



**PREVENTING HIV THROUGH SAFE  
VOLUNTARY MEDICAL MALE CIRCUMCISION  
FOR ADOLESCENT BOYS AND MEN IN  
GENERALIZED HIV EPIDEMICS**

## **WEB ANNEX 5.2**

# **CASE STUDIES ON ENHANCING UPTAKE OF VOLUNTARY MEDICAL MALE CIRCUMCISION SERVICES**

**Preventing HIV through safe voluntary medical male circumcision for adolescent boys and men in generalized HIV epidemics: recommendations and key considerations. Web Annex 5.2. Case studies on enhancing uptake of voluntary medical male circumcision services**

ISBN 978-92-4-000933-2 (electronic version)

© World Health Organization 2020

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (<http://www.wipo.int/amc/en/mediation/rules/>).

**Suggested citation.** Web Annex 5.2. Case studies on enhancing uptake of voluntary medical male circumcision services. In: Preventing HIV through safe voluntary medical male circumcision for adolescent boys and men in generalized HIV epidemics: recommendations and key considerations. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO.

**Cataloguing-in-Publication (CIP) data.** CIP data are available at <http://apps.who.int/iris>.

**Sales, rights and licensing.** To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

**Third-party materials.** If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

**General disclaimers.** The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

This publication forms part of the WHO guideline entitled *Preventing HIV through safe voluntary medical male circumcision for adolescent boys and men in generalized HIV epidemics: recommendations and key considerations*. It is being made publicly available for transparency purposes and information, in accordance with the *WHO handbook for guideline development*, 2nd edition (2014).

## WEB ANNEX 5.2

# CASE STUDIES ON ENHANCING UPTAKE OF VOLUNTARY MEDICAL MALE CIRCUMCISION SERVICES

In March 2019 WHO opened a call to programmes and implementing partners for the submission of case studies describing the implementation of interventions that had been successful in increasing uptake of voluntary medical male circumcision (VMMC). WHO received 16 cases studies. Two reviewers evaluated each case study based on preset criteria. WHO selected 11 cases for inclusion in these guidelines. Notably, the majority of these examples involve the implementation of multiple interventions or strategies that seek to address multiple barriers.

## Case study 1: Make The Cut (MTC)

### Setting

Hhohho, eSwatini; Nairobi, Kenya; Gauteng, South Africa; Entebbe, Uganda; Iringa and Njombe, United Republic of Tanzania; Lusaka, Zambia; Bulawayo and Harare, Zimbabwe. (Implementation since 2012 in seven countries.)

### Challenges

- Despite the effectiveness of medical male circumcision, VMMC uptake remained low in the communities of the 14 priority countries identified by WHO and UNAIDS. This was when MTC was created. An increase in demand and uptake of VMMC services remains critical to attaining the 2020 Fast Track target of 90%.
- MTC was inspired, in part, by the head coach of Zimbabwe's Highlanders Football Club and Grassroots Soccer (GRS) coach Mkhuphaleni Masuku's decision to get circumcised and publicize his decision as an example to his players, teammates, friends and youth. This motivated others to undergo VMMC. As a result of Masuku's decision, GRS created MTC.

### Barriers

- Adolescent boys and young men have diverse needs, interests, beliefs and barriers to accessing health services. MTC aims to educate clients on the health benefits of VMMC and condom use and support them in overcoming key barriers to the uptake of VMMC such as fear of pain and HIV testing and lack of accurate information. Key messages focus on health benefits of VMMC, including improved hygiene and protection from STIs, specifically HIV.

### Initiatives taken

- MTC is a single, 60–90 minute session designed to generate demand for VMMC and condom use and link adolescent boys and young men to services. It consists of an interactive game, a personal story shared by the coach (a circumcised adult role model) and a group discussion. The game uses the popularity of soccer to initiate discussions on a potentially sensitive topic. This is an approach that has been shown to improve HIV-related knowledge, attitudes and behaviours.
- During the educational soccer penalty shootout, the goalkeeper metaphorically tries to protect himself from HIV infection. In the first round, the goalkeeper represents an uncircumcised man who does not use condoms, frequently failing to stop the ball. In the next round, after participants identify that VMMC can reduce the goalkeeper's HIV risk, the goal's width is reduced. Fewer goals are scored, representing the partial protection of VMMC. In the final round, four additional defenders help block the goal, representing the dual protection of VMMC and consistent condom use, and very few goals are scored, if any. Key messages that are communicated focus on the health

benefits of VMMC, including improved hygiene and protection from STIs.

- Circumcised coaches share their own experiences and build participants' self-efficacy to undergo VMMC. The coaches facilitate discussions with participants on their own perceived barriers and enablers and then follow-up with interested participants.

### Results

- A 2012 cluster randomized controlled trial assessing the effectiveness of GRS's MTC intervention on VMMC uptake over 3–6 months among Zimbabwean men showed a roughly 10-fold increase in VMMC uptake in the intervention group and higher acceptability among younger men 18–29 years old compared with those 30 years or over.
- A 2014 cluster randomized controlled trial assessing the effectiveness of GRS's MTC+<sup>1</sup> intervention on VMMC uptake over 3–6 months among adolescent male students in Zimbabwe showed a roughly ninefold increase in VMMC uptake in the intervention group.
- Findings from a 2014 process evaluation of MTC and Make The Cut+ in Bulawayo, Zimbabwe, highlight the coach-participant relationship as a key factor in increasing participants' motivation to undergo VMMC, especially among younger participants.
- The feasibility of implementing the intervention in Uganda (2015–2017) was assessed by pilot-testing the intervention in one school and then modifying it and implementing it in a second school. The modification involved increasing engagement with parents and improving the liaison with schools regarding the timing of the intervention. The pilot study of the modified MTC intervention showed that it may be effective in increasing VMMC uptake in this population.

### Lessons learnt

- The Zimbabwe randomized controlled trials produced promising evidence of MTC's effect among males 14–30 years of age, with strong evidence that the intervention increased VMMC uptake within three months by nine times for adult men (18–35 years) and 2.5 times for adolescent boys (13–18 years).
- GRS also conducted a follow-up feasibility pilot study with the Centre for HIV-AIDS Prevention Studies (CHAPS) in eSwatini that generated 3000 VMMCs in three months (2016) and a follow-up national campaign. In Uganda GRS conducted a mixed-method feasibility evaluation with the Ministry of Health and the London School of Hygiene & Tropical Medicine that found a 26% uptake among secondary school students. Both of these further demonstrated that MTC can effectively increase VMMC uptake and is adaptable in diverse contexts.

<sup>1</sup> This was a modified intervention based on Make The Cut and delivered to male students attending secondary schools in Bulawayo.

## Case study 2: Using satisfied clients to bring older men to VMMC services in Chikwawa District, Malawi

### Setting

Chikwawa District in the Southern Region, Malawi (October 2017 to December 2018).

### Challenges

Historically, uptake of VMMC in the Chikwawa District was low. Only 21 168 clients sought VMMC services in the district in the four years between October 2013 and September 2017. Of these, only 34.2% were 15–29 years of age, the priority age group for VMMC in Malawi. The demand creation approaches in the district were not effective in bringing older men into services, whereas programme experiences from Mozambique and the United Republic of Tanzania at the time suggested that using satisfied clients as peer community mobilizers (CMs) was effective in increasing demand for VMMC, particularly in reaching the older age groups.

### Barriers

Men in the Chikwawa District feared experiencing pain during the VMMC procedure, had concerns about abstinence during wound healing and believed that HIV testing was mandatory. Some perceived VMMC to be an intervention for young adolescents.

### Initiatives taken

- USAID supported two assessments of demand creation in Malawi: i) A 2016 rapid assessment confirmed the barriers stated above. ii) A June 2017 assessment aimed to identify key gaps and challenges and recommend areas for improvement in generating demand. Discussions with CMs revealed that there were gaps in their training, facilitation, equipment and supervision. Demand creation teams were not considering satisfied clients for recruitment as CMs. Men who have undergone VMMC have first-hand information and personal experience with the service.
- AIDSFree Malawi trained CMs on interpersonal communication (IPC) for VMMC demand creation. They equipped them with a bicycle to facilitate easy movement within their catchment area, identification cards and branded t-shirts to help the community to identify them easily and also help boost CMs' credibility in the community as trusted sources of VMMC information. They were provided with social and behaviour change communication materials addressing the common myths, misconceptions and frequently asked questions about VMMC, as well as job aids to support IPC with community members and clients.

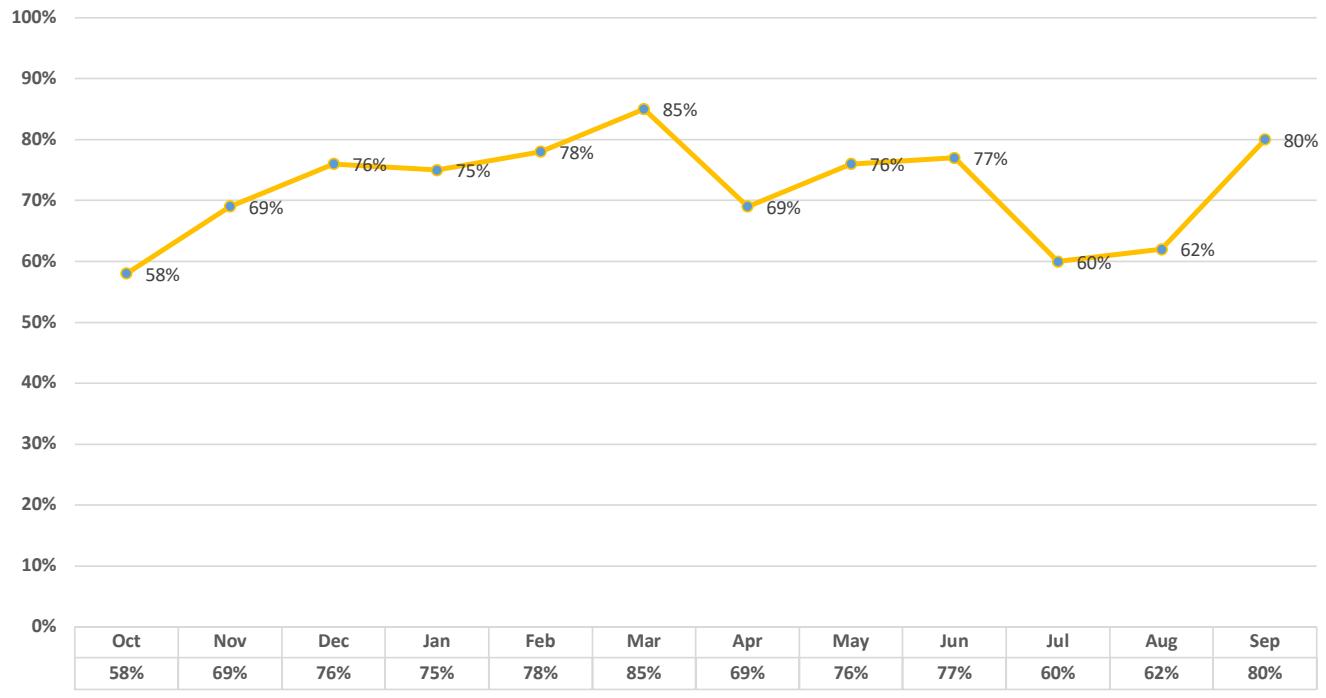
- Three community mobilization and communication assistants (CMCAs) provided regular supportive supervision visits to CMs and monitored the quality of CMs' demand creation communications.
- CMs received a fixed monthly income in addition to a performance-related payment shared equally, every two weeks, among two or three CMs from neighbouring catchment areas. This compensation arrangement ensured retention of the CMs.
- Key implementers of this initiative were AIDSFree Malawi in conjunction with the Chikwawa District Health Education Office and the Chikwawa District VMMC Coordinator's Office. The traditional leaders within the district collaborated by enabling the CMs to operate smoothly within their communities.

### Results

- A team of 40 CMs was recruited, trained and retained. More than half were satisfied clients.
- The percentage of those seeking VMMC who were ages 15–29 increased from 34.2% in FY17 to 71.3% in FY18 (Fig. 1).
- Overall, uptake of VMMC in the district also increased. The district achieved its highest number of VMMC clients in one year (18 173 clients against a 20 000 target), which was also the highest achievement against its targets (90.9%) in five years.

### Lessons learnt

- Use of satisfied clients as CMs is very effective for VMMC IPC. Their personal experience gives them first-hand knowledge of the basic information they need to communicate. They inspire more trust from their peers and are most suited to address men's common fears around managing pain and remaining abstinent during healing.
- Selection of mobilizers: The profiles of the CMs are an important determinant of who they can influence.
- Training and equipping community mobilizers helped them communicate with men in the priority age group.

**Fig. 1. The percentage of VMMC clients who were 15–29 years of age in the Chikwawa District in FY18, by month**

## Case study 3: Reaching older men with VMMC services in Zambezia Province in Mozambique

### Setting

Zambezia Province, Mozambique (2013 to date).

### Challenges

Male circumcision is common in the northern provinces of Mozambique, where it is performed for traditional and religious reasons. However, despite the Government of Mozambique's adoption of VMMC in 2009, coverage in the Zambezia Province on the central coast remained low (48%), even after scale-up was initiated in 2010.

### Barriers

Research in sub-Saharan Africa points to an "intent–action" gap, with over 60% of men ages 15–49 years being aware and interested in VMMC for HIV prevention, but only 11% actually circumcised. This gap was also perceived in Zambezia, where MC is not traditionally performed.

### Initiatives taken

- 1) In order to reach older men, ICAP's comprehensive package of care to support VMMC services included focus on the HIV prevention & care cascade; adherence to the ICAP client-centred VMMC model; an advanced strategic information system that fed into project decision-making and advocacy with local leadership around transforming gender norms.
- 2) Demand creation was achieved through communication and social marketing campaigns, outreach by mobilizers, VMMC campaigns, involvement of women as mobilizers and incentives to mobilizers.

- 3) Trained and equipped ICAP VMMC teams provided client-centred care that addressed older men's specific needs in fixed health facilities and mobile sites. They offered tailored, integrated, differentiated VMMC and prevention packages that were youth and male-friendly and services for specific age groups. This included "one-stop shopping" for services; evening/weekend clinic hours to accommodate work schedules; messaging addressing specific male concerns; use of local health promoters to educate and follow up on men who have not presented for VMMC, thus increasing the number of men who transition from simply expressing interest in the procedure to having it completed.
- 4) VMMC quality assurance and quality improvement initiatives were undertaken that helped achieve service excellence.
- 5) Interventions included intensive follow-up for wound care; comprehensive prevention; age-appropriate sexual and reproductive health education; gender norms and condoms; escorted and supportive linkage to care and treatment for HIV-positive clients; and pre-exposure prophylaxis (PrEP) for men at higher risk of HIV infection.

### Results

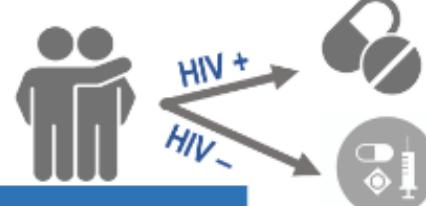
- 1) Between March 2013 and February 2019, ICAP supported 15 health care clinics providing facility-based VMMC and two mobile clinics to provide VMMC to rural areas. To generate demand, ICAP conducted age-specific outreach, including mass media campaigns and educational sessions at schools and community events. During this time 258 770 males were circumcised and, among them, 253 193 (97.84%) were screened for HIV. In total, 1943 males (0.77% of those screened) tested positive for HIV.



**robust demand creation**



**service delivery excellence**



**intensive follow-up care**

**comprehensive prevention package**

**Enabling Environment & Quality Control for VMMC Programming (HSS, Training, HR, M&E, Advocacy)**

- 2) Altogether, 130 507 (50.43%) of those circumcised were adolescents and young men 15–24 years of age. Clients 15 years or older increased from 54.7% between March 2013 and February 2014 to 61.5% between March 2018 and February 2019.
- 3) Those who underwent VMMC had heard about the service from the following sources: 30.26% from a friend; 20.22% from family members; 4.29% from TV or radio mass media campaigns; 10.58% from a health care worker; 14.05% from a community counsellor; and 0.47% through other means. Among the 660 males newly diagnosed as HIV-positive between June 2015 and May 2017, 644 (97.6%) were referred for HIV care, and 616 of these men (95.7%) were enrolled in care and treatment services.

## Lessons learnt

- 1) Targeted demand generation strategies can lead to large numbers of older men being circumcised.
- 2) Utilization of mobile clinics can help VMMC programmes ensure that they are providing services to communities not in easy reach of health care facilities.
- 3) Ensuring that men who express interest in VMMC eventually accept VMMC requires persistent and longitudinal effort – not just a single educational event. To this end, the use of VMMC champions based in the community to not only educate but ensure that older men follow up for the procedure is key.

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

### Setting

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

### Challenges

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

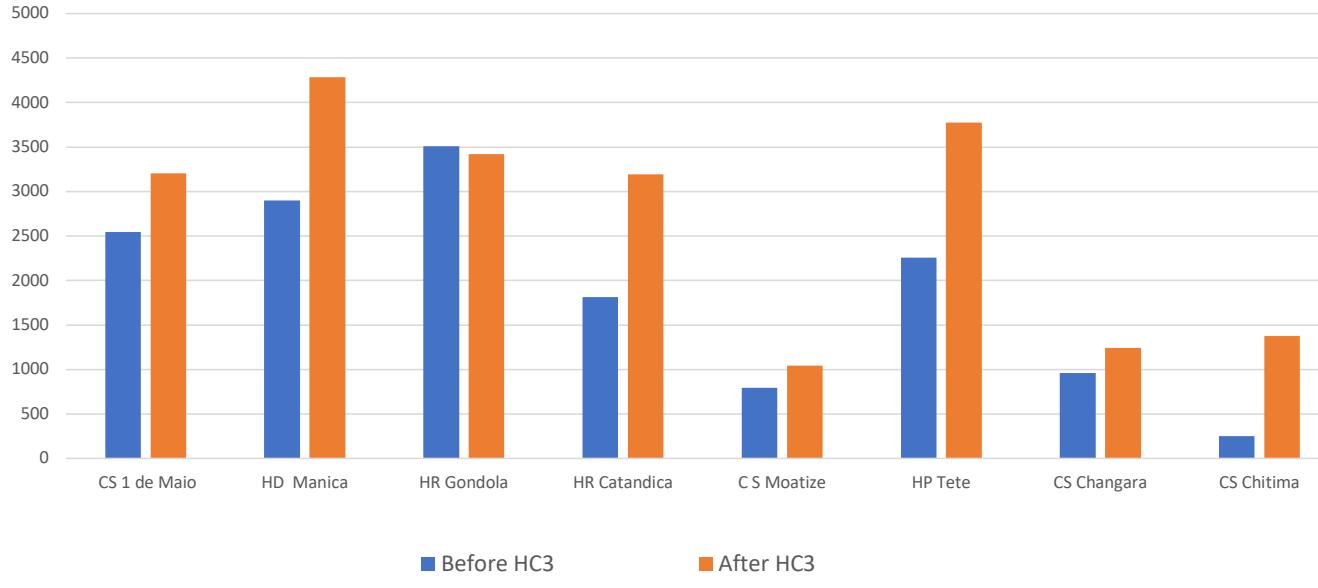
### Barriers

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

### Initiatives taken

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

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



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

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

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

## Results

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

group (80%) reported having received information and solid explanations about the VMMC services and procedure benefits from activists or community mobilizers.

## Lessons learnt

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

## Case study 5: Decision Makers' Program Planning Toolkit, Version 2 (DMPPT 2); GIS Mapping Dashboard and Site Capacity and Productivity Assessment Tool (SCPT)

### Setting

VMMC priority countries in sub-Saharan Africa (2013 to date).

### Challenges

The main challenge to be addressed was planning for appropriate demand creation based on unmet need. The USAID Technical Lead for VMMC, in coordination with USAID VMMC points of contact in country missions, identified the need for a tool that could help set VMMC targets by age group and district and visualize them, along with information about service delivery capacity.

### Barriers

- 1) quantifying and visualizing unmet need for VMMC by country, district and age group
- 2) facilitating alignment of demand creation and service availability with targets, based on epidemiological impact.

### Initiatives taken

- 1) The tool was developed by Avenir Health. Key collaborators were USAID, US Centers for Disease Control and Prevention, the Bill & Melinda Gates Foundation and country governments.
- 2) The Decision Makers' Program Planning Toolkit 2 (DMPPT 2) is a demographic and epidemiological model that estimates male circumcision (MC) coverage based on programmatic data and demographic projections. The tool can estimate age- and district-specific targets from user-specified MC coverage requirements by five-year age group. Demand creation can then be tailored to focus on those age groups and districts where there is greatest need. The tool also calculates, for each year for which there are programme data, an age-specific "uptake rate",

which is the proportion of the uncircumcised population that was circumcised in that year in that age group. From this information, programme managers can see whether they are increasing uptake within the desired age groups and assess the effectiveness of their demand creation strategies. Countries that wish to use the tools are required to submit, for the DMPPT 2, their VMMC service statistics, disaggregated by district, year and, if possible, 5-year age bands on an annual basis. These annual programme data must include all VMMCs performed in the country, including non-PEPFAR VMMCs.

- 3) To further inform VMMC programmes and policies at the country level, two additional decision-making tools were developed that provide data to facilitate active programme planning and management, rather than retrospective reporting: i) the Site Capacity and Productivity Assessment Tool (SCPT) helps improve the implementation efficiency of VMMC programmes at the facility level by identifying where programmatic resources (human resources, commodities, equipment, infrastructure, etc.) have been positioned for implementation; ii) the Geographic Information System (GIS) Mapping Dashboard enables easy visualization and mapping of VMMC data, including data from the DMPPT 2 and the SCPT, as well as the PEPFAR monitoring and evaluation system, called Data for Accountability, Transparency and Impact Monitoring (DATIM).

### Results

- 1) The DMPPT 2 and GIS Mapping Dashboard have helped to set targets and guide demand creation work by understanding need.
- 2) The DMPPT 2 was used to assess changes in VMMC uptake by adult men through:
  - i) creation of tables that showed progress in terms of VMMC coverage in each of the provinces, breaking it down in more detail, by different age groups;

**Table 2. Percent coverage by age and province by end of 2017, Mozambique**

	EIMC	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	15-29	10-29	15-34	10-34
<b>Gaza</b>	5	8	90	76	50	35	28	25	25	24	24	24	56	66	50	60
<b>Manica</b>	4	5	25	39	30	20	14	12	11	10	10	9	31	29	28	27
<b>Maputo City</b>	38	38	83	88	87	83	72	65	66	64	63	62	86	85	83	83
<b>Maputo Prov.</b>	13	22	70	73	71	70	64	61	64	63	64	63	71	71	70	70
<b>Sofala</b>	11	11	56	71	56	41	29	24	22	21	19	19	58	57	53	54
<b>Tete</b>	1	1	17	21	13	9	5	4	4	3	3	3	15	16	13	14
<b>Zambezia</b>	18	23	52	67	64	62	56	54	56	55	54	54	65	61	63	60

- ii) creation of figures showing VMMC coverage overlaid with unmet need among those 10–29 years of age by province; and
  - iii) a figure taken from the Site Capacity and Productivity Assessment Tool presented the VMMC sites in Tete Province, Mozambique, and their individual utilization rates.
- 3) Table 2, taken from the DMPPT 2 in April 2018, presents progress in terms of VMMC coverage in each of the provinces in Mozambique and breaks it down into a more detailed look by age group. In this “heat map” configuration, the red cells represent coverage levels below 50%, the yellow cells are between 50% and 70%, and the green cells are age groups in provinces that are over 70%.

## Lessons learnt

- 1) Providing data about need, epidemiological impact and service delivery capacity, visualized graphically or on maps, can assist programme planners to better focus their demand creation and service delivery capacity where it is most needed and will have the most impact.
- 2) Utilizing a demographic model (taking into account aging of those circumcised, as well as mortality and birth rates) combined with programme data enabled the creation of several metrics that can be utilized to assess changes in VMMC uptake by age group.

## Case study 6: Applying differentiated service delivery and innovative demand creation models to increase the uptake of VMMC in KwaZulu-Natal province, South Africa

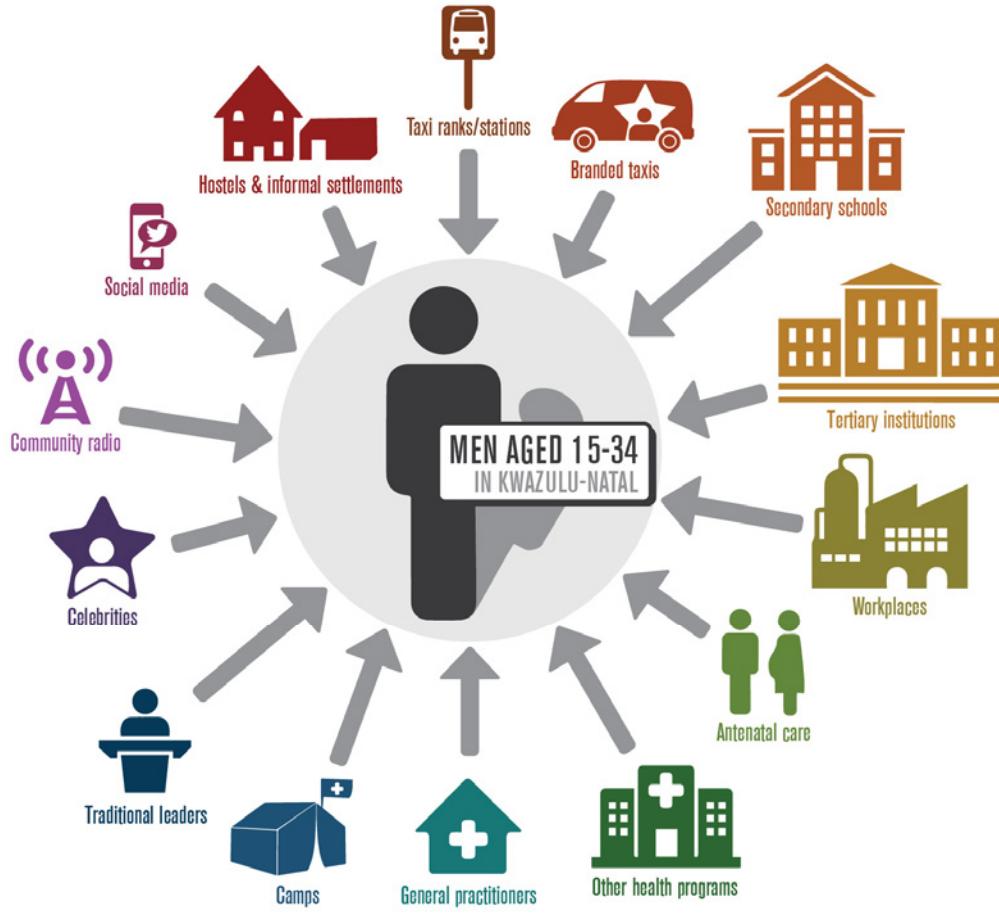
### Setting

eThekweni and Zululand districts of KwaZulu-Natal (KZN) Province, South Africa (1 October 2017 to 30 September 2018).

### Challenges

Among the nine provinces of South Africa, KZN has the highest HIV prevalence rate and low VMMC uptake, partly due to the banning of customary male circumcision (MC) in the 19th century by Zulu King Shaka. The reigning King reinstated the practice of MC in 2009. Although achieving 1 million MCs in nine years was a significant milestone, about half of the provinces' population eligible for VMMC has not yet been circumcised. Doubling the number of VMCCs in the province requires creative approaches to involve men who are difficult to reach and/or to convince of the benefits of VMMC. Research conducted by the South African Department of Health and VMMC implementing partners showed that there was low uptake of VMMC amongst the target age group (men 15–34 years of age).

**Fig. 1. Influencers of men to undergo VMMC**



### Barriers

Barriers included lack of knowledge of VMMC benefits and that free VMMC services were available in public and private sector facilities; low perception of the relevance of VMMC; and anticipated shame of men grouped with young boys whilst awaiting services. There was a need to make VMMC more accessible and convenient for the target population and amplify VMMC messages through employing multiple platforms and channels of communication.

### Initiatives taken

- 1) The King called on all Zulu men to get medically circumcised. The King's son, Prince Nhlanganiso Zulu, was an active ambassador for VMMC. Endorsement by traditional leadership has supported the province in exceeding 1 million VMCCs from 2009 to April 2018.
- 2) In KZN, the USAID VMMC Project provides VMMC services in multiple settings, ranging from public health facilities to private doctors' practices and VMMC camps serviced by contracted private clinical providers.

3) The USAID VMMC Project applies various methods to promote health seeking behaviour and increase VMMC uptake. In addition to employing trained social mobilizers, the following individuals/entities have proven efficient in influencing men to undergo VMMC: family members, sexual partners in married or committed relationships, peers and friends (especially satisfied VMMC clients), cultural, traditional and religious leaders and celebrities or ambassadors and other role models.

## Results

Differentiated service delivery and innovative demand creation contributed to significant uptake of VMMC. During the intervention period, the majority of clients were in the priority age group (15–34 years). In terms of mobilizing adult men for VMMC, eThekwini and Zululand performed better than other districts, reaching over 50% of the men ages 15–34 years. The table below shows the VMMC age pivot achieved across districts of operation for the period October 2015 to September 2018.

District	Number of VM�Cs		
	October 2015–September 2016	October 2016–September 2017	October 2017–September 2018 (interventions applied)
eThekwini	10 774	19 698	50 042
Zululand	9922	8132	21 833

## Lessons learnt

- 1) Keys to success are endorsement and collaboration with government initiatives and traditional leadership.
- 2) Employing social mobilizers from communities where they are expected to work proves effective.
- 3) Demand creation needs to be contextualized.
- 4) Mobilization activities performed at places that men frequent (for example, barber shops, taverns) can be very effective.
- 5) Promoting the comprehensive benefits of VMMC (broader than just HIV prevention) in messages aimed at mobilizing men for services has proven effective amongst adult men.

# Case study 7: Embedding VMMC within community-based HIV testing services to increase uptake in older men in the United Republic of Tanzania

## Setting

The United Republic of Tanzania's five crossover regions of Iringa, Njombe, Morogoro, Singida and Tabora, where the Jhpiego-led AIDSFree project operates (1 July–30 September 2018).

## Challenges

Nationally, only 41% of the 25–29 year-old VMMC target group was reached in 2017. Within AIDSFree, only 16% of the annual target was attained in this age group between October 2017 and September 2018.

## Barriers

Older men were facing barriers in accessing VMMC, which included distance to VMMC services, waiting time and lack of privacy.

## Initiatives taken

- 1) The Jhpiego-led AIDSFree collaborated with a Jhpiego sister project, Sauti, which offers community-based HIV testing services (HTS) plus other HIV prevention biomedical and education services. Sauti utilizes mobile teams in the same geographic areas as AIDSFree VMMC services. A comprehensive review of Sauti HTS data indicated that there was a large number of men ages 20 years and above who reported being uncircumcised. AIDSFree saw this as an opportunity to reach these men.
- 2) AIDSFree developed comprehensive standard operating procedures in order to guide the projects, focusing on the mobile VMMC teams that provide on-site VMMC services alongside Sauti's mobile teams.
- 3) AIDSFree embedded a team of five personnel (two VMMC providers, a counsellor, data clerk and logistician) within the Sauti community-based HTS mobile team to offer on-site same-day VMMC services.
- 4) The HTS teams set up tents near hotspots, with mobilization and outreach activities led by case managers and local civil society organizations. The VMMC team used an adjacent tent, set up at a nearby health facility or in suitable nearby premises, converted into an operating room. HTS clients were asked if they were circumcised, and, if they were not, they were offered VMMC services available on-site or, rarely, they would be referred to the nearest VMMC health facility and given information on VMMC clinic days. Their contact details were shared with an AIDSFree-supported Volunteer Community Advocate (VCA) from their locality for follow-up.

5) Key implementers included the Regional Health Management Teams of the five regions under the President's Office Regional Administration and Local Government (PORALG) with technical oversight from the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) through the National AIDS Control Program.

6) The Sauti HTS team uses peer educators from local civil society organizations to mobilize within their key and vulnerable populations and link clients to services, including referrals and escort to VMMC sites.

## Results

- 1) Prior to full implementation of the mobile team initiative in the fourth quarter (July–September 2018), uptake of VMMC services by older men in the previous three quarters (October 2017–June 2018) was 3% of all VMMCs. This figure increased to 5% in the fourth quarter.
- 2) When examined by modality, older men reached through mobile services were 38% of all clients served by that modality, compared with 11% served through routine services.
- 3) The total number served through the initiative during the quarter was modest (1412 VMMCs), but the comparative advantage of mobile VMMC embedded in community HTS to attract older men relative to other standalone modalities used by AIDSFree was demonstrated in all five regions, irrespective of VMMC programme maturity.

## Lessons learnt

- 1) A mobile VMMC service delivery modality is more adaptive to addressing barriers to older men accessing VMMC services, particularly distance, waiting time and privacy, which are associated with facility-based modalities.
- 2) Female providers are not a deterrent per se for older men using services since 75% of the mobile personnel were female, although not local residents – which may have helped eliminate embarrassment.
- 3) There are synergies to be realized in the collaboration between HTS targeting men who are from key and vulnerable populations and VMMC services aiming to maximize uptake among older men.

## Case study 8: Triangulating data to direct VMMC strategies for reaching uncircumcised males in the Lake Zone region, United Republic of Tanzania

### Setting

Five Lake Zone regions that IntraHealth supports through PEPFAR/CDC in the United Republic of Tanzania, namely Geita, Mara, Mwanza, Shinyanga and Simiyu (29 September 2017 to 30 September 2018).

### Challenges

- In the past, VMMC programming was often based on regional-level male population and MC prevalence estimates, missing significant geographic variability within regions and leading to inefficiencies in programme planning and implementation. The knowledge of local community members and health workers was often not ascertained prior to programme implementation.
- There are low yields of clients since most of the accessible areas have been served through outreach campaigns. There are increased transport costs, as VMMC teams must be relocated to more than one locality during the campaigns to search for more clients.

### Initiatives taken

Recognizing the increasing difficulty of reaching uncircumcised men, in late 2016 IntraHealth began triangulating quantitative data (programme, survey, census, geographic) and qualitative data to drive strategic planning in the five regions it supports. The steps followed were:

- 1) *Accessing available data sources* such as population projections disaggregated by age and sex by ward level from the National Bureau of Statistics (NBS); VMMC prevalence estimates (for example, from Population-based HIV Impact Assessment (PHIA) surveys); number of VMMCs performed in the area/region and geo-coded shape files with physical structures and geographic features such as ward boundaries, road networks, forests or vegetation and water bodies from the NBS.
- 2) *Generation of maps* of areas with high concentrations of uncircumcised men and facility locations where demand creation and VMMC scale-up can be prioritized.
- 3) *Stakeholder engagement* where maps are presented at local community-based stakeholder meetings to gain insights into the local context; confirm the accuracy of the information generated from the data triangulation and gather such additional information as religious, ethnic, and tribal composition of areas identified in the maps, confirmation of physical structures, information on additional buildings that can serve as outreach sites and

other logistical information (for example, road conditions, availability of water/electricity for sterilization of instruments and lodging for service providers); and areas where men spend most of their time during the day; men often spend time away from where they are recorded in the census at the ward level.

- 4) *Programme planning* based on this information can be undertaken by the VMMC implementing partner management team to develop a programme plan for targeted outreach campaigns for VMMC services.

### Results

- 1) Programme performance increased by over 300% across all five regions from 2016 to 2018. IntraHealth performed 305 718 VMMCs, contributing 34% of all VMMCs during a record-setting year of 905 313 VMMCs in the United Republic of Tanzania.
- 2) This strategy resulted in more efficient resource utilization. For example, in 2017 IntraHealth observed that 61% of uncircumcised men were located in 40% of the wards in the five regions, allowing it to allocate resources appropriately.
- 3) This approach contributed to a reduction in seasonal variation in VMMCs performed, a change that improves the ability to predict staffing needs and avoid VMMC kit stockouts.
- 4) IntraHealth observed a reduction in VMMC unit expenditure to US\$ 31.12 per client in 2017, compared with the national estimate of US\$ 50.
- 5) Engaging local community leaders and health workers in the planning process has built trust and facilitated collaboration with IntraHealth.

### Lessons learnt

- 1) The use of male population data triangulated with service delivery data, community expert narratives and interactive visual maps ensures efficiency in planning and monitoring for high-impact large-scale interventions at minimum cost.
- 2) The approach can be adopted by other implementing partners to improve VMMC programme performance.
- 3) Furthermore, other targeted high-impact interventions should consider triangulating different programme-related information such as baseline data and service delivery data with interactive GIS visual maps to make strategic decisions.

## Case study 9: Implementing soccer galas as a demand creation strategy to meet age pivot for the VMMC programme in Masvingo Province, Zimbabwe

### Setting

Soccer gala held at Mtimwi Secondary School, Zaka District, Masvingo Province, Zimbabwe (14 November 2018).

### Challenges

Analysis of programme data showed an average 50% enrolment of the primary target group of males 15–29 years of age. This was below the 65% target. There was low uptake of VMMC among adult men and out-of-school boys (15–29 years of age) in the district.

### Barriers

**Perception** – Cultural and religious views that the VMMC programme is for young boys.

**Reach** – Older boys and adult men shunning VMMC service delivery points, even with transportation provided.

### Initiatives taken

- Bringing VMMC to soccer fields creates an effective platform for engagement and service delivery. Community engagement entailed involving traditional, political and religious leaders, their communities, soccer teams' representatives and schools in order to obtain their buy-in. This involved collaboration with the Ministry of Health and Child Care, the International Training and Education Center for Health (I-TECH) and its implementing partners' consortium of local NGOs (ZAZIC) and local community structures. Other collaborators were the Ministries of Sport, Arts and Recreation; Home Affairs; Primary and Secondary Education; local government/traditional leaders (local chief and headmen); the local school, which provided sports fields; and the local church, which provided entertainment.
- Two caravans, four tents, VMMC consumables and three vehicles to ferry circumcised clients home were mobilized for the gala. Enough staff (12 VMMC clinicians, four counsellors, three HIV testing nurses, two VIAC<sup>1</sup> nurses) were provided to manage each station in the service provision chain from community mobilization, registration, HIV testing services (HTS), pre-op

counselling, performance of the procedure, post-op counselling and cervical cancer screening for women. There were 10 highly conspicuous mobilizers in their brightly coloured bibs.

- Service delivery was conducted at a nearby clinic and in the caravans stationed within the sports field. Ten beds were concurrently used for patients.
- Eight soccer teams played knock-out matches, with winners walking away with soccer kits and soccer balls. Four women's soccer teams also participated, making the gala a true family event.

### Results

- Women got cervical cancer screening in a caravan, where 34 adult women were screened.
- At the HIV testing tent, more than 250 clients were tested for HIV.
- Client data were recorded on routine VMMC documents, including the VMMC register and the client information form.
- A total of 187 clients were circumcised at the gala.
- 91% of the circumcised clients were in the age group 15 to 29 years – a commendable achievement.
- Details of the age disaggregation of circumcised clients are shown in the chart below.

### Lessons learnt

- When the entire community is involved, it becomes easier to reach and convince men and out-of-school boys to get circumcised.
- When communities are allowed to own and take the lead in local programmes and interventions, the yields from those programmes increase.
- Using soccer as an enticement helped to keep large numbers of people focused together on the same activity. This resulted in increases in both reach and uptake of VMMC.
- Integrating services that are related and provided in one place brings together the majority of family members who benefit together from the health messages and services.

Age (years):	10–14	15–19	20–24	25–29	30–34	35–39	40–44	45–50	50+
Number circumcised	9	83	55	32	4	2	2	0	0

<sup>1</sup> Visual inspection with acetic acid and camera for cervical cancer detection.

## Case study 10: Incorporating VMMC into traditional circumcision contexts in Mberengwa, Zimbabwe

### Setting

A traditionally circumcising VaRemba tribe in Mberengwa District of Masvingo Province in southern Zimbabwe. VaRemba are among the few ethnic groups that practice traditional male circumcision (MC) in Zimbabwe, with initiation camps to complete the rites of passage from boyhood to manhood held annually or bi-annually (2016–2019).

### Challenges

- Traditional circumcisers typically perform MCs with the help of community elders. Adverse events (AEs) are not uncommon due to lack of proper hygiene for both the procedure and the camp environment. There is no documentation of MCs performed, nor identification, treatment or verification of associated AEs.
- No clear protocols exist for guiding acquisition and disbursement of funds, food and transport, proper consent process, counselling procedure and follow-up, especially in young males. The VaRemba are also fragmented into smaller groups with separate leadership.

### Barriers

There is restriction of VaRemba camp attendance to only members of the VaRemba tribe.

### Initiatives taken

- A partnership was formed between the VaRemba community and ZAZIC, a consortium led by the University of Washington's International Training and Education Center for Health (I-TECH) and comprised of local implementing partners including the Zimbabwe Association of Church-related Hospitals (ZACH) and the Zimbabwe Community Health Intervention Research Project (ZiCHIRE), supported by PEPFAR and the U.S. Centers for Disease Control and Prevention (CDC). The partnership aimed to provide safe, standardized MCs and reduce AEs during traditional initiation rites, in collaboration with Ministry of Health and Child Care (MoHCC).
- The partnership promoted cultural competency and sensitivity, with a long-term goal of VMMC scale-up in the area.
- After years of sensitization, communication and relationship-building, the VaRemba Camp Collaboration (VCC) was formed and supported the traditional VaRemba MC camp.
- Through the VCC, the District supplied the VaRemba with medical MC kits to augment the safety of traditional MCs conducted by VaRemba circumcisers.

- In 2016 two male VaRemba nurses were trained in VMMC and in the use of documentation tools for VMMC. ZAZIC also worked closely with a trained team of circumcised VaRemba men to encourage uptake of medical MCs.
- In 2017, following a meeting held with 14 VaRemba community leaders, the District Administrator, the National AIDS Council, ZAZIC, the Mberengwa District Health officials and the Provincial Medical Director, and the National Male Circumcision Coordinator, the VaRemba formally adopted national VMMC guidelines for their initiation including consent, counselling and HIV testing. ZAZIC supported mobilization of both VaRemba and non-VaRemba males in the area.
- The camp ran from 1 August to 6 September, 2017, with VMMC offered to males above 10 years of age according to MoHCC policy. Those under 10 years of age underwent traditional circumcision.<sup>1</sup>

### Results

- Of the 725 MCs conducted during the camp, 657 (91%) received medical MC.
- Due to the support of VaRemba leaders and approval of the medical MC performed by the VaRemba nurses, almost all those eligible opted for modern MC.
- Since VaRemba nurses were resident in the camp, all MCs were reviewed on days 2 and 7, including those circumcised traditionally.
- Only 3 moderate infections occurred in medical MC cases, and all were promptly treated with antibiotics and healed well.

### Lessons learnt

- The VCC is one of the few of its kind in Zimbabwe to successfully pair traditional circumcision practices with modern MC.
- The ZAZIC/VaRemba collaboration resulted from four years of consistent consultation and collaboration between ZAZIC, MoHCC and VaRemba traditional leaders, demonstrating an earnest desire from all partners to invest in the success of the VCC.
- This partnership model, based on respect for traditional circumcisers and cultural practices, may be replicable in other Zimbabwean contexts and other countries. In 2018 ZAZIC worked with six VaRemba communities in other geographic areas in Zimbabwe, culminating in one additional successful camp collaboration in Gokwe South District, where 206 VMCMCs were performed without complications.

<sup>1</sup> Please note that WHO guidelines recommend VMMC for males 15 and above and for those with physical and cognitive maturity.

# Case study 11: Enhanced local engagement and its impact on VMMC uptake for males ages 15 to 29 years in Manicaland Province in Zimbabwe

## Setting

Three districts in Manicaland Province, Zimbabwe, with two tribes that are traditionally non-circumcising. This is a province famous for traditional healers and a high concentration of Apostolic religious groups, who largely believe in faith healing and shun mainstream health care and biomedical interventions (January – December, 2018).

## Challenges

Until the second quarter of 2018, the three PEPFAR-supported and DREAMS focus districts could not get appropriate age-eligible men (15–29 years) to take up VMMC and reach set targets, with a performance of only 40% towards set targets for the first quarter of 2018.

## Barriers

There was limited stakeholder coordination and involvement. At the beginning of 2018, it emerged that demand creation agents employed by an international NGO were single-handedly promoting VMMC without involvement of various key stakeholders including the Ministry of Primary and Secondary Education and local leaders (traditional, religious and political leaders).

## Initiatives taken

- 1) Interpersonal communication (IPC) agents used a “segmentation tool” to identify each potential VMMC client’s level of enthusiasm in order to improve targeting and to ensure appropriate and specific messages were delivered.
- 2) Discussions were held with the majority of stakeholders, which revealed that VMMC implementers either operated vertically or dictated the course and pace of programme implementation, often resulting in resentment by stakeholders. Among service providers, jealousy was instigated by perceived financial gains associated with the programme.
- 3) Frank meetings with the Provincial Health leadership, the District Health Executives and the District Hospital leadership highlighted the need to genuinely involve these stakeholders in the VMMC programme.
- 4) Each district was allocated an “innovation fund” as per its needs to fund VMMC-related activities and allow staff to quickly implement new promising ideas without administrative delays.

## Results

As a result of the above initiatives:

- 1) District Health Executives became involved in: development of monthly VMMC plans, engagement of community leaders and education authorities; conducting quality supportive supervisory visits; facilitating integrated planning and implementation of VMMC with other health activities (for example, girls’ HPV vaccination campaign).
- 2) The enhanced partnership between the international NGOs and the MoHCC resulted in enhanced service-delivery.
- 3) Local clinicians were also involved in service-delivery, permitting local buy-in.
- 4) A dedicated team provided VMMC services at night (moonlight services) where male members of sects that shun biomedical interventions were circumcised and followed up at night using Apostolic clinicians from a different province.
- 5) A WhatsApp platform was set up to allow all service-delivery teams operating in the province to share outputs, experiences, challenges and ideas.
- 6) The international NGO introduced a cadre (District Field Officer) who resides in the district and serves as the “link person” among various district stakeholders.
- 7) There was improved engagement with schools, with over 450 teachers responsible for health issues identified and trained around VMMC mobilization in March 2018.
- 8) There was improved engagement with community leaders: political, religious (including Muslim and Apostolic) and traditional leaders in each area were trained to deliver basic VMMC messaging and to use public gatherings as platforms to promote the programme.
- 9) Where traditional MC is practiced, the international NGO and the MoHCC partnered with these traditionally circumcising communities for procedures to be conducted by trained clinicians.
- 10) From May 2018, the three districts began to surpass their monthly reportable targets, scoring 102%, 138%, 123%, 134% and 130% achievements in May, June, July, August and September, respectively.

## Lessons learnt

- 1) Engaging and involving key stakeholders is an important element in demand creation for VMMC services and its delivery.
- 2) Coordination of all parties, so that they play their role, mitigates programme stalling.

**For more information, contact:**

World Health Organization  
Global HIV, Hepatitis and STIs Programmes  
20, Avenue Appia  
1211 Geneva 27  
Switzerland

E-mail: hiv-aids@who.int

<https://www.who.int/hiv/pub/malecircumcision/en/>

