AN EVALUATION OF THE *"NDIFE OTSOGOLA"* VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) COMMUNICATION BRAND IN RELATION TO VMMC UPTAKE IN DOWA, MALAWI

A

THESIS

BY

ALVIN CHIDOTHI PHIRI

Bachelor of Science in Environmental Health

Submitted

To

The Department of Language and Communication

Faculty of Education and Media Studies

THE POLYTECHNIC

UNIVERSITY OF MALAWI

in partial fulfillment of the requirements for the award of a degree of

MASTER OF ARTS IN HEALTH AND BEHAVIOUR CHANGE COMMUNICATION

13TH JANUARY, 2024

AN EVALUATION OF THE *"NDIFE OTSOGOLA"* VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) COMMUNICATION BRAND IN RELATION TO VMMC UPTAKE IN DOWA, MALAWI

A

THESIS

BY

ALVIN CHIDOTHI PHIRI

Bachelor of Science in Environmental Health

Submitted

To

The Department of Language and Communication

Faculty of Education and Media Studies

THE POLYTECHNIC

UNIVERSITY OF MALAWI

in partial fulfillment of the requirements for the award of a degree of

MASTER OF ARTS IN HEALTH AND BEHAVIOUR CHANGE COMMUNICATION

13TH JANUARY, 2024

DECLARATION

I, Alvin Chidothi Phiri, hereby declare that the work presented in this thesis is an outcome of my research effort and that it has not been previously submitted to the University of Malawi or any other institution for a degree or any award. Where other sources of information have been used, acknowledgements have been made accordingly by means of references.

Signature:

Date : 13th January, 2024

CERTIFICATE OF APPROVAL

We hereby certify that this thesis is from the student's effort and that it has been submitted with our approval:

Main Supervisor: Mr Luciano Venansio Ndalama

Signature: ___________________________________

Date: ___________________________________

Co-Supervisor: Mr Victor Lordwin Chikoti

Signature: ___________________________________

Date: ___________________________________

Head of Language and Communication: Flemmings Ngwira, PhD

Signature: ___________________________________

Date: ___________________________________

Head of Post Graduate Studies: Associate Professor Rhoda Bakuwa, PhD

Signature: ___________________________________

Date: ___________________________________

ACKNOWLEDGEMENTS

I am grateful to the almighty God for his love, mercy, care, and guidance.

My sincere gratitude to the great Mr. Luciano Venansio Ndalama and Mr. Victor Lordwin Chikoti and all lecturers at The Polytechnic for rendering continued and untiring guidance throughout the study period (You people were wonderful!).

I also thank wife Abwino, my children Alvin Phiri, Junior, Celine Christian and Amanda (the troublesome one) for their support, encouragement, concern, care, untiring love and the fervent prayers throughout my years of study, including for bearing with me during the tough times and for the times I was not available to them; and my father Mr Stansilas Esau Phiri (late) for the interest and encouragement he had that I should attain higher education. To my late mother (May her beautiful soul rest in peace), Mrs. Bertha Phiri, thank you for your everyday love all these years till today, for my nurtured, well-handled upbringing and teaching me the fear of God always. To my siblings and family members, thank you all for the love and support.

The Deputy Director of Preventive Health - Health Education Services (Retired) Mr Hector Kamkwamba, and health staff from Dowa District Health Office (Dowa District Hospital, Dzaleka Health Centre, Mtengowanthenga Mission Hospital) deserves my appreciation for the support rendered to me, during data collection. My gratitude is also extended to all the respondents in this study.

To my classmates, thank you for the experiences and knowledge we shared.

TABLE OF CONTENTS

DECLARATION ii
CERTIFICATE OF APPROVAL iii
ACKNOWLEDGEMENTS iv
TABLE OF CONTENTS v
LIST OF TABLES vii
LIST OF FIGURES viii
ABBREVIATIONS AND ACRONYMS x
ABSTRACT xii
CHAPTER 1 1
INTRODUCTION 1
1.1. Chapter overview 1
1.2. Background 1
1.3. The national VMMC program in Malawi 3
1.4 Problem statement 4
1.5 Main objective 6
1.8 Justification for carrying research in Dowa district 6
1.9 Chapter summary 10
CHAPTER 2 11
LITERATURE REVIEW 11
2.1. Chapter overview 11
2.2. VMMC as window for HIV Testing and Services (HTS) 14
2.3. VMMC procedure 14
2.4. Achievements so far 15
2.5 Perceptions and controversies on VMMC as an HIV intervention 15
2.6. Communication challenges on VMMC in Malawi 17
2.7 Theoretical framework 20
2.8. Branding and its importance 23
2.9 Chapter summary 25
CHAPTER 3 26
METHODOLOGY 26
3.1 Chapter overview 26
3.3 Sampling methods 27
3.4 Study sample 28
3.5 Data collection instruments 30

3.5.1 Questionnaires 30
3.5.2 Focus group discussions 30
3.6 Data analysis 31
3.7 Limitations 31
3.8 Reliability and validity 32
3.9 Ethics compliance 33
3.10 Chapter summary 34
CHAPTER 4 36
FINDINGS AND DISCUSSION 36
4.1 Chapter overview 36
4.2 Demographic characteristics 37
4.3 Thematic analysis 42
4.4 Knowledge Level 45
4.5 Motivation to comply 48
4.6 Behavioral beliefs 50
4.7 Normative beliefs 52
4.8 Perceived action efficacy/Behavior control 58
4.9 Chapter summary 65
CHAPTER 5 67
CONCLUSION 67
5.1. Chapter overview 67
5.2 Recommendations 70
REFERENCES 71

LIST OF TABLES

Table 1: Sample size for the qualitative study 29

Table 2: Demographic characteristics of study participants. 38

Table 3: 1 Areas Outlined in Focus Group Guide Based on the Theory of Planned Behavior (External variables and Knowledge) 42

Table 4: 2 - 3 Areas Outlined in Focus Group Guide Based on the Theory of Planned Behavior (Motivation to comply and Behavioral beliefs) 43

Table 5: 3 - 5 Areas Outlined in Focus Group Guide Based on the Theory of Planned Behavior (Behavioral beliefs, Normative beliefs and Perceived behavioral control) 44

LIST OF FIGURES

Figure 1: National VMMC brand 3
Figure 2: Morbidity and Mortality Weekly Report. 15
Figure 3: Theory of Planned Behavior. 20
Figure 4: Respondents' responses on familiarity to the brand. 46
Figure 5: Respondents' responses on effect of the brand. 47
Figure 6: Whether respondents are circumcised or not. 48
Figure 7: Whether brand can influence decision making in VMMC. 50
Figure 8: Effect of peer influence while using the brand. 52
Figure 9: Main motivators in the community. 54
Figure 10: Channels through which they saw or heard of the brand. 56
Figure 11: How often has the VMMC brand been seen in the past 3 months 57
Figure 12: Final decision maker on VMMC in the household. 60

LIST OF APPENDICES

Appendix 1: Consent form (Chichewa version) 77
Appendix 2: Consent form (English version) 78
Appendix 3: Application for ethical clearance to National Health Sciences Research Committee (NHSRC) 79
Appendix 4: National Health Sciences Research Committee protocol acceptance letter 81
Appendix 5: National Health Sciences Research Committee application fee general receipts 82
Appendix 6: Letter of support from Dowa District Health Office 83
Appendix 7: Data collection instrument for Focus Group Discussions (FGD's 84
Appendix 8: Data collection instrument for In Depths Interviews 91

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome.
ART	Anti-Retro Viral Therapy.
CDC	Centers for Disease Control and Prevention.
DHO	District Health Office.
FGD	Focus Group Discussion.
FPAM	Family Planning Association of Malawi.
HH	Household.
HIV	Human Immune Deficiency Virus.
HPV	Human Papilloma Virus.
HAS	Health Surveillance Assistant.
HTS	HIV Testing and Services.
IDI	In Depth Interview.
IEC	Information, Education and Communication.
IP	Infection Prevention.
IRB	Institutional Review Board.
MMWR	Morbidity and Mortality Weekly Report.
MOVE	Models for Optimizing Volume and Efficiency.
NAC	National AIDS Commission.
NHSRC	National Health Sciences Research Committee.
NSP	National Strategic Plan.
OHRP	Office for Human Research Protection.
PEPFAR	President's Emergency Plan For AIDS Relief.
PNG	Protecting the Next Generation.
QA	Quality Assurance.
SBCC	Social and Behavior Change Communication.
SDG	Sustainable Development Goals.
SEM	Social Ecological Model.
SOP	Standard Operating Procedure.
SPSS	Statistical Package for Social Sciences.
STD	Sexually Transmitted Disease.
STI	Sexually Transmitted Infection.
TpB	Theory of Planned Behavior.
TRA	Theory of Reasoned Action.

UNAIDS	Joint United Nations Programme on HIV and AIDS.
VMMC	Voluntary Medical Male Circumcision.

ABSTRACT

Since the Human Immune Deficiency Virus (HIV) was discovered in Malawi in 1985 it has continued to spread within different sub groups in the country. To curb the spread, there have been a number of interventions including Voluntary Male Medical Circumcision (VMMC). In order to popularize the procedure, branding of VMMC intervention was done using the "*NDIFE OTSOGOLA*" logo. Since the branding was done, the effectiveness of the brand has not been evaluated. This qualitative study was aimed at evaluating the brand's influence on the uptake of VMMC in traditionally non-circumcising rural areas like in Dowa district which started providing VMMC services in 2012. Theory of Planned Behavior (TpB) constructs were used to develop data collection tools. Interviews were done with purposely sampled 34 respondents using In Depth Interviews, and 29 respondents using two Focus Group Discussions in three selected health facilities' catchment areas. The interviews were tape recorded, transcribed and coded according to themes. The analysis revealed that awareness levels of the brand was very low although the brand had been in existence for seven years by the time of the study. The brand could not be recalled by over three quarters of the participants. The small portion able to recall mentioned that the brand informs them of the availability of VMMC services in the district and it was meant to assist them make an informed choice. Most women mentioned that they were reminded that they would be protected from developing cervical cancer in future. The majority also mentioned that the brand could play a part in decision making processes, promote readiness and motivate target groups to go for VMMC if they are exposed to it constantly. Despite some positive perceptions and attitudes towards VMMC among males and females, there still remained some pockets of negative perceptions and misunderstandings affecting uptake of VMMC services in the district arising from cultural norms. The findings also showed that peers could be an important influence in motivating men to seek VMMC services in rural areas. The study recommends that Health Workers in the district should ensure that the community members are constantly exposed to the brand on VMMC, and that visibility of the brand should be enhanced by using a mix of channels, not just the Health Office branded vehicle and posters as was the case at the time of the study to improve uptake of VMMC services in the district.

Keywords: Voluntary Male Medical Circumcision; branding; traditionally non-circumcising; cervical cancer; cultural norms

CHAPTER 1
INTRODUCTION

1.1. Chapter overview

This chapter covers several areas. It covers the definition of HIV and AIDS and briefly the epidemiological trends since it was discovered in the world. The chapter has also highlighted the magnitude of the problem both at the global and the Malawian context. I have also explained the various interventions that the Ministry of Health in Malawi is implementing to reduce the incidence, prevalence, and morbidity and mortality rates in the country. One of the interventions is Voluntary Medical Male Circumcision (VMMC) which is offered to eligible males in the country. The history of VMMC program and the "*NDIFE OTSOGOLA*" communication brand in the country has been explained. The Problem Statement, Main and Specific Objectives, and concludes on the justification why the researcher decided to conduct this evaluation in the rural areas.

1.2. Background

Malawi is one of the countries that have been severely hit by the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS) epidemic. HIV is described as a virus that is passed on from one person to another through certain body fluids and it attacks the body's immune system (Centers for Disease Control and Prevention, 2017). If this virus is not treated and managed well through proper adherence to the recommended drugs, adopting healthy lifestyle changes and good nutrition it can lead to the development of AIDS. HIV has existed in the United States since at least the mid to late 1970s (Centers for Disease Control and Prevention, 2017), but was clinically and epidemiologically confirmed in the United States of America in 1981 (Centers for Disease Control and Prevention, 1981). In Malawi it came into the limelight in 1985 (National AIDS Commision, 2009, p. 4). Since the discovery, HIV has become one of the diseases with public health concern infecting and affecting a larger number of communities in the world including Malawi. Statistics show that approximately 36.7 million people globally were living with HIV in 2016 (UNAIDS, 2017), with 1.8 million people becoming newly infected in 2016 globally (World Health Organisation, 2017). The statistics also indicate that out of those living with HIV, 34.5 million are adults, 17.8 million are women (15+ years) and 2.1 million are children (<15 years).

Since the virus was discovered in Malawi in 1985, an estimated 834,000 Malawians have died of AIDS related infections (National AIDS Commission, 2015, p. 9). According to the National AIDS Commission (NAC), the mortality rate reached the highest rate in 2004 where 93,000

people died. Since the introduction and rapid scale up of Anti Retro Viral Therapy (ART) services in the country in 2004, the mortality rate has steadily declined. Although HIV and AIDS remains the leading cause of death among adults (15-49 years), Malawi has also managed to reduce HIV prevalence in the country with overall new infections reducing from 55,000 in 2011 to 34,000 in 2013 (National AIDS Commission, 2014, p. 9), and for women and men aged 15–49 years of age the prevalence decreased between 2010 and 2015-16 from 10.6% to 8.8% (The Ministry of Health and Population, 2017, p. xi). According to population based surveys and qualitative research carried out by various players in the HIV field, this reduction is attributed to a lot of factors including but not limited to; reduction in the number of people 'buying sex', reduction in the number of multiple sexual partners, slight increase in the number of people using condoms, increase in the number of median age of sexual debut, increase in number of people going for HIV testing and accepting results and universal awareness of HIV and AIDS (National AIDS Commision, 2009, p. 15).

However, the rate of HIV prevalence in Malawi is still high with the highest concentration of infection in the country among adults aged 15-49 at 12.9% and 8.1% of women and men respectively in 2010 (The Ministry of Health and Population, 2015, p. 7). The prevalence is indeed a worrisome scenario as this is the productive age that needs to be nurtured for the future of the country. As such, there is need for efforts on preventive and control measures to continue deliberately targeting this age blanket if at all the prevalence rate of people living with HIV is to be reduced significantly in the country.

In order to prevent and reduce the number of people acquiring HIV, the Government of Malawi and its bi-lateral partners are implementing a number of preventive initiatives. Since 1985 when HIV was discovered in Malawi, the preventive and bio-medical approaches in dealing with the virus were being implemented in isolation. Due to the gaps in the approaches, there has been a paradigm shift to use a combination prevention approach, meaning that biomedical, behavioral and structural interventions are implemented as a unit that ensures a demand for health services, maintaining early health seeking behaviors amongst the community members and service provision (National AIDS Commission, 2014, p. 17). One of the combination prevention interventions is the Voluntary Medical Male Circumcision (VMMC) where Social and Behavior Change Communication (SBCC) plays a very critical role. As part of the SBCC process, the implementers agreed to brand the VMMC preventive initiative in order to make it visible to the target population.

A communication brand can be a name, term, sign, symbol intended to identify the goods or services of one service provider from another (Faircloth, Capella, & Alford, 2001, p. 61). Branding has become a very important aspect on how people make choices when making decisions on product or accessing services (Dew & Kwon, 2010, p. 1). So in this competitive world where different services are competing for different groups of people, it is not surprising that a lot of products are being branded and for those that are not, efforts and resources are being heavily invested in order to ensure that they get branded for visibility to enable people to associate the brand name with specific clear values and characteristics that are unique from the different services on offer. Dew and Kwon (2009) continue to point out that brand image, which is another area of brand knowledge, is shaped by the associations formed by a consumer which enables consumers to ably process, organize, and retrieve information in memory to aid product choice. Brand image is also defined as the perceptual beliefs about a brand's attribute, benefit, and attitude associations, which are frequently seen as the basis for an overall evaluation of, or attitude toward, the brand (Faircloth, Capella, & Alford, 2001, p. 62).

1.3. The national VMMC program in Malawi

Malawi has integrated VMMC as part of the integrated HIV prevention interventions in its health programming. Although VMMC service delivery was piloted in Mulanje district in November 2011, the Malawi National VMMC program was formally launched in 2012 by the Ministry of Health and was guided by the National VMMC Policy, VMMC Standard Operating Procedures (SOPs) for Service Providers and the 2012–2016 VMMC Communication Strategy (National AIDS Commission, 2014, p. 36).The 2012–2016 VMMC Communication Strategy included the development and use of consistent approaches and messages under a common national communication brand, slogan and messaging in order to have a common understanding of VMMC as the newly introduced HIV prevention intervention (National AIDS Commission, 2012, p. 6). Three versions of draft concepts of the communication brand were developed and pre-tested across some selected districts by the Health Education Services in the Ministry of Health, the brand which was chosen is depicted in Figure 1:

Figure 1: National VMMC brand

Source: Ministry of Health, Health Education Services archives.

The new National VMMC Communication Strategy for the period 2017 – 2021 has been developed and will carry over the "*NDIFE OTSOGOLA*" *(which literally means an individual who is modern or progressive chooses to go for VMMC)* brand into the next phase in promoting the VMMC intervention as part of the HIV prevention strategy in the country (National AIDS Commission, 2017, p. 10). The VMMC Communication Strategies overarching goal is aimed at creating demand to increase the uptake of VMMC services to reach the national target of 2,458,731 clients circumcised by 2020 (National AIDS Commission, 2017, p. 1).

A brand is a net present value of the cumulative trust that the owners past marketing efforts have earned from the consumers (Chernatony, 2010, p. 4). This means that if it is a well thought of brand, it will convey the identity of its goods or services to its targeted group for decision making purposes. Now looking at the national achievement of the VMMC targets as of September 2014 which was around 150,000 VMMC procedures done, which led to the revision of the target as well from 80% to 60% of the eligible males, the situation analysis should also have focused on the effect the "*NDIFE OTSOGOLA*" brand had on the intended target group and decisions made on whether to rebrand in line with the then to be developed 2015–2020 NSP.

The VMMC Brand was developed, pre-tested and rolled out in November 2011 during the pilot phase of the VMMC program in Mulanje district before it was adopted for the national program in 2012. The VMMC Brand has been used since 2012 up to this year, 2020 without being evaluated either by the Ministry of Health, National AIDS Commission or by any implementing partner to ascertain how the target group perceive it, how it motivates them in decision making to decide to undergo VMMC or help them motivate others to go for VMMC during routine or campaign services.

The National VMMC Communication Strategy 2012-2016 and the Draft Malawi Voluntary Medical Male Circumcision Communication Strategy 2017-2021 have both used the Social Ecological Model (SEM) which was adopted from UNAIDS which took on board the SEM as its global communication model (National AIDS Commission, 2012, p. 14) to guide its demand creation activities.

1.4 Problem statement

The high prevalence rate of HIV and low VMMC figures in Malawi made it ideal for VMMC programming as a preventive measure. Since the program started being implemented in the

country, the prevalence of male circumcision in Malawi increased slightly from 22% in 2010 to 28% in 2015/16, and that by December 2018, a total of 756,780 VMMCs had been conducted, representing 31% of the number of VMMCs required to reach the revised 60% coverage target, although the district coverage widely varies (National AIDS Commission, 2019, p. 4).

When the VMMC program was launched and implemented in the country guided by the 2011–2016 National Strategic Plan (NSP), it was anticipated that by the year 2020, 80% of males aged between 10-34 years should have been circumcised, representing 2,101,566 males in the country. The national VMMC target was arrived at by using the Decision Makers Program Planning Toolkit (DMPPT) 2.0 which showed that by circumcising 80% of males aged 10 to 34 years would result in a huge impact of preventing 128,819 new HIV infections by 2050 (National AIDS Commission, 2014, p. 36). As of September 2014, only 150,000 male circumcisions (11.5% of target) had been performed and this necessitated the reduction of the target from 80% to 60%, representing 1,300,568 circumcisions in 14 priority districts by 2020(National AIDS Commission, 2014, p. 41).

The revision of the national targets also meant that the Malawi National Strategic Plan on VMMC had to be revised. The NSP revision process required an in-depth situation analysis that involved desk reviews, midterm review of the implementation of the 2011 – 2016 NSP, an extensive desk review of each thematic area, consultations with key primary and secondary stakeholders at national, district and community levels, and engagement with the Technical Working Groups and Steering Committees (National AIDS Commission, 2014, pp. 3-4).The situation analysis that was done formed the basis for the development of the second Malawi National Strategic Plan (NSP) 2015– 2020.

The current NSP recognizes the importance of creating demand for successful VMMC service delivery using various social and behavioral change communication methods (National AIDS Commission, 2014, p. 42). One of the ways of creating demand for service was the introduction of the *"NDIFE OTSOGOLA"* brand.

However, the framers and implementers of the NSP did not take on board the need to evaluate the *"NDIFE OTSOGOLA"* brand to see the impact it has in influencing decision making in the target groups to undergo VMMC procedure. Therefore, the researcher saw the need to undertake the study to evaluate the impact of the "*NDIFE OTSOGOLA*" VMMC

communication brand on influencing the targeted groups, in rural areas, to make a decision to go for the VMMC procedure.

1.5 Main objective

To evaluate the "*NDIFE OTSOGOLA*" VMMC communication brand in relation to VMMC uptake in Dowa district, Malawi.

1.6 Specific objectives

The study will be based on the following specific objectives;

i. To explore attitudes and perceptions towards VMMC among in and out of school males and females in rural areas that were targeted for VMMC.
ii. To examine whether influencers motivate young men to seek VMMC services in relation to the "*NDIFE OTSOGOLA*" VMMC communication brand in rural areas that were targeted for VMMC.
iii. To assess whether the "*NDIFE OTSOGOLA*" VMMC communication brand is associated with an increase of VMMC services uptake among in school, out of school boys and young men in rural areas that were targeted for VMMC.

1.7 Research questions

These are some of the research questions that the researcher will try to be answered in this paper:

- What are the major perceptions and attitudes towards VMMC among in and out of school males and females in rural areas?
- To what extent do secondary sources and social networks motivate young men to seek VMMC services in relation to the "*NDIFE OTSOGOLA*" VMMC communication brand in rural areas?
- To what extent does the "*NDIFE OTSOGOLA*" VMMC communication brand increase VMMC services uptake among in school, out of school boys and young men in rural areas?

1.8 Justification for carrying research in Dowa district

Malawi struggles with one of the highest HIV and AIDS burdens in the world. In Malawi, the HIV prevalence in rural areas is only about two thirds in comparison to urban areas. However, 85% of Malawians live in rural communities, so the overall burden of HIV and AIDS is higher in rural areas. As part of the roadmap to combat the global pandemic, the United Nations saw

it proper to come up with Sustainable Development Goals. Goal number 3 of the Sustainable Development Goals is focused on ensuring healthy lives and promoting the well-being for all at all ages, with objective number 3.3 aimed at ending the pandemics of HIV and AIDS, tuberculosis, malaria and Neglected Tropical Diseases and combat hepatitis, water borne diseases and other communicable diseases by 2030. As a country, in alignment with the global strategies in combating HIV and AIDS, the Ministry of Health has been developing different strategic documents including the current Health Sector Strategic Plan II (HSSP II). One of the challenges pointed out in HIV and AIDS programming in HSSP II is that HIV has the highest commodity resource requirements for management of HIV and AIDS as it represents 61% of total commodity costs in the country, with antiretroviral treatment accounting for $394 million of the $508 million needed for HIV commodities from 2017/18 to 2021/22(The Ministry of Health and Population, 2017, p. 57), which accounts for an equivalent of 10.2% of the GDP (The Malawi Government, 2017, p. 81). This means that a lot of resources are being channeled towards clinical management of AIDS than the preventive aspect of it which is cheaper.

While there has been a clear success in the treatment of HIV and AIDS, there is unsatisfactory and inconsistent utilization of HIV preventive measures (The Ministry of Health and Population, 2017, p. 21). Although Malawi has achieved Millennium Development Goals (MDGs) on reducing and combating HIV and AIDs, with prevalence rate among women and men age 15-49 age decreasing between 2010 and 2015-16 from 10.6% to 8.8% respectively there is need to continue implementing preventive interventions. To ensure that the HIV prevalence rate continues going down, the Government of Malawi introduced and integrated VMMC as part of the HIV prevention interventions due to the overwhelming evidence of the effectiveness of VMMC in reducing the risk of acquiring HIV in men, so as to try to free up some resources to be channeled to other development activities. The VMMC program was formally launched in 2012. The National Policy on Voluntary Medical Male Circumcision, VMMC SOPs for Service Providers and the Malawi VMMC Communication Strategy 2012-2016 elevated male circumcision as a core intervention in Malawi's National HIV Prevention Strategy. Considering the low pace of scale up and uptake of the intervention especially in the rural areas, the VMMC program coverage targets have been revised downwards from 80% to 60%. The Government of Malawi now estimates a target of 1,300,568 circumcisions in 14 priority districts from 2015-2020.

Dowa is one of the rural districts in Malawi which is considered 'non-circumcising' due to its Chewa cultural setup. Male circumcision is therefore not considered as a common practice and

may sometimes be considered an insult by the community members if the topic is not introduced carefully. Dowa is located in the central region of Malawi where the circumcision rates were recorded to be at 12.2% in the Malawi Demographics Health Survey 2004; 12.3% in Protecting the Next Generation: Understanding HIV Risk Among the Youth (PNG) Project 2004 survey; and 20.2% in the Circumcision Situation Analysis 2009 (Bengo, et al., 2010, p. 32). Male Circumcision is sometimes used negatively by uncircumcised men to insult a person by associating the person with the cutting of his foreskin (Bengo, et al., 2010, p. 17).This also might result in low levels in achieving VMMC targets in the district.
Although it has been noted that by March 2020 the figures at national level in VMMC continued to rise with 139,129 circumcisions performed especially in the President's Emergency Plan for AIDS Relief (PEPFAR) supported districts in the country (President's Emergency Plan for AIDS Relief, 2020, p. 51), it is a complete opposite to Dowa district, which was being supported by World Bank funding in which figures instead of rising, dropped.

Even though the district started implementing VMMC in 2012, the total number of men who have so far been circumcised was 9,026 for over a period of over eight years, which remains very low in relation to the average prevalence percentage for the central region which is at 15% (Malawi demographic and health survey, 2015 - 16, p. 208). According to the Ministry of Health's District Health Information System (DHIS 2), during the first 3 years of VMMC implementation, the total circumcised in Dowa was 528 (5.8% of total circumcised). But starting from 2015, changes in increase in numbers was observed and reached maximum in 2017 where a total of 4,495 males were circumcised. But from 2017 to date, there has been a decrease in number of males being circumcised in the district. The data also shows that 8,026 (88.9% of total) adolescents and young adults (10 – 34 years) are the ones who were in majority in terms of the number of people who went for the procedure in the past 8 years in the district. This low attainment in the number of people circumcised in the district shows it can be attributed to several factors, one of which is inadequate demand creation activities for VMMC. The increase of circumcised males in 2015 to 2017 was due to the mass campaigns which used various demand creation interventions which included Theatre for Development, community mobilisers, village criers, mobile public announcements, village meetings, distribution of *"NDIFE OTSOGOLA"* branded posters & leaflets.

Looking at the trend in number of eligible males circumcised since 2012 to date, demand creation interventions played a very big part in ensuring that some males got circumcised,

especially between the years 2015 to 2017 which was the period where the mass VMMC campaigns took place using the *"NDIFE OTSOGOLA"* branded communication materials.

As stated earlier in the problem statement, the VMMC Brand was developed, pre-tested and rolled out in November 2011 during the pilot phase of the VMMC program in Mulanje district before it was adopted for the national program in 2012. The VMMC Brand has been used since 2012 up to this year, 2020without being evaluated either by the Ministry of Health, National AIDS Commission or by any implementing partner to ascertain its effectiveness, or how the target group perceive it when it comes to decision making for the targeted group to undergo, or help them motivate others to go for VMMC during routine or campaign services, much as the decision was reached to continue using it during the development of the second Malawi Voluntary Medical Male Circumcision Strategy and National Scale-up Plan 2015-2020.

The evaluation of the VMMC Communication Brand will give a feel and be an eye opener on how the communication brand is faring as a springboard for Social and Behavioral Change Communication during VMMC routine services or mass campaigns especially in traditionally non-circumcising districts like Dowa. It will also inform SBCC programming for future VMMC interventions. This research is also expected to also improve SBCC programming to incorporate myths and misconceptions that traditionally non-circumcising societies have in relation to VMMC for better understanding of the intervention and increase the quality of services and access.

1.9 Chapter summary

This chapter was looking at the history of HIV in Malawi including the burden of HIV and AIDS pandemic in the country since its discovery up to now, including the different mitigating measures that the Ministry of Health in Malawi is undertaking to ensure the incidence, prevalence, mortality, and morbidity rates are reduced. Some of the HIV and AIDS mitigating measures being implemented include a combination of preventive, bio-medical, behavioral, and structural interventions which are implemented as a unit that ensures a demand for health services, maintaining early health seeking behaviors amongst the community members and service provision. VMMC as one of the combination prevention interventions is guided by the National VMMC Policy, VMMC Standard Operating Procedures (SOP's) for Service Providers and VMMC Communication Strategy. The VMMC Communication Strategy uses consistent approaches and messages under a common national VMMC "*NDIFE OTSOGOLA*" communication brand, slogan, and messaging in order to have a common understanding of VMMC. Since the communications brand inception in 2012, it has never been evaluated to see the impact in both the rural and urban areas. That's why this research was designed with the main and specific objectives of evaluating the impact of the "*NDIFE OTSOGOLA*" VMMC communication brand in the rural areas of Dowa district in the three catchment areas of Dowa District Hospital, Dzaleka Health Centre, and Mtengowanthenga Rural Hospital. Dowa is one of the rural districts in Malawi which is considered 'non-circumcising' due to its Chewa cultural setup. Male circumcision is therefore not considered as a common practice and may sometimes be considered an insult by the community members if the topic is not introduced carefully. The evaluation of the VMMC Communication Brand will give a feel and be an eye opener on how the communication brand is faring as a springboard for Social and Behavioral Change Communication during VMMC routine services or mass campaigns especially in traditionally non-circumcising districts like Dowa.

CHAPTER 2
LITERATURE REVIEW

2.1. Chapter overview

This chapter examines various literature that exists in the world and Malawi on traditional/cultural and modern Medical Circumcision. The origins and beliefs associated with the practice have also been tackled in different cultural setups. The roles that the Sustainable Development Goals (SDGs) are playing in the reduction of HIV and AIDS has also been explained in this chapter. The chapter explains the available evidence on how and where controlled randomized trials took place to reach a conclusion that VMMC reduces HIV transmission considerably. VMMC is not just there for reducing HIV transmission, it also offers an opportunity for implementing organizations to increase other indicators including HIV Testing and Services. The surgical process of carrying out the VMMC has been explained including achievements on circumcised males in Southern and Eastern Africa. The chapter winds up by looking at the controversies surrounding VMMC and the Theoretical Framework guiding the evaluation.

Circumcision is a worldwide practice that is carried out in different areas around the world due to different cultural, religious and medical reasons, common not only in Islamic dominated countries but also in other parts of the world as well, although the last reason has only been popularized due to modern research and evolving surgical procedures in the 19th century (Dunsmuir & Gordon, 1999, p. 1).Circumcision is the ritual that involves the cutting of the foreskin (prepuce) from the penis of males. A lot of researchers differ on the period that the practice of circumcision started, with some even stating that it is older than what is recorded in history and was well established by 2400 BC in Egypt (Gollaher, 2006, p. 310). He goes on to indicate that up to now, no one knows where or how the practice originated or even what its meaning was during that time. Other anthropologists were able to prove that the earliest Egyptian mummies dating as far back as 2300 BCE were circumcised, and wall paintings in Egypt show that it was customary for people to be circumcised several thousand years earlier than that (Dunsmuir & Gordon, 1999, p. 1).Dunsmuir & Gordon continue to explain that different cultures and religions differed especially on when one was supposed to get circumcised, with other cultures circumcising their children on the eighth day after a male child's birth whilst others performed the procedure in early adult life as a 'rite of passage', for example puberty or marriage. In the Philippines where it is estimated that more than 90% of their male population are circumcised, they believe that if this procedure is done on them, they are able to secure and achieve their masculinity and that as a generalized tradition, circumcision

is regarded as a procedure through which one enhances his body (in terms of height and fitness), penis (in terms of form and size), sexual and reproductive capacities (to be able to cause pregnancy) and relational opportunities in order to enable them to court and marry a girl, or be preferred by women (Lee, 2009, pp. 175 - 181).

In South Africa, traditional circumcision is regarded as a gateway to sex, rather than marking the point at which responsible sexual behavior begins (Eaton, et al., 2011, p. 675).Other researchers also found the same reasons in the United States of America where parents decisions to have their children circumcised was being influenced by a pre-conceived notion of masculinity, and were therefore able to justify their action by discounting the pain and trauma that circumcision causes their child (Waldeck, 2003, p. 57).
The United Nations Summit which was held in 2015 came up with 17 Sustainable Development Goals (SDGs) and 169 targets which were focused on demonstrating the scale and ambition of the future universal agenda up to 2030. The SDGs were meant to build on the Millennium Development Goals and complete what these did not achieve. They seek to realize the human rights of all and to achieve gender equality and the empowerment of all women and girls. They are integrated, indivisible and balance the three dimensions of sustainable development: the economic, social, and environmental. The third SDG aims at ensuring healthy lives and promotion of well-being for all at all ages, with SDG goal 3.3 targeting to end the epidemics of AIDS and other communicable diseases by 2030 (United Nations, 2016). This goal can only be achieved if preventive methods are intensified. It is widely recognized that no single prevention method or approach can stop the HIV and AIDS pandemic on its own. Several methods and interventions have proved highly effective in reducing the risk and protecting people against HIV infection, and one of them is voluntary medical male circumcision (VMMC).MC in the medical field started being popularized in the nineteenth century with the procedure being done using different types of equipment and methodology (Dunsmuir & Gordon, 1999, p. 1).

Between 75% and 85% of cases of HIV infection worldwide have happened during sexual activity for both men and women(UNAIDS, 1998, p. 67), whilst about 70% of men infected with HIV acquire the virus through vaginal sex, and a smaller number have acquired it from insertive anal intercourse, therefore, on a global scale most men who are HIV positive have acquired the virus via the penis. This then raised questions of how HIV enters the penis and why men who are uncircumcised are potentially more susceptible to becoming infected with HIV.

Research showed that VMMC is an intervention to reduce the transmission of HIV due to theories that were developed and were able to show and support the biological basis for a protective effect of circumcision on HIV acquisition. It was noted that the inner mucosal surface of the foreskin of uncircumcised men is rich in Langerhans' cells, making it particularly susceptible to the HIV (Szabo & Short, 2000, p. 1593). Szabo points out that this is particularly important in HIV transmission because during heterosexual intercourse, the foreskin is pulled back down the shaft of the penis, and the whole inner surface of the foreskin is exposed to vaginal secretions, providing a large area where HIV transmission could take place. This contrasts with circumcised men who have a keratinized stratified squamous epithelium that covers the penile shaft and outer surface of the foreskin that end up providing a protective barrier against HIV infection. VMMC has been proven to reduce the risk for heterosexually acquired HIV infection among adult males by approximately 60% from controlled randomized trials in Rakai, Uganda (Gray, et al., 2007); 60% from another controlled randomized trial in the Orange Farm area, a semi-urban region close to Johannesburg, South Africa (Auvert, et al., 2005); and 60% from another controlled randomized trial which was stopped in Kisumu, Kenya (Bailey, et al., 2007). In all the controlled trials that were carried out, a sample of 3,274 men aged 18 to 24 years in the three countries were randomly assigned to an intervention group (those that were medically circumcised), or a control group (delayed circumcision) and assessed by HIV testing, medical examinations, and behavioral interviews during follow-ups at 1, 3, 6, 12, 18, and 24 months.

VMMC is not only advantageous to males just by reducing the transmission of HIV, but it also plays a vital role in the prevention of contracting other Sexually Transmitted Infections (STI’s) such as Gonorrhea, Syphilis or Chlamydia. There is indeed evidence that the presence of genital ulcers and other STI’s increases the risk of sexual transmission of HIV between people as concluded through the analysis of the clients’ history of STI’s in both homosexual and in heterosexual men and women who were also HIV positive(Piot & Laga, 1989, p. 623). Piot and Laga also noted that this positive association was independent of the number of sexual partners and became stronger with an increasing number of episodes of sexually transmitted diseases.

VMMC is not only beneficial to men but also their female sexual partners because one of the primary benefits of VMMC for women is its association with a reduction in penile Human Papilloma Virus (HPV), which is associated with cervical cancer in female partners (President's Emergency Plan for AIDS Relief, 2017, p. 1).

Other researchers also found that people who have both ulcerative and non-ulcerative Sexually Transmitted Diseases (STDs) are 2 to 5 times at risk of being affected by HIV transmission through a variety of biological mechanisms. And because a large number of people are affected by the non-ulcerative than the ulcerative STD's, these infections may be responsible for more HIV transmission in the world (Fleming & Wasserheit, 1999, p. 3).So, in essence due to these findings, it is important for policy makers to ensure that early STD treatment should be part of a high quality, comprehensive HIV prevention strategy by improving access to and quality of STD clinical services, promoting early and effective STD related healthcare behaviors including the establishment of a comprehensive surveillance system to monitor STD and HIV trends and their interrelations.

2.2. VMMC as window for HIV Testing and Services (HTS)

Another advantage of VMMC is that it also acts as a window for increasing the uptake of HTS services in the implementing countries. According to data available extracted from multi-country analyses, during the year 2013–2016, 89.3% of VMMC clients participated and benefited from HIV testing services (HTS), and among those tested, the percentage of clients globally who tested positive ranged from 0.8% to 1.3%, whilst at country level, the percentage testing positive ranged from <0.1% to 4.4% (Centers for Disease Control and Prevention, 2017, p. 1287).

2.3. VMMC procedure

There are a lot of methods that are used to conduct the VMMC procedure. As a surgical procedure, it must be provided safely in order to minimize risks of clinical complications that might result in infections (President's Emergency Plan for AIDS Relief, 2017, p. 2). According to PEPFAR, the surgical procedure can be provided safely by different cadres of health care workers in fixed or mobile settings that meet the quality assurance (QA) standards for infection prevention (IP). The services must be of the highest quality, and mechanisms must be in place for client follow up and management of Adverse Effects. To ensure that a maximum number of people are circumcised during high volume activities like mass campaigns, integration of high efficiency models such as Models for Optimizing Volume and Efficiency (MOVE) are utilized. The procedure is carried out under local anesthesia. All VMMC clients are advised to return for post-operative assessments and on average, 71.9% returned to the circumcising site within 14 days of surgery for post-operative review.

2.4. Achievements so far

It was reported that during the period 2013 – 2016, a total of 4, 859,948 adolescent and adult males were medically circumcised by CDC supported VMMC programs in 12 countries in Southern and Eastern Africa (Centers for Disease Control and Prevention, 2017, p. 1287). CDC further explains that in 2016, 181,737 (13.4%) fewer VMMCs were performed than in 2015, and that in multi-country analysis, the proportion of VMMC clients aged <15 years increased each year during 2013–2016, from 31.7% in 2013 to 47.6% in 2016. Conversely, the proportion of VMMC clients aged 15–29 years declined from 48.4% in 2015 to 45.6% in 2016 as it can be seen from figure 3 below:

TABLE 1. VMMCs provided in CDC-supported VMMC programs — 12 Southern and Eastern African countries, 2013–2016

Country	Fiscal year*				Total
	2013	2014	2015	2016	
Botswana	11,855	12,745	7,320	23,977	**55,897**
Ethiopia	14,037	10,439	9,861	10,655	**44,992**
Kenya	144,943	154,776	147,998	176,056	**623,773**
Malawi	18,398	18,889	18,910	19,180	**75,377**
Mozambique	121,369	141,113	159,299	184,488	**606,269**
Namibia	0	685	7,132	10,194	**18,011**
Rwanda	0	21,475	25,000	8,809	**55,284**
South Africa	139,174	185,193	193,311	149,081	**666,759**
Tanzania	159,230	278,948	341,544	181,199	**960,921**
Uganda	272,182	329,059	251,815	225,597	**1,078,653**
Zambia	96,183	154,941	147,962	126,765	**525,851**
Zimbabwe	6,171	39,840	44,868	57,282	**148,161**
Yearly total	**983,542**	**1,348,103**	**1,355,020**	**1,173,283**	**4,859,948**
Cumulative total	**983,542**	**2,331,645**	**3,686,665**	**4,859,948**	—

Abbreviation: VMMC = voluntary medical male circumcision.
* October 1–September 30.

Figure 2: Morbidity and Mortality Weekly Report.

Source: MMWR (2017, p. 1287).

Considering that in Malawi some of these figures came from areas that were normally considered as non-circumcising due to religious or cultural values, this was regarded as a big program achievement by the implementers. It also shows that the targeted group including their influencers had managed to break some of the social norms that were making the people to regard the procedure with suspicion, such that Malawi's performance on VMMC remained constant. This was attributed to a lot of factors some of which included prioritization of VMMC service delivery to geographic regions with the highest HIV prevalence for greater impact due to the limited resources available for the program, and possibly due to the declining demand because many early adopters had already been circumcised.

2.5 Perceptions and controversies on VMMC as an HIV intervention

In one of the studies on sexual practices and circumcision done in United States of America, it was discovered among racial groups where circumcision was the norm, a stigma was being

associated with the foreskin in areas where circumcision is the common practice (Waldeck, 2003, p. 56).

There was also this common controversy that people believe that all medically circumcised males' epithelium of the glans in uncircumcised men is keratinized whilst some authors claim that it is not. But after some research which examined glans of seven circumcised and six uncircumcised men, it was found that the epithelia to be equally keratinized (Szabo & Short, 2000, p. 1593).

It was also agreed by other quarters that VMMC will increase the number of people acquiring the virus through unprotected sexual behaviors instead of having the opposite effect. This was collated by the study done in South Africa that used generalized linear models to analyze the relationships between unprotected vaginal sex acts, number of female sexual partners, STI diagnoses and male circumcision related beliefs and risk perceptions. It was discovered that indeed there was that risk because men who were aware of the protective effect of VMMC from HIV were more likely to report unprotected vaginal sex acts, were also likely to have multiple sexual partners and were also more likely to be diagnosed with a chronic STI (Eaton, et al., 2011, p. 674).Some men have been reported to say that "Ah, I have a natural condom" once they have undergone the VMMC procedure in a phenomenon coined as "sexual dis-inhibition" (Bailey, et al., 2007). As such, it was very important that social and behavioral change communication messages should be well tailored to avoid those that decide to undergo the procedure getting infected from HIV due to wrong beliefs and behaviors. Eaton et al. (2011) furthers states that globally an estimated 30% of men are circumcised for religious or cultural reasons, which translate that most of them do not have the advantages of receiving HIV prevention messages including risk reduction counseling related to male circumcision. This means that those target groups under this category will in the long term be affected by HIV. This can also be said of the cultures that undergo the procedure due to cultural or traditional reasons using as there are variations in the types of procedures that are done in different societies and on whether those receiving through the traditional means would experience the same level of protection.

The issue of conducting traditional circumcision as a rite of sex whereby the adolescent boys are told that they are now ready for sex is also a big issue because it ends up confusing as it is mixed into other HIV prevention messages of abstinence, sexual restraint and sexual

responsibility on the one hand, and the rights and privileges that go along with traditional beliefs on the other.

2.6. Communication challenges on VMMC in Malawi

Since the VMMC was piloted and fully implemented in the country, several innovative approaches have been used for demand creation. As these were being implemented, several challenges both program and Social and Behavior Change Communication (SBCC) related were identified. These were identified during the review of the National VMMC Communication Strategy (2012-2016) to identify key issues, and define updated priorities for communication (National AIDS Commission, 2019, p. 6), as detailed in the next sections.

Insufficient audience segmentation: Previously interventions left out some key audiences, and some audiences were overreached with VMMC messages. Youths aged between 10-14 years were not adequately reached although they are the widest window of opportunity in fulfilling national targets.

Lack of a successful strategy that engages female partners: Previous strategies have not adequately focused on engaging women as community mobilizers to improve their awareness about the benefits of VMMC, and to solicit their support in helping their male partners maintain post-operative behaviors which includes abstinence in the first six weeks to avoid complications.

Inadequate reach of parents of children 10-14 years: Boys in this age bracket are required to be accompanied by their parents to the health facility for consent, care and support. In the previous Malawi Implementation Program, this category was not given adequate emphasis although this is a unique window of opportunity for the program to reach more numbers in both circumcising and non-circumcising cultural settings.

Resistance from community leaders in both traditionally circumcising and non-circumcising areas over religious and tribal identities:

Community leaders in circumcising areas: Most community leaders in circumcising communities are resistant to VMMC for the following reasons:

- All men in their areas were circumcised when they were young as such there is no need for older men to patronize VMMC services.
- VMMC is contributing to reduced authority over their subjects.

- VMMC is denying them the economic benefits that are associated with traditional circumcision.
- VMMC is deemed as a threat to their cultural initiation rituals and ceremonies.
- VMMC communication has been contradictory and confrontational to their cultural norms.

Community leaders in non-circumcising areas: Most leaders in non-circumcising communities are antagonistic to VMMC for the following reasons:

- VMMC is regarded as an unfair extension by government and donors of male circumcision traditionally practiced among the Yaos and Muslims. They fear that accessing VMMC services will make them lose their cultural and religious identity as non-Yaos and non-Muslims.
- Although traditional leaders acknowledge that VMMC has undeniable health benefits that go beyond religious and cultural identities namely: prevention of cervical cancer in women and prevention of STIs, including HIV in men. Their main worry is that information has been scanty and communication approaches have been culturally irrelevant and generally weak in engaging community structures so that communities can have the opportunity to clarify issues with experts, particularly health personnel who are widely viewed as the most trusted sources of health information.

Health care workers and community mobilizers: Some of the challenges affecting health care workers are:

- The presence of female service providers scared off potential men from accessing the VMMC services in both circumcising and non-circumcising settings.
- Most health workers at local facilities were not adequately engaged and involved in the provision of VMMC services although they had a direct interface with the communities since both technical and support staff members were coming from the DHO. As such, some of them resorted to sabotaging the VMMC program implementation in their areas because they felt sidelined on allowances.
- Community Mobilisers are inadequate, and their work is tied to the project's life span although they were recruited from within project sites.

Overall program strategy was not tailored to needs of older men: Demand among older men and boys is comparatively low, particularly in the traditionally circumcising communities. Prior

implementation has not adequately addressed the unique barriers facing older men. These include shame and embarrassment about seeking services and lack of privacy in clinics which serve boys and older men at the same space, shame and embarrassment of being circumcised by a female service provider, fear of pain and results of the HIV test, concerns about complications, myths and misconceptions of foreskin disposal, concerns of partner's infidelity during abstinence period.

- Service delivery is inconvenient: Several barriers related to services have been identified. The timing of services not always convenient, especially for older working males and school-going boys, the possibility of long waits; overly long group counseling sessions in pre-op can cause delays and disturb client flow; long distances clients must travel to access services; the services being moved to another location or not providing the service on a regular basis.
- Service delivery is inconvenient: As it has generally been experienced and documented in other health-related interventions, adult men have generally been reticent towards VMMC services. This has been noticed in both circumcising and non-circumcising communities.
- Lack of defined roles and responsibility for demand creation: There is a lack of clarity about who has overarching leadership role at the national level to review messages, develop new materials, update training guidelines and curriculum, ensure minimal standards for supervision and monitoring and oversee national communication strategy implementation. There is also no apparent system to update existing VMMC materials many of which are obsolete for they do not address currently known barriers and motivators; and/or need technical updates.
- Inadequate funding and support for multi-channel demand creation: This has made it difficult for the national response to employ multiple channels (social media, mass media, IPC, mobile) and in-service communication.
- Poorly coordinated supply and demand: There is need to improve coordination between supply and demand using strategies appropriate to different service channels (outreach, static sites) to ensure effective reach of services. There is, therefore, need for effective balancing between demand for services and the service availability.
- Poor promotion of local health facilities offering VMMC services: Most health facilities that provide VMMC services have no sign posts to create an awareness on the availability of services in their own community.

- Service delivery system unevenly burdened by demand seasonality: older men's preference to access services during off-harvest season and beliefs that healing is faster during cooler months creates high demand during May-August period. This creates an uneven demand throughout the year.
- Poor awareness of the National Campaign Brand: The VMMC Campaign Brand that is meant to create a sense of modernity among males that eligible for VMMC has not been adequately promoted particularly in rural areas.

2.7 Theoretical framework

The research on the VMMC communication brand was based on the Theory of Planned Behavior (TpB) as its theoretical framework as indicated below:

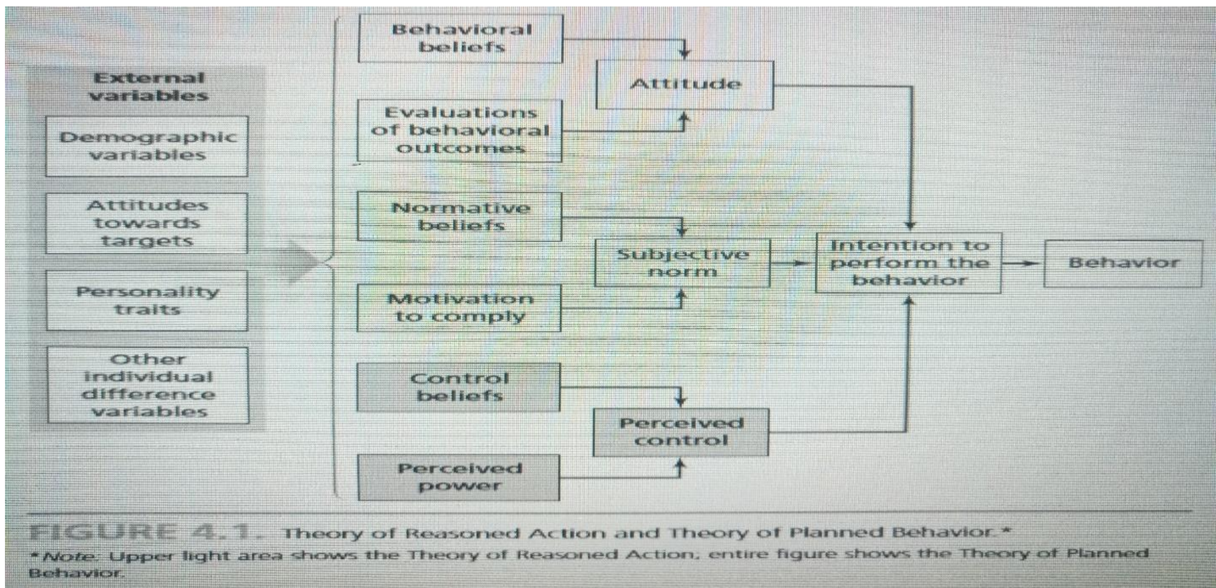


Figure 3: Theory of Planned Behavior.

Source: Glanz, Rimer, and Viswanath(2008, p. 70).

2.7.1 The Theory of Planned Behavior

The Theory of Planned Behavior (TpB) is today one of the most popular social-psychological models for understanding and predicting human behavior (Ajzen, 2015, p. 125). TpB has received substantial research support due to its strength in that it is widely applicable to a variety of behaviors in different contexts, including such diverse areas as health communications, environmental concerns, risk communication, mass transit use and technology adoption (Knabe, 2012, p. 37).

The TpB is derived from the Theory of Reasoned Action (TRA). The Theory of Planned Behavior proposes that individual motivational factors are the determinants of the likelihood of

performing a specific behavior on the assumption that the best predictor of a behavior is behavioral intention, which in turn is determined by attitude toward the behavior and social normative perceptions regarding it (Glanz, Rimer, & Viswanath, 2008, p. 68). According to TpB, the attitude of a person towards a behavior is determined by his beliefs on the consequences of this behavior, multiplied by his evaluation of these consequences. Beliefs are defined by the person's subjective probability that performing a particular behavior will produce specific results. This model therefore suggests that external stimuli influence attitudes by modifying the structure of the person's beliefs. Moreover, behavioral intention is also determined by the subjective norms that are themselves determined by the normative beliefs of an individual and by his or her motivation to comply to the norms. TpB also claims that all other factors which influence the behavior only do so in an indirect way by influencing the attitude or subjective norms which are also referred to as being external variables. These variables can be for example, the characteristics of the tasks, of the interface or of the user, the type of development implementation, the political influences, and the organizational structure.

Generally, human beings like being in control of situations. The TpB tries to explain that the more favorable the attitude and subjective norm with respect to engaging in the behavior, and the greater the perceived control, the more likely it is that a person will form an intention to perform the behavior in question (Ajzen, 2015, p. 125). Ajzen also points out that beyond the factors that constitute the theory itself as shown in Figure 4, the TpB also recognizes the potential importance of other variables, such as demographic characteristics (age, gender, race, religion, education, income, etc.), personality traits, general attitudes and life values, intelligence, emotions, and so forth. In TpB these variables are considered background factors and they are expected to influence intentions and behavior only indirectly by their effects on behavioral, normative, and control beliefs.

The TpB constructs have been used to examine critically the ability of this theory to predict the perceptions that the intended target group have of the ''*NDIFE OTSOGOLA*'' brand in relation to decision making for them to undergo VMMC in Dowa with the rationale that the findings can be used to inform future programming aimed at increasing VMMC access and acceptability. This is very important especially in predicting the usefulness of the VMMC brand in influencing decision making to undergo the VMMC procedure as it is irreversible once it has been done, therefore an individual needs to be completely convinced of the pros and cons of the procedure.

2.7.2 Operationalization of the TpB

To explore the constructs to answer the questions under investigation within the TpB, a generalized conceptual framework consisting of selected constructs was used. The data collection tool was also designed in such a way so that it should be able to address the independent TpB constructs, attitudes toward the brand, subjective norms, and perceived behavioral control as explained in the next section.

a. External variables: The external variables that were examined included age, sex, marital status, occupation, area of residence or health center catchment area and education.
b. Attitude towards the communication brand: When evaluating the brand consideration was also put into explaining the attitudes of the respondents towards the communication brand in relation to VMMC because normally a strong positive or negative attitude towards a behavior can lead to adoption or rejection of the proposed behavior respectively, and affects the intention construct. The attitude aspect focused on respondents' "familiarity with the communication brand and its effect there of" and their "overall opinion of the communication". It looked at what the respondents "expected and what not to expect from the communication brand".
c. Intention: This construct was investigated by "asking whether if circumcised, did the brand play any part in motivating them to go for VMMC", or "if not circumcised, can this brand motivate them or their friends in deciding to go for VMMC?"
d. Subjective norms: Subjective norms were investigated specifically to look at the thought processes of the significant others who matters when it comes to opinions. The measure of this construct was obtained from the expectations of various people in the social circles. The tools questions focused on asking the respondents "whether they would recommend others to go for VMMC in relation to this communication brand", "whether they thought that most people who are important to them think that it is important to go for VMMC in the next 12 months after seeing the "*NDIFE OTSOGOLA*" brand", and also "if ever there is anyone who has actually ever encouraged them to go for VMMC in the next 12 months".
e. Perceived behavioral control: the respondents were asked to state the scope to which their individual beliefs would motivate or discourage them from undergoing VMMC due to the communication brand. The measure on this construct focused on gathering data on different areas which included "stating whether it is expected of them to go for VMMC in the next 12 months after seeing the VMMC brand", "explaining the reasons why it would be possible or impossible for them to go for VMMC in the coming 12

months" and "state whether they had much control on deciding to go or not go for VMMC in the coming 12 months".

The data collection tool was piloted initially and administered to three people before finalizing using the responses that were obtained to modify it based on the feedback from the pilot participants. This step ensured validity of content of the data collection tool.

In summary, the study was operationalized using the direct and belief measures using a questionnaire. Some questions required respondents to answer retrospectively on their intentions and beliefs during the past 12 months after seeing the communication brand, whilst others wanted their opinion on their intention to act in the next 12 months in relation to the communication brand and VMMC.

2.8. Branding and its importance

A brand is defined a complex phenomenon and although different people have tried to define it in the academic world, a common understanding on what defines a brand could not be properly established among the brand experts (Maurya & Mishra , 2012, p. 122). Brands can be traced from the old civilization of Mesopotamia and Greek where they were represented as marks and names to identify or indicate their offerings of wines, ointments, pots or metals (Maurya & Mishra , 2012, p. 122). They go on to mention that the word brand is derived from Old Norse word brand, which means "to burn" (an identifying mark burned on livestock with a heated iron) as brands were and still are how owners of livestock mark their animals to identify them. Brands need to be well managed to be respected by the intended audience and enhance their visibility.

2.8.1 Components of a brand

There are also various opinions by different experts on what is supposed to make up a brand. Some of them describe the brands using simplified ways of describing the complex nature of brands, for example using brand mental models, whilst others use the "category" type models by mentioning a few category descriptors which they then expand into the constituting elements like having a core intellectual property with a mixture of elements (for example. a name, a slogan, signs registered or otherwise, bottle shapes, and so on).

There are the physical things like the name, the identity, the colour scheme and the type face and then there are the metaphysical things, like the image and reputations.

When evaluating brands different approaches are used and are applied in both theory and practice, although it is important to note that the first moves toward quantifying the value of brands were not driven by marketing issues, but were set in motion by corporate finance experts who needed a way of expressing brands in dollars and cents when either the brands themselves or the whole company that owned them was up for purchase or sale (Moisescu, 2007, p. 95). He points out that according to the types of indicators to be measured, or the measures to be considered, the methodologies currently preferred for establishing brand value can be divided into three.

a) Financial based methods: This type mainly uses quantitative measures and bases its evaluation using financial indicators and providing monetary value of the brand.
b) Behavioral based methods: These use qualitative measures, consumer behavior indicators, and providing qualitative value of the brand.
c) Composite methods using both quantitative and qualitative measures, aggregating financial and behavioral indicators, and providing a monetary value of the brand. The most worldwide spread and accepted method in this category is Interbrand's method.

Some of the areas that the behavioral based method focuses on are unaided brand recall (doubly unaided survey), aided brand recognition (by name only), aided advertising recognition (advertising recently seen), relevant set (aided question about brands in question), trial purchase (trial purchase already made), principal brand (brand currently purchased) and appeal (unaided appeal set)(Moisescu, 2007, p. 96). All these were also explored in this research, albeit some on a very limited level.

2.8.2 Importance of branding

Branding helps implementers to design strategies that help them to make improvements accordingly. They can also assist and stimulates uptake of various products thereby accomplish the set goals and targets. Brands can induce the decision making process by the intended target groups. As such when brand evaluation of various products or interventions are carried out periodically, the result would be useful for strategic planning and fill the quality (Devendra, 2017).

2.9 Chapter summary

To understand cultural and religious VMMC practices around the world, literature review was done on different topics to understand its origins and the reasons it was being done in different parts of the world. One of the common reasons why circumcision was being done differed according to religion and cultures, with some circumcising their children on the eighth day after a male child's birth whilst others performed the procedure in early adult life as a 'rite of passage'. In the 21st century, VMMC has been recognized as one way of reducing the transmission of HIV as well as preventing contracting other Sexually Transmitted Infections (STI's) such as Gonorrhea, Syphilis and Chlamydia. Another advantage is that it also acts as a window for increasing the uptake of HTS services in the implementing countries. There are a lot of methods used to conduct the VMMC procedure safely to minimize risks of clinical complications that might result in infections. The advantage of VMMC is that it is easy to be provided safely by different cadres of health care workers in a fixed or mobile health facility setting if they meet the quality assurance (QA) standards for infection prevention (IP). It has also been seen that VMMC is a controversial topic in some areas where it was agreed by other quarters that VMMC will increase the number of people acquiring the virus through unprotected sexual behaviors instead of having the opposite effect.

There are a lot of Social and Behavioral Change Communication Theories in use in the world including the Social Ecological Model (SEM) which is used by the Ministry of Health in its VMMC Communication Strategy. But for this research constructs of Theory of Planned Behavior (TpB), one of the most popular theories in the world today has been used in this research to understand, predict human behavior, and critically examine the perceptions towards the ''*NDIFE OTSOGOLA*'' brand on the VMMC target group in Dowa, with the rationale that the findings can be used to inform future programming aimed at increasing VMMC access and acceptability. This is very important especially in predicting the usefulness of the VMMC brand in influencing decision making to undergo the VMMC procedure as it is irreversible once it has been done, therefore an individual needs to be completely convinced of the pros and cons of the procedure.

CHAPTER 3
METHODOLOGY

3.1 Chapter overview

In this chapter, I am highlighting the type of research method used and its comparative advantage. The focus is on one sampling method used to choose the respondents and health facility catchment areas for data collection to be used. The sample size used has also been explained. The chapter also examines the process of developing and pre-testing data collection tools. The process of data recording, transcribing, manual content analysis has been looked at. Any research has limitations that must be accepted and the impact that they might have on the product. These were also looked at ending up with reliability, validity, and ethical compliance.

3.2 Research design

The study design was qualitative research which was mostly theory driven to investigate some of the constructs of the TpB and the communication brand in relation to uptake of VMMC in a traditionally non-circumcising district in the country. The study used a qualitative research design in order to gain a detailed understanding of why men would choose to undergo VMMC. Considering the nature of the research area face-to-face interviews and focus group discussions were used in order to engage the respondents and get an in-depth understanding of the views of the respondents. The advantages of qualitative designs are that they allow the researcher to get very close to data using different questions asked to the respondents.

Research design is defined as an arrangement of conditions for the collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy and procedure, and is described as a glue that holds all of the elements in a research project together (Akhtar, 2020, p. 68). In other words, it is supposed to guide all the decision making starting from collection of data, processing and analyzing it and at the end ensures that it becomes the basis for all decision making during the research.

The three Health Centre catchment areas were conveniently selected and had to have a blend of a large trading centre surrounded by a rural area with similar demographic characteristics. Ethical clearance was obtained from the Ministry of Health’s National Health Sciences Research Committee (NHSRC). Individual data of consenting participants was collected within different age

bands, education levels, genders and marital status were chosen. Data collection was done by going through face-to-face administration of the researchers' questionnaire in different locations within the three health centre catchment areas on different days. A nine item semi-structured questionnaire focusing on the constructs of the TpB was used to gather data.

Through this design, data was collected, analyzed and inferences were drawn for interpretation. At the end of the study, the method increased the investigator's depth of understanding of the VMMC brand to find out the extent to which it plays a part in decision making processes of the target group on whether to go for VMMC.

3.3 Sampling methods

This research did not have a sampling frame to draw its participants from. A sampling frame is where a researcher can get the members in the population who are eligible for the study (VanderStoep & Johnston, 2009, p. 312). The rule of the thumb is to use a sampling frame if it is available, and you can get it. Malawi being a developing country most of the times it is difficult to get a good sampling frame especially if the researcher is confined to a small budget.

Three health centres were selected through non-probability sampling where by participants were purposively sampled. These health facilities which are involved in implementing the VMMC program formed the study area of the research. Purposive sampling was also used to collect information from the respondents through use of questionnaires. This sampling technique suited the proposed research.

Non-probability sampling is useful especially when coming up with the deliberate choice of participants due to the qualities the participant possesses (Etikan, Musa, & Alkassim, 2016, p. 2). Etikan et. al. (2016) also writes that the researcher decides what needs to be known and sets out to find people who can and are willing to provide the information by virtue of knowledge or experience, their availability and willingness to participate, and the ability to communicate experiences and opinions in an articulate, expressive, and reflective manner. The health facilities that were chosen for this study fit this criterion as they were easily accessible by road thus facilitating easy selection of the subjects or research sample to participate in the study.

A semi structured questionnaire was developed, pre-tested, revised and finalized based on the results of the pre-test before being administered.

3.4 Study sample

Sample size calculations are very important during the design of any study as it helps in deciding how big the sample size is going to be because the greater the sample size the more statistically significant the results will be (Cornish, 2006, p. 1). This means that the reverse is true, denoting that if the investigation sample size is too small, the results might miss out on the results that are very important. For qualitative research, samples are usually small in size and points out that there are three main reasons for this (Ritchie & Lewis, 2003, p. 83). The first reason is that if the data is properly analyzed, there will come a point where very little new evidence is obtained from each additional fieldwork unit. This means that even if the sample is increased, it reaches a point of diminishing returns and increasing the sample size will no longer contribute to new evidence. The second reason is that statistical terms that deal with incidence or prevalence are not the concern of qualitative research and does not require very large samples. The third reason is that the type of information that qualitative studies gather is rich in detail and the researcher will be able to collect a lot of data for interpretation.

The study population of this study was from Dzaleka (79,689), Mtengowanthenga (81,986) and Dowa District Hospital (47,388) catchment areas totaling to 209,063 according to the National Statistical Office 2018 Projections and included single and never married participants, married with children, married without children, divorced, widowed, students, teachers, farmers and business persons. Therefore, researcher selected only 47 respondents as sample. The study was confined to the rural areas only which had been included in previous VMMC campaigns. The following will be the total sample size for the key informant interviews and focus group discussions:

Table 1: Sample size for the qualitative study

Data Collection tool	Description and number of respondents at health facility level	Description and number of respondents at district level	Total
KII	Assistant Environmental Health Officer = 1. Health Facility in Charges = 3. HSA (Supervisors) = 3. HSAs (Health Promotion Focal Persons) = 3. Primary school teachers = 3.	Health Promotion Officer = 1 District Health Office HIV and AIDS Coordinator = 1 Partners (BLM, FPAM e.t.c.) = 2	For health facility = 13 District level = 4 Total = 17
FGDs	At least 6 to 10 participants per FGD = 3	To be conducted at community level. None at health facility level.	For three health center catchment areas: 3 x 10 = 30 Total = 30
Total		47 Respondents	

The research was mostly qualitative, consisting of interviews with the questionnaire being used in addition to the qualitative data collection methods like face to face interviews and focus group discussions. The sample included thirty-four (n=34) and twenty-nine (n=29) participants who included both medically circumcised and uncircumcised males, including females (aged 17 and older) took part in In-Depth Interviews (IDIs) and two Focus Group Discussions respectively. Out of the total number of the participants, only three were adolescents less than 18 years. The Focus Group Discussions participants were from Chanansi (16 participants) and Milare villages (13 participants) in Dzaleka Health Centre and Mtengowanthenga Rural Hospital catchment areas respectively and participated voluntarily with the help of their respective Health Surveillance Assistants (HSA's). The criteria to participate was that it should be anyone from 10 years and above as a group that is targeted for VMMC in the country. The participants were from around Dowa District Hospital, Dzaleka Health Centre, and Mtengowanthenga Mission Hospital catchment areas. A total of 63 participants voluntarily agreed to participate in the research after being taken

through the contents of the consent form. The participants selected were enough as a sample capable of providing accurate data at the period of carrying out the investigation.

3.5 Data collection instruments

Data was collected using a semi-structured questionnaire using In-Depth Interviews (IDI) and Focus Group Discussions (FGD's). The questionnaire was translated in Chichewa for easy administration to respondents and easy understanding of the issues to be discussed due to the low literacy levels in the study area, and to get an in-depth understanding of the perceptions that the VMMC brand has on the target groups for decision making. Information on VMMC brand awareness, or likelihood that the brand's name will come to mind, the ease to which it does so, brand image, or perceptions about a brand as reflected by the brand associations held in the target groups memory was also captured for analysis and interpretation.

The questionnaire was semi-structured tackling the following areas: demographic information of clients, Information, Education and Communication (IEC) prevention and behavioral change messages and their sources, and general satisfaction with the VMMC brand and services and selected TpB Constructs namely motivation to comply, perceived control, perceived action efficacy, normative beliefs, and external variables like demographic characteristics. Data was collected from the sampled research participants aged 10 and above from within the three health centers' catchment areas.

3.5.1 Questionnaires

Questionnaires were administered to a sampled number of research participants in the three selected health facilities within Dowa district to collect the required data from a range of people.

3.5.2 Focus group discussions

FGD's were conducted with the following groups;

- In school males and females,
- Out of school males and females,
- Caregivers.

FGD sessions were held with study participants of the same area having similar traits and characteristics willing to share their views. Focus group method facilitated an understanding of

social rules by the real time reactions of the session participants.

3.6 Data analysis

Interviews were tape recorded and then transcribed. Notes were also taken during the FGD's during the session by a dedicated study team member. The FGDs were also tape recorded, then transcribed verbatim immediately after conducting the interviews before data analysis was conducted. During data analysis, predefined and emerging themes were manually encoded and analyzed to raise common types of themes, answers and reasons given for discrepancies. The focus groups discussed a range of behavioral determinants across VMMC as an HIV and AIDS preventive method, their access to and need for branded VMMC communication materials and information, including how VMMC related decisions were made, gender norms and behavioral expectations. Statistical Package for Social Sciences (SPSS) software version 20.0 for windows was also used to determine basic demographics of the participants. During this stage, analysis, variable coding, data cleaning and consistency checks were done for the demographics analysis. These consistency checks included, among other things, verification of the total valid cases, missing values and correct categories. In order to highlight and answer the objectives of the research, frequency tables and charts were generated for each key variable e.g. demographic characteristics of the respondents, the male circumcision status of the male respondents; and the TpB constructs like perceived behavioral control, perceived action efficacy, normative beliefs, motivation to comply and brand consideration.

3.7 Limitations

This study has a sample size limitation in terms of the number of brands for VMMC to do a thorough analysis on comparative advantage of one brand over the other. If more brands were available to be tested and assessed for brand awareness as well as brand association favorability, there would have been more of a basis on which to test the relationship between brand favorability and brand awareness. The use of non-probability purposive sampling in this study can also sometimes also restrict the generalizability of the findings.

In addition, only three health facilities were selected for data collection out of the eighteen health facilities in Dowa district. Collecting data from a larger proportion of the eighteen health facilities would have been ideal as it would provide more views about VMMC and relationships which can

vary by area in the district and provided a greater sample size for generalizing the findings to all the target areas. To ensure that the use of purposive sampling should not affect the outcome of the research, a lot of thought had to be put to ensure the quality of the end process. The facilities and the surrounding areas had to be the ones that had previously taken part in previous VMMC mass campaigns. They should also have been involved in the demand creation initiatives using various approaches and channels. The choice of health centres within some major trading centres in the district also guaranteed a wide pool of participants who would have gone and attained some form of education. Prior preparation of list of questions and objectives which were carefully considered by considering level of literacy in the area also ensured a reduction and effects of limitations.

The researcher also ensured that a wide range of factors that may play a part in changing behavior were assessed. Multiple items that were assessed for each scale helped the researcher to minimize errors and increased the probability of including all relative components of each construct. In Dowa issues to do with VMMC are seen as a taboo, which means that the researcher at some points had difficulties with handling women once they realized the topic was to do with VMMC, as they tended to opt out of the interview because they felt that the topic was explicit.

3.8 Reliability and validity

The researcher ensured the validity of the data through training of the research assistant, pre-testing the questionnaire and adjusting where necessary, providing the research assistant with clear instructions, posing the questions clearly and unambiguously in the local language (Chichewa). The researcher is also a Senior Health Promotion Officer in the Ministry of Health and therefore an expert in the field as he has been involved in a wide variety of qualitative surveys.

Reliability of the research was guaranteed by including multiple respondents during data collection. The data was also collected not once but several times, at varying times at different places. Another way of making sure that the data collected was reliable was by using of the same previously pre-tested version of the data collection instrument.

3.9 Ethics compliance

The proposal and the tools used in this research were submitted to the Faculty of Education and Media Studies Post-Graduate Committee for analysis and approval during the research proposals presentation seminar, and this was granted.

Those involved in the research were under age, whilst some were of legal age. For those who were under age, consent was sought from their legal guardians, and this was granted. For those of legal age, they were informed on what the research was all about and were given liberty on whether they wanted to continue or opt out of the interview and subsequent discussions at any point, and that any information given out in this research would be treated confidentially. In addition to that, all efforts were made not to injure the participants in the research (See appendices 1 and 2 respectively).

Ethical clearance was also obtained from Ministry of Health's National Health Sciences Research Committee (NHSRC) under Protocol # 19/01/2199 which was approved on 21stJanuary 2019 valid up to 20th January, 2020 (See appendices 3, 4 and 5 respectively). The NHSRC is registered with the USA Office for Human Research Protection (OHRP) as an International IRBIRB Number IRB00003905 FW A00005976.

A letter of support from Dowa District Health Office was also obtained which was used as an entry point when going to collect data in the catchment areas of the health facilities (See appendix 6).

3.10 Chapter summary

The study used qualitative research methods. Through this method, data was collected, analyzed and inferences were drawn for interpretation. The health facilities which are involved in implementing the VMMC program formed the sample frame of the study. Non-probability (purposive) sampling method was used in this study. Using this sampling method, the health facilities that were easily accessible by road were chosen, thus facilitating easy selection of the subjects or research sample to participate in the study. A questionnaire was developed, translated in Chichewa, pre-tested, revised and finalized based on the results of the pre-test before being administered.

A total of thirty-four (n=34) and twenty-nine (n=29) participants who included both medically circumcised and uncircumcised young adults, including females (aged 17 and older) took part in In-Depth Interviews and two Focus Group Discussions respectively. The questionnaire was semi-structured tackling different areas including, but not limited to demographic information, behavioral change messages and their sources, and general satisfaction with the VMMC brand and services and selected TpB Constructs namely motivation to comply, perceived control, perceived action efficacy and normative beliefs. Notes were also taken during the FGD's during the session by a dedicated study team member. The KIIs and FGDs were tape recorded, transcribed and translated verbatim immediately after conducting the interviews, before data analysis was conducted. Analysis of the data collected used various means including transcribing and translating verbatim. Content analysis was used to analyze the data thematically, using codes and emerging themes. SPSS was also used to complement the above processes and keep track of the major theory constructs.

Some of the limitations in the research were that sample size was small in terms of the number of communication brands for VMMC to do a thorough analysis on comparative advantage of one brand over the other. The use of purposive samples in this study also restricted the generalizability of the findings. In addition, only three health facilities were selected for data collection out of the eighteen health facilities in Dowa district. To ensure content validity, the researcher ensured that a wide range of factors that may influence behavior were assessed. In Dowa issues to do with VMMC are seen as a taboo, which means that the researcher at some points had difficulties with handling

women once they realized the topic was to do with VMMC, as they tended to opt out of the interview because they felt that the topic was explicit.

Reliability was ensured by training the research assistant, pre-testing the questionnaire and adjusting where necessary, providing the research assistant with clear instructions, posing the questions clearly and unambiguously in the local language (Chichewa). The researcher is also a Senior Health Promotion Officer in the Ministry of Health and therefore an expert in the field as he has been involved in a wide variety of qualitative surveys.

In compliance with ethical requirements of the study to ensure that ethical compliance was adhered to, the proposal and the tools used in this research were submitted to the Faculty of Education and Media Studies Post-Graduate Committee for analysis and approval during the research proposals presentation seminar. Consent from participants and legal guardians for those under age was also being sought before continuing with data collection. Ethical clearance was also obtained from Ministry of Health's National Health Sciences Research Committee (NHSRC).

CHAPTER 4

FINDINGS AND DISCUSSION

4.1 Chapter overview

Every research is supposed to have findings and discussions on areas of special interest. This evaluation was guided by some constructs of Theory of Planned Behavior. This chapter examines the constructs like external variables (Demographic characteristics) especially the age ranges, sex of the respondents, marital status, occupation, literacy levels and catchment area distribution. Other constructs include brand health (focusing on brand knowledge, brand description, availability of parallel brands), brand familiarity, brand effect and brand consideration. Another very important construct called normative beliefs (looking at thematic areas like brand recommendation, peer influence, major influencers on VMMC, the first time respondents' saw the brand, the last time respondents' saw the brand, the most common channel of seeing or hearing the brand, how often the respondents are exposed to the brand and perception of the respondents to the brand). The perceived action efficacy construct that looks at an individual's impression of their own ability to perform a demanding or challenging task, in this case perception on whether respondents felt that target groups could be reminded to undergo for VMMC in the next 12 months after seeing and being reminded by the VMMC brand was also covered. The last two constructs to be looked at included perceived behavioral control (decision making at household level on VMMC) and motivation to comply.

Data collection was done using questionnaires which were administered to both males and females in order to gather information to fulfill the above mentioned objectives. This chapter presents the results of the survey that was conducted.

The discussion will also base its flow on some of the constructs of the TpB that were used in the design of the research and data collection tool.

4.2 Demographic characteristics

4.2.1 Age ranges

A total of 34 respondents' mothers were approached and interviewed as part of the study in the three catchment areas of Dowa District Hospital, Mtengowanthenga Rural Hospital and Dzaleka Health Centre. In addition to the interviews, two FGD's were also conducted in Chanansi (16 participants) and Milare villages (13 participants) in Dzaleka Health Centre and Mtengowanthenga Rural Hospital catchment areas respectively.

Table 2: Demographic characteristics of study participants.

	Number	Percent (%)
Sex		
Male	25	73.5
Female	9	26.5
Age group		
<18	3	8.8
18 - 24	18	52.9
25 - 34	11	32.4
35 - 44	0	0
>45	2	5.9
Marital Status		
Single, never married	11	32.4
Married with children	16	47.1
Married without children	3	8.8
Divorced	3	8.8
Widowed	1	2.9
Occupation		
Student	4	11.8
Employed	5	14.7
Unemployed	3	8.8
Farmer	10	29.4
Business person	11	32.4
Other	1	2.9
Catchment area distribution		
Dowa District Hospital	12	35.3
Dzaleka Health Centre	9	26.5
Mtengowanthenga Rural Hospital	13	38.2
Literacy levels		
None	8	23.5
Primary	12	35.3
Secondary	13	38.2
Tertiary	1	2.9

Table 2 present the age ranges of the respondents to the survey in the three catchment areas that were willing to respond to the questionnaire during interviews. Fifty-three percent (52.9%) of the 34 respondents were between the age ranges of 18 – 24, followed by thirty-two percent (32.4%) within 25 – 34 years, with the least being those above 45 years who were at six percent (5.9%) and were the least willing to respond to during the interviews. The older community members were unwilling to respond to the topic because this was foreign topic to them. They have grown up in a social culture setup that is rigid in its rules and traditions such that they must conform to the social norms of the community. If they are perceived or seen to be taking part in something which is considered outside the community norms, they may in this case be ridiculed.

4.2.2 Sex of participants

The majority who were willing to take part in the survey were male at seventy-four percent (73.5%) while twenty-six percent (26.5%) of the respondents were females. The results showed that there was unequal distribution in the number of males and females who were willing to be interviewed during data collection. During data collection, it was proving difficult to carry on with some of the interviews with the females once they noted that the issue to be discussed concerned VMMC than with their male counter parts. This could be attributed due to the cultural norms of the catchment area. This in a way proved that although VMMC interventions have been going on in the district, the females still found it hard to discuss the issue openly in the community and in extension with strangers. This might be attributed to the beliefs and social norms that influence the Chewa culture on discussions of issues to do with sex and sexuality between the opposite sexes that mostly create a climate in which the discussions on such issues are discouraged. This is also in line with the study done in the central region of Malawi which found out that issues concerning sexuality are a paradox in the African context such that they are regarded as taboo not to be discussed 'openly' (Longwe, 2003, p. 3). Another reason would be that some of the participants that were interviewed were not comfortable discussing sexual issues because some were older and not comfortable discussing the issue with a younger person. Some of them maybe felt that VMMC is related to religious inclinations that were not favorable to them and would be seen as ready to embrace foreign religions. Some researchers have also found that the Bible has had a strong influence on the Chewa Christian culture, in a way it has been used and misused to keep women bound to subordinate behavior, such that women are expected to act according to certain norms, defined earlier by another culture in another time (Nyirenda, 2013, p. 25). This can also partially explain the behavior of some of the women

during the interview when they were withdrawing after noting that the topic was not in conformity with the Chewa social cultural norms.

4.2.3 Marital status

Marital status was also explored during the research to find out how many of the participants were married or not. The findings show that 47.1% were married and had children while 32.4% were single. The least number interviewed were widows 2.9%. This mixture ensured that there was a representative of different types of people at different levels of understanding of sexual related issues to give a real picture of the situation on the ground.

4.2.4 Occupation

The occupation of the respondents was also analyzed to understand the likelihood of them being exposed to the VMMC brand and how the process of undergoing the VMMC procedure can impact on their daily livelihoods. The findings showed that the majority of the participants, at 32.4% were a mixture of business people (although they are also small scale farmers) involved in operating bicycle taxis (*Kabaza*), frying and selling chips, selling secondhand clothes (*Kaunjika*) and other small scale undertakings followed closely by those who rely only on farming at 29.4%. On the other hand, 14.7% of those interviewed work as primary schools' teachers and one mechanic. The least, 2.9% are involved in other activities like peace work (*Maganyu*).The findings are in tandem with the Dowa District Social Economic profile which shows that 39 percent of the income is derived from enterprises, 30 percent from Agriculture, 24 percent from wages and 7 percent from other sources (Dowa District Council, 2015 - 2020, p. 59). It should also be noted that data collection was done mostly in the areas around the health facilities which normally have the mixture of residents as depicted. If data collection had been done in areas farther away from the health facilities maybe the results of the occupation of people would have been different and the farmers would have been in majority.

4.2.5 Catchment area distribution

The study was carried out in two health centres, Dzaleka Health Centre catchment area had the lowest number of participants at 26.5% whilst Mtengowanthenga Rural Hospital contributed the majority at 38.2%. The participation in Dzaleka catchment area was low because this area is dominated by internally displaced foreign nationals due to the multi-racial settlement of refugees dominating that area as the facility is within Dzaleka Refugee Camp. As of 31st October 2014, Dzaleka Refugee Camp was harboring 19,983 refugees mainly from Burundi, Rwanda, Somalia, Democratic Republic of Congo, Sudan, Ethiopia, Belgium, Kenya, Zambia,

Brazil, Tanzania and Angola (Dowa District Council, 2015 - 2020, p. 34). This led to difficulties in finding participants fluent in Chichewa as the interviewee had to approach two or more people before finding a respondent to take part in the research. So, the sentiments that were captured during the research were strictly Malawian citizens.

4.2.6 Literacy levels

Thirty-eight percent (38.2%) of the participants attained secondary school education, whilst twenty-four percent (23.5%) had no formal education at all. Only three percent (3%) went as far tertiary level (Teachers Training College). If we look at the district data, the literacy rate stands at 70.3, which is above the national and regional rate of 65.7 and 60.7respectively, with more males being literate than females. The sample which took part was way below the district level literacy achievements, which can also mean that their understanding of new health concepts like VMMC can also be compromised by their deep-rooted cultural norms. Literacy determines the way a person understands and reacts to new interventions in the community.

4.3 Thematic analysis

The study used the constructs in the Theory of Planned Behavior (TpB) to evaluate the "*NDIFE OTSOGOLA*" VMMC communication brand in relation to VMMC uptake in Dowa district in Malawi. Mainly the issues under discussion were broadly looked at from the perspective of external and internal variables. The external variables looked at the characteristics of the participants. On the other hand, the other variables looked at the intrinsic variables that would influence behavior. On this note, the study focused on four aspects, namely motivation to comply, behavioral beliefs, normative beliefs and perceived behavioral control. The areas which were outlined in the data collection guide based on the TpB construct are also presented in the following tables:

Table 3: 1 Areas Outlined in Focus Group Guide Based on the Theory of Planned Behavior (External variables and Knowledge)

Seq	TpB Construct	Broad Themes	Sub-themes
1	External variables.	Assess participants' characteristics.	• Participants were examined based on age, sex, marital status, occupation, knowledge, area of residence, health center catchment area and education. • Whether they would be able to recall the VMMC brand from memory, and if they were aware of other brands promoting VMMC currently available.
	Knowledge.	Adequate	• Not aware of any parallel brands. • VMMC services are available. • Protection from cervical cancer in future. • Reminds them to counsel others properly. • Brand does not remind them of anything.
		Inadequate	• Not able to recall the brand. • Brand made up of two features (Thumb and Hat). • Confusing communication brand with Demopen and the National AIDS Commission (NAC) logo. • Aware of a parallel VMMC communication brand. Brand is made up of three main features (NDIFE OTSOGOLA words, Thumb and Hat).
2	Motivation to comply.	Ascertain the participants' willingness to go for VMMC if exposed to the brand.	• Explore whether if the participants are not circumcised, can the brand influence them in deciding to go for VMMC? • Identify whether if circumcised, did the brand have an influence for them when it came to deciding to go for the procedure. • Explore if they would recommend others to go for VMMC in relation to this communication brand. • Explore if the communication brand can play a part in encouraging them to go for VMMC within the next 12 months.

Table 4: 2 - 3 Areas Outlined in Focus Group Guide Based on the Theory of Planned Behavior (Motivation to comply and Behavioral beliefs)

Seq	TpB Construct	Broad Themes	Sub-themes
2	Motivation to comply.	Positive behavior Promotes body hygiene	• Promotes body hygiene.
		Negative behavior Fear associated with VMMC	• Fear to go for the procedure. • Fear of having a wound. • Fear of becoming impotent. • Fear of committing a sin. • Shyness. • Ignorant on what really happens when they arrive at the circumcising site. • Don't know reason to go for VMMC. • Do not have time to go for VMMC. • Not interested in VMMC. • Not yet made a decision to go for VMMC. • Not culturally acceptable. • Procedure can interfere with my occupation. • Person cannot contract HIV, Syphilis, Gonorrhea, *Inguinal bubo,* Genital Warts and Cervical Cancer.
3	Behavioral beliefs	Ascertain beliefs for and against adopting VMMC behaviors	• Explore their perceptions when they see this brand? • Identify and describe the participants overall opinion of the communication brand. • Identify their expectations if they will go for VMMC within the next 12 months after seeing the VMMC brand. • Identify reasons and advantages for going for VMMC in relation to the brand. • Identify activities, circumstances, or events that make it easier or more likely to adopt VMMC in relation to the brand. • Identify activities, circumstances, or events that make it harder or less likely to adopt VMMC in relation to the brand.
		Positive beliefs.	• Helps keep penis and surrounding areas clean. • If I can understand fully and be convinced of the advantages of VMMC. • It helps in reduction of contracting STI's. • It is one way of helping the government protect people from being infected from STI's. • Can encourage colleagues to go for VMMC even though it can be a bit difficult coming from a non-doer. • Can be encouraged if they want to go for VMMC. • Couples will be having a good sexual life. • Mere picture cannot make me change my mind. • Am not a good role model to advocate for VMMC as I haven't been medically circumcised

Table 5: 3 - 5 Areas Outlined in Focus Group Guide Based on the Theory of Planned Behavior (Behavioral beliefs, Normative beliefs and Perceived behavioral control)

Seq	TpB Construct	Broad Themes	Sub-themes
3		Negative beliefs	• If a person is medically circumcised, he will become impotent. • Person cannot contract HIV, Syphilis, Gonorrhea, *Inguinal bubo,* Genital Warts and Cervical Cancer. • Will have energy to farm as they will not be pre-occupied with sex.
4	Normative beliefs.	Ascertain beliefs of friends, family, and significant others about VMMC.	• Identify sources, networks, influencers or people that encourage or discourage participants to undergo VMMC. • What do they think of friends' reaction if told to go for VMMC?
		Positive peer influence	• Can go because some friends went for VMMC. • My late father was a practicing Moslem by faith
		Negative peer influence	• We cannot be motivators because we are not circumcised. • Do not want their peers to think lowly of them. • Everyone goes on their on to do the procedure. Procedure is shrouded in secrecy. • As eldest in the family the younger ones cannot advise me what to do
5	Perceived behavioral control.	To ascertain whether they are capable of deciding to go for VMMC on their own.	• Explore whether it would be possible or impossible for them to go for VMMC within the next 12 months. • Find out if decision making process would be dependent on others within the next 12 months?
		Positive behavior	• If the advantages are explained clearly, the desire to go for VMMC can be aroused. • Discussing with someone might lead to delays
		Negative behavior	• Can be discouraged by friends. • Mere picture cannot motivate a person to do something that they do not want. • If a person wants to go for VMMC he can go, if he does not want he will not go

4.4 Knowledge Level

In all the health facilities, the research tried to find out whether the "NDIFE OTSOGOLA" VMMC communication brand would automatically be recalled by the participants once they were asked before visually being shown the VMMC brand image.

82.4% of the participants were not able to recall the brand and only 17.6% managed to recall. The local recall proportion of the research respondents does not paint a very good picture of the social and behavioral change communication initiatives that the district has been conducting to sensitize the community members about VMMC as an extra HIV and AIDS prevention intervention by the Ministry of Health. The expectation would have been that after about seven years that the VMMC intervention has been implemented in the district, the majority would have been aware and be able to recall the brand image once asked just like they are able to do with other products on the market like existence of Coca-cola, Carlsberg Green, Airtel or TNM mobile.

The research also aimed at apart from the respondents being able to describe the image of the VMMC brand, they should also try to describe some of the macro components making up the brand. Most participants, 82.4%, failed even to describe the appearance of the brand. As alluded to previously that some were able to recall the brand, only 11.8% of these managed to mention only two features (Thumb and Hat) that are on the VMMC brand and six percent (6%) managed to mention the three main features (*NDIFE OTSOGOLA* words, Thumb & hat) of the brand. There were also some who were mistaking some symbols or items as brands for VMMC. Some of these symbols included the Demopen (used during sensitization meetings and counselling sessions), the green cross (painted on emergency ambulances) and the National AIDS Commission (NAC) logo. When some of the respondents asked on the availability of a parallel brand, ninety-four percent (94.1%) were not aware of any parallel brands whilst six percent (6%) answered that they were aware of the availability of a parallel VMMC communication brand. When probed further to describe the parallel brand, two of the respondents graphically described the Demopen that is used by VMMC counsellors to teach people how the procedure is done during group and individual counselling. Given that in the previous questions most respondents were not able to describe the image and macro components of the brand, it is not surprising that some (6%) stated that a parallel brand exists.

This means that the brand has not been marketed well enough in the district for the target group to be aroused when they see the brand on the topic to trigger whether discussions on the topic between married couples, teenagers, and various groups of people in the district. The health workers and counselors are also not doing a very good work during their sessions. Such that

they are clearly not being able to explain properly the use of job aids like Demopens and why they are being used for.

The respondents were also asked if they were able to recognize the '*NDIFE OTSOGOLA*' VMMC communication brand after it was visually shown to them and what they expect the brand to promote, and the results are shown in figure 2 below.

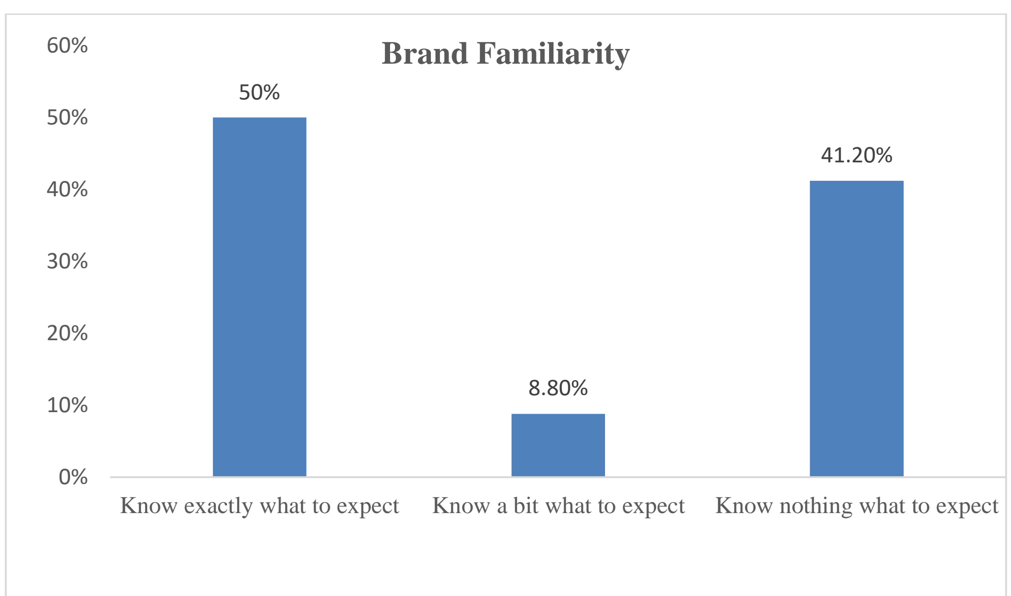


Figure 4: Respondents' responses on familiarity to the brand.

Fifty percent (50%) of the participants were able to explain some of the services and benefits that they expect from the brand whilst forty-one percent (41.2%) said that they do not know any services that they expect from the brand. Forty-one percent is a very big gap that needs not to be ignored as it can impact negatively on the success rate of the program in the district. The districts health personnel need to sensitize the target groups on the services offered at VMMC access points, which includes counselling sessions, HIV Testing Services and the VMMC procedure itself. The benefits that need to be communicated if a person goes for the procedure should be that it is easier to keep the penis and surrounding areas clean, there is a reduced risk of urinary tract infections in childhood, prevention of inflammation of the glans (balanitis) and the foreskin (posthitis), prevention of phimosis (the inability to retract the foreskin) and paraphimosis (swelling of the retracted foreskin and the inability to return the foreskin to its original location), a reduced risk of some sexually transmitted diseases in men, especially ulcerative diseases like chancroid and herpes, a reduced risk of men becoming infected with HIV, a reduced risk of penile cancer and transmission of Human Papilloma Virus which causes Cervical cancer in women.

Respondents were also asked what the communication brand reminded them of, after it was visually shown to them.

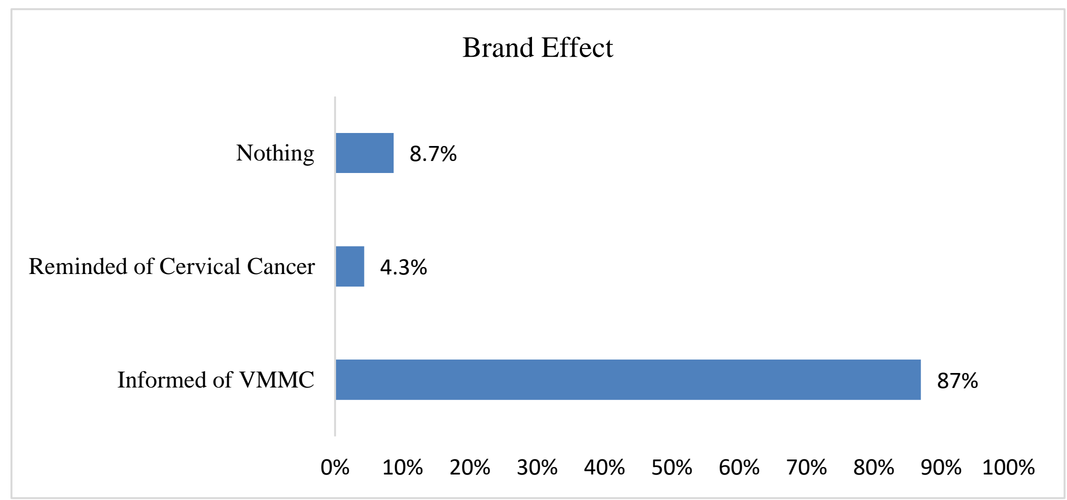


Figure 5: Respondents' responses on effect of the brand.

The results as shown in figure 6 indicate that out of the twenty respondents (50% cumulative percent in figure 5 who said they were familiar with the image, 87% of the respondents mentioned that the brand reminds them of the availability of VMMC services in Dowa district and that there were a lot of things that it reminded them of.

> *"The image reminds us that there are VMMC services being provided in the district and helps them to make informed choices or decisions………" (Alikanjero Biniwelo, Kamphimbi village, Interviewed at Dowa Boma Market, T/A Msakambewa).*

Another portion of the respondents, mostly women (4.3%), said that they were reminded that they would be protected from developing cervical cancer in future. Some of the respondents also indicated that even though they see the brand, it does not remind them of anything.

Some of the respondents had their facts partially wrong as they did mention that if a male is circumcised they are protected from getting Sexually Transmitted Infectios if they partake in unprotected sex.

> *"The advantage of medical male circumcision is that a person cannot contract HIV, Syphilis, Gonorrhea, Inguinal bubo, Genital Warts, Cervical Cancer, and it can also help to remind them to counsel others properly. Another thing that can happen to a person who has been circumcised is that a person will become impotent. It is also easier to keep the penis and surrounding areas clean"* (Grivin Mbewe, Mtengowanthenga Trading Centre, T/A Mkukula).

It can be seen from the responses that there was a mixture of factual and negative perceptions which can impact positively or negatively on program implementation respectively. The responses that a person cannot contract HIV, Syphilis, Gonorrhea, *Inguinal bubo,* Genital Warts

and Cervical Cancer is totally wrong because VMMC only offers partial protection from the said diseases and that safe sex practices like faithfully sticking to one spouse and proper use of condoms every time couples have sex is the way to go. The wrong perceptions that respondents have in the district bordering on impotence when a man is circumcised is a barrier that should be addressed using interpersonal means to increase the uptake of VMMC.

4.5 Motivation to comply

The researcher also tried to find out on whether the respondents were circumcised or not, and if they were, did the brand play a part in motivating them in deciding to go for the procedure or not. This question was only applicable to the male respondents only. The results are presented in figure 6.

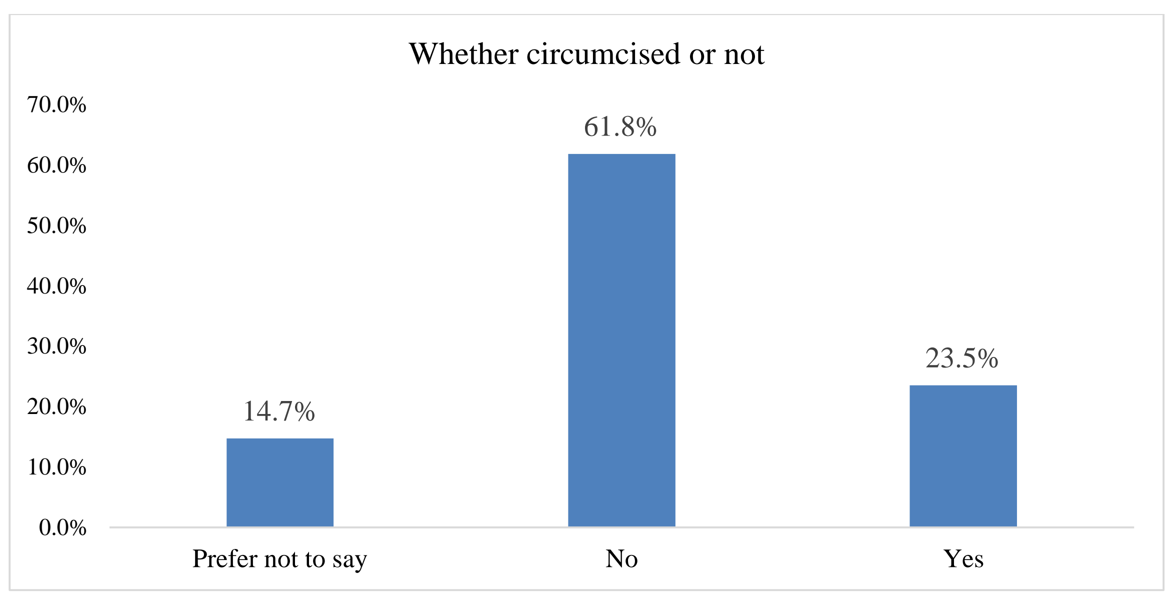


Figure 6: Whether respondents are circumcised or not.

From figure 6 out of the total respondents interviewed, sixty-two percent (61.8%, n = 21) of the respondents responded that they are not circumcised whilst twenty-four (23.5%, n = 8) underwent the procedure.

4.5.1 Negative influences: When asked why they did not go for the procedure various reasons were given.

> *"I am afraid to undergo the VMMC procedure because I do not know what really happens when a person arrives at the circumcising site …..... I don't know why I should go for VMMC, I have never been told all the advantages and disadvantages after undergoing this process …………. I have heard that the wound takes time to heal, so I*

am afraid of having a wound in the private parts which would take so long to heal", (Collins Kachere, Businessman, Mtengowanthenga Trading Centre, T/A Mkukula).

This could be attributed to the fact that sometimes those who undergo the procedure have problems in wound care. Some bluntly replied that they do not have time to go for VMMC, or they do not want to go for VMMC, or they have not yet made a decision to go for VMMC.

4.5.2 Fear of loss of income: Another interesting response came from a bicycle taxi (*Kabaza*) operator who said;

> *"The procedure can interfere with my day to day occupation because I need to ride the bicycle taxi to make money used to fend for my family because the wound takes time to heal, such that I would not be able to ride the bicycle taxi"*, (Wilfred Dzonzi, Kabaza Operator, Dzaleka Refugee Camp, T/A Msakambewa).

4.5.3 Religious influences: For others they were attaching religious connotations to the reasons for not accessing VMMC services in the district;

> *"According to the Bible, it is said in the book of Genesis that God created man in his own image, so I think it will be a sin to remove the foreskin which he gave us when we were being created as it will be against his wishes and design",* (FGD, Milare village, Mtengowanthenga Rural Hospital catchment area, T/A Mkukula).

4.5.4 Cultural influences: Some of women also had issues to do with VMMC as it is in conflict with their cultural norms;

> *"Men are afraid to go for VMMC because we do not do this in our Chewa cultural setup. I do not think anyone in our community has ever done this before. If they go and people get wind of it, they will think that man is silly and is not thinking properly",* (Eneless Jede, Nanthomba Secondary School student, Dowa Main Market).

The Chewa culture also puts pressure on married couples to have children, and if a couple do not have children in their families, they face a lot of ridicule in their communities, as such some members are not ready to go for VMMC;

> *"There are many stories out there about VMMC that we have heard. One of them is that in future we will not be able to do our conjugal rights properly. So we are afraid of going for VMMC because we are afraid of not being able to impregnate our spouses in future",* (FGD, Chanasi village, Dzaleka Health Centre catchment area, T/A Msakambewa).

For those who went for the procedure cited reasons like they wanted to protect themselves from contracting diseases like HIV, Syphilis, Gorrnohoea, *Inguinal bubo,* Genital warts. Some said that it promotes body hygiene. Much as these are some of the reasons VMMC is advocating, some of the responses are partially right and wrong. For example, if they had responded that they are reducing chances of contracting "HIV" as a virus but not as a disease, because HIV is a causative agent of the disease AIDS. As such there is great need to refocus when it comes to social and behavioral change messaging for the community members to have the right messages. The barriers outlined in the responses need to be addressed because in essence they are many and reflect on the low achievements rate of the VMMC program in the district. Deliberate efforts need to be taken by the health workers to come up with behavioral change interventions aimed with dealing with the local social cultural barriers.

4.6 Behavioral beliefs

4.6.1 Positive behavioral beliefs: The reason why interventions are branded is to ensure that they can motivate behavior change in the target groups. The perceptions on whether the brand could play a part in influencing a person to undergo the VMMC procedure if they were constantly exposed to it were also explored.

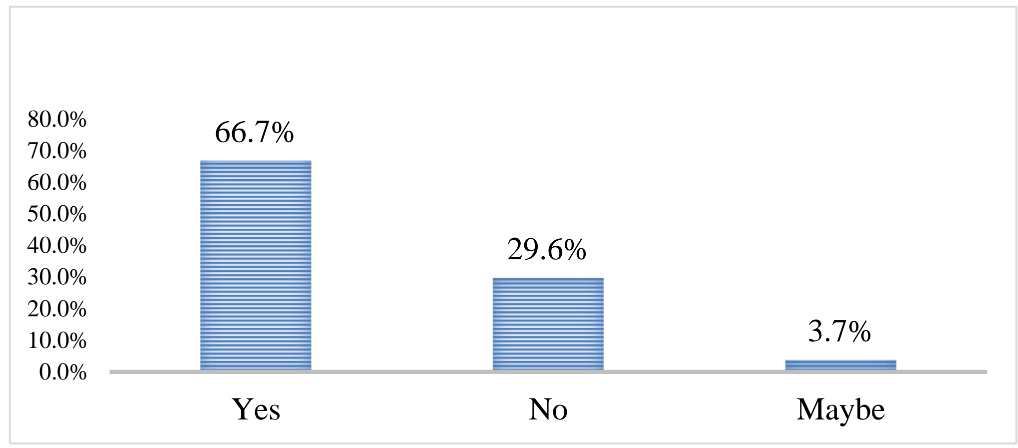


Figure 7: Whether brand can influence decision making in VMMC.

Out of all the respondents, sixty-seven percent (66.7%) of the respondents said that yes it can, whilst thirty percent (29.6%) said no (Figure 8). Some of the respondents cited reasons like they can do that if they can understand fully the benefits and be convinced of the advantages of VMMC. Some wrongly mentioned that "It helps in reduction of contracting STI's" when actually, they should have responded that it reduces chances of STI transmission, it means there is still a gap in messaging out there as previously stated. Constant exposure to a message or brand is very important in behavioral change communication. If the brand in the district on VMMC can be institutionalized with the correct messages, it will be very good to those within the twenty-seven percent band who said they cannot be swayed with the brand if it is coupled

with other social and behavioral change communication approaches like interpersonal communication.

Most of the participants, eighty-five percent (84.8%) also indicated that they could recommend VMMC to their associates using the brand while fifteen percent (15.2%) said they would not be comfortable to do that. Those who said they would be able to recommend based their responses to associated benefits of VMMC that the brand represent. Apart from saying advantages like increased penile hygiene in men, protecting themselves from contracting diseases like Cervical Cancer, HIV, Syphilis, Gorrnohoea, *Inguinal bubo* and Genital warts, some said that;

> *"It is one way of helping the government to achieve its goals of protecting people from being infected from STI's",* (Yusuf Matola, Primary School Teacher, Mtengowanthenga, T/A Mkukula).

A very strange response came from one respondent who said;

> *"I can encourage colleagues to go for VMMC even though it can be a bit difficult coming from a non-doer like me who has never been circumcised. I am not a good role model to be advocating for VMMC as I have not been medically circumcised",* (Kingsley Kabango, community member, T/A Chiwere, market interview).

Some of the participants indicated that if they want to go for VMMC they can be encouraged, which was a very positive indication, and others said that they will have energy to farm as they will not be pre-occupied with sex, as opposed to another respondent who said that couples will be having a good sexual life.

4.6.2 Negative behavior beliefs - fear associated with VMMC: Most of those who said they would not be able to recommend also had their own reasons;

> *"At the moment I cannot do that, I would only be able to do that unless I understand fully and see the advantages of VMMC, and if I have the confidence and able to know what to tell people about the procedure without any problems",* (Aleta Chitute, at a FGD, Chanasi village, T/A Msakambewa).

The importance of using a multi mix channeling when conducting communication activities is also important to avoid reaching individuals and communities with very important messages as some channels might not be appealing to some are not palatable to others, taking into account responses like these;

"I cannot go and will never go for VMMC because a mere picture cannot make a person like me change my mind", (Benjamin Kawayi, not working, Mtengowanthenga Trading Centre, T/A Mkukula).

Issues to do with role modelling can also play a very important role in ensuring that uptake of VMMC services is improved in the district. If the district can be able to identify an influential figure in the district who has embraced VMMC as an HIV preventive measure and willing to share testimonies voluntarily through various fora like open days would in the end de-mystify VMMC in the traditionally non-circumcising district, such that those community members deeply rooted in cultural beliefs would now be able to weigh the pros and cons and make an informed choice.

4.7 Normative beliefs

4.7.1 Negative peer influence: Peer influence also known as social influence has been demonstrated to be an influential tool in changing behaviors of the targeted groups. In this research, the angle to do with whether or not people who are important in the respondents, lives thought that it was important for the target group to go for VMMC in the next 12 months after seeing the VMMC brand was also explored.

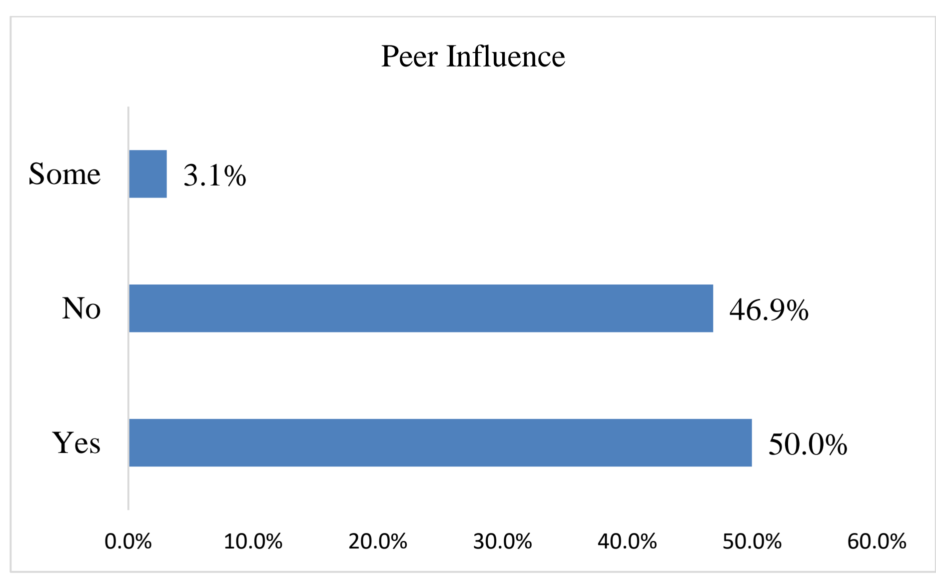


Figure 8: Effect of peer influence while using the brand.

Fifty percent (50%) thought it is possible while forty-seven percent (47%) said it is not possible (Figure 9). Those who said no based their decision by clarifying that most of them are not circumcised so it is not possible for them to act as motivators or expert clients, that they are shy and that they do not want their peers to think lowly of them.

> *"I only hear about VMMC on the radio and that he feels that the whole procedure is shrouded in secrecy. And some of us are the eldest in the family and the younger ones cannot advise us what to do",* (Paul Mtanda, Kabaza Operator, Mtengowanthenga Bus Stage, T/A Mkukula).

4.7.2 Positive peer influence: Some of the respondents were willing to be influenced because they know and have heard of their peers who went for the procedure e.g. their cousins so they have a positive outlook on the intervention and others would be willing because their late father was a practicing Moslem by faith. According to the responses, there is still a big problem in trying to deal with the barriers which are mostly based on social cultural elements to successful change behavior and make eligible males go for VMMC in the community. Looking at the differences which is minimal between those who can and cannot be influenced by their peers, there is still a long way to go in order to change their mindsets so that the balance of probabilities should lean more towards those willing to change in line with their peers on VMMC. Using peer approaches as already alluded to, behavior change can happen if this can be included in communication interventions in the district when it comes to VMMC. This is even collaborated by the VMMC situation report, a study undertaken amongst adolescents in selected districts of Malawi report youths as indicating that they underwent circumcision because they envied peers who had been circumcised and undergone initiation ceremonies (Bengo, et al., 2010, p. 47). The same is said in other traditionally circumcising districts like Machinga where boys reported that in some cases they attend the ceremonies out of peer pressure from other boys and girls who have attended the ceremonies, who had the perception that circumcised men are 'sweet' in bed and that they are clean compared to those who are uncircumcised (Munthali, Kok, & Kakal, 2018, p. vi). Munthali et. al. continues to point out that some of the respondents in their research elaborated that peers were telling their friends that a person who is circumcised is like a good 'peeled cassava' (Munthali, Kok, & Kakal, 2018, p. 37). For those who are uninitiated they are considered as not worthy to be among their circumcised peers and that they were discriminated and perceived as being a child regardless of age.

4.7.3 Major motivators in VMMC

Apart from exploring the effect of peers in decision making processes for the target groups to go for VMMC, another category of people who have ever discussed issues to do with VMMC and could play a part in encouraging uncircumcised respondents to go for the procedure in the next 12 months after the day of data collection based on the benefits shared to them.

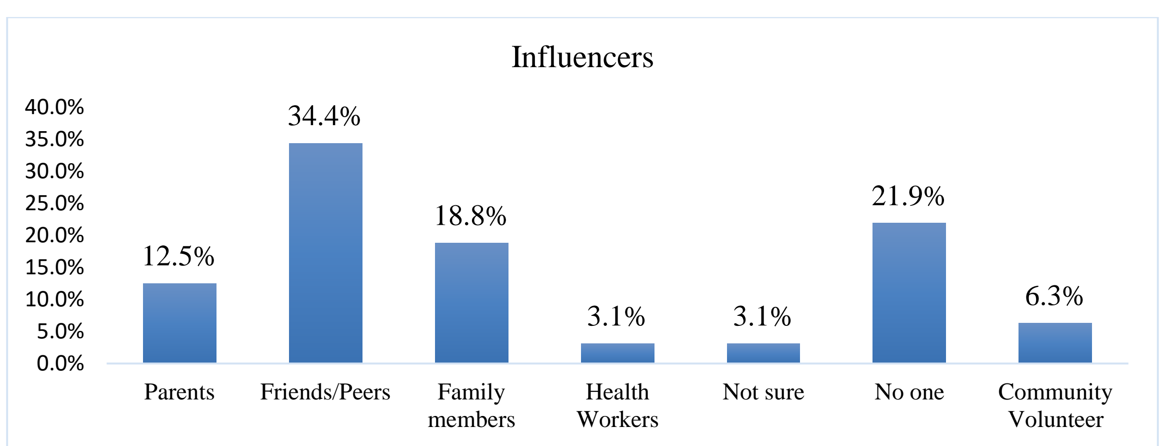


Figure 9: Main motivators in the community.

The results shown in Figure 9 indicates that friends or peers were mentioned at thirty four percent (34.4%), and no one had discussed this issue with twenty two percent (21.9%) of the respondents. Surprisingly, Health Workers came last at three percent (3.1%). Health Workers are supposed to be in the fore front in disseminating messages, and be mentioned by their communities as sources of various health related information. Health Workers command trust in the community and anything they say is taken on board and acted upon. So the Health Workers need to take a pro-active role in actively engaging the target groups to increase uptake of VMMC services in the communities. The majority of Health Workers in the community are Health Surveillance Assistants (HSA). The problem can also be attributed to the fact that HSAs' are overburdened and have inconsistent and unclear responsibilities. While guidelines on the management of task shifting to HSAs' exist, task shifting sometimes takes place with little oversight, with implementing partners sometimes adding tasks to HSAs' workloads without coordinating with the district government leading to neglecting of some core duties (Ministry of Health and Population, 2017, p. 7).

Peers remain a main or very important approach that can be used as an opportunity to propagate messages for VMMC, thereby fostering diffusion and acceptance of VMMC by the target group in the district. Seeing that one-fifth (21.9%) of the respondents did not have any discussions on the topic, this is very alarming because it presents a very big gap of the population that might have no information or motivation on the topic since the intervention rolled out in 2012. Conspicuously missing on the list of motivators in the community on VMMC are chiefs, community leaders, faith-based leaders, elder men and women. This category of people has a great role to play in HIV and AIDS prevention because they are trusted within the communities. The power that they have enables them to foster behavior change and can positively contribute to uptake of VMMC services and in the long run reduce the incidence and prevalence rate of HIV and AIDS in the district. This shows that Dowa district Health Office is missing a very crucial channel of disseminating information who are very important in the community and can

help in educating people on VMMC. These important gatekeepers need to be part of program development and ensure that their involvement is from planning phase of VMMC mass campaigns that are conducted in the district so that they own the intervention. They could also be part of the monitoring and evaluation efforts to ensure sustainability of the intervention.

4.7.4 The first time respondents' saw the brand

Various categories of people receive various messages at different times through various approaches and channels. The research explored from respondents on when they were first exposed to the VMMC brand for the first time in their various localities. In the three catchment areas, fifty-six percent (56.3%) of the participants were exposed for the first time to the brand more than 12 months (a year) from the time that the survey was conducted, with twenty-two percent (21.9%) saying that they have never seen the VMMC brand before. Those who saw the brand for the first time within the last 12 months (12.5%) specifically mentioned the months of June and July 2018 when the district had a mass VMMC campaign. This means that one-fifth of the population has been missed out by the communication efforts for them to have and make informed decisions on whether to or not go for VMMC.

4.7.5 The last time respondents' saw the brand

Due to availability of resources and differences in planning for communication interventions, various people can be reached at different times. In this case an effort was made to find out when various respondents saw the brand for the last time in their various localities. Thirty-one percent (31.3%) reported that they had seen the VMMC brand even on the day of the interview whilst twenty-two percent (21.88%) of the respondents responded that they either do not remember or have never seen the brand before. The majority of those who responded that they had seen the brand even on the day of the interview were mostly residing around Dowa District and Mtengowanthenga Mission Hospital catchment areas because it is painted on the vehicle that is based at Dowa District Hospital and it usually passes through M1 road at Mtengowanthenga Mission Hospital as it is going on its routine duties. This means that for those living in the remote areas of the district where the vehicle does not frequently go do not have a chance to see the brand which would remind them about VMMC services being offered in the district.

4.7.6 The most common channel of seeing or hearing the brand

When carrying out different social and behavioral change communication activities, various channels are used. The researchers tried to find out how and where the respondents had seen or heard of the VMMC brand in the past 3 months before data collection.

Figure 10: Channels through which they saw or heard of the brand.

According to the respondents, sixty percent (60%) of the respondents mentioned that they have seen this brand on a vehicle, followed by posters at twenty percent (20%) then heard VMMC messages through radio broadcast at eight percent (8%). This means that although various communication channels are available, only a limited number of them are being utilized by the district when it comes to passing on messages to the communities. Taking into consideration that the branded vehicle is the main channel that is more visible in the district (60%), and it is mainly seen along the main road, most of the targeted people living far from the road are denied of the message, which in the long run impacts negatively on the VMMC rate in the district. In VMMC communication programming, one of the best and most effective channels for VMMC demand creation is the referral, specifically referral from HTC (Population Services International, 2014, p. 45). According to Population Services International, hundreds of thousands of men test negative for HIV every year across the target countries. These men should be routinely referred to VMMC services. So special efforts should be made by VMMC implementers by linking up with public and private sector testing centers to advocate with and train providers on the benefits of VMMC. Referral slips, registries, short message service (SMS) booking, or other strategies should be implemented to help HTC providers make VMMC referrals to all HIV negative men. Cell phone numbers of referred men should be collected

routinely if they have them. VMMC programs should then follow up on all referrals (via cell phone) to offer support and/or address any barriers referred men may have.one other way to successfully ensure delivery of messages is to ensure that a lot of channels are used at one time. This enables communicators to increase the impact of the overall campaign because the same message is delivered in multiple ways to facilitate retention and comprehension. The communicators will also make progress if they deliver their messages when their target more receptive to the message, at the appropriate time and place. For example, talking to older men about VMMC at a bar in the evening after they've had several drinks or are busy playing pool may not be the best solution. It should also be noted that, if a target is overexposed to a message or material, he or she begins to tune out due to message fatigue. The solution would be to rotate the message through several different versions of materials or different executions of the same message to help avoid this.

4.7.7 How often the respondents are exposed to the brand

When a communication brand is being designed, its main purpose is to make it visible to the public. So the researcher deliberately made an effort to find out if the brand is constantly visible in the targeted communities as seen in Figure 11.

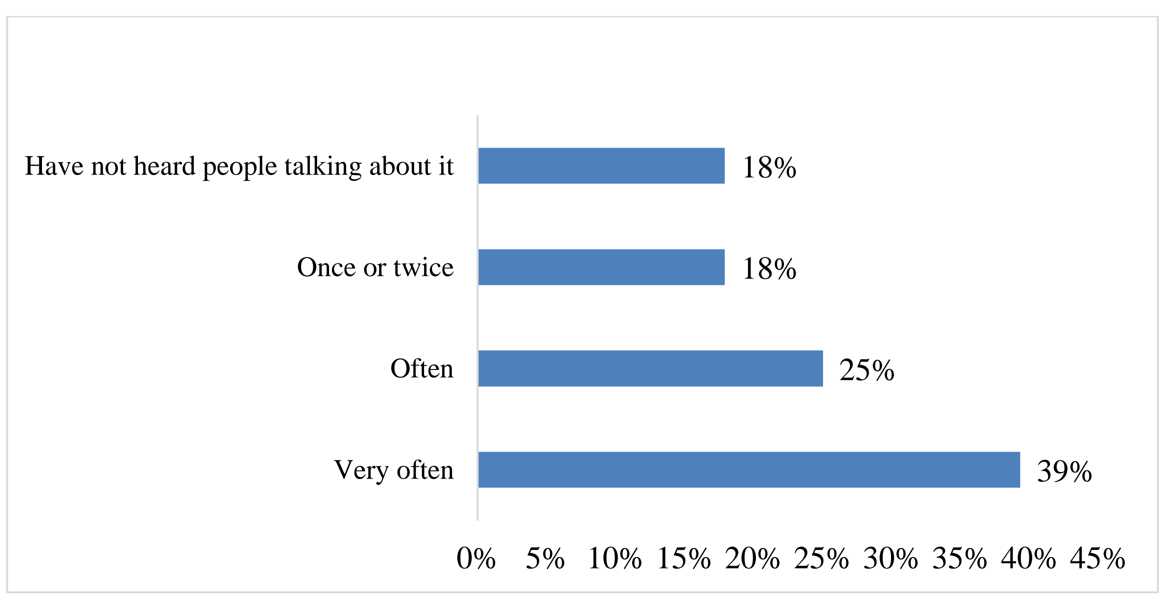


Figure 11: How often has the VMMC brand been seen in the past 3 months

From the findings, thirty-nine percent (39.3%) of the respondents mentioned that they often saw or heard people discussing the VMMC brand whilst eighteen percent (17.9%) mentioned that they have not heard people talking about the brand at all within the past three months at the time the data was being collected. The findings in this section that show that 17.9% of the

respondents mentioned that they have not heard people talking about the brand at all within the past three months at the time the data was being collected, which shows that the communication efforts which are made still miss out on some of the target groups in the district or are not well planned. Another reason can be that there are inadequate funds for the communication efforts in order to mount a comprehensive multi-channel campaign to reach out to all corners of the district.

4.7.8 Perception of the respondents to the brand

When the respondents were asked about how the brand design appeals to them or whether they believed it had to be re-designed to improve the aesthetics and visibility, the majority of them mentioned that they liked the current design. Majority, ninety-three percent (93.1%) of the respondents felt that the brand appeals to them while three percent (3.4%) somewhat were comfortable with it while another 3.4% were not happy with the design.

> *"The picture relates well to the VMMC program, the colors in the VMMC brand are good, the design is not obscene, and the brand is not leaning on any religious side",* (Ganizani Flackson, Dowa Boma Market, T/A Msakambewa).

Those who were not in favor of the brand had no alternative on how to improve the brand to make it appealing to them. In this case Ministry of Health is at liberty to continue using the brand to promote VMMC uptake in the country provided they ensure its visibility to the community members. Most of the time brands need to be changed when messages or focus have changed. The brand is supposed to describe the services or who you are, what you offer and what you do just briefly. In a competitive world of marketing where things are always fluid and dynamic, focus of our audience follows the new trends and technologies make the once brand-new and shiny old and obsolete (Leland, 2016, p. 118). In line with the results, the VMMC brand is still appealing to the target groups so there is no need to review and update it as of now. If we look at the responses from the research, those who liked the logo were able to comprehend the message, take it as culturally acceptable, relevant to their setting, visually appealing and able to contribute to positive social and behavior change. For those who said they did not like the design had no alternative to offer, and this maybe could be due to low thinking capacity coupled with low literacy levels.

4.8 Perceived action efficacy/Behavior control

4.8.1 Positive efficacy control: Action Efficacy which is an individual's impression of their own ability to perform a demanding or challenging task, in this case perception on whether respondents felt that target groups could be reminded to undergo for VMMC in the next 12

months after seeing and being reminded by the VMMC brand was assessed. After analyzing the results, eighty-two percent (82.1%) felt that they were extremely likely to be reminded by the brand to go for the procedure.

> *"If a person wants to go for VMMC he can go if he does not want he will not go it is up to them to make a decision, …….. if the advantages are explained clearly, the desire to go for VMMC can be aroused at an individual level e.g. to be protected from contracting STI's",* (Timothy Mwale, at FGD, Chanansi village, Dzaleka Health Centre catchment area, T/A Msakambewa).

Most of the respondents now have a positive attitude regarding VMMC in the district by the large proportion who stated that they were likely to go for VMMC in the next 12 months. Even though they responded in this way, it must also be noted that the rate at which they might decide to go for VMMC will vary as decision making by everyone will be made differently in accordance with Stages of Change Theory. This is where peer approaches can play a role in changing behaviors to deal with the incorrect messages that the community members have in Dowa. Peer approaches will ensure that information and experiences are shared amongst the target groups in the district. The peer educators can be those who have undergone the procedure and are satisfied with their choice, also known as Satisfied Clients. They will be able to assist others to have knowledge, positive attitudes, and the necessary skills for them to feel comfortable about going for VMMC. Peer approaches help enable people to sufficiently address issues that are considered a taboo in communities and deal with negative perceptions that are existing in the communities. Peers will help each other to set personal goals which will in the long run be decided upon by self-appraisal of capabilities. The stronger the perceived self-efficacy, the higher the goal challenges people set for themselves and the firmer is their commitment to them (Bandura, 1993, p. 118).

4.8.2 Negative efficacy control: Some of the respondents felt that even if target groups were flooded with the brand, it was extremely unlikely that they would go for the procedure as to them a mere picture cannot motivate a person to do something that they do not want as stated earlier.

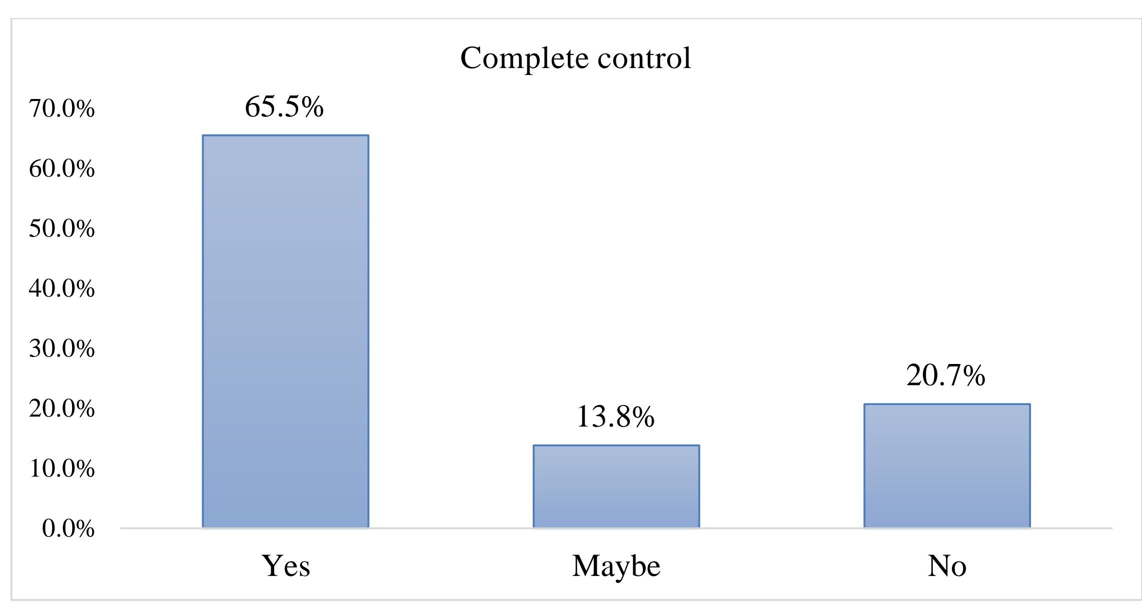


Figure 12: Final decision maker on VMMC in the household.

Sixty-six percent (65.5%) of the male respondents mentioned that they have total control on deciding whether or not to go for VMMC stating that if they try to consult, for example friends, some of their friends may end up discouraging them, whilst twenty-one percent (20.7%) mentioned that the decision would have to be made jointly with, among others, spouses, peers and relatives. Fourteen percent (13.8%) were not sure whether they would make that decision on their own.

> *"We can take time to reach to a consensus if I discuss with someone on whether I should or should not go for VMMC other than making the decision on my own as there will be a lot of ideas some good some bad as well",* (Enock Maliko Chakhulamadzi, Businessman, Dzaleka Health Centre catchment area, T/A Msakambewa).

Although Dowa social cultural dynamics are matrilineal in nature, the head of the household is still the husband, and it was not surprising that 65.5% of the males said that they would have to make the decision on their own without consulting anyone. One of the challenges the VMMC program is facing in Malawi are low demand for VMMC services, adherence to six weeks' abstinence after circumcision, return for post-operative review, and use of other HIV prevention methods after VMMC. Studies have revealed that both men and their partners experience challenges waiting for completion of the six weeks of abstinence in the post-circumcision period before resumption of sexual intercourse leading to early resumption of sexual activity poses risks of complications and acquiring infections including HIV (Lawino, Twinomugisha, Byabagambi, & Karamagi, 2018). The problem of adhering to six-week abstinence from sex after circumcision can be dealt with if both the husband and wife agree that this is a necessity for the wound to heal properly. So, if women are taken as joint decision makers in VMMC at household level, it can be a platform for health providers to hold discussions with male clients

and their partners on importance and strategies for adherence to six weeks' post-circumcision abstinence. According to Lawino et.al., men tended also not to come for post operation check-ups due to lack of post-operative information, forgetting, having no reminder systems, and not having heard of post-operative schedules for follow up on the day of circumcision due to anxiety. So, with this background, it is critical to engage women in VMMC services to enable them provide support to their male partners on post-operative follow-up schedules after circumcision. Women have also been found to play a role in motivating their male partners' decision to get circumcised, motivate the men to have their sons circumcised, and play a great role when they fully understand that VMMC provides partial protection against female to male transmission of HIV. It is therefore important for circumcised men and their partners to continue use of other HIV preventive methods after circumcision (e.g. use of condoms to prevent HIV infection) if they all understand this. This is in line with the Ministry of Health Policy in Malawi which encourages partner participation in decision making at household level when it comes to access to health. If the status quo of the cultural behaviors and practices remain the same in the district where decision making powers remain with the man (regarded as the head of the family), uptake of the intervention will still be low.

4.8.2 Couple discussion

In order to find out if there was an attempt by the respondents to change their normative beliefs on VMMC, the researcher also collected data on the same. This was basically done to find out if significant others would approve or disapprove of VMMC as part of HIV and AIDS preventive intervention. When respondents were asked on whether partners have ever discussed the importance of VMMC in their household after seeing the VMMC brand, thirty-nine percent (38.7%) of the respondents said that they had discussed as partners whilst sixty-one percent (61.3%) said they have never done that. One of the reasons mentioned by the female spouses was that their male spouses should not go for VMMC so that they should not get hurt.
Another male stated that his wife refused him from undergoing the procedure after he brought up the issue.

> *"She told me she was not for the idea as she heard the wound takes time to heal. As such we will be deprived of sex in the house",* (Malizeni Maloni, Farmer, Tembo village, Interviewed at Dowa Boma).

Some of the males also stated that they are afraid of reduced bedroom performance and becoming impotent after being circumcised. So in essence, discussions on VMMC at household level between couples is not happening to foster behavior change and can lead to challenges waiting for completion of the six weeks of abstinence in the post-circumcision period before

resumption of sexual intercourse leading to early resumption of sexual activity posing risks of complications and acquiring infections including HIV, improve circumcised men to come for post-operation check-ups to avoid complications and adhere to wound care guidelines, and enable women to motivate their male partners and sons to get circumcised. They will also be able to let each other understand that VMMC only provides partial protection against female to male transmission of HIV and helps the woman to reduce her chances of developing Cervical Cancer in future, therefore they will be able to continue using other HIV preventive methods after circumcision. It can also be seen that there are a lot of barriers that are influencing the men not go for VMMC or women not to encourage their husbands to go for VMMC rooted in information gaps and negative beliefs. If the discussions are done by both parties, the negative perceptions will be able to be dealt with accordingly.

Even for those couples who have aver discussed the issue in their households, one thirds (33.3%) had a discussion within the last three months, whilst a bigger proportion (41.7%) of the respondents had the discussion more than six months before the research was done. Eight percent (8.3%) said they do not remember ever discussing this issue in their household. This is quite worrying as this can either signify that the topic is a taboo or the couple do not have the right information on the topic. Another contributing factor can be that the mass campaigns done in the district are done at a very small scale to spark discussions amongst couples in the district or there other powerful opposing competing forces with opposing messages, including the power of social norms which are negatively influencing campaign outcomes. The campaigns that are done in the district are also maybe not sustained at a longer interval to stick in couples to spark discussions. Careful planning and testing of campaign content and format with target audiences are therefore crucial to have an impact in increasing the VMMC uptake in the district.

When conducting social and behavioral change communication activities, it is recommended that all the talking points or key messages should be given in a systematic manner to address all the areas, especially when it comes to sensitive and new interventions like VMMC which can sometimes be associated with false rumors.

Eighty-two percent (81.8%) of the respondents stated that they dwelled much on the advantages of VMMC as an HIV prevention measure whilst nine percent (9.1%) said that they discussed much on its protective effect on women from developing Cervical Cancer in future, and another nine percent (9.1%) said that it also prevents from contracting other STI's. From the limited areas that the respondents were able to state, it shows that we still have information gap that

need some filling in for them to fully appreciate VMMC as a preventive measure on HIV. VMMC is supposed to be offered as a package of several HIV prevention interventions, which provides an important entry point to improve SRH knowledge, behavior, and access to services among adolescent men as they interact with the service provider before, during, and after surgery (Njeuhmeli, et al., 2014, p. S198). According to Njeuhmeli, et al., the WHO/UNAIDS minimum package for male circumcision Services to be provided to prospective clients and those who have been circumcised should include the following: HIV testing and counseling; active exclusion of symptomatic STIs and syndromic treatment where required; provision and promotion of correct and consistent use of male and female condoms; information and counseling on risk reduction and safer sex. When programming for VMMC interventions, it is recommended that the district should target adolescents with the WHO/UNAIDS minimum package as it presents a unique chance of offering adolescents all these services, present positive sexual and gender norms while attitudes toward women are at formative stage and before boys enter their sexual lives. Furthermore, VMMC services can be integrated with a range of other effective health, education, counseling, and social services for adolescents that can be adapted to different stages of adolescent development there by ensuring that there are no gaps in information that they will be able to share when they grow up.

When asked further on who normally starts off the discussion on VMMC, the husband has been mentioned to be the one taking lead in sparking conversation at fifty eighty percent (58.3%) when it comes to VMMC, as opposed to the wife at twenty-five percent (25%) in the household, with children and relatives coming last at eight percent (8.3%) respectively. This continues to show the social cultural effects of the Chewa culture where by the husbands are supposed to take lead on issues to do with sex and sexuality.

According to research conducted in in Botswana and Tanzania, it affirms that women, as wives and sexual partners, are highly influential in men's decisions to undergo VMMC, so it is therefore important to discuss the benefits of VMMC for men and their intimate partners *(Population Services International, 2014, p. 193)*. If special interventions can be implemented specifically tailored at women so that they know the direct health benefits of VMMC to women, specifically the reduced risk of cervical cancer, chances are high that the messages can provide a basis for couples to consider mutual VMMC advantages during their discussions and women will have a basis to spark and start discussions in the households. According to the demand creation toolkit developed by Population Services International, men attending VMMC clinics

in Zambia have cited reducing cervical cancer risks in their partners as a key motivator for seeking VMMC services.

4.9 Chapter summary

There were a lot of key findings in the research. After analysis, it was found that 52.9% were between the age ranges of 18 – 24, followed by 32.4% within 25 – 34 years, with the least being those above 45 years who were at 5.9% and were the least willing to respond to during the interviews. The older community members were unwilling to respond to the topic because this was foreign topic to them. A total of 73.5% of the males and 26.5% of the females also took part in the research. During data collection, it was proving difficult to carry on with some of the interviews with the females once they noted that the issue to be discussed concerned VMMC than with their male counter parts due to the subject being a taboo to them. The findings also correlated with those in Dowa District Social Economic profile which shows that most of the income is derived from different enterprises, 30 percent from Agriculture, 24 percent from wages and 7 percent from other sources. Those who attained secondary school education were at 38.2%, whilst 23.5% had no formal education at all. The sample which took part was way below the district level literacy achievements, which can also mean that their understanding of new health concepts like VMMC can also be compromised by their deep-rooted cultural norms.

The brand could also not be recalled by 82.4% of the participants which does not paint a very good picture of the social and behavioral change communication initiatives that the district has been conducting in order to sensitize the community members about VMMC as an extra HIV and AIDS prevention intervention after about seven years that the VMMC intervention has been in operation in the district.

It was encouraging however to note that 87% of the respondents mentioned that the brand informs them of the availability of VMMC services in Dowa district for them to make informed choices, whilst 4.3%, mostly women said that they were reminded that they would be protected from developing cervical cancer in future, with 8.7% indicating that even though they see the brand, it does not remind them of anything. The results have also shown that there still exist negative perceptions in the communities which can impact negatively on program implementation. The responses that a person cannot contract HIV, Syphilis, Gonorrhea, *Inguinal bubo,* Genital Warts and Cervical Cancer are totally wrong because VMMC only offers partial protection from the said diseases and that safe sex practices like faithfully sticking to one spouse and proper use of condoms every time couples have sex is the way to go.

There is still a big number of uncircumcised males in Dowa with the respondents at 23.5% mentioning that they underwent the procedure, with the remainder stating various reasons why they did not go. Some of the reasons included that they do not know what really happens when

a person arrives at the circumcising site, they don't know why they should go for VMMC, they are afraid of having a wound after being circumcised and that they are afraid of not being able to impregnate their spouses in future. Some of the responses bordered on the disturbance to their livelihoods like the procedure can interfere with his occupation due to the time the wound takes to heal e.g. operating bicycle taxis.

It was also agreed by 66.7% of the respondents who said that the brand could motivate target groups to go for VMMC if they are constantly exposed to it whilst 29.6% said no. When it came to major motivators in the community, it was surprising to note that Health Workers mentioned at 3.1% came last while peers were at 34.4%. Health Workers are supposed to be in the fore front in disseminating messages and be mentioned by their communities as sources of various health related information. Health Workers command trust in the community and anything they say is taken on board and acted upon. So, the Health Workers need to take a pro-active role in actively engaging the target groups to increase uptake of VMMC services in the communities. Peers remain a very important approach that can be used as an opportunity to propagate messages for VMMC, thereby fostering diffusion and acceptance of VMMC by the target group in the district. There is also a limited number of channels being utilized for VMMC messaging in the district with the branded vehicle at 60%, posters at 20% and those heard through radio broadcast at 8%.

CHAPTER 5
CONCLUSION

5.1. Chapter overview

This study chapter is mainly of the summary of the main findings uncovered during the research including the recommendations on the shortfalls that Dowa District Health Office needs to act upon in order to improve the uptake of VMMC in their catchment area. It looks at the current awareness levels of the "*NDIFE OTSOGOLA*" VMMC communication brand in the district, some of the reasons why the communication brand is not popular in the district, the limited channels in use during VMMC mass campaigns in the district. The chapter is also explaining based on the synthesized evidence on how influencers motivate young men to seek VMMC services, including the negative barriers limiting the uptake of the intervention in the district. The chapter is also touching on why trusted change agents like Health workers are failing to increase the uptake of VMMC in the district. The chapter winds up with the necessary recommendations based on the objectives that the District Health Office needs to put in place to ensure a high number of males are circumcised in Dowa district.

According to the data analyzed, the findings of the study have indicated that awareness levels of the "*NDIFE OTSOGOLA*" VMMC communication brand are very low even though the brand has been in existence since 2012. Most of them were not able to fully describe how the brand looks like by mentioning the three main features. Positives can be drawn from the encouraging feedback drawn from majority of the respondents who agreed that the brand can play a very good part in influencing a person to undergo the VMMC procedure if they are constantly exposed to it. Another setback is that one-fifth of the respondents said that they have never seen the VMMC brand before. This in essence means that communication efforts are being made in the district without linking the brand to VMMC program or the efforts are constricted to one area only not covering the whole district. This can be linked to the majority who mentioned that mostly they see the brand on the vehicle, which means only one channel dominates and is in use than the others.

The research has also unearthed the misconceptions on VMMC which are still one of the barriers affecting adoption of VMMC in the district. These misconceptions are affecting both the men and women whether married or single. Special efforts need to be made to address the local barriers during mass campaigns to have a successful program in the district.

Some respondents also indicated that they can be able to motivate their colleagues to undergo VMMC using the brand if they can fully be knowledgeable of all the associated benefits of VMMC. This positive perception can be seized by the District Health Office as a missed opportunity that can be utilized to ensure there is an improvement in the uptake of the VMMC services in the district provided the target group is convinced beyond doubt about the benefits of undergoing the procedure. It is also interesting to note that cultural norms still play a big part in influencing decision making processes in relation to VMMC as seen in the findings such that some of the respondents even had doubts on recommending the procedure to their friends because they would be faced with questions on whether they themselves had undergone the procedure and were talking from a point of being a satisfied client.

Men's social networks in increasing VMMC services uptake in Dowa can be used as indicated by half of the respondents who said it is possible to be motivated by their peers to go for VMMC provided the peer underwent the procedure. For those who said it is not possible or that a mere brand image cannot make them go for VMMC, they will need other effective communication approaches like Interpersonal Communication for them to fully understand the benefits of the procedure and provide a platform for them to ask questions and have answers on the spot. The current design of the VMMC brand is still appealing to most of the respondents in Dowa district and does not need redesigning, and that it was extremely likely that they would be able to go for VMMC after being constantly being reminded by the VMMC brand especially if this is coupled with grasping the benefits of undergoing the procedure.

Privacy should also be ensured to clients intending to go for the procedure because some of the rooms where VMMC is carried out in the district is integrated with other services like ART clinics where people living with HIV and AIDS go for treatment and other associated services to avoid clients being deterred from going there as they think that their peers might conclude that if they go into those rooms they are going there to access ART and not VMMC services.

Health workers are supposed to be the major motivators in the community as they are seen as the authority in health issues but surprisingly, they were the lowest on proportion of inflencers in VMMC, which means they are not doing enough to inform their communities about VMMC as another HIV and AIDS preventive intervention. VMMC is not a popular health intervention in the district according to the number of people who had not heard people talking about the brand at all within the past three months at the time the data was being collected. This can be linked to the un-sustained communication efforts by the health workers and volunteers to ensure

that the community members are constantly reminded about VMMC leading to low figures of those accessing VMMC services in the district.

The social cultural norms of the Chewa culture emphasize in that a man is the head of the household and the decisions he makes are final. This is correlated by the findings showing that most male respondents have total control on deciding whether to go for VMMC or not in the next 12 months. The issue to do with VMMC affects both the husband and wife so it is necessary that the decision for the man to go for VMMC should be made jointly as it affects their sex life, adherence to post operation abstinence and reminding teach other of the husband's schedule of the post operation check-ups among others.

The researcher has therefore drawn these conclusions basing on the findings;

i. The "*NDIFE OTSOGOLA*" VMMC communication brand can play a part in decision making, and increase the number of the in school, out of school boys and young men aged between 10 and 34 in rural areas like Dowa district to undergo the procedure if they are exposed to it constantly.
ii. Although there exists some positive perceptions and attitudes towards VMMC among in and out of school males and females aged between 10 and 34, there still remains some negative perceptions and message gaps negatively affecting uptake of VMMC services in the district.
iii. There are still strong cultural norms negatively influencing perceptions and attitudes towards VMMC among in and out of school females in Dowa district.
iv. Motivation from secondarysources is very important in motivating young men to seek VMMC services in relation to the "*NDIFE OTSOGOLA*" VMMC communication brand in rural areas.

5.2 Recommendations

The whole purpose of branding is to help intended beneficiaries to identify the goods or services of one service provider from another such that it has become a very important aspect on how people make choices when making decisions on product or accessing services. So, in this competitive world where different services are competing for different groups of people, it is not surprising that a lot of products are being branded and for those that are not, efforts and resources are being heavily invested to ensure that they get branded for visibility to enable people to associate the brand name with specific clear values and characteristics that are unique from the different services on offer. The findings of this research have shown that intended beneficiaries in the rural areas of Dowa district can be motivated to go for VMMC if they are constantly reminded by the visibility of the VMMC brand within their communities. Therefore, my recommendations are:

i. To increase uptake of VMMC services, Dowa District Health Office should ensure that in and out of schoolboys and girls, young men and females aged between 10 and 34 are constantly exposed to the brand on VMMC which is not the case at the moment, so that they are familiar to and internalize it. Visibility of the VMMC brand should be enhanced by multi-channeling as currently only the District Health Office branded vehicle and VMMC posters are the only channels used which are seen frequently by the targeted members promoting VMMC services in the district.

ii. The district needs to produce locally based messages focusing on the local barriers and enablers, advantages on VMMC applicable to both males and females in order to reduce negative perceptions and misconceptions during community engagement activities so that they should not have half-baked information for decision making purposes.

iii. Influential gate keepers and peers in the district should be engaged with VMMC messages to positively change the norms that negatively impact on VMMC acceptance in the district. Health Workers in the district to be in the fore front engaging with community members in their respective catchment areas on VMMC.

iv. Open discussions on VMMC should be encouraged amongst married couples to increase the uptake of VMMC services in the district thereby reducing the chances of spreading HIV and ulcerative STI's in the district.

REFERENCES

Ajzen, I. (2015). Consumer attitudes and behavior: The theory of planned behavior applied to food consumption decisions. *Rivista di Economia Agraria, Anno LXX*(2), 121-138. Retrieved June 14, 2018, from www.fupress.net/index.php/rea/article/view/18003

Akhtar, I. (2020). Research design. *Research Gate*, 68. Retrieved September 1, 2020, from https://www.researchgate.net/publication/308915548

Auvert, B., Taljaard, D., Lagarde, E., Sobngwi-Tambekou, J., Sitta, R., & Puren, A. (2005, November 2). Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 trial. *PubMed, 3*(5), 298. Retrieved February 23, 2018, from https://www.ncbi.nlm.nih.gov/pubmed/16231970?dopt=AbstractPlus

Bailey, R., Moses, S., Parker, C., Agot, K., Maclean, I., Krieger, J., . . . Ndinya-Achola, J. (2007, February 24). Male circumcision for HIV prevention in young men in Kisumu, Kenya: A randomised controlled trial. *PubMed, 369*(9562), 643-56. Retrieved February 23, 2018, from https://www.ncbi.nlm.nih.gov/pubmed/17321310?dopt=AbstractPlus

Bandura, A. (1993). *Perceived self-efficacy in cognitive development and functioning*. Stanford University.

Bengo, J. M., Chalulu, K., Chinkhumba, J., Kazembe, L., Maleta, K. M., Masiye, F., & Mathanga, D. (2010). Situation analysis of male circumcision in Malawi. Blantyre: College of Medicine.

Butterfoss, F. D., Kegler, M. C., & Francisco, V. T. (2008). *Health behavior and health education: Theory, research, and practice* (4 ed.). San Francisco: Jossey-Bass. Retrieved January 2, 2018, from www.bookzz.org

Centers for Disease Control and Prevention. (1981). *Pneumocystis pneumonia - Los Angeles*. Retrieved February 14, 2018, from Morbidity and mortality weekly report: https://www.cdc.gov/mmwr/preview/mmwrhtml/june_5.htm

Centers for Disease Control and Prevention. (2017, May 30). *HIV and AIDS basics*. Retrieved January 14, 2018, from Centers for disease control and prevention: https://www.cdc.gov/hiv/basics/whatishiv.html

Centers for Disease Control and Prevention. (2017). *Morbidity and mortality weekly report.* U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved March 1, 2018, from https://www.cdc.gov/mmwr/cme/conted_info.html#weekly

Chernatony, L. d. (2010). *From brand vision to brand evaluation: The strategic process of growing and strengthening brands* (Third ed.). Burlington: Elsevier. Retrieved January 29, 2018, from www.bookzz.org

Cornish, R. (2006). Statistics: An introduction to sample size calculations. Retrieved March 6, 2018, from www.lboro.ac.uk/mlsc

Devendra, S. (2017, 4 22). Influence of brand equity on purchase intention. *International Journal of Entrepreneurship and Development Studies (IJEDS) 4(3), 4*(3), 313-322. Retrieved May 15, 2021, from https://www.researchgate.net/publication/348907070

Dew, L. K., & Kwon, W.-S. (2010, August 24). Exploration of apparel brand knowledge: Brand awareness, brand association, and brand category structure. *Clothing and Textiles Research Journal, 28*(1), 3-18. doi:10.1177/0887302X09341877

Dowa District Council. (2015 - 2020). *Dowa district social economic profile.* Dowa District Council.

Doyle, L., Brady, A.-M., & Byrne, G. (2009, March). An overview of mixed method research. *Journal of research in nursing, 14*(2), 175-185. doi:10.1177/1744987108093962

Dunsmuir, W. D., & Gordon, E. M. (1999). The history of circumcision. *BJU International, 83*(S1), 1-12. Retrieved February 9, 2018, from httponlinelibrary.wiley.comdoi10.1046j.1464-410x.1999.0830s1001.xpdf

Eaton, A. A., Cain, D. N., Agrawal, A., Jooste, S., Udemans, N., & Kalichman, S. C. (2011, 674-679). The influence of male circumcision for HIV prevention on sexual behaviour among traditionally circumcised men in Cape Town, South Africa. *International Journal of STD & AIDS, 22*(11), 674-9. doi:10.1258/ijsa.2011.011006

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics, 5*(1), 2. Retrieved April 30, 2018, from http://www.sciencepublishinggroup.com/j/ajtas

Faircloth, J. B., Capella, L. M., & Alford, B. L. (2001). The effect of brand attitude and brand Image on brand equity. *Journal of Marketing Theory and Practice, 9*(3), 61-65. doi:10.1080/10696679.2001.11501897

Fishbein, M., & Yzer, M. C. (2003, May). Using theory to design effective health behavior interventions. *International Communication Association, 13*(2), 164-183. doi:10.1111/j.1468-2885.2003.tb00287.x

Fleming, D. T., & Wasserheit, J. N. (1999, February). From epidemiological synergy to public health policy and practice: The contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Europe PMC, 75*(1), 3-17. Retrieved February 23, 2018, from http://europepmc.org/articles/PMC1758168

Glanz, K., Rimer, B. K., & Viswanath, K. (2008). *Health behaviour and health education: Theory, research and practice* (4 ed.). San Francisco: Jossy-Bass. Retrieved May 27, 2018

Gollaher, D. L. (2006, January 19). Book reviews. *The New England Journal of Medicine, 99*(8), 380-382. Retrieved February 15, 2018, from www.nejm.org

Gray, R. H., Kigozi, G., Serwadda, D., Makumbi, F., Watya, S., Nalugoda, F., . . . Moulton, L. H. (2007, March 26). Male circumcision for HIV prevention in men in Rakai, Uganda: A randomised trial. *Global Health Sciences Literature Digest, 369*(9562), 657-666. Retrieved February 22, 2018, from http://hivinsite.ucsf.edu/InSite?page=jl-11-03

Knabe, A. P. (2012). *Applying Ajzen's theory of planned behavior to a study of online course adoption in public relations education.* Milwaukee, Wisconsin: Marquette University. Retrieved June 23, 2018, from http://epublications.marquette.edu/dissertations_mu/186

Lawino, A., Twinomugisha, A., Byabagambi, J., & Karamagi, E. (2018). *Improving female involvement in voluntary medical male circumcision in Uganda.* USAID ASSIST Project. Chevy Chase, MD: University Research Co., LLC (URC).

Lee, R. B. (2009). *Filipino male experience of ritual circumcision: Perspectives and insights for Philippine-based anti-circumcision advocacy.* doi:https://doi.org/10.1007/978-1-4020-9167-4_15

Leland, K. T. (2016). *The brand mapping strategy.* Entrepreneur Press.

Longwe, M. (2003). *From chinamwali to chilangizo: The christianization of pre-christian chewa initiation rites in the baptist convention of Malawi.*

Maurya, U. K., & Mishra , P. (2012). What is a brand? A perspective on brand meaning. *European Journal of Business and Management, 4*(3), 122. Retrieved April 22, 2021, from https://core.ac.uk/download/pdf/234624169.pdf

Ministry of Health and Population. (2017). *National community health strategy 2017 - 2022.* Lilongwe: Government of the Republic of Malawi.

Moisescu, O. I. (2007). *A conceptual analysis of brand.* Munich Personal RePEc Archive. Retrieved May 24, 2021, from https://mpra.ub.uni-muenchen.de/32017/

Munthali, A. C., Kok, M., & Kakal, T. (2018). *Initiation ceremonies in traditional authority Liwonde in Machinga district in southern Malawi: What do they look like now and before; and do they influence young people’s behaviour regarding sex and relationships?* Zomba: Centre for Social Research.

National AIDS Commision. (2009). *The national HIV prevention strategy 2009-2013.* Retrieved February 12, 2018, from http://www.aidsmalawi.org.mw/index.php/downloads/category/3-behavior-change-interventions

National AIDS Commission. (2012). *Malawi voluntary medical male circumcision communication strategy: 2012-2016.* Lilongwe: Government of Malawi.

National AIDS Commission. (2012). Voluntary medical male circumcision: Community mobilization guide for district campaigns. Lilongwe: The Government of Malawi.

National AIDS Commission. (2014). National HIV prevention strategy 2015-2020. Lilongwe: The Government of Malawi.

National AIDS Commission. (2014). *The Malawi national strategic plan for HIV and AIDS 2015 - 2020.* Retrieved February 13, 2018, from https://www.medbox.org/malawi/national-strategic-plan-for-hiv-2015-2020-malawi/preview

National AIDS Commission. (2014). The national HIV prevention strategy 2015-2020. Lilongwe: The Government of Malawi. Retrieved June 10, 2017, from http://www.aidsmalawi.org.mw

National AIDS Commission. (2015). Operational plan to scale-up the rollout of VMMC in public health facilities in Malawi. Lilongwe: The Government of Malawi.

National AIDS Commission. (2017). Malawi voluntary medical male circumcision communication strategy 2017 - 2021. Lilongwe: The Government of Malawi.

National AIDS Commission. (2019). *National voluntary medical male circumcision communication strategy 2019-2025.* Lilongwe: National AIDS Commission.

National Statistical Office. (2015 - 16). *Malawi demographic and health survey.* Zomba: Malawi Government.

Njeuhmeli, E., Hatzold, K., Gold, E., Mahler, H., Kripke, K., Seifert-Ahanda, K., . . . Kasedde, S. (2014, July 1). Lessons learned from scale-up of voluntary medical male circumcision focusing on adolescents: Benefits,challenges, and potential opportunities for linkages with adolescent HIV, sexual, and reproductive health services. *PubMed, 66*(Supplement 2), 193-9. doi:10.1097/QAI.0000000000000179

Nyirenda, A. K. (2013). *Women voice in church of central africa presbyterian (C.C.A.P) Malawi - Acritical evaluation especially with Nkhoma Synod.* Diakonhjemmet University College.

Piot, P., & Laga, M. (1989, March 11). Genital ulcers, other sexually transmitted diseases, and the sexual transmission of HIV. *PubMed, 298*(6674), 623-624. Retrieved February 23, 2018, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1835849/

Population Services International. (2014). *The voluntary medical male circumcision (VMMC) demand creation toolkit.* RTI International and Population Services International (PSI). Retrieved July 15, 2019, from https://www.psi.org/wp-content/uploads/2014/09/VMMC_Demand_Creation_Toolkit.pdf

President's Emergency Plan for AIDS Relief. (2017). *Best practices for voluntary medical male circumcision site operations: A service guide for site operations* (2nd ed.). Clearinghouse on Male Circumcision for HIV Prevention. Retrieved January 22, 2018, from https://www.malecircumcision.org/resource/pepfars-best-practices-voluntary-medical-male-circumcision-site-operations-service

President's Emergency Plan for AIDS Relief. (2020). *Malawi country operational plan 2020.* PEPFAR. Retrieved June 22, 2020, from https://www.state.gov

Ritchie, J., & Lewis, J. (2003). *Qualitative research practice: A guide for social science students and researchers.* (J. Ritchie, & J. Lewis , Eds.) New Delhi: SAGE Publications. Retrieved June 5, 2018, from www.bookzz.org

Szabo, R., & Short, R. V. (2000, June). *How does male circumcision protect against HIV infection?* Retrieved February 20, 2018, from National Center for Biotechnology Information, U.S. National Library of Medicine: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1127372/

The Malawi Government. (2017). *The Malawi growth and developent strategy (MGDS) III: Building a productive, competitive and resilient nation.* Lilongwe: The Malawi Government.

The Ministry of Health and Population. (2015). The national health communication strategy 2015 - 2020. Lilongwe: The Government of Malawi.

The Ministry of Health and Population. (2017). The health sector strategic plan II 2017 - 2022. Lilongwe: The Government of Malawi.

Tongco, D. C. (2007). Purposive sampling as a tool for informant selection. *The Jounal of Plants, People, and Applied Research, 5*. Retrieved May 2, 2018, from http://hdl.handle.net

UNAIDS. (1998). *Report on the global HIV/AIDS epidemic.* Joint United Nations Programme on HIV/AIDS. Retrieved February 23, 2018, from http://data.unaids.org/pub/report/1998/19981125_global_epidemic_report_en.pdf

UNAIDS. (2017, November 31). *UNAIDS fact sheet*. Retrieved January 13, 2018, from http://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf

United Nations. (2016, January). *Sustainable development goals*. Retrieved February 16, 2018, from Sustainable Development Goals Knowledge Platform: https://sustainabledevelopment.un.org/sdg3

VanderStoep, S. W., & Johnston, D. D. (2009). *Research methods for everyday life: Blending qualitative and quantitative approaches.* San Francisco: Jossey-Bass.

Waldeck, S. E. (2003). Social norm theory and male circumcision: Why parents circumcise. *The American Journal of Bioethics, Volume 3*(Number 2), 56-57. Retrieved February 20, 2018

World Health Organisation. (2017, November). *World health organisation fact sheet*. Retrieved January 13, 2018, from World Helath Organisation: http://www.who.int/mediacentre/factsheets/fs360/en/

APPENDICES

Appendix 1

Consent form (Chichewa version)

Kalata ya chirolezo

2018 EVALUATION OF THE "*NDIFE OTSOGOLA*" VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) COMMUNICATION BRAND

Muli bwanji? Dzina langa ndine ………………………., ndipo ndine m'modzi mwa amene ndikupanganawo kafukufuku wokhudzana ndi M'dulidwe wa abambo wakuchipatala m'boma lino la Dowa. Ndimafuna kuti ndimve maganizo anu okhudzana ndi nkhaniyi pokambirana. Kucheza kwathu kutha kutenga pafupifupi 20 minitsi, kuchepera kapena kuposera apo kutengera ndi momwe zokambirana zathu ziyendere. Simukukakamizidwa kutenganawo gawo pokambirana zankhaniyi. Simulandira kanthu kenakalikonse ngati mwasankha kutengapo mbali pankhaniyi. Powonjezera apo, ngati mukuwona kuti simungathe kukwanitsa kuyankha mafunso ena, muli ndi ufulu kunena choncho. Zonse zimene tikambirane pano zikhala zachinsinsi ndipo palibe wina aliyense amene adziwe kupatula inu ndi ine. Dzina lanu silidzatuluka pena paliponse pankhani yokhudzana ndi kafukufuku ameneyu.

Zokambirana zathu tijambula pogwiritsa ntchito makina ojambulira (*tape recorder),* ndipo zojambulazo zikagwiritsidwa ntchito posanthula zomwe tapeza, ndipo zina mwazomwe tikambirane zidzagwiritsidwa ntchito kumikumano yopereka zakafukufukuyu komanso polemba ndondomeko ya momwe kafukufukuyu wayendera.

Kodi mwasankha kutenganawo mbali pakafukufuku ameneyu? (Ngati akana, athokozeni kamba kanthawi yawo).

Ndavomera kutengapo gawo pakafukufuku ameneyu.

____________________________ ______________________ _______________

Wotenga nawo gawo mukafukufuku. Tsiku lomwe mwavomereza Chizindikiro

_________________________ ______________________ _______________

Wopangitsa kafukufuku. Tsiku lopangitsa kafukufuku. Chizindikiro

Consent form

Appendix 2

Consent form (English version)

2018 EVALUATION OF THE "*NDIFE OTSOGOLA*" VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) COMMUNICATION BRAND.

Good morning/afternoon. My name is………………… and I am part of a study team evaluating the "*NDIFE OTSOGOLA*" Voluntary Medical Male Circumcision (VMMC) communication brand in Dowa district. The discussion will take approximately 20 minutes, although it could take longer or less depending on the progress of the discussions.

So I would really like to hear about your views on this topic. You are not obliged to participate in this study and no health related services will be withheld if you decide not to. Likewise, if you decide to talk to me, you will not receive any incentive inform of gifts or services in anyway. In addition, should you not wish to answer any particular question(s), you are free to decline. Everything we discuss will be held in strict confidence and will not be shared with anyone else. Also understand that your name will not be linked with the research materials.

This interview will be tape recorded and the audio recording made of this interview will be used only for analysis and that extracts from the interview, from which you would not be personally identified, may be used in any conference presentation, report or journal article developed as a result of the research.

Would you like to participate in this study? (If they decline, thank them for their time).

I agree to take part in this interview.

__________________________ ___________________ ______________________

Name of participant Date Signature

__________________________ ___________________ ______________________

Principal Investigator Date Signature

Appendix 3

APPLICATION FOR ETHICAL CLEARANCE TO NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE (NHSRC).

7th January 2019.

To : The Chairperson, National Health Sciences Research Committee, Ministry of Health, P.O. Box 30377, Lilongwe 3, Malawi.

From : Alvin Chidothi Phiri, Ministry of Health, Directorate of Preventive Health, Health Education Services, P.O. Box 30377, Lilongwe 3.

Dear Sir,

Student application to conduct an academic health research in Dowa district.

Reference is made to the above captioned issue. I am working as a Senior Health Promotion Officer at Health Education Services under the Directorate of Preventive Health, Ministry of Health in Lilongwe. Currently I am pursuing Masters in Health and Behavioral Change Communication (MHBCC) at the University of Malawi – The Polytechnic, in Blantyre.

I am undertaking research leading to the production of a thesis titled "Evaluation of the *NDIFE OTSOGOLA* Voluntary Medical Male Circumcision (VMMC) communication brand".

The main objectives of the research are:

- To evaluate the extent to which the "*NDIFE OTSOGOLA*" VMMC communication brand increase VMMC services uptake among in school, out of school boys and young men aged between 10 and 34 in rural areas like Dowa district.
- To evaluate the perceptions and attitudes towards VMMC among in and out of school males aged between 10 and 34 influenced by the "*NDIFE OTSOGOLA*" VMMC communication brand in rural areas.
- To evaluate the perceptions and attitudes towards VMMC among in and out of school females influenced by the "*NDIFE OTSOGOLA*" VMMC communication brand in rural areas.
- To assess the level of influence from secondary sources in motivating young men to seek VMMC services in relation to the "*NDIFE OTSOGOLA*" VMMC communication brand in rural areas.
- To assess the level of influence exerted by men's social networks in increasing VMMC services uptake in rural areas.

I would like to seek permission from your good office to collect qualitative data from both male and female community members to be sampled in the catchment areas of Dowa District Health Office, Dzaleka Health Centre and Mtengowanthenga Mission Hospital.

I would like to assure you that any data to be collected will be treated in the strictest confidence, and none of the participants will be individually identifiable in the resulting thesis. The participants in the research will take part on a voluntary basis and they will be free to opt out at any time or decline to answer particular questions if they are not comfortable with them.

Participants will be required to sign a consent form or verbally agreeing to the conditions outlined therein.

Any enquiries you may have concerning the data collection exercise and the Masters Programme may be directed to the Course Coordinator, MrsLusiziKambalame on 0 999 924 779 e-mail lkambalame@poly.ac.mw or my Principal Thesis Supervisor Mr Luciano V. Ndalama on 0 888 852 707 e-mail lndalama@poly.ac.mw or myself on 0 991 041 916 e-mail phiriac06@gmail.com.

Looking forward to your favourable response.

Yours sincerely,

Alvin Chidothi Phiri,
Masters of Arts in Health and Behaviour Change Communication Research Student,
University of Malawi – The Polytechnic.

Appendix 4

NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE PROTOCOL ACCEPTANCE LETTER.

Telephone: + 265 789 400
Facsimile: + 265 789 431

All Communications should be addressed to:

The Secretary for Health and Population

In reply please quote No.

....

MINISTRY OF HEALTH AND POPULATION
P.O. BOX 30377
LILONGWE 3
MALAWI

21st January, 2019

Alvin Chidothi Phiri
Malawi Polytechnic

Dear Sir/Madam,

Re: Protocol # 19/01/2199: Evaluation of the Ndife Otsogola Voluntary Medical Male Circumcision (VMMC) Communication Brand

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has **reviewed** and **approved** your application to conduct the above titled study.

- **APPROVAL NUMBER** : **2199**
- The above details should be used on all correspondences, consent forms and documents as appropriate.
- **APPROVAL DATE** : **21/01/2019**
- **EXPIRATION DATE**
  This approval expires on **20/01/2020**. After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the NHSRC Secretariat should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the NHSRC within 10 working days using standard forms obtainable from the NHSRC Secretariat.
- **MODIFICATIONS**: Prior NHSRC approval using forms obtainable from the NHSRC Secretariat is required before implementing any changes in the protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS**: Please contact the NHSRC on phone number *+265 994 063 425* or by email on mohdoccentre@gmail.com.
- **OTHER**: Please be reminded to send in copies of your final research results for our records (Health Research Database).

SECRETARY FOR HEALTH
2019 -01- 2 1
P.O. BOX 30377, CAPITAL CITY, LILONGWE 3

Kind regards from the NHSRC Secretariat.

....

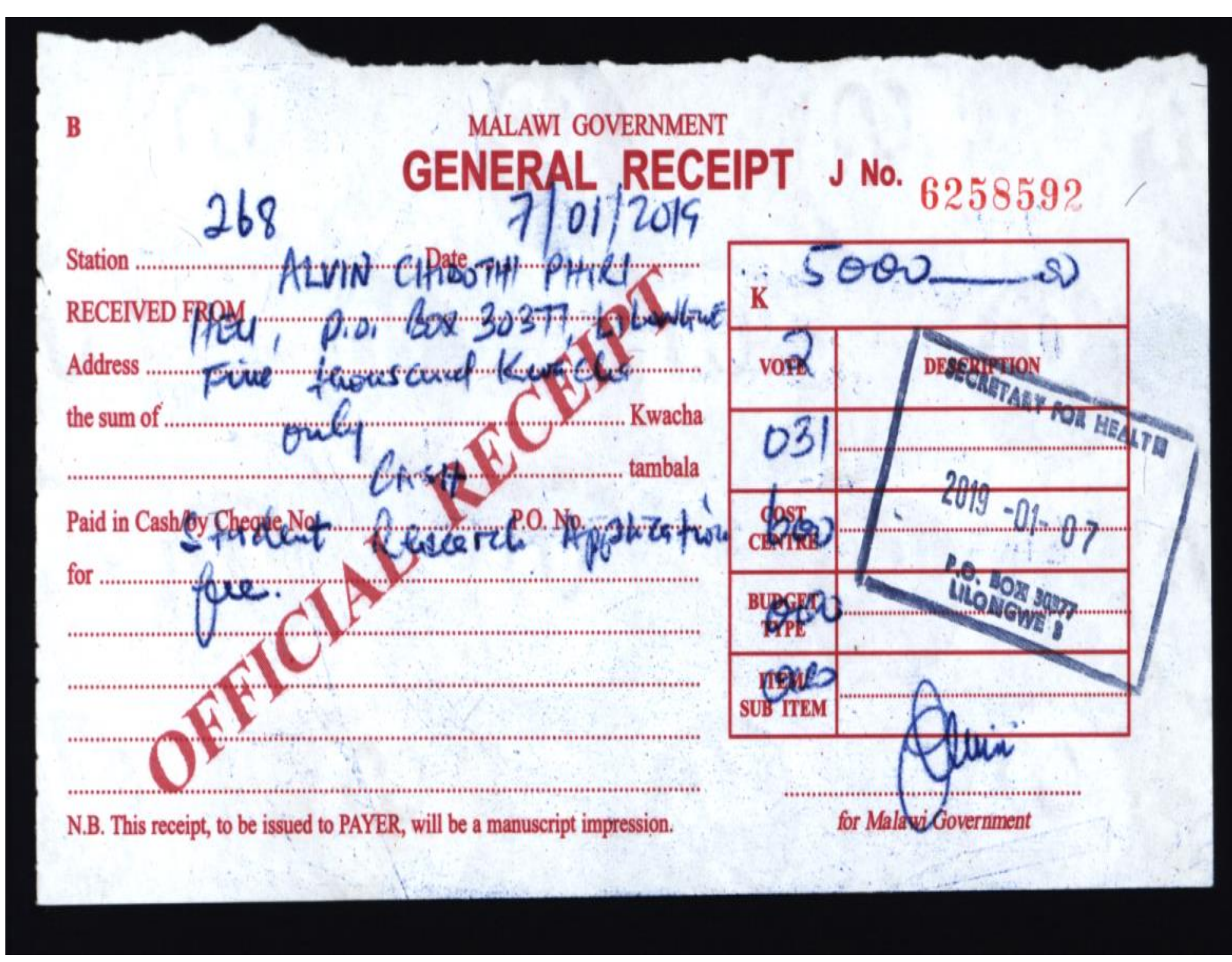
For: **CHAIRPERSON, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE**

Promoting Ethical Conduct of Research[1]

Executive Committee: *Dr B. Chilima (Chairperson), Dr B. Ngwira (Vice-Chairperson)*
Registered with the USA Office for Human Research Protections (OHRP) as an International IRBIRB Number IRB00003905 FWA00005976

Appendix 5

NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE APPLICATION FEE GENERAL RECEIPTS



B

MALAWI GOVERNMENT

GENERAL RECEIPT J No. 6258592

Station 268 Date 7/01/2019

RECEIVED FROM ALVIN CHIBOTHI PHIRI

Address P.O. BOX 30377, Lilongwe

the sum of Five thousand Kwacha only Kwacha

tambala

Paid in Cash/by Cheque No. Cash P.O. No.

for Student Research Application fee.

K	5000—00
VOTE	DESCRIPTION
	031
COST CENTRE	
BUDGET TYPE	
ITEM/ SUB ITEM	

SECRETARY FOR HEALTH
2019-01-07
P.O. BOX 30377
LILONGWE 3

OFFICIAL RECEIPT

N.B. This receipt, to be issued to PAYER, will be a manuscript impression.

for Malawi Government

Appendix 6

LETTER OF SUPPORT FROM DOWA DISTRICT HEALTH OFFICE.

Telephone: + 265 282 200
Facsimile: + 265 282 200
Email :dowa-hmis@malawi.net

All Communications should be addressed to:
The District Health Officer

In reply please quote No. ....
Ministry of Health,
DOWA DISTRICT HOSPITAL
P.O. Box 25,
DOWA.

27th December , 2018

Alvin chidothi Phiri,
Health Education Services,
P.O. Box 30377,
LILONGWE 3

LETTER OF SUPPORT TO CONDUCT A STUDY

I write to grant you approval to conduct a research study titled Evaluation of Ndife Otsogola Voluntary Medical Male Circumcision (VMMC) communication brand.

We would like to request that the findings of the study be shared upon completion of the study.

DOWA DISTRICT HEALTH OFFICER
27 DEC 2018
P.O. BOX 25, DOWA
MALAWI

Mabvuto Thomas
For : THE Ag. DIRECTOR OF HEALTH AND SOCIAL SERVICES

Appendix 7

QUESTIONAIRE 1.

Data Collection Instrument for Focus Group Discussions (FGD's)

2018 EVALUATION OF THE "*NDIFE OTSOGOLA*" VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) COMMUNICATION BRAND.

A	DEMOGRAPHICS CHARACTERISTICS.		
No.	Questions	Category	Tick
1	Average age of respondents.	17 and below.	☐
	(total to be indicated in the boxes)	18 to 24.	☐
		25 to 34.	☐
		35 to 44.	☐
		45 and above.	☐
2	Sex of the respondent.	Female.	☐
	(total to be indicated in the boxes)	Male.	☐
		Prefer not to answer.	☐
3	What is your marital status?	Single, never married.	☐
	(total to be indicated in the boxes)	Married with children.	☐
		Married without children.	☐
		Divorced.	☐
		Separated.	☐
		Widowed.	☐
4	What do you do?	Student.	☐
	(total to be indicated in the boxes)	Employed.	☐
		Unemployed.	☐
		Farmer.	☐
		Teacher.	☐
		Businessperson.	☐
		Other.	☐
5	Catchment area of respondent.	Dowa District Hospital.	☐

		Dzaleka Health Centre. ☐ Mtengowanthenga Rural Hospital. ☐
6	What is your highest level of education? *(total to be indicated in the boxes)*	None. ☐ Primary. ☐ Secondary. ☐ Higher. ☐
B	**BRAND HEALTH.**	
1	Can you please tell me the brand that first comes to your mind for VMMC?	*NDIFE OTSOGOLA. If yes, go to question 2.* None. *If no, go to sub-topic "C".*
2	Can you describe how the brand looks like?	Words with Thumb + Hat. Thumb + Hat. Multi-colored. No.
3	Are there other brands that you are aware of, apart from the '*NDIFE OTSOGOLA*' that is used to promote VMMC?	Yes. No.
C	**BRAND FAMILIARITY.**	
1	*Show the participants the image of the VMMC brand;*	

2	Can you please tell me how familiar you are with the '*NDIFE OTSOGOLA*' brand?	I know exactly what to expect from the brand. I know a bit about what to expect from the brand. I know nothing about what to expect from the brand.
3	What effect does this picture (brand) have on you as a person? Are you:	Informed of VMMC. Influenced to undergo the VMMC procedure. Helped in VMMC decisions. Irritated. Other.
D	BRAND CONSIDERATION.	
1	If circumcised, did the brand have an influence for you in deciding to go for VMMC?	Yes. *If yes, how?* No. *If not, why?*
2		Yes.

	If not circumcised, can this brand influence you in deciding to go for VMMC?	No, It cannot. Maybe.
E	**BRAND RECOMMENDATION.**	
1	Can you please let me know if you would recommend others to go for VMMC in relation to this brand?	Yes. *If yes, can you explain why?* *No. If no, why not?* If not sure, why?
2	Do you think that most people who are important to you think that it is important to go for VMMC in the next 12 months after seeing the "*NDIFE OTSOGOLA*" brand?	Yes. *If yes, why?* No. *If no, why?*
3	Who has ever encouraged you to go for VMMC in the next 12 months?	Parents. Co-worker. Friends/Peers. Family members.
F	**BRAND AWARENESS**	

1	When was the first time you heard or saw this brand?	In the last week. In the last month. In the last 3 months. In the last 6 months. In the last 12 months. More than 12 months ago.
2	When was the last time you saw or heard about this brand?	In the last week. In the last month. In the last 3 months. In the last 6 months. In the last 12 months. More than 12 months ago.
3	When you see this brand, what automatically comes to your mind?	VMMC. HIV prevention measure. Religious association. Other.
4	In the past 3 months, where have you seen or heard about this brand?	Friends, colleagues. Family members. Banners. TV advertisement. Radio advertisement. On cars. Social media. Others.
5	In the past 3 months, how often did you hear people talking about this brand?	Very often. A few times. Once or twice. Haven't heard people talking about it.

6	How would you describe your overall opinion of this brand?	Extremely favorable. Somewhat favorable. Not at all favorable.
7	It is expected of me that I will go for VMMC in the next 12 months after seeing the VMMC brand.	Extremely likely. Somewhat likely Extremely unlikely.
G	**Decision making control**	
1	Can you explain why it would be possible or impossible for you to go for VMMC in the next 12 months?	*If possible, give reasons.* *If impossible, give reasons.*
2	Do you think you have much control on deciding to go or not go for VMMC in the next 12 months?	*If yes, give reasons.* *If no, give reasons.*
H	**SOURCES OF HEALTH CARE**	
1	Where do you go to access health services?	District Hospital. Health Centre. Rural Hospital. Health Post. Private clinics. Traditional Healer. Other.

2	Do you discuss the importance of VMMC in your household?	Yes. *If yes, go to question 3.* No. *If no, close the session.*
3	When did your house hold start discussing the importance of VMMC?	Within the last 3 months. 4 to 6 months ago. More than 6 months ago. Do not remember. Other.
4	What were the topics discussed? *(Multiple responses allowed)*	Advantages of VMMC. Who is eligible for VMMC Rumors associated with VMMC. Wound care. Others.
5	Who sparks household (HH) discussion on VMMC?	HH head. Wife to HH head. Any HH member. Children. Other.
6	What was the extent of the discussion?	Long discussion. Medium discussion. Very little.

Thank you for taking part in this exercise!!!

END OF QUESTIONNAIRE.

Appendix 8

QUESTIONAIRE 2.

Data Collection Instrument for In-Depth Interviews

2018 EVALUATION OF THE "*NDIFE OTSOGOLA*" VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) COMMUNICATION BRAND.

A	DEMOGRAPHICS CHARACTERISTICS.		
No.	Questions.	Categories.	Tick.
1	Average age of respondents.	17 and below.	☐
		18 to 24.	☐
		25 to 34.	☐
		35 to 44.	☐
		45 and above.	☐
2	Sex of the respondent.	Female.	☐
		Male.	☐
		Prefer not to answer.	☐
3	What is your marital status?	Single, never married.	☐
		Married with children.	☐
		Married without children.	☐
		Divorced.	☐
		Separated.	☐
		Widowed.	☐
4	What do you do?	Student.	☐
		Employed.	☐
		Unemployed.	☐
		Farmer.	☐
		Teacher.	☐
		Businessperson.	☐
		Other.	☐
5	Catchment area of respondent.	Dowa District Hospital.	☐

		Dzaleka Health Centre. ☐ Mtengowanthenga Rural Hospital. ☐
6	What is your highest level of education?	None. ☐ Primary. ☐ Secondary. ☐ Higher. ☐
B	**BRAND HEALTH.**	
1	Can you please tell me the brand that first comes to your mind for VMMC?	*NDIFE OTSOGOLA*. None.
2	Can you describe how the brand looks like?	Words with Thumb + Hat Thumb + Hat. Multi-colored. No.
3	Are there other brands that you are aware of, apart from the '*NDIFE OTSOGOLA*' that is used to promote VMMC?	Yes. No.
C	**BRAND FAMILIARITY.**	
1	*Show the participants the image of the VMMC brand;*	

2	Can you please tell me how familiar you are with the '*NDIFE OTSOGOLA*' brand?	I know exactly what to expect from the brand. I know a bit about what to expect from the brand. I know nothing about what to expect from the brand.
3	What effect does this picture (brand) have on you as a person? Are you:	Informed of VMMC. Influenced to undergo the VMMC procedure. Helped in VMMC decisions. Irritated. Other.
D	BRAND CONSIDERATION.	
1	If circumcised, did the brand have an influence for you in deciding to go for VMMC?	Yes, it did. No, it did not. Maybe.
2	If not circumcised, Can this brand influence you in deciding to go for VMMC?	Yes, it can. No, it cannot. Maybe.
E	BRAND RECOMMENDATION.	
1	Can you please let me know if you would recommend others to go for VMMC in relation to this brand?	Yes. No. Maybe.
2		I should.

	Most people who are important to me think that ……….. go for VMMC in the next 12 months after seeing the VMMC brand.	I should not.
3	This category of people think that I should go for VMMC in the next 12 months.	Parents. Co-worker. Friends/Peers. Family members.
F	BRAND AWARENESS.	
1	When was the first time you saw this brand?	In the last week. In the last month. In the last 3 months. In the last 6 months. In the last 12 months. More than 12 months ago.
2	When was the last time you heard or saw this brand?	In the last week. In the last month. In the last 3 months. In the last 6 months. In the last 12 months. More than 12 months ago.
3	When you see this brand, what automatically comes to your mind?	VMMC. HIV prevention measure. Religious association. Other.
4	In the past 3 months, where have you seen or heard about this brand?	Friends, colleagues. Family members. Banners. TV advertisement. Radio advertisement.

		On cars. Social media. Others.
5	In the past 3 months, how often did you hear people talking about this brand?	Very often. Often. Once or twice. Haven't heard people talking about it.
6	How would you describe your overall opinion of this brand?	Extremely favorable. Somewhat favorable. Not at all favorable.
7	It is expected of me that I will go for VMMC in the next 12 months after seeing the VMMC brand.	Extremely likely. Extremely unlikely.
G	Decision making control	
1	For me to go for VMMC in the next 12 months would be ………..	Possible. Impossible. Not sure.
2	How much control do you believe you have over going for VMMC in the next 12 months?	No control. Complete control. Not sure.
3	It is mostly up to me whether or not I go for VMMC in the next 12 months.	Strongly agree. Strongly disagree. Not sure.
H	SOURCES OF HEALTH CARE	
1	Where do you go to access health services?	District Hospital. Health Centre.

		Rural Hospital. Health Post. Private clinics. Traditional Healer. Other.
2	Do you discuss the importance of VMMC in your household?	Yes. No.
3	When did your house hold start discussing the importance of VMMC?	Within the last 3 months. 4 to 6 months ago. More than 6 months ago. Do not remember. Other.
4	What were the topics discussed? *Multiple responses allowed*	Advantages of VMMC. Who is eligible for VMMC. Rumors associated with VMMC. Wound care. Others.
5	Who sparks household (HH) discussion on VMMC?	HH head. Wife to HH head. Any HH member. Children. Other.
6	What was the extent of the discussion?	Long discussion. Medium discussion. Very little.

Thank you for taking part in this exercise!!!

END OF QUESTIONNAIRE.