



Republic of Zambia  
MINISTRY OF HEALTH

# **National Voluntary Medical Male Circumcision (VMMC) Communication and Advocacy Strategy 2012-2015**



April 2012



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FROM THE AMERICAN PEOPLE

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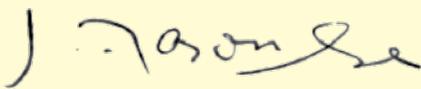
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# Forward

Voluntary medical male circumcision (VMMC) is a promising HIV prevention intervention that could avert 339,632 new HIV infections by 2025 among men and women in Zambia, resulting in significant cost-savings for the health sector while improving the lives of millions. Our best data suggests that increasing male circumcision prevalence in Zambia could dramatically reduce HIV incidence *if* coverage can be scaled up quickly to a majority of sexually active adult men and *if* preventive behaviours such as correct and consistent condom use are not compromised. This document details the communication and advocacy strategies, including those designed to minimize risky post-MC behaviour, which must be strengthened and extended into the intended communities with clear, relevant and culturally appropriate messages.

While the Government of the Republic of Zambia (GRZ) through the Ministry of Health (MoH) and civil society efforts to scale-up VMMC services in Zambia are making significant progress, there is need to improve the alignment of demand generation to service delivery, to increase the efficiency and impact of the national programme. Pairing consistent demand for VMMC with increasingly available supply will require effective communication approaches at every phase of program implementation. Engaging community and peer opinion leaders at all levels will be paramount in order to mobilize the public and ensure acceptance by all stakeholders. This National VMMC Communications and Advocacy Strategy document is the result of broad consultations with traditional leaders and community stakeholders, as well as medical and communication experts. It provides an initial starting point for developing effective, evidence-based communication strategies and for prioritizing communication efforts so that the health benefits of male circumcision can be maximized for all Zambians.



**Hon. Dr Joseph Kasonde**

**MINISTER OF HEALTH**

# Acknowledgements

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The National AIDS Council (NAC)

Communication Support for Health (CSH),

Society for Family Health (SFH),

JPHIEGO

The Center for Infectious Disease Research in Zambia (CIDRZ)

The Clinton Health Access Initiative (CHAI)

The Churches Health Association of Zambia (CHAZ)

Zambia HIV Prevention, Care and Treatment II (ZPCTII)

Zambia Center for Communications Programmes (ZCCP)

The Ministry also acknowledges with gratitude the financial support from the United States Agency for International Development (USAID), through CSH Project, for the development and execution of this report.

I would finally like to thank the Ministry of Health staff, especially the editorial team, for their participation, contributions and support.



**Dr Peter Mwaba**

**PERMANENT SECRETARY**

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# Abbreviations

<b>AIDS</b>	Acquired immune deficiency syndrome
<b>BCC</b>	Behaviour change communication
<b>CBO</b>	Community-based organization
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CHAI</b>	Clinton Health Access Initiative
<b>CHAZ</b>	Churches Health Association of Zambia
<b>CIDRZ</b>	Center for Infectious Disease Research in Zambia (CIDRZ)
<b>COH</b>	Corridors of Hope
<b>CSH</b>	Communications Support for Health
<b>CSO</b>	Central Statistical Office
<b>EIMC</b>	Early infant male circumcision
<b>FHI</b>	Family Health International (FHI 360)
<b>GRZ</b>	Government of the Republic of Zambia
<b>HIV</b>	Human immunodeficiency virus
<b>IEC</b>	Information, education and communication
<b>MC</b>	Male circumcision
<b>MCP</b>	Multiple concurrent partnerships
<b>MOH</b>	Ministry of Health
<b>MSI</b>	Marie Stopes International
<b>NAC</b>	National HIV/AIDS/STI/TB Council
<b>NGO</b>	Non-governmental organization
<b>PLHA</b>	Persons living with HIV and AIDS
<b>PSI</b>	Population Services International
<b>QA</b>	Quality assurance
<b>SFH</b>	Society for Family Health
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>USAID</b>	United States Agency for International Development
<b>VCT</b>	Voluntary counselling and testing
<b>VMMC</b>	Voluntary medical male circumcision
<b>WHO</b>	World Health Organization
<b>ZCCP</b>	Zambia Center for Communication Programmes
<b>ZDHS</b>	Zambia Demographic and Health Survey
<b>ZPCTII</b>	Zambia Prevention Care and Treatment II

# MINISTRY OF HEALTH NATIONAL VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) COMMUNICATION AND ADVOCACY STRATEGY 2012-2015

## 1. Introduction

The low coverage of male circumcision (MC) within Zambia of approximately 13% has been identified as one of the primary drivers of new HIV infections in the country. In order to reach the target coverage outlined by the Country Operational Plan for the scale-up of VMMC in Zambia 2012-2015, an estimated 1.9 million men and boys must be circumcised by 2015. Effective communication strategies are needed to educate and motivate millions of men, women, and parents of male infants to partake in the VMMC process, while simultaneously reinforcing safer sexual behaviours among sexually active men and their female partners, in line with existing HIV prevention guidelines.

### A. National VMMC Policy Framework

The Ministry of Health recognises male circumcision in the context of the *Public Health Act* of 1935, it also recognises VMMC as an important component of comprehensive male reproductive health services under the *Reproductive Health Policy* of 2008, and as part of the comprehensive HIV prevention interventions under the *HIV and AIDS Policy* of 2005.

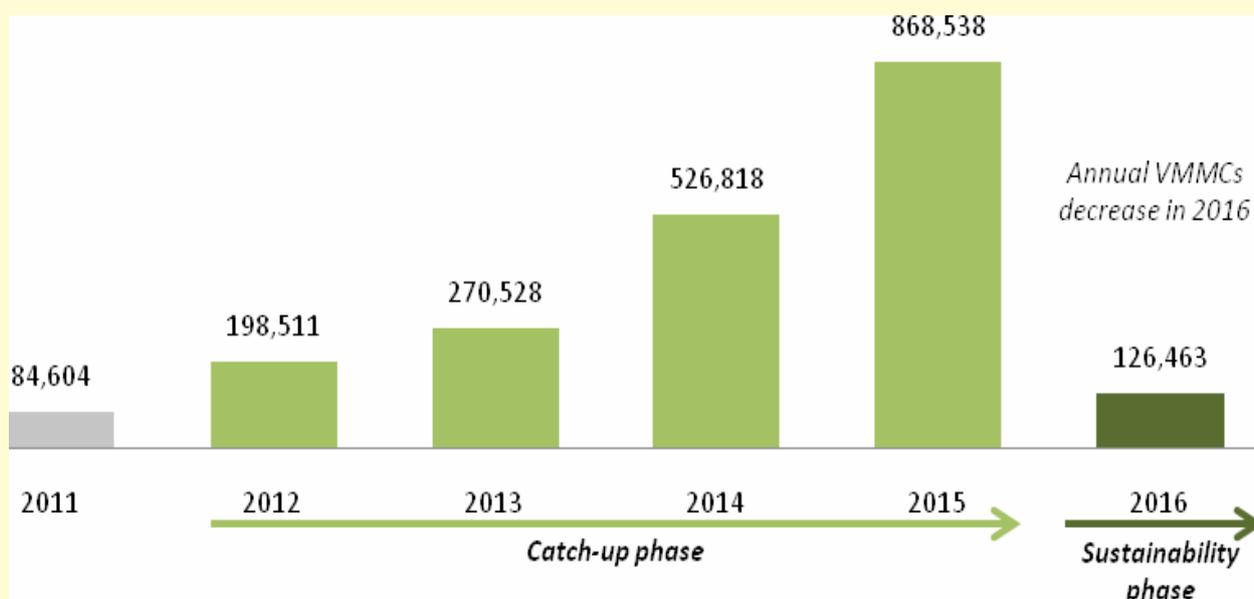
In July 2009 the Ministry of Health of Zambia launched the National Male Circumcision (MC) Programme and consequently released a *National MC Strategy and Implementation Plan* for the period 2010-2020.

This plan outlines the minimum quality standards for MC services in Zambia and establishes guidelines for the provision of high quality, safe male circumcision services. The Ministry of Health has integrated the priorities of the National MC Programme within the comprehensive HIV prevention strategy outlined under the HIV and AIDS Strategic Framework of 2011 - 2015, the National Health Strategic Plan for 2011-2015 and the Country Operational Plan for the scale-up of VMMC in Zambia for 2012-2015.

The MoH's overall target is to achieve 80% coverage of VMMC among uncircumcised, HIV-negative men aged 15-49 by 2015. To optimize long-term public health benefits, the national programme also plans to scale-up neonatal VMMC services to reach at least 80% of male neonates by 2020.

Figure 1 below illustrates the government's targets for VMMC scale-up on an annualized basis

**Figure 1: Annual VMMCs required to achieve 80% target by 2015 (with exponential scale-up)**



## B. Scope of National VMMC Communication and Advocacy Strategy

This National VMMC Communication and Advocacy Strategy offers guidance to all participating public and civil society agents for the comprehensive, effective, ethical and culturally appropriate promotion, advocacy and informed-demand generation related to national VMMC scale-up. This document is designed to strengthen communication and advocacy activities within the Country Operational Plan for the scale-up of VMMC in Zambia 2012-2015 and to complement and supplement the National HIV and AIDS Communication and Advocacy Strategy.

Recommendations contained herein were compiled with broad input and consultation from traditional, cultural and religious leaders as well medical and communications experts. A workshop was convened in Livingstone from 19-23<sup>rd</sup> July, 2011, during which leading advocates, experts and community stakeholders reviewed existing evidence and reached well-informed consensus on national communications and advocacy priorities and approaches. Subsequent stakeholder meetings were held to finalize this document, and efforts have been made to assimilate local and international best practices and evidence-based communication efforts, and to frame all guidance in accordance with the national Zambian context.

The scope of this *National VMMC Communication and Advocacy Strategy* includes the provision of guidance for:

- *Comprehensive, informative, ethical and evidence-based demand generation communications related to VMMC scale-up;*
- *Effective advocacy and influence among key stakeholders and decision-makers for the promotion of informed institutional and community participation in VMMC scale-up;*
- *Effective integration of VMMC into national HIV prevention communication strategies and activities;*
- *Effective coordination among public, private and civil society actors involved in VMMC-related*

*demand generation, promotion and/or advocacy activities; and*

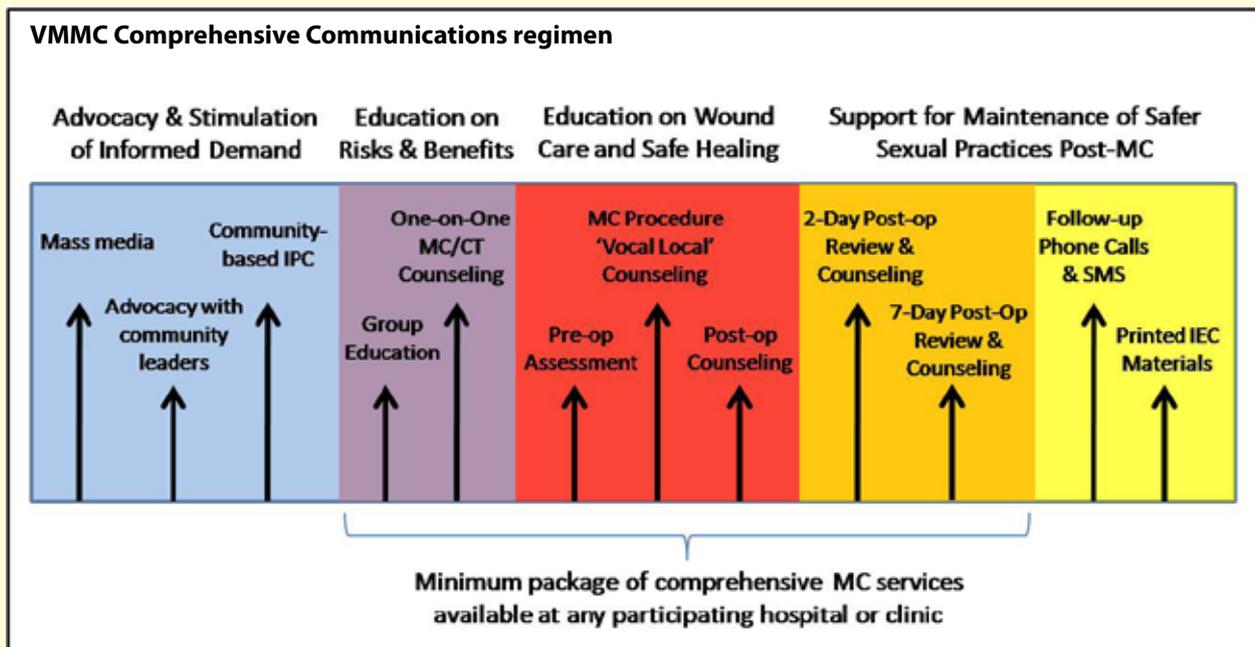
- *Monitoring and evaluation of communication and advocacy activities as well as establishing priorities for national VMMC-related communication research needs.*

### **C. Guidelines for VMMC Communication and Advocacy Implementers**

The Ministry of Health recognizes the need for effective communication and advocacy strategies in order to achieve established national HIV prevention goals. Nonetheless, increasing informed demand for VMMC should not be seen as a stand-alone objective. If clients are referred to unsafe or incomplete VMMC services, where comprehensive risk-reduction counselling is not adequately provided, the health impact of scaling-up VMMC could be reduced. Likewise, VMMC should not be viewed as a substitute for existing HIV prevention efforts, nor as a “magic bullet” for HIV prevention, but rather as an effective addition to existing preventive strategies. All public, private and civil society organizations involved in generating informed demand for increased uptake of VMMC services must therefore endeavour to:

- ***Ensure that communication activities orient potential clients to seek safe, high-quality male circumcision services at service locations offering a comprehensive package of corresponding services and informed consent procedures, as outlined in the National MC Strategy and Implementation Plan.***
- ***Ensure complete and accurate information is provided, in accordance with national guidelines, available in locally-accessible languages and formats, and that every opportunity is utilized to solicit broad community-level buy-in through interactive and culturally appropriate processes that involve key stakeholders such as traditional and community leaders, female partners, family members and other social support networks.***
- ***Coordinate activities in order to enhance synergies among stakeholders and avoid conflicting messaging at all levels in order to provide purposeful and comprehensive coverage of VMMC-related communication and advocacy activities for maximum health impact.***
- ***Make a priority of involving women in all communication and advocacy activities for demand generation as well as effective and sustained behavioural adherence post-MC, utilizing evidence-based approaches to mitigate potential risky behaviour post-MC in accordance with national guidelines;***
- ***Incorporate appropriate monitoring and evaluation systems aligned to national M&E frameworks, to allow for stringent quality controls that reinforce accurate and complete communication, as well as regular assessment of trends in knowledge and behaviour among stakeholders and beneficiaries.***

Figure 2 below illustrates a comprehensive communication regimen that should be integrated to support the provision of the minimum package of MC services.



## D. Coordination of VMMC Communication and Advocacy Activities

In order to achieve the goals established by the *National Male Circumcision Programme*, public, private and civil society partners will need to properly coordinate demand generation as well as service delivery activities on a regular basis. The Communications Subcommittee of the National Male Circumcision Technical Working Group will serve as the lead coordinating body, under the supervision of the National MC Coordinator within the Directorate of Public Health and Research in the Ministry of Health. All national-level demand creation and service delivery plans must be shared centrally with the Communications Subcommittee on a regular basis in order to ensure logical and effective utilization of collective resources.

District Health Offices will serve as focal points for the coordination of community and facility-level demand creation activities. Supporting partners will be required to provide regular updates to the District Health Office on planned demand creation activities at the community level. Provincial Health Offices will serve as focal points for high-level advocacy activities within each Province, including official launches and stakeholder meetings.

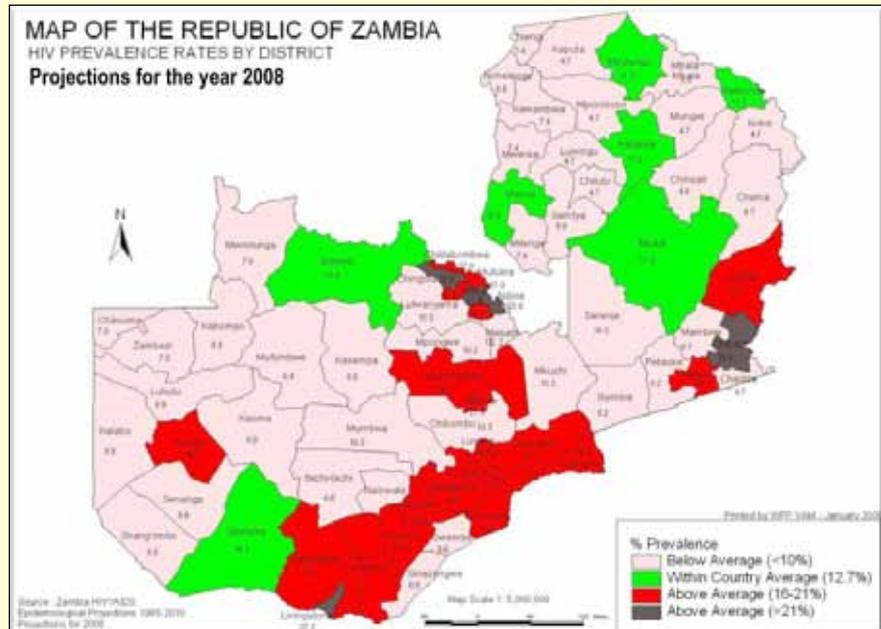
## 2. Situation Analysis

### A. The HIV/AIDS Epidemic in Zambia

The adult HIV and AIDS prevalence in Zambia is 14.3%; with an incidence rate of 1.6% this translates into an estimated 82,681 new infections occur each year, or an average of 226 new HIV infections occur in the country every day. The geographic distribution of HIV (Figure 3) reveals an urban skew, with nearly double the prevalence among the urban versus rural populations (19.7% vs. 10.3%).

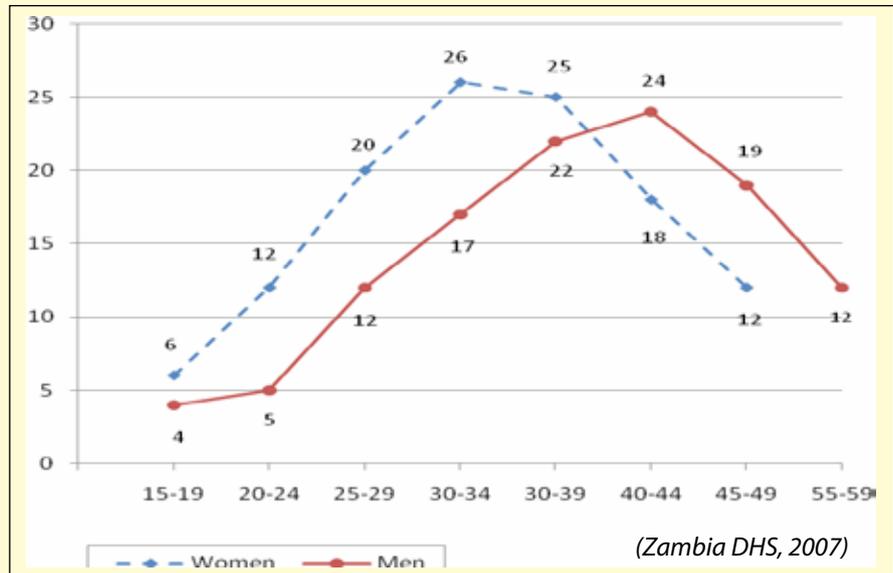
As seen in Figure 4, when disaggregated by sex and age, the HIV prevalence in Zambia shows a demographic distribution where women tend to become infected earlier in their lives as compared to men, with a more rapid ascent to peak prevalence. The skew towards earlier infection among women in Zambia has been attributed to a combination of elevated biological susceptibility and intergenerational sex with older and more affluent male partners<sup>1, 1,2,3,4</sup>.

**Figure 3: HIV prevalence in Zambia by District**



Source: Zambia HIV/AIDS Epidemiologic Projections 2008.

**Figure 4: HIV prevalence in Zambia by sex and age**



### B. VMMC for HIV Prevention in Zambia

In June 2009, Zambia's National HIV/AIDS/STI/TB Council (NAC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) released a thorough epidemiologic analysis that identifies low prevalence of male circumcision as one of three primary drivers of new HIV infections in the

<sup>1</sup> According to the 2007 DHS, 4.5% of Zambian young women aged 15-19 reported engaging in higher-risk intercourse (sexual intercourse with non-marital, non-cohabitating partner) with a man 10 or more years older than themselves during the past 12 months.

country.<sup>5</sup> Male circumcision is considered a highly cost-effective strategy for HIV prevention for the Zambian context. A recent assessment of the potential impact and costs of scaling-up male circumcision in Zambia found that expanding MC coverage to 80% of adult men and boys by 2015 would avert an estimated 486,000 new HIV infections (approximately 50% of all new infections) and would result in a cumulative net savings for the public health sector of US\$2.4 billion between 2009 and 2025.<sup>xvii</sup> Evidence suggests that Zambia's National MC Programme would have the greatest and most immediate impact by focusing on HIV negative adult males age 15-49. Nonetheless, early infant male circumcision (EIMC) is recognized as essential to the sustainability of the initiative.<sup>6</sup>

Evidence to date in Zambia is consistent with the broader consensus within the international public health community that VMMC should be added as a priority component to existing comprehensive HIV prevention strategies in countries such as Zambia, which have generalized heterosexual epidemics and low MC prevalence.<sup>7,8,9,10</sup> The efficacy of male circumcision in reducing the risk of transmission of HIV from women to men has been well documented in Eastern and Southern Africa, and supporting evidence for sustained effects from follow-on cohort studies continues to emerge.<sup>11,12,13</sup> These findings demonstrate the efficacy of male circumcision in preventing HIV transmission from women to men to be significantly greater than any HIV vaccine developed to date.<sup>14,15</sup>

While there is no evidence establishing a direct protective effect of male circumcision on HIV acquisition for women, the indirect benefits for the female population in Zambia over time are expected to be substantial.<sup>16,17,18</sup> An estimated 30% of the HIV infections averted over a 20-year period due to increased MC prevalence will be among women, as the prevalence of HIV among the male population decreases as a result of improved VMMC coverage and the risk of contracting HIV among the female population also declines.<sup>19</sup>

### C. Acceptability and Facilitating Factors for VMMC Uptake in Zambia

**Adult VMMC:** According to the 2007 DHS, approximately 13% of all men in Zambia reported being circumcised. Despite the relatively low prevalence of male circumcision in Zambia, ethnographic and qualitative studies have demonstrated high levels of acceptability for the introduction of the medical procedure for adults and children among traditionally circumcising and non-circumcising ethnic groups.<sup>20,21</sup> More recent quantitative surveys have confirmed this trend; according to a 2010 household survey conducted among male respondents age 15-35 in five Provinces (Lusaka, Eastern, Copperbelt, Southern and North-Western) by Society for Family Health<sup>22</sup> (SFH):

- Knowledge of MC is almost universal; **91%** of "not circumcised" respondents reported having heard about MC, while only **58%** reported having heard of MC as an HIV prevention method.
- **30%** of the "not circumcised" reported contemplating accessing VMMC services in the near future.
- **22%** of the "not circumcised" are considered in preparation stage for accessing VMMC services (have undertaken critical steps such as talking to a health provider about MC).
- The main reasons cited for accessing VMMC services were: prevention of STIs (83%), hygiene and cleanliness (53%), prevention of HIV (48%) and improving appearance of the penis (3%).

According to the same survey, statistically significant factors associated with accessing adult VMMC services include:

- *Availability of MC Services.* Increasing availability and hence perception about the availability

of MC services increases the likelihood that a man go for VMMC

- *Quality of MC services related to waiting time:* Reducing the waiting time and hence improving perceptions about waiting time before getting circumcised would increase the likelihood that a man go for VMMC
- *Quality of care related to perceptions about the quality of providers:* men who have positive perceptions about the quality of VMMC providers are more likely to go for VMMC.
- *Quality of care related to type of facility:* men who have positive perceptions about the available MC facilities are more likely to go for VMMC.
- *Peers norms about VMMC:* men who belong to peer groups that have favourable norms about MC are more likely to go for MC.
- *Knowledge about healing time:* men who have positive perceptions about the healing time of the wound after the operation are more likely to go for VMMC.
- *Self-efficacy:* confidence about one's ability to go for VMMC increases the likelihood that a man go for VMMC.
- *Myths about MC:* men who have negative beliefs about the effects of being circumcised are less likely to go for VMMC.
- *Social support from friends:* men who receive encouragement from friends about going for MC are more likely to go for VMMC.
- *Perceived negatives about bleeding:* men who have positive perceptions about the severity of post MC bleeding are more likely to go for VMMC.
- *Perceived Benefits:* men are more likely to go VMMC if they expect sexual and hygiene related benefits after MC.

Further analysis of these facilitating factors indicates that effective informed-demand generation efforts for adult MC should highlight aspects of **availability** (including **waiting time**) and **quality** of VMMC services, and will address men's concerns about **healing time** as well as **pain** and **bleeding** during and after the procedure.

**Early Infant MC:** Recent research<sup>23</sup> into the acceptability of early infant male circumcision conducted by the Centre for Infectious Disease Research in Zambia (CIDRZ) in 2011 found that while reported acceptability among women and men was at 91%, actual uptake among women agreeing to EIMC during antenatal visits was approximately 11%. CIDRZ has identified the following as key barriers among to EIMC uptake in Zambia:

- Fear of negative outcomes (pain, death, damage to penis, wound not healing well);
- Concern over riskier behaviour later in life;
- Lack of a circumcising cultural identity within the family unit; and
- Resistance among non-circumcised fathers and grandparents (87% of women from the refusal surveys indicated they did not bring the baby because the father refused).

Reasons reported for accessing EIMC services include HIV and STI disease prevention, hygiene and less pain compared to adult MC (almost all participants thought it best to circumcise males before

puberty; suggesting an ideal age range of 1 day -13 years).

**Acceptability of VMMC among Women:** When excluding women from North-western Districts, where male circumcision is nearly universal, 90.8% of women surveyed during a household survey in 2007 reported that they would like their male partner to undergo VMMC if it were found to be an effective method of HIV prevention, and 98.1% of women with children reported that they would like their male child/children to be circumcised if the same condition were true. According to the same survey, more than one-third of women stated that if given a choice, they would prefer a circumcised male partner. When asked the reasons for wanting their partners to be circumcised, 70% indicated “disease prevention”, while 25% indicated “sexual satisfaction”.<sup>24</sup>

Evidence for circumcision preference among women was substantiated by a recent behavioural surveillance study (BSS) carried out in 2009 among unemployed and out-of-school youth in four Districts of Zambia by Family Health International’s<sup>2</sup> (FHI) Corridors of Hope (COH) project. The study found that while fewer than 80% of all sexually active female respondents had heard of male circumcision as an HIV prevention intervention, 58.2% reported that they would prefer a circumcised male partner as compared to an uncircumcised partner.

## D. Risky Behaviour Post-VMMC

Data suggests that the effectiveness of VMMC as an HIV preventive intervention in Zambia could be compromised if those undergoing the procedure engage in riskier sexual behaviour as a result of over-confidence in the protective benefits of VMMC.<sup>25</sup> This effect, known as *risk-compensation*, has the potential to offset the health impact of male circumcision by up to 70%.<sup>26</sup> This is partly due to the fact that the risk of HIV transmission is increased for men during the healing period, due to increased likelihood of tearing or bleeding.<sup>27</sup>

**Risky Behaviour during the VMMC Healing Period:** The WHO recommends an abstinence period of six weeks for all men undergoing VMMC, in order to allow for complete wound healing. Evidence from Zambia suggests that a large portion of VMMC clients are not adhering to this recommended abstinence during the healing period. According to a study conducted by the Population Council in 2010, approximately 24% of men circumcised reported resuming sex within six-weeks; of these men, 82% reported at least one unprotected sex act and 37% had sex with two or more partners during the healing period. Furthermore, 46% of the men who resumed sex early did so in the first three weeks following surgery, including 22% in the first week.<sup>28</sup> This early resumption of sex is expected to have a disproportionately negative impact on women.<sup>29</sup> Although there is a net benefit over the long term for women and men in terms of HIV infections averted by VMMC scale-up in Zambia, minimizing risky behaviour during the healing period remains an important priority.

**Risky Behaviour after the VMMC Healing Period:** To date there has been no evidence of significant increases in risk behaviour related to male circumcision in other countries.<sup>30</sup> Nonetheless, previous VMMC programs have by and large taken place under strict clinical trial conditions that have included high-quality pre and post-operative counselling to ensure consistency of messages as well as verifiable recall on behalf of participants that VMMC does not provide 100% protection.

For these reasons, international experts insist that male circumcision programs must provide a minimum package of services that includes adequate client-centred behavioural counselling, and

2 Emily Waters, Elizabeth Stringer, Bridget Mugisa, Salome Temba, Kasonde Bowa & David Linyama (2012): Acceptability of neonatal male circumcision in Lusaka, Zambia, *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, 24:1, 12-19

should be accompanied by communication campaigns that emphasise the need for condom use and the need to minimize the number of sexual partners before and after VMMC. Evidence-based communication efforts must be bolstered to minimize risk behaviour that may result from the wide-scale introduction of the service among the already sexually-active adult population.

The MOH recognizes the importance of mitigating risky post-VMMC behaviour and maintains that pre-and post-operative counselling must be included as part of the comprehensive package of services offered at all VMMC service locations. Additional research is needed to continue to identify the most effective behavioural counselling approaches for VMMC clients and their female partners in the Zambian context. However, couples HIV counselling and testing has already been identified as a promising add-on to the minimum package of VMMC services which could help to reduce risky post-VMMC behaviour. In addition, targeted public health messages will be needed to ensure that women understand that male circumcision does not protect them from contracting HIV from circumcised male partners if those men are already infected with the virus.

## E. VMMC Service Delivery Models in Zambia

Drawing on the combined service delivery experiences in Zambia to date, the *Country Operational Plan for the scale-up of VMMC in Zambia* highlights the need to bring VMMC services as close to the population as possible (within short walking distance if possible) due to the need for multiple visits and the restricted mobility of clients after surgery. In order to maximize existing resources, the operational plan provides “VMMC efficiency guidelines” that underscore the importance of scheduling dedicated VMMC service days at all participating clinics. For these reasons, outreach models of service delivery will be an important part of VMMC scale-up in Zambia.

As such, there will be a need for strong coordination of the movements of human resources and supplies to ensure that all VMMC services include a complete and comprehensive service package that meets the established minimum standards, even in remote settings. To address this need for synchronization, all VMMC service delivery activities in Zambia will be coordinated at the district level through the District Health Office.

Public health facilities identified to offer the standard VMMC package will be categorized into four service levels (A, B, C, and D), according to the facility type, availability of human resources, and the support needed from other levels. Technical and financial support from collaborating partners will be directed towards assisting facilities within each District to take ownership of the seven core service delivery responsibilities outlined in the operational plan:

- 1) *Community-level demand generation*
- 2) *Clinical service provision*
- 3) *Infection prevention*
- 4) *Behavioural counselling*
- 5) *Quality assurance*
- 6) *Data management*
- 7) *Supply-chain management*

**Level A:** Usually a District or General Hospital equivalent- health facilities in Level A will take on full responsibility for all seven core VMMC service delivery responsibilities, and will also be responsible for providing additional support to surrounding lower-level clinics through outreach activities coordinated by the VMMC Coordinator. Level A facilities will be expected to provide dedicated

VMMC services nearly every day of the week, as needed. Level A facilities will also need to serve as clinical training hubs for the District, with sufficient infrastructure to support a 3-bed operating team. Level A facilities will also typically house a resident medical officer to provide technical support for the District, and will serve as a referral hub for any adverse events requiring specialized attention.

**Level B:** Usually a Zonal Health Center equivalent- Level B facilities will also be able to take on full responsibility for all seven core VMMC service delivery responsibilities, with sufficient staff to offer dedicated VMMC services on a regular basis. Level B facilities will be expected to provide dedicated VMMC services between 1-12 days per month. On days when VMMC services are offered, facility staff time and clinic space will be dedicated to VMMC using 2-3 bed operating teams. In some cases, Level B facilities will also serve as a referral hub for any adverse events requiring specialized attention.

**Level C:** Usually a Health Centre equivalent- Level C facilities will rely partially on external assistance from Level A or B facilities, through the VMMC Coordinator, to offer dedicated VMMC services. Level C facilities may not be able to take on full responsibility for all seven cores VMMC service delivery responsibilities initially, but will be responsible for coordinating all necessary demand creation activities to ensure sufficient numbers of eligible clients are available on designated service days. They will offer sufficient infrastructure so that the minimum package of services can be offered using an outreach approach. Level C facilities will be expected to involve any available health care providers from the facility during VMMC outreach service days, The number of operating beds to be used at Level C facilities as well as the frequency of service days (weekly, monthly, quarter or bi-annually) will be established according to the needs of the catchment population. The use of medical tents or other temporary structures may be used to increase capacity where infrastructure is lacking.

**Level D:** Usually a Health Post equivalent, Level D facilities will rely entirely on external assistance from Level A, B or C facilities, through the VMMC Coordinator, to offer dedicated VMMC services on specific days. Level D facilities may not offer any human resources or sufficient infrastructure for the minimum package of services, and will often require the use of medical tents or other temporary structures to increase capacity. Services provided at Level D sites will often be implemented as part of “mini-campaigns”, usually only a few times per year, and/or during special events or special occasions. These “mini-campaigns” will usually last for several consecutive days and will offer dedicated services to large numbers of people using temporary structures such as tents, with multiple operating tables.

# 3. VMMC Communication and Advocacy Implementation

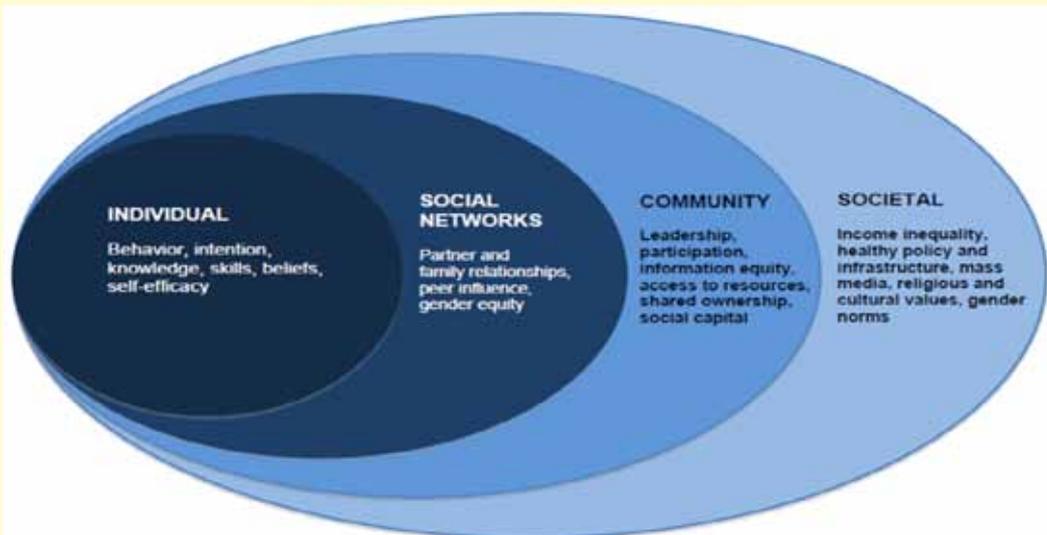
## A. Theoretical Considerations for VMMC Communications

The following theoretical frameworks can be drawn upon for the development of effective demand-generation and behavioural mitigation strategies related to MC scale-up. These frameworks offer insights for effecting positive health behaviour change at the individual, social and policy levels:

- i. Social-ecological model (social and policy levels):

The social ecological model emphasizes that the environment in which an individual lives in can have greater influence on how they make their decisions hence influencing their behaviours positively or negatively. Proponents of this theory emphasize on the environmental and policy contexts of behaviour in addition to the social and psychological processes. The social ecological model of behaviour change recognizes that behaviour has multiple levels of influence: intrapersonal (biological and psychological), interpersonal (social and cultural norms), organizational (occupational, academic, athletic, religious, etc.), community (family, neighbours, etc.), physical environment and policy, as seen in Figure 5 below. Healthy behaviours such as MC adoption can only be fully utilized when environment and policies support healthy choices, and individuals are motivated to make those choices. Hence the theory lies on the need for individual and environmental policy level interactions to achieve significant changes in behaviours. When social issues are attended to in a holistic approach, the various social components can be attuned to the desired MC communication goals. As such, this communication strategy encompasses the targeting of specific enablers as well as obstacles to the uptake of MC in order to enhance its acceptability, accessibility and uptake.

**Figure 5: Social Ecological Model**



- ii. Diffusion of Innovations theory of behavioural adoption (individual level):

The Diffusion of Innovations theory of behavioural adoption provides an excellent conceptual framework from which to devise communication strategies that will capitalize on latent demand and amplify demand-generation and advocacy successes through careful targeting

and accentuation of key characteristics of MC as an HIV and STI prevention innovation for men. According to the theory, there will inevitably be certain individuals within any given group that are more prone to adoption of novel technologies and practices. These individuals are termed early adopters, and they tend to be younger, more educated, wealthier, socially progressive, more exposed to mass media and outside influences, and have a high degree of opinion leadership or influence over their peers. Once early adopters within a given community or group begin to use a given innovation, others will slowly follow, and once enough individuals have adopted the innovation (referred to as a critical mass), the psycho-social forces of diffusion take hold and wide-scale adoption ensues. Based on these tenets of the Diffusion of Innovations model, there are certain communication approaches that will more readily facilitate the rapid adoption of male circumcision within Zambia:

*Engage credible public figures:* When innovations are adopted by highly respected individuals within a social network they can engender an instinctive desire to model the adoption of that specific innovation among the public.

*Target and support early adopters:* By promoting male circumcision first among individuals within a group or community displaying characteristics of opinion leaders and early adopters, and by providing positive incentives and support for early adopters of an innovation, it is more likely to be adopted by others within that group.

Given the breadth of priority audiences and communication messages that must be addressed as part of a comprehensive VMMC program, as well as the need for rapid scale-up, it will be important for all agencies to coordinate and focus communication and advocacy activities in support of national goals, utilizing evidence-based approaches wherever possible. Promotional activities will need to be coordinated carefully with service delivery efforts to ensure an appropriate balance of supply and demand. In order to maximize the impact of communication initiatives, each activity must have clearly defined priority audiences, behavioural objectives, communication objectives, key messages, and logical channels for reaching the intended audiences.

The following sections provide guidance on national VMMC communication and advocacy priorities. Primary and secondary beneficiaries and advocacy audiences are described below, along with behavioural and communication objectives for each. Guidance is also provided for the development of key messages and for the selection of effective communication channels for these priority beneficiary and advocacy audiences. Considerations are also provided to help inform the execution and implementation of communication and advocacy activities according to relevant, evidence-based theories of behavioural change.

## B. Primary Beneficiary Audience Profiles

For the purposes of this document, primary beneficiary audiences are defined as those who seek and undergo medical male circumcision, and thus directly receive messages related to MC demand creation and risk mitigation. The following groups constitute primary decision-makers in the process of undergoing male circumcision at the individual level. These audiences have been selected based on epidemiologic priority, homogeneity, overall size, as well as ease of reaching through existing communication channels. Priority audiences identified here are reflective of the priorities outlined in the *National Male Circumcision Strategy and Implementation Plan (2010-2020)*

- 1. *Uncircumcised, HIV negative<sup>3</sup> adolescent males age 15-17:*** HIV prevalence in this age group is low coupled with evidence showing that teenagers are delaying their first sexual debut to 18.5 years. However, this age is most easily influenced by friends, role models and other powerful institutions such as media (local and international). Although adolescents in this age group are not the primary decision-makers for MC, it will be crucial to generate informed demand within this population in order to prime the next cohort of consenting young men. In many cases, these younger adolescents will need to be the primary drivers of MC; requesting permission from their parents or guardians. For those males under the age of 18, many will also not be aware of their HIV status, due to the fact that national consent guidelines do not allow individuals under the age of 15 to receive an HIV test without parental or guardian consent. Young males above the age of consent but under the age of eighteen are also less likely to access health services, including HIV testing<sup>4</sup>. Parents and guardians will need to provide consent for MC and for the recommended HIV testing of underage male children prior to the male circumcision process; those under-age children who test positive for HIV will be discouraged but not prohibited from undergoing circumcision, further these children will be referred for ART support according to MOH guidelines. In terms of male circumcision, this group cannot make independent decisions to go for the procedure as they need parental/guardian consent.
- 2. *Uncircumcised, HIV negative young adult males age 18-25:*** This is a group that is sexually active, single/married and is able to make independent decisions. Laws governing consent for surgical procedures in Zambia stipulate that anyone under the age of 21 must present written parental or guardian consent. However, the MOH National MC Strategy and Implementation Plan states that only males under the age of 18 must provide such consent for MC. Therefore, Zambian males 18 years and above are capable of opting to undergo male circumcision on their own. This means that demand creation efforts can and should be targeted at this population directly. Epidemiological data suggests that the greatest immediate health impact will be among this age group because that's where the most new infections will occur.
- 3. *Uncircumcised, HIV negative adult males age 26-39:*** This is the target group that is mostly sexually active and able to make independent decisions about their sexual lives. Most are married or are thinking about getting married. It's also this group that tends to be prone to multiple concurrent partnerships, a trend that puts them at higher risk of HIV infections.
- 4. *Uncircumcised, HIV negative adult males age 40-49:*** This group tends to have disposable income and is prone to multiple-concurrent relationships with younger women. In urban areas men in this group tend to have established careers and stable income. In the rural area, men from this age group often maintain multiple families. These men are also decision-makers within the home and have a strong influence on the community.

<sup>3</sup> The benefits of male circumcision in terms of HIV prevention are unavailable for HIV positive individuals, and the likelihood of transmission of the virus to an uninfected female partner through unprotected sexual contact is elevated significantly during the healing period (Waver F, et al, 2009). In addition, HIV positive individuals whose immune systems are compromised due to advanced HIV disease run the risk of delayed wound healing and/or more serious complications (Mcombe S, & Short, 2006, Beaten JM, et al, 2009). For these reasons, male circumcision as an HIV prevention method is not recommended for HIV positive males in Zambia (MOH, 2009).

<sup>4</sup> Only 7.9% of males age 15-17 who had sexual intercourse in the previous 12 months reported having been tested for HIV in the past 12 months and receiving their results, compared with 17.7% of similar females (ZDHS, 2007)

**Table 2. Behavioural and Communication Objectives Matrix: Primary Beneficiaries Uncircumcised, HIV negative adolescent males age 15-17**

Behaviour Change Objectives	Key Barriers to Action	Key Motivating Factors	Communication Objectives	Key Messages
Increase the percentage of adolescents aged 15-17 who actively obtain more information about VMMC.	Inadequate information on the availability and benefits of VMMC services.	Social support from friends, family and female partner	To increase the percentage of aged 15-17 adolescents who know the benefits of VMMC, from the 2011 baseline to... by 2015.	VMMC services are available at Government and private health facilities in most districts.
Increase the percentage of adolescents aged 15-17 who seek out and undergo VMMC.	Myths/misconceptions/fear of negative outcomes (pain, damage to penis, loss of infertility, risk of death etc.)	Affective appreciation of functional benefits of VMMC: improved hygiene, HIV/STI prevention.	To increase the percentage of adolescents aged 15-17 who know where VMMC services are available nearest to them, from the 2011 baseline to... by 2015	VMMC is a simple and safe procedure done by qualified medical staff.
Increase the percentage of adolescents aged 15-17 who participate in voluntary HIV counselling and testing prior to undergoing VMMC.	Perceptions of long waiting-time at health facilities.	Affective appreciation of emotional benefits of VMMC: sense of accomplishment and self-confidence; sense of "becoming a man"; identification with /belonging to a recognized group of (circumcised) young men.	To increase the percentage of adolescent males aged 15-17 who know the benefits of VMMC prior to MC from the 2011 baseline to more than.... by 2015	Pain and bleeding are minimal during VMMC when done by qualified medical staff.
Increase the percentage of adolescents aged 15-17 who follow medical instructions regarding abstinence and proper wound care during the healing period.	Perceptions of long healing-time after VMMC.			To get the most benefit from VMMC, it is important to know your HIV status.
Reduce the percentage of adolescents aged 15-17 engaging in risky sexual behaviour after VMMC, including:	Parents do not consent to MC			Follow medical advice for abstinence and proper wound care during the healing period in order to avoid injury, disfigurement or HIV/STI infection.
Abstain from sex and masturbation <b>during</b> the 6-week healing period;	Lack of knowledge about the VMMC procedure			
	Lack of knowledge on immediate benefit of MC			

## Uncircumcised, HIV negative young adult males age 18-25

Behaviour Change Objectives	Key Barriers to Action	Key Motivating Factors	Communication Objectives	Key Messages
Increase the percentage of young men age 18-25 who actively obtain more information about VMMC.	Inadequate information on availability and benefits of VMMC.	Social support from friends, family and female partner. Affective appreciation of functional benefits of VMMC: improved hygiene, HIV/STI prevention.	To increase the percentage of young men age 18-25 who know the benefits of VMMC, from the 2011 baseline to.... by 2015.	VMMC services are available at Government and private health facilities in most districts.
Increase the percentage of young men age 18-25 who seek out and undergo VMMC.	Belief that VMMC offers 100% protection.	Affective appreciation of emotional benefits of VMMC: sense of accomplishment and self-confidence; sense of "becoming a man"; identification with /belonging to a recognized group of distinguished (circumcised) young men.	To increase the percentage of young men age 18-25 who know where VMMC services are available, from the 2011 baseline to.... by 2015.	VMMC is a simple and safe procedure done by qualified medical staff.
Increase the percentage of young men age 18-25 who participate in voluntary HIV counselling and testing prior to undergoing VMMC.	Concerns and perception about pain, bleeding and long healing-time after VMMC. Perceptions of long waiting-time at health facilities.		To increase the percentage of young men age 18-25 who believe VMMC services are safe, from the 2011 baseline to..... by 2015	Pain and bleeding are minimal during VMMC when done by qualified medical staff.
Increase the percentage of young men 18-25 who follow medical instructions regarding abstinence and proper wound care during the healing period. Increase the percentage of young men aged 18-25 who adhere to safe sexual behaviour after VMMC, including:	Concerns about the expertise or proficiency of health facility staff.		To increase the percentage of young men age 18-25 who know VMMC services are offered by well-trained and qualified staff, from the 2011 baseline to..... by 2015.	For good benefit from VMMC, it is important to know your HIV status.
Abstain from sex and masturbation <b>during</b> the 6-week healing period;	Myths/misconceptions: loss of sensitivity, loss of fertility, risk of death, etc.		To increase the percentage of young men aged 18-25 who know the advantages of following medical advice during wound healing period from the 2011 baseline to .... by 2015	Talk to your wife or girlfriend about going for VMMC.
Use condoms correctly and consistently with every sexual partner <b>after</b> the 6-week healing period; and	Highly socializing and likely to abuse alcohol.		To increase the percentage of young men aged 18-25 who know benefits avoiding risky sexual behaviour.	Follow medical advice for abstinence and proper wound care during the healing period in order to avoid injury, disfigurement or HIV/STI infection.
Refrain from multiple or concurrent sexual partners.				Use condoms consistently and correctly with every sexual partner after VMMC.

**Uncircumcised, HIV negative adult males age 26-39**

Behaviour Change Objectives	Key Barriers to Action	Key Motivating Factors	Communication Objectives	Key Messages
<p>Increase the percentage of men age 26-39 who actively obtain more information about VMMC.</p> <p>Increase the percentage of men age 26-39 who seek out and undergo comprehensive VMMC.</p> <p>Increase the percentage of men age 26-39 who participate in voluntary HIV counselling and testing prior to undergoing VMMC.</p> <p>Increase the percentage of men age 26-39 who follow medical instructions regarding proper wound care during the healing period.</p> <p>Increase the percentage of young men aged 26-39 who adhere to safe sexual behaviour after VMMC, including:</p> <p>Abstain from sex and masturbation <b>during</b> the 6-week healing period;</p> <p>Use condoms correctly and consistently with every sexual partner <b>after</b> the 6-week healing period; and</p> <p>Refrain from multiple or concurrent sexual partners.</p>	<p>Inadequate information on availability and the benefits of VMMC.</p> <p>Myths/ Misconception (adverse effects, not enjoying sex, little confidence in health services, male circumcision will prevent HIV by 100%, loss of sensitivity, loss of fertility, risk of death, not suitable for older men, etc.)</p> <p>Concerns and perception about pain, bleeding and long healing-time after VMMC</p> <p>Perceptions of long waiting-time at health facilities.</p> <p>High sexually activity among this group</p> <p>Highly socializing and likely to-abuse alcohol</p>	<p>Social /partner support (girlfriend, family, colleagues) when perceived as cool, when they affectively appreciate the protective benefits of MC</p> <p>Affective appreciation of functional benefits of VMMC: improved hygiene, HIV/STI prevention.</p> <p>Affective appreciation of emotional benefits of VMMC: sense of accomplishment and self-confidence</p> <p>identification with /belonging to a recognized group of distinguished (circumcised) men.</p>	<p>To increase the percentage of men age 26-39 who know where VMMC services are available, from the 2011 baseline to.... by 2015.</p> <p>To increase the percentage of men age 26-39 who know that VMMC is a simple and safe procedure</p> <p>To increase the percentage of young men age 26-39 who know the benefits of VMMC, from the 2011 baseline to.... by 2015.</p> <p>To increase the percentage of men age 26-39 who know the benefits HIV VCT prior to VMMC from the 2011 baseline to more than..... by 2015.</p> <p>To increase the percentage of young men aged 26-39 who know the advantages of following medical advice during wound healing period from the 2011 baseline to ... by 2015</p> <p>To increase the percentage of men aged 26-39 who know benefits avoiding risky sexual behaviour</p>	<p>VMMC services are available at Government and private health facilities in most districts.</p> <p>VMMC is a simple and safe procedure done by qualified medical staff.</p> <p>Know your HIV status before VMMC.</p> <p>Talk to your wife or girlfriend about going for VMMC.</p> <p>Follow medical advice to ensure wound care during the healing period in order to avoid injury, disfigurement or HIV/STI infection.</p> <p>Use condoms consistently and correctly after VMMC MC with every sexual partner.</p> <p>HIV VCT before MC enforces positive living</p> <p>Abstain from sex with circumcised partner during 6-week healing period.</p>

## Uncircumcised, HIV negative adult males age 40-49

Behaviour Change Objectives	Key Barriers to Action	Key Motivating Factors	Communication Objectives	Key Messages
Increase the percentage of men age 40-49 who actively obtain more information about VMMC.	Inadequate information on availability and the benefits of VMMC.	Social support from friends, family and female partner	To increase the percentage of men age 40-49 who know where VMMC services are available, from the 2011 baseline to.... by 2015.	VMMC services are available at Government and private health facilities in most districts.
Increase the percentage of men age 40-49 that seek out and undergo comprehensive VMMC.	Myths/ Misconception (not enjoying sex, little confidence in health services, male circumcision will prevent HIV by 100%, loss of sensitivity, loss of fertility, risk of death, not suitable for older men, etc.)	Affective appreciation of functional benefits of VMMC: improved hygiene, HIV/STI prevention.	To increase the percentage of men age 40-49 who know that VMMC is a simple and safe procedure.	VMMC is a simple and safe procedure done by qualified medical staff.
Increase the percentage of men age 40-49 who participates in voluntary HIV counselling and testing prior to undergoing VMMC.	Concerns and perception about pain, bleeding and long healing-time after VMMC	Affective appreciation of emotional benefits of VMMC: sense of accomplishment and self-confidence	To increase the percentage of men age 40-49 who know the benefits of VMMC, from the 2011 baseline to.... by 2015.	Pain and bleeding are minimal during VMMC when done by qualified medical staff.
Increase the percentage of men age 40-49 who follow medical instructions regarding proper wound care during the healing period.	Perceptions of long waiting-time at health facilities.	Identification with / belonging to a recognized group of distinguished (circumcised) men	To increase the percentage of men age 40-49 who know the benefits HIVVCT prior to VMMC from the 2011 baseline to more than..... by 2015.	o get the most benefit from VMMC, it is important to know your HIV status. Talk to your wife or girlfriend about going for VMMC.
Increase the percentage of men age 40-49 who adhere to safe sexual behaviour after VMMC, including:	High sexually activity among this group		To increase the percentage of young men age 40-49 who know the advantages of following medical advice during wound healing period from the 2011 baseline to .... by 2015.	Follow medical advice for proper wound care during the healing period in order to avoid injury, disfigurement or HIV/STI infection.
Abstain from sex and masturbation during the 6-week healing period, including:	Highly socializing and likely to-abuse alcohol		To increase the percentage of men age 40-49 who know benefits avoiding risky sexual behaviour	Use condoms consistently and correctly with every sexual partner after VMMC.
Use condoms correctly and consistently with every sexual partner after the 6-week healing period; and				
Refrain from multiple or concurrent sexual partners.				

## C. Secondary Audience Profiles

The following secondary audiences include individuals who may influence the actions and behaviours of the primary beneficiaries:

- 1. *Parents and guardians of uncircumcised males, age 0-60 days:*** Early infant MC is a much faster, simpler and cheaper procedure than adult circumcision.<sup>31</sup> Due to the miniature blood vessels in the infant penis, the procedure does not require suturing, and results in less blood loss and lower rates of complications than adult MC. There are a number of devices and techniques that have been recommended for wide-scale use, and the results from a user-acceptability and safety trial will be released soon regarding which method will be most appropriate for the local context. Fathers in particular have been an obstacle to uptake or EIMC, but grandparents and other caregivers are also important target audiences within this group, especially when acting as the primary decision-makers and/or heads of household.
- 2. *Parents and guardians of uncircumcised, HIV negative males age 15-17:*** Given the legal limitations of voluntary consent for MC among children under the age of 18, parents and guardians of male children will be critical decision-makers and hence target audiences for generating informed demand for male circumcision among these younger groups. Children who are either sexually active or near to sexual debut are priority beneficiaries, and so parents of children in the 15-17 age group are thus a priority over other ages.
- 3. *Female partners of uncircumcised, HIV negative males age 15-49:*** Given the potential for increased risky behaviour among circumcised males during and after the healing period, it will be essential to communicate directly to women about the limited protection that male circumcision offers their male sexual partners, and of the complete lack of direct protection against HIV acquisition that male circumcision offers female partners of circumcised men. Female partners of uncircumcised men will play a crucial role in both encouraging men to undergo MC, encouraging men to partake in couples counselling and testing as part of the MC process, and encouraging men to adhere to the recommended sexual abstinence period and other behaviours post-MC.

Behaviour Change Objectives	Key Barriers to Action	Key Motivating Factors	Communication Objectives	Key Messages
<p>Increase the percentage of parents and guardians of uncircumcised males aged 0-60 who actively obtain more information about early infant male circumcision (EIMC).</p> <p>Increase the percentage of parents and guardians of uncircumcised males aged 0-60 who seek comprehensive EIMC services for their infant male children.</p> <p>Increase the percentage parents and guardians who provide informed parental consent for their children to undergo EIMC.</p> <p>Increase the percentage of parents and guardians of uncircumcised males aged 0-60 who follow medical instructions regarding proper wound care for their infants.</p>	<p>Inadequate information on the benefits of EIMC.</p> <p>Inadequate information on availability of EIMC services.</p> <p>Concerns about the safety, expertise or proficiency of EIMC.</p> <p>Myths/misconceptions: loss of fertility, risk of death, not suitable for infants, etc.</p> <p>Father is not circumcised and male children should "be like father"</p>	<p>Feeling of being a good parent or guardian who supports his/her child during the EIMC.</p> <p>Affective appreciation of functional benefits of VMMC: improved hygiene, HIV/STI prevention.</p> <p>Affective appreciation of emotional benefits of VMMC: sense of "being a good mother" for protecting son from future threat of HIV and other STIs.</p>	<p>To increase the percentage of parents and guardians of uncircumcised males aged 0-60 days who know where EIMC services are available nearest to them, from the 2011 baseline to.... by 2015.</p> <p>To increase the percentage of parents and guardians of uncircumcised males aged 0-60 days who have comprehensive knowledge of the benefits and risks of VMMC, from the 2011 baseline to.... by 2015</p> <p>To increase the percentage of parents and guardians of uncircumcised males aged 0-60 days who believe EIMC services are offered by well-trained and qualified staff, from the 2011 baseline to.... by 2015</p> <p>To increase the percentage of parents and guardians of uncircumcised males aged 0-60 days who support EIMC for their children, from the 2011 baseline to..... by 2015</p>	<p>EIMC services are available at Government and private health facilities in most districts.</p> <p>EIMC is a simple and safe procedure done by qualified medical staff.</p> <p>EIMC is the safest and easiest way for males to get circumcised.</p> <p>EIMC reduces the risk of urinary tract infections in male infants.</p> <p>Pain and bleeding are minimal during EIMC when done by qualified medical staff.</p> <p>Follow medical advice for proper wound care during the healing period in order to avoid injury or disfigurement.</p>

Table 3. Behavioural and Communication Objectives Matrix: Secondary Beneficiaries *Parents and guardians of uncircumcised males, age 0-60 days Parents and guardians of uncircumcised, HIV negative males age 15-17*

Behaviour Change Objectives	Key Barriers to Action	Key Motivating Factors	Communication Objectives	Key Messages
Increase the percentage of parents and guardians of uncircumcised males aged 15-17 who actively obtain more information about VMMC.	Inadequate information on the benefits of VMMC. Inadequate information on availability of VMMC services. Myths/misconceptions: loss of fertility, risk of death, not suitable for older children, etc.	Social support from child's father, grandfather and extended family. Affective appreciation of functional benefits of VMMC: improved hygiene, HIV/STI prevention.	To increase the percentage of parents and guardians of uncircumcised males aged 15-17 who know where VMMC services are available, from the 2011 baseline to.... by 2015	VMMC services are available at Government and private health facilities in most districts.  VMMC is a simple and safe procedure done by qualified medical staff.
Increase the percentage of parents and guardians of uncircumcised males aged 15-17 who seek VMMC services for their adolescent children.	Concerns about the expertise or proficiency of health facility staff. Concerns about the safety of VMMC. Cultural identity as "not circumcising".	Affective appreciation of emotional benefits of VMMC: sense of "being a good mother" for protecting son from future threat of HIV and other STIs.	To increase the percentage of parents and guardians of uncircumcised males aged 15-17 who know that VMMC is a simple and safe procedure offered by well-trained and qualified staff, from the 2011 baseline to..... by 2015	Pain and bleeding are minimal during VMMC when done by qualified medical staff.  To get the most benefit from VMMC, it is important for your child to know his HIV status
Increase the percentage of parents and guardians of uncircumcised males aged 15-17 who provide support to their adolescent children to follow medical instructions regarding proper wound care.	Father is not circumcised and male children should "be like father"		To increase the percentage of parents and guardians of uncircumcised males aged 15-17 who know the importance of supporting VMMC for their children, from the 2011 baseline to..... by 2015	Follow medical advice for abstinence and proper wound care during the healing period in order to avoid injury, disfigurement or HIV/STI infection.

**Female partners of uncircumcised, HIV negative males age 15-49**

Behaviour Change Objectives	Key Barriers to Action	Key Motivating Factors	Communication Objectives	Key Messages
<p>Increase the percentage of female partners of uncircumcised males aged 15-49 who actively obtain more information about the risks and benefits of VMMC.</p> <p>Increase the percentage of female partners of uncircumcised males aged 15-49 who talk to their male partner about VMMC.</p> <p>Increase the percentage of female partners of uncircumcised males aged 15-49 who talk to their friends and family members about VMMC.</p> <p>Reduce the percentage of female partners of uncircumcised males aged 15-49 who engage in risky sexual behaviours with circumcised partner(s), including:</p> <p>Abstain from sex during 6-week healing period;</p> <p>Use condoms correctly and consistently with partners after the healing period.</p>	<p>Inadequate information on the benefits of VMMC.</p> <p>Low self-efficacy and lack of skills for initiating dialogue with male partner on reproductive health issues, including VMMC.</p> <p>Lack of social support from friends or extended family members.</p> <p>Misconception about VMMC providing 100% protection from HIV and other STIs</p>	<p>Social support from male partner; friends; extended family members.</p> <p>Affective appreciation of functional benefits of VMMC: improved hygiene of man, HIV/STI prevention; reduced risk of cervical cancer; potential for improved sexual satisfaction.</p> <p>Affective appreciation of emotional benefits of VMMC: sense of "being a responsible partner" by protecting partner and self from future threat of HIV and other STIs.</p>	<p>To increase the percentage of female partners of uncircumcised males aged 15-49 who have comprehensive knowledge of the benefits and risks of VMMC, from the 2011 baseline to..... by 2015</p> <p>To increase the percentage of female partners of uncircumcised males aged 15-49 who know the type of support needed by their partners to undergo VMMC, from the 2011 baseline to..... by 2015</p> <p>To increase the percentage of female partners of uncircumcised males aged 15-49 who know how to initiate a discussion with their partner about VMMC, from the 2011 baseline to..... by 2015</p> <p>To increase the percentage of female partners of uncircumcised males aged 15-49 who understand that VMMC provides only partial protection from HIV and other STIs, from the 2011 baseline to..... by 2015</p>	<p>MC makes it easier for a man to maintain good hygiene of the penis.</p> <p>MC reduces the risk of getting and passing-on the virus that causes cervical cancer in women.</p> <p>MC offers partial protection against HIV and some other STIs.</p> <p>Your partners needs your presence during VMMC</p> <p>Use condoms correctly and consistently with every sexual partner, regardless of whether or not they are circumcised.</p> <p>Abstain from sex with your circumcised partner during 6-week healing period.</p> <p>Talk to your friends and family members about the benefits and risks of VMMC.</p>

## D. Advocacy Audience Profiles

In the context of male circumcision advocacy should be used to improve awareness and create enabling social and political environments at the national and community-levels for rapid and impactful MC scale-up, in line with MoH guidelines. The following are priority audiences for targeted education and advocacy efforts:

**Journalists and Media Spokespersons:** It is imperative that all media houses and members of the press have correct information on adult and neonatal male circumcision so that myths and misinformation are corrected. Male circumcision poses a number of advocacy challenges including addressing negative media coverage, misinformation and resistance from some groups. Consequently, wide support in civil society is necessary. It is important to target journalists and media representatives both to gain support for advocacy efforts and to prevent misrepresentation of MC-related information.

**Politicians and Policy-Makers:** Advocacy with decision-makers at the international, national and community levels is an important mechanism for generating national support and encouraging consensus on the expansion of male circumcision for HIV prevention. Once codified, national-level priorities have a bearing on public and private MC service delivery and communication efforts at all levels. All government sectors should be involved and this must be coordinated at the highest possible level.

**Health Practitioners and Administrators:** In order for male circumcision to become a viable and sustainable programme there is a need to ensure that men and women, communities, policy and decision-makers and health administrators (e.g. programme managers) all have the opportunity to participate in developing supportive communication interventions.

**Leaders of Women's Groups and other Community-Based Organizations (CBOs):** Women may act as powerful advocates or opponents of male circumcision. It is important that woman's groups are engaged in on-going dialogue about MC so that they are well-informed of the benefits and understand the impact that increased coverage of MC will have on them, their partners and sons. Collaboration with women's groups is critical in leveraging MC scale-up as an opportunity to address broader issues that directly affect women, including men's sexual and productive health, shared decision making, gender roles and equality.

**Community and Social Leaders:** According to a qualitative acceptability study conducted in 2007 among men and women in three non-circumcising communities in Zambia, the majority expressed high levels of awareness and interest in MC but, "*would need clear endorsement of circumcision by government and community leaders before they would go themselves or send their sons for the procedure.*"<sup>5</sup> It is essential to identify community-level actors who may aid or inhibit individual adoption of male circumcision-seeking behaviour and even moderate risky sexual behaviours.

**Traditional and Religious Leaders:** Community leaders have a great deal of influence in personal decisions about health and other family practices in Zambia. Traditional leaders therefore have an important role to play in leading advocacy efforts at the national and community level, and should be engaged early and substantively in the development and planning of MC demand creation messages and activities.

**Representatives from Vulnerable Groups:** The *National Male Circumcision Programme* could have an unforeseen impact on various sectors of the population, including women, young people

5 Sheena Carey and Steve Gesuale. Zambia (2007): Preliminary Findings on Target Group Profiles and Perceptions about the Brand, Product and Place regarding the Provision of Male Circumcision Services to Men (15 to 30 years)

and vulnerable subgroups such as people with HIV infection. It is therefore important that their representatives and advocates be involved in developing and delivering advocacy messages surrounding male circumcision.

**Table 4. Behaviour and Communication Matrix: Advocacy Audiences**

Advocacy Audiences	Behavioural Objectives	Key Barriers to Action	Key Motivating Factors	Communication Objectives	Key Messages
Journalists and Media Spokespersons.	To increase the number of journalists and media spokespersons who write or talk about VMMC in an informed way.	Lack of correct information on adult and early infant MC. Lack of understanding of where to get complete information about VMMC.	To generate media attention and interest.	To increase the number of journalists and media spokespersons with comprehensive information about adult and early infant MC.	VMMC is a topic that is likely to get the public's attention.  Write articles and do documentary about VMMC
Politicians and Policy Makers.	To increase the number of politicians and policy makers who publicly express their support for the expansion of VMMC for HIV prevention.	Lack of correct information on adult and early infant MC. Lack of understanding of the level of support for VMMC among the public and among other policy-makers.	To respond to broad public support for VMMC among the constituency.	To increase the number of politicians and policy makers with comprehensive information about adult and early infant MC.	VMMC is one strategy against the spread of HIV.  Zambia needs your voice on VMMC
Health Practitioners and Administrators	To increase the number of health practitioners and administrators who contribute to the implementation of VMMC service delivery and communication activities.	Lack of correct information on adult and EIMC. Lack of understanding of their role in VMMC implementation. Competing health sector priorities.	To respond to calls for implementation of VMMC from within the medical establishment.  To reduce the incidence of HIV within their communities.	To increase the number of health practitioners and administrators with comprehensive information about adult and EIMC;  Increase the number of health practitioners and administrators who understand their role in VMMC implementation.	You are key in the expansion of VMMC for HIV prevention.

Advocacy Audiences	Behavioural Objectives	Key Barriers to Action	Key Motivating Factors	Communication Objectives	Key Messages
Leaders of Women's Groups	To increase the number of women leaders who publicly express their support for the expansion of VMMC and contribute to the implementation of communication activities.	Lack of correct information on adult and EIMC. Lack of understanding of where to get complete information about VMMC.	To ensure VMMC expansion efforts address the needs of women and girls. To reduce the incidence of HIV and cervical cancer within the community.	To increase the number of leaders for women's groups with comprehensive information about adult and early infant MC; Increase the number of leaders of women's groups who understands their role in VMMC communication activities.	VMMC can reduce the level of HIV and cervical cancer among women in the community. Women have a key role to play in the promotion of VMMC.
Community and Social Leaders	To increase the number of community and social leaders who publicly express their support for the expansion of VMMC and contribute to the implementation of communication activities.	Lack of correct information on adult and EIMC. Lack of understanding of where to get complete information about VMMC. Not well-informed of the benefits and understand the impact that increased coverage of MC Lack of clear endorsement of circumcision by government and community leaders	To respond to calls for implementation of VMMC from within the community. To reduce the incidence of HIV within the community.	To increase the number of community and social leaders with comprehensive information about adult and early infant MC; Increase the number of community and social leaders who understand their role in VMMC communication activities.	VMMC can reduce the level of HIV in the community. All community leaders have a key role to play in the promotion of VMMC.

Advocacy Audiences	Behavioural Objectives	Key Barriers to Action	Key Motivating Factors	Communication Objectives	Key Messages
Traditional and Religious Leaders	To increase the number of traditional and religious leaders who publicly express their support for the expansion of VMMC and contribute to the implementation of communication activities.	Lack of correct information on adult and EIMC. Lack of understanding of where to get complete information about VMMC.	To respond to calls for implementation of VMMC from within the community. To reduce the incidence of HIV within the community.	To increase the number of traditional and religious leaders with comprehensive information about adult and early infant MC; increase the number of traditional and religious leaders who understand their role in VMMC communication activities.	VMMC can reduce the level of HIV in the community. All community leaders have a key role to play in the promotion of VMMC.
Representatives from Vulnerable Groups	To increase the number of representatives from vulnerable groups who publicly express their support for the expansion of VMMC and contribute to the implementation of communication activities.	Lack of correct information on adult and EIMC. Lack of understanding of where to get complete information about VMMC Not knowing their role in VMMC	To ensure VMMC expansion efforts meet the needs of vulnerable groups.	To increase the number of representatives from vulnerable groups with comprehensive information about adult and early infant MC; Increase the number of representative from vulnerable groups who know their role in VMMC communication activities.	VMMC can reduce the level of HIV in the community. All community leaders have a key role to play in the promotion of VMMC.

## E. VMMC Key Messages

The execution of VMMC-related communication and advocacy messages should be audience-specific and based on a solid understanding of the unique characteristics of each intended recipient group. Communication messages should be thoroughly pre-tested with representative members of the intended audience before being made public, in order to increase the likelihood that the message will contribute to the outlined priority communication objectives and result in the priority behavioural outcomes listed above. Executions should be regularly updated according to new behavioural evidence and changing trends in knowledge, attitudes, motivations and other factors influencing the uptake of VMMC services. Annex I contains detailed audience profiles and suggestions for appropriate message characteristics for each priority beneficiary and advocacy audience.

While diversity of message execution is encouraged, the content of all print, radio, television, verbal, or other communication media used to promote VMMC services should be consistent with a standard set of critical and complete VMMC information, listed below. While it may not be possible to communicate all critical information about VMMC at all times and through all channels, the following summarized compendium of critical information should be made available to the public, in the preferred language of the community, as part of any and all VMMC promotion or demand generation activities.<sup>6</sup>

This critical VMMC information compendium has been organized into seven categories: *Benefits, Risks, Partial Protection, Eligibility, and Preparation for MC, Wound Care & Healing, and Cultural Neutrality.*

<sup>6</sup> National MC Communication efforts should offer the public the option of getting more detailed information in local languages from a toll-free hotline service that is staffed by trained medical personnel.

### Benefits of VMMC

- MC provides partial protection for men against HIV and some other sexually transmitted infections (STIs) such as herpes, syphilis, chancroid, and human papilloma virus, as well as cancer of the penis.
- MC can make it easier for a man to clean and maintain good hygiene of the penis.
- MC can reduce the risk of getting and passing-on the virus that causes cervical cancer in women.
- MC for male children can reduce the risk of urinary tract infections.

### Risks of VMMC

- MC is a surgical procedure, and as such may result in certain complications such as bleeding, swelling, and/or some pain during the healing process.
- There is a small chance of more serious complications, especially if the MC provider is not adequately trained, or if wound care instructions are not followed. Speak to your provider about these risks before you undergo the procedure.
- MC is most safe when done under local anaesthesia, meaning you will be awake during the procedure.

### Partial Protection Offered by VMMC

- MC does not provide 100% protection from HIV and other STIs; a circumcised man can still get HIV and other STIs.
- MC does not cure a man who is infected with HIV.
- MC does not protect a woman from contracting HIV or other STIs from her male partner.
- MC should not replace other HIV and STI preventive methods such as abstinence, mutual fidelity, & correct and consistent condom use.

### Eligibility for VMMC

- The Ministry of Health recommends voluntary medical male circumcision for all HIV negative males who are physically suitable to undergo the procedure under local anaesthesia; certain medical conditions may render men ineligible.
- Under the current national guidelines Children aged 60 days to 7 (seven) years are not eligible for VMMC for safety reasons.
- HIV positive men are discouraged to undergo male circumcision, but shall not be denied the service unless they are deemed medically unfit by a qualified health provider.
- Caretaker to male new-borns are encouraged to take their children for
- Early infant medical male circumcision by trained health care providers before the age of 60 days.
- Written or documented parental or guardian consent is required for new-borns to 17 (seventeen years)
- Written or documented client consent is required for any client age 18 years and above.
- Clients under the age of 18 who report that they do not have a parent or guardian to provide consent shall be referred to the appropriate resources at the Ministry of Community Development and Social Welfare to provide consent.

### Preparation for VMMC

- It is important to identify an MC Service centre or clinic with qualified and trained health care providers that meet the minimum standards outlined by the Ministry of Health and the Health Professionals Council of Zambia.
- Clients planning to undergo MC should take care to wash themselves thoroughly the day of the procedure before arriving at the clinic and to wear a pair of clean, loose-fitting underpants in order to help reduce the chance of post-MC wound infection.
- It is best to wear loose-fitting pants with a belt or drawstring on the day of MC.
- It is important to eat in the morning before going to the clinic for MC.
- Clients undergoing MC will need to plan to return to the clinic where the MC was performed for a clinical review 48 hours after the procedure as well as one week after the procedure to monitor proper healing, or as instructed by the health care provider.

### Wound Care and Healing After VMMC

- Clients undergoing MC should plan to rest for one or two days after the procedure and should avoid highly physical activity for up to seven days after the procedure to promote proper wound healing.
- Clients undergoing MC should carefully follow the instructions of their health care provider regarding wound washing and wound care to avoid unnecessary complications.
- Clients undergoing MC must refrain from all sexual activity and masturbation for at least six weeks after the procedure to allow for proper wound healing and to avoid increased risk of wound infection.

### Cultural Neutrality of VMMC

- In promoting voluntary medical male circumcision, the Government of the Republic of Zambia does not disregard the symbolic and cultural importance that male circumcision holds among Zambia's rich and diverse traditions and history but emphasis is placed on safety of the procedure
- Voluntary medical male circumcision (MC) is currently being promoted by the Government of the Republic of Zambia, as well as by the World Health Organization, due to the recently discovered HIV and STI preventive benefits of the procedure.
- The promotion of male circumcision by the Ministry of Health and its collaborating partners, as part of the nation's comprehensive HIV prevention strategy, must not conflict with the long-standing position of ethnic and cultural neutrality.
- The Government of the Republic of Zambia acknowledges the important contributions of traditional leaders and traditional male circumcision rites and rituals in the promotion and preservation of ethical and cultural values and practices, and wishes to support existing cultural practices by strengthening associated surgical and infection prevention procedures through the introduction of voluntary medical male circumcision, in order to contribute to the health and wellbeing of all Zambians.

## F. VMMC Communication Channels

The selection of appropriate communication channels must also be audience-specific and evidence-based. Four categories of communication channels that will be essential for the successful implementation of the *National VMMC Operational Plan* are described below: targeted advocacy, mass media, mid-media and interpersonal communications (IPC). Annex I contains detailed suggestions for appropriate channels to be used for each priority beneficiary and advocacy audience.

1. **Targeted Advocacy:** This approach refers to the critical process of identifying and engaging influential "gate-keepers" who will have a critical bearing on the behaviour of those

under their direct or indirect influence. These may include policy-makers, administrators, celebrities or community leaders. Prior to the initiation of any VMMC promotional efforts within a given community, it is essential that credible representatives of Government and/or civil society meet with influential decision-makers within a given community to explain the intentions and rationale for the introduction of VMMC services. Only when community leaders have given their blessing should informed demand generation efforts begin.

2. **Mass Media:** These channels include all forms of radio, television, e-mail, SMS and any widely-distributed print media such as newspapers, magazines or even billboards that reach large masses or segments of the population. These channels are best for reaching broader (and hence less targeted) audiences with simple and concise messages. Selecting the right broadcasting channels and the right timing for airing of mass media will depend on the intended audience.
3. **Mid-Media:** This refers to promotional activities that are aimed at large groups, such as public announcements using loud speakers, presentations, speeches, special promotional events, posters, drama group presentations, etc. Lessons learned to date for effective promotion of male circumcision indicate that interactive group sessions led by knowledgeable and credible spokespersons are the most efficient method of generating informed demand. Community-level drama shows and presentations to large groups of 50+ people have not proven as successful, though more rigorous evaluation of these approaches is needed. Though limited in its reach, **social media** also fits within this category, and has promise as a channel for engaging young people in open discussions and for sharing personal experiences and thoughts about MC with large groups of friends and family members.
4. **Inter-Personal Communications:** This category encompasses one-to-one and small group interactions, ideally led by one or more informed and motivated spokespersons. IPC has proven to be the single most effective method to date for generating informed demand for male circumcision in Zambia. This may be because the complexity of male circumcision as a medical procedure, as well as the opinion on benefits and risks of partial protection, require longer-format and interactive community-based discussions to allow potential clients and community leaders to ask questions and receive complete information to allay fears and any misconceptions.

## G. Implementation Timeline

See annex1 which outlines the specific activities that must be achieved during the first year of implementation of this National Communications & Advocacy Strategy. All activities are aligned to the National Operational Plan.

# 4. Monitoring and Evaluation

## A. Objectives of Monitoring and Evaluation Plan

Monitoring and evaluation of the National Male Circumcision Communication and Advocacy Strategy is essential for tracking the performance of the strategy and assessing progress towards achieving the strategy's stated goal and objectives. The M&E plan will serve to provide guidance to all partners, including public and civil society organizations, on how to monitor and evaluate their IEC/BCC activities related to male circumcision. This will help to harmonize monitoring and evaluation efforts across partners and streamline information to track progress towards the goal and objectives outlined within the strategy. This M&E plan has been developed in line with the 2011-2015 National HIV/AIDS/STI/TB M&E plan.

The specific objectives of the monitoring and evaluation (M&E) plan are threefold:

1. To provide relevant and timely information to determine if the strategy and related activities are being implemented as planned and reaching the targeted audiences.
2. To provide information to make any necessary adjustments to the strategy and related activities to improve the effectiveness of the national strategy.
3. To evaluate whether the strategy has met its stated objectives and intended impact.

## B. Monitoring and Evaluation Strategy

The M&E strategy is based upon the overarching goal, the corresponding behavioral and communication objectives, and the major communication activities outlined within this strategy. The M&E strategy consists of a set of illustrative process and output level indicators that can be used to guide the monitoring and evaluation of the IEC/BCC activities implementation and reach. They will need to be selected and tailored to fit each implementing partner's specific needs, based on the activities that they are responsible for implementing. The M&E strategy also consists of a set of outcome level indicators for measuring progress towards the strategy's goal and behavioural and communication objectives; data sources for indicators; a data collection and reporting plan; and an evaluation plan.

## C. Performance Monitoring Indicators

Process and output level indicators are important to monitor in order to track the progress of implementation of communication activities and to ensure that the specific activities are reaching their targeted audiences. Table 5 provides a set of illustrative process and output level indicators to be used to track the four main categories of communication activities outlined within the National Strategy, including: targeted advocacy, mass media, mid-media and inter-personal communication. These indicators are intended to serve as a guide for implementing partners and should be tailored according to each implementer's set of activities.

**Table 5. Process and Output-Level Indicators for Monitoring Activity Implementation and Reach**

Indicator	Disaggregation	Data Source
<b>Process Level Indicators</b>		
IEC/BCC activities/ interventions developed based on existing evidence and/or formative research	N/A	Formative research report, communication strategy document, literature review
IEC/BCC activities/ interventions developed according to GRZ national standards/guidelines	N/A	Activity reports
IEC/BCC activities and materials reviewed by the IEC/ BCC Technical Working Group	N/A	TWG meeting reports
# of communication channels used by activities/campaign	N/A	Activity/campaign reports
# of materials produced	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Type of material (leaflets, folders, t-shirts, job aides, counselling materials, etc.)</li> </ul>	CSO/NGO reports
# of radio/TV spots produced	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Radio/TV</li> <li>• Type of message</li> </ul>	CSO/NGO reports, media company reports
# of radio/TV testimonials produced	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Radio/TV</li> </ul>	CSO/NGO reports, media company reports
# of billboards/wall paintings posted	N/A	CSO/NGO reports, media company reports
# of newspaper inserts/articles developed	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Type of message</li> </ul>	CSO/NGO reports
# of training workshops held	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Type/content of training</li> <li>• Group targeted for training (e.g. health providers, community leaders, etc.)</li> </ul>	CSO/NGO training reports
# of health talking points and presentation materials produced	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Audience for talking points (e.g. policy-makers, advocacy groups, etc.)</li> </ul>	CSO/NGO reports

Indicator	Disaggregation	Data Source
<b>Indicators for Monitoring Implementation of Activities</b>		
# of promotional advertisements aired per week/month	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Communication channel (TV, radio)</li> <li>• Type of advertisement</li> </ul>	CSO/NGO reports, media plans/reports
# of radio spots aired per week/month	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Radio channel</li> <li>• Type of radio spot</li> <li>• Level (e.g. national/community)</li> </ul>	CSO/NGO reports, media plans/reports
# of TV spots aired per week/month	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• TV channel</li> <li>• Type of radio spot</li> <li>• Level (e.g. national/community)</li> </ul>	CSO/NGO reports, media plans/reports
# of SMS messages sent out per week/month	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Audience</li> <li>• Type of message</li> </ul>	CSO/NGO reports, SMS company records
# of materials placed or mounted	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Type of material (posters, flyers, bumper stickers, billboards, branding placed on buses or walls, etc.)</li> </ul>	CSO/NGO reports
# of materials distributed	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Type of material (leaflets, folders, t-shirts, job aides, etc.)</li> </ul>	CSO/NGO reports
# of newspaper inserts/articles produced and disseminated	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Type of health newspaper insert</li> <li>• Newspaper</li> </ul>	CSO/NGO reports
# of one-on-one or small group activities conducted	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Sex</li> <li>• Age-group</li> <li>• Type/content of message</li> </ul>	CSO/NGO reports

Indicator	Disaggregation	Data Source
# of promotional events held	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Location (e.g. Province/District)</li> <li>• Type of event (e.g. community drama, special promotional event, presentation, etc.)</li> </ul>	CSO/NGO reports
# of people trained IEC/BCC for male circumcision	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Sex</li> <li>• Group targeted (community and social leaders, traditional and religious leaders, health providers, etc.)</li> <li>• Type of training</li> </ul>	CSO/NGO reports
# of community leaders and/or policy-makers/politicians involved in advocacy efforts	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Sex</li> <li>• Type of leader/policy-maker</li> </ul>	CSO/NGO reports
<b>Indicators for Monitoring Reach of Activities</b>		
# of individuals reached through interpersonal communication activities	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Sex</li> <li>• Age group</li> <li>• Type of message</li> <li>• One-on-one vs. Small group</li> </ul>	CSO/NGO reports
% of audience who recall (spontaneously and aided/prompted) seeing and/or hearing about male circumcision activities/campaign	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Spontaneously vs. aided/prompted</li> <li>• Sex</li> <li>• Urban/rural</li> <li>• Type of communication channel</li> </ul>	Rapid survey
% of audience who recall a specific component or characteristic (spontaneously and aided/prompted) from male circumcision activities/campaign	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Spontaneously vs. aided/prompted</li> <li>• Sex</li> <li>• Urban/rural</li> <li>• Type of communication channel</li> </ul>	Rapid survey

Indicator	Disaggregation	Data Source
% of audience who recall a hearing or seeing (spontaneously and aided/prompted) a specific health message from male circumcision activities/campaign	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Spontaneously vs. aided/prompted</li> <li>• Sex</li> <li>• Urban/rural</li> <li>• Type of communication channel</li> </ul>	Rapid survey

#### D. Evaluation Indicators

Table 6 outlines the set of outcome level indicators that will be used to evaluate whether the strategy achieved its overarching goal (to increase the percentage of uncircumcised males who undergo voluntary medical male circumcision) and had an impact on the behavioural and communication objectives. These indicators measure the changes we expect to see in knowledge, attitudes, and beliefs, and in behaviour among the different primary and secondary audiences. These indicators are intended to be measured at baseline and in 2015 to assess for change over the life of the implementation of the strategy.

**Table 6. Outcome Level Indicators for Evaluating National VMMC Strategy**

Goal	Indicator	Disaggregation	Data Source
To increase the percentage of uncircumcised males aged 15-49 who undergo voluntary medical male circumcision	% of uncircumcised males aged 15-49 who have undergone voluntary medical male circumcision according to national standards	<i>Disaggregated by:</i> – Age group (15-17, 18-25,25-39, 40-49) – Urban/Rural – Region	ZDHS  HMIS records
To increase the percentage of uncircumcised male neonates aged 0 – 60 days who undergo early infant male circumcision	% of uncircumcised neonates aged 0-60 days who have undergone early infant medical circumcisio	<i>Disaggregated by:</i> – Urban/Rural – Region	HMIS records

Behavioural Objective	Indicator	Disaggregation	Data Source
<b>Primary Audience: Uncircumcised HIV negative males aged 15-49</b>			
Increase the percentage of uncircumcised males aged 15-49 who actively seek information about voluntary medical male circumcision	% of uncircumcised males aged 15-49 who sought information about voluntary medical male circumcision	<i>Disaggregated by:</i> – Age group (15-17, 18-25,25-39, 40-49) – Urban/Rural – Region	Special Survey (NAC)
Increase the percentage of uncircumcised males aged 15-49 who participate in voluntary HIV counselling and testing prior to undergoing voluntary medical male circumcision	% of uncircumcised males aged 15-49 who received voluntary HIV counselling and testing prior to undergoing voluntary medical male circumcision	<i>Disaggregated by:</i> – Age group (15-17, 18-25,25-39, 40-49) – Urban/Rural – Region	HMIS records, NACMIS
<b>Primary Audience: Circumcised HIV negative males aged 15-49</b>			
Increase the percentage of circumcised males aged 15-49 who follow medical instructions regarding abstinence and proper wound care during the healing period after medical male circumcision	% of males (15-49) circumcised who return at least once, for post-operative follow up care within 14 days after medical MC  % of circumcised males aged 15-49 who followed medical instructions regarding proper wound care during the healing period after medical male circumcision	<i>Disaggregated by:</i> – Age group (15-17, 18-25,25-39, 40-49) – Urban/Rural – Region	HMIS  Special Survey

Behavioural Objective	Indicator	Disaggregation	Data Source
<p>Increase the percentage of circumcised males aged 15-49 who adhere to safe sexual behaviour after voluntary medical male circumcision, including:</p> <p>Abstaining from sex and masturbation <b>during</b> the 6-week healing period;</p> <p>Using condoms correctly and consistently with every sexual partner <b>after</b> the 6-week healing period; and</p> <p>Refraining from multiple or concurrent sexual partners.</p>	<p>% of circumcised males aged 15-49 who have adhered to safe sexual behaviour after voluntary medical male circumcision</p> <p>% of circumcised males aged 15-49 who abstained from sex and masturbation during the 6-week healing period after undergoing medical male circumcision</p> <p>% of circumcised males aged 15-49 who used condoms correctly and consistently with every sexual partner after the 6-week healing partner</p> <p>% of circumcised males aged 15-49 who have not had multiple or concurrent sexual partners after undergoing medical male circumcision</p>	<p><i>Disaggregated by:</i></p> <ul style="list-style-type: none"> <li>- Age group (15-17, 18-25,25-39, 40-49)</li> <li>- Urban/Rural</li> <li>- Region</li> </ul>	Special Survey
<b>Secondary Audience: Parents and guardians of uncircumcised HIV negative males aged 15-17</b>			
Increase the percentage of parents and guardians of uncircumcised males aged 15-17 who actively obtain more information about voluntary medical male circumcision	% of parents and guardians of uncircumcised males aged 15-17 who sought information about voluntary medical male circumcision	<p><i>Disaggregated by:</i></p> <ul style="list-style-type: none"> <li>- Urban/Rural</li> <li>- Region</li> </ul>	Special Survey (NAC)
Increase the percentage of parents and guardians of uncircumcised males aged 15-17 who seek voluntary medical male circumcision services for their adolescent children	% of parents and guardians of uncircumcised males aged 15-17 who sought voluntary medical male circumcision services for their adolescent children	<p><i>Disaggregated by:</i></p> <ul style="list-style-type: none"> <li>- Urban/Rural</li> <li>- Region</li> </ul>	Special Survey (NAC)

Behavioural Objective	Indicator	Disaggregation	Data Source
Increase the percentage of parents and guardians of uncircumcised males aged 15-17 who provide informed parental consent for their adolescent children to undergo voluntary medical male circumcision services	% number of parents and guardians of uncircumcised males aged 15-17 who provide informed parental consent for their adolescent children to undergo voluntary medical male circumcision services	<i>Disaggregated by:</i> – Urban/Rural – Region	HMIS records
Increase the percentage parents and guardians of uncircumcised males aged 15-17 who provide support to their adolescent children to follow medical instructions regarding proper wound care	% parents and guardians of uncircumcised males aged 15-17 who provided support to their adolescent children to follow medical instructions regarding proper wound care	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
<b>Secondary Audience: Parents and guardians of uncircumcised males aged 0-60 days</b>			
Increase the percentage of parents and guardians of uncircumcised males aged 0-60 days who actively obtain more information about early infant male circumcision	% parents and guardians of uncircumcised males aged 0-60 days who sought information about early infant male circumcision	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
Increase the percentage of parents and guardians of uncircumcised males aged 0-60 days who seek comprehensive and high-quality early infant male circumcision services for their infant male children	% of parents and guardians of uncircumcised males aged 0-60 days who seek comprehensive and high-quality early infant male circumcision services for their infant male children	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
Increase the percentage of parents and guardians of uncircumcised males aged 0-60 days who provide informed parental consent for their children to undergo early infant male circumcision	% parents and guardians of uncircumcised males aged 0-60 days who provide informed parental consent for their children to undergo early infant male circumcision	<i>Disaggregated by:</i> – Urban/Rural – Region	HMIS records
Increase the percentage of parents and guardians of uncircumcised males aged 0-60 days who follow medical instructions regarding proper wound care for their infants	% parents and guardians of uncircumcised males aged 0-60 days who follow medical instructions regarding proper wound care for their infants	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)

Behavioural Objective	Indicator	Disaggregation	Data Source
<b>Secondary Audience: Female partners of uncircumcised HIV negative males aged 15-49</b>			
Increase the percentage of female partners of uncircumcised males aged 15-49 who actively obtain more information about the risks and benefits of voluntary medical male circumcision	% of female partners of uncircumcised males aged 15-49 who sought information about the risks and benefits of voluntary medical male circumcision	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
Increase the percentage of female partners of uncircumcised males aged 15-49 who talk to their male partner about voluntary medical male circumcision	% of female partners of uncircumcised males aged 15-49 who have talked to their male partner about voluntary medical male circumcision	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
Increase the percentage of female partners of uncircumcised males aged 15-49 who talk to their friends and family members about voluntary medical male circumcision	% of female partners of uncircumcised males aged 15-49 who have talked to their friends and family members about voluntary medical male circumcision	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
Reduce the percentage of female partners of uncircumcised males aged 15-49 who engage in risky sexual behaviours with circumcised partner(s), including:  Abstaining from sex during 6-week healing period; and  Using condoms correctly and consistently with circumcised male partners after the healing period.	% of female partners of uncircumcised males aged 15-49 who engage in risky sexual behaviours with circumcised partner  % of female partners of uncircumcised males aged 15-49 who have abstained from sex with their partner during the 6-week healing period of their partner  % of female partners of uncircumcised males aged 15-49 who have used condoms correctly and consistently with their partner after the healing period	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
<b>Advocacy Audiences</b>			
To increase the number of journalists and media spokespersons who write or talk about voluntary medical male circumcision	# of journalist and media spokespersons who write or talk about voluntary medical male circumcision	N/A	Special Survey (NAC)

Behavioural Objective	Indicator	Disaggregation	Data Source
To increase the number of politicians and policy-makers who publicly express their support for the expansion of voluntary medical male circumcision services for HIV prevention	# of politicians and policy-makers who publicly express their support for the expansion of voluntary medical male circumcision services for HIV prevention	N/A	Special Survey (NAC)
To increase the number of health practitioners and administrators who contribute to the implementation of voluntary medical male circumcision service delivery and communication activities	# of health practitioners and administrators who contribute to the implementation of voluntary medical male circumcision service delivery and communication activities	N/A	Special Survey (NAC)
To increase the number of women leaders who publicly express their support for the expansion of voluntary medical male circumcision and contribute to the implementation of communication activities	# of women leaders who publicly express their support for the expansion of voluntary medical male circumcision services  # of women leaders who are engaged in community mobilisation for MC	N/A	Special Survey (NAC)
To increase the number of community and social leaders who publicly express their support for the expansion of voluntary medical male circumcision and contribute to the implementation of communication activities	# of community and social leaders who publicly express their support for the expansion of voluntary medical male circumcision services  # of community and social leaders who are engaged in community mobilisation for MC	N/A	Special Survey (NAC)
To increase the number of traditional and religious leaders who publicly express their support for the expansion of voluntary medical male circumcision and contribute to the implementation of communication activities	# of traditional and religious leaders who publicly express their support for the expansion of voluntary medical male circumcision services  # of traditional and religious leaders who are engaged in community mobilisation for MC	N/A	Special Survey (NAC)

Behavioural Objective	Indicator	Disaggregation	Data Source
To increase the number of representatives from vulnerable groups who publicly express their support for the expansion of voluntary medical male circumcision and contribute to the implementation of communication activities	# of representatives from vulnerable groups who publicly express their support for the expansion of voluntary medical male circumcision services  # of representatives from vulnerable groups who are engaged in community mobilisation for MC	N/A	Special Survey (NAC)
Increase PMTCT centres integrated with MC services	% of PMTCT centres integrated with VMMC services	N/A	HMIS
<b>Primary Audience (Uncircumcised Males Aged 15-49)</b>			
To increase the percentage of uncircumcised males aged 15-49 who know the benefits of voluntary medical male circumcision	% of uncircumcised males aged 15-49 who know the benefits of voluntary medical male circumcision	<i>Disaggregated by:</i> – Age group (15-17, 18-25,25-39, 40-49)  – Urban/Rural  – Region	Special Survey (NAC)
To increase the percentage of uncircumcised males aged 15-49 who know where voluntary medical male circumcision services are available nearest to them	% of uncircumcised males aged 15-49 who know where to access voluntary medical male circumcision services	<i>Disaggregated by:</i> – Age group (15-17, 18-25,25-39, 40-49)  – Urban/Rural  – Region	Special Survey (NAC)
To increase the percentage of uncircumcised males aged 18-25 whom believe that voluntary medical male circumcision services are safe	% of uncircumcised males aged 15-49 whom believe that voluntary medical male circumcision services are safe	<i>Disaggregated by:</i> – Urban/Rural  – Region	Special Survey (NAC)
To increase the percentage of uncircumcised males aged 25-49 who know that voluntary medical male circumcision is a simple and safe procedure	% of uncircumcised males aged 25-49 who know that voluntary medical male circumcision is a simple and safe procedure	<i>Disaggregated by:</i> – Age group (25-39, 40-49)  – Urban/Rural  – Region	Special Survey (NAC)

Behavioural Objective	Indicator	Disaggregation	Data Source
To increase the percentage of uncircumcised males aged 18-25 who believe voluntary medical male circumcision services are offered by well-trained and qualified staff	% of uncircumcised males aged 18-25 who believe voluntary medical male circumcision services are offered by well-trained and qualified staff	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
To increase the percentage of uncircumcised males aged 25-49 who know the benefits of HIV voluntary counselling and testing prior to voluntary male medical circumcision	% of uncircumcised males aged 25-49 who know the benefits of HIV voluntary counselling and testing prior to voluntary male medical circumcision	<i>Disaggregated by:</i> – Age group (25-39, 40-49) – Urban/Rural – Region	Special Survey (NAC)
To increase the percentage of uncircumcised males aged 15-49 who know the benefits of following medical advice during the wound healing period after voluntary medical male circumcision	% of uncircumcised males aged 15-49 who know the benefits of following medical advice during the 6 week healing period after voluntary medical male circumcision	<i>Disaggregated by:</i> – Age group (15-17, 18-25, 25-39, 40-49) – Urban/Rural – Region	Special Survey (NAC)
To increase the percentage of uncircumcised males aged 18-49 who know the benefits of avoiding risky sexual behaviour	% of uncircumcised males aged 18-49 who know the benefits of avoiding risky sexual behaviour	<i>Disaggregated by:</i> – Age group (18-25, 25-39, 40-49) – Urban/Rural – Region	Special Survey (NAC)
<b>Secondary Audiences: Parents and guardians of uncircumcised males aged 15-17</b>			
To increase the percentage of parents and guardians of uncircumcised males aged 15-17 who know where voluntary medical male circumcision services are available nearest to them	% of parents and guardians of uncircumcised males aged 15-17 who know where to access voluntary medical male circumcision services	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
To increase the percentage of parents and guardians of uncircumcised males aged 15-17 who know that voluntary medical male circumcision is a simple and safe procedure offered by well-trained and qualified staff	% of parents and guardians of uncircumcised males aged 15-17 who know that voluntary medical male circumcision is a simple and safe procedure offered by well-trained and qualified staff	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)

Behavioural Objective	Indicator	Disaggregation	Data Source
To increase the percentage of parents and guardians of uncircumcised males aged 15-17 who believe voluntary medical male circumcision services are safe	% of parents and guardians of uncircumcised males aged 15-17 whom believe that voluntary medical male circumcision services are safe	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
To increase the percentage of parents and guardians of uncircumcised males aged 15-17 who believe voluntary medical male circumcision services are offered by well-trained and qualified staff	% of parents and guardians of uncircumcised males aged 15-17 who believe voluntary medical male circumcision services are offered by well-trained and qualified staff	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
To increase the percentage of parents and guardians of uncircumcised males aged 15-17 who know the importance of supporting voluntary medical male circumcision for their children	% of parents and guardians of uncircumcised males aged 15-17 who know the importance of supporting voluntary medical male circumcision for their children	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
<b>Secondary Audiences: Parents and guardians of uncircumcised males aged 0-60 days</b>			
To increase the percentage of parents and guardians of uncircumcised males aged 0-60 days who know where early infant male circumcision services are available nearest to them	% of parents and guardians of uncircumcised males aged 0-60 days who know where to access early infant male circumcision services	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
To increase the percentage of parents and guardians of uncircumcised males aged 0-60 days who have comprehensive knowledge of the benefits and risks of voluntary medical male circumcision	% of parents and guardians of uncircumcised males aged 0-60 days who know the benefits and risks of voluntary medical male circumcision	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
To increase the percentage of parents and guardians of uncircumcised males aged 0-60 days who believe early infant male circumcision services are offered by well-trained and qualified staff	% of parents and guardians of uncircumcised males aged 0-60 days who believe early infant male circumcision services are offered by well-trained and qualified staff	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)

Behavioural Objective	Indicator	Disaggregation	Data Source
To increase the percentage of parents and guardians of uncircumcised males aged 0-60 days who support early infant male circumcision for their children	% of parents and guardians of uncircumcised males aged 0-60 days who support early infant male circumcision for their children	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
<b>Female partners of uncircumcised males aged 15-49</b>			
To increase the percentage of female partners of uncircumcised males aged 15-49 who have comprehensive knowledge of the risks and benefits of voluntary medical male circumcision	% of female partners of uncircumcised males aged 15-49 who know the risks and benefits of voluntary medical male circumcision	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
To increase the percentage of female partners of uncircumcised males aged 15-49 who know the type of support needed by their partners to undergo voluntary medical male circumcision	% of female partners of uncircumcised males aged 15-49 who know how to support their partners to undergo voluntary medical male circumcision	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
To increase the percentage of female partners of uncircumcised males aged 15-49 who know how to initiate a discussion with their partner about voluntary medical male circumcision	% of female partners of uncircumcised males aged 15-49 who know how to initiate a discussion with their partner about voluntary medical male circumcision	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
To increase the percentage of female partners of uncircumcised males aged 15-49 who understand that voluntary medical male circumcision provides only partial protection from HIV and other STIs	% of female partners of uncircumcised males aged 15-49 who understand that voluntary medical male circumcision provides only partial protection from HIV and other STIs	<i>Disaggregated by:</i> – Urban/Rural – Region	Special Survey (NAC)
<b>Advocacy Groups</b>			
To increase the number of journalists and media spokespersons with comprehensive information about adult and early infant male circumcision	# of journalists and media spokespersons with comprehensive information about adult and early infant male circumcision	N/A	Special Survey (NAC)
To increase the number of politicians and policy-makers with comprehensive information about adult and early infant male circumcision	# of politicians and policy-makers with comprehensive information about adult and early infant male circumcision	N/A	Special Survey (NAC)

Behavioural Objective	Indicator	Disaggregation	Data Source
To increase the number of health practitioners and administrators with comprehensive information about adult and early infant male circumcision	# of health practitioners and administrators with comprehensive information about adult and early infant male circumcision	N/A	Special Survey (NAC)
To increase the number of health practitioners and administrators who understand their role in voluntary medical male circumcision implementation	# of health practitioners and administrators who understand their role in voluntary medical male circumcision implementation	N/A	Special Survey (NAC)
To increase the number of women leaders with comprehensive information about adult and early infant male circumcision	# of women leaders with comprehensive information about adult and early infant male circumcision	N/A	Special Survey (NAC)
To increase the number of women leaders who understand their role in voluntary medical male circumcision communication activities	# of women leaders who understand their role in voluntary medical male circumcision communication activities	N/A	Special Survey (NAC)
To increase the number of community and social leaders with comprehensive information about adult and early infant male circumcision	# of community and social leaders with comprehensive information about adult and early infant male circumcision	N/A	Special Survey (NAC)
To increase the number of community and social leaders who understand their role in voluntary medical male circumcision communication activities	# of community and social leaders who understand their role in voluntary medical male circumcision communication activities	N/A	Special Survey (NAC)
To increase the number of traditional and religious leaders with comprehensive information about adult and early infant male circumcision	# of traditional and religious leaders with comprehensive information about adult and early infant male circumcision	N/A	Special Survey (NAC)
To increase the number of traditional and religious leaders who understand their role in voluntary medical male circumcision communication activities	# of traditional and religious leaders who understand their role in voluntary medical male circumcision communication activities	N/A	Special Survey (NAC)

Behavioural Objective	Indicator	Disaggregation	Data Source
To increase the number of representatives from vulnerable groups with comprehensive information about adult and early infant male circumcision	# of representatives from vulnerable groups with comprehensive information about adult and early infant male circumcision	N/A	Special Survey (NAC)
To increase the number of representatives from vulnerable groups who understand their role in voluntary medical male circumcision communication activities	# of representatives from vulnerable groups who understand their role in voluntary medical male circumcision communication activities	N/A	Special Survey (NAC)

## E. Data Collection and Reporting Plan

Routine monitoring data for communication activities for VMCC will need to be incorporated into the established National AIDS Council Activity Reporting System (NARF) and feed into the monitoring data collected under the National HIV/AIDS Communication and Advocacy Strategy. Data collected in this system will be mainly at the output results level, and will be collected on a quarterly and annual basis.

Monitoring data will be collected routinely by implementing partners and stored and tracked in a database housed at the Ministry of Health and National AIDS Council. Monitoring data will be collected on a monthly basis, and reviewed and analysed on a quarterly and annual basis.

Evaluation data (outcome level) will be collected using a combination of HMIS data and other special surveys. HMIS data will be reviewed and collected on an annual basis to track progress towards goal of the strategy. Data collected through special surveys, specifically outcome level indicators measuring changes in knowledge, attitudes, beliefs and behaviours will be measured at baseline and in 2015. Evaluation data will also be stored in the database at the MOH and NAC.

## F. Evaluation Plan

An evaluation to assess if the strategy achieved its stated goals and objectives will be conducted. Table 6 includes the indicators that will be used for evaluating the strategy. A baseline and end line survey will be carried out to assess for positive changes in the strategy's behavioural and communication objectives during the four year implementation of the strategy.

Table 7. Implementation Timeline for National MC Communications &amp; Advocacy Strategy

Activity Description	Responsible Person(s)	Q1	Q2	Q3	Q4
<b>National-level Advocacy</b>					
National technical launch of final Communications and Advocacy Strategy document, together with Operational Plan	National MC Coordinator	X	X		
Design and produce MC advocacy toolkit, including folder with glossy hand-outs for policy and decision-makers highlighting and summarizing expected public health impact and cost-savings of rapid VMMC scale-up, as well as binder/CD with all relevant official plans and strategy documents.	MC Communications Team		X		
Advocacy presentations with National Assemblies, House of Chiefs, relevant Ministries, business and professional association leadership, and other national and provincial-level decision-makers.	MC Communications Team		X	X	
Identification of official MC Champions at national-level and from each Province, including musical/cultural/sports figure(s).	National MC Coordinator				
Media training on MC for influential journalists, with follow-up for production of newspaper articles and TV and radio segments.	MC Communications Team		X	X	
National launch of MC scale-up, to include high-level political participation and appearances by musical/cultural/sports champions.	MC Communications Team		X	X	
<b>Provincial and District-level Advocacy</b>					
Dissemination of Communications and Advocacy Strategy document through Provincial-level meetings with DMOs.	National MC Coordinator		X		
Orientation meetings led by DMOs in each District with facility managers on Communications and Advocacy Strategy as well as roles and responsibilities.	District Medical Officers		X		
Development of facility-level service delivery schedules, with input from facility managers.	District Medical Officers		X		
Provincial launches of MC scale-up, including local champions and political leadership.	National MC Coordinator			X	
Advocacy meetings with business and community leaders in each District, led by DMOs.	National MC Coordinator			X	

Activity Description	Responsible Person(s)	Q1	Q2	Q3	Q4
<b>National-Level Mass-Media Production and Placement</b>					
Develop and finalize a commercial creative brief for the production of national mass media and IEC executions.	MC Communications Sub-Committee/Task Team		X		
Release of commercial tender with creative brief for mass media and IEC production; technical presentation to interested creative firms.	MC Communications Sub-Committee/Task Team		X		
Selection creative agency; on-going technical guidance provided for development of appropriate national mass media and IEC executions.	MC Communications Sub-Committee/Task Team		X		
Selected creative agency produces the following national-level mass media executions with input from Communications Sub-Committee. <ul style="list-style-type: none"> <li>• National-level TV and/or radio spots targeting <ul style="list-style-type: none"> <li>○ uncircumcised males 18-25</li> <li>○ uncircumcised males 26-49</li> <li>○ parents of uncircumcised children 13-17</li> <li>○ parents of early infants</li> <li>○ female partners of uncircumcised males age 18-49</li> </ul> </li> <li>• Poster and billboard designs targeting <ul style="list-style-type: none"> <li>○ uncircumcised males 18-25</li> <li>○ uncircumcised males 26-49</li> <li>○ parents of uncircumcised children 13-17</li> <li>○ parents of early infants</li> <li>○ female partners of uncircumcised males age 18-49</li> </ul> </li> <li>• Brochures and leaflet designs targeting <ul style="list-style-type: none"> <li>○ uncircumcised males 18-25</li> <li>○ uncircumcised males 26-49</li> <li>○ parents of uncircumcised children 13-17</li> <li>○ parents of early infants</li> <li>○ female partners of uncircumcised males age 18-49</li> </ul> </li> </ul>	MC Communications Sub-Committee/Task Team			X	X
Pre-testing of final drafts of mass media and IEC executions in English as well as local languages.	MC Communications Sub-Committee/Task Team				

Activity Description	Responsible Person(s)	Q1	Q2	Q3	Q4
Development of detailed media placement plan, including national-level TV and radio, as well as billboards placement and IEC material distribution.	MC Communications Sub-Committee/Task Team			X	
Airing of national-level TV, radio and billboard placement, including for Provincial and District-level community radio stations.	Cooperating Partner support		X	X	X
Development of web page/Facebook page for VMMC in Zambia, with links to on-line schedule of services and service locations.	Cooperating Partner support			X	
Training for 990 hotline staff in order to respond to questions from the public in multiple local languages and refer clients using on-line service schedule.	Cooperating Partner support			X	
Design and production of national promotional materials, including t-shirts, wristbands and chitenges, for advocacy and demand generation.	Cooperating Partner support			X	
<b>Provincial-level Mass-Media Production and Placement</b>					
Develop discussion guides and pre-recorded client testimonials and interviews with MC Champions and other stakeholders for community-radio call-in shows in each Province/District.	MC Communications Sub-Committee/Task Team		X		
Conduct Provincial-level MC sensitization and media trainings with DJs and producers from community radio stations.	MC Communications Sub-Committee/Task Team		X		
Organize weekly or monthly call-in shows at all community-level radio shows with input from local champions, satisfied clients and providers.	MC Communications Sub-Committee/Task Team		X	X	X
<b>Mid-Media Production and Placement</b>					
Develop creative briefs for locally-developed video testimonials and short video clips for MVU and waiting-room displays.	Provincial MC Coordinators		X		
Develop standardized national MC presentation materials, including printed flip-stands, power-point slides and talking points for use in large-group settings such as churches, schools, workplaces, etc.	MC Communications Sub-Committee/Task Team		X		
Conduct MVU shows in each district using locally identified satisfied clients and champions.	Cooperating partners		X	X	X

Activity Description	Responsible Person(s)	Q1	Q2	Q3	Q4
Activity Description	Responsible Person(s)	Q1	Q2	Q3	Q4
<b>Inter-Personal Communication (IPC)</b>					
Develop standardized Training and Training of Trainer (TOT) curriculum for community-level MC health promoters, including guidelines for the recruitment, management and supervision of volunteer health promoters at the facility-level.	MC Communications Sub-Committee/ Task Team		X		
Identify and train two IPC TOTs from each District responsible for identifying and training health promoters.	Provincial MC Coordinators		X		
Recruit and train sufficient numbers of health promoters to support demand creation at each facility.	District MC Coordinators		X		
On-going monitoring and supervision of health promoters, and regular distribution of IEC materials.	District MC Coordinators		X	X	X

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