

**SOCIAL MOBILIZATION, IPC, MEDIA, FEMALE PARTNERS, RESEARCH,
ADVOCACY, ICT**

PROMISING PRACTICE Tanzania: Jhpiego Tanzania, Community Mobilization for “Older Men” and use of SMS and GIS technology.

INTRODUCTION

Key Promising Practices:

- Research based strategy for attracting older men to tailored services.
- Effective collaboration with local NGO’s to deliver demand creation through Peer Promoters and advocacy.
- Intense service delivery and demand creation during campaigns.
- SMS and toll free phone service to help men find their local service and access key information
- Geographical Information System created to pinpoint “hotspots” and low take-up / less covered areas.

Introduction:

In Tanzania, the Ministry of Health and Social Welfare has identified 12 priority regions for VMMC.

As a USAID–funded service provider, Jhpiego has been appointed to provide technical and financial assistance to the regions of Iringa, Njombe and more recently Tabora, all areas that had high HIV prevalence and low VMMC prevalence before the program began.

Jhpiego operates at 17 fixed sites, has worked at over 200 outreach sites, trains health workers, implements advocacy and demand creation activities, and conducts several high volume VMMC campaigns each year.

Jhpiego’s core demand creation activities are based on interpersonal communication, combining a mix of peer promotion, advocacy and experiential media. These are based on formative research conducted by Jhpiego. This research



is also provided to Jhpiego's mass media partner JHU·CCP. Jhpiego carries out the pre and post-testing of communications materials and provides feedback to JHU·CCP.

Jhpiego has also pioneered an SMS service for clients to obtain information about VMMC, and a Geographical Information System which maps out where procedures have been performed, and features layers of client and population data to help Jhpiego identify 'hotspots' and locations of communities that haven't been reached.

Since the project began in 2009, Jhpiego has performed over 220,000 circumcisions (as of July 2013).

In April 2013 Jhpiego also started four pilot projects in the Iringa region to provide Early Infant Male Circumcision (EIMC).

Integrated projects

When Jhpiego started offering VMMC services, it was already running an HIV Counseling and Testing program which covered the Njombe and Iringa regions. Therefore the C&T program provided a platform from which VMMC could be launched. Jhpiego engaged an NGO in Iringa to do outreach C&T, and these counselors became the first demand creation agents, receiving training in VMMC so that they could counsel clients as part of the C&T portfolio.

In 2009 Jhpiego was also heavily engaged in delivering maternal and child health services (through their Maisha program), cervical cancer testing (CECAP), and PMTCT. Efforts have been made to channel VMMC referrals through these and other services, and posters are on display at all outpatients sites which also offer VMMC, but Jhpiego hasn't been able to consistently rely on referrals through these routes, and so has invested time and money into going to people directly, through the demand creation activities described below.

Older Men – 'The Unpeeled Mango' Paper

When Jhpiego started offering VMMC in Iringa, demand creation was fairly easy to engineer. Simple advertising about the availability of services in local areas was attracting high numbers. In 2010 Jhpiego began its first major campaign with a mix of radio ads and experiential media groups – and actually attracted more clients than the sites could handle. However these were mostly young clients, in the age bracket 10–19.

Jhpiego undertook some formative qualitative research to try to get to the heart of why men aged over 20 weren't attending, with the aim of designing a more appropriate communications strategy for this age group. "The Unpeeled Mango" study was conducted in Iringa in early 2011. The study engaged 142 men and women from three districts in a series of focus groups and participatory exercises. The "older client" was defined by the participants as someone aged over 20, and a number of barriers were identified as to why these clients were not seeking VMMC. Some participants cited VMMC as not being regarded as appropriate for a man who is married and has fathered children. Mixing with younger boys, female providers and opening hours were also explored as factors, and a key discussion point was the "shame" factor for older men. It was revealed that not only do older men feel a lot of shame to be circumcised while mixing with young people at the clinics, they feel shame in general that they have not been circumcised, and so being seen by anyone in their community going to the clinic could cause a negative impact. These factors are also explored in the Global Health: Science and Practice research paper "Man What Took You So Long", which members of the Jhpiego contributed to.

Making Changes to Services

Taking the learnings from these studies, Jhpiego decided it wasn't necessarily the messaging that needed changing to attract older men – but the services themselves. This presented the challenge of how to make changes to the services, without restricting or deterring the high demand from younger clients, who were, after all, contributing significantly to the national targets that needed to be met. (NOTE: The national targets are boys and men aged 10–34.)

One of the reasons Peer Promoters were brought on board this year was to increase the IPC being done specifically with older men (aged 20 and above.) Jhpiego also experimented this year with opening a clinic for three weeks in Iringa, which was only for men aged 20 and above. They chose a facility that was brand new, and wasn't in a very public place. The clinic had male-only providers, was open 7 days a week, and also opened in evening. 219 "older men" attended. When asked informally why they attended that clinic, several expressed their preference to have the procedure done far from home. Some had travelled 30–40 kms to get circumcised there, even though there were facilities nearer to them.

Jhpiego is keen to test whether "distance" from home and/or other factors such as hours and privacy are significant considerations for older men in Iringa. A protocol to study why older men attend special clinics is currently with the local IRB awaiting approval. Jhpiego expects to conduct this research in August 2013.

Older men and private sector clinics

A combination of anecdotal evidence, and looking at the national take-up figures, has indicated that some older men are being successfully mobilized to go for VMMC, but are deciding to go to a private provider, rather than the free clinics. Jhpiego is currently developing a protocol to understand the private sector for VMMC in Iringa and Njombe. E.g. who is performing the procedures, safety aspects, and how to collect data on the private procedures? Jhpiego is keen to explore if this is an area it can expand into, and is also planning a feasibility study on providing mobile VMMC at older men's homes.

Jhpiego will also begin a 'Prepex' study in January 2014 to see how receptive clients might be to this method of circumcision.

Target Groups

The broad target group is HIV negative males aged 10 to 49. More tailored approaches, detailed above, are used for men aged 20 and above. Between 20%–25% of Jhpiego's circumcisions are performed on men over the age of 20.

Jhpiego has also developed materials and approaches for female partners of men aged 20 to 49, adolescents and their guardians, and key gatekeepers.

Scale and scope

Jhpiego's VMMC work has scaled up significantly over the last few years, with funding increasing from \$400,000 USD in 2009 to \$6,000,000 USD in 2013. Since 2009 the program has seen a progressive move from fixed sites to outreach and campaign sites – enabling the service to become very rural and extremely mobile. This in turn has necessitated a larger staff base (clinical and demand creation) and partnerships with local NGO's to deliver the work on the ground.

Jhpiego has offered circumcision at over 200 sites in Iringa and Njombe (which used to be one region), and in 2011 added Tabora region to its portfolio. This is a more populous region, with an estimated 400,000 men to be circumcised. So far Jhpiego have delivered 70,000 circumcisions in this area – and so this is the region which will see the largest scale up in the coming year.

With the increase in service delivery, the demand creation arm of the project has grown significantly – culminating in the full-time employment of 35 Peer Promoters last year. Jhpiego estimates it allocates approximately 20% of its budget to direct demand creation activities.

Organisations Involved

Lead

- Jhpiego, under the global award Maternal and Child Health Integrated Program

Funding

- USAID

Partners

- JHU·CCP(collaboration of IEC Materials) IDYDC, COCODA and TDFT (Regional partner NGO's for Demand Creation activities), Text To Change (SMS provider), Engender Health (NGO – collaboration on their Champion scheme)

Who is carrying out demand generation activities?

A mix of Peer Promoters employed by Jhpiego and volunteers from their regional partner NGO's deliver demand creation on the ground – using interpersonal communication and experiential media. Both Peer Promoters and NGO volunteers also identify and engage with respected community members and local leaders to undertake advocacy activities with them. Health facility staff will also go out to community groups and schools to raise awareness of the service if take up in an area is slow.

Regional NGOs:

In each of its three regions, Jhpiego has partnered with a local NGO to help deliver their demand creation activities. In Iringa the NGO is IDYDC (Iringa Development of Youth, Disabled and Children Care). In Tabora they have partnered with TDFT (Tabora Development Foundation Trust) and in Njombe with COCODA.

Demand Creation Materials:

John Hopkins Center for Communication Programs (JHU·CCP) carries out the graphic design for the leaflets, posters and flyers which are used by Peer Promoters, counselors and clinic staff when talking to people about VMMC. Jhpiego works closely with JHU·CCP to provide the text that goes into leafleting, and to carry out the pre-testing of the communication materials, as well as giving general feedback on how the materials are received.

JHU-CCP also produces radio spots and magazine shows in close collaboration with the Jhpiego teams on the ground, who often supply contributors and give feedback about the broadcast content.

VMMC ACTIVITIES

VMMC Activities:

Jhpiego delivers VMMC services at a mix of fixed and outreach sites (with the use of occasional mobile sites) during routine service delivery and campaign-style service delivery across Iringa, Njombe and Tabora. Its 17 fixed sites provide routine services at regional and districts hospitals and some large health centers, and perform VMMC all year round. Outreach sites are usually set up at local health centers or dispensaries and will run for two–four weeks at a time with campaign-style service delivery. Outreach activities are organized approximately every other month in each of the three regions, at around four sites per outreach activity.

The outreach sites also differ from the fixed sites in the way staff are deployed – VMMC providers will often be seconded from normal duties at fixed sites and paid an extra duty allowance to go to work at these more remote facilities, staying on site for the duration of the outreach activity.

Jhpiego also coordinates intensive four to eight week “campaigns” twice per year in each region. These are the most “intense” service delivery periods because staff are deployed to as many as 20 local sites, and will work six days a week, and some evenings to allow for older clients to attend outside working hours.

Jhpiego also uses SMS text messaging to communicate where and when VMMC services are available and deliver post-operative messages to those who have been circumcised.

Jhpiego’s pioneering of a GIS mapping project has assisted the teams in planning where to take outreach and campaign sites and demand creation activities, and to quantify how the different regions vary in VMMC take up.

THE APPROACH TO DEMAND CREATION

The approach to Demand Creation:

Rationale/theory of change

Jhpiego makes use of a number of theories to guide its work, including Stages of Change and Diffusions of Innovation theories, but does not feel that there is a one-size-fits-all theory for VMMC. Jhpiego seeks to shift social norms around VMMC and to help foster an enabling social environment for VMMC.

Key message

Messaging focuses on modernity, the fact the service is free, hygiene and health benefits. A shift away from making HIV prevention the “main” message has been experimented with – although it is important to note that the significant accomplishments of the program to-date have been achieved with HIV-prevention as the primary message. There is some experience and anecdotal evidence from the team suggesting understanding of the partial HIV prevention benefits of VMMC is well known now, and so a focus on other benefits may be appropriate for some audiences. There has also been some debate as to whether HIV may be stigmatising and therefore dissuade older men, since older men may not consider themselves at risk, or may be concerned that VMMC for HIV prevention could suggest infidelity to female partners. Since no formal research has been done to test out these theories, Jhpiego continues to promote HIV prevention strongly along with the other benefits during all demand creation activities.

DEMAND CREATION ACTIVITIES

Demand creation activities

While the most intensive demand creation tends to happen during campaigns, creating demand for both the fixed and outreach sites is a growing and important part of Jhpiego’s core work, given that big towns are starting to reach “saturation point” and teams are needing to travel further and work harder to attract clients.

Demand creation activities start a week before each outreach program, and two weeks or more before each campaign. Jhpiego employs a dedicated Community Mobilization manager in each of the three regions who co-ordinates all demand creation activities and manages the region’s Peer Promoters, NGOs and their district counterparts.

Campaigns are closely planned around seasonal times that are seen as “preferential” by local communities for VMMC – i.e. the cooler winter months are generally regarded as a better time to go for VMMC as it is believed healing times will be shorter (even though Peer Promoters and counselors do explain that the season makes no difference.)

Intervention components

Social Mobilisation

Social Mobilization activities using Peer Promoters: Jhpiego had informally engaged local people to carry out social mobilization activities for several years, recognizing the importance of talking to community leaders and getting to know an area before setting up a clinic. Community mobilizers and PA vans would be hired on an ad-hoc basis and regional community mobilization managers would carry out a number of advocacy and publicity based tasks all year round.

But as time went by, the team concluded that more “mobilizers” were needed on the ground to go further away from fixed sites and into remote areas on a regular and sustained basis. It was also felt that a more tailored approach was needed for older men. The Peer Promoter role was created recently to meet these needs.

Jhpiego employs a team of approximately 35 Peer Promoters across their three regions on a full-time basis, who go door-to-door and engage small groups of men in conversation about VMMC wherever they congregate. Peer Promoters also engage in talks in outpatient and MCH service waiting areas, discussions in workplaces, experiential media, and organize community football games and advocacy events.

Jhpiego primarily recruits people who are aged over 25 as Peer Promoters (so that they can talk more easily to older men and women), and they often come from health backgrounds and / or have good community links. Peer Promoters are paid a fixed monthly salary – and their performance is reviewed each month.

Experiential media is being used increasingly for campaigns and outreach sites. The experiential media agencies use a PA truck, drive through small areas and play music to catch people’s attention and perform skits and quiz shows to engage audiences. The Peer Promoters and trained staff from the experiential media agencies then hand out flyers and talk to groups or individuals about the VMMC campaign.

Training and mentoring

Jhpiego offers a practical training package to Peer Promoters and NGO volunteers which addresses both the scientific elements of VMMC and the skills needed to be able to talk to people knowledgeably and appropriately. The training package is currently being assessed and evolved by a consultant specializing in public health and social mobilization.

The curriculum spans five days training, broken down into:

1) What is VMMC?

This involves an exploration of the science, and a site visit to a clinic so that Peer Promoters can shadow the steps a client goes through, and observe the actual procedure.

2) Social and Cultural Issues / Target Groups

This covers how to deal with cultures that don't traditionally circumcise, perceptions and myths about VMMC, and explores the findings of The Unpeeled Mango research into older men. This theme also involves practical exercises, requiring Peer Promoters to go out into their own communities to do their own mini study to test out these ideas and theories, and gain other people's knowledge, perspectives and concerns.

3) Social Mobilization Approaches

The trainees undergo a practical exploration of the three main social mobilization approaches, and when they are most useful: peer education, performing arts and community dialogues. The team using role play and practical exercises to play out scenarios and test communication techniques. The trainees also look at the best way to use materials such as brochures and demo kits, and how to access the free SMS and phone hotline.

Supervision and Performance

Once in the field, the Peer Promoters receive ongoing mentoring from their supervisors (Peer coordinators) who regularly attend the sites where they are operating, to work with the Peer Promoters and give them on the spot feedback. Each region also has a regional manager responsible for community mobilization who manages the Peer coordinators, and organizes monthly group meetings to provide further feedback and a forum to discuss any arising issues.

Partner NGO's also send out district coordinators to visit their Peer Promoters at campaigns and static sites. Coordinators try to tackle any challenges on spot but will also take these to the Jhpiego manager for collaborative problem solving.

Performance of Peer Promoters can also be monitored to a certain extent through the referral system. 'Referral books' are given to Peer Promoters, who fill out slips for each person they mobilize. The aim is that the client will take the slip along to their appointment, so that Jhpiego can trace how many men who have been reached by Peer Promoters are making it into the services. However the system isn't foolproof, sometimes men will forget to bring the slips or forget to mention that they'd talked to a Peer Promoter – so the feeling on the ground is that the success

rate of Peer Promoters is probably better than the referral slips would suggest. [Click here](#) to read more about insights from Peer Promoters in Sawala, rural Iringa.

One strong indicator of the success Peer Promoters are achieving is the analysis of attendance at fixed sites in Njombe. The uptake at fixed sites in Njombe in June 2013 rose to 534 clients. This was double the attendance from the same time the previous year. Anecdotally staff in Iringa province have also noticed huge difference in attendance at fixed sites since Peer Promoters started working there.

Payment and motivation

Peer promoters get paid 15,000 shillings – about \$100 per month to carry out their demand creation activities 5 days a week. This sum covers transport and logistics, plus a little more for their pockets.

Keeping morale high is certainly an issue Jhpiego is addressing. Managers do the best to motivate their teams – both counselors and Peer Promoters are often reminded that for every six circumcisions performed, one HIV infection has been averted. But Jhpiego recognizes that money is still a big, if not the main motivating factor and is working on fine-tuning the payment arrangements.

Collaboration with local NGO's

By contracting local NGO's to work in their three designated regions, Jhpiego has been able to widen the reach and number of Peer Promoters on the ground, and capitalize on the local knowledge and resources that NGO's can offer.

Case Study: Jhpiego and NGO partner IDYDC in Iringa

Jhpiego has forged a successful partnership with IDYDC, a local NGO which already had a pool of 80 volunteer Peer Promoters in Iringa, delivering a range of health based interventions.

IDYDC are subcontracted to send out their volunteers to do advocacy and social-mobilizing. Their volunteers join with Jhpiego's Peer Promoters to undertake a variety of demand creation activities across the region, both during campaigns and for routine service delivery at both outreach and fixed sites.

Before they joined with IDYDC, most of Jhpiego's demand creation efforts were focused on campaigns. As a result they found fixed sites were suffering – attracting relatively small numbers of clients. So the initial remit was for IDYDC's volunteers to carry out demand creation for their fixed sites. This worked so well

that their work has been expanded to outreach and campaigns too, combining efforts with Jhpiego's 14 Peer Promoters in Iringa.

Training and selection of IDYDC's Peer Promoters:

Peer Promoters are selected by IDYDC via community leaders, who they consult to nominate suitable and well known candidates in the local community. A mix of men and women are recruited, as IDYDC have found some men are comfortable talking to women, but others for cultural reasons are not. And as they are targeting men aged over 20, they feel using women as Peer Promoters is very useful for talking to wives and partners to reach married men by proxy.

Criteria for Peer Promoter selection include:

- Ability to speak well to people
- A suitable level of knowledge / education
- Ability to convince people and listen well
- Ability to volunteer
- Age 20+ as they need to be comfortable talking to older people.

The IDYDC volunteers receive the same training as Jhpiego's Peer Promoters, which also helps them build strong working relationships with each other, as Peer Promoters from both organizations will visit sites and carry out outreach activities together.

Payment and motivation

IDYDC PP's are volunteers but get a personal allowance for food and transport. When recruited, the strong motivating factor for taking the role is about serving and helping their community. [Click here](#) to read more about Jhpiego and IDYC Peer Promoters in Sawala, rural Iringa.

3) Collaboration with the Champion Project Community Action Teams

Jhpiego have also partnered with NGO Engender Health who run a project called Champion to specifically engage with older men. Champion trains and sends out Community Action Teams (CATS) comprised of older men to reach out to older men and their partners on a variety of topics surrounding health and gender behavior. Jhpiego saw this as a great opportunity to increase demand for VMMC, and so have subcontracted these CAT's to do VMMC recruitment for static sites. They received training from Jhpiego to streamline messaging. The Engender Health project finishes in early 2014.

4) Toll Free SMS and Hotline Number

In order to make information about VMMC more widely available, keep communities up to date on newly opened sites and to improve post-operative adherence, Jhpiego set up a mobile phone system in partnership with Text to Change in 2011. This partnership established a toll-free SMS service available on all mobile phone networks. Men who are interested in learning more about VMMC can text the Swahili word “Tohara” to the number 15014 and begin to receive a series of SMS messages with information about the benefits of VMMC, plus other messages promoting uptake. Men can also text “Wapi” to locate their nearest VMMC facility and to access information about opening hours. In each of the three regions, men can text “Iringa”, “Tabora” or “Njombe” to receive the details of the current local facilities also.

Jhpiego co-ordinates its service plans with Text to Change regularly to make sure their details of sites are as accurate as possible. Via email, Jhpiego can submit preferences for what the text message should say at any given time. For example, during a four week campaign in rural Iringa, anyone texting “Iringa” would get details of the campaign sites during those four weeks, but the text would revert back to listing static sites once the campaign had finished. All messages are designed first in English and then translated to Swahili.

There is also a text service dedicated to helping clients after they have had VMMC. By texting “Baada” to 15014, they will receive eight messages over six weeks with post-operative information about wound care, the abstinence period and reminders on when to return for check-ups. Nearly 10% of individuals who requested VMMC information by SMS later went on to request post-op circumcision information.

None of these text services are interactive – i.e. clients can’t text back questions or responses, but Jhpiego also provides a number which can be texted or called 24/7 by clients with questions or concerns. On the other end of this number is a person “on call” to answer questions, who will call or text back the caller if necessary.

Peer Promoters, counselors and other supply staff are equipped with the knowledge and frequently reminded to refer clients to the SMS and toll free number. The text number is also advertised on flyers, posters, banners, brochures, bumper stickers, tire covers and on the t-shirts worn by Peer Promoters.

5) Geographic Information System (GIS)

Jhpiego has pioneered the use of a Geographic Information System (GIS) to map its VMMC activities, explore trends and inform decisions on where to set up new outreach and campaign sites.

To create these maps, Jhpiego's research coordinator adapted a program called Quantum GIS, which is open source software and free to use.

The GIS was then populated with a range of data from several sources – Jhpiego's client data, MoH health facility locations (delineated by wards, villages and districts), population and road data, HIV research data and census results (which are useful for working out where to find married men).

The research coordinator then added new and remote health facilities, and cross-checked their GPS coordinates using Google Earth. Data was put into SHAPE files which produce tables that are represented visually, like a map. These files can be layered on top of each other to tell a story with the data.

The results have proved incredibly insightful for the Jhpiego team. They have used the maps to cross-check recommendations on where to conduct demand creation, and to identify which populations still need to be reached. Layered maps helped Jhpiego to select 24 facilities for a 2012 campaign in which over 26,000 men were circumcised in six weeks. Applying the maps to "older men", the team has looked at where the black spots are, revealing that they've served 80% of younger men but only 4% of older men in certain areas.

As well as using GIS to plan where to take campaigns, site assessment data has been added so that the team can see at a glance where they have things like water and electricity, but where would need to bring their own generator / supplies.

As the VMMC program heads closer to its 80% coverage target, GIS has become invaluable in working out how to maximise efforts in remote areas. The team use the mapping to focus on "hotspots" for HIV transmission and clusters of populations which haven't been able to access services.

An interesting observation using the GIS is that no areas in Iringa, Njombe and Tabora are fully saturated – yet. This is mostly down to the lower uptake numbers of older men, so even in Iringa town as an example, there are still considerable numbers who have not been served.

The mapping has also steered the team towards some surprising trends, i.e. the uptake of VMMC among older men seems stronger in Njombe compared to Iringa (despite Iringa having a higher volume of campaigns aimed at older men).

The challenge with using GIS has been to keep the data “clean” and up to date. Checking the facilities have been mapped correctly has been time intensive and needs constant monitoring. With hundreds of circumcisions being performed each day, the GIS ideally needs updating at least every month, whereas at the moment lack of personnel to take on this task means it can only be updated every six months. The team feel they have only just started to scratch the surface of GIS’s potential applications, and would like to integrate the GIS fully into the VMMC project’s scope of work.

The potential to scale up the GIS for use among all implementers is an exciting prospect – as in theory the mapping could be extended to cover the whole of Tanzania (or at least the 12 priority regions), using the data that is available from the National Institute of Medical Research. But the question remains as to how it would be managed and who would manage it.

EVALUATION OF INTERVENTION PERFORMANCE

Evaluation of intervention performance

Jhpiego has not conducted a formal evaluation of its demand creation activities around VMMC but has researched both the social and service related barriers and facilitators to uptake in order to inform and improve their demand creation activities. See the “Unpeeled Mango” paper.

Client forms and data analysis

The data from client record forms has been able to provide some insight into client’s motivations for attending a clinic, and is being used by teams both at site and regional level to monitor attendance trends and target groups, as well as analyse some of the impact demand creation is having.



(BLUE CLIENT FORM)

The client form is a four page document which is filled out by counsellors, and includes personal details (such as age, marital status and address), medical history and HIV status. The form also contains a box asking where the client was referred from. The options are 1) Self-referred 2) VCT 3) PITC and 4) Other.

The vast majority of people tick the “self-referred” box. The counsellor will then try to probe a bit further as to whether this self-referral was as a result of speaking to a Peer Promoter, hearing a PA or radio spot, or other reasons, and they will note this on the form.

Data from the client cards is uploaded to Jhpiego’s client database on a daily basis at each site during campaigns and outreaches, and analysts can extrapolate how many people list Peer Promoters, or radio for example, as their primary motivating factor for attending that site.

On a visit to Sawala, a site in rural Iringa, the data manager was able to look back at the last 10 days of the winter campaign and deduce that almost two thirds of clients had attended as a result of talking to Peer Promoters.

Jhpiego recognises that this analysis has its limitations – the current structure of the client form does not list the “referral methods” individually, in an easy tick-box format, and so the demand creation data is relying on counsellors to obtain the information verbally, which may not always be possible given the time constraints and other priorities of their job. Some men also attend in groups, and so the “self-referred” box doesn’t always allow for enough explanation for what motivated the group overall. Nor does it unpick the multiple influences which may have led to the man choosing to come for VMMC.

The client form is produced by the Tanzanian government, and so it might take some time and political will to modify these forms to better reflect demand creation

avenues, but Jhpiego continues to encourage its staff to talk to clients about their motivations for attending as much as possible, and staff have much anecdotal evidence of the success of Peer Promoters, PA vans and radio spots.

In order to qualify some of this anecdotal evidence, Jhpiego has recently implemented a research study into what motivated a man to attend for VMMC. The study asked a selection of clients about their reasons for attending. Analysis of the results is underway, and the final report is due later in 2013.

Results so far

Jhpiego has achieved 220,000 circumcisions in total since 2009 (as of July 2013).

Targets have been a little complicated by the fact that Iringa and Njombe used to be one region called “Iringa”. Jhpiego originally had a target of 264,000 in “Iringa” (both regions combined) and had achieved 180,000+ VMMCs in three years of implementation (post the pilot period) in both regions combined. So Jhpiego is well on the way to meeting the target. Tabora has a target of 310,000. Jhpiego started scaling up there around a year ago and have reached 51,000 circumcisions.

LEARNING AND SCALE UP

Behind the Demand Creation approach: success and challenges

- Jhpiego has successfully diversified from fixed site provision to rural, mobile outreach, and in doing so has risen to the challenge of reaching people in less populated areas. As time goes by, and as use of the GIS system has shown, Jhpiego will need to go into increasingly remote areas, with dispersed populations, where the “hit” per square mile is significantly lower. Therefore to keep meeting its targets the team have to do more to reach and motivate people, and getting the final hundred thousand clients might require further innovation and strategic planning.
- Jhpiego’s efforts to attract older men to their services have revealed a number of significant successes and challenges. The “older male” clinic trialled in Iringa demonstrated that changing a service and making it more tailored to their personal preferences can attract the numbers, but the bigger challenge is to roll out this kind of adaptation out without losing clients in younger age brackets and also ensuring that there are enough providers working long enough hours.

- Jhpiego currently gives priority to men aged above 20 at the majority of its fixed, outreach and campaign sites, and at some of these is able to provide separate entrances, waiting areas and procedure rooms. Peer Educators publicise this, and this information is also included in the local radio spots. This adaptation has meant the sites are better able to balance older men's requirements, with the high volume of youths and boys who still attend in large numbers, but as a result young boys are sometimes asked to come back the next day when the site can't get through all their procedures in one day.

The section below examines the challenges and successes Jhpiego staff and partners have encountered while working on the winter campaign in Mufindi, which has involved a strong push to attract older men to the sites.

Case Study: Winter Campaign in Sawala, Mufindi District (Rural Iringa Province)



(PICTURE OF RURAL MUFINDI)

The Mufindi District is a rich area for timber manufacture, which means there are high volumes of men working and travelling into the area, which has also attracted

sex workers, and contributed significantly to the high HIV infection rate in this part of Iringa.



(PICTURE OF COUNSELLOR)

Ordina, a counsellor on site identifies her biggest challenge is that men come to her fearing the HIV test, and often ask if it is compulsory to take it in order for them to receive VMMC. Their fear comes from not wanting to be perceived as HIV positive if people find out they have taken the test. Ordina does her best to reassure the clients that it is not compulsory, but still an easy and advantageous thing to do.

Consolata Masasi, also a counsellor working on the rural Iringa campaign, thinks older men can be reached effectively by their peers acting as “ambassadors”. During campaigns she’s often witnessed friends and colleagues of men who have been circumcised turning up while the site is there, as their peer had a good experience.

Clients are frequently concerned about the effect VMMC will have on their fertility and performance. Some men come with the perception that their penis will be smaller afterwards. The older clients often ask when they can engage in sex again. So one of the biggest challenges Consolata faces is persuading the men why they must abstain from sex for six weeks.



(FELLY AND MARGARET, PEER PROMOTERS)

Felly, Peer Promoter for Jhpiego and Margaret, Peer Promoter for IDYC often work together in their local community and during outreach / campaigns to bring men to the clinics. Felly says the work isn't easy – but often by teaching the clients the consequences of not being circumcised is the most effective way he feels he can convince them. From his experiences men are often shy and insecure about coming for VMMC. So being able to offer an evening / night services has been a successful option to have at hand.

When specifically working with older men he has observed that they wait a long time between been told about the service and actually turning up – weeks or months sometimes. He finds one of the effective ways to convince them is to highlight how they can be a role model for their community. In Iringa town he's observed that the older men are getting the message through posters and radio spots, and so they are much easier to convince compared to the men in rural areas. Felly and his colleagues will often actually try to escort a man to the clinic if they can agree a time and date for the procedure.

Felly says he is strongly motivated by the desire to serve and educate his own community. He thinks looking the part is key to success – wearing the 'Tohara' t-shirt, wrist bands and bandanas mean he is instantly recognised and the community members will come to him and feel able to ask him questions.

A practical addition that would make his work easier is a bicycle or motorcycle. Getting around the spread out villages is hard logistically and often time consuming.

Margaret, a Peer Promoter from IDYC concentrates on getting clients into fixed sites outside of campaign time. She says some of the challenges include access – getting into schools often requires special letters and permissions from the regional educational officer, which takes time, and persuading people to travel long distances can also be difficult. There is also sometimes a suspicion about why the service is free – what is the agenda for the government and people providing the service? In the Sawala area the Peer Promoters have observed that the education level is fairly low and so a lot of myths and rumours about VMMC exist. A big part of her work is educating and correcting the myths and misconceptions about VMMC.

Anna is a Peer Coordinator and supervises 20 of IDYDC's peer educators on the VMMC program, including Margaret. She helps the Peer Promoters with difficulties and also does talks and networking within communities. She is in contact with each

team member every week and will be on site with around 5 Peer Promoters each day.

She cites the main challenges the Peer Promoters come to her with are cultural barriers, such as the perception that VMMC is for young people, not adults. Some



communities in rural Iringa also believe in the traditional way of circumcising, so the medical type of circumcision is not always welcome. In rural areas it is always a challenge reach people – farmers are often working, and so her Peer Promoters have to make several visits sometimes to find people when they are available and receptive to speak to them.

(PICTURE L TO R OF FELIX – PEER PROMOTER, CAESAR – JHPIEGO COMMUNITY MOBILIZATION OFFICER FOR IRINGA, ANNA – IDYDC PEER COORDINATOR AND ESTHER SAWALA VILLAGE EXECUTIVE OFFICER)

Jhpiego works closely with village leaders to get support from the local community, such as Esther Michael Ngolole, the village executive officer for Sawala. Her observations are that older men are shy, and so less willing to turn up to the service compared to the young boys and teens. She thinks the best ways to reach these men is to give them more detailed information, and increase radio ads and materials to let them know about evening appointments. She also thinks the teams need to increase the length of time they are doing outreach services – and to come back more frequently to catch the men who didn't come first time round, but may have spoken to friends and colleagues since.

On-going challenges and looking for solutions

- Jhpiego continues to use feedback from Peer Promoters on the ground to shape their knowledge and understanding of different communities, and the best ways to reach them. A common challenge that the team continues to explore is how to approach communities that don't traditionally have a culture of circumcision and regard it as something that other people do. Teams have tackled this by focussing as much as possible on the medical benefits and the modernity of the procedure, in the hope that over time this

leads to a bigger “cultural shift”, which implementers are seeing has already occurred amongst many younger groups of men.

- In Njombe, the teams have met some significant challenges when trying to secure support from the Catholic Church, which has considerable presence and influence in the region, and owns hundreds of medical facilities which Jhpiego would like to work with.
- The main challenge encountered has been to the acceptability of the HIV and condom use messaging. Some church leaders are not keen for the 60% HIV reduction statistic to be used in materials such as booklets and flyers, and don't want to actively promote condom use or distribution. These leaders would prefer Jhpiego to focus on other health benefits, such as hygiene..
- Jhpiego is currently in negotiations to see how the materials can be modified to strike an acceptable balance. This challenge raises wide questions about how to accommodate religious and cultural values within medical campaigns. It also presents the practical problem of whether producing two sets of different messaging for two geographically close areas (Iringa and Njombe) are feasible or sustainable.
- Some church leaders have shown much stronger support for the full package of messages – and so one solution the team is considering is more in-depth advocacy work with influential leaders who can help the teams make some inroads in Njombe.
- In Njombe isolating and engaging the influentials is a challenge Jhpiego's training consultant is keen to address. He would like add to the training some tools for helping the Peer Promoters build up relationships with community leaders over time. It might have been assumed in the past that buy-in to the project could be secured after a couple of conversations, but in actual fact more time and effort is needed to build up a rapport and identify what could motivate these leaders to become not just interested, but actively engaged in support for VMMC.