

PROMISING PRACTICE Uganda: Makerere University Walter Reed Project (MUWRP): Using cross-country learning to develop new technologies to create SMC demand and meet SMC needs

INTRODUCTION

Key Promising Practices:

- Highlighting the importance of demand creation and adaptability of approach
- New technology - increasing accessibility for remote communities with an SMC surgery van
- Sharing experiences and technologies between countries
- Peer-to-peer communication for youth

Introduction

The Makerere University Walter Reed Project (MUWRP), a project of the U.S. Military HIV Research Programme (MHRP), began offering safe male circumcision (SMC) as a pilot in 2009 in Kayunga District. The pilot's aim was to assess acceptability and outcome: would SMC be adopted by men in the target areas. During the pilot and in the first few months of the project SMC services were provided at Kayunga District Hospital.

MUWRP's intention was for SMC to be treated as any other surgery. Demand creation activities were started during the pilot, but were relatively small scale, community-based health education talks and promotion by community mobilisers. Interest in SMC and uptake was very high during the pilot. As the full project was rolled out it was felt that demand creation activities could be based at health facilities, such as health education talks while people waited for other services or when they accessed other services.

After a period of high SMC uptake during the pilot and into the first year of implementing the full project, the demand for SMC started to decline. It was also found that approximately 70% of men attending SMC services were less than 30 years old (most were 12-20 years old). Initially, MUWRP went back to community mobilisers and trained them in how to do formal referrals to Kayunga District Hospital. This supported some increase in uptake, but uptake amongst further away communities was still limited by the distance to the surgery site. This led to the design of a larger community mobilisation strategy and the development of mobile SMC services, including a truck that was renovated as an operating theatre. The subsequent mobilisation campaign employed radio, billboards, posters, community mobilisers and peer educators. The project sensitized political, religious and

cultural leaders and dealt with fears about a religious agenda underlying SMC and myths about SMC.

During the one-year pilot phase at Kayunga District Hospital, 600 men were screened for HIV and 513 circumcised. By mid-2011 an average of 35 men were circumcised daily at the Kayunga Hospital site, and the hospital is used as one of the two training facilities in Uganda for safe male circumcision. More recently, MUWRP partnered with the Mukono District health authorities to open a new circumcision clinic for Mukono, which opened in 2011, and a new training centre to help roll out SMC in Eastern Ugandan clinics.

To build demand and deliver a comprehensive package of HIV prevention services, MUWRP has also opened two “youth centres”/HIV care facilities purposely built to serve youth by providing facilities for entertainment and indoor and outdoor games, alongside health education, HIV counselling and testing, as well as antiretroviral therapy (ART). The centres are effective at mobilizing youth to get circumcised.

MUWRP has also been involved in providing SMC at health fairs in Kampala. This has included one fair for the Parliament of Uganda in December 2011 at which circumcision was provided for nearly 400 Parliament members and their children (MUWRP had to extend the health fair for two extra days to meet the demand).

In addition to SMC service provision, MUWRP is engaged in policy, training, technical support to other SMC implementing partners, outreach, service delivery, quality assurance, and equipment and commodities related to male circumcision.

Target groups

- Men aged 15 years old and above in districts where MUWRP is working.
 - If a boy is younger than 18 years goes he must attend with a parent and have the parent’s permission to have SMC.

Scale and scope

- Kayunga District
- Mukono District
- Selected events in Kampala

Organizations involved

Lead

- Makerere University Walter Reed Project (US Military HIV Research Programme)

Funding

- U.S. Department of Defence (PEPFAR)

Other partners

- U.S. Peace Corps (Peace Corps Volunteer directs youth centre activities)
- Uganda Ministry of Health
- Uganda AIDS Commission
- Kayunga District Health Authorities
- Mukono District Health Authorities

Who is carrying out demand generation activities?

MUWRP train community mobilisers and have dedicated SMC medical teams to provide services. Demand creation activities are coordinated by MUWRP's SMC Coordinator and the SMC team. SMC team is responsible for:

- Making monthly plans
- Coordinating monitoring
- Contact with community mobilisers

Management of demand creation

- Makerere University Walter Reed Project (MUWRP)

VMMC ACTIVITIES

SMC activities

SMC provision is offered as part of a package that includes health education, sexually transmitted infection (STI) testing and treatment, HIV testing and referrals, information and

advice on family planning, and provision of modern contraceptives and condoms. MUWRP provides a range of direct SMC services to clients, and advice on SMC service provision, monitoring and policy development to Ugandan policy makers and other partners working on SMC. The following list of activities outlines the different activities MUWRP have undertaken so far:

- *SMC team* – a dedicated SMC team at MUWRP oversees all research, demand creation, service provision and policy advice services. The team has an SMC Coordinator who oversees the SMC team.
- *Technical advice for policy makers, implementing partners and agencies* – MUWRP provides advice and support on SMC provision and demand creation to policy makers, USAID and CDC, and implementing partners in Uganda and other countries. These include STAR–E, STAR–EC, TASO, SPEAR and MJAB.
 - In May 2013, Tanzania Walter Reed Project colleagues came to Uganda to see how the SMC Van/Truck works in the field. MUWRP shared their truck design and linked them with the company in South Africa that built the truck for them so the Tanzania team can do the same thing.
 - In addition, MUWRP has developed SMC guidelines and monitoring & evaluation tools that have been used in the development of national tools to be rolled out over the next few months.
- *Training in SMC surgical techniques for health care providers* – MUWRP has set up specific training centres to provide training for staff engaged in MUWRP SMC activities and for health care providers from other agencies. Health care provider training is given to:
 - District Health Officers (DHOs).
 - Surgeons, nurses and counsellors to become part of dedicated SMC teams at static and mobile sites.
- *Static SMC sites* – MUWRP renovated and equipped an operating theatre at Kayunga District Hospital and supported the development of an SMC clinic at Mukono District Hospital for facility-based SMC provision.
- *SMC Outreach: mobile SMC services* – outreach services were implemented as the demand for SMC close to Kayunga District Hospital was met. Outreach services are implemented based on demand – community mobilisers record the number of men wanting SMC and communicate this to the MUWRP SMC team. Depending on the

demand, the team may return to a community twice a year, or only go once in two years to provide SMC services. Outreach is delivered in two ways:

- Residential – team stays with the community (guesthouses or small hotels)
- Non-residential – within 1 hour of base – team return home each night (and a guard is left with the van / truck or tents).

Outreach is provided through either through SMC camps made up solely of tents, or the SMC Van/Truck, which combines a truck adapted as an operating theatre with tents for non-surgical services.

- Community-based SMC camps – this uses a land cruiser (4x4) and surgical tents, which are carried on top of the land cruiser.
 - Tents are used for pre-surgery check-ups, HIV counselling and testing (HCT), physical exams, surgery and post-surgery recovery.
 - The tents are cheaper than the SMC Van to develop but require more time to set up than the van. The surgical environment is also harder to control so more rapid SMC techniques, such as diathermy, so it may not always be possible to carry out in tent-only camps.
- SMC Van / Truck – designed, built and implemented during the 2010 – 2011 financial year. The SMC surgical van was adapted from a flat-bed truck, which was renovated and equipped to act as an operating theatre for SMC. Tents are put up around the van to provide space for general health check-ups, HCT, physical exams and post-surgical recovery.
 - Most outreach surgeries are now done in the van.
 - MUWRP worked with a company in Cape Town, South Africa, to build the van. Community sensitization activities are carried out for 1–3 months prior to the arrival of the van to ensure there is adequate demand and to maximize the efficient use of resources.
 - The van has a generator and is air-conditioned so that diathermy circumcisions can be carried out (diathermy circumcision takes around 15 minutes).
 - The van has two operating beds so can accommodate 2 circumcisions at a time – approximately 60 in a day.
 - Due to demand, MUWRP have now also added a surgical tent with 4 beds, which raises the number of SMCs to a possible 130 in one day in areas of high population density (in villages where the population is more sparse the numbers will be lower).

Pictures and description on a short video at:
<http://www.youtube.com/watch?v=dsjQACizyaA>

- *SMC follow up services* – these consist of a physical assessment and post-surgery care information given verbally as well as in an information leaflet. During the pilot phase, prior to national guidelines being developed, MUWRP followed up with surgical clients after 48 hours, 1 week, 1 month and 1 year. The ministry of health has now developed surgery follow up guidance for SMC, and follow is now done at 48 hours and 1 week. Follow up check-ups are further supported by:
 - A hotline – clients are given a telephone number on the appointment card for follow up visits. This number can be called at any time if a client has any concerns about the wound or healing process.
 - Follow up for community-based mobile services – how this is achieved is dependent on how long mobile services are in a community.
 - Mobile services will also undertake follow up with clients whilst SMC is being provided.
 - When a mobile service leaves a community, a clinician is left in the community for a week to carry out any follow up that was not possible before the mobile services moved on.
 - Community mobilisers will also follow up with SMC clients to ensure they are recovering well and ask for any feedback on the service.

- *Demand creation and community mobilisation activities* – carried out during the pilot phase and prior to outreach services being implemented. These are described in more detail below.

APPROACH TO DEMAND CREATION

The approach to Demand Creation

Key message

To communicate:

- Where SMC is being offered
- The role of SMC in demand creation and its partial efficacy as an HIV prevention strategy
- Debunking myths about SMC policy and practice
- Eligibility criteria for circumcision

- That SMC is free of charge

Type of intervention

During the pilot and first few months of the project, demand creation was based around more one-off activities in communities with awareness of SMC spreading more widely via word of mouth. Demand creation activities focussed on awareness raising about SMC and services: community health talks and health education at Kayunga District Hospital. But as patterns of SMC uptake changed during 2010–2011, mobile SMC service provision was introduced and community mobilisation activities expanded. Mobilisation activities continued to include group discussion, drama and interpersonal, small group or one-to-one communication. But mass media was also incorporated and the SMC Van also attracts crowds as it drives around a community prior to set up.

Mobilisation approach 1: Pilot – community-based mobilisation, registration and appointments to promote static services. On an SMC mobilisation day, demand creation activities included:

- Drama – carried out 2–3 hours before the health education session
- Health education and Question & Answer session
- Registration for SMC and appointments given at Kayunga District Hospital
- Training for health care providers
- Interpersonal communication with young people at youth centres as part of discussions about HIV

Mobilisation approach 2: Roll out of full project (2010) – no community-based mobilisation.

- Demand creation carried out at static sites whilst people were waiting for or seen at other services.

Mobilisation approach 3: challenge – to increase demand for SMC, particularly amongst men in communities at some distance from static sites and men over 25 years old. Community-based approaches combined with mass media, additional training for community mobilisers to strengthen referral pathways, and new technology (SMC van):

- Community-based mobilisation (as in approach 1)
- Mass media – awareness raising, public dialogue, normalisation
- SMC van / truck and mobile camps – innovation, motivator
- Training for community mobilisers in how to do formal referrals to static sites for SMC

Rationale

Demand creation was initially limited to community-based, small scale interpersonal communication and peer-to-peer activities to avoid demand outstripping the capacity of Kayunga District Hospital to provide SMC. In addition MUWRP wanted to normalise SMC so demand activities were integrated into wider HIV prevention campaigns. As demand was met in areas close to static sites, MUWRP included mass media and new technology (the SMC van) to increase the reach of communication activities.

EVIDENCE BASE

Evidence Base

MUWRP has a well-established research base. They began in 1998 with research into HIV trends, and research now includes investigating HIV prevention, care and treatment activities. Data about SMC is collected through SMC registration and appointment follow up, community-based assessments of risk for clinical outcomes, discussions, interpersonal communication and larger surveys. Demographic data is also collected.

DEMAND CREATION ACTIVITIES

Demand Creation Activities

Demand creation activities started at a relatively small scale during the pilot with the aim of trying to ensure that demand for SMC did not significantly outstrip the ability to provide SMC. MUWRP has trialled a few different approaches to demand creation, building and expanding their approach based on community response and SMC uptake.

1. Research (ongoing since the start of the pilot)

Research has been a part of MUWRP activities from the start. The pilot SMC project was carried out in 2009 to assess acceptability and outcome of SMC demand creation and service delivery activities carried out by MUWRP. Demand creation and service delivery activities have been adapted over the years depending on the research results.

- a. *Quantitative*: pre-existing surveys on HIV behaviours incorporated questions on SMC.

- b. *Qualitative*: during mobilisation days, the team carries out couples counselling, evaluates community risk factors for clinical outcomes such as hygiene practices, and other community issues that may impact upon SMC uptake.

2. Campaign development

Early, minimal demand creation activities and locally produced materials are now being replaced by larger scale activities and now incorporate national communication strategies and materials.

- a. 2009: The pilot initially indicated that demand for SMC was strong enough such that no further community-based mobilisation activities were needed. Further demand creation activities were limited to facilities: health talks whilst people were waiting for services or meeting health personnel for other services, such as HCT, family planning or STI testing and treatment.
- b. 2010: After one year of roll out at Kayunga Hospital, the number of men having SMC started to decline and 70% of those attending were less than 30 years old (most between 12–20 years old). This led to a reassessment of demand creation and SMC service delivery.
- c. 2011: It was determined that a change in service delivery and community mobilisation strategy was needed to attract more and older men. An expanded campaign was developed involving community-based, print and mass media components to demand creation, as well as retraining community mobilisers and the development of new, mobile SMC services.

3. Community entry

The MUWRP SMC team identified a geographic area, such as Kayunga sub-county, and met with key personnel in each area to sensitise them about SMC and gain support for implementing SMC activities.

- a. MUWRP met with the District Health Team (DHT) to discuss and provide training on SMC.
- b. The District Health Officers met with Local Council 1 (LC1) chairpersons to notify them of MUWRP's arrival and organise a meeting with them.
- c. MUWRP met with LC1 chairpersons and the District Health Teams to discuss SMC – what it is, how it works, and the benefits for their communities – and talk about plans for SMC activities and service delivery. These meetings also included identifying existing community mobilisers that MUWRP could contact.

4. Community mapping (1 day per meeting with the LC1 chairperson, 1–2 days per community for training of community mobilisers)

- a. Community mobilisers identified in meetings with the LC1 chairperson (see above). Community mobilisers were drawn from existing health and/or mobilisation structures in each community, such as active Village Health Teams (VHTs) and non-VHT active members already working with other agencies / organisations; religious leaders, especially Muslim leaders, journalists, and other community leaders and trusted people.
 - b. Community mobilisers contacted regarding upcoming meeting and training for SMC.

- 5. Community sensitisation (1–2 day training of community mobilisers is followed by community sensitisation, usually 1 week prior to service delivery. But sensitisation may take from 2–3 days up to 1–2 weeks, depending on population density – the denser / closer the population the quicker the sensitisation process)
 - a. Sensitisation and training sessions run with community mobilisers. Community mobilisers are trained on SMC: the process, the benefits, wound healing and dispelling myths about SMC. Mobilisers are also trained in demand creation activities and communication techniques, such as couples counselling.
 - b. During the sensitisation period, community mobilisers travel around their communities to raise awareness and interest in upcoming community mobilisation days and events, and encourage men to attend with spouses.
 - c. Contact with the community mobilisers is overseen by the SMC Coordinator at MUWRP. Either a community mobiliser calls the team to say they think there is enough demand for some sort of outreach service, or the SMC team contacts the community mobilisers, assesses demand and makes monthly plans for SMC demand creation activities and services.

- 6. Community mobilisation (1 day per village for community-based activities, although may be more, again depending on population density. Mass media components will go on for longer than 1 day)

The MUWRP SMC team and community mobilisers run community mobilisation activities. As these are going on, community mobilisers will undertake couples counselling, do registrations and referrals for SMC at static sites, or direct people to mobile services.

 - a. *Village meetings*: Health education sessions about SMC are carried out by a health educator, clinic officer or nurse at central locations in the community, at local health facilities or at the site of MUWRP mobile SMC services.
 - i. These sessions provide information about SMC: what it is, the surgery process, the benefits, healing time, sexual resumption, and challenge

myths and misconceptions. They also discussed HIV counselling and testing, the ABC strategy (Abstain, Be Faithful, use a Condom), family planning, domestic violence and sexually transmitted infections (STIs). These are followed by a Q&A session.

- ii. If men are interested they can immediately register with a community mobiliser who refers them to the mobile or static site.
- b. *Health Fairs*: In Kampala, MUWRP ran SMC health fairs. These are one day events at high profile locations, such as the Ugandan Parliament or Makerere University that combined health education, interpersonal communication and on the day SMC service provision.
 - c. *Peer-to-peer*: Youth Centres are supported by a U.S. Peace Corps volunteer who trains and coordinates area youth to run youth centre activities around HIV and SMC. Activities include sports, games, clubs, competitions, videos, data capture and a library. These youth also run community HCT, provide information on HIV prevention, and weekly talks to sensitize other young people in their area about issues relating to HIV, including SMC.
 - d. *Film shows*: Films about HIV are run for youth at the Youth Centres.
 - e. *Drama (theatre)*: the Peace Corps volunteer and MUWRP SMC team worked with youth centre volunteers to come up with an entertaining skit about SMC. This is performed to the community at a central meeting place 2–3 hours before health education sessions. The 10–15–minute dramas covered a variety of issues relating to HIV prevention but with a focus on SMC. They helped to attract large crowds and interest in the health education sessions.
 - f. *Interpersonal Communication (IPC)*: This has been a core part of the MUWRP strategy. Community mobilisers talk directly with large and small groups and offer one-to-one counselling; youth peer educators talk with small groups and one-to-one. IPC is used to:
 - i. Raise awareness about upcoming mobile SMC services – the date and place where SMC is provided.
 - ii. Talk through people’s reservations about SMC.
 - iii. Where trained, community mobilisers provide couples counselling to talk through a variety of issues related to SMC and wider family health, such as the responsibilities of men towards partners and families.

- g. *“Mobile mobilisation”*: the SMC van/truck drives around communities prior to set up to raise interest and attract people to the mobile site for further mobilisation activities.
- h. *Mass media*: radio broadcasts focussed on more public service–style announcements, raising awareness about HIV, SMC and service availability. These announcements were broadcast through loudspeakers in target areas to avoid drumming up more demand than could be met.
- i. *Technology –SMC Van*: innovation and new technology was utilised for service provision but also helped to mobilise communities and raise demand for SMC.
 - i. The SMC Van, whilst not specifically designed for demand creation, as a new, innovative twist to a known vehicle attracts crowds to the mobile site as it drives through the community. As people arrive where the van sets up, the drama may be performed, and health education and IPC may be carried out.
 - ii. Mobile phones were also used to maintain contact between the MUWRP SMC team and community mobilisers.
- j. *Communication materials and tools for demand creation*: initially MUWRP produced its own flipcharts and leaflets. These would be used during health education sessions, couples counselling and post–surgery follow up. MUWRP materials have been used to support the development of national SMC printed materials designed by the Health Communication Partnership (HCP). These now include flipcharts for health education, posters, billboards, information leaflets targeting different groups, such as religious leaders, healthcare providers, SMC recipients (pre– and post–surgery).

EVALUATION OF DEMAND CREATION

Evaluation of demand creation

MUWRP has been undertaking research relating to HIV since 1998. MUWRP has a dedicated Monitoring and Evaluation (M&E) team. The team have designed tools to capture demographic data, findings from physical exams, any contraindications to circumcision, HIV tests and results, type of circumcision done and follow up.

The evaluation of demand creation activities is achieved through a combination of SMC registration and surgery data, surveys and more informal feedback mechanisms, such as feedback during couples counselling, Q&A sessions, or peer-to-peer conversations. SMC registration data is collected by community mobilisers whilst surveys are carried out by the MUWRP team.

Initial findings

During the pilot, one day community mobilisation activities were very effective in creating demand amongst smaller groups of men and their spouses (groups of less than 400 people). But the demand increased beyond these groups to the point that the number of people requesting SMC at Kayunga Hospital exceeded service delivery capacity. In addition, as data from the pilot was analysed it was found that treatment outcomes were good, acceptance of SMC was very high, healing after surgery was within time and adverse outcomes were very few. As a result, community-based demand creation activities were stopped and demand creation focussed solely on health facility-based activities.

The full project was rolled out during 2009–2010. But after one year the number of men taking up SMC rapidly declined. It was also found that SMC clients were mainly teenagers and young adults: 12 – 20 year olds made up around 70% of SMC clients. This led to a re-evaluation of the need for community-based demand creation, particularly amongst older men, and raised the issue of community-based SMC provision.

Results

To date, MUWRP has circumcised more than 10,000 men – approximately 40 per day at hospital sites and 70 per day at mobile clinics. The SMC van has also increased demand to the point where demand is exceeding service capacity. As a result additional surgery tents and a separate tent-only SMC service have been developed and rolled out.

LEARNING AND SCALE UP

Successes / Challenges

Successes

It is essential to understand your area: the community, behaviours around HIV, geographical area, population movements and demand cycles e.g. demand often increases during school

holidays, especially in semi-urban areas, as SMC is still very popular amongst teenagers who may be in school.

- Well-established, ongoing qualitative and quantitative research enables understanding of what works, what does not, and any changes that need to be made to any activities.
- Sharing experiences between implementing partners and across countries has helped to supporting the introduction of new technology and ideas, and better meet the needs of communities in MUWRP target areas.

Innovation in service provision has enabled quicker SMC surgery techniques in mobile services, and cheaper mobile services that can be deployed in a very short space of time.

- The SMC Van is quick and easy to set up, acts as a community mobiliser in its own right as it attracts crowds, and can be driven anywhere.
- The van has also enabled the use of *diathermy technique* for circumcisions in the community, which only takes 15 minutes.
- The tents (carried on the land cruiser) are a bit slower to set up than the van but are lower cost and can still be deployed quickly.

A dedicated SMC surgical team means that other hospital and clinic staff and services are not overburdened, and that SMC is readily available from Monday to Friday.

Being an established training institution has ensured high quality training:

- Ongoing course evaluation and student feedback means courses incorporate creativity in teaching techniques.
- MUWRP has been able to easily incorporate training of other and new medical staff and health teams into its training programmes.

Community mobilisers undertaking direct registration and referrals to static sites for SMC for small numbers of clients has helped to speed up the registration to surgery process and supported more rapid uptake of SMC.

Adaptability of approach and activities has increased MUWRP's opportunities for success and created space for trialling new ideas and technologies. It has helped MUWRP adapt to changing circumstances and the different needs of the communities within the target area.

Small scale community-based mobilisation activities increase the opportunities for interpersonal communication, providing people with the opportunity to ask specific questions, take part in couple counselling and discuss SMC and related issues in-depth in small groups or one-to-one.

Ongoing communication with other implementing partners, donors and ministries has enabled MUWRP to feed into the sharing and development of monitoring and evaluation tools, and the sharing of experience to feed into national policy development.

Challenges & their mitigations

A static service at Kayunga Hospital was extremely successful at the beginning, but once the demand for SMC was met in nearby communities it raised a number of issues:

- Distance to the static site was too far for many.
- Renovating the operating theatre was very expensive.

To mitigate:

- MUWRP set up outreach services, which were cheaper and took services to people who were not accessing services at Kayunga Hospital.
- Community mobilisers carry out community sensitisation to raise awareness about mobilisation days.
- Community-based and mass media mobilisation is carried out in the 2–7 days before mobile services reach a community.
- The new SMC van/truck helps to raise further interest in SMC mobile services as it arrives.

Low uptake of SMC amongst older men has been a challenge throughout the MUWRP intervention. Older men have talked about having different “responsibilities” compared to younger men. They feel they have to consult a third party, be that a spouse or employer. This is also related to older men’s fears of losing productive time due to wound healing and misunderstandings around the time off that may be needed from work and not wanting to wait 45 days before having sex. Older men may be supportive of SMC for their sons but not for themselves. To mitigate:

- Use mass media to increase the number of people reached with information about SMC and services.
- Use older mobilisers to specifically target older couples and families with older men in communities.
- Specifically address the perception of lost time amongst older men:
 - Talk about time needed for recovery in manual and non-manual work;
 - Discuss with men and women why they need to wait 45 days before having sex after surgery;
 - Reassure men and women about the benefits of SMC;
 - Reassure men that they will not lose as much time as they fear.

- Offer to talk directly to employers to support proper time off for surgery, recovery and healing:
 - MUWRP has spoken to some employers and commits that they will manage any post-surgery follow up and complications for employees undergoing SMC. This has led to positive responses so far from the employers they have spoken to.
 - MUWRP has also offered to take the SMC van to specific work places. For example, the van went to Makerere University resulting in some teachers and lecturers getting SMC. This would only work for larger businesses as it would not be cost-effective for smaller businesses.
- Offer to talk to spouses through couples counselling and through targeting women directly (see below).

Women act as barriers to SMC uptake amongst particularly older men. Women may bring their sons for SMC (although they are turned away if the child is under 12 years old) and some may promote SMC to their husbands. But anecdotally men and women have said that some women question why, if a man does not have HIV, he should get circumcised unless he is planning to be unfaithful: if it is for HIV prevention and both partners are negative why is it needed? This leads to low uptake of SMC amongst older men or, where men do go for SMC, pressure to resume sex early (either because a man has been circumcised without telling their partner or because the partner worries if they wait too long the man will have sex with someone else). To mitigate:

- Target women directly about the health benefits for themselves if their partners are circumcised and the need for men to wait 45 days before resuming sexual relations.
- Women have better health-seeking behaviours so when women are seeing a health provider for another reason, discussions about health should include the benefits for them of their partner undergoing SMC.
- Undertake couples counselling during community mobilisation days, SMC service days and other HIV and FP services. Discuss SMC in relation to family responsibilities, the role of men and the benefits for women.
- Ensure good training in communication and counselling for health care providers, counsellors and mobilisers engaged in couples counselling to ensure that discussing SMC in terms of the responsibilities of men does not reinforce negative gender stereotypes:
 - Training should include how to start a discussion e.g. “what are your responsibilities as a man at home?” Talk about issues such as safety and then start to introduce health issues such as vaccination of children, support for a pregnant wife or family member in getting to hospital.

- The assumption is most men know their responsibilities but have abandoned them.

Small stipend paid to community mobilisers per engagement (from mobilisation to surgery to follow up) may lead to false reporting or aggressive mobilisation techniques. To mitigate:

- Use pre-existing structures to engage mobilisers who are experienced in health, mobilisation and leadership and are well-known and so accountable to the community.
- Ensure sensitisation and training for community mobilisers is participatory and good quality.
- MUWRP SMC team stay in close contact to build the relationship with community mobilisers.
- Check registration numbers against numbers attending for SMC surgeries.
- MUWRP SMC team talk to health facilities to establish whether or not a community has received sensitisation and mobilisation activities.
- If a mobiliser calls to say an SMC camp is needed, the SMC team will go to the community to check registrations for SMC and speak to people in the community to gauge the level of demand before following up with mobile services.

Animosity between religious leaders as some saw SMC as a “win” for Islam as male circumcision already practised under Islam. To mitigate:

- Ensure religious leaders are included early on, during research and community entry, to understand where any challenges might lie.
- Run sensitisation sessions with religious leaders early on to avoid SMC being seen as solely Islamic, avoid any resentment between religious groups, and promote understanding and endorsement amongst all religious leaders.

Scale up opportunities

MUWRP have already fed into the national scale up of SMC activities and Ministry of Health policies and materials. There are now national guidelines for:

- Side effects management
- Surgery follow up
- Communication strategy
- A minimum package of SMC service provision

Standardised tools and materials are being rolled out over next few months nationally, which include flipcharts, posters and information leaflets targeting different groups as well as client cards for registration and follow up and M&E tools.

In the future, MUWRP would like to get another surgery truck / van but the cost is currently too high.