Bill & Melinda Gates Foundation

Male Circumcision Demand Generation Meeting

7-9 January 2015

Seattle

Report

Contents

PART 1. INTRODUCTION AND SUMMARY

1.1 Introduction

The Bill & Melinda Gates Foundation (BMGF) has invested in generating evidence to inform innovations in demand generation activities and approaches for male circumcision (MC). These efforts include 1) identifying, analyzing, and sharing best practices, 2) adopting market-research and private-sector approaches, and 3) evaluating the impact of various demand generation interventions. BMGF and its partners have the opportunity to demonstrate the effectiveness of innovative demand generation approaches and to inform and influence the field in scaling up evidenced-based interventions.

The foundation held a three-day workshop at its headquarters in Seattle, USA, on January 7-9, 2015, bringing together researchers, implementers, and other donors and multilateral partners. (For a list of meeting participants and the agenda, please see Annexes 1 and 2.) On the first two days, the results of the studies funded by the foundation were presented by and to the foundation's partners, and discussed in detail. The aim was to facilitate collaboration, further develop synergies, and support the achievement of the strategic objectives of the foundation and its partners. On the second day, an overview of the demand generation work was also shared with a wider audience of BMGF staff at one of the foundation's "Evaluation & Eats" sessions. Key global stakeholders joined the foundation partners on the final day: the partners summarized their methodologies and results, and the global stakeholders shared some of their recent research, leading to a joint discussion of feedback, insights, remaining gaps and challenges, and the implications for demand generation activities and the overall VMMC landscape.

The remaining portion of this introductory section summarizes the key themes and insights that came out of the meeting, and synthesizes the points that were raised in discussion over the three days. Part 2 of the report summarizes the discussion of the VMMC Clearinghouse website and forum, and plans for the dissemination of the research presented at this meeting in a journal supplement. Part 3 summarizes the market research conducted in Zambia and Zimbabwe by Ipsos Healthcare, Upstream, and Final Mile, and the resulting framework for understanding demand generation, which was used later in the meeting to reconsider the programs presented by the foundation partners. Parts 4 and 5 of the report provide brief summaries of the partners' presentations on their programs in Kenya, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe, while Part 6 summarizes the presentations made by the global stakeholders. The presentations are available separately on the Clearinghouse website where possible. Summaries of questions and answers specific to some of these presentations are also provided.

If you would like a copy of the slide decks that accompanied any of the presentations, please contact Maaya Sundaram at Maaya.Sundaram@gatesfoundation.org.

1.2 Summary of key themes and findings

Giving an overview and context for the meeting, Sema Sgaier explained that the approach of the foundation and its partners was to identify best practices in VMMC demand generation through desk reviews and research, and to conduct market research that would inform innovative strategies as well as help to evaluate current programs (see Figure 1 on the next page).

The purpose of the meeting was to introduce a behavioral economics approach to understanding demand generation that was focused on the individual man's journey towards VMMC, and to discuss how insights gained from the development of this approach could be applied to existing interventions and used in the design of new ones. Impact evaluations of demand generation interventions would also be presented, as well as research from global stakeholders. Communication via the VMMC Clearinghouse website and Demand Generation Forum, and via a journal supplement, would also be discussed.

Session 1: Innovative market research approaches to VMMC Demand Creation

In the first part of the meeting, Ipsos Healthcare, Final Mile, and Upstream presented the results of their **market research into men and their influencers** in Zambia and Zimbabwe, and a framework that allows us to map precisely the beliefs, emotions, and actions at each point along the path towards (or away from) circumcision. The framework identifies **three approaches that can be used to help a man lessen "emotional dissonance"** and decide to take action to be circumcised: 1) decreasing the near-term negative consequences; 2) increasing the positive near-term consequences, and 3) decreasing the time period in which the man anticipates being circumcised, and during which negative near-term consequences could develop.

Ipsos also previewed the quantitative work that they will undertake to **segment men according to their place on the path to MC** and the barriers and motivators that apply to them, so that men in each segment can be quickly identified by community mobilizers using a simple questionnaire, and thus reached more effectively by interpersonal communication (IPC).

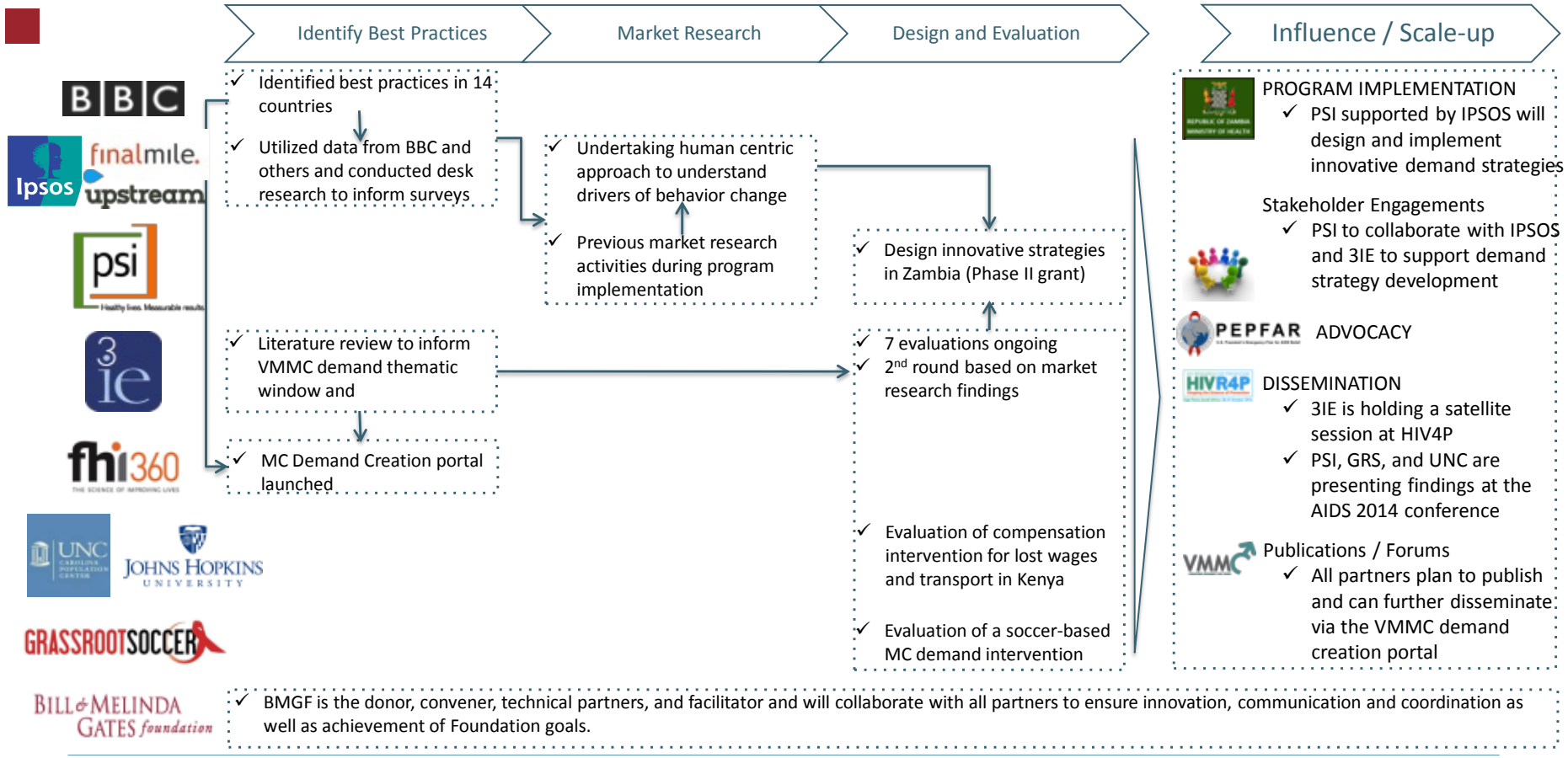
Results of Ipsos research into **early infant medical circumcision** (EIMC) and **early adolescent medical circumcision** (EAMC) were also presented, revealing both opportunities and barriers to expanding these interventions. Finally, Ipsos discussed a prospective mixed-methods survey that will be used to develop a **tool for forecasting demand for devices** for MC.

Session 2: VMMC Demand Creation Impact Evaluations

Partners presented their **programs and the results of impact evaluations**. Key themes that emerged included:

- The need to reach older men (i.e. those in the 20-29 age range), and not only the "low-hanging fruit" of adolescents and young men
- Messages of modernity, group cohesion, sexual pleasure, and appeal to women may be stronger motivators for MC than preventing HIV or other STIs
- Men and their partners have differing expectations and concerns about the consequences of MC for their sex lives, and these must be addressed openly
- Wives are often not effective advocates of MC for their husbands, either because they are reluctant to discuss it with them, or because their husbands distrust their motives when they do

Figure 1. A partnership approach to demand generation for VMMC



- Fear of pain during and after the procedure is a significant concern for men, but it is rarely addressed frankly by advocates of MC
- Seasonal demand is a concern, but strategies for overcoming it have been successful in some countries
- Cost-effectiveness is complex to measure and a challenge to improve, especially when persuading older men to be circumcised

Financial or other compensation (i.e. incentives) has been shown to be effective in several interventions in increasing uptake of MC by men who have not yet followed through on their stated intent to be circumcised. However, care and creativity are needed to avoid coercion, or even the appearance of it, and funders such as PEPFAR remain extremely reluctant to fund programs that use incentives.

1.3 Summary of discussions

These notes synthesize the points raised during the discussions in the following Sessions:

1. *Innovative Market Research Approaches to VMMC Demand Creation*
2. *VMMC Demand Creation Impact Evaluations*
3. *Summary and Implications of BMGF Studies and Sharing Other Ongoing Demand Creation Activities.*

Session 2 (Communication, Advocacy, and Policy) is summarized in Part 2. For details of the meeting agenda, please see Annex 2.

Messaging around HIV prevention vs STI prevention

- Demand generation efforts have exhaustively covered the Relate phase: men know what the benefits of VMMC are, and we don't need to talk further about this.
- We have to separate motivation – which continues to be around HIV prevention, protecting future generation, etc. – from triggers, which may be different. HIV prevention plays a big role in driving intent, but a lot of the conversation is about other STIs, especially HPV (the ISPOS research reflects current communications by implementers, e.g. in Zambia).
- STI prevention is a more immediate benefit than HIV prevention. Many partner organizations are using this as a trigger, and it is working. But it is not as immediate a motivator as some of the negative consequences of VMMC.

Social desirability of VMMC

- VMMC for some is seen as a way to be part of the group. Modernity is an important trigger, for young people especially. Younger men (17-20 years) think women will find them smarter and more attractive if they are circumcised.
- HIV/STI prevention may be far from people's thoughts, especially in the younger age group. But sometimes a new piece of information, e.g. about HPV prevention for males, "glamorizes" MC.

Emotional dissonance

- Emotional dissonance does not cause people to rebound back from Anticipate phase to the Relate phase. The intent to be circumcised remains strong, but people may procrastinate or create a justification around religious scruples.

- The quantitative study (still to be implemented) should show who will get stuck in the Anticipate phase and who will move on, although it will not answer the question of exactly what intervention will unlock each group and move it forward.
- We may not be able to eliminate emotional dissonance completely, e.g. socially based shame around MC, but we may be able to leverage other emotions to counteract this.

Psychology of time

- Research on online shopping has shown that people spend a long time searching but do not purchase because there is too much choice. But they will make a decision if you can show them how much effort (time) they have put in because they want to find a value in that. It is possible that letting people know how long they have spent thinking about VMMC might incentivize them to actually make the decision.
- You can also shortcut the time taken to make a decision by changing the choice, e.g. with PrePex you are deciding between surgery and device, rather than between surgery and not-surgery.
- The only time-related anchor that can be used as leverage is sexual debut (i.e. for adolescents).

Sexual pleasure

- Fear of loss of sexual pleasure is very strong for men, and it is a belief they start to form when they consider VMMC in detail. It is more of an issue for older men, who have the experience to make a before-and-after comparison.
- Although men express concern that their sexual pleasure may decrease post-MC, Ipsos was not sure if that really plays a role in the decision-making process, or whether it is just used as a justification for delay.
- Among older men, the belief that women derive more sexual pleasure from a circumcised man can be a trigger to getting circumcised. A man's self-esteem can increase if he can give more pleasure to his partner.
- Advertising that contains sexual connotations can run afoul of government regulations. Instead it may be better to use more veiled messaging, e.g. "your wife/partner will be happy", or that MC makes a relationship better. Data show no risk compensation or increase in sexual disinhibition as a result of VMMC, and this might help reassure policy-makers and donors that it is not necessary to shy away from sexual happiness messages.

Role of female partners

- Ipsos had a strong expectation based on prior evidence that female partners have a huge role. But women did not show up as influencers in any interviews with men.
- The Uganda intervention provided materials to women in their third trimester of pregnancy to communicate to men. The idea was that the man's sexual abstinence period following circumcision could overlap with the woman's following birth. But preliminary results show it didn't have an effect.
- In the South African intervention, the information on the postcard was that women prefer men to be circumcised, but in that pilot, this was the approach with the lowest effect.
- Where men are stuck in the Anticipate phase, we find a lot of wives who say they cannot talk about MC with their husbands. There is a severe breakdown of communication between a

man and his primary partner in the Anticipate phase, which prevents them from offering the required support for the decision. A girlfriend advocating VMMC for her partner is much more successful trigger than a wife doing so.

- If each partner is focused on the benefits of MC for themselves individually, the man will mistrust the woman and the woman will not empathize with the man's fear of pain. We need to empower female partners to communicate support around healing, rather than talking about the benefits of circumcision for themselves, otherwise the man feels that his fears are not being taken seriously, and may suspect his partner's motives for wanting circumcision. We need to talk about moving from "me" to "we", i.e. better sex for the couple which can be framed as "better intimacy for us". Nevertheless, the "better sex" message is probably best given by someone other than the partner.

The role of advocates

- Even when men who have been circumcised attempt to advocate for VMMC, they may create more anxiety by talking about how painful the procedure was.
- Conversely, if a circumcised man talks only about long-term benefits and avoids the subject of pain altogether, he may make it loom larger in the mind of the uncircumcised person. Men who hear only positive things about MC will distrust the messenger, because they know that there is pain involved. This creates an emotional dissonance and uncertainty about the procedure and about the credibility of the messenger, even if he is a friend.
- Uncertainty about VMMC relates not just to the question of pain, but to other practical issues such as whether the man will be able to see the surgery being done, and the number of injections of anesthesia required. The man already knows about the benefits and requires different types of information and reassurance.

Other influencers

- Ethnolab results indicate that tribal and religious leaders play a very small role in the decision-making, though they may play a larger role in *justifying* the decision to be circumcised after the fact – or, conversely, in justifying procrastination.
- For adolescents, schools play an important role in the Relate and Anticipate phases, especially where parents are not well educated and look to schools to make decisions on their behalf. 13-17-year-olds appear to move quickly through the Anticipate phase because although they have negative emotions, e.g. fear of pain, these are largely overcome by systemic triggers such as group circumcision (i.e. peer pressure) and the role of schools and parents. A problem group is youth out of school, who are less socially cohesive, which makes it harder to reach them during these phases.

Community mobilizers

- Mobilizers must be credible and trustworthy to potential clients. They should be circumcised, because an uncircumcised man cannot relieve the emotional dissonance of another uncircumcised man (i.e. uncertainty around what the procedure will be like). Women can be involved in mobilization, but finding the right messaging for wives of uncircumcised men is difficult.
- We should look at how we are engaging men who come in for VMMC to be mobilizers themselves: they are already trusted by their friends and could be "hired" (i.e.

compensated) to do this. But they have to be given the right IPC tools – share their experience, don't hide the pain, etc.

- In Tanzania peer promoters call people on the phone and initiate a series of chats, which allows a relationship to develop and makes it easier to influence men to choose MC. A buddy system can be used in which a peer promoter offers to accompany the client to the clinic.
- Some interventions create positive environments (MCUTS, Stylish Man programs), rather than environments of distrust; this is the state you want to generate for people to make decisions in. MCUTS (Grassroot Soccer) uses "caring coaches" who have a long-term relationship with the young person and can facilitate access to various services, not just VMMC.

Perceptions of pain

- Fear of pain is about the pain inherent in the procedure (rather than that it might be poorly performed) and pain during the healing period. Communication around pain differs a lot by age group. Younger boys may share their experiences with one another, almost in a competitive way.
- There is currently no incentive for men who have been circumcised to talk about pain honestly, i.e. without downplaying or exaggerating it (in either case to make themselves appear brave). In addition, most people have poor pain empathy, are unsympathetic to those in pain or make jokes about it. Even if nothing is said explicitly, this attitude creates shame and helps generate the emotional dissonance that keeps men stuck. The solution is to talk honestly about how the pain is, how it can be managed, and where possible to give a point of comparison, i.e. "It's as painful as [reference point]."

Reaching harder-to-reach men

- Programs were initially asked to focus on older men, but evolved to a focus on younger males because less effort was involved. Now there is a push back to older men, but there can be a conflict between the payment structure and calculations of cost-effectiveness, since cost-effectiveness does not relate so much to the number of MCs performed, but rather to their impact on HIV. The foundation doesn't yet have the means to quantify these variables but is thinking about how to do it.
- Those most resistant to VMMC often have the highest-risk behaviors, so we need to find ways to reach them. The Ipsos quantitative segmentation exercise will help understand which of the MC-resistant men are in fact high-risk, and which are simply monogamous, married men. The questionnaire will try to understand men who say they will definitely not get circumcised, because we need to know what the realistic pool is of people who might get circumcised.
- Among older adults, the employer plays a major role in terms of giving time off work. This is a concern for self-employed men also.

Post-circumcision attitudes

- Relief at having been circumcised seems to be universal: men are happy that the journey is over and don't seem to express regret about having made the choice. What differentiates men is whether or not they will talk about VMMC and advocate for it ("pride or hide"). If the

social environment is positive, people are comfortable revealing that they've been circumcised, and proud of it, but in a negative environment (e.g. where MC is associated with promiscuity) they are more likely to hide the fact.

Seasonality

- Seasonality plays a big role in some parts of South Africa, i.e. a belief that it's better to be circumcised in the cooler season. Ipsos found that in Zambia and Zimbabwe, this belief may be used to justify procrastination but doesn't seem to play a major role. In Uganda, schools heads refer programs seeking to do MC "out of season" back to the parents, who prefer to wait until the holidays because they say VMMC will interfere with their son's studies.
- In Tanzania, VMMC is offered via mobile sites in rural areas, so parents know that if they delay there will be opportunity costs of travel in the cold season. In South Africa, areas with more mobile outreach have far less seasonality, though it is not clear if this is due specifically to the outreach delivery model.

Managing demand in outreach clinics

- The idea of scarcity can be a motivator, e.g. offering VMMC in some locations for only a limited time. Everyone seems to come for VMMC in the last moments of a campaign. Limited-time clinics seem to see more people than those that provide services over a long period. People also need to know the cost of delay. Some outreach clinics make a point of not saying when they'll return: on the second visit they see a great increase in numbers. Some participants said that in their experience the highest service-delivery day is always the second Monday of a campaign: early adopters have come the first week, and once people see that the men are healing, there is an increase in clients.
- In South Africa, only doctors can perform VMMCs and it's not possible to send them to a large number of sites. Advocacy is needed to change the model.

HIV testing

- Qualitative findings indicate that the perceived requirement for HIV testing is a big barrier for men. Men didn't talk a lot about this in the Ipsos focus group discussions, but it came out in the Ethnolab exercise. In a discrete choice survey, men listed testing as their fourth greatest concern (after having male providers, counseling for their partners, and separate waiting areas for adults and young people).
- In the MCUTS program there was confusion among youth and soccer coaches as to whether testing was required. In much of the South Africa program facilities do not make it clear that testing is not mandatory.
- The Ipsos research in Zimbabwe indicated that men fear finding out that they are HIV positive. This also has implications for the use of self-testing kits, i.e. testing without immediate counseling being available. However, in Kenya, uncircumcised men have the same rate of ever testing as recently circumcised men, implying that testing is not a barrier to VMMC.

Integrating VMMC with other services

- It is possible that offering other services alongside VMMC, e.g. blood pressure or diabetes testing, would make a difference to demand. However, care must be taken about duplicating services available at government facilities, which can make the government providers

unhappy. In Tanzania, the program considered pairing VMMC with cervical cancer screening, but men didn't want their partners to accompany them to the health facility.

Longevity of campaigns

- It is important to consider where a program is in its lifecycle and scale-up: needs for demand generation are different when 20% of the target has been reached than when 80% has been covered. Once MC has become a social norm (e.g. among 15-19-year-olds in the 2012 Orange Farm Survey, where nearly 80% were already circumcised), a tipping point has been reached and almost no effort is needed to recruit from that group.
- We have to be careful not to over-generalize, and we must consider contextual factors. There are big differences between eastern and southern Africa. The Ipsos quantitative survey will make it possible to identify a baseline of interest and segment the population, and do follow-up surveys to identify progress.

Impact and cost-effectiveness

- The finite group of men who require circumcision is getting smaller as the program evolves, leaving programs to address the ones who are hardest to reach. As programs mature, it is necessary either to reach the older men, or focus on the younger males who are becoming eligible for VMMC. Give the limited resources, it is important to know which groups it is most cost-effective to reach.
- Older men are more expensive to reach than adolescents, and there are extra costs for service delivery because they prefer not to come to mass sites. However, modeling indicates that it is nonetheless more cost-effective to reach older men than adolescents. In Tanzania, nearly all 10-19-year-olds have now been circumcised, and it's interesting that older men are coming in increasing numbers. The cost-effectiveness of VMMC compared to Treatment As Prevention suggests that even where demand generation costs are high, there is still an overall advantage to VMMC. However, this does not mean that younger age groups should not be targeted as well.
- Circumcising communities already pay for their circumcisions, and perhaps men considering VMMC (or families that wish to have their boys circumcised) would do so too. On the other hand, financial incentives can also increase uptake.
- We need a combination of interventions for different men depending on their perceptions, where they are on the path to VMMC.
- If demand generation is targeted at an entire community, the unit cost per MC conversion will be very high. Because of the need for interventions that target specific segments of the community (by motivator, barrier, etc.), generalizing a cost benchmark that is consistent across countries will be hard to develop.
- As we plan further interventions we must be mindful of the fact that donors expect impact in the short term as well as the longer term, and may be reluctant to support programming that addresses only a 20-year time frame. (A related consideration is that the HIV landscape is changing: it may not be such an issue in 20 years, so we need to show effectiveness today).

Incentives

- PEPFAR guidance on incentives (financial payments) means that we can't implement them in interventions with PEFPAR funding. Potential objectives to incentives include the risk of coercion (or the appearance of coercion), and the fear of historical precedents, e.g. the male sterilization campaign in India. There are also concerns about the appearance of unfairness if payments are made to clients now but were not available to early MC adopters, or if payments are stopped at some point in the future. A related fairness question is why incentives should not then be given to other populations for health interventions, e.g. for pregnant women to visit the ANC? Finally, there is a concern about losing people from regular government programs to the incentivized programs.
- An approach is needed for talking to donors, ethics boards, and decision-makers about incentives. It is necessary to lay out a clearer rationale for incentives that are not coercive and that increase autonomy, and to present data in a way to show that programs can remove structural barriers by compensating people for opportunity costs, which is quite different from influencing their behavior (e.g. in South Africa, a "transport allowance" is given upon completion of counseling and is not dependent upon the client's decision to take up VMMC). If the intent to be circumcised is strong but there is procrastination, we could argue that incentives are not being used to coerce someone into doing something they don't want to do, but simply to convince them to do it sooner. The incentive shortcuts the Anticipate phase of the process and reduces emotional dissonance. It is worth pointing out that the Stylish Man program (Uganda) is acceptable to the NIH, which has the most stringent regulatory process. In addition, no men express regret following VMMC, which indicates they do not feel they were coerced.
- Using alternative terminology for incentives could make the topic easier to discuss. Examples proposed include "conditional economic compensation", compensation for time and transport (CTT), an enabler, or simply transportation reimbursement.
- Alternatives to "direct" incentives include offering payment upon completion of counseling session, not upon conversion to MC (as in the South African example noted above); non-financial incentives such as t-shirts; compensating circumcised men for acting as "mobilizers" who call a friend after the procedure (since programs already pay mobilizers, this would be in line with current practice); and community-level incentives, e.g. building a soccer field once a target number of men has been circumcised.
- It was agreed that incentives may not always be appropriate. Programs are at different stages in different countries, and incentives may be best when trying to improve coverage of the harder-to-reach, older men.
- There was discussion about whether more evidence is needed about incentives, for example by first scaling up some of the pilots. One way forward would be to fund studies to show that there is no coercion with incentives, including in interventions at scale. There is also a need to study whether the opportunity cost of VMMC is of a different order of magnitude for men than preventive health interventions for women, i.e. whether this might justify use of compensation for men when it is not offered to women, and whether offering an incentive brings someone in to the program who would not have come through a non-incentivized demand generation intervention. These research topics would be suitable for the planned *J AIDS* supplement on VMMC, where an article addressing ethical issues around incentives would also be appropriate.

PART 2. COMMUNICATION

2.1 Clearinghouse website and demand generation forum

The Clearinghouse on Male Circumcision for HIV Prevention website is at www.malecircumcision.org. Its original goal was to provide a central source of high-quality, authoritative information on VMMC for target audiences (public-health community, researchers, academics, policy-makers, program designers and implementers).

The clearinghouse has received more than 165,000 visits since Feb 2009, averaging 2,000 a month. The top three African countries accessing content are South Africa, Kenya, Uganda. (The three first RCTs on VMMC were conducted in these countries; South Africa and Kenya have infrastructural advantages too.) The share of the site's overall traffic from Africa has increased every year, from 12% in 2009 to 26% in 2014. More users are now accessing the site via mobile and tablets in 2014 compared to 2013. Desktop traffic is roughly static.

Areas for improvement that have been identified include more regular, prominent updates on country progress, and a more effective and user-friendly search function. The new integrated Clearinghouse that is being developed includes easier and faster navigation, enhanced search functionality, and an improved user experience (with a responsive design for smartphones, which are increasingly used in Africa).

The VMMC Forum aims to create a safe space where members can share ideas and resources. Anyone can join the forum and post articles, photos, comments, etc. Membership and messages are moderated, so that people will not be attacked by critics of MC.

The presenters asked the group for ideas on how to make the Clearinghouse and the Forum more useful, how to encourage more participation and contributions, and how to promote the forum more widely without attracting MC opponents? Responses are listed below (it was agreed that Jesse and Kathleen would survey the group further to find out whether they are willing to engage more with the Forum and Clearinghouse):

- Hosting webinars and other interactive events rather than just hosting content.
- Inviting people/organizations to be a "host" on the Forum for a week, e.g. put out questions each day to stimulate dialogue.
- Using the Forum as a platform for discussion, webinars on the IPSOS research insights, e.g. following a teleconference on a particular subject, using the forum to summarize and continue the conversation.
- Using the Forum as a place for discussing research processes and coming up with ideas, also for questions and answers to be placed when implementers and researchers are working in different places and time zones.
- Sending out a feed with summaries of new articles.
- Making sure that country information on the Clearinghouse site is as up to date as possible.

It was pointed out that it is important to remind people that the Forum exists; it's easy for it to slip people's minds when they are members of similar groups. People are unlikely to visit it daily or even weekly, but are more likely to go when they have a specific question. Limited traffic therefore isn't a sign of failure. Repeat use may be a more useful metric than unique users.

Some participants felt that the forum should not be so afraid of the "intactivists" (anti-MC activists) that it closes itself to potential new participants. We close ourselves down. Although there is a risk of expending a lot of energy responding to them, the Forum is not a general MC forum but is only about demand generation. Participants can be blocked if they don't play by the rules, and the moderators can set the parameters.

2.2 Demand generation supplement

A supplement of *JAIDS* is being planned to cover the foundation-funded studies. It will be open-access, and the editorial team (a group of researchers) will choose the peer reviewers. Final versions of papers are due to be submitted by late February/early March. The supplement will include an ethical perspective on demand generation, in light of the discussion around incentives.

PART 3. INNOVATIVE MARKET RESEARCH APPROACHES TO VMMC DEMAND GENERATION

3.1 Path to MC and behavioral economics

Ipsos/Upstream/Final Mile – Steve Kretschmer, Masha Eletskaya, Francine Fram, Alice Nanga, Katie Polcheck, Ram Prasad, Anurag Vaish, Jeff Mulhausen, Tim Sweeney

The presentation is summarized in Part 1.2 above, and discussion points arising from the Path to MC framework are summarized in Part 1.3.

3.2 Quantitative segmentation

Ipsos – Steve Kretschmer

The presentation is summarized in Part 1.2 above. The discussion raised the following points:

- The sequencing of the questionnaire was queried, i.e. broaching sensitive topics about sexual behavior before demographics. Ipsos found that being direct about sensitive questions and getting them out of the way early was easier for respondents, although this wouldn't necessarily be the case in all countries. The team will discuss the possibility of asking questions in a different order, to establish rapport before asking the more sensitive questions, but is concerned not to compromise the data by having varying sequences of questions or by dividing the group into different samples.
- A single questionnaire is used for both circumcised and non-circumcised men, but there are some jumps and different questions where appropriate.
- Using devices instead of a person is not practical because in one of the countries literacy is an issue.

3.3 Sustainability

Ipsos – Sunny Sharma

The sustainability study assessed the potential drivers and barriers to parental decision-making for MC for infant (EIMC) and early adolescent (EAMC) boys in Zambia and Zimbabwe. It sought to identify existing potential integration points for an EIMC service within existing healthcare systems

and use behavioral economic principles and heuristics to plan a successful demand generation program for sustainable MC.

In both countries, the VMMC campaign seemed to have generated a positive effect on EIMC and EAMC. Parents believe that circumcision will become the norm in the future, and that HIV will continue to be a serious health issue when their boys grow up. However, uptake rates are well below intent scores, and there is uncertainty on the ideal time to circumcise. The study uncovered barriers and motivators to EIMC/EAMC uptake, and identified potential levers, including getting the husband circumcised as well, creating regret for inaction, testimonials from current VMMC experiences, communication on the benefits, risks, and process of MC, and communicating a pain scale for adults and infants. Discussion centered around:

- **Role of group dynamics:** for EAMC it's the boy's friends, for EIMC it's the parents. Can group dynamics positively influence mothers and fathers, e.g. a social group for expectant parents or mothers? A challenge is that the mother may not bring the message home to the household. Men are disengaged from the health care system, and mothers say that someone should educate the husband but don't want to do it themselves. A campaign is needed for viral understanding. There may be an opportunity to advocate for EIMC with young men who are themselves circumcised, but it is still necessary to tackle the emotional dissonance they feel.
- **Norm change:** Some countries have gone from being uncircumcising to circumcising in the past 50 years. It may be possible to work for structural change, i.e. advocate with governments to change policies and the scope of practice for nurses, for example to make EIMC as normal as vaccinations. However, it is not possible to advocate for mandatory EIMC, and maybe not even for a requirement that EIMC be recommended. Consideration must be given to consider how to deal in each country with those who oppose MC.
- **Incentives:** Currently there are incentives for HCPs to provide VMMC; if EIMC is integrated into general healthcare, HCPs may not promote it as much. At the same time, if MNCH providers are asked to promote EIMC without the additional compensation that they see HCPs receiving, they will be disincentivized to do so.
- **Location:** Offering EIMC at VMMC centers instead of at ANCs would remove the burden from the MNCH providers. But there is a question of whether VMMC centers are wanted in the long term, and whether it is a good idea to take children away from the ANC, where other relevant services are also provided.

3.4 Demand-based device forecast

Ipsos – Fred Church

Ipsos discussed a prospective mixed-methods survey that will be used to develop a tool for making volumetric forecasts for devices for MC in Zambia and Zimbabwe and calculating the potential for incremental additional demand generation. The tool will provide forecasts by region and age and will be able to indicate the level of cannibalization of surgery by each device (i.e. individuals who choose a device over surgery, rather than individuals choosing a device who would otherwise not have chosen to be circumcised). The tool will also incorporate supply/service-side variables to enable decisions about programs costs and scale-up. Discussion raised the following points:

- **Costs:** Current costing studies indicate that costs of different devices are similar to those of surgery. Devices are still be introduced, so costs may change.
- **Acceptability issues:** One device doesn't require anesthesia, and no cutting upon placement. However, it requires two medical visits vs one for VMMC. PrePex may let men return to work sooner, but odor and pain on removal are significant demotivators. With PrePex there is a higher rate of attempted self-removals and adverse events, and this can dramatically affect acceptability. It will be necessary to tailor communications to address public perceptions of the device.
- **Device eligibility:** The forecasting much take into account the ineligibility of certain age groups for certain devices. Manufacturers are working on devices appropriate for younger age groups, so eligibility may change.
- **Provider bias:** If there are multiple devices available, provider bias will play a role in which the client is ultimately offered. The Ipsos research will be able to get a qualitative understanding of provider bias, and to ask clients their likelihood of going an HCP's recommendation. Although Zambia will not introduce three devices, the study will help them decide which to introduce. Piloting has shown clear differences in demand between devices and between devices and surgery. (The Zambia pilot preference was for UniCirc.)

PART 4. VMMC DEMAND GENERATION IMPACT EVALUATIONS

Brief descriptions of each of the interventions and their evaluations are given below, along with points that were raised in the discussions that were specific to the interventions. More general issues about demand generation that arose in discussion are summarized in Part 1.2, and included in more detail in Part 1.3.

4.1.a Effect of providing conditional economic compensation on uptake of voluntary medical male circumcision in Kenya

IRDO, UNC Chapel Hill – Harsha Thirumurthy, Kawango Agot

4.1.b Optimizing the use of economic incentives to increase male circumcision demand: a randomized trial to compare fixed vs. lottery-based incentives in Kenya

CIDRZ, UNC Chapel Hill – Harsha Thirumurthy

The two studies showed that providing compensation of US$8-15 in the form of food vouchers was effective in promoting VMMC among men aged 21-49 years. Lottery-based incentives, however, were not effective. The intervention was highly cost-effective and sustainable, and concerns about coercion did not arise among participants.

4.2 The use of peer referral incentives to increase demand for voluntary medical male circumcision in Zambia: an impact evaluation

CHAPS, 3IE – Harsha Thirumurthy

The study aimed to determine whether peer referral incentives would facilitate greater advocacy for VMMC by MC clients by prompting them to discuss MC more. Preliminary results suggest that the

incentive did not result in increased demand. It is possible that higher incentive amounts would have yielded larger effects. Further data is being obtained for the evaluation.

4.3 Advertising for demand generation for voluntary medical male circumcision in South Africa

CHAPS, Reed College – Nicholas Wilson

The intervention used a door-to-door postcard-based social marketing campaign focusing on three determinants of demand for VMMC: compensation (US$10 for attending a counseling session); information ("two out of three partners prefer a circumcised man"); and framing ("Are you tough enough?"). Compensation helped overcome procrastination and structural barriers. Messages could be delivered on billboards or via radio, TV or SMS as well as by postcard.

4.4 Using smart phone raffles as a method to increase demand for male circumcision in Tanzania

Jhpiego – Hally Mahler

In this study of motivational encouragement, clients aged 20 years or older undergoing VMMC were each given a raffle ticket that could be entered in a raffle for a smartphone at the first follow-up appointment following VMMC. Peer promoters were also eligible for a ticket for every 25 men they referred for VMMC. Preliminary results indicated that while 61% of all clients aged 20+ receiving VMMC were seen at the intervention sites, the proportion was higher at control sites than at intervention sites, requiring further analysis to understand the reasons. The study does suggest that while it is possible to reach older clients, it requires considerably more effort.

4.5 VMMC demand generation in Zambia

SFH, PSI – Namwinga Chintu, Brittany Thurston

Health promoters (HPs) are community volunteers engaged by SFH to create demand for VMMC, responding to the expansion of VMMC sites and the need to reach ever-increasing VMMC targets with reduced funding. HPs are satisfied clients and couples. A health promoters dashboard was launched in 2013 as supervisory tool to monitor the productivity and efficiency of HPs via days worked, men booked for MC, and men actually circumcised. There were increases in the number of men booked and the number circumcised after the dashboard was introduced, but they cannot be attributed solely to the dashboard, pointing up the need for robust M&E to be in place at the beginning of programs. Discussion raised the following points:

- **Profiles of health promoters:** it as noted that some HPs are women, and some of the male HPs are uncircumcised. Dashboard data indicates no difference in the effectiveness of men over women, but FHS has not yet analysed dashboard data for any difference in the effectiveness of circumcised and uncircumcised HPs. In a South African program, women have proved more effective than men in recruiting men for VMMC, perhaps because they find it easier to engage them in IPC.
- **Using dashboard for incentivization:** HPs are employed directly by FHS, and paid US $100 monthly. FHS has considered using dashboard data as part of an incentive plan, but the dashboard was introduced too late in the program to try this. Some HPs have been

terminated because of non-performance, based on dashboard data, but FHS recognizes that sometimes low performance may be due to other factors.

- **Home visits:** It was questioned whether repeated visits are very resource-intensive. If someone does not choose MC after a few visits, perhaps it indicates that they're not amenable to persuasion by someone they don't know well. FHS pointed out that while labor-intensive, they were a response to the very low MC rates in Lusaka, and sending HPs out in a structured way provides valuable information about attitudes to MC.

4.6 "Pinda muSmart": targeting adolescents and adult men for VMMC in Zimbabwe

PSI – Karin Hatzold

Pinda muSmart ("get smart, get clean") is a mass media campaign for VMMC demand generation targeting 13-29-year-olds. The communications strategy is based on research using PSI tools: TRaC (Tracking Results Continuously). VMMC is positioned as a lifestyle choice: being "smart" means being cool and fashionable. Celebrities are used as role models for young and older males, and there are social events and road shows, and school holiday campaigns, with outreach via media, social media and IPC. Key recommendations include that communication be informed by evidence, constant monitoring and adaptation. It is important to consider the influence of cultural and social norms, tailor approaches by age segments, and base messages on motivators beyond HIV prevention. The program acknowledges the importance of peers and influencing audiences, role models, and women. Short-term campaigns are held during periods where priority audiences are available, and year-round promotional activities for sustained demand for services over time. Enabling access to services to address structural barriers is critical, e.g. transport for people who can't afford to get to health care facility (through transport or reimbursement for costs). Discussion raised the following points:

- Pinda muSmart is the main MC provider for the Ministry of Health, so its communication strategy is the national one and was presumably responsible for the large increase in VMMC uptake.
- Mass media is very important to raising awareness, but by itself it doesn't bring people through the doors, and must be complemented by IPC. IPC materials are oriented to mass media campaign. Since the campaign has both mass media and IPC, it is hard to attribute the increase to one factor or the other.

4.7 Mobile phone short-text (SMS) platform 'Zambia U-Report' to increase demand for voluntary medical male circumcision among adolescents and young adults

CHAMP, IDinsight – Alison Connor

Zambia U-Report is a free SMS platform for young people to confidentially access information related to HIV/AIDS and STIs. Sending packages of messages about VMMC tailored to individuals with different intention levels over a six-month period did not produce significantly greater uptake of VMMC than sending the same package of messages to all participants. Participants may already have had access to information about VMMC, and segmentation may have been too crude. U-Report and SMS campaigns may have a place in demand generation alongside other interventions.

4.8 Innovative demand creation for voluntary medical male circumcision amongst potentially high-impact male populations in Uganda

IDinsight – Andrew Kambugu

This pilot study was an intervention to increase demand for VMMC among partners of pregnant women attending ANC clinics by empowering them to deliver comprehensive circumcision information to their uncircumcised male partners. Overall uptake of circumcision was low (less than 2%) in both the control phase and intervention phase. The single interface for the delivery of the intervention may not have been sufficient for critical knowledge and attitude change among the female partners to encourage them to engage with their male partners about VMMC.

4.9.a MCUTS I: Male Circumcision Uptake through Soccer in Zimbabwe

Grassroot Soccer, LSHTM – Jeff DeCelles

4.9.b MCUTS II: Male Circumcision Uptake through Soccer in Zimbabwe

Grassroot Soccer, LSHTM – Jeff DeCelles

These cluster-randomized trials involved 60-minute soccer-based sessions with adult soccer team members (MCUTS I) and youth aged 14-19 years in schools (MCUTS II), facilitated by circumcised men. MCUTS I led to a nine-fold increase in uptake of VMMC by the adult men. MCUTS II, which was based on the findings of the earlier study, used follow-up calls and accompaniment to the MC clinic by the soccer coach to encourage uptake among the adolescents, and led to a 12.2% uptake of VMMC in the intervention schools, compared with 4.6% in the control schools. Overall the intervention was more effective and scalable with adolescent students.

4.10 Testing innovative demand creation for safe medical male circumcision: the "Stylish Man" program, Uganda

RHSP – Maria Wawer

The Stylish Man pilot study aimed to "demedicalize" VMMC to make it more attractive to men, to involve the whole community in the MC conversation, and to improve access to VMMC services. Components included mass media (radio, posters), and a community "Stylish Man" event lasting 3-4 days with music, games, raffles, and testimonials about VMMC, with simultaneous access to circumcision via a mobile camp for men aged 18-49. The pilot mass media roll-out, and mass-media followed by the event, each led to the largest annual increases (8 percentage points) in VMMC uptake.

PART 5. PRESENTATIONS FROM GLOBAL STAKEHOLDERS

5.1 Kenya: Male Circumcision for HIV Prevention in Kenya: Seeking Effective Strategies to Recruit Older Men

CDC – Jonathan Grund

This study, and the two CDC studies following it, are ongoing, with results expected in 2015. The first study examines strategies for increasing VMMC uptake among men aged 25-39, who are exposed to interventions that address knowledge and structural barriers – either via enhanced IPC (door-to-

door one-on-one discussions) or through the use of dedicated service outlets special VMMC clinics/spaces for men aged 25 years or above, with dedicated counseling and waiting areas, flexible days and hours, and exclusively male service providers.

5.2 Tanzania: Increasing uptake of voluntary medical male circumcision among men aged 20-34 years in Njombe & Tabora Regions, Tanzania: A cluster randomized controlled trial

CDC – Jonathan Grund

This study examines whether communications and service delivery tailored to men aged 20-34 years will increase VMMC uptake among this group, and also aims to assess the relationship between client age and reported risk of HIV acquisition. The intervention uses community promotion (radio ads and mass media on non-HIV-related benefits of MC), peer promotion, and improved facilities through dedicated waiting and counseling areas and improved customer service.

5.3 South Africa: An implementation science study investigating profiles of men interested in medical male circumcision (MMC), barriers and methods to increase the uptake of MMC among older men in South Africa

CDC – Jonathan Grund

This study is examining whether VMMC uptake will increase among men aged 25-49 years when an "exclusive intervention package" is offered to them, including its own branding, an invitation to a VMMC forum with elders, separate queues for older men, VIP access to a private Facebook page, and exclusive services (newspapers, wifi, etc.) at the clinic.

5.4 Overcoming the seasonality barrier: a case study from Tanzania

USAID – Hally Mahler

Most countries experience some seasonality with regard to VMMC preferences, for reasons of cultural beliefs and traditions, the school calendar, or the agricultural season. This intervention aimed to break seasonality by operating mobile VMMC clinics in remote areas during the "off season"(including using GIS for better targeting of site placement); working with schools; sharing stories of "off season" circumcision; and operating a year-round campaign. These strategies were found to work, along with emphasizing the advantages of less waiting time during off-season clinics, training providers to address seasonality, and ongoing monitoring of results.

5.5 Adolescent VMMC multi-country assessment: highlights from the literature review

USAID – Lynn Vann

The goal of this review was to gain a better understanding of whether VMMC programs adequately meet adolescent needs in age-appropriate ways by exploring counseling, communication and client-provider interaction, disaggregated by age. The review highlighted the role of parents, families and educators in driving decisions to be circumcise, and that women are a key force for their husbands and sons and girlfriends. Fear of pain and of HIV testing, along with tribal and religious aversions, and opportunity costs, are the main barriers to VMMC. Misconceptions about what is involved in the

procedure were also a barrier, but counseling was of limited use for adolescents. Following this review, qualitative and quantitative data collection is being planned.

5.6 Demand generation implications: VMMC modeling consensus

USAID – Kim Seifert

USAID presented the findings of a modeling consensus meeting held in September 2014 with representatives from PEPFAR, BMGF, UNICEF and the World Bank, which discussed modeling outcomes for seven countries along four parameters—geography, magnitude of impact, cost-effectiveness, and immediacy of impact. There was consensus that VMMC services should not be denied to any adolescent or adult male who comes forward for services and who is medically eligible. Programs should simultaneously strive to Increase uptake among young adults aged 20-34 and improve the quality of services for adolescents. This will require innovations to make services more attractive to young adults at the recruitment and service levels. Apart from modeling, there is a need for improved program data to inform resourcing for programming, and better costing data to understand the complete cost of delivering VMMC services, including communication and demand generation costs.

5.7 McCann VMMC Demand Creation Partnership, South Africa

OGAC – Catey Laube

The partnership is designing a campaign to complement existing communication programs to accelerate uptake of VMMC in South Africa. Findings were presented from qualitative immersion interviews which form part of the market research phase of the campaign. There was a general but not universal understanding that VMMC is healthy, and an important intervention. Clinics were the primary source of information; it was somewhat common for men to discuss VMMC with friends but not with community leaders or females. There were inconclusive findings on female influence. Fear of circumcision was reported to be low. There was positive response to device-based circumcision, but muted interest, and negative responses in traditionally circumcising regions. There was a high degree of regional heterogeneity. OGAC is now planning a quantitative survey to verify and clarify observations from the qualitative immersion, and to explore males' self-image and aspirations, as well as issues of sexuality, demand seasonality, and barriers to action on VMMC, and to differentiate VMMC beliefs at cultural and individual level.

ANNEXES

Annex 1. Meeting participants

Annette	Brown	3IE	abrown@3ieimpact.org
Nancy	Diaz	3IE	ndiaz@3ieimpact.org
Kate	Abbot	BMGF	kate.abbott@gatesfoundation.org
James	Baer	BMGF	jbaer66@yahoo.com
Douglas	Hopper	BMGF	Douglas.Hopper@gatesfoundation.org
Krishna	Jafa	BMGF	Krishna.Jafa@gatesfoundation.org
Patrick	Odawo	BMGF	patrick.odawo@gatesfoundation.org
Renee	Ridzon	BMGF	reneeridzon@gmail.com
Sema	Sgaier	BMGF	sema.sgaier@gatesfoundation.org
McKenze	Sigler	BMGF	mckenze.sigler@gatesfoundation.org
Maaya	Sundaram	BMGF	maaya.sundaram@gatesfoundation.org
Crispin	Sapele	CHAMP	crispin.sapele@champ.org.zm
Dino	Rech	CHAPS	dino@chaps.org.za
Dirk	Talgaard	CHAPS	dirk@chaps.org.za
Jesse	Hastings	FHI360	JHastings@fhi360.org
Kathleen	Shears	FHI360	kshears@fhi360.org
Michael	Stalker	FHI360	mstalker@fhi360.org
Ram	Prasad	Final Mile	ram@finalmile.in
Anurag	Vaish	Final Mile	anurag@finalmile.in
Tommy	Clark	GRS	t.clark@grassrootsoccer.org
Jeff	DeCelles	GRS	j.decelles@grassrootsoccer.org
Sam	Mayer	GRS	smayer@grassrootsoccer.org
Methembe	Ndlovu	GRS	methembe@grassrootsoccer.org
Andrew	Kambugu	IDinsight	AKambugu@idi.co.ug
Alex	Muganzi	IDinsight	AMuganzi@idi.co.ug
Alison	Connor	IDinsight	alison.connor@idinsight.org
Fred	Church	IPSOS	fred.church@ipsos.com
Masha	Eletskaya	IPSOS	Maria.Eletskaya@ipsos.com
Francine	Fram	IPSOS	Francine.Fram@ipsos.com
Steve	Kretschmer	IPSOS	Steve.Kretschmer@Ipsos.com
Alice	Nanga	IPSOS	Alice.Nanga@ipsos.com
Katie	Plocheck	IPSOS	Katie.Plocheck@Ipsos.com
Sunny	Sharma	IPSOS	Sunny.Sharma@ipsos.com
Kawango	Agot	IRDO	mamagifto@yahoo.com
Hally	Mahler	JHPIEGO	Hally.Mahler@jhpiego.org
David	Ross	LSHTM	david.ross@lshtm.ac.uk
Catey	Laube	OGAC	LaubeMacDonaldCH@state.gov
Jason	Reed	OGAC	reedjb@state.gov
Kumbirai	Chatora	PSI	kchatora@psi-zim.co.zw
Namwinga	Chintu	PSI	namwingac@sfh.org.zm
Karin	Hatzold	PSI	khatzold@psi-zim.co.zw
Beth	Skorochod	PSI	eskorochod@psi.org
Brittany	Thurston	PSI	brittanyt@sfh.org.zm
Willa	Friedman	Reed College	whfriedman@uh.edu
Nicholas	Wilson	Reed College	nicholas.l.wilson@gmail.com
Stephen	Mugamba	RHSP	smugamba@rhsp.org
Maria	Wawer	RHSP	mwawer1@jhu.edu
Harsha	Thirumurthy	UNC	harsha@unc.edu
Jeff	Mulhausen	Upstream Thinking	jeff@upstreamthinking.com
Tim	Sweeny	Upstream Thinking	tim@upstreamthinking.com

Annex 2. Meeting agenda

Wednesday, January 7

Participants: BMGF partners

Welcome		
7:30-8:15am	Registration and breakfast	
8:15-8:30am	Welcome, meeting objectives, overview of BMGF demand generation strategy	Sema Sgaier BMGF
8:30-8:45am	Introductions	All
Session 1: Innovative Market Research Approaches to VMMC Demand Creation **Moderator: Sema Sgaier**		
8:45-10:00am	Path to MC and behavioral economics • Presentation of methods and analytical approach • Key findings and implications for demand creation activities in Zambia and Zimbabwe (preliminary)	IPSOS / Final Mile
10:00-10:10am	Break	All
10:10-10:50am	Quantitative Segmentation • Methods for questionnaire development • Presentation of survey draft and plan for implementation	IPSOS
10:50-12:00pm	Discussion • Questions / comments on Path to MC and behavioral economics • Discussion and feedback on quantitative survey instrument and approach	All
12:00-12:45pm	Lunch (continue discussion)	All
12:45-1:30pm	Sustainability • Presentation on methods and findings of qualitative surveys • Design considerations for quantitative work	IPSOS
1:30-2:15pm	Discussion	All
2:15-2:25pm	Break	All
2:25-2:50pm	Demand Based Device Forecast • Presentation of results and implications for device introduction	IPSOS
2:50-3:00pm	Break	All
3:00-3:30pm	Discussion	All
3:30-5:00pm	Demand generation strategies in Zambia and Zimbabwe	PSI
5:00-6:00pm	Discussion	All
6:00-7:00pm	Cocktails – BMGF Cedar / Duwamish	

Thursday, January 8

Participants: BMGF partners

7:30-8:15am	Registration and breakfast	All
8:15-8:30am	Summary of day 1, introduction of day 2	Sema Sgaier
Session 2a: VMMC Demand Creation Impact Evaluations - Incentives **Moderator: Annette Brown**		
8:30-8:45am	Effect of providing conditional economic compensation on uptake of voluntary medical male circumcision in Kenya	UNC / IRDO

8:45-9:00am	Optimizing the use of economic incentives to increase male circumcision demand: a randomized trial to compare fixed vs. lottery-based incentives in Kenya	UNC / IRDO
9:00-9:15am	The use of peer referral incentives to increase demand for voluntary medical male circumcision in Zambia: an impact evaluation	UNC / CIDRZ
9:15-9:30am	Advertising for demand creation for Voluntary Medical Male Circumcision in South Africa	CHAPS / Reed College
9:30-9:45am	Using smart phone raffles as a method to increase demand for male circumcision in Tanzania	JHPIEGO
9:45-10:00am	Break	
Session 2b: VMMC Demand Creation Impact Evaluations - Other **Moderator: Annette Brown**		
10:00-10:15am	Mobile phone short-text (SMS) platform 'Zambia U-Report' to increase demand for voluntary medicalized male circumcision among adolescents and young adults	CHAMP / IDInsight
10:15-10:30am	Innovative demand creation for voluntary medical male circumcision amongst potentially high-impact male populations in Uganda	IDI
10:30-10:45am	MCUTS I: Male Circumcision Uptake through Soccer in Zimbabwe	GRS / LSHTM
10:45-11:00am	MCUTS II: Male Circumcision Uptake through Soccer in Zimbabwe	GRS / LSHTM
11:00-11:15am	Testing innovative demand creation for safe medical male circumcision: the "Stylish Man" Program	RHSP
11:15-11:45am	Discussion	All
11:45-12:00pm	Break and walk to Evaluation & Eats session	All
12:00-1:30pm	Lunch; *Unpacking the Black Box of Demand Generation: Lessons from a holistic approach to demand generation for VMMC* • ***12:00-12:15*** *– Overview of BMGF approach to innovations in demand generation for VMMC* *Sema Sgaier (BMGF)* • ***12:15-12:35*** *– Market research & behavioral economics research* *Steve Kretschmer (Ipsos) & Ram Prasad (Final Mile)* • ***12:35-12:55*** *– Impact evaluation of innovative interventions* *Annette Brown (3ie)* • ***12:55-1:30*** *– Q&A with partner panel* *Sema Sgaier (BMGF), Jason Reed (PEPFAR), Steve Kretschmer (Ipsos), Ram Prasad (Final Mile), & Annette Brown (3ie)*	All
1:30-1:40pm	Break and walk back to conference room	All
Session 3: Communication, Advocacy, and Policy **Moderator: Maaya Sundaram**		
1:40-2:10pm	Clearinghouse website, demand generation portal, demand generation forum	FHI360
2:10-3:00pm	Discussion • How do we improve the portal? • What other communication/sharing tools could we create and utilize?	All
3:00-3:15pm	Break	All
3:15-4:00pm	Demand generation supplement	All
4:00-5:30pm	Policy considerations	All
5:45-8:00pm	Dinner – The Ruins	

Friday, January 9

Participants: BMGF partners + Global stakeholders

7:30-8:15am	Registration and breakfast	
8:15-8:30am	Summary of days 1-2, introduction of day 3	Sema Sgaier
Session 4: Summary and implications of BMGF studies and sharing other ongoing demand creation activities **Moderator: Sema Sgaier**		
8:30-10:30am	BMGF summary for global stakeholders	TBD
10:30-10:40am	Break	All
10:40-11:25am	CDC presentations: • Kenya: Male Circumcision for HIV Prevention in Kenya: Seeking Effective Strategies to Recruit Older Men • Tanzania: Increasing uptake of voluntary medical male circumcision among men aged 20-34 years in Njombe & Tabora Regions, Tanzania: A cluster randomized controlled trial • South Africa: An implementation science study investigating profiles of men interested in medical male circumcision (MMC), barriers and methods to increase the uptake of MMC among older men in South Africa	CDC
11:25-12:05pm	USAID presentations: • Overcoming the seasonality barrier: a case study from Tanzania • Report out on the Adolescent literature review (and brief update on the Adolescent Assessment) • Summary of consensus on demand creation implications based on modeling results	USAID
12:05-12:50pm	OGAC presentations: • Report out from McCann VMMC marketing partnership in South Africa • Update from PEPFAR HQ MC TWG Communication Sub-Group	OGAC
12:50-1:50pm	Lunch	All
1:50-3:30pm	Discussion	All
3:30-3:45pm	Break / Closing of the Demand Generation Meeting	All
3:45-6:00pm	Discussion – demand generation program implications	BMGF / Global Stakeholders