasing short-term uptake of VMMC by hosting a national meeting of all VMMC partners. The purpose of the meeting would be to provide direction on geographical and age targeting and share short-term strategies and promising practices. It may also go some way to building more positive relationships among the partners by bringing together USAID and CDC partners, as well as demand-creation and service-delivery partners.

In the medium and longer term, systems and structures should be put in place at various levels to facilitate national ownership and coordinated implementation at district level. For example, the technical working group should be strengthened and structures created at provincial and district level to ensure coordination, especially as it relates to demand-creation activities.

Developing a systematic approach to knowing the client

One of the benefits of stronger national ownership of the programme could be a coordinated and coherent approach to understanding the client. A detailed segmentation of the target audience should be undertaken to truly understand the specific barriers to and motivators for VMMC. This should be based on formal research and yield information that is more valid and nuanced than existing informal knowledge. A deep and multifaceted appreciation of barriers and motivators is required in order to tailor demand-creation interventions for various segments of the target population. For example, research should be conducted on whether it is effective to utilise young women as social mobilisers, and whether it is important for male social mobilisers to be circumcised.

The application of behavioural economics, a discipline which combines psychology and economics to understand and influence human behaviour, could strengthen the development of nudges towards VMMC for each segment of the target group.

Creating a supportive environment using mass media

Once the target audience's views and feelings about VMMC have been thoroughly explored and different segments have been identified, messages can be developed to appeal to specific segments. This targeted messaging would build on the high general awareness and fairly strong support for VMMC in South Africa.

Mass media campaigns are valuable in ensuring that the target audience as a whole is exposed to repeated messages encouraging circumcision. At least one large mass media campaign which addresses VMMC is needed annually in order to maintain high knowledge levels, promote positive attitudes to VMMC, and establish VMMC as a social norm.

The limited research which is currently available suggests that mass media interventions should promote VMMC as an aspirational activity and associate it with responsible masculinity, while allowing scope for different elements of the campaign to be adapted for specific audience segments. This might include messaging on women perceiving circumcised men to be better lovers.

Mass media campaigns should also improve knowledge of available VMMC services and facilitate the making of appointments for circumcision. Messaging should indicate that VMMC services are free.

Mass media campaigns should generally focus on motivators and leave communication about the barriers to social mobilisers. In other words, mass media should usually avoid issues such as pain, HIV testing and post-operative abstinence as there is a risk of causing men to fixate on these barriers and actually weaken intent rather than building it.

There should be a supplementary summer campaign that specifically addresses the barrier to uptake in the warmer months, namely, the misconception about poor wound recovery in summer.

Improving the social mobilisation component of demand creation

Social mobilisation teams would benefit from the proposed evidence-informed approach to understanding barriers to VMMC and the development of appropriate responses to various barriers. All of this should become part of standardised training for social mobilisers. Training should be based on best practices for mobilising clients and social mobilisers should develop the confidence to modify these techniques to suit their local context.

Selection of social mobilisers

The selection of social mobilisers is crucial to their effectiveness in the field. When selecting social mobilisers, the following should be considered:

- Social mobilisers should have a sales or marketing background, not just knowledge of the HIV, STI and TB fields.
- They should ideally be men whose age enables them to relate to the target age group of men aged 20 - 34 years.
- Young women should be appointed on a case-by-case basis, if their sales expertise is high and they are trusted by the community.
- Suitable men who have been circumcised could be identified through the follow-up process and recruited as peer mobilisers.

Training of social mobilisers

The training of social mobilisers needs to be standardised. All social mobilisers should undergo the same training in order to ensure adherence to a standard operating procedure, consistency of factual information delivered to clients, and the application of best practices in the field. The training should cover:

- The benefits of VMMC.
- Identifying segments of the target population and adjusting approaches to meet specific needs.
- Sales techniques and how to “close a deal”.
- Methods for uncovering and addressing barriers to VMMC.
- M&E.

Experiential learning should form part of the training, giving new mobilisers an opportunity for practical application of the theoretical knowledge learned. It would be helpful if there was a probation or trial period during which new mobilisers would be observed in the field in order to identify possible problems early.

Social mobilisers should be trained on how to apply insights from the McCann Report. This document would have to be simplified for the purpose, with key findings and recommendations highlighted. An example of this is presented on page 27 of this report.

Call centre agents should also be trained on how to close the deal with men who express an intention to undergo circumcision. The principles of behavioural economics would be valuable in this aspect of training, both for social mobilisers and call centre personnel.

Materials development

Social mobilisers require two types of materials: to guide their conversations with prospective clients and to distribute to members of the target population. It is important that the messaging used in all materials is consistent. It is also desirable for materials to be linked to a current or recent mass media campaign, so that members of the public experience a coherent approach to VMMC.

To ensure that this occurs, a national message brief should be developed with and for all partners. While this brief should be followed closely in all materials, the creative execution of materials should be original and unique to the various partners. In this way, locally appropriate materials and innovation can be achieved without sacrificing the accuracy and relevance of messaging.

The materials used by mobilisers in the field should address specific barriers to VMMC. For example, a locally relevant “pain scale” could be devised to show men that the experience of pain is not uniform and to help them locate it along a continuum. This would assist social mobilisers to discuss the issue of pain clearly and truthfully at various points during and after the procedure.

Monitoring and evaluating for better impact

M&E should underpin and strengthen all of the above recommendations. A structured M&E framework should be developed to help partners meet specific goals. The process should include identification of key demand-creation indicators, such as conversion rates.

These uniform demand-creation indicators should be applied by all partners and all health districts.

Partners responsible for mass media interventions should measure their performance against indicators related to the building of knowledge, the shaping of favourable perceptions of VMMC, and increased intention to circumcise.

Partners undertaking social mobilisation should be required to collect information to enable them to work out their conversion rates (that is, the number of men they need to mobilise to secure one circumcision) and to determine the average time period required to achieve conversion. The latter would help to guide the allocation of limited resources. The goal is to be able to measure the effectiveness and efficiency of various channels in order to improve programming continually.

It is important to recognise that success is a continuum and there are useful intermediate indicators that can be developed to measure whether progress is being made towards the ultimate goal.