

Social mobilisation, IPC, research, incentives and performance based payment

PROMISING PRACTICE South Africa: The Centre for HIV/AIDS Prevention Studies (CHAPS)

INTRODUCTION

Key Promising Practices:

- CHAPS has achieved record numbers of VMMC.
- Despite success to date, they are currently undertaking qualitative and quantitative research which will inform a revision of their demand creation strategy.
- CHAPS management constantly review their approaches. They are able to do this by maintaining very close contact with their mobilisers to hear regular feedback from clients and potential clients.
- CHAPS has a collective incentive structure which encourages teams to work together.
- Strong systems, motivated staff and a high performance culture are pillars of the organization and its demand creation success.

Introduction

The Centre for HIV/AIDS Prevention Studies (CHAPS) is a service provider and research organisation. CHAPS is a leading service provider of VMMC in South Africa offering on average over 8000 VMCMCs per month through the Bophele Mele Circumcision Project which launched in 2008 and 30 similar HIV prevention focused clinics. CHAPS works on multiple projects funded by USAID, Global Fund and the ANRS and provides vital technical support to national efforts to scale up high volume sites.

CHAPS was involved in the original circumcision trials in South Africa and played the central role in the development of the WHO MOVE model. They focus on Gauteng, North West and Limpopo provinces and have performed about 150,000 circumcisions since April 2012, more than any other USAID implementer. They have a mixed service model with over 30 fixed clinics with mobile teams attached to them. They have launched a mobile truck initiative to target remote areas. They believe in the saturation approach, though they note it's more difficult to maintain numbers than with the roving model.

Target groups

- Primary audience: CHAPS' main target audience for demand creation is the 15 – 49 age group, with a particular focus on demand creation resources targeting men between 15 –25. CHAPS notes that targeting men 25 and above has a lower yield per rand spent.

Scale and scope

- Gauteng and North West and Limpopo.

Organizations involved

Lead

- CHAPS

Funding

- USAID, Global Fund, PEPFAR and the ANRS.

CHAPS estimates that it costs about R1 million per year for to run each site. Some of the sites do not operate every day, although there are three sites supported by the Global Fund which run 7 days a week. The actual budget of CHAPS is difficult to calculate, as it depends on how many circumcisions they perform. Their grant from USAID is a service contract which is performance-based.

Other partners

- South African National Health Department, Right To Care, Anova, R2P and Foresight,

Who is carrying out demand generation activities?

- CHAPS. They also make use of content developed by JHESSA in their demand generation activities.

Management of demand creation

- CHAPS

VMMC ACTIVITIES

VMMC activities

CHAPS provides free medical male circumcision as part of HIV prevention through more than 30 fixed clinics, achieving a high number of MMC per site per day. Such efficiency is achieved through the organisation's pioneering Models of Optimising Volume and Efficiency (MOVE) approach which has been adopted by the World Health Organisation.

CHAPS has also trained more than 2000 doctors and nurses from the private, non-government and government sectors in safe medical male circumcision practices and procedures.

Providing a safe, welcoming and positive environment at clinics is key to CHAPS' approach to building demand amongst candidate clients. Part of the education of the clinic staff involves teaching them to add comforting and personal touches, such as offering tea and biscuits while people wait.

CHAPS recognise the fundamental importance of word of mouth and the testimonies of men who have had the procedure in driving demand for VMMC. All recognise that demand will quickly plateau if clients have and then share a negative experience at the clinic. This is backed up by their qualitative and quantitative research.

APPROACH TO DEMAND CREATION

The approach to Demand Creation:

Key message

CHAPS intends to revise its demand creation strategy, including the choice of media channels and messages, based on the findings of qualitative and quantitative research projects underway in 2012 and 2013 which are described below.

Type of intervention

The main focus of demand creation for CHAPS is social mobilization, though they have also commissioned print and promotion materials and have worked with a number of local radio stations.

Rationale

CHAPS is focused on achieving its numerical targets and its demand creation activities are not guided by a particular theory of change. CHAPS is guided by a pragmatic approach and is keen to adopt messages that build on research showing that women prefer circumcised men, exploring messages around sexual attractiveness rather than focusing on function benefits such as HIV prevention.

EVIDENCE BASE

Evidence base

CHAPS is also a research organisation and conducted a number of focus groups 3 to 4 years ago which explored barriers and motivators to VMMC uptake. Over the past year CHAPS have been conducting a major qualitative assessment in Gauteng Province featuring 12 focus group discussions with circumcised and uncircumcised males of different ages and 6 in-depth-interviews with female partners of circumcised males. The objective has been to explore how young men and women understand VMMC within the context of existing demand creation efforts in their own communities, to explore communication dynamics around the VMMC decision-making process, to inform content and strategy for future VMMC communications as part of comprehensive HIV prevention efforts and to explore how SMS technology might be leveraged to drive demand for VMMC. The report on the first group of focus groups discussion and in-depth interviews that were conducted in mid-2012, entitled "Digging up the Dirt on Demand Creation", is available on this website.

Broadly, the study concluded that there exists a complex interplay of factors which impact on the decisional balance of males, whether circumcised or uncircumcised. Findings included:

- Uncircumcised men in Gauteng Province are not a homogenous group. While certain barriers and motivators were common across the respondents, important differences emerged along ethnic lines, age, and relationship status and around conceptions of masculinity.
- Enlisting proactive outreach workers emerged as a key strategy to establish a rapport with uncircumcised men in the community. These outreach workers are most effective when trained in communications skills and equipped with print materials providing facts about the benefits and limitations of VMMC that they can leave with potential clients and their families. (For more on topics to be addressed through print materials see research report).

Respondents also expressed a desire to learn more about what happens at the clinics, a request easily addressed by outreach workers.

- The cultural norms of potential clients should be respected to avoid alienation. However, it is clear that they present a real threat to VMMC scale up which will grow more acute as demand creation shifts to rural areas where culture remains an important factor in decision making. The Xhosas and Sothos describe themselves culturally as ‘circumcising’, while the Zulus still define themselves as ‘non-circumcising’ (despite King Goodwill’s support of circumcision). The Xhosa and Sotho participants cited their fear of the ancestors if VMMC was undertaken. Participants also described feeling forced to be circumcised traditionally due to family pressures and restrictions. One respondent suggested that communications activities could begin delinking cultural identity from circumcision.
- Both circumcised and uncircumcised men cited fear of pain during and after the procedure as a barrier.
- Female partners were cited as a source of information on VMMC, but their role in the decision-making process was unclear.
- Most respondents knew about the HIV risk reduction benefits of VMMC, yet could not always explain exactly why VMMC reduces the risk of contracting HIV. There appeared to be a correlation between VMMC and eradicating ‘dirt’ which might have implications for how HIV risk reduction is communicated.
- The role of discussion is key: respondents described how the decision to undergo or reject VMMC was taken as the result of a consultative process involving friends, family, peers, partners and outreach workers. Peers, in particular, exert an enormous amount of influence on each other. It is therefore critical that they are fully informed. There is also scope to enlist circumcised males in discussions with their uncircumcised peers led by outreach workers.

To complement the ongoing qualitative work, they are also currently conducting a quantitative survey (sample 1920) with clients who present themselves at clinics to undergo the VMMC procedures to explore the factors which motivated them to

come and where they got their information about VMMC. They will triangulate the data across both the qualitative and quantitative studies.

CHAPS intends to revise its demand creation strategy, including the choice of media channels and messages, based on the findings of these qualitative and quantitative research projects underway in 2012 and 2013.

DEMAND CREATION ACTIVITIES

Demand Creation Activities

CHAPS usually begins demand creation work in the communities in which it operates by engaging with the community leadership, both formal and informal structures. The preliminary sensitisation process also includes reaching out to traditional circumcisers and running informational workshops with key local organisations and in schools and clinics. This is supported by through the line communications activity, of which social mobilisation is a key element.

Social mobilisation

CHAPS employs a core outreach team of about 30 on a full-time basis, which increases to 60 or 70 persons during peak periods. The teams are comprised of 5–8 recruiters with 1 supervisor and work towards meeting set targets. CHAPS provides a group bonus for each team if targets are met. These teams go door-to-door and engage in community outreach, at malls, soccer practices and other social gatherings. They've found that women tend to make better mobilizers and hence the majority of their team are women. They register those that they have spoken to and CHAPS measures those that turn up at a clinic.

CHAPS also conducts multiple outreach campaigns during the course of each year, during which they deploy clinical and outreach teams and set up gazebo tents, hire PA systems, play music, hand out branded t-shirts, bracelets and flyers encouraging people to visit nearby clinics.

Each area has a coordinator who works with the local political structures and clinic so as to draw up a plan of who, when and how the mobilisers are going to approach different areas and people. The outreach manager revises this with the coordinators on a regular basis to assess what the upcoming plans are and why certain decisions were made.

An average mobilisation runs as follows: The team are delivered to a site in a mini-bus. From there they fan out, stopping everyone that crosses their path, knocking on doors and encouraging playing children to take them back to their parents' houses to start the process of getting consent for VMMC. The mobilisers are goal-focused and well able to find creative ways of bringing people to the clinic. Those showing an interest give their phone numbers to the recruiters, who make follow-up calls the next day or the same evening, and arrange for the interested parties to be collected and taken to the relevant clinics for their circumcision operations.

Mobilisers focus on taxi ranks, sporting events, malls and other places where people congregate in large groups. They have also found that approaching VMMC from the angle of HIV/AIDS prevention is not as effective as discussing the procedure as a health matter. Once the men are at the clinics, more is said about HIV/AIDS. This is a practical solution to a key barrier to VMMC: the idea that by agreeing to it, the patient will have to subject himself to an AIDS test.

CHAPS offers free transport to men who wish to attend the clinics for the procedures. Each manager who is in charge of an area with as many as five clinics has a six-seater vehicle that can be used to transport patients from various pick-up points in the area. CHAPS pays some local taxi drivers a fortnightly retainer so that they can be on standby if a larger vehicle is needed to get the VMMC volunteers to the clinics.

Some patients prefer to come in for the procedure under their own steam. Travelling in a CHAPS vehicle may carry some sensitive social connotations for young men. However, overall this transport system works well.

A day and a half is spent training the mobilisers. They are provided with background information which helps them argue key points during a discussion with a potential client. New mobilisers are then put together with experienced mobilisers in order to learn the negotiation process through observation and begin working with clients with a colleague at hand to provide guidance and support. They are coached on how to talk to various groups with a range of distinct concerns.

The mobilisers meet with their local mobilising co-ordinator every morning to work out their plans for the day. The outreach manager and mobilising co-ordinator meet every week, and the local outreach managers regularly meet with the overall outreach manager. The CEO meets regularly with the management team to find out what's going on on the ground. Twice a year there is a break-away session where the whole team gets together to strategise, impart new skills, talk about how to improve things and discuss what is and isn't working.

Incentive framework

The CHAPS team members are committed to providing VMMC for its HIV prevention and other benefits and undertake this work with pride. However, keeping the record level of numbers up, day in, day out, is also a product of good management and careful staff motivation efforts.

A practical incentive framework drives the mobilisation effort. There are a number of different teams within CHAPS, each looking after different sites. Teams consist of mobilisers and clinical staff and the people that manage and support them. Each team is given a group incentive in the form of a bonus (percentage of monthly salary that can range from 25% to 80% or even a full 13th cheque).

This means each member of the group has to pull his/her weight and is put under pressure by the others in the group to do so, or each person in the group forfeits their bonus. For the mobilisers the bonus works according to the numbers of men brought in for VMMC who were then circumcised. This is a group target. Incentive bonuses are not allocated on a per client basis.

The clinic staff members (doctors and nurses) that perform the procedures receive the same percentage bonus as the group. This means that mobilisers and clinicians are incentivised to work together, to communicate, and to address any problems that arise. Site managers may phone headquarters to ask for more mobilisers, or mobilising teams may request more transport. Any obstacle that stops targets being reached, and bonuses being granted, becomes a shared problem which the entire team needs to address. They have to work well with each other and give feedback on all fronts. They aim for collective targets, and all numbers are recorded on a central database at CHAPS and evaluated monthly.

Each mobiliser must bring in at least 40 clients a month. Those failing to meet this target are given support, training and advice. However, if they fail repeatedly eventually they are let go. Conversely, those that repeatedly bring in high figures can look forward to promotion, for example to the position of team leader or some level of management.

While being a mobiliser is occasionally stressful, many have been with the organisation for many years. There is not a very high staff turnover rate, since those not suited to the job are spotted very quickly and move out.

There is also an element of competition because the winning team is acknowledged by a trophy award ceremony which takes place three times a year. This 'carrot and stick' approach reaps rewards because the pride of the team is prodded and no team wishes to lose to another, while the financial benefit pushes the recruiters and managers along.

The impression of the work at CHAPS is that top management know what is going on, and communication is good between all ranks, from mobilisers up to the directors. While out on the streets each mobiliser is supervised by a team leader who feeds back to upper management, and there is a lot of discussion around what works, what doesn't, what should change and which areas have particular problems, be they cultural or otherwise.

Media

Whilst the main focus of demand creation for CHAPS is social mobilization, they have also commissioned and distributed print and promotion materials, run billboard advertising and have worked with a number of local radio stations... CHAPS has created its own brand identity and brands all of its promotional and informational materials. This activity helps to build the brand and lend legitimacy to the activities of the mobilisers. They are also in the early stages of exploring the use of SMS with their partners on the Brothers for Life Campaign.

In terms of print media, CHAPS has developed posters and billboards in the past few years in consultation with target audiences, with inputs on visuals, slogans and messages provided through focus group discussions (FGDs), They also leverage JHU CCP for billboards and mass media (and JHU CCP's social mobilizers also make referrals to CHAPS sites). In addition, CHAPS staff appear on local radio talk shows as guests whenever possible and on several occasions have gotten local papers to publish articles on VMMC and their clinics. In some cases, CHAPS have commissioned local radio stations to develop a series of chat shows dedicated to VMMC and structured around VMMC-related topics in a sequence. The shows convene different discussants for each topic and are heavily trailed to ensure that listeners know to call in with their questions.

CHAPS has also commissioned production of 4 or 5 radio spots which have been aired on local radio stations over the last few years, each of which was broadcast about 20 times. These provided information about where and when VMMC could be accessed, as well as bite-sized information about key benefits and risks.

An obvious advantage of radio exposure is that the FM range is far-reaching. Once when CHAPS was broadcasting in Orange Farm and the Vereeniging area (or so they thought), there were men listening to the show as far away as Dube, Soweto as well.

An influx of calls from that show made CHAPS realise there was a real demand for VMMC in Soweto, and led to the opening of a branch there.

They have also worked to help a local TV station in Soweto to produce a short TV documentary on VMMC.

EVALUATION OF DEMAND CREATION ACTIVITIES

Evaluation of demand creation activities

CHAPS has never conducted a formal evaluation of its demand creation activities apart from reviewing data on their intake forms. They now recognise this data is not sufficient to understand the relative impact of different demand generation activities on man's decision to undergo VMMC, however have not yet developed an alternative which is able to definitely isolate the single factor within media, social mobilisation and conversations within peer networks which triggered the clinic visit. It is a challenge common to all organisations working in demand creation, particularly where media coverage plays a role.

CHAPS intends to revise its demand creation strategy, including the choice of media channels and messages, based on the findings of the qualitative and quantitative research projects underway in 2012 and 2013.

Data capture at the point of delivery is nonetheless important to CHAPS, and every referral is logged at the clinics and by the teams. These figures have to match, and any discrepancy is investigated. Because each register entry is linked to an ID number, double entries and false claims of success are less likely. Each site shares data with a central office, where the up-to-date figures are maintained.

In addition, CHAPS continually revise their approach based on feedback from clients and mobilisers. Open channels of communication support a constant flow of information between all levels of the organisation, enabling nimble and reactive course correction as and when required. This is more challenging during the busy winter months, with summer allowing more time to review and revise activities.

LEARNING AND SCALE UP

Scale up opportunities

CHAPS' ultimate goal is to provide free VMMC for men across the length and breadth of South Africa, recognising there will be a need to explore new ways of generating demand as services reach new communities.

CHAPS sees clear opportunities to conduct additional research around the following areas:

- Perceptions of the safety of medical versus traditional circumcision.
- Mapping of VMMC seeking by ethnic make-up of catchment area.
- Positive deviance: pro-health conceptions of masculinity.
- Understandings of disease progression.
- Outreach recruitment messages.
- Tailoring of messages by ethnic identity and measuring changes in uptake.

Challenges

One of the challenges of the CHAPS mobilisation approach is that it centres around street mobilisers. This increases salary costs, and makes the work expensive to fund.

Another challenge is transport – funders initially did not want to pay for transport for VMMC clients. However, this problem has now been resolved. CHAPS says most of the funders now realise that demand creation requires the kind of effort that needs resources put into it.

Another challenge CHAPS faces is around the age of consent for VMMC. In the current national guidelines there is some discussion over whether the age of consent should be 16 or 18 years. It has varied between the two ages, and is now set at 18 years. This means that 16- and 17-year-olds have to bring their parents in to the clinic, which they do not like to do. It is seen as embarrassing for a teenage boy to attend a clinic with his parents.