Case study 4: VMMC demand generation and in-service communication in Manica and Tete, Mozambique

Setting

Manica and Tete provinces in Mozambique (since December 2015).

Challenges

A rapid assessment of VMMC clients 15–29 years of age conducted by the Health Communication Capacity Collaborative (HC3) in November 2016 showed that fear of pain prevents men from accessing the VMMC service because some circumcised men spread information about pain, and there was generally a lack of adequate information on circumcision. The assessment also showed that there was a lack of comprehensive training for counsellors and challenges with communication materials; the specific communication and information needs of younger clients were not met; there was a need to strengthen immediate post-op and follow-up counselling; there was under-utilization of community radio; and there were under-performing activists from community-based organizations.

Barriers

Fear of pain during circumcision, the period of sexual abstinence, suspicion about use of foreskin for obscure purposes and adults not wanting to mix with children in the circumcision units were the main barriers.

Initiatives taken

1) The initiative focused greatly on strengthening fine-tuned and personalized community mobilization. This occurred in secondary, tertiary and technical schools and at public events and festivals that attract older men – with individual follow-up conducted afterwards.
2) The initiative received technical assistance by Johns Hopkins Centre for Communication Programs and support from the JHPIEGO/AIDSFree project in Manica and Tete provinces. It leveraged satisfied client testimonials via multiple channels and closely coordinated with AIDSFree and community leaders on mobile brigades (outreach).
3) There was prioritized hiring of community mobilizers who were circumcised, had secondary education and were above 20 years of age. They were trained in VMMC messages appropriate for clients ages 15–29 years.
4) Supervisors provided support and performed quarterly evaluation of performance, based on knowledge of key messages and ability to meet monthly targets. There were regular refresher trainings, on-the-job training and effective use of social and behaviour change communication materials.
5) Mobilizers distributed personal invitations to men attending sessions and events. Invitations included the mobilizer's personal contact phone number – to facilitate follow-up and booking – and the phone number of the circumcision unit and its operating times. Follow-up of clients was via telephone or home visits.

Fig. 2. Evolution of VMMC in pivot range (15–29 years) between December 2014 to November 2015 (before HC3) and December 2015 to November 2016 (after HC3)

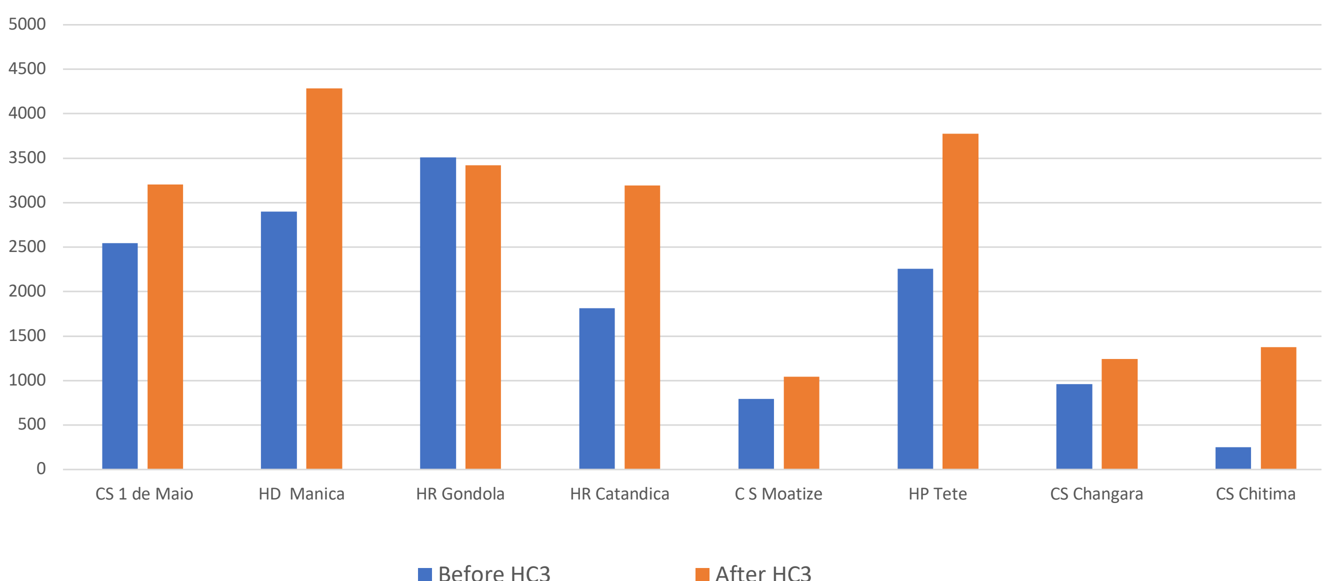

Table 1. Targets and numbers of people who sought and received VMMC during October 2016–September 2017 and October 2017–September 2018

	October 2016–September 2017	October 2017–September 2018
Number of people who received the service	100 636	107 756
Number of people who sought the service	101 337	109 452
Target	95 296	120 470

6) Each mobilizer had a minimum number of men that should be referred for VMMC, by age group.
7) There was continuous coordination with the clinical partner to ensure a balance of demand and supply of services and provision of transport for clients.
8) Community leaders were trained on circumcision to support the mobilization of their communities. They were involved in the selection of community mobilizers and in the dissemination of messages about circumcision during community meetings.

Results

1) There was improved reach of the priority age group (15–29 years of age) when compared with the period before the intervention (Fig. 2).
2) More than 80% of the target was reached (Table 1).
3) While clients reported having received information on VMMC from several sources, such as radio, TV and friends, the majority of clients in the 15–29 year age group (80%) reported having received information and solid explanations about the VMMC services and procedure benefits from activists or community mobilizers.

Lessons learnt

1) Effective recruitment, supervision and motivation of community mobilizers is key to reaching targets.
2) Mobilization works better when the mobilizers are divided according to their abilities and background.
3) Including the health unit's and mobilizer's contact numbers on invitations allowed men to ask follow-up questions and book their appointments in a more private manner.
4) Mobilization in schools, especially in the night courses where students are men over 15 years of age, works well to reach men of the pivot age group.
5) Mobilizing in places with greater concentrations of women works well because women exert great influence on men.