

Social mobilisation
IPC
Traditional leaders
Female partners
Coordination
Messaging
Incentives

PROMISING PRACTICE: Demand creation by the BRIDGE II Project, southern Malawi

Promising practices:

- *Drawing on existing community mobilisation structures and building community trust:* Having a longstanding presence in communities makes a difference. BRIDGE I and II have initiated and maintained far-reaching and continuous relationships with all stakeholders in communities across the country, creating forums for sharing information and concerns, and training cadres of volunteers to help mobilise community members to take various actions to reduce the risk and consequences of HIV infection. These structures were easily adapted to incorporate VMMC, and VMMC was well received because the local partners and volunteers were trusted and respected in the community. This represents an efficient use of resources from prior and concurrent projects.
- *Using a combination of high-intensity and low-intensity mobilisation approaches:* The elaborate district-entry process that BRIDGE II has used to gain trust of communities and garner support for healthy behaviour change requires ongoing, low-intensity effort, including meetings with traditional leaders, regular discussion groups using health education toolkits, door-to-door visits of community referral agents, and presentations during open days. This activity projects a presence of the BRIDGE II project in communities, while building a base of information and understanding in communities. High-intensity activities such as roadshows and dramas get individuals excited to go get circumcised, and are conducted just before VMMC services arrive in an area. These high-intensity activities lead to increased numbers at mobile outreach sites.
- *Balancing supply with demand:* Close coordination is necessary when demand creation is done by a different entity than the service delivery provider. Where new static or mobile sites are being introduced, particularly where VMMC has never been offered previously, demand often exceeds supply. Nimble coordination to attempt to offer additional mobile camps or bring in new teams can address this supply limitation.

BRIDGE II has wisely discouraged mass media promotion of VMMC (TV and radio), especially at the national level, to avoid building up too much demand in areas where VMMC is not yet available, instead focusing on entertainment–education approaches and interpersonal communication.

- *Considering the couple:* In the challenge to get older men to seek VMMC, BRIDGE II has honed in on the importance of the female partner and on the psychology and mechanics of the couple relationship to design materials to which both genders can relate. A 12–minute video BRIDGE II has produced, which follows a couple as the man decides to be circumcised, has the procedure, and recovers, is shown by video vans to rave reviews.

Introduction

The BRIDGE II Project is an HIV prevention program aimed at promoting behaviour change and increasing HIV preventive behaviour among adults in Malawi. The BRIDGE II project, a partnership led by JHU–CCP in partnership with international and local NGOs, followed on from the BRIDGE Project. BRIDGE II is active in 11 out of 13 districts in Malawi and since 2001 (under BRIDGE I) has been engaging in community mobilisation efforts there, following an intensive district–entry process. PEPFAR–funded VMMC service delivery is underway in four priority districts in southern Malawi. The BRIDGE II Project is managing demand creation in three of these (Mulanje, Phalombe, and Thyolo); PSI–Malawi manages demand creation in Blantyre, an urban district. BRIDGE II’s demand creation strategy for VMMC utilises and expands upon existing BRIDGE community structures and relationships, including with local partners, local units of government (traditional authorities), and various levels of the government health system.

BRIDGE II is also the national communication partner for VMMC in Malawi, working in partnership with the Malawi Ministry of Health (MoH) to develop and pretest materials for VMMC demand creation. BRIDGE II facilitated the development national strategy for demand creation interventions. As the national communication partner, it has been active in the development of a national multi–channel strategy for demand creation (to which the BRIDGE II experience cleaves), as well as has spearheaded, alongside the MoH Health Education Unit, a series of branded, national behaviour change materials with consistent messaging for use by all the implementing partners involved in demand creation and service delivery in Malawi.

Target groups

- Primary audiences:
 - Males aged 25–49 years in non–circumcising communities
 - Males aged 15–24 years in non–circumcising communities

- Males aged 25–49 years in circumcising communities
- Males aged 15–24 years in circumcising communities.
- Secondary audiences:
 - Partners of men
 - Peers
 - Parents and guardians of adolescent males (10–15 years).
- Tertiary audiences:
 - Stakeholders and gatekeepers: traditional, religious and political leaders, health care workers, and the media.

Scale and scope

Mulanje, Phalombe, and Thyolo Districts, Malawi

Organizations involved

Lead

- Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs (JHU–CCP), through the BRIDGE II Project (a partnership between JHU–CCP, Save the Children International, The International HIV/AIDS Alliance, PACT Malawi, and local partners)

Funding

- USAID (with funding from PEPFAR; 5–year grant 2009–2013)

Other partners

- MCHIP, Population Services for Health (PSI) Malawi, JHPIEGO, Ministry of Health Health Education Unit (HEU), local traditional authorities, Christian Health Association of Malawi (CHAM), Banja La Mtsogolo (BLM)

Who is carrying out demand generation activities?

- BRIDGE II staff, Community referral agents, volunteers, local community–based organisations including church groups and community volunteer groups

Management of demand creation

VMMC activities

BRIDGE II is solely responsible for demand creation activities in the Phalombe, Thyolo, and Mulanje Districts. VMMC services are delivered by its service delivery partners , including BLM and CHAM, in different areas of these districts.

The approach to Demand Creation:

Key message(s)

- VMMC is a minor surgical procedure that will reduce a man’s risk of getting HIV from an infected female partner.
- VMMC does not impact sexual function as a man.
- VMMC for HIV prevention won’t change your culture or religion.
- VMMC will also reduce the chance of a female partner getting cervical cancer.
- VMMC provides better hygiene (research shows this is a major perceived benefit for female partners).
- Your friends will want to follow in your footsteps; talk to them about the benefits of safe VMMC.
- VMMC is a minor, painless surgical procedure. Drugs are provided after the initial postoperative period to control pain.
- Keeping the wound clean and allowing the wound to heal properly is very important.
- All clients that have undergone VMMC should abstain from sexual activity for 6 weeks to ensure the wound is healed. Having sex before you’re fully healed can put you at high risk of HIV infection.
- Complications following VMMC are not common and usually not serious. See your VMMC provider immediately if you notice signs of infection such as bleeding, fever, excessive pain, swelling, etc.
- VMMC does not guarantee you won’t be infected with HIV. After circumcision you need to continue to practice other safer sexual practices such as condom use, reduction of number of sexual partners and faithfulness.
- Partial circumcision (through traditional rituals) does not offer the same benefits as complete medical VMMC. Go to any VMMC site to have an assessment of whether you are completely circumcised.

Type of intervention

BRIDGE II uses two main community-focused channels for demand creation, relying heavily on community mobilisation approaches:

- Ongoing activities which educate specific VMMC target groups about the benefits of VMMC and integrate VMMC information into existing community health education structures (e.g. traditional leaders' forums, community-based organisation networks, peer educators, community referral agents, and village discussion groups), and
- High-intensity activities that are part of a targeted mobilisation effort conducted immediately before and when VMMC services are introduced at a new static site or for mobile circumcision campaign or mini-campaign (during traditional circumcision season or school holidays).

Rationale

- Socio-ecological model focusing on barriers to uptake and creating an enabling environment, with attention to dyadic couple relationships shape decision-making, and efforts to help men overcome barriers to accessing VMMC.
- Entertainment-education

Evidence base

BRIDGE II has a well-established system for implementing their activities because of its prior HIV prevention and care activities. Because of its longstanding community presence, it is able to mobilise structures quickly.

Particularly relevant are networks that were set up to deliver home-based care to support those living with HIV and AIDS. Home-based care structures, led by CBOs including church groups and community volunteer groups, have become the backbone of structures being mobilised for VMMC. The deep levels of trust and respect these groups have developed after a long presence in communities has given the VMMC message a level of respect and credibility that it might not otherwise have received.

Additionally, BRIDGE II draws upon cadres of incentivised volunteers including Community Referral Assistants to mobilise communities and educate community members about the health benefits of VMMC.

Demand Creation

1. Research

- a. *Quantitative*: Participated in and drew from the situation analysis conducted by the National AIDS Commission and strategy documents from the Ministry of Health
 - b. *Qualitative*: MoH officials, BRIDGE II personnel, and other USG partners took study trips to South Africa, Kenya, and Botswana to observe progress of VMMC campaigns and think about demand creation. The MoH then conducted a barrier analysis to segment the audience and explore potential barriers to uptake of the service. This analysis and the multi-pronged approach to campaign development that followed were codified in the national communications strategy, and the decision was made that all partners providing VMMC in Malawi should use nationally standardized media materials. The MoH partnered with BRIDGE II to manage demand creation materials at the national level.
2. Campaign development: BRIDGE II initiated its campaign with planning meetings at local level, which include talks and discussions with local authorities.

Once the primary, secondary, and tertiary audiences were delineated, BRIDGE II asked the following questions about each group to design the campaign:

- Who are the participant/target group(s)?
- What are the current knowledge, attitudes, and practices?
- What should change to promote adoption of the recommended behaviour?
- What are the benefits of adoption of the recommended behaviour?
- What are the existing barriers to the recommended change?
- What are the risks?
- What are the main existing facilitating factors for adopting the recommended behaviour?
- What are key messages to address the barriers and risks?
- What are the channels of communication?
- What are the support messages?

BRIDGE II then designed a separate campaign strategy for each target audience:

For primary audiences

- Conduct drama briefing session on key messages
- Conduct community interactive drama sessions
- Develop a community education video
- Conduct interactive community film sessions using mobile vans
- Conduct IPC session using expert male circumcision men/role modelling
- Develop and print IEC materials (posters and leaflets)
- Write letters to the community to be read in churches and other gatherings

For secondary audiences

- Conduct briefing sessions with community health workers and counsellors
- Conduct routine health education session on male circumcision at outpatient departments, under-five clinics and antenatal clinics
- Conduct interactive village group discussions with women

For tertiary level audiences

- Conduct one district stakeholders meetings
- Conduct District Aids Coordinating Committee briefing session
- Conduct VMMC briefing sessions in each Traditional Authority
- Conduct VMMC briefing sessions in each Traditional Authority
- Advocacy meetings with tea estate owners

Logistical meetings on roll-out then took place with government support, attended by BRIDGE personnel alongside service delivery partners and/or circumcision team training organisations.

3. Community entry: BRIDGE II has a well-defined district entry process. From the planning stages of the campaign, BRIDGE II ensured that it built consensus among different stakeholders, including religious leaders and representatives of particularly vulnerable groups (people living with HIV, sex workers, men who have sex with men, truck workers, uniformed services, etc.). Once district level authorities were on board, BRIDGE II approached various groups, such as traditional leaders and schools, to discuss VMMC.
4. Community mapping
5. Community sensitisation:
 - a. *Open days*: Opportunities to showcase what organisations are doing: drama, singing, dances, poems, explaining toolkits that have been developed. These attract around 300 people each.
 - b. *Traditional leaders' forums*: Builds on a pre-existing BRIDGE II structure where BRIDGE staff meet with community leaders, expanded in VMMC impact districts to include gatekeepers, opinion leaders and change agents, repeated quarterly. Community referral agents (CRAs, see below) can use these meetings to seek the cooperation of traditional leaders with posters, booklets, audio and visual materials.
 - c. *Community action groups*: BRIDGE II also runs community action groups that work within and through the village structures. Each traditional authority (roughly equivalent to a county) can have up to 10 community-based

organisations (CBOs). These CBOs are supervised by development committees, and each CBO's responsibility is to mobilise communities for VMMC. In each area, the CBOs hold a monthly meeting used to troubleshoot any problems and come up with new ideas for marketing and mobilisation. Based on numbers being circumcised, mobile units may be sent to certain areas; for example, in Teola district, there are ten static sites and ten mobile sites.

6. Community mobilisation

- a. *Village meetings*: Here, large numbers of people (200–300) can be educated at once, with visible support of the chiefs and tribal leaders. After CRAs have convinced traditional leaders about the merits of the VMMC initiative, they are allowed to spend a few days briefing villagers about upcoming open days, roadshows, or other events.
- b. *Small group discussions with toolkits* – Groups of 20–25 use the BRIDGE II *Tasankha!* discussion guide, where VMMC has been introduced as one issue. Trained facilitators go through the toolkit with groups that commit to meet for a number of weeks for this purpose.
- c. *Forum discussion*: Facilitated by two facilitators on a specific chosen topic such as VMMC. An expert such as a service provider is part of the discussions to respond to specific questions. These discussions attract around 50 people.
- d. *Roadshows*: 2-hour afternoon show with competitions, interactive drama and quizzes and information about benefits of VMMC and locations where VMMC will be provided. These involve going around the community with megaphone and songs to increase interest before settling at one place to perform participatory drama, games, traditional dance and a quiz. A service provider is present to answer questions about VMMC. These can attract up to 1000 people.
- e. *Film shows*: BRIDGE II partners with BLM, the Ministry of Health (MoH) and other organisations that have mobile “video vans” with movie screens and sound systems to show a 10-minute couples’ video at dusk with educational information about VMMC. Facilitators are present to use a discussion guide to generate interactive discussion about VMMC. The MoH has created a comedy video about VMMC that BRIDGE II plays after their video to add interest. These video showings can attract up to 100 people.
- a. *Drama (theatre)*: Trained interactive drama groups of about 10 people each from the BRIDGE II project (BRIDGE II trained one drama group per traditional authority, 6–10 per district). These groups pre-dated the initiation of VMMC activities, but have found it easy to piggyback VMMC content into shows, allowing pauses for questions. Performances are for 50–100 people each.
- f. *Interpersonal Communication (IPC)*:

- i. *Community referral agents (CRAs)*: These individuals, initially recruited and trained for other education/promotion purposes for BRIDGE I & II's earlier activities (such as home-based care), were given 2–3 days' training on VMMC. Their role is to go door-to-door to talk to people about available services including VMMC, benefits of VMMC, provide a referral form and leave leaflets to inform their communities when VMMC is coming. They have been trained in interpersonal communication by the BRIDGE project, and there are about 500 in the four priority districts. Because of their history and recognition in the communities, their introduction of VMMC to communities has been very well received. CRAs also promote and are involved with open days, forum discussions, and discussion groups. The number of clients mobilised by each CRA is recorded in a register and regularly given to the local team coordinator, who in turn feeds it to headquarters.
- g. *"Mobile mobilisation"*: See "Film Shows" above. The van with a public announcement system drives around before showings announcing the time and place of the film(s). This same approach is often used for roadshows and street theatre productions.
- h. *Communication materials and tools for demand creation (NOTE: Materials have just been printed and dissemination to demand creation partners has begun as of March 2013)*:
 - i. 3 posters – 1 for older men, one for younger men, one for couples
 - ii. 3 brochures – one for couples, one for older men, one for postoperative care
 - iii. BRIDGE II *Tasankha!* discussion guide, into which VMMC has been introduced as a topic
 - iv. TV advertisements
 - v. Couples video (often shown by a traveling video van owned by the Ministry of Health, video created by BRIDGE II) – Shows a real young couple deciding whether the man should get circumcised, demonstrates the factors going into the decision, describes the experience and the healing process, models support by the female partner, stimulates discussion at the community level
 - vi. Comedy video (often shown by a traveling video van owned by the Ministry of Health, video created by MoH HEU)
 - vii. Sports video (often shown by a traveling video van owned by the Ministry of Health, video created by MoH HEU)

Evaluation of demand creation activities

Feedback from CRAs, CBOs, and field staff: Community-level meetings where different community volunteer cadres meet with the supervisor to report issues or challenges offer an opportunity for program feedback. The supervisor reports to a local coordinator, and this hierarchy of supervision reaches to BRIDGE II headquarters in Lilongwe. For example, initially there were rumours that circumcision made men sterile, but as circumcised men have been seen to be bringing more children into their families and communities, this has ceased. Concerns such as these can be voiced by CRAs or CBOs, allowing BRIDGE II to respond by tailoring its messages.

Surprising success of mobile VMMC sites: Mobile VMMC campaigns bring in larger numbers than static facilities, not just because of the burst of mobilisation activity but because they can offer some measure of anonymity and confidentiality. BRIDGE II led demand creation activities during a mini-VMMC campaign conducted in March 2013 in Thyolo district, with over 3,368 circumcisions conducted over a period of two weeks in just three sites. The projected target for this campaign was 1,500 circumcisions. BRIDGE aims to meet a national target of 16,000 circumcisions by October 2013, with around 12,000 circumcisions still to undertake.

Methods to evaluate success: Routine data are collected by BRIDGE II on its operations and potential clients. A register records each potential client's name and sociodemographic data. These records are linked to a database with information about the pool of potential clients within BRIDGE II's catchment areas. Routine data are also collected through the evaluation framework for the BRIDGE II project (to reduce bias, this is independently collected and BRIDGE II program heads do not have access to evaluation data). Based on its own assessment, BRIDGE II reports that most successful methods for demand creation have been roadshows, door-to-door visits and community awareness campaigns such as BRIDGE II is planning to conduct a study on impact of demand creation on increased service uptake.

Successes / Challenges

Successes

Importance of working through trusted local agents, people who have a standing in and are recognised and trusted by local communities.

Engaging in high-intensity and low-intensity activities for different types of demand generation: This bifurcation of approaches is something BRIDGE II has found to work well to generate demand and educate clients. Ongoing activities such as IPC activities by community referral agents, or village discussion groups, help educate a community about VMMC and

sensitise them to the health benefits of VMMC. These set the stage for high-intensity activities, such as roadshows, drama performances, and door-to-door recruitment, which are methods that both advertise the imminent arrival of a new VMMC opportunity and which encourage participation with peers in a VMMC campaign or mini-campaign.

Offering small monetary incentives while building the social status of CRAs: CRAs receive a small allowance of one or two dollars for attending each meeting. While these incentives were cut to their current level after funding was reduced. The cash incentive is certainly welcome in these predominantly subsistence economies, but the CRAs are reportedly motivated by the respect they garner in their communities because of their knowledge and their position with BRIDGE. BRIDGE II also offers opportunities for career advancement, as well as useful information that further reinforces CRAs' high status in their communities.

Working with traditionally circumcising communities: BRIDGE II is finding that many people within traditional circumcision communities are turning to medical circumcision because traditional initiation is expensive (boys must be away for 2 weeks and payment must be made to the chief, plus the boys must be provided with three meals a day for the duration). People also aware that the chances of botched operations and secondary infections are much lower with VMMC. Also, it is socially unacceptable for parents to have sex while their son is away at initiation, but with VMMC this proscription falls away.

Seasonal variation in circumcision demand: Demand for VMMC is highest in winter, while schools are on holiday and schoolboys have time to recover from the procedure before returning to school. Winter is also the common season for traditional circumcision, and clients who come of age for traditional circumcision may opt for medical circumcision during this time. Conducting mobile campaigns and mini-campaigns during this time has proven highly effective in bringing in numbers.

Challenges & their mitigation

Young people are early adopters, but it is a big challenge to recruit older men. The Malawi Government has conducted numerous consultations with religious and local political leaders to overcome the perception that circumcision is a cultural (traditionally circumcising community) and/or Muslim practice, distinguishing between religious, traditional and medical circumcision. The decision for VMMC for a sexually active man in a relationship necessarily involves women, who don't know enough about VMMC to help influence the decision. Couple communication is key to driving older men to choose VMMC. As the national communications partner with capacity to develop and pretest entertainment-education materials, BRIDGE II consequently produced a video portraying a couple as the man goes through the experience

of getting circumcised. This video, played by video vans and in other locations, has been credited with convincing men to go for circumcision.

Coordinating demand creation activities with service delivery partners in terms of timing mobilisation activities to maximise demand continues to be a challenge. However, coordination meetings between demand creation and service delivery partners provide an avenue for addressing challenges.

Balancing demand with supply of services: BRIDGE II reported that one of its major problems is not demand creation, but demand control. CRAs have only been creating demand where VMMC sites are available. Even so, after one recent VMMC promotion, BRIDGE II was expecting 1,600 men to report for the procedure, but 3,000 men arrived. This latent demand for circumcision is attributable to VMMC having been talked about for years in Malawian newspapers and online, but services only now being scaled up. BRIDGE II feels confident that as services are rolled out, demand will rise with current activities, despite cultural and traditional resistance to medical circumcision. National-level media have not yet been used to promote VMMC because services are not available in all areas; this is planned to boost demand once service catches up to demand.

Lack of transport and long distances: CRAs work on a voluntary basis and have to pay for their own transport; some are struggling to reach all of the people within their catchment areas. There is a shortage of transport and resources to get them around. Similar shortages impact their ability to record and present information; there were inadequate supplies of the nationally-produced leaflets and posters at sites visited during this review.

Slow production of national-level behaviour change communication materials: The Malawi government and stakeholders decided to conduct development, finalisation, production, and dissemination of behaviour change materials (leaflets, flyers, posters, etc) at the national level to ensure harmonisation of messages, minimise misinformation, and allow for branding of materials. BRIDGE II was the lead national communication partner and has had a hand in developing these materials. However, the bureaucratic approval process, which involves multiple rounds of review, has been time-consuming and delayed availability of materials such that sufficient numbers are not available even in sites where BRIDGE II is coordinating demand creation activities.

Logistics of project end: BRIDGE II is slated to end in 2013, and at present it is unclear whether there will be a BRIDGE III to continue demand creation activities, or if another organisation with a strong capacity to mobilise communities and/or draw on BRIDGE relationships and community structures could do this task. If there is not a BRIDGE III, other

projects that could be tasked with demand creation could innovate upon and expand of BRIDGE's demand creation, but may suffer for lack of institutional memory.

Scale up opportunities

Currently, VMMC is only available in 14 of 30+ districts in Malawi. However, BRIDGE I and II have created community mobilisation structures for other health promotion purposes in almost all districts in Malawi, offering an opportunity for scale-up to the national level, particularly as the government facilities increase their provision of VMMC.



Logo developed by BRIDGE II to brand all national behaviour change materials for VMMC