



Republic of Malawi

# **MALAWI VOLUNTARY MEDICAL MALE CIRCUMCISION COMMUNICATION STRATEGY**

**2012-2016**





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## ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BCC	Behavior Change Communication
BLM	Banja La Mtsogolo
CHAM	Christian Health Association of Malawi
DHS	Demographic and Health Survey
HCWs	Health Care Workers
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
NAC	National AIDS Commission
MC	Male Circumcision
MCP	Multiple and Concurrent Sexual Partnerships
MoH	Ministry of Health
NGO	Non Governmental Organisation
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
RCTs	Randomized Control Trials
SBCC	Social and Behavioural Change Communication
SITAN	Situation Analysis of Male Circumcision in Malawi
STI	Sexually Transmitted Infections
VCT	Voluntary Counselling and Testing of HIV
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

## FOREWORD

Malawi has integrated Voluntary Male Medical Circumcision (VMMC) as part of the HIV prevention interventions. The overwhelming evidence of the effectiveness of VMMC in reducing the risk of acquiring HIV in men is compelling. While, there has been so much progress on service delivery and strategic planning of the VMMC program in Malawi, there is also a need to ensure that the general public is aware of VMMC and its benefits and risks through a comprehensive communication strategy. Most importantly is the partial protection that VMMC offers and also choices and decisions that couples should make to make certain that VMMC does not increase the risk but rather reduces the risk.

The VMMC policy and the standard operating procedures have already set up the base for effective scale up of services and policy direction. It is therefore, imperative that a communication strategy should aim at improving the knowledge and understanding of VMMC within the general public thereby increasing the demand for the service. VMMC is very effective if targets that have been set are achieved because of its public health benefit. As such, intense demand creation strategies are required while also acknowledging that all men that have been circumcised need to follow other safer sexual practices post VMMC. It is also important to promote VMMC for HIV prevention and delink it from the cultural and religious bases from which it has been associated with for a long time.

This communication strategy guides all the communication initiatives around VMMC in Malawi and should be used alongside other service delivery documents such as the standard operating procedures with the overall guidance of the VMMC policy. We expect all organizations to use this strategy as their reference document when designing VMMC campaigns and utilize the messages contained in the document.

Willie Samute  
**Secretary for Health**

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We also wish to thank all the members of the VMMC national task force, National BCC sub group and the HIV Prevention Technical Working Group (TWG) for their technical support and guidance throughout the development of the document.

## 1.0 INTRODUCTION

Male circumcision, the surgical removal of all or part of the foreskin of the penis is one of the oldest and most common surgical procedures worldwide. It is usually practiced for religious, cultural, and/or social reasons. Recently, scientific evidence has shown that medical male circumcision, defined as the complete surgical removal of the foreskin, has a number of health benefits including reduced risk in acquisition of urinary tract infections, syphilis, chancroid, and the human papilloma virus. Furthermore, it has been established that cervical cancer is 2 to 5.8 times more frequent among women partners of uncircumcised males compared to partners of circumcised males.

The linkage between male circumcision and HIV infection acquisition has also recently been explored. A 25-year longitudinal study of a birth cohort of New Zealand children concluded that male circumcision may reduce the risk of sexually transmitted infection acquisition and transmission by up to one half, suggesting that there are substantial benefits accruing from routine neonatal circumcision. More recently, a 60% reduction in HIV acquisition among circumcised men aged 18-24 years was demonstrated in a study from South Africa<sup>1</sup>. Subsequently, two other studies in Kenya and Uganda have demonstrated reduction in risk of HIV acquisition of 53 and 48% respectively among circumcised men<sup>2</sup>. In addition, an ongoing follow-up study in Kenya found that this protective effect was sustained over 42 months, reducing men's chances of becoming infected with HIV by 64 percent.<sup>3</sup>

Since the publication of these results, there has been an immense interest in using male circumcision as part of HIV prevention strategies in countries with high HIV prevalence rates and low male circumcision rates. In March 2007, the WHO and UNAIDS recognized male circumcision as an effective intervention for HIV prevention in regions with high HIV prevalence and low male circumcision rates, such as the Sub-Saharan Africa. Globally, guidelines have been developed on the practice of safe male circumcision and tools developed for countries to use when considering scaling up of this intervention.

Malawi is one such country in Sub-Saharan Africa with high HIV prevalence and where the majority of males are not circumcised. However, even though male circumcision is now considered a proven public health intervention, its widespread introduction in countries such as Malawi, where communities either circumcise males using traditional methods or do not circumcise at all, is an issue that requires careful consideration. In light of this, several stakeholders' consultations have been held in the country to examine the applicability of these research findings to the Malawian context and to inform the best way forward with regard to male circumcision for HIV prevention in Malawi.

Previously, some stakeholders have expressed concern regarding the apparent discrepancy in HIV prevalence rates in circumcising communities in Malawi as compared to those in non-circumcising

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<sup>1</sup> Auvert B, Taljaard D, Lagarde E, et al. [Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 trial](#). *PLoS Medicine* 2005;2(11):e298.

<sup>2</sup> Gray, RH, Kigozi G, Serwadda D, et al. [Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial](#). *The Lancet* 2007; 369: 657-666.

<sup>3</sup> Bailey RC, Moses S, Parker CB, et al. [Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial](#). *The Lancet* 2007;369:643-656.

<sup>3</sup> Bailey RC, Moses S, Parker CB, et al. [\(Abstract only\) The protective effect of male circumcision is sustained for at least 42 months: results from the Kisumu, Kenya trial](#). XVII International AIDS Conference, Mexico City, August 3-8, 2008.

communities. This apparent discrepancy centres on the fact that districts where male circumcision is traditionally practiced were found to also have high prevalence of HIV. Through the National Situation Analysis (SITAN 2009) on Male Circumcision<sup>4</sup>, it was noted that this apparent discrepancy may be attributable to a number of confounding factors:

- Incompleteness of circumcision as traditionally practiced with lower protective effects,
- Confounding of HIV status by ethnicity as high prevalence of male circumcision and HIV is associated with ethnicity. In fact, amongst the circumcising ethnic groups, Yao and Lomwe, circumcised males had a lower HIV prevalence than uncircumcised males, 13.4% and 9.5% versus 16.8% and 13.5% respectively.
- Ceremonies around traditional/cultural circumcision that result in high-risk sex, with high-risk defined as unprotected sex with multiple partners immediately following circumcision that promotes HIV transmission.
- Male circumcision offers partial protection as such, the risk of HIV transmission is still there in circumcised men if they continue to practice unsafe sex and have multiple and concurrent sexual partners among other risk factors.

In view of the foregoing, the Ministry of Health, in collaboration with other major partners in HIV prevention in the country, convened a national stakeholders meeting to map out the process for developing a Communications Strategy that will address the communication needs of men and others with regard to VMMC as well as promoting the uptake of VMMC for HIV prevention. At the meeting it was agreed that a task force be instituted to facilitate the process of developing the Communication Strategy.

The Government of Malawi, through the Ministry of Health (Health Education Unit and HIV and AIDS Department) and partners, has developed this National Communication Strategy for Voluntary Medical Male Circumcision (VMMC). The Strategy will guide communication interventions aimed at promoting VMMC as an HIV prevention intervention in Malawi and increasing demand for VMMC service in the country, 2012 – 2016.

## **1.1 Goal**

The goal of the Strategy is to contribute to the reduction of HIV incidence in Malawi by providing a framework for all communications regarding VMMC, including demand creation activities, as an integral part of the national HIV prevention strategy.

## **1.2 Communication Objectives**

The National VMMC Communication Strategy aims to achieve the following objectives:

- To increase levels of knowledge on the facts regarding and benefits of VMMC
- To increase informed demand for and uptake of VMMC services
- To create an enabling environment for VMMC and foster its widespread acceptance

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<sup>4</sup> National AIDS Commission (2010). Situation Analysis of Male Circumcision in Malawi. Lilongwe, Malawi.



- ♦ To increase consistent safer sexual practices post-VMMC

### **1.3 Purpose**

The purpose of developing this National VMMC Communication Strategy is:

- ♦ To improve the current awareness, knowledge, attitude and practice of Malawians regarding the effectiveness of VMMC in reducing HIV incidence levels (partial protection)
- ♦ To outline strategic and effective communication, advocacy, and community mobilization activities to promote VMMC at national, regional and community levels
- ♦ To ensure that the timing and content of VMMC messages is appropriate and closely aligned to VMMC service delivery processes

### **1.4 Who should use this VMMC Communication Strategy?**

This communication strategy has been developed as the formal National VMMC Communication Strategy in Malawi. All senior Ministry of Health personnel, international and local NGO program managers, as well as any implementing agencies conducting VMMC communications interventions, including but not limited to demand certain activities should use this document to guide and inform their work.

### **1.5 Guiding Principles**

The National VMMC communication strategy shall be implemented under the following guiding principles:

- ♦ VMMC shall be implemented and promoted as part of a minimum package as guided by the National Action Framework and the National HIV prevention Strategy.
- ♦ Communication activities shall be implemented to ensure that demand for services meets the capacity of the health system to provide such services.
- ♦ The social ecological model of communication and behaviour change shall be used to guide multilevel communication interventions by addressing the barriers identified and levels of influence in decision-making.
- ♦ Timing and content of messaging shall be linked to the specific requirements of clients at each step in the VMMC process (see Annex 1).
- ♦ Intervention messages shall be tailored to each respective audience as defined in this communication strategy.
- ♦ All SBCC implementing partners shall work under the direction and guidance of Ministry of Health (MoH) and the National AIDS Commission (NAC).
- ♦ The national Behaviour Change Communications (BCC) subgroup of the HIV Prevention Technical Working Group (TWG) will need to approve the design, implementation, and evaluation plans for the VMMC communication activities before they are put into effect at district or national level.

## 2.0 SITUATION ANALYSIS ON MALE CIRCUMCISION IN MALAWI<sup>5</sup>

### 2.1 Distribution and Determinants of Male Circumcision in Malawi

Malawi has a low prevalence of male circumcision (MC) with a national circumcision rate between 20.7% and 26.7% of men. The majority of circumcised men reside in Southern Region, where according to the 2004 DHS 33.1% of men self-report as circumcised with significant pockets of circumcision along the Lakeshore. This compares to 12.2% in Central Region and 5.0% in Northern Region.

The majority of circumcision that takes place in Malawi occurs in the context of religious and traditional rites of passage, although increasingly, modern healthcare facilities are being sought out for the procedure both as part of the traditional process and as uncircumcised men become increasingly aware of the benefits of VMMC. In a review of selected district healthcare facilities, the Situation Analysis on Male Circumcision (SITAN) found that the vast majority of medical circumcisions were being performed on children between the ages of 5 and 10 years.

The most common reason nationally for MC is religion (see table 2), although there is substantial regional variation for the indication for performing MC in modern medical facilities (see Table 2.).

Table 1. Age distribution of males circumcised in selected district hospitals

Age	Frequency	Percent
<5 years	179	10.3
5-10 years	1200	69.2
11-17 years	100	6.8
>17 years	203	11.4
Missing	52	3.0
<b>Total</b>	<b>1734</b>	<b>100</b>

Along with its religious significance, the Yao, Mang'anja and some Lhomwe peoples practice MC as a traditional rite of passage. These procedures are typically performed during the traditional initiation ceremonies at the initiation camp commonly known as *Ndagala* among the Yao, *Tsimba* among the Mang'anja, and *Thezo/Zoma* among the Lhomwe. Although each shares a similar English language description (circumcision), there appears to be significant variation between the types of procedures performed amongst different ethnic groups in Malawi. According to the SITAN, among the Lhomwe, for example, *Lupanda*, or partial circumcision is mainly practiced. Researchers in other countries in the region have reported that this type of circumcision would not provide the same level of protection as medical MC, thus creating some question as to the actual prevalence of medical MC, or full foreskin removal, in Malawi.

<sup>5</sup> All data presented is drawn from the National Situation Analysis on Male Circumcision presented to the Male Circumcision Task Force on 27<sup>th</sup> May 2010, unless otherwise noted. For a copy of the full report, contact Blackson Matatiyo at [matatiyo@malawiids.org.mw](mailto:matatiyo@malawiids.org.mw)

**Table 2: Regional distribution of indications for MC (n=1648) in selected district hospitals**

		<b>INDICATIONS</b>				
		<b>On demand</b>	<b>Medical</b>	<b>Religion</b>	<b>Ritual</b>	<b>Total</b>
<b>Region</b>	<b>North</b>	7.6	54.6	18.5	7.6	100.0
	<b>Centre</b>	1.2	84.5	2.8	4.7	100.0
	<b>South</b>	0.5	6.3	89.3	0.2	100.0
	<b>Total</b>	<b>1.2</b>	<b>25.4</b>	<b>72.0</b>	<b>1.6</b>	<b>100.0</b>

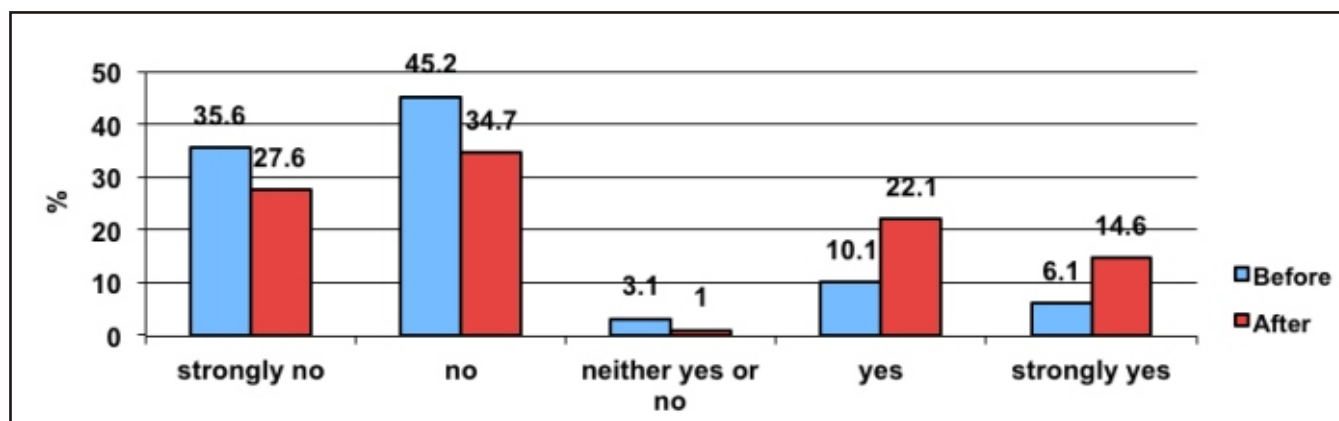
The practice of partial or incomplete circumcision has also been observed by other studies within the sub Southern African region. Studies were done in Tanzania and Lesotho where men who self-reported as circumcised had a clinical examination; it was found that only 50% of those reporting MC had complete removal of the foreskin; 23% of the men who reported to be circumcised had no evidence of any procedure, with foreskins completely intact; and the remaining 26% were partially circumcised. The SITAN findings and the 2004 DHS data for Malawi, when looked at in light of findings in other countries, indicate that the HIV prevention benefit of traditional MC would not be the same as VMMC. This means that traditional circumcision would not provide the same HIV prevention protection as medical circumcision, which could explain why Malawi still has high HIV prevalence in areas where men are circumcised traditionally.

## **2.2 Knowledge, Attitudes and Practices Surrounding Male Circumcision**

Given the religious and ethnic connotations that surround the concept of circumcision in Malawi, understanding acceptability of VMMC nationally is an important component to a VMMC scale-up. With as few as 1 in 5 men currently circumcised, and most of those circumcised restricted to a few districts in the country, success in the promotion of VMMC would hinge on the ability of the national program to clearly distinguish between traditional circumcision and voluntary medical MC as a public health intervention.

Interestingly, there is already a significant amount of knowledge among SITAN respondents regarding the health benefits of VMMC. In a sample of 1,211 women and 3,734 men from all over Malawi, 44.8% of urban women and 30.2% of urban men identified HIV risk reduction as a benefit of VMMC. Although less likely to have information compared to urban counterparts, 23.5% of rural women and 23.7% of rural men had information about the benefits of VMMC especially HIV prevention. Not surprisingly, information about the HIV risk reduction benefits of VMMC has a large impact on individual and parental acceptability of VMMC.

Figure 1: Proportion of un circumcised males accepting VMMC before and after male circumcision HIV link is provided

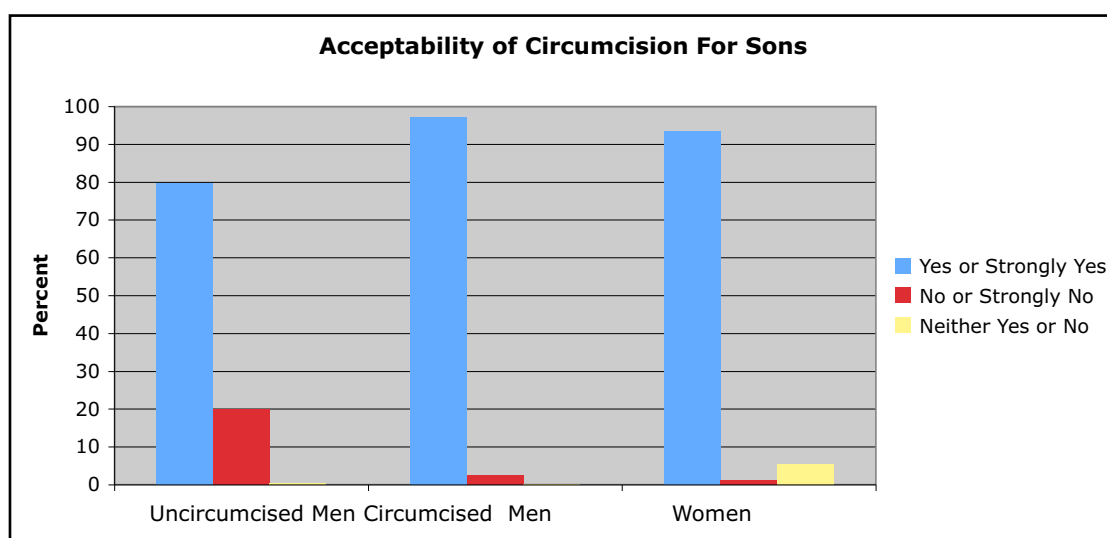


Participants were asked about their level of VMMC acceptability prior to being given information about the health benefits of the procedure. After information about the protective effect of VMMC was provided to respondents, the level of acceptability for VMMC services increased by 126% (see Figure 1.). This is a significant change in acceptability based on the provision of very little information, which shows the potential for massively increasing acceptance of VMMC through a strong communications strategy.

Although acceptability of VMMC for male children started with low acceptability at baseline (26.6% of uncircumcised men and 43.3% of women), when information about the HIV prevention benefits of VMMC and other health benefits was provided, very high levels of acceptability were recorded (see figure 2 below).

The results of the acceptability component of the SITAN clearly shows that even brief information about the health benefits of VMMC significantly improves the acceptability of VMMC in non-circumcising communities with the level of acceptability shown in the SITAN sufficient to conclude that VMMC has the potential to be widely accepted across the nation for both health and HIV prevention reasons.

Figure 2: Acceptance of male circumcision for male children in three groups after the provision of information on health benefits



### 2.3 Discreption of Male Circumcision Service Delivery in Malawi

Although historically most circumcision has been conducted in a traditional setting by *Ngalibas* with the skills passed down by other traditional circumcisers, the modern medical procedure requires a formally

trained medical/clinical personnel and an assistant along with a runner and one or more people to assist with cleaning and infection prevention activities including instrument sterilization. The procedure itself usually requires three people in theatre, and is currently performed by Clinical Officers, Medical Officers, and Surgeons. Clinical Officers perform the majority of procedures nationally (79.3%). Additionally, the Malawi standard operating procedures identify and recommend more efficient models that are responsive to outreach campaigns and high volume sites and also embrace task shifting models.

As recommended by WHO, Malawi's minimum package for voluntary male medical circumcision includes client booking and appointments, group education, individual/couple counseling, HIV testing and counseling, screening for MC (eligibility and consenting), male circumcision procedure, post operation care, promotion of other HIV prevention strategies and the involvement of guardians and sexual partners.

Although a detailed cost analysis was not done as part of the situation analysis, Banja La Mtsogolo has reported the marginal cost of providing a circumcision as being just under MK1,200. 00 per procedure. This price does not capture indirect facilities costs or the cost to mobilize clients for the procedure. There are three techniques that are recognized by the WHO with the most commonly practised being the forceps-guided technique and the dorsal slit technique. The Standard Operating Procedure for Malawi adopted the forceps-guided technique for medical MC. However other emerging efficient techniques are currently being reviewed. Just like any operative procedure, MC is also associated with some adverse events (AEs) that include haematoma, bleeding, swelling, and infection. However no data from healthcare centres in Malawi captures the occurrence of the adverse effects. Nevertheless, BLM has recorded mild and moderate AE rate of 2.6% using the dorsal slit procedure in 545 cases tracked in 2009 (with no major complications) after an in-service training program standardized the organization's surgical technique<sup>6</sup>.

## **2.4 Factors Affecting Rates of Male Circumcision in Malawi**

The situation analysis used key informant interviews and focus group discussions to explore the reasons men accept MC, and what could be done to improve uptake of the procedure. In addition to the well-documented religious and cultural determinants for circumcision, several issues were raised in this discussion and thereby inform the design of this strategy. Some of these factors include the following:

- ♦ Although some communities are requesting to have their boys circumcised in a clinical setting as part of the traditional rites of passage, the majority of boys currently being circumcised are undergoing the procedure in the community. Circumcising communities would need clear information on the difference between voluntary medical male circumcision (VMMC) and traditional circumcision as it relates to HIV prevention to support uptake of VMMC services as part of traditional practices.
- ♦ There is limited capacity in the public sector to meet massively increased demand for VMMC. In order to increase the uptake of VMMC, there is need to train and retrain medical staff and space created at offering facilities. Time available to conduct VMMC will also need to be considered, and many countries have developed innovative solutions such as "Circumcision Saturdays", in order to meet the need.

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<sup>6</sup> BLM Operations Research reported by Brendan Hayes, 31 May 2009.

- ♦ Access to information about the benefits of MC is limited. The SITAN reported that the majority of Malawian men and women are not aware of the public health benefits of VMMC
- ♦ The agreement of community, religious and traditional leaders on the importance of VMMC could potentially have a strong influence on the demand for this procedure. Strategies to increase access to information and foster agreement among leadership were identified as important ways to increase acceptance of MC nationally.

#### **Demonstration VMMC campaigns: The 2011 Mulanje VMMC Campaign experience**

While VMMC is routinely offered in public and other private facilities, there have been deliberate efforts to design and implement a VMMC campaign to demonstrate on how district targets can be met by using efficient delivery models and demand creation strategies. A campaign was therefore done in October 2011 in the southern region district of Mulanje. During the four week campaign, a total of 4,516 men received VMMC against a target of 5,760. There were a number of challenges during the campaign which some of them include

#### **Challenges**

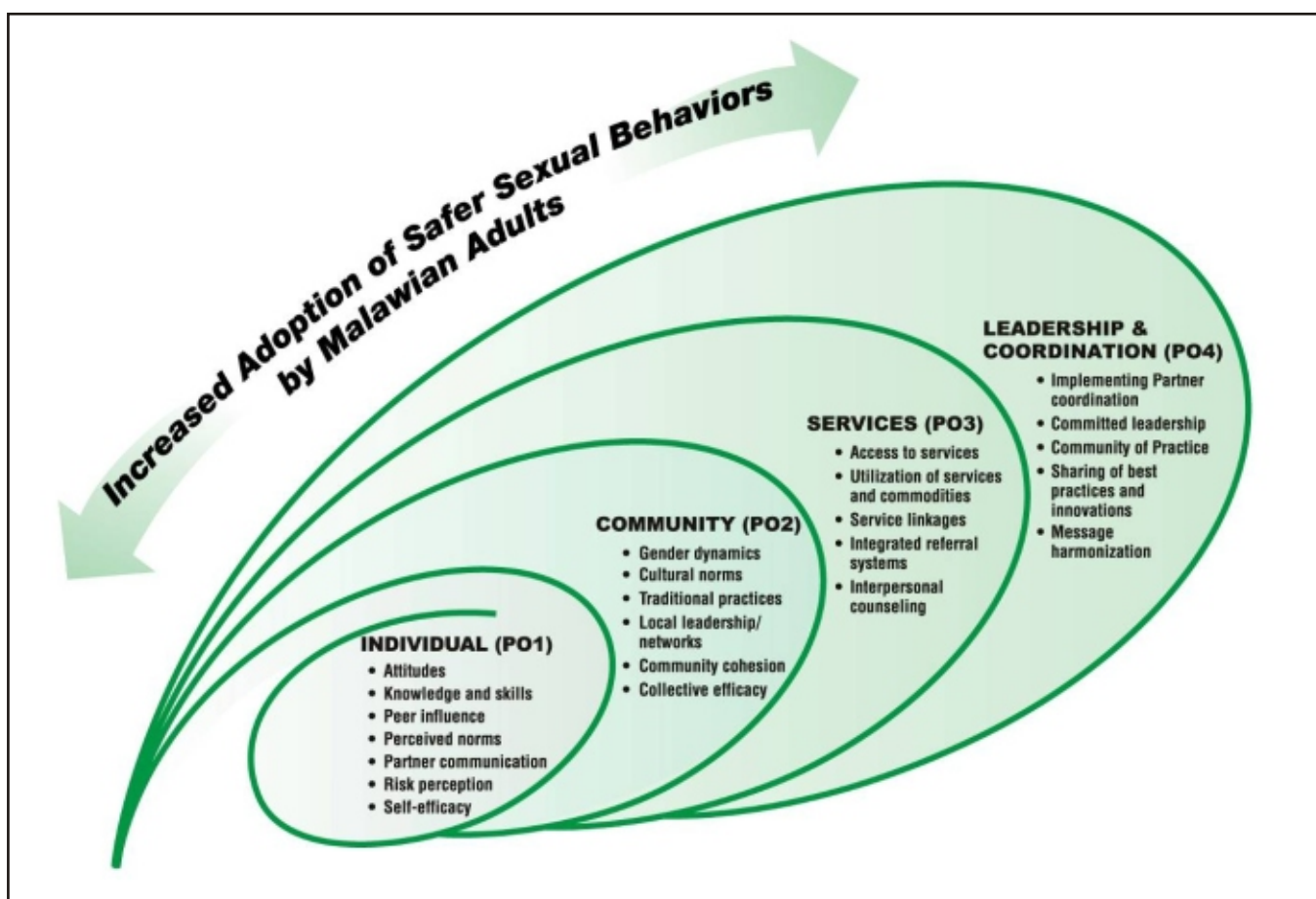
1. Inadequate time to plan for the event which also impacted on demand creation. This resulted in other activities starting late such as demand creation in the communities and outstanding consignments of supplies arriving after the campaign had started.
2. Procurement of pharmaceuticals was a challenge due to rules and regulations surrounding procurement of pharmaceuticals such as lignocaine and STI drugs.
3. The role of partners in demand creation was not clearly defined and this resulted in coordination problems.
4. Long queues of clients as the demand increased in some sites resulted in unhappy clients due to long waiting as they were not provided with any lunch.

#### **Recommendations**

1. Planning for demand creation needs to start at least 4 months in advance of the planned launch date for intensive campaigns.
2. All partners involved in Community Mobilization should participate in daily team debriefs and weekly management debriefs with DHMT.
3. The community mobilization campaigns need to start at least two weeks in advance of the MMC services open for large volume MMC.
4. The SBCC campaigns need to use multiple channels to reach all key stakeholders at all levels of the Socio-Ecological model: leaders at district and community level; all key personnel in the MMC services, especially those in contact with clients; all adult men in the catchment areas to all the services; and especially the partners/wives of all those men. All these groups need to understand the process and implications of VMMC.

### 3.0 THE SOCIAL ECOLOGICAL MODEL FRAMEWORK

The National VMMC Communication Strategy has adopted the Socio-Ecological Model as its theoretical framework, providing a comprehensive approach that addresses four key domains for social behavior change communications (SBCC) interventions: the enabling environment, the health services, the community, and the individual/family. It also addresses the relevant communication aspects within the Combination Prevention Framework. The Socio-Ecological Model has been adopted by UNAIDS as its global communication model.<sup>7</sup> The social ecological model framework will help the users of this communication strategy to understand factors that affect behavior and also provide guidance to developing small scale demand creation campaign. Social ecological model emphasize and recognize multiple levels of influence and the idea that behaviours both shape and are shaped by the social environments<sup>8</sup>. This model therefore directly assists and guides MC communication bearing in mind that MC already exists in some of the Malawian societies and that its increased demand and uptake is dependent upon several levels of influence that exist in every population.



<sup>7</sup> The Socio-Ecological model illustration needs to have the 4 POs removed. We will have that model for the next draft.

<sup>8</sup> The role of behavioural science theory in development and implementation of Public Health Interventions, Karen Glanz and Donald Bishop. Annual Review Public Health 2010. 31 pp399-418



It is therefore, important to recognize that at each level of influence, the specific audiences relevant to that level should be engaged, provided with correct messages with clear calls to action, as well as information relevant to the topic itself.

### **3.1 Audience Analysis and Segments**

Audience analysis is important in identifying groups of people that would require specific messaging and are associated with common behaviours that may impact on the uptake of VMMC.

The following audiences have been identified as important for the VMMC communication interventions and include:

#### **3.1.1 Primary audience**

The primary audience are males aged 15-49 that are from circumcising and non-circumcising communities in Malawi. The Malawi VMMC policy identifies males in the age group 15 to 49 as the primary target because of their behaviours as regards sexual activity. They are considered as the potential VMMC clients. The focus of this communication strategy is to reach to the uncircumcised men between ages 15 to 49 years old to raise their demand for VMMC. Given age, marital status, levels of sexual activity and other differences within this primary audience, the primary audience will be further segmented with a particular emphasis on men aged 25-49.

#### **Primary audience segments:**

The primary audiences have been segmented as follows:

- ♦ *Males aged 25 – 49 in non-circumcising communities*
- ♦ *Males aged 15 -24 in non-circumcising communities*
- ♦ *Males aged 25 – 49 in circumcising communities*
- ♦ *Males aged 15 – 24 in circumcising communities*

Regional experience of VMMC programs shows that younger men (15-24) take up VMMC services more readily than adults in the age group 25 and above. Given that some communities practice male circumcision as a rite of passage to adult hood, communications to younger men should differentiate between those drawn from circumcising communities and those drawn from non-circumcising communities.

It is also important to consider that communications to primary audiences must address all communication needs from awareness rising, pre-procedure, complete wound healing before resumption of sex and adoption and maintenance of safer sexual behaviours post VMMC.

#### **Primary audience analysis**

##### ***Males aged 25 – 49 in non-circumcising communities***

According to the HIV national prevalence data, men in the aged 25 – 49 have the highest HIV prevalence. Consequently, these men represent a considerable risk to their sexual partners that include their wives or other non-spousal partner if they are engaged in multiple concurrent partnerships. Promoting VMMC in this group would directly reduce their risk of HIV acquisition and thereby indirectly reduce the risk of HIV transmission to their partners and to others in the sexual network.



Additionally, other men in this age bracket may also be in discordant relationships (with their partner being HIV positive) and VMMC would directly reduce their risk of acquiring HIV from their HIV positive partner.

Considerations should be made while engaging these men because most of them are married or living in union with a woman and this adds a layer of complexity to communicating the primary benefit of VMMC which is the risk reduction of acquiring HIV. It is therefore critical that their female partners are actively engaged in any communications effort of VMMC.

#### Current behaviours:

Research shows that:

- ♦ More than half of all men (57%) are currently in union<sup>1</sup>
- ♦ More than 50% of adult men in Malawi have concurrent partners<sup>1</sup>
- ♦ 20-26% of all men self-report as circumcised. However, it is unclear how many of these men have undergone a complete circumcision which is protective against HIV transmission.<sup>1</sup>
- ♦ Condom use is very low with non-spousal partners as only 35% of men and 25% of women use a condom always, with non-regular partners.
- ♦ Low uptake of HTC by older men?

#### Barriers to VMMC uptake<sup>1</sup>:

Currently men have a low awareness of the facts regarding and benefits of VMMC<sup>1</sup>

- ♦ Little knowledge about the difference between traditional circumcision and VMMC
- ♦ Misconceptions around VMMC (sexual performance compromised, infertility)
- ♦ Fear of pain related to the procedure
- ♦ Fear of complications (bleeding and Infection)
- ♦ Concerns around the cost of the procedure
- ♦ Perception that religion and/or culture determines who undergoes VMMC
- ♦ Lack of exposure to people who have gone through VMMC and therefore few role models or champions for VMMC at this stage
- ♦ Strong cultural and religious reasons prevail regarding circumcision with circumcision associated the Islamic religion and the Yao and Lomwe tribes
- ♦ Norms that encourage MCP that could impact on post surgical abstinence and long term partner reduction.
- ♦ Decision to undergo VMMC could reinforce lack of trust between men and women

### Desired behaviours

While several barriers exist amongst this audience, men in this age group are expected to be reached with various communication channels and eventually, they should be able to:

- ♦ Know and understand detailed facts regarding and benefits of VMMC
- ♦ Talk with their sexual partners about VMMC
- ♦ Go for HTC to know their HIV status as a couple (married or in any union) or alone.
- ♦ Go for VMMC and HTC in safe, clinical setting
- ♦ Abstain from sex and masturbation for 6 weeks after surgery
- ♦ Talk to their partners on how they can effectively abstain from sex together while the wound is healing
- ♦ Use condoms consistently with all partners whose HIV status is unknown
- ♦ Reduce their number sexual partners
- ♦ Go for HTC regularly
- ♦ Support and encourage peers to take up VMMC for HIV prevention and other broader male reproductive health benefits

### Opportunities for VMMC uptake and compliance:

Despite the prevailing barriers and current undesirable behaviours, opportunities to promote VMMC still exist and they include:

- Discussion of the benefits of medical VMMC as a health intervention focus on partial protection from HIV, improved hygiene and cleanliness, reduction of STIs, reduction of cervical cancer risks for female partners of circumcised men, and potentially greater perceived sexual desirability and sexual pleasure (though this is contentious, with studies supporting both states—non- and fully-circumcised)<sup>9</sup>
- Perception by men that sexual satisfaction is enhanced following male circumcision<sup>10</sup>
- Using HTC interventions to refer HIV negative male clients for VMMC: including couples testing through PMTCT, and on-going community HTC outreach efforts.
- PMTCT program could be used that already reaches out to female partners would be used to promote VMMC just as it has done on couple testing.
- Existing MCP communications targeting older men and partners provide opportunities to integrate VMMC messages for all stages

#### Support messages

- VMMC is a minor surgical procedure that does not impact long-term sexual function as a man.
- VMMC for HIV prevention won't change your culture or religion, but it will help protect you from acquiring HIV and has other reproductive health benefits to you and your sexual partner.
- Your friends 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 post-operative period to control the pain.

### Males aged 15 to 24 in non-circumcising communities

This group comprises two important age groups. These are males aged 15 to 20 years of age and males aged 21-24 years. Further description of this age group is that:

- Of males aged 15 to 20 in the adolescent stages of maturity. Some are sexually active and quite susceptible to peer pressure. Regionally, VMMC programs have found that this age group forms a large swathe of early adopters of VMMC services.
- Of males between the ages of 21 to 24 that have reached that age of majority and are sexually active. They take individual decisions about their sexual lives. This group has a lower rate of HIV than females their same age but their future behaviours could be influenced at this age.

<sup>9</sup> Krieger JN, Mehta SD, Bailey RC, Agot K, Ndin ya-Achola JO, Parker C, and Moses S. Adult male circumcision: Effects on sexual function and sexual satisfaction in Kisumu, Kenya. *J Sex Med* 2008; 5:2610–2622. **Conclusion:** Adult male circumcision was not associated with sexual dysfunction. Circumcised men reported increased penile sensitivity and enhanced ease of reaching orgasm. These data indicate that integration of male circumcision into programs to reduce HIV risk is unlikely to adversely effect male sexual function.

<sup>10</sup> Krieger JN, Mehta SD, Bailey RC, Agot K, Ndin ya-Achola JO, Parker C, and Moses S. Adult male circumcision: Effects on sexual function and sexual satisfaction in Kisumu, Kenya. *J Sex Med* 2008;5:2610–2622. **Conclusion:** Adult male circumcision was not associated with sexual dysfunction. Circumcised men reported increased penile sensitivity and enhanced ease of reaching orgasm. These data indicate that integration of male circumcision into programs to reduce HIV risk is unlikely to adversely affect male sexual function.

These young men are from traditionally non-circumcising communities therefore circumcision may be viewed as something foreign or culturally inappropriate by them. It is important that this audience appreciates the benefits of VMMC and that VMMC is delinked from any cultural or religious associations. As these young men tend not to have established long-term relationships, their decision to undergo VMMC will not be as heavily influenced by wife/long-term female partners concerns/considerations but by the perceived personal benefits.<sup>11</sup>

#### Current behaviours:

- Majority of these young people do not currently seek out VMMC services.
- Some young men are going for VMMC for medical conditions and to reduce risk of STIs, HIV, or for hygiene (age 15-30).
- Many young men do not go for HTC
- Many young men do not report use of condoms consistently and correctly (although they do report higher and more consistent use than older men and report approval of and intention to use condoms, get tested).

#### Barriers to VMMC uptake:

- Knowledge gaps regarding VMMC definition as complete removal of foreskin and its associated benefits.
- Misconception that VMMC offers 100% protection.
- Fear of pain related to the procedure.
- Fear of complications (bleeding and Infection).
- Perception that religion and/or culture determines who undergoes VMMC.
- Concerns around the cost of the procedure.
- Low uptake of HTC due to fear of positive result (BLM reports low uptake).

### Desired behaviours

The communication strategies targeting this age group are expected to make the audience adopt or consider the following behaviours:

- Seek out and understand more detailed information on the facts regarding and benefits of VMMC
- Go for HTC to know their HIV status
- Go for VMMC and HTC in safe, clinical settings
- Abstain from sex and masturbation for 6 weeks after surgery
- use condoms correctly and consistently with all partners after complete healing
- Reduce the number sexual partners
- Share their positive experience of VMMC with peers and family
- Go for HTC regularly post VMMC,
- Act as role-models of VMMC

### Opportunities

Despite the prevailing barriers and current undesirable behaviours, opportunities to promote VMMC still exist and they include:

- Benefits of VMMC as health intervention include partial protection from HIV, hygiene, reduces risk of STI acquisition are already prevailing in this age group.
- Reassure information regarding pain expectations and low adverse events is available.

<sup>11</sup> BRIDGE II qualitative research found that males of this age group who had undergone VMMC were motivated to do so for sexual performance considerations not HIV prevention benefits

- Most of them are school going(able to read) therefore information access and reinforcement may not be a challenge.

#### Support messages

- VMMC is a minor surgical procedure that does not impact long-term sexual function as a man
- VMMC for HIV prevention won't change your culture or religion, but it will help protect you from acquiring HIV and has other reproductive health benefits to you and your sexual partner
- Your friends 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 post-operative period to control the pain.
- Keeping the wound clean and allowing the wound to heal properly is very important. Abstain from sex and masturbation for six weeks after the operation.

### Males aged 25 – 49 in circumcising communities

#### Rationale

While many of this population may already have been circumcised, it is important to ascertain the completeness of the circumcision. This group is important to be considered because while many of them may claim to have been circumcised, a proportion of them according to the SITAN are partially circumcised and others are not circumcised entirely. This group is also sexually active and may be involved in multiple and concurrent sexual partnerships.

#### Current behaviours:

- A larger proportion of them are partially circumcised and others not circumcised at all
- Most of them have not undergone HTC
- Many of this age group do not report use of condoms consistently and correctly with non regular partners
- Some of the people in this age group are involved in multiple an concurrent sexual relationships

#### Barriers to VMMC uptake:

- Knowledge gaps regarding definition of VMMC as the complete removal of fo reskin
- Lack of appreciation of benefits of VMMC
- Misconception that VMMC offers 100% protection
- Low uptake of HTC due to fear of positive result (BLM reports low uptake and concerns that mandatory HTC could be a barrier)
- Six weeks sexual abstinence post VMMC
- Fear of ridicule for those non circumcised old men

#### Desired behaviours

This age group is expected to:

- Seek out and understand more detailed information on the facts regarding and benefits of VMMC
- Actively seek out and use VMMC minimum package of services at safe, clinical setting or with trained provider through outreach/mobile services (potentially delivered through initiation camps)

- Go and ascertain if they are completely circumcised at any VMMC site
- Abstain from sex and masturbation for 6 weeks after surgery
- use condoms consistently with sexual partners whose status is unknown
- reduce the number sexual partners
- Share their experience of VMMC with peers and encourage others to access the service

### Opportunities for VMMC uptake

In this age group, several opportunities already exist. Some of them are:

- MC is widely accepted and emphasis should be on undergoing VMMC at a clinical site or with trained provider through outreach/mobile services (potentially delivered through initiation camps)
- Prevailing perception by men and women that sexual satisfaction is enhanced following male circumcision<sup>12</sup>
- VMMC can be integrated into traditional practices (and have already been integrated by many communities to ensure safety/hygiene of this practice)
- Social desirability after undergoing circumcision

#### Support messages

- All clients that have undergone MC should abstain from sexual activity for six weeks to ensure the wound is healed.
- VMMC reduces your chances of acquiring HIV by up to 60%. But having sex before you're fully healed can work against that. Abstain for at least 6 weeks after VMMC.
- Complications following VMMC are very uncommon and are 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 get HIV. After circumcision you need to continue to practice other safer sexual practices such as condom use, reduction of the number of sexual partners and faithfulness.
- Partial circumcision does not offer the same benefits as complete VMMC. Get to any VMMC site to be assessed if you are completely circumcised.

### Males aged 15 to 24 from circumcising communities<sup>13</sup>

This group comprises of young men aged 15 to 24 years of age. Many member of this group are sexually active and are susceptible to peer pressure. In traditional circumcising communities, this is part of the age group that commonly undergoes traditional circumcision. As they are from traditionally circumcising communities, circumcision will not be a new concept to them. However, ensuring that they seek out

<sup>12</sup> Krieger JN, Mehta SD, Bailey RC, Agot K, Ndinya-Achola JO, Parker C, and Moses S. Adult male circumcision: Effects on sexual function and sexual satisfaction in Kisumu, Kenya. *J Sex Med* 2008;5:2610–2622.

**Conclusions.** Adult male circumcision was not associated with sexual dysfunction. Circumcised men reported increased penile sensitivity and enhanced ease of reaching orgasm. These data indicate that integration of male circumcision into programs to reduce HIV risk is unlikely to adversely effect male sexual function.

<sup>13</sup> Note: In circumcising communities, it is assumed that most men beyond this age bracket will already be traditionally circumcised and therefore communications are focused on 12 to 17 year olds. (I disagree. Given that the SITAN suggests that many traditional circumcisions could be incomplete and have no protective benefits as highlighted above, we want to make sure that this message is also highlighted for older men as well so that traditional "circumcision" is not understood as necessarily protective for HIV. They should also be targeted, particularly given our southern districts planned for saturation.



VMMC services and undergo a medical MC is important. This group may have also been partially circumcised and medical ascertainment for complete circumcision is paramount.

#### Current behaviours:

- Many youth undergo partial non-medical MC as part of traditional (cultural or religious) practice
- Many youth do not go for HTC even if they undergo circumcision at a health facility (circumcision as part of traditional MC ceremony)
- Many youth do not report use of condoms consistently and correctly (although they do report higher and more consistent use than older men and report approval of and intention to use condoms, get tested, etc.<sup>1</sup>)

#### Barriers to VMMC uptake:

- Cultural norms/expectations regarding undergoing traditional male circumcision
- Knowledge gaps regarding definition of VMMC as the complete removal of foreskin
- Lack of appreciation of benefits of VMMC
- Misconception that VMMC offers 100% protection
- Low uptake of HTC due to fear of positive result (BLM reports low uptake and concerns that mandatory HTC could be a barrier)

### Desired behaviours

This age group is expected to:

- Seek out and understand more detailed information on the facts regarding and benefits of VMMC
- Actively seek out and use VMMC minimum package of services at safe, clinical setting or with trained provider through outreach/mobile services (potentially delivered through initiation camps)
- Abstain from sex and masturbation for 6 weeks after surgery
- Delay sexual debut for as long as possible especially those who have not commenced sex
- use condoms consistently with all partners especially for those who are already sexually active after complete healing of the wound
- reduce the number sexual partners in those who are already sexually active:
- Share their experience of VMMC with peers and family and encourage others to access the service

### Opportunities for VMMC uptake

In this age group, several opportunities already exist. Some of them are:

- MC is widely accepted and emphasis should be on undergoing VMMC at a clinical site or with trained provider through outreach/mobile services (potentially delivered through initiation camps)

- Prevailing perception by men and women that sexual satisfaction is enhanced following male circumcision.<sup>14</sup>
- VMMC can be integrated into traditional practices (and have already been integrated by many communities to ensure safety/hygiene of this practice).

#### Support messages

- Wouldn't you do everything you can to protect yourself from HIV? VMMC is a safe and effective way to reduce risk of HIV and STIs among men. Seek safe, no-cost VMMC services at your nearest VMMC facility.
- Your friends 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 post-operative period to control the pain.
- VMMC reduces your chances of acquiring HIV by 60%. But having sex before you're fully healed can work against that. Abstain for at least 6 weeks after VMMC.
- Complications following VMMC are very uncommon and are 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 get HIV. If you haven't had sex yet, wait until you are older to have sex.

### 3.1.2 Secondary Audience

This group comprises individuals that have the responsibility to directly influence the decisions within the primary audience. Further secondary segmentation identifies different group of people as below. For example, sexual partners of men who have undergone VMMC need to be targeted to ensure that they continue to insist on safer sexual practices in order to reduce their vulnerability to HIV infection.

The Secondary audience has been segmented as follows:

- *Female partners*
- *Peers*
- *Parents and guardians of adolescent males (10-15)*

In this segmentation, peers directly and indirectly influence each other to adopt new behaviours while parents and guardians of neonates directly control uptake of neonatal VMMC services. Parents and guardians of adolescent males (age 10 - 15) may also be required to give consent for their charges to undergo VMMC. While this strategy recognizes the role of parents and guardians, neonatal circumcision and any circumcision of a male aged below 13 will require consent from either a parent or guardian. Neonatal circumcision will be integrated into the routine service provision of VMMC and may require attention not greater than the age group 15 to 49.

<sup>14</sup> Krieger JN, Mehta SD, Bailey RC, Agot K, Ndinya-Achola JO, Parker C, and Moses S. Adult male circumcision: Effects on sexual function and sexual satisfaction in Kisumu, Kenya. J Sex Med 2008;5:2610–2622.

**Conclusions.** Adult male circumcision was not associated with sexual dysfunction. Circumcised men reported increased penile sensitivity and enhanced ease of reaching orgasm. These data indicate that integration of male circumcision into programs to reduce HIV risk is unlikely to adversely affect male sexual function.

## Secondary audience analysis

### Female partners

Women play a central role in men's lives as spouses and partners. They hold a vital place in influencing men's decisions and are key secondary audiences. Women are within the interpersonal level of the Socio-ecological model. Relatively little is known about the role of women in decision-making around VMMC. As the evidence base in this area grows, it is expected that messages and communication approaches will become more narrowly targeted and refined. It should be noted, however, that in some countries men in the target age range for VMMC tend not to be in steady partnerships, so it may also be relevant to target young women with messages addressing social norms around VMMC and safer sex as well as communicating to older women regarding supporting a current partner through the VMMC process.

#### Current behaviours:

- Women do not advocate with their male partners to undergo VMMC
- VMMC is considered an issue for men only

#### Barriers:

- Do not know much about VMMC
- Do not appreciate the benefits of VMMC – the direct benefits for men and the indirect benefits for women
- Many women are suspicious as to why their partner wants to undergo VMMC if they are married or in long-term relationship
- Women have religious and cultural reservations about VMMC
- Many women have poor communication with their male partners around sexual health issues that impact both of them.
- Many women may not be able to negotiate safe sex post VMMC with male partners (i.e. condom use, partner reduction, etc.)

### Desired behaviours

Despite the existing barriers in women, the strategy expects women to:

- Support her partner to gather more information on the facts and benefits regarding VMMC
- Discuss the advantages and disadvantages of VMMC with their partner
- Accompany him to the HTC site and agree to get tested together
- Support him post-operatively to remain abstinent for 6 weeks
- Talk to her friends and neighbours about VMMC and its associated benefits
- Advocate that VMMC does not change a man's cultural or religious identity.

### Opportunities for supporting men to uptake VMMC

The strategy also recognizes the existing opportunities that can be maximized to make women strategic advocates of VMMC to their partners. Some of these opportunities include:



- Female partners are vulnerable to being exposed to HIV from their male partners, therefore if VMMC reduces a man's risk of HIV acquisition, this may be a good pragmatic reason to support VMMC given the fact he may still be having outside partners.
- There is evidence that women appreciate that circumcised men are cleaner and more hygienic<sup>15</sup>
- There is increasing empirical evidence of the reduced risk of developing cervical cancer in women whose partners are circumcised.<sup>16</sup>
- Strategic platforms to reach women are already existing which may include PMTCT services, antenatal and others.

#### **Support messages**

- VMMC reduces your partner's risk of acquiring HIV by up to 60%. Talk to your partner about the decision to go for VMMC and how you can practice safer sex after VMMC.
- If your partner is circumcised, the risk of getting cervical cancer is reduced. Talk to your partner about the advantages and disadvantages of VMMC.
- Complete healing of the wound is very important following VMMC. Support your partner in abstaining during the healing period by discussing ahead of time how you will manage this.
- VMMC for HIV prevention won't change your partner's culture or religion but it will help protect him and you from acquiring HIV. Talk to your friends and neighbours about the facts and benefits of VMMC.
- VMMC includes a minimum package of services, including MC counselling, HTC, STI screening and post-operative care. Support your partner by going for HTC together.

## **Peers**

### **Rationale:**

Men are influenced by their peers, both overtly and covertly. It is therefore important that men are addressed as peers who will influence the decision of their friends to go for VMMC. Such influence operates at the interpersonal level of the Socio-ecological model.

### Support messages

- Wouldn't you support your friends to do everything they can to protect themselves from HIV? VMMC is a safe and effective way to reduce risk of HIV and STIs among men. Support your friends to seek out safe, no-cost VMMC services at their nearest VMMC facility.
- VMMC reduces a man's risk of acquiring HIV by up to 60%. Talk to your peers about their decision to go for VMMC and how you can support them through VMMC.
- Complete healing of the wound is very important following VMMC. Support your peers to abstain during the healing period.
- VMMC does not guarantee that a man won't get HIV. Support correct and consistent condom use among your peers.
- VMMC for HIV prevention won't change a man's culture or religion but it will help protect him from acquiring HIV. Talk to your peers about the facts and benefits of VMMC.

### Barriers:

- Low knowledge on the facts and benefits of VMMC.
- Low knowledge about the difference between traditional circumcision and VMMC.
- Do not appreciate the direct benefits of VMMC as men and other existing indirect for women.
- Lack of exposure to people who have gone through VMMC and therefore few role models or champions for VMMC at this stage.
- Strong cultural and religious reasons prevail regarding circumcision with circumcision associated the Islamic religion and the Yao and Lomwe tribes.
- Misconceptions around VMMC (compromised sexual performance and infertility).
- Fear of pain and excessive during the surgery.
- Six weeks abstinence to allow wound healing is considered long.

### Current behaviours:

- Do not advocate for their peers to undergo VMMC.
- Do not take up VMMC services themselves.
- Encourage peers to engage in risk behaviours (MCP), alcohol abuse and low condom use.

### Desired behaviours

The strategy will engage circumcised men to engage their peers to go for VMMC. Peers are therefore expected to:

- Support their peers to access more information about the facts and benefits of VMMC
- Discuss the advantages and disadvantages of VMMC as peers
- Support peer(s) post-operatively to observe the 6 weeks abstinence to ensure the wound is completely health before the resumption of sex
- Advocate that VMMC does not change a man's cultural or religious identity
- Advocate with peers to practice safer sex, post VMMC

## Opportunities for VMMC uptake

While engaging peers the following opportunities have to be explored and utilized:

- A lot of men already talk about MCP and VMMC could easily be introduced
- VMMC is a reproductive health decision for men that can easily be adopted
- Most men are getting circumcised and as part social desirability, it would not be difficult to encourage them to do just as their peers.

### 3.1.3 Other audiences: Stakeholders and Gatekeepers

These are stakeholders and individuals that indirectly influence the identified primary audience. They create a supportive environment for VMMC and influence issues related to MC policy, cultural traditions, VMMC services, media and capacity for service provision. These audiences include the leaders (*including political, traditional, religious and other leaders*), *healthcare workers, policy makers (government and other people of higher authority) and the media*

The category of opinion Leaders include but not limited to religious Leaders, traditional circumcisers, Local Government officials (District AIDS Committee Coordinator, District Executive Committee members, Area Development Committee members, Traditional Authorities, etc.) and informal leaders (*connectors, mavens, group leaders*.) Leaders' influence operates at the community level of the Socio-ecological model. Leaders, both formal and informal, shape the community and society in which individuals live and are a key audience in influencing an individual's ability to adopt and maintain new behaviours. With respect to VMMC, leaders opinion on the benefits of VMMC and the need to adopt/maintain safer sexual behaviours, post-VMMC, will greatly influence an individual's ability to seek out and use VMMC services.

A countrywide, consultative meeting was conducted with local and religious leaders to mobilize support for VMMC and acceptance of VMMC was found to be high. This support came from traditionally circumcising communities, such as the Yao and Muslim communities, as well as from Christian communities. Additionally, other local leaders from non-circumcising communities, such as those from the Northern region, highly accepted the intervention from a public health understanding that VMMC can reduce the risk of HIV acquisition among men. Most local leaders are all to aware of the impact of HIV on their communities and are serious in wanting to reduce that impact through whatever means is safe, effective and socially acceptable.

On the other hand, Policy makers have the ability to greatly facilitate or impede new programs scale-up. As the MC Situation Analysis continues to be widely circulated or disseminated in national fora, it will eventually garner more support for program scale-up. Most of the policy makers are also decision makers at top government level and they include the national, zonal, and district level staff in government, donors and partner organizations that can effect change in program planning and implementation.

The tertiary category also includes Health Care Workers (HCWs). These include all cadres of HCWs providing facility and community-based services. HCWs are the point of contact for all citizens entering the health system. HCWs need to understand the benefits of VMMC and the long-term impact of VMMC on HIV incidence and costs (increasing sustainability) to act as advocates at community level for

VMMC. HCWs are also considered as the principal sources of health information and any misconstrued information that could be provided by health workers would affect the uptake of the program. Their engagement is therefore very paramount.

Finally, the media are an important group in information dissemination from both program level and policy. With the increasing access to any type of information through the internet and other sources, there is need to engage the media to provide them correct information regarding VMMC. While access to incorrect VMMC information is not limited, a well established relationship with the media would prove worthwhile when they would wish to verify the facts. The media in Malawi has not been reporting much of the VMMC information and this is the result of the impulsive engagements that have been there. It is therefore important to establish closer and stronger links with the media to reinforce correct information dissemination.

#### Current behaviours:

- Do not promote VMMC at various forums
- Low personal uptake of VMMC
- Most of them have inadequate information on benefits of VMMC
- No planning to prioritize VMMC service delivery in their respective institutions
- There is low uptake of VMMC among HCWs
- Reported high levels of stigmatizing and negative attitudes towards patients/clients seeking VMMC
- Inaccurate media reporting on VMMC Lack of general knowledge about VMMC benefits
- Lack of fora for sharing new medical knowledge/research studies results and easily operationalizing results into policy and practice

#### Barriers:

- Concerns that VMMC efforts could undermine other prevention initiatives (MCP reduction, condom use, gender imbalances)
- Attitudes of stigma and lack of kindness to clients/patients by health care workers
- Access to VMMC services is associated with a cost
- Belief that circumcision is for specific cultures and religions
- Misconceptions around VMMC as a painful procedure that may even lead to excessive bleeding
- Lack of exposure to people who have gone through VMMC and therefore few role models or champions for VMMC

#### Desired behaviours:

By engaging all the groups of people in this category, it is expected that they will:

- Seek and understand more detailed information on the facts regarding and benefits of VMMC
- Support and encourage those they can influence access VMMC services
- Promote VMMC as a culturally neutral HIV prevention approach
- Organize community meetings (town hall meetings, meetings with specific groups within the community) to explain and advocate for VMMC services
- Integrate VMMC into all their discussions about health in their community
- Integrate referrals for HTC and VMMC through existing community agents/structures.
- Promote continued safer sexual practices, post VMMC as part of normative change interventions to reduce MCP and facilitate condom use.
- Promote VMMC outside the cultural context.
- Support VMMC scale-up/service delivery at every opportunity
- Use HTC as an opportunity to talk to negative men about benefits of VMMC.
- Provide verbal affirmation to clients requesting VMMC

- Reinforce key messages of partial protection and comprehensive risk reduction strategy for men (and partners) seeking VMMC
- Reinforce importance of post operative follow-up visits and home care.
- Support couples to identify strategies to remain abstinent during healing period of six weeks.
- Use all VMMC M&E tools as provided, so targets met can be recorded (including adverse effects/complications found in follow-up visits)
- Ensure quality care.
- Support referrals for men found HIV+ to treatment and care services.

#### Support messages

- Your community wants to follow your guidance. Hold community meetings to explain the facts regarding and benefits of VMMC and to advocate for uptake of VMMC services.
- VMMC doesn't guarantee a man won't get HIV. Advocate for men to continue to adopt safer sexual practices (correct and consistent condom use, partner reduction, and regular HTC tests) post-VMMC.
- VMMC is a safe and effective way to reduce risk of HIV and STIs among men. Explain plans for VMMC scale-up plan in Malawi, including:
  - ◆ Funding sources
  - ◆ Current geographic foci and rationale
  - ◆ Targeting
  - ◆ Implementing partners
  - ◆ Future opportunities
- AT PITC sites: now you have tested for HIV and have been found negative, have you considered VMMC.
- Providing accurate and verified information on VMMC to the public is my responsibility as a health worker and as a media practitioner.

### Opportunities for VMMC uptake

In order to achieve most of the desired behaviours and other associated outputs, other opportunities already exist that could be mounted on to ease the process of getting to the results. Some of the opportunities include:

- Initial meetings by NAC and MoH with leaders have shown that once leaders are informed of the facts regarding the safety and effectiveness of VMMC they become keen advocates for implementation of VMMC programs in their communities.
- Situation analysis report is available and has been disseminated to some strategic populations.
- Support expressed through parliamentary committee, traditional and religious leaders creates a good platform for further entry into the community with VMMC information.
- Other new HIV programmes and approaches are being formally articulated at national level policy, and included in zonal and district level planning.
- Wide understanding of low sustainability of ART program.
- DHMT and zonal offices are already experienced in supporting new programs and relevant communications.
- VMMC has been positioned as part of comprehensive prevention strategy that continues to emphasise MCP reduction, condom use, and addresses damaging gender norms/practices.



## 4.0 UNDERSTANDING THE COMMUNICATION MESSAGING NEEDS AROUND VMMC

While this strategy provides key and support messages for all audience and other support messages, it is important to acknowledge important themes that each message design process has to consider as well. Looking at the results of the Mulanje campaign, and at other much larger VMMC campaigns conducted over the last two years in East and Southern Africa, there are some key lessons learned about developing strong and responsible messaging around VMMC, before, during and after the operation itself.

### 4.1 Missing checkups

Check -ups after 48 hours and after 7 days as stipulated in the SoPs are important element because it helps to monitor any developments of adverse events. Without those checkups neither the medical system nor the men themselves, nor their partners know what the potential risk of increased HIV infection might be over that six week period.

In Mulanje, of a total of **4348** men who got circumcised, over two thirds (almost 3000 men) missed one or more checkups (2 days, 7 days and 6 weeks). This is a huge number of men who are at very high risk of getting infected by HIV if they have any adverse effects, or if they have sex during the 6 week abstinence period. . The dropout rates on a similar but even larger scale VMMC campaign in Tanzania were between 20 – 37%, potentially putting many thousands of men at higher risk of HIV infection than normal!

### 4.2 Sex during the 6 week abstinence period

In a recent study about much larger campaigns in Kisumu, Kenya<sup>1</sup>, data shows that almost 1/3 of all men circumcised (31%) in the last year were not abstaining during the 6 week recovery period. That means that potentially over 10,000 men in this specific campaign are putting themselves and others at risk of HIV Infection during that recovery and abstinence period.

### 4.3 Regular Condom Use<sup>17</sup>

Reinforcing condom use post VMMC a critical factor for the success of VMMC, because the 60% protection number that is used widely referred to is not MMC alone—it *includes* the use of condoms. Without ready access to condoms, the efficacy would be much lower.

Reports in three RCT trials and in various large scale VMMC campaigns on condom use during and beyond the 6 week period has been varied. Some studies show post-op decreased use of condoms, others showed marked increases. But regardless, all campaigns emphasize the critical need for regular consistent and correct use of condoms as a parallel HIV prevention strategy even after a successful VMMC. All the RCTs provided free condoms to all those enrolled.

It is therefore important for Malawi that much greater emphasis on a few critical issues before any VMCC mass campaign is launched is necessary. This will therefore require the following:

<sup>17</sup> Auvert B, Taljaard D, Lagarde E, et al. [Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 trial](#). *PLoS Medicine* 2005;2(11):e298.

<sup>17</sup> Gray, RH, Kigozi G, Serwadda D, et al. [Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial](#). *The Lancet* 2007;369:657-666.

Bailey RC, Moses S, Parker CB, et al. [Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial](#). *The Lancet* 2007;369:643-656.

- Providing better and more in-depth information that people need about VMMC well in advance of the service delivery
- Engaging women (as wives, partners or simply as informed members of the community) in the discussion around VMMC. Couples are, by definition, a partnership of two. They both need to be part of the decision around VMMC and general HIV prevention.
- Ensuring the quality of the medical pre-op counseling and post-op follow-up. Unless campaigns can successfully get across to the men BEFORE they get circumcised, that they absolutely need to abstain for 6 weeks (and also go for all 3 checkups) then the campaigns pose serious risks to people's health.
- Ensuring easy and continuous access to free condoms in all communities across the country. Condoms were an integral part of all the RCTs. The efficacy of VMMC is closely related to regular condom access and use.

This requires a very well developed SBCC approach, but also demands better training of providers and counselors, so they too carry the message effectively to their potential clients.

### **Key messages and important information**

At every point of delivery of VMMC services and any campaign or other routine health facility education sessions, the following key messages and information have to be provided to the clients before the support messages.

#### **Key messages**

- Voluntary Medical Male Circumcision (VMMC) is the complete removal of the foreskin under local anaesthetic by a trained medical provider.
- Male circumcision reduces the risk of men acquiring HIV infection by up to 60% and that this protective effect is only partial and that the procedure is additional but not a substitute for other proven HIV prevention methods.
- VMMC is a safe and effective way to reduce risk of HIV and STIs among men and it is only part of the comprehensive HIV and STI prevention package and must be used together with the other known strategies such as faithfulness, proper and consistent use of condoms.
- Knowing your HIV status before you go for VMMC is important as you can only gain the HIV prevention benefits if you are HIV negative.
- Traditional circumcision may not offer the same HIV protective benefits as VMMC. It is therefore necessary that all those that were traditionally circumcised go to a VMMC provider for assessment and follow further recommendation.
- Men should not resume sexual intercourse for at least 6 weeks after circumcision to ensure that the healing process is complete and that ideally sex should only recommence once a medical assessment confirms that the healing is complete. The prolonged duration of abstinence indicates the need to involve the sex partners in the decision making before and after opting for male circumcision services.

### Important information for VMMC

#### **Before** you make a decision:

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1. VMMC provides only *partial* protection from HIV Infection
2. Circumcised men still need to use other effective methods of prevention: consistent and correct condom use; reduction of partners; regular HIV testing to ensure the best possible protection
3. Get the facts: Visit a health centre to get information on VMMC
4. Talk to your partner/wife about the idea of VMMC before you decide if you want to do it
5. Talk to your friends about the issue
6. Agree to go for testing with your partner. You live together, you plan a family together, so test together to know your future together
7. Prepare yourself for the idea of 3 checkups and 6 weeks of abstinence after the operation. Make a plan to stay abstinent

#### **Before** the operation:

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1. Confirm all the details of the operation with the counselor before you get tested
2. Make sure you are committed to going for the check-ups and abstaining for 6 weeks
3. If you do not think you can abstain from sex for 6 weeks after the operation, perhaps you should postpone the operation until you can.

#### **After** the operation:

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1. Ask your partner to remind you of all your checkups: at 2 days, at 7 days, and after 6 weeks
2. Go for all the checkups
3. Discuss again with your partner how you will stay abstinent for the 6 weeks
4. Reduce the risks of wanting sex during the 6 week period
5. Make sure you clean your penis every day with a soft cloth
6. Visit the clinic as soon as you feel there is pain or infection



## **5.0 COMMUNICATION APPROACHES AND STRATEGIES**

The implementation of the communication strategy for voluntary male circumcision in Malawi will be done at different stages while recognizing the presence of various organizations and institutions that work at different levels. Considering that national programs scale up is yet to be implemented and most of the programs are district based, different organizations need to recognize how important it is to use this strategy and design effective demand creation strategies. In collaboration with the national task force, organizations implementing localized VMMC programs develop and work together with the national task force.

For the effective implementation of the strategy, there is need to embrace and recognize the role of the interlinked communication strategies of advocacy, social mobilization, behavior change communication (BCC), capacity building and research evaluation.

### **5.1 Advocacy**

Advocacy is an important component of the strategy to mobilize political commitment and policy change that would enhance positive behavior change. By strengthening advocacy, more resources will be committed towards VMMC that would scale up the provision of the service.

The advocacy programs will also be undertaken to develop a positive attitudes and behavior in areas of VMMC among all partners, allies and local leaders thereby creating an enabling environment and increase resources.

### **5.2 Social /Community Mobilization**

Social /community mobilization will be initiated to empower communities to take up actions that will increase demand for VMMC and also promote the practice of seeking safer VMCC at clinical settings. This approach will ensure that civil society, non-governmental organizations, community based organizations, religious groups, and the private sector are part of the programs. Some of the components of the mobilization will involve community engagement. Considering that VMMC is a complex issue both technically and culturally and the best approach for discussing all those issues is through interpersonal communication at community level—small group discussions, leaders fora, targeted video-based discussions, and so forth. Interpersonal communication strategies at Community level will inform local stakeholders of the issues and benefits around VMMC, helping them to make more informed decisions collectively and individually.

The community or social mobilization will have to be very closely coordinated with the mass media roll out in order to create a synergistic effect of exposing the adult population to a wide variety of communication approaches but all carrying consistent, clear and action-oriented messaging around VMMC. This will require a highly coordinated effort by District Health Officers (DHOs), HEU and HIV/AIDS unit at national level, international, national and local NGOs and CBOs, and local stakeholders mandated to address VMMC.

### 5.3 Behavior Change Communication (BCC)

Behavior Change Communication (BCC) will also be part of the strategies to help individuals and communities gain the knowledge to improve their understanding on the benefits and risks of VMMC. In order to reach out to various groups of people there is need to use multi-media communication channels that will help influence changes in people's knowledge, attitudes and behavior. Additionally, other approaches for BCC will be in the form of a multimedia entertainment-education campaign that can help to simplify complex issues.

Mass media can play a key role in preparing the population at large for a greater understanding of the issues and benefit around VMMC. However, mass media need to be used carefully and tactically and in balance with the supply side. It could be counter-productive to carry out a mass media campaign in advance of health services being able to respond to a sudden and significant increase in demand. Once services are ready and capable of responding to a rapid increase in demand, then mass media can be effective through a number of approaches:

1. High volume airplay of radio spots addressing VMMC from different angles: explaining what VMMC is; explaining its benefits and limits (6 week abstinence, and only partial protection); providing testimonials of men who have been circumcised and find it successful; providing testimonials of wives or partners who agreed to VMMC for their partner and are happy with the results
2. Talk shows and interviews in regular radio programs, dealing with the more complex issues of post-operative abstinence, partial protection, continuing condom use, etc
3. Local road shows and mid-media performances at community level that cover the same issues through interactive drama and dialogue with groups at community level

Effective implementation of the above approaches would require the development of various tool and materials. Some of them may include:

- i. Brand Development to increase visibility of service delivery sites and communicate key qualities of services (safe effective, health choice)
- ii. Client Education within relevant service delivery sites: (HTC, PMTCT, STIs,)
  - Job aids (counseling – and + clients\_)/referrals
  - Provider flipcharts (integrate MC into HTC, PMTCT, MC specific)
  - Low literacy friendly take home materials
  - Education videos
- iii. Community mobilization Toolkit targeting:
  - Circumcising communities
  - Non-circumcising communities
  - Boys, men, women and peers.
  - Workplace interventions
  - VMMC songs, VMMC videos, discussion guides, message briefs etc

- iv. Targeted Advocacy Toolkits for decision makers , business leaders, faith leaders, traditional leaders.
- v. Capacity building strategy for
  - Community Based Organizations
  - Community Referral agents: vouchers
  - Journalists
- vi. Mass media (radio and TV platform) including community filming

## **6.0 CAPACITY BUILDING**

Capacity building around competence to deal with the SBCC implications of VMMC needs to happen at all four levels of the Socio-Ecological model.

### **6.1 Enabling Environment Level**

At the Enabling Environment level there needs to be advocacy to bring all key stakeholders and gatekeepers up to speed on the latest evidence around VMMC, its benefits, issues, and priority messaging; and to have them understand where and how VMMC fits into the larger Combination Prevention Approach to HIV Prevention in Malawi. At the district level, the DHOs, DHMTs and local authorities need the skills and information to coordinate (if not to develop, which requires different skills) comprehensive demand creation plans, building on the processes, messages, and approaches identified in the national strategy. This involves the capacity to coordinate a wide range of local partners, including civil society, traditional leaders, local businesses and high volume employers, and the large networks of CBOs working on HIV and AIDS prevention programs.

### **6.2 Service Delivery Level**

At Service Delivery level, On the job training and provision of job aids and client materials will be required to help all levels of health providers better understand the theory, practice, and potential preventive results of VMMC, and to help improve their client-centered approaches, including a focus on couple testing. Recent evidence demonstrates the need for female partners of men contemplating VMMC to be well-informed about the benefits and caveats around VMMC, so that they can assist their partner to adhere to the post-op conditions (assigned check-up visits, 6 week abstinence and consistent condom use)<sup>18</sup>.

### **6.3 Community and Individual Level**

At the community and individual level, there needs to be the capacity within the CBO and local community structures to facilitate informed discussion around VMMC. These stakeholders include local CBOs, Traditional Leaders, FBOs, Traditional Initiators, and various informal groups—youth clubs, mothers' clubs, etc.

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<sup>18</sup> Mahler HR, Kileo B, Curran K, Plotkin M, Adamu T, et al.

## **7.0 PARTNERSHIP AND COLLABORATION**

For the national VMMC communication strategy to be successfully implemented there is needs for effective collaboration of all implementing partners and key stakeholders at all levels--national, district, and community. The list of partners includes but is not restricted to MoH, HIV prevention and reproductive health experts, nongovernment organizations and community-based organizations, traditional community units or tribal leaders, international partners and donors, private sector organizations, faith-based organizations, medical organizations and associations, strategic communication practitioners, including, script writers, designers, advertising and public relations experts and journalist groups. The coordination needs to be driven by the two lead government bodies overseeing implementation of VMMC in Malawi: HIV/AIDS Unit (MoH) and the Health Education Unit (HEU), with approval from the HIV Prevention and Biomedical TWGs.

The Ministry of health constituted the multi-sæctoral national task force that will guide the implementation and scale up of VMMC program in Malawi. The national VMMC task force is chaired by the HIV and AIDS Department of the Ministry of health. Within the national task force, a sub group to lead communication programs was constituted which is chaired by the Health Education Unit of the Ministry of Health. The sub group comprises an exclusive group of institutions that are highly specialized in social and behaviour change interventions while others also have the biomedical understanding of VMMC. However, while this sub group reports to the national task force, it is also mandated to report to the HIV national BCC sub technical working group.

## 8.0 MONITORING AND EVALUATION

A strong monitoring and evaluation framework is needed to measure the success of the National Communication Strategy for Voluntary Medical circumcision for Malawi. While the monitoring aspect will track progress of implementation of every activity that has been developed and routinely tracks a program's activities, the evaluation component will measure outcomes and impact that are closely linked with the key objectives.

It is widely known that evaluation is used to assess the overall effectiveness and outcomes of the strategies, and within this communication strategy, the focus will be on the changes of knowledge, attitudes, beliefs and behavior based on the individual and community responses through research and other data collection methodologies.

The monitoring and evaluation shall be coordinated by the Ministry of health while various program implementers may use their own monitoring systems while also acknowledging and complimenting to the already developed indicators. All organizations will therefore be required to use the indicators outlined in this strategy besides those that they are interested in.

**Monitoring and Evaluation Matrix**

<b>Communication objective</b>	<b>Data sources</b>	<b>Outcome indicators</b>
To increase levels of knowledge on the facts regarding and benefits of VMMC	<ul style="list-style-type: none"><li>• Campaign Reports</li><li>• Routine reports</li><li>• Surveys</li></ul>	<ul style="list-style-type: none"><li>• % of primary audience exposed to MC messages.</li><li>• % increase in demand for MC services (national/localized).</li><li>• % of population with correct knowledge on the benefits and risks of MC.</li><li>• % of the age group 15 – 49 yrs with correct knowledge of male circumcision</li></ul>
To increase informed demand for and uptake of VMMC services	<ul style="list-style-type: none"><li>• Facility reports</li><li>• Campaign reports</li><li>• Evaluation reports</li></ul>	<ul style="list-style-type: none"><li>• % males (15 -49) receiving circumcision,</li><li>• % increased demand for MC services.</li><li>• # of new sites offering MC services</li><li>• # of mobilization campaigns conducted</li><li>• # of men who seek MC while accompanied by their wife/female sex partners.</li></ul>
To create an enabling environment for VMMC and foster its widespread acceptance	<ul style="list-style-type: none"><li>• Activity reports</li><li>• Evaluation reports</li></ul>	<ul style="list-style-type: none"><li>• # of facilities offering VMMC</li><li>• % of communities taking their young men to facility for VMMC</li><li>• # of communities engaged on VMMC</li></ul>
To increase consistent safer sexual practices post-VMMC	<ul style="list-style-type: none"><li>• Research reports</li></ul>	<ul style="list-style-type: none"><li>• # of young men who have undergone MC and still follow other safer sexual practices</li><li>• % of circumcised men who resume sex within the 6 week abstinence period</li></ul>

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