International Initiative for Impact Evaluation

Impact evaluation brief

HIV and AIDS

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Can peers and other influencers increase voluntary medical male circumcision uptake?

HIV infection continues to be a major global public health crisis. Sub-Saharan Africa is the most affected region and, with 25.6 million people living with HIV in 2015, accounts for two thirds of all new HIV infections globally.[1]

Voluntary medical male circumcision (VMMC) reduces the risk of heterosexually acquired HIV in men and boys by approximately 60 per cent.[2] However, VMMC uptake rates are much lower than the target of 80 per cent coverage in 11 of the 14 priority countries identified by WHO and UNAIDS in eastern and southern Africa.[3]

Need for innovative interventions

Innovative interventions are needed to stimulate demand for and uptake of VMMC. Some theories suggest that influencers, such as role models and peers, and social norms can affect an individual's behaviour.[4] In order to test the effectiveness of this approach, 3ie funded pilot interventions in Zimbabwe, South Africa, Zambia and Uganda that used role models, peers, partners and normative attitudes to evaluate whether or not these influencers had a positive impact on VMMC uptake.

Main findings

3ie-supported impact evaluations of pilot interventions to increase VMMC uptake show mixed results:

- Circumcised soccer coaches were effective as role models in conveying the benefits of VMMC through a schools-based soccer programme. Direct communication through text messages and phone calls, and assistance with transportation or accompaniment to the clinic were central to success.
- A simple framing message – *Are you tough enough?* – is a cheap and effective way of increasing VMMC uptake.
- The effectiveness of incentivising peers and intimate partners to promote uptake was difficult to determine, due to limitations in the evaluations' designs.
- Social norms and acceptance clearly influence decisions and behaviours related to VMMC. It is less clear however, how best to harness that influence to increase uptake.

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Country statistics

HIV prevalence among males aged 15–49 years

- South Africa: 14.9%
- Uganda: 5.9%
- Zambia: 10.9%
- Zimbabwe: 12.1%

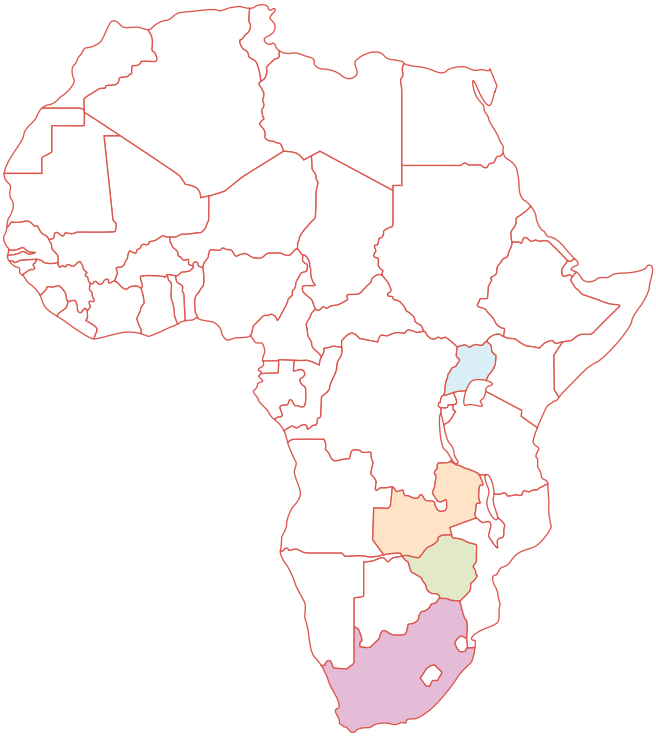
Source: aidinfo.unaids.org

VMMCs completed through 2014*

- South Africa: 43%
- Uganda: 50%
- Zambia: 49%
- Zimbabwe: 22%

*Based on targets set in 2011

Source: aidinfo.unaids.org



Interventions that promoted VMMC

Using soccer coaches as role models in Zimbabwe: *Grassroot Soccer* used a soccer-themed educational session in secondary schools in Bulawayo to reach adolescent boys aged 15–19 years to promote VMMC. The intervention, *Make the Cut Plus*, used coaches to relay information about the preventive benefits of circumcision in HIV transmission. They also provided support to adolescent boys to help them reach a decision, through follow-up phone calls and transportation assistance, to go to the clinic. **Boys in schools where these soccer interventions were conducted were two and a half times more likely to get circumcised than boys in schools without these interventions**.

Innovating with postcard messages in South Africa: This pilot intervention distributed postcards containing six different combinations of messages. These were then analysed to understand the effects of different types of advertisements on VMMC uptake. One postcard contained the message, *Are you tough enough?* Another offered a transportation voucher worth 100 Rand (about US$10). A third contained a message stating that two thirds of partners of uncircumcised men would prefer their partners to be circumcised. Three additional postcards contained different combinations of the messages and the voucher, or a simple message about the preventive benefits of circumcision. To reach eligible men, the study team distributed the postcards to 6,000 households in the township of Soweto in Johannesburg. **Men who received the *Are you tough enough?* postcard were twice as likely to get circumcised than those who received only a simple message about preventive benefits.**

Using referral vouchers as incentives in Zambia: This intervention provided male clients receiving circumcision with referral vouchers that allowed them to refer up to five peers for circumcision over a three-month period. Clients were offered an incentive of US$2 for each referral. Each referred man was then offered the same opportunity. **On average, 10 more circumcisions per month were observed in facilities offering peer referral incentives than in facilities not offering them**. **However, the study did not include enough men to be able to determine whether this difference was real or due to chance**.

Informing and training pregnant women in Uganda: This intervention in Kampala provided a comprehensive package of information and training to pregnant women in their third trimester. These women were asked to inform their partners of the benefits of circumcision and encourage them to have it done. The intervention sought to capitalise on the period of post-partum abstinence. The study was conducted in two distinct and separate time periods. Pregnant women in their third trimester were randomly enrolled into the control group which was conducted from May to August 2014, or the intervention period from October 2014 to January 2015. While about 70 per cent more partners accessed circumcision in the intervention period than in the control period, the overall number of participants was small. Potential seasonal differences could also have affected the results, since the control period was summer and the intervention period was during fall or winter. As a result, **the authors were not able to draw any firm conclusions regarding effectiveness**.

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What next: lessons learned for future research and implications for evidence uptake

Peers and other influencers may contribute to modest gains in circumcision rates. Simple interventions, such as postcards framing the decision to undergo circumcision as being 'tough enough', or soccer coaches conveying information and providing support, can increase the uptake of VMMC. However, **more evidence is needed to assess how these interventions would work at scale**. While peers and intimate partners may be able to encourage partners and friends to get circumcised, more studies are needed to fully determine whether these promising ideas will work. These should include more people and be implemented over a longer period.

Qualitative information from a Kenya study suggests that men who are already interested in circumcision are more likely to be persuaded or nudged into action by these short-term interventions. Further research can help identify mechanisms to reach men who have not yet considered circumcision, or are still uncertain as to whether it is right for them.

3ie-funded VMMC studies

As part of its Voluntary Medical Male Circumcision Thematic Window, 3ie funded seven pilot interventions and impact evaluations to increase the evidence on what works, for whom and why. These were around ways to increase VMMC demand for HIV prevention in eastern and southern Africa. This brief presents the findings from four impact evaluations: *The use of peer referral incentives to increase demand for voluntary medical male circumcision in Zambia*; *Voluntary medical male circumcision uptake through soccer in Zimbabwe*; *Using advertisements to create demand for voluntary medical male circumcision in South Africa*; and *Assessing the impact of delivering messages through intimate partners to create demand for voluntary medical male circumcision in Uganda*.

About 3ie

The International Initiative for Impact Evaluation (3ie) is an international grant-making NGO promoting evidence-informed development policies and programmes. We are the global leader in funding, producing and synthesising high-quality evidence of what works, for whom, why and at what cost. We believe that high-quality and policy-relevant evidence will help make development more effective and improve people's lives.

Endnotes

1) WHO HIV/AIDS Factsheet.

2) Auvert et al. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. *PLoS Med*. 2005;2:e298., Bailey et al. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. *Lancet*. 2007;369:643–656., Gray et al. Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. *Lancet*. 2007;369:657–666.

3) WHO/UNAIDS. 2011. Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa. Geneva: UNAIDS.

4) Bandura A. 1986. Social foundations of thought and action: a social cognitive theory. Englewood Cliffs, NJ: Prentice-Hall.

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For more information on VMMC or these pilot interventions, email **info@3ieimpact.org**