

PROMISING PRACTICE Uganda: Infectious Diseases Institute (IDI) Adult Male Medical Circumcision in Kampala (AMAKA) project – using local community resources and structures for demand creation

INTRODUCTION

Key Promising Practices:

- Meeting the demand for SMC through existing local community structures and resources: engaging local transport for journeys to static SMC sites
- Increasing support and demand for SMC through integration with other health services, including women's health services

Introduction

The Infectious Diseases Institute of Makerere University in Uganda launched its AMAKA (“Adult Male Medical Circumcision in Kampala”) programme in April 2011 at two static sites in Kampala: one public facility and one private hospital (International Hospital Kampala) through a public–private partnership. This was followed with the roll out of 5 static sites providing Safe Male Circumcision (SMC) in rural areas outside of Kampala. Adding SMC to existing health units enabled an integration of SMC with other services, such as voluntary HIV Counselling and Testing (HCT) and Antenatal Care (ANC).

Due to the challenges for some people in rural areas of reaching static sites, mobile SMC camps were also implemented in more distant communities.

Demand creation activities were carried out to in the first instance build SMC uptake in static sites. Where there was interest but distance was a major factor, mobile SMC camps would be organised to meet demand. Activities were made up of a combination of community–based campaigns and mass media activities. Communities were sensitized using local and community radio, village meetings, and mobilization in high–density areas such as markets.

At the start of the AMAKA project SMC uptake increased from 10 to 860 SMCs per month, reaching on average 3,500 SMCs per month by November 2012. But from February 2013, SMC uptake started to decline to a monthly average of around 2,600 circumcisions per month. Rapid research and community conversations were carried out to understand why and new measures for demand creation were implemented in April 2013. This included providing transport from communities to static sites. Since then numbers have increased rapidly, and as of May 2013 were up to 7,600 SMCs with similar increases in June.

Target groups

1. Uncircumcised men aged 15–49 years old in Kampala and surrounding rural areas
2. Women (as partners, mothers and community-based health workers)

Scale and scope

1. 7 static sites: 2 static sites in Kampala since April 2011 (1 hospital and 1 health centre) and 5 static sites in rural areas since October 2012 (at Kikuube HC IV and Kigorobya HC IV in Hoima District; at Kagadi Hospital in Kibaale District; at Kiboga Hospital in Kiboga District; and at Kiryandongo Hospital in Kiryandongo District).
2. Mobile clinics provided by 5 teams in rural areas in Kibaale and Kiboga Districts

Organizations involved

Lead

- Infectious Diseases Institute

Funding

- CDC (Centers for Disease Control and Prevention)

Other partners

- Ministry of Health (and their Village Health Teams)
- Kampala Capital City Authority

Who is carrying out demand generation activities?

- IDI Mobilisation team, Village Health Teams (VHTs), traditional leaders, *matatu* / taxi drivers, Community-Based Organisations, Peer Educators, Village Drama Groups

Management of demand creation

- IDI mobilisation team

VMMC ACTIVITIES

SMC activities

The AMAKA project enabled the expansion of existing health services to include SMC. This meant that SMC could be provided along with HIV counselling and testing (HCT), condom distribution, Antenatal Care (ANC) and related services.

In addition, ongoing research enabled IDI to understand the challenges some communities faced in reaching static sites providing SMC so added transportation to these sites to their activities. If the demand for SMC in a community is relatively low IDI will offer transport to the nearest clinic. If the demand becomes or is high and the community is some distance from a static site, will implement a mobile SMC camp.

- Research – ongoing regular monitoring of the service with some more informal qualitative research to understand the details of community needs around SMC.
- SMC services at static clinics – ongoing SMC integrated into other health services at 2 hospitals in Kampala, 5 clinics in rural areas outside Kampala.



Voluntary medical male circumcision being performed at one of the static SMC sites

- Mobile SMC clinics – SMC camps implemented in communities on demand depending on feedback from the IDI Demand Creation Team. Depending on the distance from static sites, mobile camps may be 1–2 weeks long with the IDI team staying in the community. Or they may be shorter, “mini” camps, where the IDI team just visits during the day but returns home at night.

Surgeons carry out voluntary medical male circumcisions being performed at a mobile SMC camp



- Transportation to static SMC sites – this involves organising local transportation of men interested in SMC to one of the static sites.



Local taxis are hired to transport men who have registered for SMC to a static site.

- Training of Village Health Teams (VHTs) and community mobilisers – IDI train VHTs and anyone involved with community mobilisation for SMC on HIV prevention and SMC. IDI provide daily support to VHTs as well as refresher training for all community mobilisers.
- Demand creation for SMC is ongoing.

THE APPROACH TO DEMAND CREATION

The approach to Demand Creation:

Key message

SMC is both a means of HIV prevention for men as well as part of improved health within relationships. SMC is one means of HIV prevention (along with knowing HIV status, abstinence, being faithful to your partner, condom use and HIV treatment). SMC should be a normal part of health services and of maintaining good health practices.

IDI also uses the Ugandan Ministry of Health materials. One of the key message is that women are proud of and more attracted to men that are circumcised as it indicates responsibility and care for a woman's health as well as a man's.

Type of intervention

The AMAKA project has used existing health and community structures to roll out demand creation activities and mobilise communities to take up SMC. Urban campaigns combine mobilization at public events with mass media. Upcountry rural campaigns use existing health infrastructure such as Village Health Teams as well as the IDI mobilisation team to run community-based group meetings and one-to-one conversations providing health education around SMC and HIV. This is complemented by use of local and community radio, distribution of SMC campaign materials produced by the Health Communication Partnership (HCP), and the provision of transport to increase access to static SMC clinics.

Rationale

Demand creation activities have been built from years of working in the target communities around HIV and other health issues. Activities use peer influence and approval, role models and traditional leadership to influence social networks and individual behaviour. At the same time, IDI works on building a local enabling environment by supporting existing health and community structures, and working with traditional leaders, local council and local health workers. Building knowledge around SMC amongst leadership, health workers and individuals underpins all IDIs work.

EVIDENCE BASE

Evidence

IDI has been working in Kampala and the districts of Kibaale and Kiboga since 2008 on a variety of health issues with a focus on HIV. IDI carries out quantitative and qualitative research in all its project sites to build knowledge and evidence of best practice and models that can be used by other facilities in Kampala and Uganda. For this project, additional research activities include monitoring of SMC registrations and SMCs actually carried out is also undertaken on an ongoing basis. Feedback on the reasons why and why not men

approve, disapprove and do or do not take up SMC is also being collected and fed into ongoing programme development.

DEMAND CREATION ACTIVITIES

Demand Creation

IDI's approach to demand creation is built around using evidence to build and update community-based activities complemented by mass media. IDI uses district chairpersons and local council leaders to plan and roll out activities one sub-county at a time to ensure that all communities receive all services in an orderly way and that no villages are missed out. Ongoing research findings and feedback help to ensure activities are relevant and targeted in an appropriate way.

1. Research (every 3 months): Used to monitor SMC uptake and understand reasons behind any changes in uptake rates.
 - a. *Quantitative*: cohort studies are carried out to follow changes in behaviours relating to HIV and HIV prevention. Quantitative research methods are also used to monitor SMC registrations and SMCs carried out. Analysis of patterns of SMC will also look at the relationship between specific interventions and the demographic characteristics of men taking up SMC, for example, does the introduction of transport to static sites influence the age of men going for SMC. Audience research is also analysed to guide mass media elements of demand creation using the radio.
 - b. *Qualitative*: more informal conversations during demand creation activities, mobilisation and follow up to SMC surgeries to build on understanding of the influences around behaviours affecting HIV prevention, care and living with HIV.
2. Campaign development (1–2 months)
 - a. IDI community mobilisation team set up. It includes a Mobilisation Officer, Assistant Mobilisation Officer, mobilisation volunteers and then IDI volunteers (not mobilisation specific).
 - b. Demand creation activities developed using research findings (see above) and learnings from the Health Communication Partnership (HCP).
3. Community entry (2 weeks)
 - a. Meet with District Officers to organise introduction to sub-country chairpersons.
 - b. Sub-county chairpersons – responsible for a number of villages – contacted to discuss SMC and related activities.

- c. Sub-county chairpersons endorse IDI activities.
 - d. Sub-county chairpersons introduce IDI to sub-county local councillors (LCs).
4. Community mapping (1 week)
- a. Meet with sub-county local councillors (LC5 first as responsible for several villages, then LC1 as head of a single village) to identify traditional leadership structures and influential persons, VHTs, and other opinion leaders.
 - b. Community-based sensitisation meetings with traditional and opinion leaders and health workers organised.
5. Community sensitisation (5 days)
- a. Attend local council meetings to undertake health education talks on SMC, discuss SMC campaign and messaging, and provide opportunities for questions and answers on SMC with health experts.
 - b. Run sensitisation meetings on SMC, demand creation and campaign messaging for community mobilisers. These mobilisers will work with the IDI mobilisation team.
 - i. Meet with traditional leaders and other opinion leaders to carry out health education discussions around SMC, the IDI campaign and SMC messaging, and needs around demand creation for SMC. IDI health experts will be available to answer questions around SMC.
 - ii. Attend meetings of women's groups to carry out sensitisation discussions (as above) to gain support for SMC and engage in demand creation activities. Women are important influencers of their husbands and sons for SMC uptake.
 - iii. Meetings with Community-Based Organisations (CBOs) and AIDS Community Volunteers (ACVs).
 - iv. Local *matatu* / taxi drivers who may be transporting people to SMC clinics to act as community mobilisers.
 - v. People who have already had SMC to act as community mobilisers.
 - vi. Run training for VHTs to act as contact people, referral mechanisms and community mobilisers.
 - c. Agree with local council leaders, traditional leaders and community mobilisers which day they will run the transport.
 - d. VHT teams acting as contact people and referral mechanisms have daily contact with the IDI Mobilisation Officer and IDI Mobilisation Team:
 - i. Can call the IDI team from 4am each day (keep a separate telephone for this purpose)
 - ii. If the IDI team has not heard from a VHT will contact them to ensure daily conversations to understand what is happening on the ground.

- iii. VHTs provide IDI with reports that include name, numbers registrations for SMC, and requests for particular IDI activities (outreach, transport or further mobilisation).
- iv. Refresher training courses provided for VHTs in messaging around SMC.
- v. VHTs are compensated for their time only if a man attends SMC services. Any concerns around possible coercion from VHTs is mitigated by using existing health services and the structure that VHTs already work within.

6. Community mobilisation (1–4 weeks)

The time taken to run community mobilisation and related SMC activities will depend on community population size and the SMC activities to be carried out. Approximately one community is visited per month by the IDI Community Mobilisation team. The IDI team with local community mobilisers will start demand creation activities a few days before SMC activities start – either the launch of a static SMC site, a mobile camp or transport to a more distant static site. As the SMC activities draw to a close the IDI mobilisation team will move onto the next community in advance of the next SMC activities.

- a. *Sub-county meetings and village meetings:* IDI use village meetings as platforms to discuss what SMC is, how it works as a process and in terms of HIV prevention as well as the wider health benefits. They will also discuss when, where and the type of services available, answer questions and dispel myths and misconceptions. Accompanying the IDI team to village meetings will be role models, VHTs and ARCs – people the community believes in and trusts, to help facilitate discussions and share experiences.
- b. *Traditional celebrations:* the IDI SMC team were approved to join in the Bunyoro Kitara King’s anniversary celebrations. IDI were able to set up an SMC camp on land by the King’s palace during key events and the King gave them his blessing to circumcise his subjects.
- c. *Open days:* health fairs and open days would be held at static sites and popular meeting places. Entertainers, drama groups and loudspeakers would be used to attract attending to the health fair. People would have opportunities to discuss SMC one-to-one and participate in group health education sessions with IDI personnel and VHTs. One of the key mobilisation places was the biggest market in Kampala, which is very close to one of IDI’s two Kampala-based SMC sites.
- d. *Drama (theatre):* local drama groups used to share information and messages about SMC at central meeting places.

- e. *Interpersonal Communication (IPC)*: word of mouth has been a very important part of IDI's demand creation. The IDI Community Mobilisation team and local trained mobilisers will go to churches, mosques, markets including Kampala's main market, and particularly places where older men gather, such as places where men play games such as ludo; bus stations and small trading centres. They will then start conversations with individuals and small groups around family health, HIV and SMC – process, service availability etc. The IDI team and VHTs may also take names and contact details for men who want to register at the time for SMC. Where VHTs are not able to talk to people, they inform IDI, then collect people in one area for IDI to run SMC health talks and activities as part of village meetings (see above).
- f. *Public announcements*: megaphones and PA systems have been used to attract people to talks and mobilisation events as well as SMC services.
- g. *Mass media*: local and community radio is used to broadcast adverts, talk shows and call ins. IDI developed their own radio advert, broadcast in Luganda. Talk shows were done at different sites in the different districts. Guests included LC5 officers, health officers and hospital staff to discuss SMC, HIV and SMC follow up, such as why it is important to wait 6 weeks before resuming sexual activity. Call ins allowed the audience to have specific questions answered by health experts. Radio is also used to promote particular services or events.
- h. *Technology – Transportation*: Mobile phones are used solely to maintain contact between VHTs and the IDI mobilisation team. But transport to static SMC sites has become an important part of IDI's demand creation and realisation activities in rural areas.



Transporting men to static clinics for SMC was implemented in April 2013 (can stay up to a month, depending on need). Local *matatus*, taxis or whatever local transport is available in the community is commissioned to provide transport to and from the static SMC sites on a regular day each month. Drivers are paid the normal journey rate for the transport service by IDI. Drivers are also trained by the IDI teams to ensure they have correct, up-to-date information about SMC and can act as community mobilisers as well.

In general only men having SMC are driven to the clinic. Women sometimes want to attend and if there is space may also join the *matatu*.

- i. *Communication materials and tools for demand creation*: brochures, postcards, flyers and posters produced by the HCP are distributed at mobilisation events. Posters have been the most popular as particularly in rural areas as literacy is low and the posters have very little text compared to the other materials. Most people take posters to put up at home.

EVALUATION OF DEMAND CREATION ACTIVITIES

Evaluation of demand creation activities

Despite the decline in numbers going for SMC at IDI clinics, each year, IDI has exceeded its targets for SMC. They have steadily increased the number of teams and now have 5 teams upcountry doing mobile circumcision clinics and transportation to static sites, and 2 in Kampala providing services primarily at static sites.

Different types of research have been carried out to inform different aspects of demand creation and SMC uptake. For mass media, radio audience research among early adopters of SMC and local businessmen showed radio listening was high in morning and evening. This informed broadcasts of IDI radio programmes.

Demand for SMC is monitored through VHT reports and updates, clinic attendance data, cohort studies, and informal conversations during demand creation events. Data on SMC attendance is evaluated monthly and has already helped highlight changes in trends and the impact on uptake of certain interventions. For example, areas close to static clinics offering SMC saw high levels uptake early on followed by early saturation in those areas. In contrast, there was low uptake in communities at some distance from those clinics. Awareness of this allowed IDI to explore why uptake was low in these areas and respond rapidly with relevant, appropriate solutions. Within a month there was a more than 200% increase in SMC uptake.

IDI's research has so far found that the demand creation activities are resulting in the key reason for why men are going for SMC is as a way of reducing the risk of being infected with HIV.

Whilst IDI have not yet analysed the demographic data to understand the impact of specific interventions on specific age and social groups, visually VHTs and IDI have noticed an increase in older men (rather than teenage boys) going for SMC with the introduction of transportation in April 2013.

LEARNING AND SCALE UP

Successes / Challenges

Successes

Regular analysing existing data to see what is happening on the ground, where changes need to be made and what changes need to be made.

Working with existing infrastructure – following the traditional, respected routes of community entry, engaging with the Local Council and traditional leaders, and working with Village Health Teams and Community-Based Organisations rather than introducing new structures, helps to build community support and a sense of ownership over activities around SMC. As existing, trusted members of the community they can build wider community acceptance of SMC and the services provided for it. In addition, most of the organisations and structures are already working in health and awareness so individuals may have a greater understanding of the way demand creation can work, and possibly of HIV prior to training on SMC and SMC demand creation. Working with existing infrastructure has additional benefits:

- It can reduce costs, as new volunteers or staff do not need to be engaged with and services do not need to be set up from nothing.
- In ensuring local government health facilities can provide high quality SMC services, local clinics may benefit from some additional equipment and training for staff. This equipment may not only be used for SMC so health services overall are improved and the skills and confidence of health workers increases as they gain more training.
- By putting particularly men in touch with the local health services can build confidence in accessing those services and increase overall awareness and demand for the available health services beyond SMC.
 - Depending on local government structures, the increase in demand may help to increase government spending on those health facilities, further building their capacity and quality of service.

- Working with CBOs as mobilisers may lead to them adopting SMC and the skills learnt from training as part of their work so that the SMC programme that exists now is not a short-term, one off measure.

Word of mouth has been a key means of creating demand for SMC and individuals realising that demand by accessing SMC services. It is part of the notification system for when services and/or transport to services are available, and is a strong contributor to peer approval, as peers are often seen as a trusted source of information and are a crucial part of adopting new behaviours.

Role models and peer and community approval are extremely powerful ways of endorsing new practises and changing individual's behaviour. Engaging men who have had SMC to act as community mobilisers, gaining public support from local leaders, and sitting with men and women in informal settings, such as when they are playing games, at market or just chatting, provides a safe space for people to ask questions they may be nervous of asking in more formal settings, and discuss the pros, cons and different options for HIV prevention. Seeing a friend, colleague or someone in the community walk out after surgery in a good state of health is one of the most powerful ways of encouraging uptake.

Including women in direct targeting for demand creation is an essential part of any SMC demand creation work. A lot of referrals for SMC come from mothers for their sons and from wives / partners bringing in their husbands. Engaging women can help build dialogue between couples around sexual health and HIV, and can mitigate problems such as men not admitting they have had SMC so resuming sexual relations with their partners before the recommended 6 week healing period. In addition, most VHTs are women of a similar age to older men of 35 years of above who have the highest risk of HIV and lowest uptake of SMC. Building support amongst women more widely will help VHTs to increase demand amongst older men specifically.

Transport to static clinics is new but has had a very positive response in terms of increasing SMC uptake. Although specific funding currently does not fully cover transport in this way, it is already having a wide impact for a small cost. In the long-term it may also be more sustainable than mobile sites as it helps to improve health seeking behaviour amongst men overall as they get to know their local health facilities. Once men are aware of where the health facilities are they are most likely to travel there on their own in the future. Whilst a full analysis of the data is yet to be done, anecdotally transport in local *matatus* or taxis is also starting to show increasing numbers of older men attending. Also, some men who missed the IDI transport organise their own to get to the clinic as they have heard about facility from their friends.

An External Quality Assurance audit was carried out in Uganda in December 2012 by PEPFAR and has already helped to increase the quality of SMC services and increased the sense of accountability if an organisation or health facility is not carrying out SMC properly. Setting centralised standards for service provision ensures good quality services and helps to mitigate long-term health problems and negative attitudes to SMC as a whole.

Challenges & their mitigations

The following are examples of some of the key challenges the IDI team have faced and how they are trying to mitigate them.

Distance to static SMC sites can deter many men in rural areas as they do not have the money to pay for themselves or their sons (young boys, teenagers) and cannot all take the time to go to the clinic for SMC. As a result, men tend to send their sons first, who they see as able to walk the longer distances, or will pay for them first as a priority over themselves. To mitigate:

- IDI is working with local VHT teams and local *matatu* / taxi drivers to organise regular transport to the static clinics. Local drivers are trained as community mobilisers and are paid the local cost of the journey (nothing additional – see above in Demand Creation Activities).

Saturation in areas close to static SMC sites and clinics occurred quite quickly in the areas where IDI have been working, but uptake did not extend to more distant communities. To mitigate this:

- As above – IDI is trialling transport from distant communities to static sites with initially positive results in SMC uptake.
- In distant communities with high demand, IDI will run mobile SMC camps or smaller outreach services. This meets demand quickly and easily for the community and ensures hundreds of men can be circumcised in a short space of time.

Lack of support amongst women for SMC may be real lack of support, or may be perceived by men without actually discussing it with women. Several reasons have been highlighted for this lack of support, such as the associated with SMC being about men wanting to or having multiple partners, the need for abstinence from sexual intercourse during the six week recovery period, and SMC not being seen as directly beneficial for women. To mitigate this:

- Women are directly targeted during demand creation activities to discuss the benefits for themselves (not just their partners).
- Integrating SMC into existing health services means if women accompany their sons or husbands, they can access their own health services at the same health facility.

High demand for SMC for children and young men below 15 years is positive in terms of approval for SMC but results in children being turned away because they are too young according to the PEPFAR guidelines. To mitigate:

- Community mobilisers discuss age range for SMC services.
- IDI and community mobilisers make it easier for older men to access services (see above regarding targeting women directly, transport to static sites etc.)

Coercion or falsifying data to over report numbers registering for SMC when community mobilisers are compensated for SMC uptake was a possible challenge but has so far not occurred as:

- By using existing health services and a structure that VHTs already work within, IDI can be assured that VHTs are trustworthy, well-known and accountable to the community.
- VHTs are only compensated for time if a man actually attends SMC services. This means there is no reason to increase registration data as it will not result in additional compensation.
- VHTs are only helping a man get to SMC services, and are not involved in providing the actual service so cannot influence a man once he is at a clinic.

Stigma, myths and misconceptions are an ongoing challenge. Issues around poor quality SMC surgeries provided by other organisations help to contribute to ideas that SMC is very painful; it destroys fertility and kills ‘manhood’. As there is a greater risk of post-surgical infection in rural areas, tetanus injections are given but there are rumours that the government and international community are using this injection to sterilise Ugandan men. These rumours can be very powerful, and in some areas have high levels of last minute drop outs as the rumour goes round on the day men are due to be collected for SMC. To mitigate this:

- Endorsement of SMC from local leaders.
- Providing the same, up-to-date, practical information to everyone IDI is working with, from the sensitisation of local council leaders to training of VHTs and community mobilisers, to demand creation events with the community. Once everyone is saying the same thing about SMC it builds trust and support and acceptance in SMC.
- Using existing, trusted community members and VHTs as community mobilisers to endorse the IDI team, demand creation activities and SMC.
- Bring role models to village meetings and public events to talk about their experience of SMC helps to build peer approval.
- External Quality Assurance (EQA) review done in Uganda in December 2012 by PEPFAR will reduce the risk of poor SMC surgeries and the resulting negative experiences and attitudes towards SMC. In addition, as an organisation understanding that sometimes gaining support for SMC can take time to build trust in the organisation and the services you provide.

- Always follow up with men who have had SMC to ensure good wound healing and quality of care.
- Specifically, the 6 weeks sexual abstinence period is off-putting to many, particularly older men (younger men appear to be more willing to abstain). Talking to men and women about why they need to wait 6 weeks and reinforcing the longer-term benefits of SMC helps. In addition, talking about the fact that SMC is optional – it is an individual choice – and part of a range of options helps people to be more committed to all aspects of SMC once they do choose it.

Conflicting messages and information around SMC has resulted in some confused messaging around SMC and in some areas contributed to low uptake of SMC. To mitigate:

- Building strong relationships and support for SMC with district and community level leaders.
- Ensuring consistent messaging within IDI activities and across all CBOs and community mobilisers IDI is working with.
- Ongoing quality assurance reviews to ensure all SMC services are of good quality.
- The Ministry of Health is centralising the coordination of all SMC activities. This will also help to build relationships and enable open sharing of experience and learnings between implementing partners in different parts of Uganda.

Scale up opportunities

IDI is already applying for funding to scale up activities, including:

- Increasing the different channels for targeting women, such as including information about SMC during ANC appointments.
- Increasing transport to static SMC sites
- Training local radio presenters on SMC so that radio presenters help to reinforce correct, up-to-date information on HIV and SMC on a mass scale.
- Further research on the specifics of integrating SMC into more women-oriented health services such as ANC.

An enabling environment for SMC implementation and scale up is essential, and IDI highlight the following as key to developing that enabling environment:

1. Dialogue with Ministries and King
2. Dialogue and sensitisation with political and traditional leaders at the district level
3. Dialogue and sensitisation with political and traditional leaders at the sub-county, parish and village level

4. Work with existing community structures, contacting districts sub-county by sub-county to ensure no communities are excluded and all communities are supportive of SMC.
5. Implement regular research to understand the best ways of creating demand, providing services, and who is and is not getting circumcised and why.
6. Engage all gatekeepers, including local leadership, women's groups, VHTs, CBOs and volunteers, local driver and associations, and men who have had SMC to gain endorsement and can act as mobilisers
 - a. Consider all types of SMC service provision to ensure the most suitable approach can be developed for the community.
 - b. Ensure capacity and quality of services has been reviewed prior to any community agreement on which services will be provided.
7. Develop mobilisation activities with these gatekeepers to build community ownership.
 - a. Consider seasonal, intensive mobilisation at social events such as sports competitions to access older men.
 - b. Consider interventions that connect communities with existing health services (such as transportation) rather than always bringing mobile services to a community.
8. Start mobilisation activities several days before to build interest, give people time to make decisions and raise demand prior to service implementation.