



Adaptive Social and Behavior Change Communication Strategies Achieve Modification in Social Norms around Uptake of Voluntary Medical Male Circumcision Services in Traditionally Noncircumcising Communities in Three Regions of Tanzania

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Poster # PEE605

Background

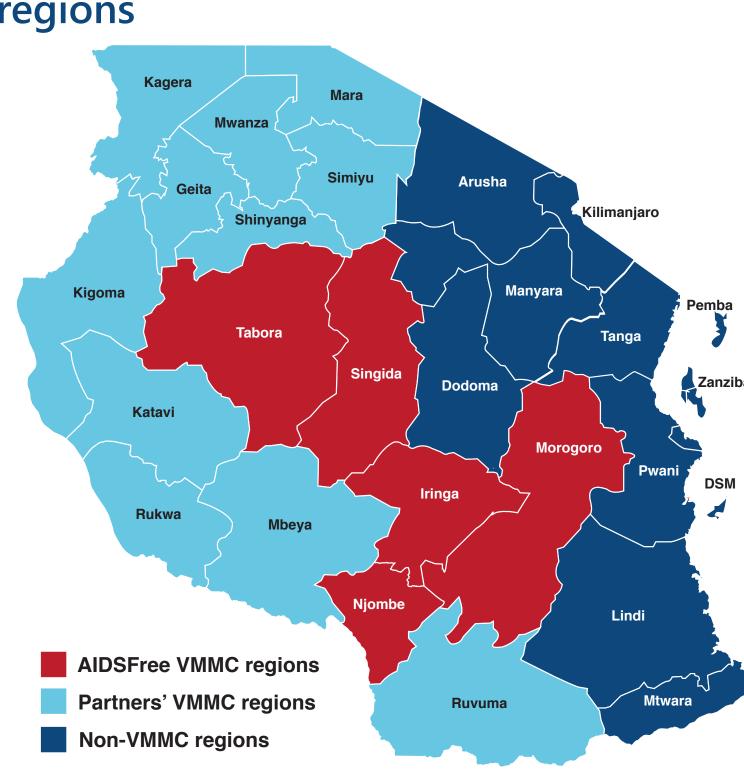
September 2009

- Jhpiego started collaborating with the Tanzania Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) to offer voluntary medical male circumcision (VMMC) services—for HIV prevention—to males aged 10 years and older in Iringa Region.
- Later, Jhpiego and MOHCDGEC expanded VMMC services to the Njombe and Tabora Regions

October 2017

- Jhpiego initiated VMMC services in Singida and Morogoro Regions as part of the Strengthening High-Impact Interventions for an AIDS-Free Generation (AIDSFree)
- This effort is funded by the U.S. President's Emergency Plan for AIDS Relief and supported by the United States Agency for International Development.

Figure 1. AIDSFree Tanzania's VMMC regions



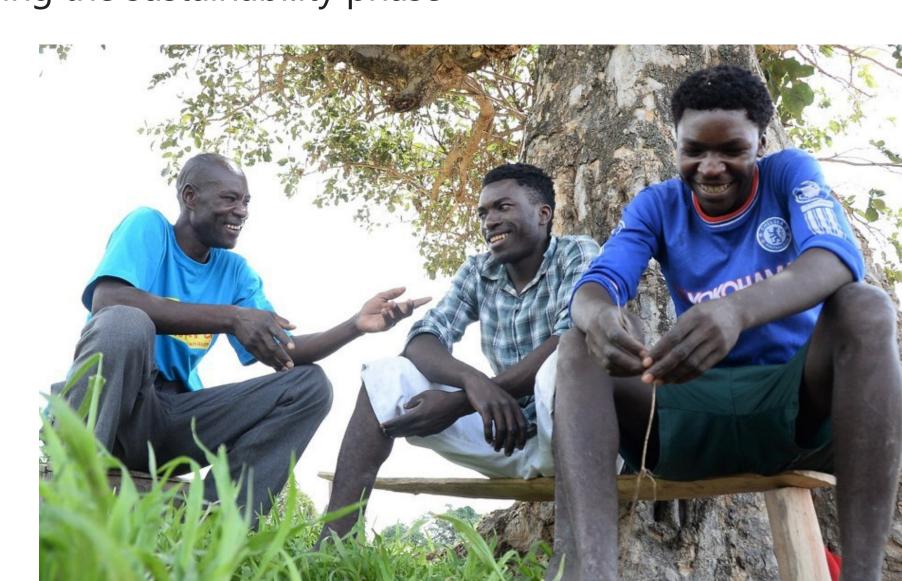
Methods

Description of the Intervention

- AIDSFree Tanzania developed social and behavior change communication (SBCC) strategies in response to three predetermined VMMC implementation phases (see Figure 2):
- Scale-up phase: SBCC strategies are focused on normalizing VMMC services in traditionally noncircumcising communities. This focus was implemented at the beginning, when coverage of VMMC services was low among all age groups.
- Catch-up phase: SBCC strategies are used to mobilize female partners to influence the uptake of VMMC services among older youth and men. This mobilization effort was implemented as AIDSFree Tanzania expanded VMMC services to all communities in the three regions.
- Sustainability phase: SBCC strategies are directed at leveraging parental advocacy to cultivate future demand for infant and adolescent VMMC services. This advocacy effort was implemented as MC prevalence reached 80% among males aged 15–29 years.

Implementation Strategies

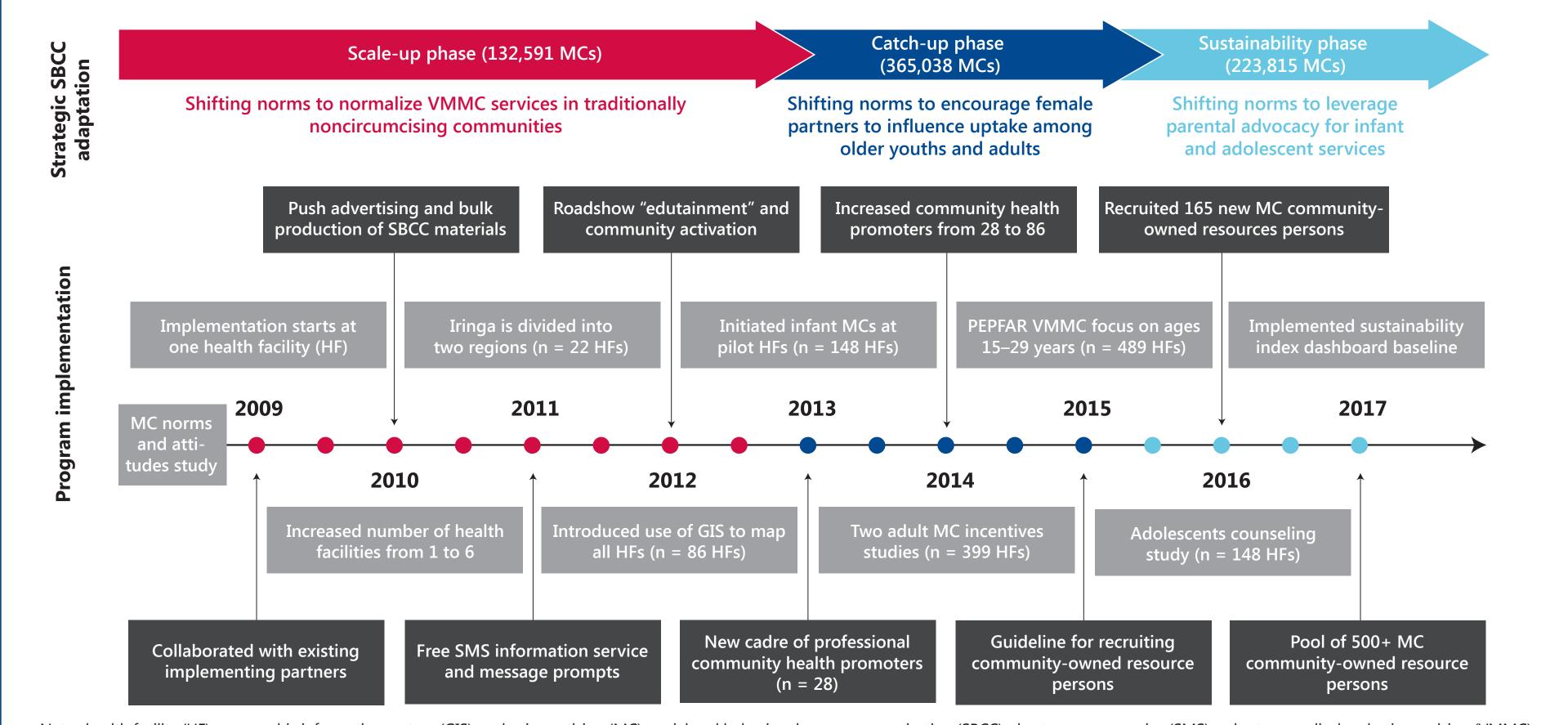
- The AIDSFree-supported VMMC program used experiential learning approaches, backed by independent operational research, to assess motivational incentives, message dissemination, timing options, service environment, and the role of community-owned resource persons (CORPs) as drivers of VMMC uptake.
- The primary SBCC strategies for each phase are:
- Mass media campaigns promoting self-reinforcing messages during the scale-up phase
- Community mobilization at the village level to incorporate social routines and local schedules during the catch-up phase
- Setting-based, one-to-one interactions to address individual needs and to support linkage to services during the sustainability phase



A community-owned resource person (left) supporting AIDSFree Tanzania by promoting VMMC services among young men at their kijiwe (regular meeting point). Photo by Frank Kimaro, Jhpiego.

Results Figure 2

Figure 2. Phased timeline of VMMC services and SBCC strategies



Notes: health facility (HF), geographic information system (GIS), male circumcision (MC), social and behavior change communication (SBCC), short message service (SMS), voluntary medical male circumcision (VMMC) U.S. President's Emergency Plan for AIDS Relief (PEPFAR)

Figure 4. VMMC targets and results, Tanzania: FY 2009–FY2017

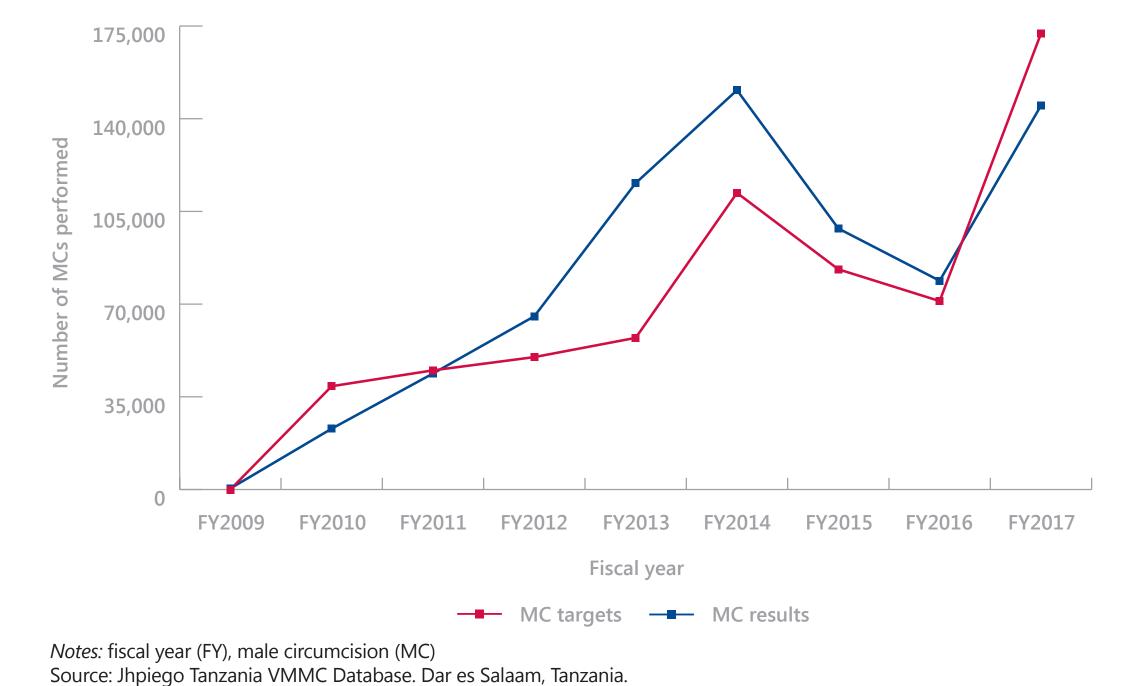
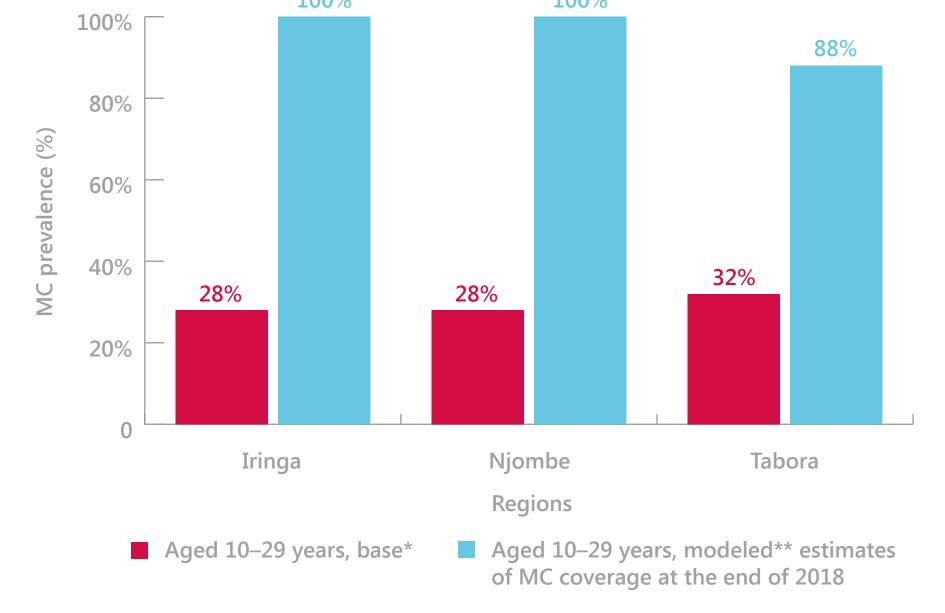


Figure 5. Progress in coverage of VMMC services in Iringa, Njombe, and Tabora Regions: 2009–2018

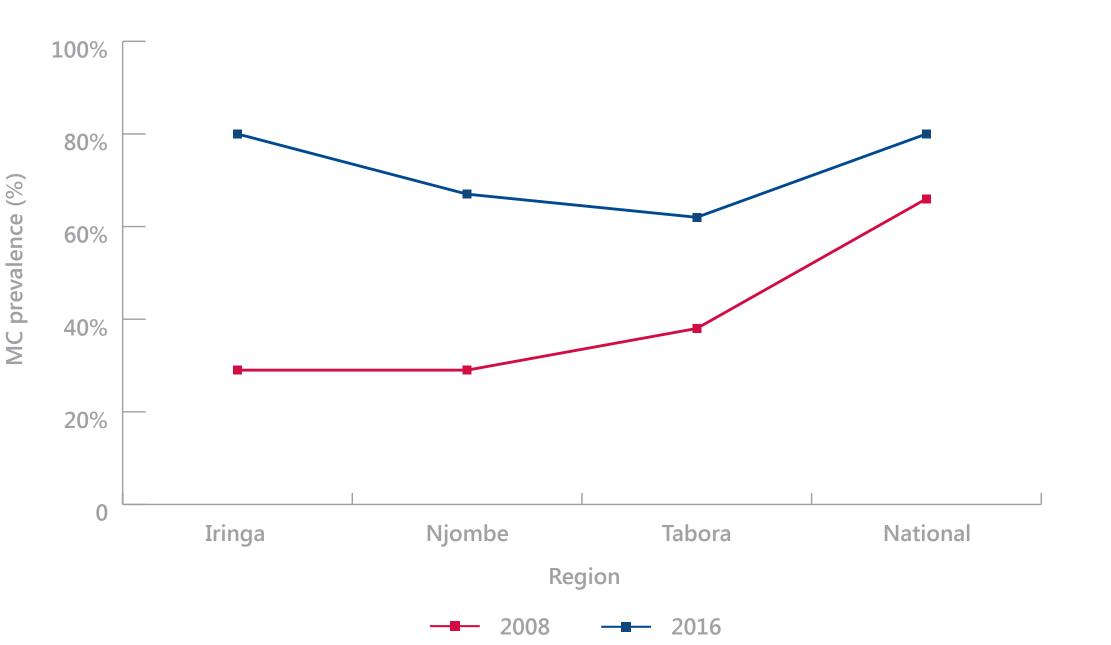


* Base is denoted as follows: "The male circumcision prevalence prior to initiation of the VMMC program in the specified country/province/SNU. This is a fixed input that the user cannot change. It is derived from the most recent Demographic and Health Survey or other official survey prior to the start of the VMMC program. In most cases the male circumcision prevalence is not available below the provincial or regional level; if this is the case, the provincial/regional prevalence is used for every SNU in the province/region." (http://avenirhealth.org/policytools/DMPPT2/)
** Modeled estimate is denoted as follows: "Modeled MC coverage is a result of both baseline (e.g., traditional) circumcisions, and circumcisions conducted through the VMMC program." (http://avenirhealth.org/policytools/DMPPT2/)
Notes: male circumcision (MC), voluntary medical male circumcision (VMMC)

Source: Voluntary medical male circumcision decision-maker's program planning toolkit 2. Avenir Health website

http://avenirhealth.org/policytools/DMPPT2/index.html. Accessed May 22, 2018

Figure 3. Prevalence of male circumcision in Iringa, Njombe, and Tabora Regions: 2008 and 2016

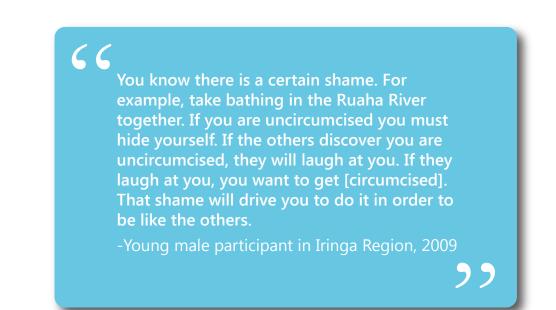


Note: male circumcision (MC)
Sources: 1) Tanzania Commission for AIDS, Zanzibar AIDS Commission, National Bureau of Statistics, et al. 2008.
Tanzania HIV/AIDS and malaria indicator survey 2007–2008. The DHS Program website.

https://dhsprogram.com/pubs/pdf/AIS6/AIS6_05_14_09.pdf. Accessed May 22, 2018.

2) Ministry of Health, Community Development, Gender, Elderly and Children; Ministry of Health Zanzibar; National Bureau of Statistics; et al. 2016. Tanzania demographic and health survey and malaria indicator survey 2015–2016. The DHS Program website. https://dhsprogram.com/pubs/pdf/fr321/fr321.pdf.

Accessed May 22, 2018.



I wanted to [get circumcised] when the program began. But because of our norms, I was reluctant.

I did not think the procedure was appropriate for a man my age—a father of 12 children, some of them adults. But my perceptions changed during a VMMC campaign in my village, when my son-in-law [a VMMC promoter] persuaded me. Now I am very happy and clean. Thanks to this program, my sons and I are now circumcised. I am also protecting my wives.

-45-year-old farmer, Tabora Region, 2017

Prevalence of Male Circumcision

- According to national data from 2008, the prevalence of male circumcision (MC) was 29%, 29%, and 38% in Iringa, Njombe, and Tabora Regions, respectively (see Figure 3). All three were traditionally noncircumcising regions.
- National rate was 66%.
- According to national data from 2016, the MC prevalence was 80%, 62%, and 67% in Iringa, Njombe, and Tabora Regions, respectively (see Figure 3).
- National rate was 80%.
- The Jhpiego-supported VMMC program contributed to 721,444 MCs being performed from September 2009 to September 2017 (see Figures 4 and 5).

Lessons Learned

- In the three regions, using SBCC strategies to promote MC as a desirable health value increased the acceptance and uptake of VMMC services, especially among adolescents (aged 10–19 years) living in traditionally noncircumcising communities.
- SBCC strategies that target social influencers, who then convey key values by word of mouth, are proving to be persuasive in changing the minds of persons who previously may have held out from using VMMC services, especially older youth and adults.
- Service barriers outside the control of SBCC strategies restrict full utilization of VMMC services, especially among older youths and young men (aged 20–29 years).
- These barriers include traveling long distances to VMMC facilities, long waiting times, predominance of female health care providers, and lack of privacy at facilities.

Next Steps

- Reinforce advocacy and SBCC strategies to integrate VMMC into routine facility-based health services.
- Leverage the opinion leadership and social network of VMMC adopters to sustain future demand for VMMC services.
- Engage young men (aged 20–29 years) in targeted SBCC interventions, reaching them directly or through partners, to use or promote VMMC services.
- Recruit more CORPs as SBCC drivers especially influential proponents of VMMC services (including users)—and peers, partners, and parents of VMMC users.
- CORPs have been MC role models, and their personal testimony is vital in creating credibility of and counteracting misconceptions about VMMC services.



