THE IMPORTANCE OF PARTICIPATORY COMMUNICATION FOR THE VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) PROJECT IN ALEXANDRA TOWNSHIP IN GAUTENG, SOUTH AFRICA-

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A dissertation submitted to the Faculty of Humanities, in fulfilment of the requirements for the degree of Masters of Arts in Journalism and Media Studies at the University of the Witwatersrand in 2016

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DECLARATION

I declare that this dissertation is my own, unaided work. It is being submitted for the degree of Masters of Arts in Journalism and Media Studies, Johannesburg. It has not been submitted before for any degree or examination in any other university.

Signature of Candidate

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ACKNOWLEDGEMENTS

To my supervisor, Alan Finlay and reader, Sara Nieuwoudt, and my mentors, Dr Khethisa Taole and Steve Thobela, thank you for clarifying my ideas. To my family, Wenzo Lebelo and Mazwi Maphumulo who supported me throughout this enduring process, I hope I made you proud.

In memory of my late mothers, Khulisiwe, Samukelisiwe, Nomusa and Themba; uncle, Velekhaya Shange, and grandmother, Siyiko Zulu Shange, with God all things are possible.

ABSTRACT

The research set out to investigate how the Voluntary Medical Male Circumcision (VMMC) programme in South Africa facilitated stakeholder participation in its communication processes to improve the uptake of services in the context of national targets. Studies reviewed have highlighted challenges in the implementation of the participatory model to achieve communication goals. This qualitative study used document analysis, in-depth interviews and Focus Group Discussions (FGDs) for data collection. The research has revealed other limiting factors including unequal opportunities to influence decisions as a result of varying levels of authority and access to mediated public spheres. While those with power end up being further empowered through participatory approaches in terms of voice and visibility, the representation of the inputs of the lower level stakeholder group is limited to head count. A five-day visit to a VMMC clinic in Alexandra Township regards the exclusion from decision-making processes as one of the reasons for people's inability to translate knowledge into the positive response. The study was inconclusive about the influence of the participatory model on the actual service uptake because the focus was not the impact but to provide a textual description of the participants' experiences and not the impact.

Keywords: participatory communication, development programmes, stakeholder participation, medical male circumcision

LIST OF ACROYNMS USED IN THE STUDY

ACSM	Advocacy, Communication and Social Mobilisation
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Therapy
CAB	Community Advisory Body
CCI	Centre for Communication Impact
CDC	Communicable Diseases Centre
CHAPS	Centre for HIV and AIDS Prevention Studies
CMT	Community Media Trust
DHIS	District Health Information System
DOH	Department of Health
FGDs	Focus Group Discussions
GCIS	Government's Communication and Information Services
HIV	Human Immunodeficiency Virus
HCT	HIV Counselling and Testing
HTA	High Transmission Areas
IECs	Information, Education and Communication
JHHESA	Johns Hopkins Health and Education in South Africa
MDGs	Millennium Development Goals
MMC	Medical Male Circumcision
NGOs	Non-Governmental Organisations
PSAs	Public Service Announcements
PEPFAR	The President's Emergency Plan for AIDS Relief
RCTs	Randomised Controlled Trials
SCI	Soul City Institute
SDG	Sustainable Development Goal
STIs	Sexually Transmitted Infections
SANAC	South African National AIDS Council
TB	Tuberculosis
TWG	Technical Working Group for the MMC programme
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific & Cultural Organization
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organisation
WBOTs	Ward-based Outreach Teams

USE OF TERMS

Development

The term "development" in the context of this study goes beyond the economic aspects, towards a greater appreciation of an individual's freedom and control over their lives and environment (Tufte & Mefalopulos, 2009, Servaes & Malikhao, 2002 and Mefalopulos, 2008). It focuses on whether or not the activities of a development programme translate to the development of those directly or indirectly affected. It also suggests that through the creation of communication and media platforms as well as a transfer of skills, ordinary people can be empowered to participate meaningfully in decision-making processes and make informed decisions about their lives.

Communication

The study is informed by the definition of communication by Tufte & Mefalopulos, (2009), Servaes & Malikhao, (2002) and McPhail, (2002 and 2009) that regards it as a vital tool in the dynamic of human development, because it enables people to share ideas needed to help them construct a social environment in which behaviour change becomes possible. In this case, communication is not only about raising awareness, informing, persuading or changing behaviour but it is also about listening, exploring, understanding, empowering, and building consensus for change (Tufte & Mefalopulos, (2009), Servaes & Malikhao, 2002 and McPhail).

Development Communication

Development communication is the sharing of knowledge that aims to reach a consensus for action that takes into account the interests, needs and capacities of all concerned. Communication media is important in achieving this process but its use is not the sole aim - interpersonal communication too must play a fundamental role. Servaes, 2002, p. 1).

Participation

The study regards participation as a development process through which people with interest influence decision-making and share control over development initiatives that affect them directly or indirectly through dialogue and transfer of skills (McPhail, 2002, Tufte & Mefalopulos, 2002 and Mefalopulos, 2008).

Participatory Communication

As a theory, participatory communication tends to lean towards the evaluation of change implementation with real world projects and examining the effectiveness of inclusion of native citizens in the development (McPhail, 2009). It thrives on input from people from all walks of life and of every socioeconomic sphere (McPhail, 2009). As a component of development communication, it is based on dialogue, which allows the (i) sharing of information; (ii) consultation of stakeholders and (iii) collaboration of the various stakeholders, and in this way, facilitates their empowerment in terms of knowledge, attitude and practice. Additionally, its core components, namely communication method, community representation, the level of participation and development impact, assist in the evaluation of its implementation of the objectives of a development programme thereby improving its chances of achieving its goals (Tufte, 2001, Mefalopulos, 2008 and Tufte & Mefalopulos, 2002).

Dialogue

The dialogue process in the context of development communication involves a two-way horizontal flow of communication which is contrary to a vertical, linear communication process (Sarvaes, 2002, Servaes & Malikhao, 2002). In this context, the dialogue is not simply about the discussion of issues or communication information, but generates knowledge and protects stakeholder interests (Servaes, 2002, Tufte, 2002 and Mefalopulos 2008).

Primary Stakeholders

The participatory communication approach requires the involvement of key stakeholders at all levels of the project cycle to ensure that participation and communication, as well as media, become part of the process that improves programme effectiveness (Servaes, 2002; Kerzner, 2001, McPhail, 2002, Tufte & Mafalopulos, 2009). Primary stakeholders, in this case, are beneficiaries of a development programme, who are directly affected by its activities where the programme is located.

Secondary Stakeholders

According to Servaes, (2002), Kerzner, (2001), McPhail (2002) and Tufte & Mafalopulos (2009), secondary stakeholders are indirectly affected by a development intervention but

they influence it through the provision of technical and funding. In this study, they include programme coordinators, communicators, implementing partners as well as development partners, NGOs, traditional authorities and health workers who participate in decision-making processes.

Community Representation

According to Mefalopulos, (2008) and Tufte & Mefalopulos, (2009), development practitioners should involve local community groupings so that decisions taken are reflective of the views and interests of these groupings who are affected by a common development problem and reside where the programme is located. This is because these groupings represent the interests and culture of the people who directly benefit from a development programme and so it is important to work with these community groups to ensure that they can express the viewpoints of the masses they represent (Tufte and Mefalopulos, 2009).

Empowerment

Tufte, (2001), Servaes, (2002) and Mefalopulos, (2008) define empowerment as the process by which individuals, organisations and communities gain control over their social and economic conditions because it improves competencies and capacities required to engage in dialogue and participate in development processes meaningfully (Mefalopulos 2008, Melkote, 2001). In this case, empowerment is linked to development impact, which is one of the core components of participatory communication.

SUMMARY OF THE DISSERTATION

The dissertation is divided into five chapters:

Chapter 1 - Discusses the background to the study in relation to the national treatment and prevention interventions in place to achieve national targets and international goals and stresses the relevance of communication and stakeholder participation in the creation of demand for VMMC services.

Chapter 2 - Reviews the relevant literature on the phenomenon being studied with the purpose of establishing an academic basis for the study.

Chapter 3 - Gives an overview of the research methodology used.

Chapter 4 - Presents and analyses qualitative data collected.

Chapter 5 - Interprets and describes findings.

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CHAPTER 1

BACKGROUND OF STUDY

1.1 INTRODUCTION

The background of the study identifies the broader issues underpinning the problem statement, research question, rationale, aim and objectives of the study, so as to provide a clear context of the study. It is contextualised to the VMMC clinic in Alexandra Township in Gauteng. It outlines a broad overview of the national treatment and prevention interventions established to achieve the international goal of a zero HIV infection rate by 2030 and these include the Voluntary Medical Male Circumcision (VMMC) programme.

It also describes national efforts regarding the VMMC programme, such as the plan to perform 1, 6 million VMMCs by 2015; 4, 3 million by 2016; and 1 million each year thereafter (DoH, 2014). It argues for the scaling up of the VMMC to reduce the risk of transmission of HIV and stakeholder involvement to generate demand for services (DoH, 2014, and Nieuwoudt, et al, 2012). Communication and creation of demand for MMCs which forms part of the country's strategic plan are both crucial for the successful implementation of the VMMC programme (DoH, 2012).

> *By offering MMC, there is hope for significant health benefits, not only for men who directly benefit from expanded access to services but also for women through a lower risk of exposure to HIV infected men, (Weiss et al 2009, p. 3).*

1.1.1 National Efforts on HIV Prevention

The HIV and Acquired Immune Deficiency Syndrome (AIDS) epidemic has been on the South African healthcare agenda for over two decades. AIDS is caused by HIV, which attacks the body's immune system by entering the bloodstream from an infected mother-to-child, through contact with contaminated blood or blood products; by the sharing of needles; as well as unprotected sexual intercourse with an infected person including multiple sexual partners, sexual assault, harmful myths and social norms, uncircumcised men and intergenerational sex (sugar daddies or blessers) (DoH, 2011).

The combination of historical, socio-economic and development factors also facilitate the easier spread of the virus, making HIV and AIDS the primary cause of death in South Africa (DoH, 2011 and Karsten, 2013). The eradication of HIV and AIDS forms part of the national health priorities for the South African health sector (DoH, 2011). The epidemic impacts on life expectancy and in keeping with the National Development Plan (NDP) vision, DoH strives to attain a life expectancy of over 70 years by 2030 (DoH, 2015).

The total life expectancy improved from 62, 2 years in 2013 to 63, 0 years in 2015, according to the Rapid Mortality Surveillance Report 2016 (DoH, 2016). The country has experienced improved life expectancy which can also be attributed, among other things, to its vigorous response to the HIV and AIDS in recent years, (Bradshaw, 2015).

According to Pillay (2015), if one looks at the increase in life expectancy in South Africa in relation to the reductions in maternal mortality and under-5 mortality, one may conclude that the HIV programme by the government and its partners is indeed making a difference even though much still needs to be done**.** The challenges still exist as a result of the new HIV infections, but a plan is in place to address them (Pillay, 2016).

South Africa has the largest number of 6, 2 million people with HIV who need medical treatment and prevention services as of 2015 (Pillay, 2016 and DoH, 2015). This has increased the strain on an already burdened health care system (DoH, 2015). With the new "test and treat" ARV treatment strategy, the expected increase in patients receiving treatment also places further pressure on the country's limited resources (DoH 2016).

South Africa hopes that through prevention, the greatest impact can be made in the reduction of new HIV infections through a prevention package that includes HIV counselling and testing (HCT); male and female condom distribution; Sexually Transmitted Infections (STIs) management; High Transmission Areas (HTA) management; and VMMC (Pillay, 2016 and DoH, 2014).

These interventions could contribute towards the new international vision to end new HIV infections and achieve a zero infection rate by 2030. The NDP 2030 vision for South Africa also reinforces this international vision. It declares that no person who is younger than 20 years of age should be infected with HIV or living with AIDS (DoH, 2015).

Prevention is the mainstay of efforts to combat HIV and AIDS, and since the HIV Counselling and Testing (HCT) campaign was introduced in 2010; over 30 million HIV tests were done, with about 10 million tests in 2014/15 and over 44 million in 2016 since its inception (DoH, 2015, 2016).

The number of people receiving ART from public hospitals, health centres and clinics has also increased to 3.2 million (DoH, 2015). This is seen as a major achievement since epidemiological data shows that HIV-infected individuals who take ART therapy are substantially less likely to transmit HIV to their sexual partners (Kesinger, and Millard, 2012 and Venter et. al., 2012).

The South African National AIDS Council (SANAC) is concerned that the country is not seeing the declines in new infections that are needed to burn out the epidemic by 2030, adding that it needs to balance the investments between prevention and treatment to find the optimal mix given the limited resources (Abdullah, 2014/15). The council is working in partnership with NDOH, UNAIDS and University of Witwatersrand to conduct the Investment Case Study that models the optimal mix of interventions needed to bring the HIV and TB epidemics under control by 2030 (Abdullah, 2014/15).

> *At present, we estimate that the country spends approximately R21 billion on HIV and TB, and, at the same time there is a growing demand for more treatment regardless of the CD4 count. Unless we are able to control new infections through effective prevention programmes, the bill for ART will continue to rise exponentially bringing into serious question the long-term sustainability of treatment, (Abdullah, 2014/15, p. 8).*

The need for a combination prevention approach that includes VMMC for effective HIV transmission prevention is urgent (Kesinger and Millard, 2012, Njeuhmeli et al., 2011 and Westercamp and Bailey, 2007). WHO also recommends the implementation of VMMC intervention as part of an effective HIV and AIDS prevention strategy to provide long-term indirect protection to women by reducing the risk of heterosexual men becoming infected with of HIV (Njeuhmeli et al., 2011 and Weiss et al., 2009).

The major concern is that the uncircumcised foreskin is more likely to tear during sex and these tears form pathways through which HIV can enter the body (Njeuhmeli et al., 2011), which is why DOH recognises VMMC as an important element of South Africa's comprehensive package of HIV prevention services (Nieuwoudt, et. al., 2011).

The adoption of VMMC as part of a comprehensive package of prevention services can play an important role in averting new HIV infections, (Pillay, 2016, p. 8)

1.1.2 Scaling Up VMMC

Reports from other countries reflect different levels of VMMC implementation and outcomes but suggest that by offering VMMC, there is hope for significant health benefits, not only for men who directly benefit from expanded access to VMMC services but also for women through a lower risk of exposure to men infected with HIV (Weiss et al. 2009). The Aurum Institute Annual Report, (2011) written in partnership with DoH and USAID, concedes that women who only have sex with circumcised men have a lower risk of HIV infection than women who have sex with uncircumcised partners.

In the absence of a direct protective effect of circumcision on male-to-female transmission of HIV, these benefits will take several years to become evident and an increase in VMMC, over time, will also lead to a reduction in mother-to-child transmission rates (Weiss et al., 2009). This means that circumcision has an evidence base for efficacy — especially for protecting men — rivalling the best-proved interventions in medicine (Venter et al., 2012).

Randomised controlled trials (RCTs) have shown that VMMC provides about a 60 percent reduction in risk of heterosexual female to male transmission of HIV (Westercamp and Bailey, 2007, Jimmyns et al., 2013). Three RCTs conducted in Africa to determine whether medically performed circumcision reduced the risk of HIV acquisition in males (Westercamp and Bailey, 2007, Jimmyns et al., 2013, Auvert et al., 2006, Gray et al., 2007 and Bailey, et al., 2007), also support this claim.

The first study, conducted in South Africa (Auvert, et al., 2006), which was stopped in 2005, confirms that men who are circumcised have a 60 percent lower incidence of HIV infections. Subsequent studies in Kenya (Bailey et al., 2007) and Uganda (Gray et al., 2007) were also stopped in 2006 after initial analyses from each found that MMC significantly reduced male participants' risk of acquiring HIV infection (Westercamp and Bailey, 2007 and Jimmyns et al., 2013). The studies confirm a lower incidence of HIV infection in 53 percent of the men in Kenya who were assigned to a circumcised group

during the study (Bailey et. al. 2007) and 51 percent of the men in Uganda assigned to a similar group (Gray et. al., 2007).

As a result of these three trials, MMC has been promoted as an important initiative for HIV prevention as it acts as a direct biological protective factor for men due to the risk reduction of contracting HIV (Westercamp and Bailey, 2007 and Jimmyns et al., 2013). Therefore, it is necessary to scale up MMC in the countries with high HIV prevalence and low VMMC prevalence (Westercamp and Bailey, 2007 and Jimmyns et al., 2013).

It is estimated that one HIV infection could be averted for every 5 to 15 MMCs performed and this would be cost-effective for the governments (Njeuhmeli et al., 2011). The RCTs studies also suggest positive implications of scaling-up of MMC in averting millions of infections and deaths and saving billions of Rands in the long run (Njeuhmeli et al., 2011 and Venter et al., 2012).

> *While large-scale circumcision implementation will be complex and costly, according to Hillary Clinton, she adds that "it works, and is needed as part of our prevention toolbox" (Venter et. al. 2010 p. 125). However, she is aware that this will consume resources, energy and time, but "we all must step up our use of combination prevention" because the impact of medical circumcision is so much greater in South Africa, (Kesinger and Millard 2012, p. 123).*

In light of the estimation that the cost-saving in HIV prevention in high-prevalence areas is between US$150 and nearly $900 per infection prevented over a 10-year time period, if 1000 adult males were circumcised in Gauteng province, $2.4 million could potentially be saved in HIV treatment over 20 years (Venter et al., 2012).

The money saved on treatment could be reinvested in testing, treatment, and prevention of vertical transmission (Venter et al., 2012). As such, VMMC could influence the coming continuum of interventions (Njeuhmeli et al., 2011). If successful, Taljaard, (2014) also estimates that South Africa could avert more than 1.2 million HIV infections between 2009 and 2015 and save up to US$6.5 billion in HIV-related health care costs.

In 2012, South Africa set a target to perform 1.6 million circumcisions on males between 15 and 49 years by 2015, achieve 4.3 million circumcisions by December 2016, and 1 million each year (DoH, 2012).

The VMMC programme, which is one of the South Africa's combination HIV prevention interventions, began in 2010 with approximately 140 000 circumcisions performed that year through a pilot project conducted in partnership with the United States Government via the President's Emergency Plan for AIDS Relief (PEPFAR).

In 2012, VMMC was regarded as a key prevention strategy in the South African National Strategic Plan (NSP) for HIV, STIs and Tuberculosis (TB) 2012-2016 and was included as part of a comprehensive package of sexual and reproductive health services to reduce the number of new HIV infections (Pillay, 2016).

As a public health intervention, VMMC is regarded as more than just the surgical removal of the foreskin as it is offered as a comprehensive package of HIV prevention services in combination with other methods, such as HCT, counselling on safe sexual practices including consistent and correct condom usage, and reduction of multiple concurrent sexual partners (DoH, 2012 and Pillay, 2016). If eligible for HIV and TB treatment, the uncircumcised men are linked to local public health facilities for further assessment, care and support for other conditions including STIs (DoH, 2011, 2014).

The South Africa's Strategic Plan for the Scale up of VMMC for 2012/16 also guides the work to ensure improved uptake of services. The plan is a collaboration of government and its stakeholders, including international development partners, local civil society organisations and institutions of higher learning (DoH 2012).

It is reviewed on an annual basis to ensure evidence-based decision making and programming (DoH, 2012). Its strategic goal is to contribute to the reduction of HIV incidents by scaling up VMMC to 80% of HIV-negative men between 15-49 years by 2016, with a target of 4.3 million VMMC's by 2016 (Pillay, 2016).

> *While annual programme performance has accelerated quickly, it has fallen short of annual targets. As of March 2015, a total of 2.05 million VMMCs had been completed since 2010, 48% of the NSP target, (Pillay, 2016, p. 8).*

The Strategic Plan for the scale-up of VMMC in South Africa 2012-2016 and the South Africa Voluntary Medical Male Circumcision (VMMC) Operational Plan for 2015/2017–2018/19, also highlight the role of communication to create demand for VMMC services. The plans have seven pillars; (1) Leadership and Advocacy; (2) Governance and

Coordination; (3) Service Delivery; **(4) Communication and Demand Generation;** (5) Monitoring, Evaluation and Operations Research; (6) Resource Mobilization; and (7) Early Infant and Adolescent Male Circumcision. The study focuses on pillar four, which is informed by the following vision statement:

> *Communication plays a central role in supporting all project efforts to improve the uptake of VMMC services. Creation or generation of demand is crucial for the successful implementation of the VMMC programme. Critical to this success is increasing the awareness of the population in relation to the availability of services through various communication approaches, (DoH, 2012, p. 30).*

However, the decision on whether or not to be circumcised can be influenced by different factors including the attitudes and opinions of the immediate social networks, which include interaction with the individual (awareness, knowledge); social networks (partner, family); community (ownership, consultation, empowerment); and societal influences (Johnson, 2002 and DoH, 2002). All these factors are necessary to significantly scale up communications that drive demand for MMCs in ways that are accessible and easy for men to use, according to Johnson, (2012) and DoH, (2012).

In this case, pillar 4 outlines a multi-pronged mass media approach which combines community engagement and stakeholder involvement to address such influences (DoH, 2012, 2016). It also prioritises access to information as an entry point for transforming initiation schools into sites for HIV and gender education (Njeuhmeli, et al., 2011, Birch 2013). This means that the initiates could be medically circumcised before going for initiation (Njeuhmeli, et al., 2011 and Birch 2013).

1.1.3 Context

In view of the background, a qualitative case study is identified to understand the phenomenon to assist to improve the uptake of services by investigating how the VMMC programme facilitates stakeholder participation in its communication processes using participatory communication to achieve its desired objective. The rationale for using a case study is that human learning and experience is best researched by using qualitative data (Creswell, et al., 2003, Yin, 2003 and Baxter & Jack, 2008).

A case study can be a person, an event, a programme, a time period, a critical incident or community (Patton, 1987). In this study, a VMMC clinic in Alexandra Township in Gauteng

provides a controlled environment to investigate the phenomenon within its real-life context (Bryman, 2008, Yin, 2003 and Creswell, et al., 2003). This assists with textual description of how people experience a given research issue by interpreting a variety of participant perspectives and actions as a single group or community (Bryman, 2008, Marck, et al., 2005, Yin, 2003, 1984 and Patton, 1987).

A total of 77 MMCs were conducted in five-days during a visit by this researcher to the VMMC clinic in Alexandra Township in October 2016, according to the records from Centre for HIV and AIDS Prevention Studies (CHAPS) (2016). The CHAPS is a lead implementing partner for the VMMC programme.

Table 1 – Medical Circumcisions Done During the Study Period in 2016

	Uptake	Temp	Perm	Uptake		Procedure			Language	
Day	Total	Hostel	House	Recruits	Walk-ins	Prepex	Surgical	Not done	Zulu	Other
1	12	10	2	12	0	8	4	0	12	0
2	31	25	6	29	2	20	11	0	30	1
3	9	5	4	8	1	7	2	0	8	1
4	15	7	8	12	3	7	7	1	11	4
5	10	5	5	10	0	4	6	0	8	2
Total	**77**	**52**	**25**	**71**	**6**	**46**	**30**	**1**	**69**	**8**

Source: CHAPS 2016

More than 50% of the men who were circumcised were migrant workers and spoke isiZulu. The majority of them were recruited by VMMC volunteers from a nearby men's hostel (CHAPS, 2016). When asked to choose a method of circumcision, most of them preferred Prepax replacements and said their friends had told them that it was not as painful as a surgical procedure (CHAPS, 2016). See Table 1.

1.2 PROBLEM STATEMENT

The VMMC programme was launched in South Africa in 2010 as one of prevention strategies to reduce the risk of Human Immunodeficiency Virus (HIV) transmission (DoH, 2012). Its success depends on its ability to expand the number of health facilities offering VMMC and increase demand for services, using a multiplicity of communication approaches as a prerequisite of participation (DoH, 2012, Kerzner, 2001 and Kumar, 2011). The country's national strategic plan for the scale up of the Voluntary Medical Male Circumcision (VMMC) for 2012/16 also supports this approach (DoH, 2012)..

However, studies reviewed on the implementation of the participatory approach by government and non-governmental organisations (NGOs) in South Africa and elsewhere in the world highlight challenges in implementation of this in development programmes because of a lack of information on how to utilise the approach to achieve programme goals (Msibi and Penzhors, 2010, Mathagu, 2010 and Doku, 2013).

Against this background, this researcher, as a government communicator and former print journalist, seeks to describe the importance of participatory communication in for the VMMC programme by investigating how the programme facilitates stakeholder participation in its communication processes to improve the uptake of services in the context of national targets.

1.3 RESEARCH SUB-QUESTIONS

The sub-questions were developed and related to the core components of participatory communication, namely: (i) communication methods; (ii) community representation; (iii) level of participation and (iv) development impact (Tufte & Mefalopulos, 2009) — in order to assist the coding of data. Findings related to the fourth component were classified as unexpected results because the study sought to understand the experiences of the participants with the phenomenon and not its impact.

Sub-questions:

1. What was the strategic approach used by the VMMC programme to facilitate stakeholder involvement?
2. What activities did the VMMC programme and stakeholders conduct to improve uptake of services?
3. What was the level of participation of stakeholders in the work of the VMMC programme to improve uptake of services?

1.4 RATIONALE

Since the VMMC programme was new when it was launched in 2010, the researcher used qualitative methods to collect information about its successes and challenges. Seeing that previous studies had alluded to the challenges in practical implementation

of participatory communication in development programmes, the researcher identified their findings for further research. Moreover, participatory communication, being a relatively new field, the research will contribute to deepening the use of participatory communication approach in development programmes as well as in terms of knowledge about the role of stakeholder participation in achieving communication objectives.

1.5 AIM OF THE STUDY

The aim of this study is to determine how the VMMC programme facilitates stakeholder participation in its communication processes to improve the uptake of services in the context of national targets.

1.6 OBJECTIVES OF THE STUDY

In order to achieve the aim of the study, the following objectives, that also informed the sub-questions, will be addressed. The study sought to:

1. Identify communication approaches used to facilitate participation of stakeholders in the work of the VMMC programme;
2. Illustrate communication efforts undertaken by the VMMC programme and stakeholders to improve uptake of services; and
3. Investigate the level of participation by stakeholders and the community in the communication processes to improve VMMC uptake.

1.7 CONCLUSION

The background of the study, including the national targets to prevent HIV through improved uptake of VMMC services have been stated to contextualise the research statement, research questions, rationale, aim and objectives of the study. This assists the investigation to address the research problem about the challenges that militate against the use of participatory communication in development programmes.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter outlined the background of the study and identified the wider issues underlying the research question, as well as discussed the case study in relation to participatory communication which was investigated as a component of development communication.

This chapter reviews the relevant literature published on the phenomenon with the purpose of establishing the academic basis for the study. The researcher traces the history of the phenomenon to provide the viewpoint of the critics and proponents of communication approaches for development. The theoretical framework sets the tone for a discussion of the successes and failures of participatory communication from the global perspective to the South African context. This is achieved by identifying cases where the participatory approach was employed to achieve development goals. The literature and theoretical framework resonate with the research questions and objectives of the study, revealing how the researcher plans to investigate the problem.

Based on the literature reviewed, development communication is, itself, a contested concept with various contexts in which the practice is situated and no consensus exists around a common definition of participatory communication either because it also varies depending on the perspective applied (Quebral, 2006 and 2012, Servaes, 2002 and 2008, Servaes & Malikhao and 2002, Tufte, 2001, Tufte & Mefalopulos, 2009).

However, the experts share a common understanding that participatory communication is a component of development communication. This view informs the discussion of the study on the theory and practice of participatory communication. It also assists the researcher to answer the research problem.

2.2 CONCEPTUAL AND THEORETICAL PERSPECTIVES

(I) The Phenomenon

Communication is a vital tool in the dynamic of human development as it enables people to share ideas needed to help them construct a social environment in which behaviour change becomes possible (Tufte, 2001, Mefalopulos, 2008, Servaes & Malikhao, 2002 and McPhail, 2002). It is not only about raising awareness, informing, persuading, or changing behaviour, it is also about listening, exploring, understanding, empowering, and building consensus for change (Tufte, 2001, Mefalopulos, 2008 and McPhail, 2002).

Quebral, (2006 and 2012), elaborates that the science of human communication assists the transitioning of communities from poverty in all its forms to a dynamic state of overall growth that fosters equity, free flow of knowledge and information, and the advancement of individual potential.

The core of her message is that a person who is affected by a development programme must be involved in processes to find solutions to situations that are in need of change in order to engender a willingness and commitment to the behaviour that will bring about this change (Quebral, 2006 and 2012). In this sense, "participatory community stresses the basic right of all people to be heard, to speak for themselves and not be represented or reworded by another party", (McPhail, 2009, p. 27).

The involvement of ordinary people is also important in the development of communication processes because it eliminates unjust hierarchies of knowledge, power and economic distribution (Tufte and Mefalopulos, 2009). Through their participation, they can then influence decision-making and share control over development initiatives that affect them directly or indirectly (Mefalopulos 2003, Tufte, 2001, McPhail, 2002). In this way, it thrives on input from people from all walks of life and of every socioeconomic sphere and this approach to communication attempts to facilitate trust through their participation in their own development (McPhail, 2009,).

A multiplicity of communication approaches is applied including the monologue (diffusion model) or dialogic (participatory model) approaches in order to achieve these objectives (Tufte & Mefalopulos, 2009).

The diffusion model encompasses a broad range of strategies aiming to solve problems due to lack of knowledge and information and rely on external change agents to drive the processes, with little to no room for participation and this is a linear, monologue-like, top-down communication approach (Tufte & Mefalopulos, 2009).

On the other hand, the participatory model based on Freire's liberating pedagogy from the 1960s, argues that the point of departure must be the community because it is at the community level that the problems of living conditions must be discussed which supports their basic right to speak for themselves in a free and open dialogue (Huesca, 2002, Servaes & Malikhao, 2002, Mefalopulos, 2008, McPhail, 2002, Mefalopulos, 2008 and Tufte & Mefalopulos, 2009).

This, however, does not imply that there is no longer a role for development specialists, planners, and institutional leaders, but only means that the viewpoint of the local groups of the public is considered before the resources for development projects are allocated and distributed, and that their suggestions for policy changes are also taken into consideration (Tufte & Mefalopulos, 2009).

Therefore, participatory communication facilitates the participation of people who are affected directly or indirectly by a development programme through dialogue, which allows for the (i) sharing of information; (ii) consultation; and (iii) collaboration of the various stakeholders, and in this way, facilitates their empowerment, in terms of knowledge, attitude and practice (Tufte, 2001 and Tufte & Mefalopulos, 2009).

Tufte & Mefalopulos, (2009), outline four levels of participation which are passive participation; participation consultation; participation by collaboration and empowerment participation, as the typology of participation which helps to understand and assess the role of stakeholders.

- Passive participation is described as the least participatory of the four. Stakeholders participate by being informed about what is going to happen or has already happened. People's feedback is minimal or non-existent. Participation is assessed through methods of head-counting or number of people who received communication materials such as pamphlets.

- In participation by consultation, stakeholders provide answers to questions posed by outside researchers or experts during fieldwork or meetings. This consultative process keeps all the decision-making power in the hands of external professionals who are under no obligation to incorporate stakeholder input.
- Participation by collaboration involves primary stakeholders in the discussion and analysis of pre-determined objectives set by the programme. It does not usually result in changes what should be accomplished as this is already determined without the stakeholders. It does, however, require an active involvement in the decision-making process about how to achieve it. This process incorporates dialogue and capacity building among all stakeholders to achieve a joint collaborative effort. Even if initially dependent on outside facilitators and experts, with time, collaborative participation has the potential to evolve into an independent form of participation.
- In empowerment participation, primary stakeholders are capable and willing to initiate the process and take part in the analysis. This leads to joint decision-making about what should be achieved and how. While outsiders are equal partners in the development effort, primary stakeholders are significant partners in decisions concerning their lives. Dialogue identifies and analyses critical issues; an exchange of knowledge and experiences that lead to solutions, ownership and control of the process that rests in the hands of the primary stakeholders.

In this way, participatory communication addresses the past mistakes of the top-down economic-oriented viewpoint on development, which was founded on theories of Modernization; Growth; Dependency and Underdevelopment in the 1950s and 1960s which, promoted dominance through the one-way flow of information and communication (Huesca, 2002 and Servaes & Malikhao, 2002). This viewpoint which relied on Everett Rogers' (1964) diffusion and innovation theory, was criticized as a limited view of development communication because it did not take into account the influence of persons and groups who were directly affected by development programmes (Huesca, 2002 and Servaes & Malikhao 2002).

The critics of diffusion of innovations cited that the information, education, and communication (IEC) approaches were also insufficient to achieve the desired development results because people needed motivation through participation which

allowed shared information, dialogue and greater representation of voices (Huesca, 2002 and Servaes & Malikhao, 2002). In the 1970s and 1980s, these linear communication paradigms which were formulated by Western experts without the involvement of the people in the targeted societies also underwent interrogation by scholars across disciplines, who pointed out that they deprived people of ownership of local development plans (Servaes & Malikhao, 2002).

As a result, two major approaches to the participatory communication model were developed. The first was the dialogical pedagogy of Paulo Freire (1983), whose outcomes and implications are not always easy to pre-determine (Servaes, 2002). The second involves the ideas of access, participation and self-management, as articulated in the United Nations Educational, Scientific and Cultural Organization (UNESCO) debates of the 1970s (Huesca, 2002, Servaes, 2002 and Mefalopulos, 2008).

It was Freire's 1985 work that caused a direct shift in the understanding of development communication in that people can be passive recipients of knowledge or they can engage in a problem-posing approach in which they become active participants (Huesca, 2002, McPhail, 2002, Servaes, 2002 and Tufte & Mefalopulos, 2009).

His view was that people could link knowledge to action and actively work to change their societies at a local level through dialogue (Huesca, 2002, McPhail, 2002, Servaes, 2002 and Tufte & Mefalopulos, 2009). However, Freire's notion of dialogic communication as a normative theory of participatory communication was also unpopular with elites, even in the Third World countries (Servaes, 2002).

One problem was that his theory of dialogical communication was based on group dialogue rather than such amplifying media as radio, print and television. Another problem that was highlighted was that the theory gave little attention to the language or form of communication and instead, devoted focus to the intentions of communication actions, according to Huesca, (2002) and Mefalopulos, (2008).

The scholars insisted that participatory communication, as a dialogic and horizontal approach to communication for development, should involve access to mass media, permit participation of users and provide a platform for relatively open and unedited input to decisions (Servaes & Malikhao, 2002, Tufte, 2001 and Yoon, 2004). Access to

spaces of communication and dialogue was seen as crucial for any community that was affected by the programme, according to Servaes & Malikhao, (2002 and Tufte, (2001).

The UNESCO discourse proposed the main focus on access, participation and self-management, according to Huesca, (2002) and Tufte & Mefalopulos, (2009):

- Access, which refers to the use of media for public service and may be defined in terms of the opportunities available to the public to choose varied and relevant programs and to have a means of feedback to transmit its reactions and demands to production organizations (Huesca, 2002 and Tufte & Mefalopulos, 2009).
- Participation, which implies a higher level of public involvement in communication systems, which includes the involvement of the public in the production process as well as in the management and planning of communication systems. In this case, participation may be no more than representation and consultation of the public in decision-making (Huesca, 2002, Mefalopulos, 2008 and Tufte & Mefalopulos, 2009).
- Self-management, which is the most advanced form of participation. In this case, the public exercises the power of decision-making within communication enterprises and is also fully involved in the formulation of communication policies and plans (Mefalopulos, 2008 and Tufte & Mefalopulos, 2009).

”Development communication is the sharing of knowledge aimed at reaching a consensus for action that takes into account the interests, needs and capacities of all concerned and communication media are important in achieving this process but their use is not an aim in itself — interpersonal communication too must play a fundamental role” (Servaes, 2002, p. 1). Also crucial are the core competencies required to engage actively and participate meaningfully in all processes (Tufte & Mefalopulos, 2009).

So, Participatory communication does not call for a replacement of the basic communication functions associated with information dissemination, but rather broadens its boundaries to include more interactive ways of communicating and “this new conception contains the monologic and the dialogic, which means that when the two are fully understood and properly applied, if needed, combined together, development is used to its fullest advantage”, (Tufte & Mefalopulos, 2009, p. 14).

(II) Approach

In 2006, World Congress on Communication and Development recommended that diffusion of innovations and participatory approaches should be adopted in parallel in programme initiatives to allow development and communication practitioners to reach broad audiences through large-scale campaigns (Tufte & Mefalopulos, 2009).

For example, mass media (one-way communication) should be supported by interpersonal communication (two-way communication) because these approaches facilitate the participation of stakeholders (Tufte & Mefalopulos, 2009, Huesca, 2002 and Servaes & Malikhao, 2002). In this way, the sustainability of development initiatives is enhanced when the two-way communication approach is combined with the effective use of one-way communication approaches (Tufte, 2001, Servaes, 2002, Mefalopulos, 2003 and Geoghegan et al., 2004).

> *Modern mass media and alternate or parallel networks of folk media or interpersonal communication channels are not mutually exclusive by definition. Contrary to the beliefs of diffusion theorists, they are more effective if appropriately used in an integrated fashion, according to the needs and constraints of the local context. However, they can be effectively combined, provided the limits of the mass media are recognized, (Serveas & Malikhao, 2002, p. 30).*

> *"On one hand, the diffusion model encompasses a broad range of strategies aiming to solve problems due to lack of knowledge and information. This approach is linear, monologue-like, top-down communication. On the other hand, is the participatory model based on Freire's liberating pedagogy from the 1960s, - articulates processes of collective action and reflection by relevant stakeholders. The center of attention is the empowerment of citizens by their active involvement in the identification of problems, development of solutions and implementation of strategies. The participatory model is a dialogic and horizontal approach to communication and development," (Tufte & Mefalopulos, 2009, p. 7).*

The fact that the two main communication perspectives, monologic (one-way) and dialogic (two-way) rely on different theoretical perspectives and methodological frameworks should not be considered as contradictory but rather as an asset capable of better addressing the complexity of many situations Tufte & Mefalopulos, (2009). For example, the decision-making phase can be based on two-way communication methods to reduce the possibility of relying on incorrect assumptions and avoid the risk of

alienating relevant stakeholders by leaving them out of the decision-making process initiative. They assert that after this phase, both approaches can be used according to the needs and scope of the initiative.

This means that participation and communication must be part of a development process to ensure that priorities and objectives are agreed to and refined by a wider base of the constituencies, thus increasing a sense of project ownership by local stakeholders and enhancing sustainability through monologic and dialogic communication approaches (Tufte, 2001, Servaes, 2002, McPhail, 2002 and Mefalopulos, 2008). However, McPhail, (2002), cautions that unless policymaking and the social process are themselves participatory, it is unlikely that the result will be a democratic pattern of communication.

(III) Application

According to Mefalopulos, (2008) and Tufte & Mefalopulos, (2009), development practitioners should involve local community groupings so that decisions taken are reflective of the views and interests of these groupings who are affected by a common development problem and reside where the programme is located.

This is because these groupings represent the interests and culture of the people who directly benefit from a development programme so it is important to work with these community groups to ensure that they can express the viewpoints of the masses they represent (Tufte & Mefalopulos, 2009).

Tufte & Mefalopulos (2009) recommend that two-way communication is adopted from the beginning and be applied consistently in each phase of the process to reinforce mass media messages but also points out that full participation by all stakeholders in any step of the process is not possible and, in some, cases probably not entirely desirable.

The key stakeholders who are affected by the change should have the opportunity to participate in the entire decision-making process defining the needed change, but after their input is taken into account, they do not need to be directly involved in decisions, especially technical ones that might go beyond their specific interest or knowledge (Tufte and Mefalopulos, 2009, Servaes & Malikhao, 2002 and Huesca, 2002).

Whereas McPhail, (2009, p. 27), stresses the basic right of all people to be heard, to speak for themselves and not be represented or reworded by another party, it is not possible to involve everybody because participatory communication requires professionalism and expertise of specialists who are knowledgeable about the diverse range of methods, techniques and tools of development communication.

For example, to build a bridge in a certain spot, there is no need to involve all stakeholders in the technical decisions concerning the type of concrete, bolts and other technical specifications for construction (Tufte & Mefalopulos, 2009, Servaes & Malikhao, 2002 and Huesca, 2002).

> *Unless there are people familiar with different technical engineering specifications, general participation would only delay the process and would not benefit the end result, (Tufte & Mefalopulos, 2009, p. 20).*

The ideological debate on what constitutes participation ranges from those who believe that true participation should put communities in charge of making all the decisions about development processes that affect them against those who acknowledge that some people lack the skills to participate meaningfully in all processes and that their participation should be restricted to certain levels because general participation would only delay the process and would not benefit the end result (Servaes & Malikhao, 2002, Huesca, 2002 and Tufte & Mefalopulos, 2009).

There are four elements of participatory communication, namely: communication methods; community representation; the level of participation; and development impact. These all drive the work of development and communication practitioners (Tufte & Mefalopulos, 2009, Servaes & Milikhao, 2002). These are recommended to ensure that participation and communication, as well as the media, become part of the process to improve programme effectiveness (Tufte & Mefalopulos, 2009, Servaes & Milikhao, 2002). They can also help identify key stakeholders and engage them in their positions and perceptions about a development programme McPhail, 2002, Servaes & Milikhao, 2002 and Tufte & Mefalopulos, 2009).

Proper application of these elements should also consider broader contextual requirements, such as a flexible project framework in terms of timelines, a politically conducive environment, allowing open and transparent communication and an enabling

attitude by key stakeholders, including project management (Tufte & Mefalopulos, 2009, Servaes & Milikhao, 2002, Huesca, 2002).

- **Communication method:**

The principles of participatory communication, which are dialogue, voice, liberating pedagogy and action-reflection-action, should be considered to answer key questions about appropriate communication methods for a development programme. The principles can be used to assess relevant problems, risks and needs as well as identify best options, opportunities and solutions. There will also be a need to prioritise key issues, reconcile different perceptions, validate findings and define solutions and objectives (McPhail, 2002, Servaes & Milikhao, 2002 and Tufte & Mefalopulos, 2009). However, dialogue about these issues must be free and open. Central to the process is a shift in power to give voice to marginalised people (Tufte & Mefalopulos, 2009). This process is guided by a facilitator identified to articulate the dialogic process. There must be an emphasis on the collectiveness of the process and the need for mutually reinforcing the commitment to change as well as the actual issue of power (Tufte & Mefalopulos, 2009).

- **Community representation**

Local communities should be able to influence and share control over development initiatives, decisions and resources that affect them. Additionally, their viewpoint should be considered before the resources for programmes are allocated and distributed and their suggestions for policy change must be taken into account (Servaes & Malikhao, 2002, Tufte & Mefalopulos, 2009). To achieve this, the participation of local communities and their collaboration must be at all levels of development processes that concern them but restricted to representation and consultation (Servaes & Malikhao, 2002).

However, the experts are still adamant that they do not need to be directly involved in technical decisions that might go beyond their specific knowledge because participatory communication requires expertise in diverse range of methods, techniques and tools of development communication (Tufte and Mefalopulos, 2009, Servaes & Malikhao, 2002 and Huesca, 2002).

- **Level of participation**

There are four levels of participation:

(i) Passive participation which focuses on information sharing (one-way communication) where people are included in the development process by informing them about what is being done;

(ii) Consultation (primarily one-way communication with a stronger emphasis on feedback) where stakeholders provide their input but do not have a significant say in the decision-making process;

(iii) Collaboration (two-way communication supporting open interaction in decision making and input in decision making is balanced) involves primary stakeholders in discussions and analysis of pre-determined objectives set by the programme; and

(iv) Empowerment (two-way communication ensures shared decision-making through transfer of control over resources) primary stakeholders are capable and willing to initiate the process and take part in the analysis resulting to joint decisions about what should be achieved and how (Tufte & Mefalopulos, 2002 and Mefalopulos, 2008).

- **Development impact**

This component includes access, empowerment and self-determination i.e. access to information suggests that when people become aware of their rights, they are empowered to confront and deal with the many challenges affecting their existence which lead to articulation of awareness and commitment to action (Servaes & Malikhao 2002, Servaes, 2007, Mefalopulos, 2008). The participatory communication model is therefore self-determining in that it also seeks to perpetuate environments that encourage the indigenous populations and the intervening parties to communicate in such a fashion (McPhail, 2002). Three rationales exist for this model; the native populations possess relevant information regarding their own circumstances and are a unique resource without which a development project might fail; the native populations have the fundamental human right to contribute to the formation of their own advancement; and inclusion of the native population will draw more support which will, in turn, facilitate the achievement of common goals (McPhail, 2002).

2.3 GLOBAL EXPERIENCE

In practice, applying participatory communication in projects has several hurdles, according to McPhail, (2002). Participatory communication tends to lean towards the evaluation of change implementation with real world projects and examining the effectiveness of inclusion of native citizens in the development (McPhail, 2009, p. 27-8).

Proper application of participatory communication methods and tools are not enough to ensure a project's success. Broader contextual requirements such as a flexible project framework (especially in terms of timelines); a politically conducive environment, allowing open and transparent communication; and an enabling attitude by key stakeholders, including project management, are also needed (Tufte & Mefalopulos, 2009).

> *By its nature, participatory communication rejects the analytical scientific method inherent in Western evaluation methods for an inclusive acceptance of individual opinions,* (McPhail, 2002, p. 29).

While the participatory communication process can enhance the overall results and sustainability of any development initiative, its outcomes and implications are not always easy to pre-determine because it requires a predominantly dialogic process (Tufte & Mefalopulos, 2009). Additionally, given the subjective non-quantifiable terms that describe the participatory approach, implementation and evaluation become difficult when dealing with concrete practicalities (McPhail, 2002 and Tufte & Mefalopulos, 2009), such as answering the following questions:

- How much participation should the indigenous population have before a development project can be labelled participatory?
- How does one facilitate that participation with enough neutrality as to not overly influence the people who want to participate, thus negating the entire approach?
- What about education and translation issues? Indigenous people might not be equipped with the skills to participate actively.
- How easily can the term be manipulated to cover up a venture that is more profit and power based than they are well meaning?
- Who should hold the ultimate responsibility for a project — the intervening party, the investors, or the stakeholders?

However, there are no definitive answers to these questions and there are also no concrete, quantifiable definitions for participatory communication, according to McPhail, 2002 and Tufte & Mefalopulos, 2009). These are some of the challenges with applying the notion of "theory" to the participatory communication approach and Doku, (2013) recommends the use of experts in participatory communication and training on participatory communication for programme coordinators.

Tufte & Mefalopulos (2009) cites one example to highlight that a two-way communication approach supported by the diffusion of innovations should be adopted from the beginning and be applied consistently in each phase of the development process. This combination approach assists development and communication practitioners to reach broad audiences, according to Tufte & Mefalopulos, (2009) and Tufte, (2001).

Case 1

Tufte & Mefalopulos, (2009) report that in a water project, officers of an international organization identified as a key development priority, the need to improve the water system of a poor region in a Central American country. Based on their knowledge and expertise, the officials defined what was needed and which aspects should be improved, with little or no input from local stakeholders. Expectations of the stakeholders were not considered and as problems emerged, project management came under increased pressure from the donor and national political authorities to gain the support from the people who were supposed to benefit from the project. Thus, a more participatory stand was adopted in the following stages and local stakeholders were involved in decisions concerning the technical design of the new water system. The end results of this combination approach — that is, top-down in the beginning and participatory from the halfway mark — were less than satisfactory. Managers and a subsequent review mission ascribed much of the failure to participate, when in fact; it should have been ascribed to a faulty use of participatory communication.

According to Tufte & Mefalopulos, (2009), the project should have sought participants' inputs at the beginning when assessing the situation and making

decisions. Local stakeholders should have been included in defining the needed outcome of the improved water system. Subsequent actions in the process could have been restricted to technical experts. Local stakeholders would have gained interest and been knowledgeable about which services were needed to improve their lives. Rather, they found themselves in a discussion of the technical design of a water system in which they had limited knowledge or interest.

Case 2

Doku, (2013) also highlights the need for a dynamic, interactional and transformative process of dialogue between people, groups and institutions that enable people, both individually and collectively, to be engaged in their own welfare and realize their full potential. Doku, (2013), in his investigation of how participatory communication affected the practical implementation of Livelihood Empowerment Against Poverty (LEAP) project in Ghana, his study found that communication between LEAP officials and the beneficiaries was largely top-down and also that the communication strategy of the programme was prepared by outside experts with the minor inputs of the communities it targeted to serve. The minor inputs only happened to fine tune the document that had already been prepared without them. One of the reasons he cited for reliance to external support was that the programme did not have the communication person to engage the outside experts intelligently on communication methods. According to Doku, (2013), the top-down flow of information at LEAP did not satisfy the normative principles of participatory communication and he recommended the use of experts in participatory development communication and training on participatory communication for social welfare officers.

When comparing the experiences of the water system of a poor region in a Central American country and Ghana's poverty empowerment projects, both projects relied on external technical support and used the top-down approach for community involvement and as a result of the exclusion of the people who were beneficiaries of the projects from decision-making processes at the beginning, they failed to achieve their development goals.

2.4 LOCAL EXPERIENCE

South Africa views development communication as a tenet of a thriving democracy through continued interaction with all stakeholders in all the stages of policy-making and project planning (GCIS, 2014). It recognizes the importance of ordinary people's participation in development processes and the accompanying policies and strategies, both at national and local levels (GCIS, 2014 and Msibi & Penzhors, 2010).

As a result, the Strategic Plan for the scale-up of VMMC in South Africa 2012-2016 also prioritizes a combination of a multi-pronged mass media and interpersonal communication approaches to bring together the various stakeholders to address information needs as identified by communities in its attempt to improve service delivery (DoH, 2012 and 2016).

Karsten, (2013) agrees that participatory approach features prominently in strategies for planning and programming in South Africa, but also observes that the implementation of development programmes promoted through different communication intervention is slow and coverage of the target audience remains low.

While no evidence could be found to support the claim, DoH has adopted an integrated perspective to support all communication campaigns, moving from the premise that the department exists to ensure that the citizens should have access to an equitable, efficient and effective public health system that meets their needs (Maja, 2016).

> *To do this we need to know what people expect and what people think of the services provided. In order to carry out our constitutional responsibility of developing public health policies properly, we need to engage and communicate with communities and other stakeholders in the healthcare sector. Our integrated strategic approach is people-centred and facilitative and entails two-way communication channels in order to encourage communities to be active participants in finding solutions to their problems. In this way, we can take properly informed decisions based on public feedback and ensure that our services are well anchored in and are accountable to the communities we serve, according to Maja, (2016, p. 1).*

However, studies reviewed on participatory approaches in South Africa highlight challenges in the practical implementation of participatory communication in development programmes. They attribute the challenges to a lack of information on

how to utilise the approaches to achieve programme goals, adding that the approaches were not well understood or appreciated by programme coordinators and communication practitioners who did not have the necessary information and skills, (Msibi & Penzhors, 2010 and Mathagu, 2010).

Case 3

The *Imbizo* campaign launched by the South African government in 2000 experienced challenges in the implementation of the participatory approach. The *Imbizo* concept was used to bring democracy closer to the people through unmediated community engagement in order to improve service delivery (Mathagu, 2010). According to Collins English Dictionary, the origins of *Imbizo* can be traced to a gathering of Zulu people called by a traditional leader. In this context, the *Imbizo* constitutes a form of a participatory approach to meet development goals (Mathagu, 2010 and Hartslief, 2006). Although the *Imbizo* was a good concept, it was not a success on a large scale in practice (Hartslief, 2008). In theory, the *Imbizo* could improve communication and government's responsiveness to the needs of the people, but in practice, it was compromised by competing for political interests since it was used as an electioneering tool for canvassing support for the ruling party (Hartslief, 2008 and Mathagu, 2010).

Case 4

Msibi & Penzhors, (2010) confirm that South Africa acknowledges the importance of following a participatory approach for development and policies and strategies both on national as well as local government level. They support this resolution because it focuses on the active involvement of the people in all stages of development projects, which is crucial for sustainable development. Their study which aimed at ascertaining to what extent local government follows accepted participatory communication principles and practices to communicate with the community in the Kungwini Local Municipality, found that participatory communication was appreciated as being critical for development at local government level and was being successfully applied by the local municipality, but

challenges for further practical implementation of this approach were also identified.

In South Africa, various stakeholders, including government health workers, traditional leaders, local and international organisations all work together. Not all of them have the required expert knowledge of participatory communication to achieve development goals. As a result, work related to development communication is outsourced to development partners who provide advisory or technical support (GCIS, 2014). Four of these implementing partners have been identified, as follows:

Case 5

The Centre for HIV and AIDS Prevention Studies (CHAPS) has been playing a technical advisory role in the development of communication methods to generate and maintain demand for VMMC services (Nieuwoudt, et al., 2012). It has also been instrumental in the establishment of high volume circumcision sites throughout the country to ensure that services are widely available, training health workers to conduct surgical procedures, directly managing these sites, conducting outreach and communication campaigns and assisting in seeking new clients. According to a report by Nieuwoudt, et al. (2012), the organisation employs a number of strategies to create awareness and demand in the communities where it operates. Any demand creation activities usually start with engaging the community leadership. These include formal political structures like ward counsellors through very informal community structures like street committees. Consultation has also included traditional circumcisers who are active in the communities. A number of community workshops are scheduled with community organisations including NGOs working in the identified areas. The activities also include distribution of informational pamphlets and a regular local call-in-radio show that provides information and gets feedback from the community. To increase the visibility of VMMC in community settings, CHAPS also erects billboards and distributes posters and stickers in popular places where there is a lot of passerby traffic. School and clinic settings are also targeted to give information talks. It also trains community outreach field-workers who go through

the community in a structured way to talk to residents about VMMC. Lastly, it also uses mobile phones to generate demand by using SMS to reach clinics.

Case 6

The institute for health and development communication in South Africa, *Soul City* (SCI), is well known for encouraging community participation in its activities through mass media edutainment programmes. These interventions are reinforced through on-the-ground interventions that focus on interpersonal communication, social mobilization and advocacy that are supported by evidence-based approaches (Goldstein, 2012). Its campaign is supported by participatory communication and strategies based largely on the diffusion model of communication (Tufte, 2001). An edutainment programme *Soul City* series II also addressed norms around VMMC. In this way, "South Africa has found its own way to educate adults and teenagers of the danger of HIV/AIDS, using a soap opera with its very own mission called "*Soul City*", which is the first show of its kind on television and radio to examine many health and development issues", (McPhail, 2002, p. 43). SCI also employs short-term campaigns, such as VMMC camps, to help increase VMMC service uptake.

Case 7

By focusing on disseminating HIV and AIDS information, mainly through television and outreach programmes, Community Media Trust (CMT) also contributes to the improvement of quality of life of communities in South Africa (Johnson, S. et al., 2012). They assist through the provision of technical support for the formulation, implementation and monitoring and evaluation of the VMMC strategic plan and using both mass media and interpersonal communication approaches to support demand creation (Johnson, S. et al., 2012). Their expert work also includes building public knowledge and changing behaviour patterns. In addition, their communication interventions, which include mass media campaigns, are sustained by various participatory models (Johnson, S. et al., 2012).

Case 8

John Hopkins Health and Education in South Africa (JEHHESA), now called Centre for Communication Impact (CCI), supports health campaigns including HCT, ART, dual protection and treatment by providing advisory and technical services for the design, implementation, managing and evaluation of strategic communication interventions. Using its campaign called Brothers for Life, it also assists with mass communication involving advertising and outreach activities to improve behavioural related outcomes relating to VMMC using a P-Process approach. According to Johns Hopkins, (2013), this five step approach to strategic communication includes; inquire, design strategy, create and test, mobilise and monitor and evaluate and evolve. It guides professionals from a loosely defined concept about changing behaviour to a strategic and participatory programme with a measurable impact on the intended audience.

The cases on South Africa's experience have clearly demonstrated the need for the knowledge of communication methods in order to achieve success in the implementation of the participatory approach. It also shows how the organisations employed a multiplicity of communication approaches to achieve development objectives.

For example, CHAPS focuses more on inter-personal communication to improve the uptake of VMMC services, Soul City on edutainment and CMT on mass media campaigns sustained by the participatory approach and JEHHESA (CCI) uses a P-Process to address social and behaviour change. This demonstrates the power of their knowledge in participatory approach which allows them to control the communication process.

2.5 CONCLUSION

The literature review confirmed that development programmes are best served by a combination of communication strategies involving a participatory approach. The background has also explained that the benefits of VMMC could take several years to become evident (Weiss et. al. 2009). Tufte, (2001) and Servaes, (2002) also agree that since development programmes are linked to sustainability, similarly, their activities, need to be sustained for over a long period of time because of their long-term goals.

In view of this knowledge, the context within which the research methodology and study design for data collected must be selected is therefore outlined, as well as global perspectives and the local experience with the phenomenon being studied, to answer the research question.

CHAPTER 3

RESEARCH METHODOLOGY AND PROCEDURES

3.1 INTRODUCTION

The previous chapter sought to understand existing knowledge about the phenomenon being studied and theoretical contributions to participatory communication and how this model featured in the strategies of development programmes in South Africa.

This chapter gives an overview of the research methodology and design used and describes the research strategy, sampling and data collection methods as an anticipated plan of how the empirical investigation of the study will be carried out to answer the research question. The research methodology, according to Baxter and Jack, (2008) and Creswell et al., (2003),

should include the strategy, rules and procedures of the research. Data collection was informed by this view.

The data was primarily sourced by an interview question guide and secondary data from documents reviewed. All preparatory work was informed by the research question, problem statement and literature reviewed. The rationale for a qualitative study was that human learning and experience was best researched by using qualitative data (Creswell et. al. 2003, Yin 2003 and Baxter & Jack, 2008). The strategies used sustained contact with people in settings such as workplaces and clinics.

De Vos, (2002), advised that the first thing a researcher should outline was the paradigm that underpinned the study — the researcher's point of view or frame of reference used to organise her observation or reasoning. All qualitative researchers approached their studies with a certain paradigm or world view. That is to say, they had a basic set of beliefs or assumptions that guided their inquiries, such as, the relationship of the researcher to that which is being researched (Creswell, et al., 2003 and 1998). In this regard, the researcher, as a communicator in the Department of Health was aware of the research problem but because of the limitations of her rank and job description, which did not afford her opportunity to participate in the planning or decision-making processes of the VMMC programme or the phenomenon being studied, her knowledge about the background of the study was limited to annual reports.

3.2 RESEARCH METHODS

The study used qualitative research methods to answer the research question. According to Creswell et al., (2003), Yin, (2003) and Bryman, (2008), these methods provided insight into the diverse impact of services by government and non-governmental organisations (NGOs) and the methods were useful for revealing rich information about the social processes that led to particular outcomes and in this case, helped to understand the characteristics and experiences of the people benefitting from the VMMC programme or supporting the programme.

The approach was suitable for the study because the VMMC was a new programme in South Africa after it was officially launched in 2010 and its first national strategy developed in 2012. A statement by Servaes (2001) that generally qualitative approaches

were better when investigating meaningful phenomena in development communication also supported the approach.

The focus of the study was the richness of information from the experiences of the participants of the study obtained through in-depth interviews and focus group discussions with people working in the Department of Health, implementing partners as well as community members who benefitted from the VMMC programme.

The researcher was able to uncover the significance the subject of the research ascribed to the topic being researched. This was because the qualitative approach involved an interpretive, naturalistic approach to its subject matter and gave priority to what the data contributed to important research questions or existing information (Creswell et al., 2003, Yin, 2003 and Bryman, 2008).

However, Creswell et al., (2003), Yin, (2003) and Bryman, (2008) cautioned that while qualitative methods were rich in detail and could include unexpected and immeasurable impact, they were not suitable for demonstrating that findings were representative of wider populations.

3.3 RESEARCH DESIGN

A research design was defined as a master plan of a research that described how the study was to be conducted, and how all of the major parts of the study worked together to answer the research question (Creswell et al., 2003, Yin, 2003 and Baxter & Jack, 2008). It used qualitative methods which related to the general aim of the study and involved a case study which informed planning and steps for research.

> *It is an action plan for getting from here to there, where 'here' may be defined as the initial set of questions to be answered and 'there' is some set of conclusions or answers', (Yin, 2003, p. 19).*

3.3.1 Case Study Strategy

A case study was defined as an empirical inquiry that investigated a phenomenon within its real-life context (Yin, 2003, Bryman, 2008, Patton 1987 and Yin, 2003). It was referred to as a process, activity event, period of time, programme, individual or multiple individuals (Yin, 2003, Bryman, 2008, Patton 1987, Yin, 2003 and De Vos,

2002). It was one of the several ways of doing research to understand human beings in a social context by interpreting their actions as a single group or community (Yin, 2003, Bryman, 2008, Patton 1987 and De Vos, 2002). It was also an appropriate approach to understand a particular situation through a variety of participant perspectives (Creswell, et al., 2003 and Yin, 2003). As a result, the VMMC programme in the Alexandra Community Health Centre was identified for this purpose. It provided a controlled environment for the study.

The exploration and description of the case study took place through detailed, in-depth data collection methods, involving multiple sources of information that were rich in context (Yin, 2003, Bryman, 2008 and 2012). Document analysis, in-depth interviews and focus group discussions were used to inform the overall research direction and the investigation process (Yin, 2003, Bryman, 2012). The case study also helped to answer "how" and "why" type of questions to contextualise the research question and to provide a textual description of how people experienced a given research issue (Yin, 2003 and Baxter and Jack 2008, Yin 2003, Bryman 2012, Baxter & Jack 2008, Creswell, et al., 2003 and Mack et al., 2005).

The study did not investigate the impact of the phenomenon which meant that the findings should not be used to predict possible outcomes (Yin, 2003 and Baxter and Jack 2008, Yin 2003, Bryman, 2012, Baxter & Jack 2008, and Creswell, et al., 2003). It also did not claim to be representative, but it emphasized what was learnt from a single case study (Yin 2003, Bryman, 2012, Baxter & Jack 2008 and Creswell, et al., 2003).

3.3.2 Population and Sampling Techniques

- **Population**

A study population related to the entire group of persons or objects that were of interest to the researcher and that met the criteria the researcher was interested in investigating was selected. The study population comprised of two groups i.e. the target population and the accessible population from which the sample was actually selected (Yin 2003, Bryman, 2008 and 2012, Baxter & Jack 2008, De Vos, 2002 and Creswell, et al., 2003). This section introduced the population of the study from which the sources for data collection would be sampled for investigation.

The population of the study was purposively drawn from the VMMC programme for document reviews. People responsible for co-ordinating activities for uptake of VMMC services were selected and these included programme coordinators, communication managers and senior communicators of the Department of Health who provided oversight and technical support to the creation of demand for services as well as external experts from local NGOs and international development organisations who provided advisory technical support on communication, advocacy and social mobilisation to ensure the attainment of the national strategic goal to reduce HIV incidents by scaling up VMMC to 80% of HIV negative men between 15-49 years by 2016, with a target of 4.3 million VMMCs by 2016 and the international vision of zero HIV infection rate by 2030 (Pillay, 2016). The population of the study also included uncircumcised men between 15-49 years who were benefitting from the VMMC programme in Alexandra Township and volunteers who supported outreach campaigns to ensure recruitments of men for VMMCs.

Sampling techniques

The sampling process involved the selection of a portion of the population to represent the entire population (Creswell, et al., 2003 and De Vos, 2002). The study used a purposive sampling of the identified population on the grounds of existing knowledge of the population. That was a unique selection of participants because it was based on the belief that these participants would provide information that had been lived by participants themselves (Yin 2003, Bryman, 2008 and 2012, Baxter & Jack 2008, De Vos, 2002 and Creswell, et al., 2003). This section discusses what was sampled and its relevance to the study.

1st Source - Document Reviews

The documents of the VMCC programme; Strategic Plan for the Scale up of Medical Male Circumcision (MMC) in South Africa 2012-2016 and South Africa Voluntary Medical Male Circumcision Operational Plan for 2015/2017–2018/19, were purposively selected for reviews. The plans had seven pillars: (1) Leadership and Advocacy; (2) Governance and Coordination; (3) Service

Delivery; (4) Communication and Demand Generation; (5) Monitoring, Evaluation and Operations Research; (6) Resource Mobilization; and (7) Early Infant and Adolescent Male Circumcision. Pillar 4 was the centre that held the work of the VMMC programme together. As such, it was the focus of the study.

These documents were developed after the launch of the programme in 2010 by programme managers from the Department of Health working closely with development partners who included CHAPS, Centres for Disease Control and Prevention South Africa (CDC), SACTWU Health Program, John Hopkins Health Education South Africa (JEHHESA), US Agency for International Development (USAID), Right to Care, Joint United Nations Programme on HIV and AIDS (UNAIDS), World Health Organisation (WHO), Bill and Melinda Gates Foundation and Clinton Health Access Initiative (CHAI).

The documents were targeted to understand targets, objectives and communication methods of the programme to achieve its development goal and their relevance to the phenomenon being studied.

2nd Source – Individual Interviews

The researcher purposively targeted programme coordinators and communication managers as well as implementing partners for interviews according to their skills and proximity to the VMMC programme. The researcher also handpicked the communicators based on predefined criteria i.e. they were relevant and possessed specific and sufficient knowledge of the phenomenon of interest (Yin 2003, Bryman, 2008 and 2012, Baxter & Jack 2008, De Vos, 2002 and Creswell, et al., 2003). According to Morrow, (2005), that could help achieve the most accurate analysis of the phenomenon being studied.

Some of the communicators were indirectly involved with the programme because of their junior positions. The researcher conducted a pilot study of the interview guide to determine if questions would generate adequate information and their knowledge levels about the phenomenon and involvement in the work of the VMMC programme. It helped establish if questions were valid enough to elicit appropriate answers or useful information related to the issue of interest

(Halloway, 1997 and Mack, et al, 2005). The exclusion criterion was then applied to those who were unable to contribute meaningfully to the research study.

3rd Source – Focus Group Discussions

Men between 15-49 years who were benefitted from the VMMC programme in Alexandra Township were purposively identified as well as volunteers who supported outreach campaigns by recruiting uncircumcised men. They had certain characteristics in common that related to the topic of the focus group (De Vos, 2002). The discussions were conducted at the VMMC clinic which provided a controlled environment for study. Locations for focus groups could include professional facilities (De Vos, 2002).

Sampling size

It was important to state how small or large a sample might be (Miles and Huberman, 1994). This was because sampling was an important aspect of research methodology and it was essential for the general conclusions that yielded findings that inspired confidence (Miles and Huberman, 1994, Halloway, 1997 and Mack, et al., 2005 and Creswell et al., 2003).

Since there were no established criteria or rigid rules for sample size in qualitative research (Miles & Huberman, 1994, Creswell, 1998 and Bonde, 2013), the sample size of the study was determined by data saturation. The principle was applied to the point at which no new data emerged or when adding more participants to the study did not result in additional information (Creswell, et al., 2003 and Bonde, 2013).

With regard to focus group discussions, eight uncircumcised men and six volunteers who were responsible for VMMC recruitments participated. Focus groups usually included six to ten participants, according to De Vos, (2002).

Table 2 - Multiple data sample sources

Document reviews	VMMC Strategic plan and operational plan
Individual interviews	Pilot study of interview guide
	Communicators
	Managers

	Implementing partners
Focus group discussions	People visiting the clinic
	VMMC recruiters

3.4 SETTING

Qualitative researchers studied a phenomenon in its natural settings in a bid to make sense of, or to interpret people's experiences in terms of the meanings people brought to the issue of interest (Yin, 2003, Creswell et al., 2003 and De Vos, 2002). As a result of this background, the Alexandra Community Health Centre in Alexandra Township was identified to conduct discussions with uncircumcised men visiting the VMMC clinic to talk to volunteers responsible for their recruitment during the study period in October 2016. The setting provided a controlled environment for research.

The research setting was easily accessible given the rapport that was established with the gate keepers. The Centre for HIV and AIDS Prevention Studies (CHAPS), a key implementing partner of the Department of Health, was responsible for establishing and managing the VMMC clinic at the centre. CHAPS provided human resources including training of doctors, nurses and volunteers for advocacy work, medical equipment and medicine as well as transport for men who had no financial means to come to the clinic.

The set up of the clinic was such that a reception would include a waiting area with chairs for clients, an administration office with a desk and filing cabinet. The administrator's duties included opening and keeping patient files, records of performed circumcisions and doctor's instructions for referrals for observations and tests as well as remind clients of further check-up appointments and arrange transport for them. There was also a sitting area for a doctor, two nurses and social worker as well as consultation rooms where HIV and AIDS Counselling and Testing (HCT) and medical procedures were conducted. The walls were had posters and images related to VMMC.

The clinic was situated in Alexandra Township in Johannesburg which was said to have been named after Alexandra, the daughter of EH Papenfus, township secretary and owner of the ground it was laid out on in 1912. Covering an area of 800 ha, its infrastructure was originally designed for a population of 70 000 but recently exploded to about 750 000 people who live in formal housing, rental units, shacks, men's hostels

and informal settlements along Jukskei river banks, according to the Eastern Metropolitan Local Council of Johannesburg (2016). Overcrowding had overloaded the infrastructure such that water pressure was low and sewers frequently blocked and overflowed.

As a result, most of the of men who were at the clinic during the period of study were migrant workers or unemployed from other provinces in South Africa or foreign African nationals without permanent residential addresses which meant they did not stay in one place long enough for anyone to track and evaluate the benefits or limitations of any development programme (CHAPS, 2016).

3.5 DATA COLLECTION PROCEDURES

Document reviews, in-depth interviews and focus group discussions were used for data collection which corresponded with qualitative studies. Data collection and analysis occurred simultaneously in qualitative research methodologies because the researcher kept notes and immediately after collection of data, began the process of analysis. Thus qualitative data collection and analysis were active, interactive and iterative processes, according to Yin, (2003), Creswell et al., (2003) and De Vos, (2002).

These multiple sources were identified based on the advice of the reader, Sara Nieuwoudt, who worked as a lecturer of Social and Behaviour Change Communication at the University of the Witwatersrand's School of Public Health. The researcher used multiple sample sources for data collection because the VMMC programme was new after it was launched in 2010. Multiple sample sources helped ensure adequacy of data (Creswell et al., 2003 and Marrow, 2005):

> *I recommend the use of multiple data sources - participant observation, field notes, interviews, focus groups, participant checks, site documents, journals, and electronic data - to achieve the goal of adequate variety, (Marrow, 2005, p. 255).*

The researcher also enter-twined themes emerging from the documents, such as the core components of participatory communication, namely, communication method, community representation, the level of participation and development impact with pre-set themes such as access and participation, to guide questioning during document

reviews. The researcher also escalated the same approach to in-depth interviews and focus group discussions, befitting qualitative studies.

Each sample source had its own question guide for data collection, but all the questions were related to pre-set themes, namely, access and participation, which were also used to code data. The sample sources were VMMC programme documents, programme coordinators, support service, implementing partners, uncircumcised men who benefitted from the programme and volunteers who worked at the VMMC clinic in Alexandra Township and also assisted with recruitment of uncircumcised men.

The research sub-questions were used to manage and organise data and core components of participatory communication used for analysis and interpretation.

1st Source - Document Reviews

Documents could serve a variety of purposes, mainly, to provide background, context and supplement data when events and details were forgotten by informants according to Yin (2003). The Strategic Plan for scale up of Medical Male Circumcision in South Africa 2012/2016, and South Africa Voluntary Medical Male Circumcision Operational Plan for 2015/2017–2018/19 were purposively identified as a benchmark to set parameters for the study.

Search terms related to pre-set themes, namely, access and participation, which were used to track information to answer the research question. The phrases and sentences related to these terms were presented as direct extracts. See Appendix 1 and 2.

2nd Source – Individual Interviews

The research experts stated that an interview was an attempt to understand the world from the participant's point of view and unfold the meaning of people's experiences as well as uncover their lived world prior to scientific explanations. They also added that the quality of the interview depended mainly on the skills of the researcher as the interviewer (De Vos, 2002, Halloway, 1997 and Mack, et al. 2005). As a journalist by profession, the researcher also used the acquired

interviewing skills to achieve that. The use of interviews and selection of interviewees were guided by purposive sampling which selected subjects on the basis of specific characteristics or qualities (De Vos, 2002, Halloway, 1997 and Mack, et al., 2005)

The interviews started with the communicators of the Department of Health, who provided support services. Some of them were indirectly involved with the work of the VMMC programme because of their junior positions. For the purpose of this study, junior communicators were those who were involved in the communication work under supervision and ranked below an assistant director level. As a result, an interview guide/ basic checklist was piloted to pre-test its adequacy to generate relevant information as well as the knowledge levels of junior communicators. According to Halloway, (1997) and Mack, et al, (2005), the approach helped to establish if questions were valid to elicit appropriate answers or useful information related to the issue of interest.

An exclusion criterion was applied to those who were unable to contribute meaningfully to the research study. Only senior communicators and their managers subsequently remained to talk about their experiences in relation to the VMMC programme and the phenomenon being studied. For the purpose of this study, senior communicators included assistant directors and deputy directors. Managers were from director to chief director positions.

On the other hand, the people who developed the strategic plan and operational plan of the VMMC programme as well as NGOs who supported the programme were also purposively targeted for interviews. The list included programme coordinators from the Department of Health and local and international organisations, such as CHAPS, Soul City, Community Health Trust (CMT) and JEHHESA (now called Centre for Communication Impact). The researcher hand-picked these organisations based on predefined criteria i.e. they were relevant and possessed specific and sufficient knowledge of the phenomenon of interest (Yin 2003 and Bryman, 2008).

The piloted question guide was revised and used for interviews. When the time allocated for interviews was short due to busy schedules, informal conversations were done and reports related to the issues raised during interviews used to supplement information from short interviews. Informal conversational interviews resembled a chat and most questions asked flowed from the immediate context (De Vos, 2002). The approach was used to address information gaps or clarify issues from a formal guided interview. See Appendix 4; 5 and 6.

3rd Source – Focus Group Discussions (FGDs)

The discussions were used to understand how people felt or thought about an issue, product or service and participants were selected and they had certain characteristics in common that related to the topic of the focus group (De Vos, 2002). A question guide informed by pre-set themes, access and participation, was used for discussions which helped capture the variety of opinions, and allowed a high-level of involvement of the researcher with the participants which meant that the researcher became the main instrument for data collection, according to Mack et al., (2005). The discussions were conducted in two phases with uncircumcised men and volunteers who worked at the VMMC clinic. See Appendix 7 and 8.

3.6 DATA MANAGEMENT, ANALYSIS AND INTERPRETATION

3.6.1 Introduction

The qualitative data from multiple sample sources generated a huge amount of data. As such pre-set themes such as access and participation as well as tables were used to code data collected and research sub-questions were used to organise data and the core components of participatory communication: (i) communication methods; (ii) community representation; and (iii) level of participation (Tufte & Mefalopulos, 2009 and Mefalopulos, 2008) used for analysis and interpretation.

Additional information which related to the fourth component of participatory communication — development impact — was classified as ''unexpected' since the

purpose of the study was to understand the experiences of the participants with the participatory approach and not the impact. Unexpected information classified under the fourth element included empowerment and training initiatives and benefits relating to access, empowerment and self-determination.

According to development communication experts, access to information or communication platforms suggested that people would become aware of their rights and they would be empowered to confront and deal with the challenges affecting their existence which resulted in articulation of commitment, leading to action and self-determination (Servaes & Malikhao 2002, Servaes, 2007, Mefalopulos, 2008).

3.6.2 Data Management

Search terms related to the pre-set themes of access and participation, were highlighted in colour and used to track information during document reviews to answer the research sub-questions. According to Bryman, (2008) and Creswell et al., (2003), phrases and sentences related to the pre-set themes could be presented as direct extracts from data collected. A table was developed and information related to research sub-questions was presented as direct extracts.

A question guide which was informed by pre-set themes was used for interviews and discussions. Notes including empirical observations were written and checked against the interview guide and thematically classified under the research sub-questions to put the gathered data into perspective. According to De Vos, (2002), field notes were written accounts of the things the researcher heard, saw, experienced and thought about in the course of reviews, interviews and discussions and they included both empirical observation as well as interpretations. At the end of each day, the researcher reflected on what was narrated by the participants and wrote down her emotions and expectations in order to provide a description of people's experiences with the phenomenon being studied.

3.6.3 Data Analysis

Qualitative studies were not based upon standardized instruments, according to Lincoln & Guba (1985), but often utilized in smaller and non-random samples to question the meaning. Therefore, data analysis was the process that brought order, structure and

meaning to the mass of collected data by searching for general statements about relationships among categories of data (De, Vos, 2002).

In this case, the data was examined to find the meaning of the information and how it contributed to the issues being explored. The research experts described the approach as the intuitive and creative process to explore perspective and meaning of experiences (Miles & Huberman, 1994, Creswell et al., 2003, Bryman, 2008 and Yin, 1994).

After the preliminary coding, the second close reading of the text from all the sources was done to produce tables for visual description (Miles & Huberman, 1994). That promoted accessibility and helped to cross-check findings to ensure that all questions were answered (Miles & Huberman, 1994). The data that was generated was analysed against the theoretical framework and cross checked with sub-questions. The findings were then presented and interpreted according to the core components of participatory communication for triangulation, interpretation and description of findings.

In conducting data analysis, the researcher referred to the theoretical framework and considered some of the tools such as triangulation of data to confirm research findings.

3.6.4 Data Interpretation

According to Bryman, (2008) and Huberman & Miles, (1994), valid information from multiple sample sources should be combined and summarised by means of triangulation of data. That facilitated validation through cross verification from two or more sources (Bryman, 2008 and Huberman & Miles, 1994).

Therefore, the analysed data was combined by means of triangulation of data which helped to facilitate cross verification from more sources (Creswell, et al., 2003).

The core components of participatory communication were used to combine findings related to communication method, community presentation, levels of participation as well as unexpected findings about development impact from multiple sampled sources in order to gain more confidence in the results. It also assisted the interpretation and discussion of the findings.

3.7 TRUSTWORTHINESS

To enhance the trustworthiness of the study, the researcher used four strategies of credibility, transferability, dependability and conformability (Lincoln & Guba, 1985). It could be obtained by answering the following questions (Lincoln & Cuba, 1985).

(i) How credible are the particular findings of the study?
(ii) How transferable and applicable are these findings to another setting or group of people?
(iii) How can we be reasonably sure that the findings could be replicated if the study were conducted with the same participants in the same context?
(iv) How can we be sure that the findings are reflective of the subjects and the inquiry itself, rather than a creation of the researcher's biases or prejudices?

(i) Credibility

The goal is to demonstrate that the inquiry was conducted in such a manner so as to ensure that the subject was accurately identified and described (Lincoln & Guba, 1985). In this study, the researcher attempted to achieve that by the in-depth description of the problem statement and context of the study and by identifying the parameters of the study as informed by the theoretical framework.

The researcher described the complexities of the setting and its effects to the population. For example, the majority of the people who participated in the study were migrant workers without permanent home addresses in Gauteng because they came from other provinces and lived in hostels in Alexandra Township, which presented challenges for tracking the impact of programmes. See Table 1, 14 and 15.

(ii) Transferability

Since the parameters for research were identified to answer the research question as core components of participatory communication, as well as pre-set themes, which were access and participation, the researcher could demonstrate the applicability of the findings of the study to another context if the same research methodology and same theoretical parameters were followed.

(iii) Dependability

To achieve dependability, the same question guide would have to be used for interviews and discussions and conducted in the same setting with the same conditions and limitations. The profiles of the participants would have to be the same as well as the parameters of the study which are the components of participatory communication. According to Bryman (2008), themes and categories could be used to condense and analyse varied raw material. This approach could be replicated by another researcher who could get more or less the same results (Yin 1994, 2003).

(iv) Conformability

The findings of the research would be easy to confirm. Study notes were kept in a file as well as signed letters by the gatekeepers and consent forms by the participants accompanied by images of group discussions to demonstrate trustworthiness. Member checking was used to verify facts after interviews by sending a transcript to an interviewee for confirmation.

3.8 ETHICAL CONSIDERATIONS

The rights of individuals involved in the research study included confidentiality, anonymity, voluntary participation and informed consent. Approvals from the relevant authorities were also sought and acquired prior to fieldwork. Discussions during interviews were confidential and participations in the discussions were informed of the nature and purpose of the research verbally.

3.8.1 Permission from gatekeepers

The researcher sought written permission from the gatekeepers to obtain relevant documents and conduct study within their premises, and written confirmation that the researcher had visited the clinic was also obtained. For example, the researcher was requested sign a register at the clinic on daily basis in the morning and afternoon during fieldwork which lasted five working days. See Annexure A, B, C and D.

3.8.2 Informed consent

Informed consent from all the participants was obtained after the purpose of the study was explained and their questions answered. A form further explained that the study was voluntary and that the participants had the right to refuse to participate or withdraw from the study at any time they wished. See Annexure E.

3.8.3 Protection of identity

To protect the identity of the informants and confidential information obtained, the study will not disclose the interview notes to anyone other than the supervisors and examiners. The participants were informed that all the data would be filed away in a safe place to protect their identity. The identities of the participants in the photographs taken during discussions or the name of the health facility were concealed. No reference was made to their clinical records. See Annexure G.

3.9 CONCLUSION

An overview of the research methodology and design including the research strategy, sampling and data collection methods, were outlined to answer the research question as well as procedures to inform the analysis and interpretation of data.

CHAPTER 4

PRESENTATION AND ANALYSIS OF FINDINGS

4.1 INTRODUCTION

The previous chapter outlined the research methodology used for sampling, data collection and analysis of findings to answer the research question.

This chapter presents the qualitative data from three sampled sources whose capturing involved document reviews, individual interviews and focus group discussions. It provides the background on the sources and describes the coding procedure used to contextualise the research question how did the VMMC programme facilitate stakeholder participation in its communication processes to improve the uptake of services in the context of national targets?

For the purpose of data collection, sub-questions were formulated and they related to the three core components of participatory communication: (i) communication method; (ii) community representation; and (iii) level of participation (Tufte & Mefalopulos, 2009). The focus was not on the fourth component — development impact — because the purpose of the study was not to measure the impact but to understand the experiences of the participants with the phenomenon being studied.

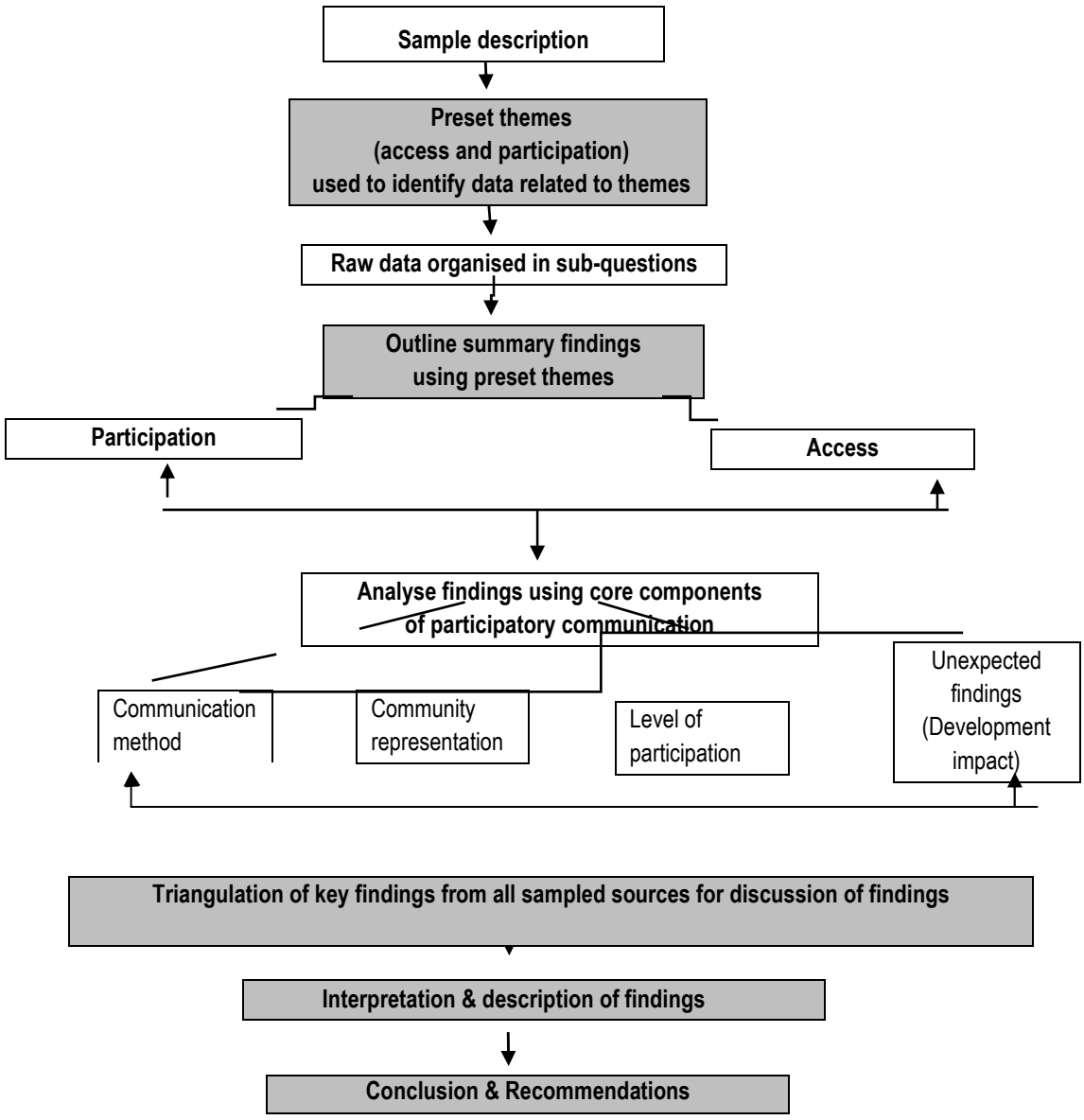
4.1.1 Sub-questions

1. What was the strategic approach used by the VMMC programme to facilitate stakeholder involvement?

2. What was the level of participation of stakeholders in the work of the VMMC programme to improve the uptake of services?
3. What activities did the VMMC programme and stakeholders conduct to improve the uptake of services?

The core components of participatory participation are used to code information collected and to place the limit on the scope of the study (Bryman, 1992). The findings related to the fourth component were classified as ''unexpected results''

Table 3: Structure for data management



The researcher developed her own structure to simplify the process of data management, analysis and interpretation

4.2 REVIEWS OF PROGRAMME DOCUMENTS

4.2.1 Introduction (1st Sampled Source)

The VMMC programme documents were purposively selected and reviewed to establish the DoH's commitment to a participatory approach to improving the uptake of VMMC services. According to Yin (1994, 2003), documents served a variety of purposes but mainly to provide background and context, to corroborate evidence from other sources and to supplement data when events and details were forgotten by the informants.

4.2.2 Sample Description

The Strategic Plan for the scale-up of VMMC in South Africa 2012-2016 and South Africa Voluntary Medical Male Circumcision Operational Plan for 2015/2017–2018/19 were purposively selected for document review. The plans had seven pillars: (1) Leadership and Advocacy; (2) Governance and Coordination; (3) Service Delivery; **(4) Communication and Demand Generation;** (5) Monitoring, Evaluation and Operations Research; (6) Resource Mobilization; and (7) Early Infant and Adolescent Male Circumcision. (See Annexure A, B, C). However, the study focused on pillar 4, whose mission statement was:

> *"Creation of demand is crucial for the successful implementation of the VMMC programme and critical to this success is increasing the awareness of the population in relation to the availability of services through various communication approaches", (DoH, 2012: 30).*

4.2.3 Key Findings on Document Reviews

Terms related to participatory approach were identified and coded to show stakeholder participation in the communication processes of the VMMC programme in order to improve the uptake of services. Phrases and sentences relevant to these terms were presented as direct extracts (See Appendix 1 and 2). The raw data was combined and organised in sub-questions (See Appendix 3) and the pre-set themes used to categorise

key findings (See Table 4) for analysis using the core components of participatory communication (See Table 5). According to Bryman (2008), themes and categories could be used to condense and analyse varied raw material. This approach could be replicated by another researcher who could get more or less the same results (Yin, 1994, 2003).

Key finding 1 - Communication Method

The strategic and operational plans of the VMMC programme were reflective of a multi-sectoral approach which supported the vision of the NDoH which was to involve stakeholders for the purposes of scaling up the provision and uptake of services in South Africa. Good practices to enhance governance and decision-making processes proposed included strong horizontal and vertical collaboration and coordination across different administrative levels and among stakeholders. The VMMC plans were developed through collaborative processes that brought together government, development partners and civil society including faith-based organisations and tertiary institutions with diverse interests and technical skills. Plans also prioritised engagement with traditional authority and close collaboration with provincial and district health authorities. A well-coordinated approach to decision-making was used to involve relevant stakeholders in the work of the VMMC programme. Major decisions regarding VMMC were made in consultation with the national Technical Working Group (TWG) of leaders across various sectors. As chair of the working group, DoH led all coordination and collaborative efforts by incorporating partners who provided advisory, financial and technical support to the programme. It also provided oversight over ongoing input to strategic decision making. A multi-pronged mass media approach supported by a combination of different interpersonal communication channels was used for face-to-face public engagement, radio talk-shows and entertainment education such as drama, arts and culture. Plans proposed the use of one-way and two-way communication methods to deliver and reinforce messages.

Key finding 2 - Community representation

The plans prioritised engagement with traditional and community leaders and proposed partnerships with civil society, schools of higher learning and faith-based organisations. Interpersonal communication channels, including outreach activities and entertainment education approaches such as drama, theatre arts and culture themes as well as call centres and community dialogues, focus group discussions and house visits, were used to create platforms and opportunities for the public to give their views about decisions and services affecting them. Community media which represented the local interests were also used to facilitate the dialogues with communities through live call-in talk shows. The VMMC programme used the national Technical Working Group (TWG) for representation of the local interests and consultation on decisions as well as conduct feedback sessions for regular updates on progress. Ward-Based Outreach Teams (WBOTs) involving community cadres such as community health workers, health promoters, community caregivers and circumcised men who volunteered as ambassadors also played a critical role in

reinforcing messages delivered by mass media. They conducted face-to-face interaction with men between 15-49 years and with their guardians and sexual partners respectively during house visits and provincial forums. They also distributed information, education and communication (IEC) materials to help them make informed decisions. Lastly, they promoted the uptake of MMC through engaging people in their communities and maintaining a list of interested clients who could be referred to nearby service providers for follow-ups and surgical procedures.

Key finding 3 - Level of Participation

The plans outlined a strong horizontal and vertical approach for collaboration and coordination on financial and technical support. As a result, plans were developed through collaborative processes that brought together government, development partners, civil society and other interested parties with various technical skills to strategise for the acceleration of the VMMC programme. DoH led all collaborative and coordinative efforts by incorporating partners who *provided advisory, financial and technical support. Major decisions regarding VMMC were made in consultation with the national VMMC Technical Working Group (TWG) and chaired by the DoH to provide oversight for on-going technical input to strategic decisions and appropriate communication methods. Working committees representing stakeholders across various sectors worked to identify potential implementation challenges and ways to overcome them. A dedicated full-time staff with clear roles and responsibilities as well as coordination mechanisms that brought stakeholders together on a regular basis drove decision making and ensured accountability. At national level, DoH drove activities that generated demand through mass media while partners led outreach advocacy and social mobilisation activities at the provincial and district levels. Plans prioritised community representation through their community and traditional leaders. DoH funded civil society to create platforms, in close collaboration with provincial and district health authorities, to engage communities and enable them to voice their views about services affecting them. Incorporating partners played a critical role in providing technical, coordinative and financial support. Not only did they provide VMMC services, but they also provided technical input into research and capacity building for the expansion of VMMC. Field mobilisation teams also played an important role in reinforcing messages delivered through mass media as well as in identifying, recruiting and enrolling uncircumcised men into the programme. Community dialogues, focus group discussions, feedback sessions and house visits were conducted to give people opportunities to ask questions and address negative public perceptions. Community cadres also conducted health education and awareness campaigns including delivering community based primary health care services and referrals to clinics.*

Key finding 4 - Unexpected Findings on Development Impact

The programme also prioritised the empowerment of stakeholders through capacity building but not all of them benefitted from the empowerment initiatives. Civil society was targeted for training on media advocacy in order to create communication platforms and opportunities for community engagement and to ensure that the views of the people who directly benefit from the programme were also considered. To enable meaningful participation, the plans prioritised

information sharing, new knowledge, skills transfer and training for volunteers. Provincial forums were also proposed to conduct training to equip grass-root organisations with advocacy skills. The WBOTs were deployed at public health facilities for capacity building, mentorship and supervision tasks. Provincial advocacy forums were also convened to train and equip church groups, workshops on development of content for IEC material, training for radio spots and monthly "Demand Creation Group" communication meetings were held with community mobilisers to share lessons learnt.

4.2.4 Conclusion

The VMMC plans were reflective of a multi-sectoral approach which brought together key stakeholders and advocated for a multi-pronged mass media approach which included interpersonal communication channels to increase access to information and participation through representation and consultation.

The plans were developed through a dialogical collaborative process involving external experts in consultation with programme coordinators who led the collaborative effort to ensure alignment to national priorities. The plans were expert-driven because not everyone participated in their development process and people without expert knowledge of communication methods were excluded from the list of contributors.

The plans also prioritised empowerment initiatives on advocacy and social mobilisation but not everyone benefited from capacity building initiatives. Civil society was targeted for media advocacy to ensure the creation of platforms to ensure that the views of those who benefitted from the programme were voiced, heard and considered during decision-making processes.

It was not clear how technical skills would be transferred to empower the internal staff to ensure the sustainability of the programme when external support and funding were in short supply.

The level of the participation of stakeholders in decision-making processes varied. Implementing partners had functional roles through the provision of advisory and technical support and they were actively involved in decision-making processes. Whereas communities were consulted through their representatives on decisions and progress, they were mainly engaged in service delivery through outreach activities

involving community dialogues and mass media talk-shows to test messages and obtain information about client satisfaction.

Table 4: Key Findings on Preset Themes

No.	Terms	Participation
1	Interpersonal communication channels (p. 34)	Outdoor media to reinforce the messaging through the other mass media and **interpersonal communication** channels.
2	Discussion (p. 33)	IEC materials to ensure that **discussions** are reinforced after the event.
3	Partner involvement (p.30)	Activities such as educational sessions and counselling can address partner involvement.
4	Social mobilization (p. 30)	**Social mobilization** strategy work to increase knowledge.
5	Social interaction with peers (p. 30)	The uptake of services, especially during the catch-up phase, is dependent not only on demand creation but also on **social interaction** with peers.
6	Engage (p.31, 33)	Men from local communities who have been medically circumcised should be recruited to promote the uptake of MMC through **engaging** with men in communities. Primary Health Care teams undertaking home based visits should be capacitated to engage women and men around MMC.
7	Small group workshops (p. 33)	Social mobilization approaches such as **small group workshops** in communities must be used to improve uptake of services.
8	Participatory approaches (p. 33)	Large community events using entertainment education **participatory approaches** such as arts and culture can be used to improve uptake of services.
9	Dialogue (p. 33)	Community radio must be used to engage in **dialogue** on medical circumcision.
No.	**Terms**	**Access**
1	Messages (p. 30)	• Advances in information and communication technology including the usage of geographic positioning services (GPS) combined with advances in internet and short message services (SMS) technology make it easier for people to access information regarding available services. • The key **messages** are provided as a guide and while they may vary from intervention to intervention, they should be consistent with the core essence of the messages and expanded upon based on new and emerging evidence. • Post-operative care SMS service that provides regular messages and reminders of follow-up clinic visits.
2	Community media, Edutainment (p. 30, 33)	• Community action teams should be encouraged to harness the power of their **community media** to support social mobilisation activities. • Field workers should also be trained on approaches on how to work with the **media.** • To promote demand for MMC a multi-pronged mass media approach should be supported that combines different channels of communication such as the use of **entertainment education,** television, drama, advertising, radio and television talk shows and print media adverts supported by advertorial and editorial content should be undertaken to promote the uptake of MMC.
3	IEC materials (p. 34)	• **Brochures** can be distributed following the discussions to reinforce messaging with reference to a national resource such as the national SMS line, Life Line or the HealthSites Website that allow people to search for their nearest health facility.

		• A brochure that provides information on caring for their wounds following medical male circumcision and (how to act responsibly during the healing phase and thereafter).
4	Outdoor media (p. 34)	**Outdoor** media, including the use of **billboards** and mobile media, should be placed in high population transit areas such as commuter junctions, shopping malls and along major transport routes within the vicinity of sites to reinforce the messaging through the other mass media.

Table 5: Key Findings on Core Components of Participatory Communication

(i) Communication Method

Integrated Approach	**Participatory Approach**	**Top-Down Approach**
Strong horizontal and vertical approach to collaboration and coordination	Reflective of a multi-sectoral approach	Expert-driven
Multi-pronged mass media approach was supported by a combination of different interpersonal communication channels	Developed through collaborative approach	NDoH led all coordination and collaborative efforts
Both one-way and two-way communication methods used to deliver and reinforce messages.	Decisions made in consultation with working group	Pre-determined priorities/ objectives

(ii) Community Representation

Dialogue (Free and open)	**Voice** (Power relations)	**Liberating pedagogy** (Facilitate dialogue/articulate process)	**Action-Reflection-Action** (Action-oriented)
Community dialogues	Partnerships	Focus group discussions	Maintain client list
House visits	Working groups	Radio call-in talk-shows	Conduct follow-ups
	Regular updates	Ward-based outreach	Do referrals
	Feedback sessions	Provincial forums	

(iii) Level of Participation

Passive (Head-count)	**Consultation** (External decision power)	**Collaboration** (Pre-determined objectives)	**Empowerment** (Equal powers)
Communities represented by working committees and leaders	Programme relies on external technical support	NDoH Lead collaborative efforts	Decisions made in consultation with working groups
	On-going technical expert input on decisions already taken	Staff with predetermined roles and responsibilities	Working group drives decisions and ensures accountability
	DoH lead nationally and partners drove activities at provincial and district level		
	Traditional leaders updated on decisions and progress		
	Radio talk-shows and focus group discussions on decisions and progress		

(iv) Unexpected Findings on Development Impact

Access (Use of media for public service)	**Participation** (Higher level of public involvement)	**Self-management** (Advanced form of participation)	**Access** (Use of media for public service)
Civil society was targeted for training on media advocacy in order to create communication platforms and opportunities for community engagement.	Community engagement to ensure that the views of the people who directly benefitted from the programme were also considered.	Empowerment of stakeholders through capacity building.	Civil society was targeted for training on media advocacy in order to create communication platforms and opportunities for community engagement.
Provincial advocacy forums were also convened to train and equip church groups; workshops on development of content of IEC; and training for radio spots were conducted.	Monthly "Demand Creation Group" communication meetings held with community mobilisers	To enable meaningful participation, the plans prioritised information sharing, new knowledge, skills transfer and training for volunteers.	Provincial advocacy forums were also convened to train and equip church groups; workshops on development of content of IEC; and training for radio spots were conducted.
		Provincial forums were also proposed to conduct training to equip grass-root organisations with advocacy skills.	
		The WBOTs were deployed at public health facilities for capacity building, mentorship and supervision tasks.	

4.3 INDIVIDUAL INTERVIEWS

4.3.1 Introduction (2nd Sampled Source)

Interviews were conducted to demonstrate how the strategic and operational plans were translated into practice. This was achieved by interviewing stakeholders who were directly and indirectly affected by the VMMC programme.

The researcher targeted DoH communicators and their managers and programme coordinators as well as development partners for interviews. A question guide was prepared with open-ended questions to gather information related to their experiences with the programme and the phenomenon being studied.

4.3.2 Pilot Study of Interview Guide

A pilot study of the interview guide was conducted to pre-test the adequacy of the knowledge of the communicators who were indirectly involved in the communication processes of the VMMC programme. The pilot study was conducted following the finding of the document reviews that the VMMC plans were expert-driven by external support and that not everyone participated in the decision-making processes. The pilot study helped to establish if questions were valid to elicit appropriate answers (Halloway, 1997 and Mack, et al., 2005) and if the questions could provide useful information related to the programme and the phenomenon being studied, which according to literature reviewed required expert knowledge of communication methods (Tufte & Mefalopulos, 2009) and Servaes & Malikhao, 2002).

Sample Description

Data saturation was applied for sampling. Data saturation was applied to the point at which adding more participants to the study does not result in additional information, according to Creswell, (1998) and Bonde, (2013). When the communicators failed to give new data the researcher ended the pilot study with five participants. The initial questions were prepared to verify their knowledge about the phenomenon and level of participation in decision-making processes. See Table 6 and 7.

Key Findings on Pilot Study of Interview Guide

Text and visual data were presented as answers to questions. Information about the participants' qualifications and communication experience informed the adequacy or inadequacy of their answers. See Table 6. When asked about their work experience, qualifications and knowledge about VMMC and the phenomenon being studied, their answers were summarised as follows:

Table 6 – Profile of Communicators

Participate	Academic Qualification				Years of Experience		
	Journalism/ Media studies	Communication Science	Health Communication	Development Communication	>5	>10	>15
P1		✓				✓	
P2		✓				✓	
P3	✓					✓	
P4		✓					✓
P5		✓					✓

Table 7 – Pilot Study of Interview Guide

No	Question	P1	P2	P3	P4	P5
Q1	Do you know about VMMC?	Yes	Yes	Yes	Yes	Yes
Q2	How did you first learn about the VMMC programme?	As an official working in the communication unit, information about MMC is readily available.	Media platforms and IEC material	Brothers for Life adverts	Workplace notice boards and intranet	Planning meetings for HIV, Counselling and Testing (HCT) campaigns. However, one could learn more if we had access to the minutes of Branch meeting or if supervisors gave us feedback on decisions taken by management.
Q3	How would you prefer to receive information about VMMC?	Internal communication channels	Road-shows	IEC material	Meetings	Meetings
Q4	Have you ever attended meetings or campaigns about VMMC?	No	No	No	No	No
Q5	What communication support can you offer?	Social mobilization, targeting shopping malls, taxi/bus ranks	Formulation and testing of communication messages	Planning meetings for campaigns	Awareness raising through information distribution	Outreach communication campaigns

Key finding 1: **Communication Method**

The participants defined participatory communication as interpersonal communication involving door-to-door campaigns, community dialogues, meetings with stakeholders and a communication blitz used to interact with people in public places, which also required distribution of IEC materials, branding and exhibition of available services.

Key finding 2: Community Representation

As people who provided support services to health campaigns, the participants did not participate in any activities involving the distribution of material to the community or community mobilisation for VMMC programme.

Key finding 3: Level of Participation

Their level of participation in any decision-making processes about VMMC was limited with no specific roles to support the programme. As a result, they had no opportunities to make inputs to strategic issues about VMMC. Their participation in the VMMC activities was limited to the distribution of information developed by experts, photography, branding or manning exhibition stands. While their work experiences should have been enough to afford them opportunities to participate meaningfully, they were excluded from strategic communication processes.

Key finding 4: Unexpected Findings on Development Impact

The participants were excluded from decision-making processes because of their junior positions. As a result, they had no access to information about the programme or specific roles to support the programme which meant that their long-term work experience was under-utilised.

Conclusion

The communicators in the department who had no qualifications in health communication or development communication and occupied junior ranks were excluded from the high-level strategic meetings and decision-making processes despite their long-term work experience. By exclusion from strategic communication processes, the communicators were unable to participate meaningfully because they had no specific roles to support the programme which meant that there was an inefficient use of internal resources and opportunities for transfer of technical skills through knowledge exchange and dialogue.

4.3.2 Interviews with Communicators

Sample Description

Based on the outcome of the pilot study of the interview guide, two communicators were excluded and three retained because they participated in the VMMC activities. The selection was based on pre-defined inclusion criteria that participants should possess relevant knowledge about the phenomenon through experience (Creswell, et. al., 2003 and Bryman 1992). Saturation determined the final number of participants to the study.

The questions were reviewed and modified to establish if the communicators had the authority to make decisions or access to information and adequate knowledge to support the VMMC programme. The interview guide was revised with open-ended questions which included; the "how... and why...." type of questions. According to Creswell, et al. (2003) and Bryman, (1992), it assisted in understanding the participants' experiences with the programme and the meaning they attached to that experience.

To manage the huge amount of data generated by open-ended questions, responses have been summarised and presented per question as Appendix 4. Key findings were drawn and presented to illustrate their relationship to the core components of participatory communication

Key finding 1: Communication Method

The participants had no authority to make inputs to decisions without a brief or under supervision. They often accompanied their supervisors to planning meetings or in their absence, represented them with a brief which guided all inputs to decisions. They also referred technical decisions or decisions with financial implications to supervisors for final inputs. Their inputs to discussions on communication issues were also limited to job descriptions. Other than tabling what their supervisors had requested them, they participated passively as receivers of decisions or messages developed without them. Functions such as simplifying technical messages or distributing messages also required the approval of a supervisor before distribution to the public. In this way, they had no meaningful role in decision-making processes and could not influence strategic decisions.

Key finding 2: Community Representation

The participants had no specific role in relation to community representation but assisted with planning public events and distribution of information to the public.

Their functions as communicators did not include participation in interpersonal communication activities including advocacy and social mobilisation, which were driven by the civil society.

Key finding 3: Level of Participation

The participants had no health communication or development communication qualifications, to participate meaningfully in the communication processes or make technical inputs in decisions about VMMC. They participated indirectly under supervision and their inputs were guided by briefs. Their involvement in content development was based on information supplied by technical experts and approval from supervisors was required before distribution. They were not involved in the development of VMMC strategic or operational plans. In this way, they had no adequate knowledge or specific roles to support the programme. As support service, their participation in decision-making processes was informed by the level of seniority and in most cases, they participated passively without any meaningful roles.

Key finding 4: Unexpected Finding in Relation to Development Impact

The top-down and inconsistent flow of information on decisions taken by management or the programme were viewed as disempowering by the participants who did not benefit from the sharing of knowledge about campaigns or transfer of technical skills.

Conclusion

The participants were not involved in the development processes of VMMC strategies which were expert-driven by the external technical support. The participants were indirectly involved in the activities of the programme but their involvement was supervised or informed by the level of seniority. In most cases, they passively participated in decisions with no authority or meaningful roles to influence decisions. A lack of feedback on technical decisions and top-down communication flow were viewed as disempowering by the participants who preferred staff meetings to engage their supervisors. Those who were directly attached to the programme performed selective tasks which were events driven and included publicity while the external support drove most of the programme activities.

See Table 8.

4.3.3 Interviews with Programme Managers

Sample Description

Managers who were involved in decision-making processes in relation to the VMMC programme activities including advocacy, social mobilisation and communication were purposively selected for interviews. Information about their experiences with participation in the communication processes of the programme was obtained through formal interviews and informal conversations. Handouts were also used to verify transcripts during member-checking. Member-checking assisted to achieve the accuracy of data according to Patton (1997). See Appendix 5.

Key finding 1: **Communication Method**

The activities of the programme managers were informed by the strategic and operational plans of the programme which promoted multi-sectoral partnerships and collaborations through a multiplicity of participatory methods to improve the uptake of services as well as the DoH integrated communication strategy, "which moves from the premise that the department exists to ensure that the citizens should have access to an equitable, efficient and effective public health system that meets their needs through an integrated strategic approach that is people-centred that does not tell, but shows and encourages communities to be active participants in finding solutions to their problems," according to a communications manager, who added that when communications were integrated, professionals became aware of what was going on across the entire organisation and about campaigns emanating from other units, and industries, which was critical for maximising their potential to align communication support for the programme with the overall organisational strategy. Both one-way and two-way communication channels were used for ongoing interaction with internal and external stakeholders who were directly and indirectly affected by the programme through various mass media and interpersonal communication means including radio and TV talk-shows, education entertainment programmes, social media platforms and outreach activities such as community dialogues, house visits, the department's senior management meetings and national health council of the Minister and provincial Members of the Executive Council (MECs).

Key finding 2: **Community Representation**

Consultation and representation were the main activities used to engage people. Task teams were established to conduct outreach campaigns and the civil society structures promoted direct community involvement through face-to-face interactions involving community dialogues, focus group discussions, feedback

sessions, youth camps, house visits, education entertainment and call-in radio and TV programmes as well as call centres to link up men with nearby services. DoH funded NGOs demand generation activities to assist with community mobilisation to utilise available services. Engagement with traditional leadership also helped with community mobilisation and to address negative cultural or public perceptions which prevented men from accessing available VMMC services. One manager indicated that it was important to consult and engage communities because of diverse cultural differences in South Africa and to target women as enablers as well as inhibitors of circumcision, adding that; "I have no confidence in any strategy or campaign that targets communities but does not involve them in the processes of decision-making, whether directly by going out to the communities to talk to people or indirectly by consulting community leaders who should also consult with their constituencies to ensure proper representation of their interests and concerns. This is because we can only achieve our goals by understanding people's experiences on what works or does not work for them".

Key finding 3: **Level of Participation**

At the national level, DoH defined government's priority and pre-determined the objectives of the programme and through stakeholder engagement encouraged inputs on evidence-based communication methods to refine its ideas. It also chaired the national technical working group in order to ensure a coordination of collaborative efforts guaranteeing that activities by cooperative partners were aligned to the national priority. It also ensured resource mobilisation, sharing and distribution and accountability. The programme also provided oversight on the following:

- *A multi-stakeholder technical structure involving VMMC funders, implementing NGOs, service demand generation partners, etc. held monthly meetings to consult on decisions, review progress and share lessons learned and challenges experienced;*
- *Meetings with private implementers like medical schemes and general practitioners were also conducted, as well as with technical committees for quality assurance, monitoring and evaluation, demand generation and research developments, to engage cooperating partners;*
- *Gatekeepers such as traditional initiation guardians including house of traditional leaders and CONTRALESA were engaged. Partnerships were created to ensure continued community representation and mobilisation;*
- *Civil society structures were funded to promote direct community involvement for inputs to decisions and to assist with community mobilisation to utilise available services;*
- *Community mobilisation partners such as Brothers for Life assisted to conduct community awareness and education campaigns where direct engagement with men happened;*
- *The programme also utilised VMMC champions (men who underwent MMCs) to share experience and recruit other men, using community dialogues, community events and conducted house-visits;*
- *NGOs assisted with the production and distribution of messages and communication materials as well as the creation of media opportunities and*

platforms to ensure representation of the voice or views of those who benefited from the programme.

- *Outreach events involving the Minister and Deputy President to engage communities were also conducted and their activities were supported by electronic and print media campaigns including talk-shows to reinforce our messages.*
- *The programme also worked with communication partners and researchers who provided feedback about gaps in our messages, effective communication mechanisms and engaged VMMC implementers in other countries to share ideas and lessons learnt.*

There were work-streams with different functions and partners learned from one another which helped to redefine effective ways to communicate. Stakeholder involvement assisted to address knowledge and skills gaps within the department, as well as limited financial resources. Partnerships and representation of various affected sectors also assisted in terms of buy-in, ownership and accountability.

Stakeholder participation occurred from planning to service delivery and the level of participation in communication processes varied from levels of technical skills and seniority to organisational interest and agenda. While it was people's constitutional right to participate in or have a say in decisions affecting them directly or indirectly, it was not possible to consult or engage everybody on everything and at all the levels of the campaign, as with any other, which was why technical committees or community forums were established to ensure fair representation and that decisions were made in consultation with the people who benefitted from the programme, according to one manager. However, the same manager emphasised that "employees are a critical part of our successes or failures, they are our produce and the essence and the brand. If they don't get it, the external world doesn't get it. If you want the correct take away externally, you have to get it right internally". Therefore, the officials who do not have access to high-level meetings should benefit from horizontal communication flow to empower them to be brand ambassadors.

Key finding 4: **Unexpected Finding in Relation to Development Impact**

The VMMC programme created external partnerships to achieve communication objectives and to augment the limited technical skills and financial resources. While the department had a budget for skills development to ensure effective support for health campaigns, the programme had no concrete plan for the transfer of technical skills to enable meaningful participation by the internal staff.

Conclusion

The study found that the VMMC programme's multi-sectoral approach for stakeholder participation in the communication processes to promote the uptake of services was supported by one-way and two-way communication methods which were aligned to the overall integrated strategic communications approach of the department in order to ensure that collaborative efforts were aligned to the national priorities and targets. The

involvement of the managers in the VMMC work varied accordingly — those who were attached to the programme had specific functional roles and others who were indirectly involved provided support services. While some of them had access to opportunities to influence decisions by shaping their formation, others were consulted for inputs.
See Table 9.

4.3.4 Interviews with Development Partners

Sample Description

Senior programme managers from various development organisations, who contributed to the development of VMMC strategic and operational plans, including implementing partners who assisted the DoH with advocacy, communication and social mobilisation campaigns, were purposively selected for interviews (See Annexure F). They included participants from Soul City Institute (SCI), Community Media Trust (CMT), Centre for HIV and AIDS Prevention Studies (CHAPS) and Centre for Communication Impact (CCI) formerly known as John Hopkins Health and Education in South Africa (JEHHESA). An interview guide with open-ended questions was prepared to engage the participants on their experiences with the VMMC programme (See Appendix 6).

- Centre for HIV and AIDS Prevention Studies (CHAPS) is a non-profit organisation that offers a diverse range of services in healthcare and skills development, with a specific focus on medical male circumcision as a biomedical intervention for HIV prevention.
- Community Media Trust (CMT), also a non-profit organisation in South Africa, specialises in communication in the fields of health, human rights and gender based violence, using media across all platforms including interpersonal communication and training in communities.
- Centre for Communication Impact (CCI) (formerly known as JEHHESA) in South Africa, is a non-profit organisation that designs and implements evidence-based HIV campaigns and HIV communication programmes aimed at HIV prevention to educate the public to understand their risk of HIV infection in relation to multiple partners, correct and consistent condom use, transactional sex and alcohol use.
- Established in South Africa in 1992, the Soul City Institute (SCI) for Health & Development Communication is an influential nonprofit organisation in social and behavioural change programmes, focusing on sharing information and affecting social norms, attitudes and practice for the better through education-entertainment and outreach communication channels, using TV, radio and face-to-face interaction.

Key finding 1: Communication Method

While three of the four organisations approached for interviews were involved in the development of the VMMC strategic and operational plans, their strategies to assist South Africa to achieve its communication objectives varied. These approaches were guided by a government-defined priority and pre-determined objectives to expand VMMC services and improve uptake of services. To ensure that their activities were aligned with the national vision, the government led all collaborative and coordination efforts in relation to VMMC through a technical working committee which represented the interests across sectors.

- *CHAPS, as a major implementing agency for VMMC, took a multi-pronged approach to communications and demand creation, utilising both local and national channels of communication as well as workshops, community dialogues, house visits, TV and radio talk-shows for the expansion and uptake of the VMMC programme services.*
- *CMT, as leading demand creation partner of the TB and HIV Consortium, used the mass media approach and interpersonal and participatory channels with an emphasis on TV documentaries working closely with the consortium and provinces to design, develop, implement, evaluate and monitor demand creation campaigns to increase the uptake of VMMC services.*
- *CCI supported the VMMC with its evidence-based strategic communication approach informed by a social ecology model called P-Process which used formative research to understand the environment that influences men's decisions to circumcise or not to circumcise and used mass media and interpersonal communication channels to drive demand creation activities.*
- *SCI supported the VMMC programme through mass media edutainment programmes using prime-time TV and radio drama, evidence-based advocacy and social mobilisation approaches including VMMC camps to engage men on the value of VMMC.*

Whereas the cooperative partners used combination communication approaches involving mass media and interpersonal communication channels, their individual strategies were reflective of their individual roles and responsibilities. For example, when the VMMC strategic and operational plans were developed, their involvement also differed vastly.

- *CHAPS involvement in the development process of the VMMC plans was by attending strategic planning meetings in an advisory capacity to influence decisions as a major implementing agency.*
- *CMT was involved in the revision and consultation process of the VMMC strategic and operational plans and as a leading demand creation partner of the TB and HIV Consortium, focused on the creation of demand and strengthening community mobilisation.*
- *CCI was involved in the development process of the VMMC plans mainly in an advisory role limited to demand creation and communication strategy for improved uptake of services.*
- *SCI was not involved in strategic decision processes and its activities in relation to VMMC were informed by its organisational strategy.*

Key finding 2: Community Representation

The study found that a people-centred approach was envisioned to ensure fair representation of the interests and views of communities who benefited from the programme but that representation was limited to inputs on a government-defined vision and expert-driven communication processes which excluded the participation of community representatives in key decision-making processes such as the development of VMMC plans. While the government provided leadership at the national level, development partners drove all communication, advocacy and social mobilisation activities at provincial and district levels which included the use of mass media and interpersonal communication channels such as radio call-in shows and community dialogues.

- *CHAPS used social mobilisation through targeted interventions to disseminate information and increase positive public perception, including VMMC brand ambassadors to sensitise communities about the benefits and limitations of medical circumcision. It used local broadcasting and print media as well as community health workers to implement targeted campaigns at schools, taxi ranks, prisons and hostels, to recruit uncircumcised men. As a member of the Community Advisory Board (CAB), CHAPS formed close relationships with local community leaders but there were also disagreements.*
- *CMT conducted mass media and interpersonal communication campaigns, using community radio call-in shows and face-to-face interaction to engage the public. Communities were empowered through the sharing of knowledge in their own language and participation in face-to-face dialogues and discussions. A flip chart and training manual were produced for all VMMC mobilisers and partners. Three radio stations were identified for live-shows Mondays, Wednesdays, and Thursdays for a month. Outreach teams were used to raise awareness and test messages through door-to-door campaigns, focus group discussions and large community awareness events. CMT also created communication platforms such as call-centres and free "please call" mobile services so that people could ask questions and get answers about VMMC. Through these activities, they managed to link-up clients with nearby service providers.*
- *CCI used mass media activities and interpersonal communication channels to engage communities – one-way communication channel as a point of kicker to introduce the message for conversations and to establish a knowledge base for meaningful discussions and then went out to the communities to conduct focus group discussion and road-shows to add a local voice to our plans and messages. Thereafter, they presented feedback to their creative agency to advise on the best approach for demand creation and then go back to communities to pre-test their ideas before they finalised planning a campaign or message. Through these activities it obtained useful lessons. For example, "our initial campaign targeted men as people who directly benefited from the VMMC programme activities, but we later learned through face-to-face interaction with communities that women were influential in decisions on whether men circumcised or not, and not just any woman, but those that men have long-term relationships with and respect for. Whereas our initial campaign approach sought to create awareness targeting men, driven by a male voice and image, as our campaign matured, women were considered as a secondary target audience and our communication material, images and voices also represented women as enablers as well as inhibitors to uptake of service".*

- *SCI used the TV cut-down DVD with stories about VMMC to stimulate the uptake. This seemed to work as an edutainment vehicle to engage men and their partners. It also conducted community dialogues and youth camps to discuss the value of VMMC and held jamborees to bring services to distant communities.*

Key finding 3: Level of Participation

Vertical and horizontal communication approaches with emphasis on technical expert input were used to introduce a government-defined vision and pre-determined objectives set by the VMMC programme. The development partners offered advisory support for the development of evidence-based intervention methods to expand the services throughout the country and improve the uptake of services. Their participation in decision-making processes as part of the technical working committee which represented interests across the sector, were from initiation to delivery. They collaborated on advocacy, communication and social mobilisation as well as assisted the programme, to address existing scientific knowledge gaps within the department. As a result, they drove programme activities, while the programme provided oversight to ensure alignment of collaborative efforts with national priorities and targets. A multi-stakeholder technical structure was used to ensure synergy. Their activities required expertise in a diverse range of methods in development communication and social behaviour change.

- *CHAPS, as major implementing agency, provided advisory and technical support on service delivery to ensure clinic coverage and penetration as well as the efficient use of mobile clinics. It was also responsible for capacity building along with enhanced span of Quality Assurance and General Practitioners (GPs) and focused on research, monitoring and evaluation. It also attended to social mobilisation through targeted interventions to disseminate information and increase positive public perception and the task required expertise in diverse range of communication methods.*
- *CMT, as a lead demand creation partner, focussed on strengthening community mobilisation as part of a consortium which was led by TB/HIV Care, designing, developing, implementing, evaluating and monitoring campaigns to increase the uptake of VMMC. CMT designed and tested a men's campaign. It was initially developed as "Man Up" and tested through focus group discussions with circumcised and uncircumcised men and was well received. However, when this was presented to KwaZulu-Natal where the campaign was due for rollout, there were concerns that the tagline had no direct isiZulu translation and the campaign was tweaked to SOKA, meaning circumcise, and which showed that what would work for one province might not necessary work for another because of the diverse cultural differences*.
- *CCI, a lead partner in social behaviour change research, drove demand creation activities through an approach informed by a social ecology model, P-Process, using formative research to understand the environment that influences men's decisions to circumcise or not to circumcise. Through community dialogues and focus group discussions when pre-testing ideas, it found that women were influential in decisions on whether to circumcise or not, and not just any woman, but those that men had long-term relationships with and respected. While CCI's initial campaign approach targeted men with a male voice and image to drive messages and as the campaign matured it included women's voices and images to increase the uptake of services – men as primary audience and women as a secondary audience*.

- *SCI, an expert in communication development including social and behaviour change communication, used education-entertainment television and radio drama series to engage men, their sexual partners, families and communities across all languages. This vehicle worked well, especially the idea of engaging them in their indigenous languages, using stories that reflected their socio-economic-cultural circumstances, to stimulate discussion and learning. The use of youth camps and community radio call-in shows for follow-up dialogues on issues raised, particularly added much value to its people-centred outreach approach.*

Key finding 4: Unexpected Findings in Relation to Development Impact

The involvement of development partners in the VMMC work was to address technical knowledge and skills in evidence-based communication and development methods within the department so as to improve the uptake of services. Pertinent to their technical support was the need to transfer skills so that when their funding became scarce, the employees of the department and other implementing partners were empowered to ensure the sustainability of the programme. However, there was no concrete plan to ensure that.

- *CHAPS responsibility for capacity building included the training of health workers in surgical procedures and quality assurance. Members of the communities were to provide efficient support to the VMMC programme, many of whom also informally benefitted from the sharing of lessons learned during Community Advisory Board meetings, but other than that there was no concrete plan for the transfer of skills in terms of leadership.*
- *CMT's efforts to empower the communities through sharing of knowledge were in their own language and participation through face-to-face dialogues and discussions. In addition to this, a flip chart and training manual was produced for all VMMC mobilisers and partners to help increase the uptake of services. There was no mention of a formal plan for a handover.*
- *CCI worked in partnership with government officials during outreach and through the processes of working together and dialogues during meetings, hoped to address knowledge gaps about participatory approaches for development programmes. There were also opportunities for training on communication strategies from which communicators could benefit. They covered the P-Process approach in these training, but there were no immediate plans for the capacity building.*
- *SCI also worked with officials from DoH to develop and test communication messages as well as training other implementing partners in media advocacy to create communication platforms to engage their audience. In 2010, SCI partnered with the Wits School of Public Health to introduce a division of social and behaviour change communication (SBCC) from which health communicators could also benefit by acquiring skills in the application of SBCC theory to a range of interventions that include social mobilisation, advocacy, social marketing and edutainment, monitoring and evaluation.*

Conclusion

The activities of the VMMC programme were expert-driven by external technical professionals who were also responsible for the development of its strategic plans to

provide advisory support on effective communication methods to achieve government-defined priority and pre-determined objectives. Although the development partners employed combination one-way and two-way communication methods to improve the uptake of services, they used different approaches influenced by their organisational positions and individual interests. They assisted in addressing the limited technical knowledge on participatory approaches for advocacy, communication and social mobilisation (ACSM) in the department. Their participation in decision-making processes from inception to delivery through multi-stakeholder structures yielded some positive results even though declining resources, disagreements with the traditional authority and time-consuming stakeholder engagement processes as well as an oversight on the value of transfer of skills to the internal staff, affected the rollout of the programme to meet set time frames and ensure the sustainability of the programme.

See Tables 9-13

Table 8 – Participation in the VMMC work (Communicators)

Key finding 1	Key finding 2	Key finding 3	Key finding 4
Top-down communication flow. No significant say in decision-making process.	No specific roles.	Passive participation by being included in the development process where information sharing was done through one-way communication channels. Input minimal or non-existent.	Disempowered by a lack of feedback on technical decisions.
No meaningful role in decision-making processes.	Indirectly involved.	No specific roles to provide support services.	Disempowered by top-down communication flow.
Inputs to decisions limited by a brief.	Input by request	Involvement under supervision.	
No authority to influence decisions with financial implications.		Participation in decision-making processes informed by a level of seniority.	
Technical decisions referred to supervisors for final inputs or approval.			

Table 9 – Participation in the VMMC Work (Programme Managers)

Key finding 1	Key finding 2	Key finding 3	Key finding 4
Multi-sectoral approach.	Partner driven initiative.	Functional level of participation to ensure alignment of collaborative efforts with national priorities.	Insufficient technical skills within the department. Empowerment through consultative meetings and knowledge sharing.
Technical working committee.	Consultation and representation as the main activities for engagement.	Lead all coordination and collaboration efforts.	Empowerment through community dialogues and feedback sessions.
Provision of support services to ACSMs officials attached to the programme, and provision of leadership and advisory role for alignment of efforts to department's integrated strategic approach to communication.	Events-driven: community mobilisation is aligned to a theme related to the objectives of the campaign.	Provision of communication services through publicity and information dissemination upon request to support ACSM officials who are attached to the programme.	Limited specific roles to support the programme and participation in decision-making processes. Empowerment through working together and knowledge sharing.

Table 10 – Participation in the VMMC Work (Development Partners)

Key finding 1	Key finding 2	Key finding 3	Key finding 4
Vertical and horizontal approach to decision-making.	People-centred approach.	Collaborative level of participation.	Training and capacity building.
Consulted on government-defined vision, with a stronger emphasis on feedback.	Identify and define communication interventions.	Expert-driven demand creation activities.	
Open dialogue on pre-determined objectives set by the programme.	Use of one-way and two-way communication channels.	Work as a consortium for the creation of demand.	
Multi-stakeholder structures for consultation on decisions.		External support augment internal technical skills gap.	

Table 11 - Participation in the Development of VMMC Strategic Plans (Development Partners)

	Role	**Influence**	**Decision-making processes**	**Technical support**
CHAPS	Involved in an advisory capacity	As a major implementing agency and member of the TB and HIV Consortium	Attended the strategic planning meetings	Service delivery, research, quality assurance, capacity building, demand creation, expansion of services
CCI	Involved in an **advisory role** on demand creation	Social and behaviour change communication informed by a social ecology model, P-Process, using formative research to understand environment influences	Attended the strategic planning meetings	Communication strategy to improve the MMC uptake
CMT	Involved in an advisory role in strategy revision and consultation on creation of demand	As the lead demand creation partner of the TB and HIV Consortium	Attended the strategic planning meetings	Focusing on creation of demand and strengthening community mobilisation
SCI	Not involved	Social and behaviour change communication through education-entertainment campaigns	Not involved	Indirectly involved through prime-time TV and radio drama series

Table 12 – Unexpected Findings in Relation to Development Impact (Development Partners)

	Capacity building	Intervention	Recognition of qualifications	Empowerment/ career development
CHAPS	Formal training for health workers (nurses and doctors)	Practical & Theoretical Voluntary Medical Male Circumcision	Issue of certificate of attendance	Functional and related to VMMC surgical procedures
	Informal training in advocacy work	Training of field workers	No formal qualification	Functional and programme-specific
		Targeting Civil Society and other implementing partners	No formal qualification	Functional and programme-specific
CCI	Informal training in advocacy work	Training of field workers	No formal qualification	Functional and programme-specific
		Targeting the Civil Society and other implementing partners	No formal qualification	Functional and programme-specific
CMT	Informal training in advocacy work	Training of field workers	No formal qualification	Functional and programme-specific
		Targeting Civil Society and other implementing partners	No formal qualification	Functional and programme-specific
SCI	Training in media advocacy	Targeting Civil Society and other implementing partners	No formal qualification	Functional and programme-specific
	Workshops on development and testing of messages	Targeting government programme coordinators	No formal qualification	Functional and programme specific
	Formal training by Wits School of Public Health	Social and behaviour change communication (SBCC)	Master's Degree training programme, Dept. of Public Health	Health communicators, Health promoters, Programme coordinators

Table 13 – Key Success and Challenges (Development Partners)

Although these approaches generated positive results to promote the uptake of services, there were also challenges encountered along the way.

Name	Successes	Challenges
CHAPS	CHAPS experienced increased clinic coverage to approximately 80 clinics/sites in six short years and performed approximately 400 000 medical circumcisions since programme inception in 2010, Strong relationships and membership with leading implementing agencies resulted in efficient resource sharing and heightened capacity for demand creation.	There were late adopters, traditional sector infiltration and broadened age pivot.
CMT	CMT mainly experienced successful VMMC work in KwaZulu-Natal, where the issue of medical male circumcision was not as contentious as in Eastern Cape. It had challenges of insufficient VMMC services which were overcome by using the Careworks call-centre to make booking and direct clients to the most suitable service providers. It was also supported by field mobilisers who recruited and linked up men with nearby services. Radio work on VMMC using public service announcements (PSAs) on both regional and community radio platforms also assisted with quick results and this contributed to a high number of "please call me" requests from clients for services to approximately 1198 in six weeks, which showed that they were reaching the intended audience.	CMT experienced challenges with the Advertising Standards Authority objecting to one of their PSAs, saying it promoted experimentation among young people. They also had issues of timing of deliverables. "Stakeholder engagement is important and necessary in order to implement accurate and useful communication campaigns, but they often take time and partners do not always respond with feedback timeously and we are under pressure to roll out the campaign in set time frames," according to CMT.
CCI	According to the CCI evaluation of their campaigns, there was a direct linkage to the MMC uptake and their interventions because people talked about MMC and risk reduction. For example, only 8% talked about MMC and risk reduction in their initial research, but in 2012, the knowledge levels increased to 42%.	Resources were declining and CCI was not only focussing on MMC but on other health programmes as well. It needed to strike balance and still ensure that the existing awareness about MMC responded to challenges on the ground that prevented men from accessing available services. One of the challenges was that the services were not enough, with complaints that people walked long distances to reach the nearest services and still joined long queues. CCI also needed to convert the high knowledge levels that were already out there into action in spite of the negative attitudes towards medical circumcision and the thriving culture of circumcising only in winter in SA, and shift that habit so that men could access services throughout the year and not only in winter.
SCI	The 11th Soul City television drama series was successful in dealing with MMC and engaging audiences in some of the discussions and debates that were happening at the time. Using TV cut-down DVDs worked well as an edutainment vehicle to engage men and their sexual partners about MMC, and to dispel the negative myths about medical circumcision.	SCI was less successful working through the PEPFAR programme and their partners to encourage more enrolments into MMC programme. This was because the funding was very limited and SCI had to rely on the partners to implement many aspects of the programme. In the past, SCI promoted MMC through a television series and held community dialogues on the value of MMC. The interventions to improve the uptake of VMMC services, however, were terminated in 2013 when the funding ran out.

4.4 FOCUS GROUP DISCUSIONS (FDGs)

4.4.1 Sample Description

Two focus group interviews were done during the five-day period of study. Group 1 involved uncircumcised men between 18 and 39 years old who were recruited from a nearby men's hostel and transported to the VMMC clinic for medical circumcision. The men were temporary residents from KwaZulu-Natal and were in Johannesburg as migrant contract workers looking for jobs.

A total of 12 men were recruited on the first day of study. Eight of them were purposively drawn from the list and classified as group 1 for focus group discussions. They all gave consent to participate in the discussions after the purpose of the study was explained to them. Text and visual data were obtained about their general perceptions and level of knowledge about VMMC.

For group 2, VMMC recruiters were also requested to participate in group discussions. The VMMC recruiters were responsible for community mobilisation including conducting house sits to educate, identify and recruit other men for medical circumcisions. They also conducted follow-ups to confirm appointments and pick-up spots and did bookings. In this way, they enrolled more men for circumcisions than any other form of communication.

See Annexure D, E, G, I, K, and L, and Table 14 and 15.

FGD 1 (uncircumcised men)

The researcher conducted participant observation to gain insight into the key issues before a group discussion. The observation assisted with additional information to supplement data collected during discussions. The time allocated for discussions was too short to cover all the areas of interest.

Summary 1 – Participant Observation of Uncircumcised Men

- The men were young, tidy and apprehensive;
- The majority of them were unemployed and could not afford a taxi fare;
- They were temporarily staying in men's hostels without permanent addresses;
- They debated who would go in first for a procedure and then probed if it was painful when one returned;
- They were relieved that male nurses and a doctor were performing procedures;
- Most of them preferred a Prepex placement instead of a surgical procedure because those who went in before them had chosen it;
- Only one man was not circumcised because he required further examination and treatment for sexually transmitted infections;
- The clinic walls were plastered with posters and tables with pamphlets. They were in plain sight in the reception area but they did not take them;
- They were interested in the wall posters with graphic images about MMC;
- They all had a mobile-phone and submitted their numbers for patient records;
- They were happy that they were being transported instead of using public transport, and travelling as a group instead of coming to the clinic alone; and
- The same group of men participated in discussions in isiZulu. The group discussion was conducted to understand their perceptions and level of knowledge about VMMC. The information below was a summary of the key findings.

Summary 2 – Discussion with Uncircumcised Men

- The participants understood the health benefits but did not act on their knowledge because they were afraid they would be permanently injured and never be able to have children;
- Others were unable to go to the clinic because they were unemployed and had no money for a taxi fare which meant they required assistance with transport. A few of them were walk-ins (arrived at the clinic on their own);
- Men who had cell-phones used them to listen to radio programmes and music and they preferred to receive information about VMMC through this channel;
- The majority of them spoke isiZulu and later said they preferred to read communication material in their own language;
- Some of the men were married and had stable relationships but admitted that they had also had multiple sexual partners;
- They agreed to come to the clinic for circumcisions because everyone at the hostel was being circumcised;
- Others came to the clinic because they were having casual sex and wanted to protect themselves against infections;
- Most of them were unemployed with a maximum of Grade 5 education and no formal professional qualifications or technical skills;
- The majority of them returned for check-ups with no complications but complained about painful erections; and
- One of them returned before their appointments asking for medication to manage painful erections. He said it was becoming difficult to abstain from sex because he stayed with a woman.

Key finding 1: Communication Method

Radio was the most preferred communication channel to receive information about VMMC because they used their cell-phones to listen to the radio and could access information wherever they were. They also preferred to communicate in their own languages. Almost all the participants already knew about medical circumcision when they were approached by VMMC recruiters but did not act on the information for various reasons. Their main reason was that they did not have the money to come to the clinic and others were afraid of permanent injuries after stories about botched traditional circumcisions. Most of them first learned about medical circumcision through radio and posters but preferred a radio to receive information because they could use their cell-phones. They said that a face-to-face discussion about VMMC with the recruiters helped them to ask questions about their fears. They also said the Zulu King had encouraged them to get circumcised through a radio broadcast. They understood the benefits of MMC for both men and women and the need to go through HIV Counselling and Testing (HCT) but they confessed that they had multiple sexual partners because they had left their wives and stable girlfriends back home. They were afraid of contracting HIV and transmitting infections to their wives.

Key finding 2: Community Representation

The participants never had a face-to-face engagement about MMC with an expert to be able to ask questions before they were approached by recruiters during the period of study. The challenges and fears that had prevented them from accessing services or making decisions on whether or not to circumcise were only addressed by a face-to-face engagement with the recruiters. In this way, representation of their voices did not exist prior to their interaction with the recruiters. It was not clear if the information they shared would be escalated to decision makers.

Key finding 3: Level of Participation

The participants were not aware of any platforms to express their views about MMC prior to their interaction with the recruiters who created opportunities for them to ask questions through face-to-face engagements. The level of their participation in VMMC work or decisions was non-existent.

Key finding 4: Unexpected Finding in Relation to Development Impact

The participants who knew about MMC but did not act on that information were empowered to make informed decisions through face-to-face engagements with the VMMC recruiters.

FGD 2 (VMMC Recruiters)

Discussions were also conducted with VMMC recruiters to understand their experiences during field work. The discussion was summarised in direct quotes and then categorised according to the core components of participatory communication.

Summary 3 – Discussion with VMMC Recruiters:

"We report to the clinic every morning and leave as a group to conduct house visits and talk to men we meet in the street. We also target taxi and bus ranks as well as community events to recruit uncircumcised men.

"This week, we are targeting men's hostels. Some of the men are reluctant to circumcise because someone in their family or a friend or someone that they know had a bad experience at the clinic or have read somewhere about permanent injuries as a result of circumcisions.

"So, the men who came to the clinic today already knew about medical circumcision but did not do anything about that information because of these negative perceptions about circumcisions which include that if they are injured their private parts will fall off or they will be unable to make children.

"We build their trust by talking to them about the benefits of MMC and give them enough time to ask questions. We also give our names and telephone numbers to call us when they have thought about it and are comfortable to come to the clinic. We don't rush them to make a decision.

"Others had not acted on the information they had about MMC because they are unemployed and can't afford taxi fares. We provide transport for them to go for circumcisions and fetch them for checkups as well.

"The community also has negative perceptions about the VMMC clinic; that men who attend the clinic are HIV-positive because we can't talk about circumcision without saying something about HIV and AIDS and also because of our posters which also talk about HIV and AIDS. This makes it hard for us to recruit more men.

"Most of the men at the hostel do not stay there permanently and move around when they find jobs or relocate to other places to stay. Since we have their contact

numbers, we conduct follow-ups to make appointments for pickups or to link them up to their nearest clinics.

“The fact that they move around makes it difficult for us to plan our activities or to know if any new people needing education have moved into an area that we have already covered.

“There are many homeless people in the township who sleep in the street but they still want to circumcise. We do not discriminate against them but refer them to a nurse for a decision because they need access to water to keep their wound clean.
”Some men are easily persuaded to circumcise if they know someone who has done it and have spoken to them about their experiences. Others are motivated by being accompanied to the clinic.

“Reasons for agreeing to be circumcised vary; from wanting to reduce chances of getting infections, to improving sexual performance to impress female partners. Some of them are accompanied by their women to the clinic.

“Others agree to come to the clinic because they have STIs and need treatment but when we make follow-up some of them refuse to come back for circumcision.

“Our work increases the number of men who test for HIV because counselling and tests are done before they are circumcised. If found HIV positive, they are referred for further medical examination, CD4 count and treatment, which means we also help to enrol more people for ART.

”We collect useful information about why men do not come to the clinic which could be used to improve planning..

Key finding 1: Communication Method

The VMMC recruiters created opportunities for community engagement through various face-to-face interpersonal communication channels including house visits. Their activities resulted in more enrolments of clients than any other form of communication channel — followed by radio and pamphlets. For example, the men already knew something about medical circumcision through one-way communication channels when they were approached by the recruiters but needed more information to make informed decisions.

Key finding 2: Community Representation

By conducting community mobilisation, the VMMC recruiters created opportunities for people to ask questions and receive more information about MMC in order for them to make informed decisions. Their face-to-face approach also assisted to reinforce messages delivered by one-way communication channels and to address challenges that prevented men from making informed decisions on whether or not to circumcise. The recruiters also accumulated new knowledge about their communities which they could used to improve community representation but there were no structured methods to capture and recount their experiences..

Key finding 3: Level of Participation

The level of the participation of VMMC recruiters to improve the uptake of services at the community level included educating, identifying and recruiting men for MMC as well as address existing negative public perceptions about medical circumcision. They mainly targeted people in the streets, including bus and taxi terminals, schools, sports and community events and also conducted house visits. They assisted in distributing information material and conducted follow-ups for bookings. Their attempt to influence decisions affecting them was through their afternoon brainstorming meetings which they attended to share lessons learned during their community activities. It was not clear on whether the information was escalated to decision-makers because they said they did not get feedback to assist them to plan their activities better. They also did not use note books to capture their experiences which meant that most information was forgotten and lost.

Key finding 4: Unexpected Finding in Relation to Development Impact

Regular meetings were held to empower one another through knowledge sharing which included their experiences, challenges and successes during community mobilisation activities..

Conclusion

The main finding was that the uncircumcised men who were recruited for circumcisions already knew about VMMC and its benefits through one-way communication channels but failed to act on that information until the VMMC recruiters presented them with opportunities to ask face-to-face questions about their concerns and negative public perceptions that prevented them from making decisions about whether or not to circumcise. In this way, interpersonal communication channels were effective in reinforcing messages already delivered through one-way communication approaches such as mass media and distribution of communication material. As a result, the activities of the VMMC recruiters resulted in more enrolments for medical circumcisions than any other form of communication during the period of study.

Table 14 – Recruitments of Uncircumcised Men

No.	Address	Year of Birth	Mobile	Language	Employment	Recruited/ Walk-in
1	Alex hostel	1989	Yes	IsiZulu	Unemployed	Recruited
2	Alex hostel	1985	Yes	IsiZulu	Contract worker	Recruited
3	Alex hostel	1986	Yes	IsiZulu	Unemployed	Recruited
4	Alex hostel	1991	Yes	IsiZulu	Unemployed	Recruited
5	Alex hostel	1989	Yes	IsiNdebele	Unemployed	Walk-in
6	Alex home	1993	Yes	IsiZulu	Unemployed	Walk-in
7	Alex hostel	1994	Yes	IsiZulu	Contract worker	Recruited
8	Alex home	1998	Yes	IsiZulu	Unemployed	Recruited

Table 15 - Summary on Perceptions and Level of Knowledge (Group 1)

Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Participant 6	Participant 7	Participant 8
Who told you about this VMMC clinic?							
Recruiters	Recruiters	Recruiters	Recruiters	Recruiters	Recruiters	Recruiters	Recruiters
Did you know about VMMC before the recruiters spoke to you?							
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
What did you know about VMMC before the recruiters spoke to you?							
That I won't get sexual infections	That I will not get HIV	That I will not get HIV	That I will not get HIV	That I will not get HIV	That I will not get HIV	That if I circumcise and use a condom I won't get HIV	That I won't get HIV
How did you first learn about VMMC?							
Radio	Posters	Friends	Radio	Radio	Posters	Posters	Friends
Why did you not circumcise after you learned about VMMC?							
I was afraid that people will say I have HIV because the clinic has HIV posters	I was afraid to undress in front of a female nurse	I was afraid to come alone.	I was afraid that I will be injured and never have babies again	I was afraid, it will never erect again	I was afraid it will get rotten and fall off	The clinic is far and I do not work to pay for a taxi	I am busy looking for a job and do not have time.
What changed your mind and come to the clinic?							
Because everybody at the hostel is circumcising.	Recruiters told me male nurses are doing circumcisions.	Because my friends were also coming	I felt better after I got more information from recruiters	I am not afraid after talking to recruiters,	I was told the professionals will teach me how to take care of the wound	Recruiters are providing transport	Since there's transport, I decided to go.
Who encouraged you to circumcise?							
People who have already done medical circumcision.	When I saw that people who came before me were not injured	Friends	People I stay with at the hostel	Family	Family	Girlfriend	Friends
What benefits do you think you are going to get from being circumcised							
I left my wife back home, and i don't want to give her infections	Recruiters say it reduces chances of getting HIV by 60%. I will also use a condom and wash for protection	It is easy to clean it, and infections can't not hide	Jozi women love men who are circumcised. They call them real men, and those who are not boys.	When I am tempted to sleep with another woman, I won't take HIV home	It reduces chances of getting infections. I will also protect my wife from getting cervical cancers.	My girlfriend says it will improve our sexual experience	I don't want to die young. This is why I decided to circumcise.
Do you think after circumcision you are going to be able to abstain from sex for 6 weeks?							
Yes. Will not visit home because I don't want to be tempted.	Yes, they told me I will get infections very easy since the wound is open.	Yes, I don't want any complications.	Eish, I will try. It's going to be hard. But I will try.	Yes. I have no girlfriend here and my wife will understand.	Yes. My wife is not here in Jo'burg.	Yes, I asked my girlfriend not to visit at night.	If my girlfriend does not support me, I will end it.
Which Communication Channel Would you Prefer to Receive More Information About VMMC?							
Radio	Radio	Billboards	Radio	TV	Radio	Radio	Radio

4.5 CONCLUSIONS FROM MULTIPLE SAMPLE SOURCES

(I) Document Reviews:

The VMMC plans were reflective of a multi-sectoral approach which brought together key stakeholders and advocated for a multi-pronged mass media approach which included interpersonal communication channels to increase access to information and participation through representation and consultation.

The plans were developed through a dialogical collaborative process involving external experts in consultation with programme coordinators who led the collaborative effort to ensure alignment to national priorities. The plans were expert-driven because not everyone participated in their development process and people without expert knowledge of communication methods were excluded from the list of contributors.

The plans also prioritised empowerment initiatives on advocacy and social mobilisation but not everyone benefited from capacity building initiatives. Civil society was targeted for media advocacy to ensure the creation of platforms that enabled the voicing of views of those who benefitted from the programme so that they were heard and considered during decision-making processes.

It was not clear how technical skills would be transferred to empower the internal staff, therefore, ensuring the sustainability of the programme when external support and funding were in short supply.

The level of the participation of stakeholders in decision-making processes varied. Implementing partners had functional roles through the provision of advisory and technical support and they were actively involved in decision-making processes. Whereas, communities were consulted through their representatives on decisions and progress and they were mainly engaged in service delivery through outreach activities involving community dialogues and mass media talk-shows to test messages and obtain information about client satisfaction.

(II) Individual Interviews

- **Pilot Study**

The communicators in the department who had no qualifications in health communication or development communication and occupied junior ranks were excluded from the high-level strategic meetings and decision-making processes despite their long-term work experience. By exclusion from strategic communication processes, the communicators were unable to participate meaningfully because they had no specific roles to support the programme which meant that there was an inefficient use of internal resources and opportunities for transfer of technical skills through knowledge exchange and dialogue.

- **Communicators**

The participants were not involved in the development processes of VMMC strategies which were expert-driven by external technical support. The participants were indirectly involved in the activities of the programme but their involvement was supervised or informed by the level of seniority. In most cases, they passively participated in decisions with no authority or meaningful roles to influence decisions. A lack of feedback on technical decisions and top-down communication flow were viewed as disempowering by the participants who preferred staff meetings to engage their supervisors. Those who were directly attached to the programme performed selective tasks which were events-driven and included publicity while the external support drove most of the programme activities.

- **Programme Managers**

The study found that the VMMC programme's multi-sectoral approach for stakeholder participation in the communication processes to promote the uptake of services was supported by one-way and two-way communication methods aligned with the overall integrated strategic communications approach of the department that sought to ensure that collaborative efforts were aligned to the national priorities and targets. The involvement of the managers in the VMMC work varied — those who were attached to the programme had specific functional roles and others who were indirectly involved

provided support services. While some of them had access to opportunities to influence decisions by shaping their formation and others were consulted for inputs.

- **Development Partners**

The activities of the VMMC programme were expert-driven by external technical professionals who were also responsible for the development of its strategic plans to provide advisory support on effective communication methods to achieve government-defined priority and pre-determined objectives. Although the development partners employed combination one-way and two-way communication methods to improve the uptake of services, they used different approaches influenced by their organisational positions and individual interests. They assisted in addressing the limited technical knowledge on participatory approaches for advocacy, communication and social mobilisation (ACSM) in the department. Their participation in decision-making processes from inception to delivery through multi-stakeholder structures yielded some positive results even though declining resources, disagreements with the traditional authority and time-consuming stakeholder engagement processes as well as an over-sight on the value of transfer of skills to the internal staff, affected the rollout of the programme to meet set time frames and to ensure the sustainability of the programme.

(III) Focus Group Discussions (FGDs)

The main finding was that the uncircumcised men who were recruited for circumcisions already knew about VMMC and its benefits through one-way communication channels but failed to act on that information until the VMMC recruiters presented them with opportunities to ask face-to-face questions about their concerns and negative public perceptions that prevented them from making decisions about whether or not to circumcise. In this way, interpersonal communication channels were effective in reinforcing messages already delivered through one-way communication approaches such as mass media and distribution of communication material. As a result, the activities of the VMMC recruiters resulted in more enrolments for medical circumcisions than any other form of communication during the period of study.

CHAPTER 5

INTERPRETATION AND DESCRIPTION OF FINDINGS

5.1 INTRODUCTION

The findings from the multiple sources reported in the previous chapter were combined by means of triangulation of data in relation to the core components of participatory communication, which are; communication method, community representation, the level of participation and development impact, which guided the investigation and studies reviewed. The findings which were related to the impact were classified as "unexpected" results because that was not the purpose of the study.

This study was based on an understanding that while South Africa had prioritised participation and communication for development programmes, there were challenges in the implementation of the participatory approach to achieve communication goals (Msibi & Penzhors, 2010, Mathuga, 2010 and Doku, 2013). A case study method including document reviews, in-depth interviews and focus group discussions were used to understand the model. The method informed the overall direction of the research was used to understand the phenomenon (Yin, 2003 and Bryman, 2008).

In this chapter, a textual description of the experiences of the participants was outlined to answer the research question on how the VMMC programme facilitated stakeholder participation in its communication processes to improve the uptake of services in the context of national targets. While the programme recognised the value of the approach through its plans and processes which were found to have been prepared in a participatory manner, the study also revealed limiting factors in the application of the participatory communication model.

To contextualise the findings of the study, the limiting factors were described in relation to the principles of the participatory communication model, which included:

- Free and open *dialogue*;
- Giving *voice* to marginalised groups, which primarily;

- Gives marginalised groups *time* and *space* to articulate their concerns, define their problems, formulate solutions and act on them;
- *Liberating Pedagogy* which facilitate the process whereby collective problem and solution identification would occur, and;
- *Action-Reflection-Act*ion which emphasise on the need for mutually reinforcing the commitment to action and change.

The challenges in the translation of the participatory approach into practice were as a result of the following limiting factors:

1. Varying levels of authority which limited participation through hierarchies and briefs, resulting in unequal opportunities to influence decisions;
2. Lack of knowledge and skills around the participatory approach which resulted in dependency on and transfer of decision power to external support;
3. Expert-driven communication processes, which resulted to hierarchies of knowledge and vertical communication flow;
4. Lack of meaningful and empowering inclusion in decision-making processes experienced by marginalised stakeholder groups;
5. Lack of a programme reporting mechanism on joint communication efforts, which resulted in challenges to synchronisation public information activities;
6. Lack of access to information and spaces of communication, which led to challenges in effecting a more horizontal participatory structure within DoH;
7. Lack of knowledge retention mechanism on lessons learnt from fieldwork which resulted in loss of institutional memory;
8. Time-consuming engagement processes against inflexible tight time frames which suggested lower levels of public participation and public voice;
9. Challenges in converting the high knowledge levels about VMMC in the communities into action by addressing negative public perceptions;
10. Declining funding for demand creation campaigns which led to insufficient community mobilisation and visibility;
11. Lack of formal plans for transfer of technical skills to marginalised groups to ensure sustainability of the programme in the event of funding scarcity;

5.2 APPROACH

The study found that the plans of the VMMC programme were reflective of a multi-sectoral approach which was supported by monologic and dialogic communication methods.

> *The plan was developed through a collaborative process that brought together government, international partners and civil society to strategically plan for the acceleration of this important programme, Minister of Health, Dr Aaron Motsoaledi, (DoH, 2012, pg.1).*

Also in keeping with South Africa's National Development Plan (NDP) vision for 2030, DoH's through its plans and processes which were prepared in a participatory manner used achieve sector-wide integration and alignment of funding and technical support to acheive the programme's goal to reduce HIV incidence by scaling up VMMC to 80% of HIV-negative men between 15 - 49 years (DoH, 2012).

> *The NDP on Chapter 10, p. 69, refers to stakeholder collaboration "by bringing additional capacity and expertise to strengthen the health system," as such demonstrating government's commitment to a participatory approach.*

The focus of the study was on Communication and Demand Generation, pillar four (4) of the seven pillars of the Strategic Plan for the scale-up of VMMC in South Africa 2012-2016 and the South Africa Voluntary Medical Male Circumcision (VMMC) Operational Plan for 2015/2017– 2018/19, which plays the central role in improving the uptake of services (DoH, 2012), as informed by this vision statement:

> *Creation of demand is crucial for the successful implementation of the VMMC programme and critical to this success is increasing the awareness of the population in relation to the availability of services through various communication approaches, (DoH, 2012, p. 30).*

This was also consistent with the DoH's integrated perspective on communications, which discredited the top-to-down approach and advocated for a people-centred and facilitative approach that "that does not tell but encourages communities to be active participants in finding solutions to their problems so that the government is able to make informed decisions based on public feedback and deliver services that are anchored in and are accountable to the communities, (Maja, 2016).

The VMMC programme used the horizontal and vertical communication methods for collaboration and coordination across different administrative levels and among stakeholders to facilitate the participatory approach.

It also chaired the national Technical Working Group (TWG to ensure that all major decisions were made through consultation or representation to serve the interests and of all those who were directly and indirectly affected by the programme.

This process, to be considered genuinely participatory and truly effective, according to Servaes & Malikhao, (2002) and Tufte & Mefalopulos, (2009), should encourage the active involvement of stakeholders in the identification of problems, development of solutions and implementation of strategies aimed at reaching a consensus about their needs and capacities, especially of those who were most vulnerable and marginalised.

As such, the cooperative partners used a multiplicity of approaches, also involving one-way and two-way communication methods to support the work of the VMMC programme, as follows:

- CHAPS, as a major implementing agency was involved in the development process of the VMMC plans by attending strategic planning meetings in an advisory capacity. To support to the collaborative efforts for the expansion of the VMMC programme services and improvement of the uptake of services, it took a multi-pronged approach to communications and demand creation, utilising both local and national channels of communication, including TV and radio talk-shows, as well as workshops, community dialogues and house visits.
- CMT was involved in the revision and consultation process of the VMMC strategic and operational plans and, as a leading demand creation partner of the TB and HIV Consortium, focused on the creation of demand and strengthening community mobilisation through mass media and interpersonal and participatory channels with an emphasis on TV documentaries. Working closely with the consortium and provinces, it also designed, developed, implemented, evaluated and monitored demand creation campaigns.
- CCI was involved in the development process of the VMMC plans mainly in an advisory role limited to demand creation and communication strategy. It used mass

media and interpersonal communication channels to drive demand creation activities. It also supported the programme with its evidence-based strategic communication approach which was informed by a social ecology model, called P-Process, including formative research to understand the environment that influences men's decisions to circumcise or not to circumcise.

- SCI was not involved in the development of the VMMC plans but supported the campaign using social behaviour and change strategies including mass media activities including education entertainment TV and radio drama programmes, as well as evidence-based advocacy and social mobilisation activities for the VMMC camps to engage men on the value of VMMC.

These communication approaches were premised on the resolution of the 2006 World Congress on Communication and Development that diffusion of innovations and participatory approaches should be adopted in parallel in programme initiatives in order to allow development and communication practitioners to reach broad audiences through large-scale campaigns.

> *"On one hand, is the diffusion model which is a linear, monologue-like top-down communication, encompasses a broad range of strategies aiming to solve problems due to lack of knowledge and information. On the other hand, is the dialogic and horizontal participatory model which articulates processes of collective action and reflection by relevant stakeholders to ensure their empowerment, which a shift in power to give a voice to marginalised groups, time and space to articulate their concerns, define their problems and formulate solution", according to Tufte & Mefalopulos, (2009, p. 7).*

5.2 PRACTICE

The application of the participatory communication model required professionalism and expertise of specialists who were knowledgeable about the diverse range of methods, techniques, and tools of development communication, according to Servaes & Malikhao, 2002), which were scarce and far between among DoH employees.

The VMMC programme experience similar challenges as outlined in Cases 1 and 2 in the literature review, as follows:

> *...that the top-down approach in the beginning of the programme and participatory from the halfway mark — was less than satisfactory, and;*

...that reliance on the external support was because could not engage the outside experts intelligently on communication methods, and endorsed use of outside experts and training.

Privileged stakeholder groups

This stakeholder group was privileged through varying levels of authority by benefiting far more from participatory processes, resource deployment and empowerment than others especially with regard to being able to influence decisions than those who did not have the knowledge of participatory approaches.

The DoH led all the collaborative efforts to support a government-defined priority and predetermined objectives, through vertical and horizontal approaches, which facilitated stakeholder participation in line with Freire's (1970) liberating pedagogy principle on dialogue, to find solutions to pre-defined problems through sharing of different experiences and knowledge. In this way, it attempted to balance inclusiveness with time frames, resources, interest and knowledge of the contributors to the VMMC plans.

As such, the plans were developed by the experts without the active involvement of those who stood to benefit from the programme, which meant that those with power ended up being further empowered with little or no regard for those who reported to them, especially in the DoH where advantage was arrayed more or less hierarchically, as well as among the external expert partners, as shown in Annexure F.

This expert-driven approach excluded the lower level stakeholders who lacked the knowledge of participatory approaches, such as communicators and ordinary people whose interests were represented by their supervisors and leaders during in decision-making processes.

According to a DoH manager, communication partnerships assist to address the shortage of skills and limited funding, according to a DoH manager.

However, according to the typology of participation, this consultative process keeps all the decision-making power in the hands of external professionals who are under no obligation to incorporate stakeholder' inputs, (Tufte & Mefalopulos, 2009, p. 6).

Whereas McPhail, (2009, p. 27) stressed the basic right of all people to be heard by speaking for themselves and not be represented or their views reworded by another

party, CMT highlighted a practical challenge in the implementation of this idea in that "we often experienced issues of timing of deliverables".

Stakeholder engagement was important and necessary in order to implement accurate and useful communication campaigns, "but it often takes time and partners do not always respond with feedback timeously and we are under pressure to roll out the campaign in set time frames".

CCI also pointed out a crucial limiting factor for implementation that "resources are also declining to fulfil our mandate. We are not only focussing on MMC but on other health programmes as well, and need to strike a balance."

> *While collaboration with external partners enhanced ownership, the, full participation by all stakeholders in any step of the process was not possible and in this case not desirable because "general engagement would delay the process" especially when the marginalised groups did not possess the required knowledge to enhance the process of development of plans.*
>
> *Without a certain level of technical expertise, they were restricted to certain participation levels* (Tufte & Mefalopulos, 2009 and Servaes & Malikhao, 2002).
>
> *Of, course, it is not possible to consult or engage everybody on everything and at all levels of the campaign which is why we use representation to ensure fair representation of all sectors, according to the DoH manager.*

In relation to this, Tufte & Mefalopulos, (2009), stated that proper application of participatory communication methods and tools were not enough and that broader contextual requirements such as a flexible project framework (especially in terms of timelines), a politically conductive environment and an enabling attitude by key stakeholders, including project management, were needed (Tufte & Mefalopulos, 2009).

> *While stakeholder involvement happens from planning stages and throughout implementation and through feedback sessions – which meant from degree of involvement is from planning to delivery, according to a programme manager.*
>
> *"We also engage gatekeepers such as traditional leadership to ensure community representation, and created communication partners and research feedback about gaps in our messages, effective communication mechanisms and continued community representation and mobilisation."*
>
> *"...and fieldwork experience and research also assist with effective methods of stakeholder engagement and promote the inclusion of the voiceless in decision-making processes."*

> *Community mobilisation partners such as Brothers for Life also assisted with community awareness and education campaigns where direct engagement with men happened.*

However, consideration for the inclusion of the voice of the ordinary people came in many forms - through passive participation when they were informed about what was going to happen or had already happened, and if their feedback was allowed, it was minimal and limited to head counting or answers to questions by researchers, according to the typology of passive participation (Tufte & Mefalopolus, 2009).

The higher level of participation for primary stakeholders did not usually result in dramatic changes in what should be accomplished, which was often already determined, but required their active involvement through representation in the decision-making process about how to achieve it, (Tufte & Mefalopolus, 2009).

While CHAPS used strong relationships and membership with leading implementing agencies resulted in efficient resource sharing and heightened capacity for demand creation, other cooperating partners were battling with the declining resources.

> *Resources are declining and we are not only focussing on MMC but on other health programmes as well and need to strike a balance, and still ensure that the existing awareness about MMC responds to the challenges on the ground that prevent men from accessing available services, according to CCI*

> *Our interventions to improve the uptake of VMMC services, were phased out when funding ran out, according to SCI.*

The VMMC programme, focused on the empowerment of the privileged stakeholders, such as the civil society through advocacy training in order to create media opportunities for communities to voice their concerns.

As a result of varying levels of authority and access to mediated public spheres, the external partners got more opportunities to influence decisions, which also meant that "those with power end up being further empowered through participatory approaches in terms of voice and visibility, and the representation of the inputs of the lower level stakeholder groups is limited to their participation by head count and answers to research questions," according to the study finding.

Marginalised stakeholder groups

The needs of the key stakeholders affected by the programme were marginalised by the programme to a certain extent and considered the fact that they did not have to participate in the processes especially technical ones that might go beyond their specific interest and knowledge.

According to Tufte and Mefalopulos, (2009), Servaes & Malikhao, (2002) and Huesca, (2002), the key stakeholders affected by the change should have the opportunity to participate in the decision-making process defining the needed change, but after their input was taken into account, they did not need to be directly involved in decisions.

According to the study findings; only one DoH communications manager had the relevant health and development communication qualifications, which suggested a great need for technical support to augment a skills gap on participatory communication.

> *...but overlooked the empowerment of the DoH communicators through skills transfer to ensure the sustainability of the programme since the resources were said to be declining.*

The communicators were marginalised also by a lack of access to information and spaces of communication, which led to challenges of effecting a more horizontal participatory structure within DoH, as well as meaningful and empowering inclusion in decision-making processes or through feedback on management decisions.

According to Mefalopulos, (2003), Tufte, (2001) and McPhail, (2002), these varying levels of authority and hierarchies of knowledge could be balanced through joint collaboration and shared control over development initiatives. For example:

> *The DoH communicators who had no qualifications in health communication or development communication and occupied junior ranks were excluded from the high-level strategic meetings and decision-making processes despite their long-term work experience.*
>
> *By exclusion from strategic communication processes, the communicators were unable to participate in the processes because they had no specific roles, which also meant an inefficient use of internal resources and opportunities for skills transfer through knowledge exchange.*

Those who were involved in the VMMC work did so indirectly through supervision but were also excluded from the development process of the VMMC strategies. It was not clear whether the reason was that they lacked the knowledge of participatory approaches or due to the level of seniority. Their involvement was limited by briefing notes.

In most cases, they passively participated in decisions with no authority or meaningful roles to influence decisions. The top-down communication flow also disempowered them as they preferred staff meetings which were held occasionally.

Those who were directly attached to the programme performed selective tasks which related to their job descriptions.

The interests, needs and capacities of all concerned and communication media were important in achieving this process but their use is not an aim in itself — interpersonal communication too must play a fundamental role" (Servaes, 2002, p. 1).

Also crucial was the core competencies required to engage actively and participate meaningfully in all processes (Tufte & Mefalopulos, 2009). Others defended their positions on the issues, as follows:

Unless there were people familiar with different technical engineering specifications, general participation would only delay the process and would not benefit the end result, (Tufte & Mefalopulos, 2009, p. 20).

CCI said they worked in partnership with government officials during outreach and through the processes of working together and dialogues during meetings, we hoped to address knowledge gaps about participatory approaches for development programmes.

The study found that there were also opportunities for training on communication strategies from which communicators could benefit which covered the P-Process approach, but there were no immediate plans for the capacity building.

On the other hand, uncircumcised men who benefit from the programme through expansion of VMMC services and access to information were marginalised by challenges in converting knowledge to action, as a result of fewer or no opportunities to engage an expert about their fears and concerns.

This group also had no direct access to decision-making processes where collective problem identification and solution took place, which implied insufficient face-to-face opportunities to ask questions.

> *The main finding was that the uncircumcised men who were recruited for circumcisions already knew about VMMC and its benefits through one-way communication channels but failed to act on that information until the VMMC recruiters presented them with opportunities to ask face-to-face questions about their concerns and negative public perceptions that prevented them from making decisions about whether or not to circumcise.*
>
> *In this way, interpersonal communication channels were effective in reinforcing messages already delivered through one-way communication approaches such as mass media and distribution of communication material. As a result, the activities of the VMMC recruiters resulted in more enrolments for medical circumcisions than any other form of communication during the period of study*.
>
> *However, a number of challenges prevented them from acting on the information they had about VMMC - this group was also marginalised because of the insufficient VMMC services which meant they had to walk long distances to reach the nearest services and still joined long queues, according to CCI.*
>
> *We need to convert the high knowledge levels that are already out there into action by addressing the negative attitudes towards medical circumcision and the thriving culture of circumcising only in winter by shifting the habit so that men access services throughout the year, and not only in winter, CCI*.

According to Servaes & Malikhao (2002), Servaes, (2007) and Mefalopulos, (2008) when people become aware of their rights, they are empowered to confront and deal with the many challenges affecting their existence which result to commitment to action

The activities of the VMMC recruiters were the most effective communication methods during the period of study in terms of recruitments by reinforcing mass media messages using interpersonal communication channels.

As such, their activities were action-oriented because they speak to the need for mutually reinforcing the commitment to change by shifting power to the ordinary person to make informed decisions instead of being told what to do, Tufte & Mefalopulos, (2009, p. 11).

However, they were also marginalised by a lack of knowledge retention mechanisms on the lesson learnt from fieldwork, which resulted in the loss of memory when their experiences could be used to improve community mobilisation approaches.

> *Their attempt to influence decisions affecting them was through their afternoon brainstorming meetings which they attended to share lessons learned during their community activities.*
>
> *But, they also did not use note books to capture their experiences which meant that most unrecorded information which could assist to address negative public perceptions was forgotten and lost forever.*

While they understood the communities they served better than anyone in the programme, it was not clear if the information they shared was escalated to management to give effect, to some degree, to the principle of the voice of those most affected being heard and influenced decisions.

5.3 UNEXPECTED RESULTS

The study alluded to the fact that any additional information which related to the fourth component of participatory communication — development impact — was ''unexpected' since the purpose of the study was to understand the experiences of the participants with the participatory approach and not the impact. Unexpected information classified under the fourth element included empowerment and training initiatives and benefits relating to access, empowerment and self-determination.

According to development communication experts, access to information or communication platforms suggested that once aware of their rights, people would be empowered to confront and deal with the challenges affecting their existence resulting in a greater likelihood of a commitment to change which in turn would lead to action and self-determination (Tufte & Mefalopulos, 2009).

The study found possibilities of that happening among the interviewed communicators and uncircumcised men who participated in the discussions were unlikely in the absence of a willingness to share control or the recognition of the disempowering top-down attitudes in the upper echelons as it was the case elsewhere in the world. The programme managers collaborate with other stakeholders to augment a skills gap and often make little or no effort to empower the marginalised groups. See Case 2.

5.4 LIMITATIONS AND DELIMITATIONS

- Some of the participants to the study were not directly involved with the VMMC programme but offered support services whenever they were requested to do so. A pilot study was therefore conducted to establish the adequacy of questions related to their experiences with the programme;
- When the researcher experienced challenges in securing interviews with the participants because of their busy work schedules or short time allocated for interviews, informal conversations were conducted to address information gaps and to verify facts;
- The researcher was allocated less than an hour to conduct FGDs because the participants (uncircumcised men) relied on the transport provided by the clinic. Participant observations and formal discussions were done when they arrived at clinic and informal conversations after the procedures and when they returned for check-ups;
- The time allocated for FGDs with the VMMC recruiters was also short because it was conducted after their working hours when they returned to the VMMC clinic to submit a list of potential recruits for procedures. Informal interviews were done to clarify issues with an administrator who was responsible clinic files, two nurses who performed procedures and a social worker who conducted HCT at the clinic;
- It was also difficult to secure appointments with programme coordinators, communication managers and development partners because of their busy schedules. Some of the appointments were cancelled at short notice and others allocated short time for interviews. The researcher attempted the following:
    - Communicators who provided support services to all communication campaigns were targeted for interviews. While they were not involved in decision-making processes, some of them accompanied their supervisors to planning meetings or represented them in their absence; and
    - Managers, who included programme coordinators and communication managers, as well as development partners, who could not avail themselves for long interviews were requested to submitted supporting documents related to the subjects covered by the interviews. The researcher also conducted informal conversations to verify information and the researcher met one of them in a

corridor and posed a question or two to address information gaps. Transcripts were emailed to them for approval and were returned with additional information.

- The researcher relied on taking notes during interviews and focus group discussions but there was danger to misrepresent some of the information during transcription. To address this challenge, member checking was done to verify facts or elaborate on existing information.
- The research study was phenomenological and qualitative in orientation. The nature of the study does not claim to be generalisable and representative. This means that the results and conclusions can only be applied to the research setting in which it was conducted.

5.5 CONCLUSION

The interpretations of findings to answer the research question together with the limiting and delimiting issues relating to data collection have suggested the importance of participatory communication for development programmes through the use of approaches and applications premised on international participatory principles, and associated challenges — which in a way confirm the problem statement.

The study has also demonstrated a link between (i) varying levels of authority and hierarchies of knowledge and vertical communication flow; (ii) challenges in synchronising public information activities, knowledge retention mechanisms and lack of access to spaces of communication; (iii) technical skills gaps and poor planning for transfer of skills; as well as (iv) time-consuming engagement processes, declining campaign funding against challenges of converting high levels of knowledge into action.

By so doing, it has confirmed South Africa's commitment to a participatory approach for development programmes and the accompanying challenges in its application which include a requirement of technical skills which are scarce and far between in the DoH. It also demonstrates the implementation challenges and contradictions relating to the model, which subsequently lead to the dependency of the programme on the external technical support, and in a way also suggesting an inefficient use of internal staff.

The study also found startling similarities in the local and global experiences with the participatory approach. For example, Tufte & Mefalopulos, (2009) found that the top-down approach in the beginning of programme and participatory from the halfway mark — was less than satisfactory (see Case 1) which speaks to the expert-driven approach applied for the development of the VMMC plans.

On the other hand, Doku, (2013), found that reliance on the external support was inevitable because the programme did not have the communication person who could engage the outside experts intelligently on communication methods (see Case 2). This was also more or less the reason why the VMMC programme restricted the development of its plans to experts. Whereas Doku, (2013) recommended the use of external experts and training of communicators the plans of the VMMC programme made no reference to their training.

In this way, the study demonstrates that the participatory approach is difficult to implement even for those who profess to have the know-how because it depends much on stakeholder participation which either frustrates the "timing of deliverables or delays implementation" because of its long-drawn processes which explain the temptation to restrict the process to representation or consultation activities involving key decision-makers.

5.6 RECOMMENDATIONS

1. Staff meetings should form part of the Key Performing Areas (KPAs) for all DoH managers in order to improve feedback on management decisions relevant to the activities of those who report to them;
2. All communication strategies involving external technical support should include a plan for capacity building or transfer of skills and in turn, a commitment of shared budgets to ensure sustainability;
3. A questionnaire should be designed for VMMC recruiters to use during their community mobilisation activities to capture and report on their experiences; and
4. A writing committee involving DoH communicators and external technical experts be established so as to ensure effective reporting on all partnership efforts.
5. A bottom-up approach involving fieldworkers is recommended for advocacy including community mobilisation strategies

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APPENDICES

Appendix 1: Strategic Plan for the Scale up of Medical Male Circumcision (MMC) in South Africa 2012-2016

Author: Department of Health Document
Date: 2012
Category of document: Strategic plan
Audience: programme coordinators, technical support staff, development partners
Preset themes access and participation

Preset themes access and participation used to identify related terms	
Page	1. **Sub-question 1:** What was the strategic approach used by the VMMC programme to facilitate stakeholder involvement?
1, 2, 6 7, 11, 12, 14, 1632, 33	NDOH will continue to lead coordination efforts, and ensure participation by cooperating partners involved in the MMC programme. All major decisions regarding MMC will be made in consultation with the national MMC Technical Working Group. A well-coordinated and strategic approach is needed that brings together the various stakeholders involved in the MMC programme. The plan is reflective of a multi-sectoral approach, which supports the vision of the NDOH to work in partnership with stakeholders to scale up the provision and uptake of MMC in South Africa. A National Technical Working Group has been established that regularly meets to discuss the overall program, A technical working group is currently operational, to ensure on-going coordination and collaboration, a national MMC TWG will be established and chaired by NDOH and include participation from partner organizations All major decisions regarding VMMC are made in consultation with the national VMMC Technical Working Group, NDOH also has regular meetings with provincial MMC coordinators and has established a system whereby provinces share lessons learned in implementation of the program Given SANAC's multi-sectoral mandate, and the needs of the MMC program to involve various sectors, SANAC will play a critical role to ensure coordination. SANAC will increase its support for the programme, especially around coordination, to leverage its multi-sectoral mandate to involve various sectors in the national HIV response. This will require an unprecedented level of commitment and leadership, as well as advocacy efforts, from leaders and stakeholders across various sectors. This plan represents NDOH's goals for MMC, but only working together in partnership will government, civil society, international organizations, and others achieve the goals of the programme. NDOH is committed to working with all stakeholders to strengthen its commitment to the MMC programme and to achieve our goals in HIV prevention. Close collaboration with district and provincial health authorities is critical, and has resulted in cost sharing for the MMC program. This plan was developed through a collaborative process that brought together government, international partners, civil society to strategically plan for the acceleration of this important programme. The joint framework outlines key strategic pillars and activities for the expansion of medical male circumcision (MMC) to contribute towards the global goal of "getting to zero" new HIV infections.
Page	***Sub-question 2.*** What activities did the VMMC programme and stakeholders conduct to improve uptake of services?
7, *11,16,* *12, 34,* *32, 33,*	Community dialogues, small group workshops will be conducted in communities, workplaces, tertiary institutions, schools and faith based organisations and large community events using entertainment education participatory approaches such as drama, theatre arts and culture Rapidly identifying any potential implementation challenges and engaging key stakeholders to overcome them NDOH also has regular meetings with provincial MMC coordinators and has established a system whereby provinces share lessons learned in implementation of the program. The coordinators are working in partnership with various stakeholders. The MMC programme operates with involvement with various stakeholders, rapidly identifying any potential implementation challenges and engaging key stakeholders to overcome them Field workers from provinces, districts and civil society partners will be trained to ensure that messages regarding MMC are accurately translated and on how to work with the media and refer potential clients for services Lessons learned will be incorporated to ensure on-going use of information to achieve the goals of the program. Various implementing partners are now incorporating both mass media and participatory approaches for service delivery A number of implementing non-governmental organizations are also intricately involved in the programme and provide not only MMC services but also technical input into training, service delivery, research, evaluation, and innovation. Cooperating partners will play a critical role to provide technical, coordination and financial support. Advocacy efforts must ensure engagement with political, community, entertainment, traditional and other stakeholders. A core technical team will be established to support NDOH's efforts and may include NDOH (e.g., M&E and training coordinator) and non-NDOH staff (i.e., technical staff seconded by cooperating partners). Close collaboration with district and provincial health authorities is critical, and has resulted in cost sharing for the MMC program. Engagement with traditional leaders and with community through outreach will be prioritized. Coordination will be instrumental as the MMC programme continues to grow and close coordination among partners will be instrumental in monitoring achievements towards targets, setting strategic directions, and ensuring accountability.

7, ***34***	A multi-prong mass media approach that combines different communication channels and participatory approaches; such as the use of IEC materials, advertising, editorial content, television drama, radio talk-shows Mass media campaigns, billboards and communication approaches were undertaken across the country Outdoor media, including the use of billboards and mobile media should be placed in high population transit areas such as commuter junctions, shopping malls and along major transport routes within the vicinity of sites to reinforce the messaging through the other mass media and interpersonal communication channels. Mass media approaches do contribute towards addressing knowledge, attitudes and norms relating to health interventions. The programme will use community radio, television and print media to engage in dialogue on medical male circumcision; to profile the services available within the community, highlighting men within the community that have undergone medical male circumcision and ensuring that services within the community are widely advertised and known. Brochures that can be distributed following the discussion to reinforce messaging with reference to a national resource such as the national SMS line, the Life Line or the HealthSites Website that allows people to search for their nearest health facility. Interpersonal communication channels to be used to interact with communities, such as community meetings, forums, etc Communication materials will provide an update on service delivery and other key areas of interest including engagement with the traditional sector, Community dialogues, small group workshops will be conducted in communities, workplaces, tertiary institutions, schools and faith based organisations and large community events using entertainment education participatory approaches such as drama, theatre arts and culture Facilitate small group discussions around sexual prevention, HIV counselling and testing and MMC within communities
Page	**Sub-question 3:** What was the level of participation of stakeholders in the work of the VMMC programme to improve uptake of services?
2, 5, 6, 7, 11, 12, 14, 32, 33	At the national level, the priority will be to set direction towards achieving targets, strengthen coordination of services, maintain up-to-date information on the programme, and communicate information with stakeholders. NDOH leads the programme with strong coordination, financial and technical support from PEPFAR and the Global Fund. WHO, UNAIDS, CDC and USAID provide ongoing technical input, especially in the areas of policy and operational considerations. District technical committees should be established (if not already existing) to coordinate across stakeholders A National Technical Working Group has been established that regularly meets to discuss the overall program, Primary Health Care teams undertaking home based visits should be capacitated to engage women and men around MMC and provide referral to services through maintaining lists that can be provided to service providers for follow-up with interested clients. Health Care Workers will be trained around the district hospitals, community health care centers and high volume sites to promote the uptake of MMC as part of their household assessments There are also community action teams that have a specific focus to promote the uptake of MMC through engaging with men in communities and maintaining lists of interested clients that can be provided to service providers for follow-up Mobile teams conducted high volume of circumcisions in district hospitals, and community health centres Coordinating MMC administrative structures at provincial and district levels, will support implementation and monitoring and evaluation Field workers from provinces, districts and civil society partners will be trained to ensure that messages regarding MMC are accurately translated and on how to work with the media and refer potential clients for services. There teams operating in South Africa, with various approaches including fixed and roving services, but with the capacity to perform at least 30-40 circumcisions per day. A core technical team will be established to support NDOH's efforts and may include NDOH (e.g., M&E and training coordinator) and non-NDOH staff (i.e., technical staff seconded by cooperating partners). .

Appendix 2: South Africa voluntary Medical Male Circumcision Operational Plan for 2015/2017–2018/19

Author: Department of Health **Document date:** 2015
Focus: Strategic Pillar 4 – Communication and demand generation (Pages 48-53)
Category of document: Operational plan
Audience: programme coordinators, technical support staff, development partners
Preset themes: access and participation

Preset themes access and participation used to identify related terms	
Page	***Sub-question*** 1: What was the strategic approach used by the VMMC programme to facilitate stakeholder involvement?
1, 7, 11, 12, 14, 23, 25, 28,	Well-coordinated strategy that considers the distinct informational needs of males is critical in a national MMC scale-up plan. Communication activities are: Good practices will be identified and disseminated to enhance governance and coordination initiatives include: strong horizontal and vertical collaboration and coordination across the different administrative levels and among stakeholders; dedicated full-time staff with clear roles and responsibilities; and coordination mechanisms that bring stakeholders together on a regular basis, drive decision making and ensure accountability Provide training to NGOs, existing DoH community cadres (CCWs, HBCs, school health, teams, WBOTs) on MMC demand generation activities Field workers from provinces, districts and civil society partners will be trained to ensure that messages regarding MMC are accurately translated and on how to work with the media and refer potential clients for services.
Page	***Sub-question 2:*** What activities did the VMMC programme and stakeholders conduct to improve uptake of services?
7, ***34,*** 32, 33 48	Teams of field mobilisation plays an important role in reinforcing the messages delivered through mass media, commur dialogues and other MMC awareness-raising activities. Conduct special events targeting higher education and technical institutions Conduct mobilization events targeting high schools and male-dominated workplaces Conduct monthly meetings for community mobilisers Convene provincial forum of church diocese to train and equip church groups for advocacy Engage workplaces and important gate keepers at the traditional councils, FBOs, high schools, and sports leagues for advocacy activities The uptake of services is dependent on demand, availability of services, the attitude of the health care workers and clients' experiences and their social interaction with peers Convene monthly "Demand Creation Group" communication meetings Convene workshops on development of content of IEC, training and radio spots The main strategies used in MMC demand generation are mass media communications, advocacy, education and behaviour change communication, field mobilisation, booking support, monitoring, evaluation and operational research. At the national level, the DoH drives demand generation via radio and television advertisements, while traditional leaders and partners lead demand generation activities at the provincial and district levels Cooperating partners use advocacy, communication and social mobilization strategies work to increase knowledge about the benefits and limitations of MMC, awareness of the availability of services, address social, cultural and traditional norms and attitudes that may impede or facilitate the uptake of MMC. Mass Media on television focus on the free-to-air channels such as SABC 1, 2, 3 and eTV to build reach on a national level and the spill over to the lower LSM market. Pay TV (DSTV) should also be considered as an important part of the media mix. Community Media should also form part of the mix. While community stations have a low reach, they are free-to-air and are growing. Community TV stations are frequently looking for content and thus do not have significant broadcast fees and sometimes even offer free broadcast. Communities identify with content presented on their community TV because it is more representative of their local interests. Radio is a dynamic medium that can respond immediately to events unlike much of television content, which is pre-packaged. It is also easy for audiences to interact with. For this reason, audiences often feel more connected to and understood by radio stations. Radio as a medium has the greatest impact in mass communication and therefore offers the best return on investment. Radio has the highest reach amongst the diverse target audience. While regional radio provides the highest cost-to-reach ratio, community radio is a critical medium that can be effectively used to facilitate dialogue with communities through live call-in shows and should be considered as an important element of the mass media strategy. In addition, a combination of national and regional radio stations, ensuring coverage Engage media houses as key opinion leader stakeholders to promote MMC in media outlets Increase knowledge of the HIV and sexual health benefits of MMC amongst males and their social networks; Increase awareness of the availability of safe MMC services within communities, schools and workplaces; Television and radio dramas, advertising, and talk shows. Print media adverts supported by advertorial and editorial content

	Outdoor media, including the use of billboards and mobile media, placed in high population transit areas such as commuter junctions, shopping malls and along major transport routes within the vicinity of sites that reinforce the messaging through the other mass media and interpersonal communication channels. Develop and produced standardised IEC and training materials for demand generation Finalise key messages by target population for media advocacy (National, regional, community, outdoor, social and print). Engage media houses as key opinion leader stakeholders to promote MMC in media outlets Develop and produce media engagement materials (fact sheets, question/answer sheets etc.) Develop M&E system to monitor impact of demand generation activities (IEC materials, PSA's, field mobilization) Develop and produce district-specific radio spots (content, language, PSA's, simulated recordings, radio drama's etc.) Print and distribute MMC leaflets, posters/calendars, teardrops, billboards, taxi rank impact signs and banners in all the main languages for target audience Print and distribute newspaper insertions for MMC theme campaigns and school holiday campaigns
Page	***Sub-question 3:*** **What was the level of participation of stakeholders in the work of the VMMC programme to improve uptake of services?**
23, 25, 28, 48, 50, 52, 53	Good practices will be identified and disseminated to enhance governance and coordination initiatives include: strong horizontal and vertical collaboration and coordination across the different administrative levels and among stakeholders; dedicated full-time staff with clear roles and responsibilities; and coordination mechanisms that bring stakeholders together on a regular basis, drive decision making and ensure accountability. Traditional leaders and partners have led demand activities at the provincial and district levels Teams of field mobilisers are able to activate and support males to access MMC clinical services by seeking out those who are eligible and interested in the procedure and linking them to support services. Teams of field mobilisers to be deployed into community settings surrounding available MMC clinical services, and where large numbers of eligible uncircumcised men can be found (workplaces, schools, churches, community gatherings, etc.) The provincial technical teams consist of 3 to 5 members, and are tasked with the responsibility of communicating and monitoring implementation

Appendix 3 – Presentation of raw data on document reviews

Sub-question 1: What was the strategic approach used by the VMMC programme to facilitate stakeholder involvement?

- VMMC plans reflective of a multi-sectoral approach which supports the vision of the DoH, to involve stakeholders to scale up the provision and uptake of services in South Africa.
- Plans developed through collaborative process that brings together government, development partners, and civil society, with various technical skills to strategize for the acceleration of the VMMC programme.
- DoH leads all collaborative and coordination efforts by cooperating partners, who provide advisory, financial and technical support and on-going technical input on strategic decisions and appropriate communication methods.
- Good practices identified to enhance governance and decision-making included strong horizontal and vertical collaboration and coordination across different administrative levels and among stakeholders
- A well-coordinated and strategic approach to decision-making used to bring together the various stakeholders involved in the work of the VMMC programme and DoH leads coordination of efforts by cooperating partners.
- All major decisions regarding VMMC made in consultation with the national VMMC Technical Working Group, which represents the interests of leaders and stakeholders across various sectors.
- A multi-pronged mass media approach supported by a combination of different channels of communication including various interpersonal communication channels, using entertainment education participatory activities such as drama, theatre arts and culture and information delivered using both one-way and two-way communication messages.
- Plans also prioritized engagement with community and traditional leaders, and worked in partnership with the civil society, in close collaboration with provincial and district health authorities.

Sub-question 2: What activities did the VMMC programme and stakeholders conduct to improve uptake of services?

- A joint framework outlines key strategic pillars and activities for the expansion of VMMC to contribute towards the attainment of the Sustainable Development Goal (SDG) of a zero rate of new HIV infections by 2030.
- NDOH conducts regular meetings with provincial VMMC coordinators and established a system whereby provincial coordinators share lessons learned in implementation of the programme, working in partnership with various stakeholders. Lessons learned are incorporated to ensure on-going use of information to achieve the goals of the programme.
- DoH operates with various stakeholders, identifying any potential implementation challenges and engaging key stakeholders to overcome them. Cooperating partners play a critical role providing technical, coordination and financial support. Advocacy efforts ensure engagement with political, community, entertainment, traditional and other stakeholders.
- Good practices identified and disseminated to enhance governance and coordination initiatives across the different administrative levels and among stakeholders.

- A dedicated full-time staff with clear roles and responsibilities; and coordination mechanisms that bring stakeholders together on a regular basis, will drive decision-making and ensure accountability.
- Implementing non-governmental organizations are involved in programme activities, to provide not only VMMC services but also technical input into training, service delivery, research, evaluation, and innovation.
- VMMC field workers from provinces, districts and civil society partners are trained to ensure translation of messages regarding MMC and referral of potential clients for services, and reinforcing messages delivered through mass media, community dialogues and other MMC awareness-raising activities.
- Close coordination among partners also helpful in monitoring achievements towards targets, setting strategic directions, and ensuring accountability.
- Various implementing partners incorporate both mass media and participatory approaches for service delivery - including advocacy, communication and social mobilisation strategies - to increase knowledge about VMMC, address social, cultural and traditional norms and attitudes relating to health interventions that may impede or facilitate the uptake of VMMC.
- Interpersonal communication channels including entertainment education approaches such as drama, theatre arts and culture themes are used to interact with communities, workplaces, tertiary institutions, schools and churches.
- Interpersonal communication channels including entertainment education approaches such as drama, theatre arts and culture themes, as well as radio talk-shows, call centres and face-to-face engagement during community dialogues and focus group discussions, are used to create opportunities for the public to give their views about the services.
- At the national level, DoH drives demand generation via radio and television advertisements, while traditional leaders and partners lead demand generation activities at the provincial and district levels.
- Community media which representative of local interests used to facilitate dialogue with communities through live call-in shows.
- Outdoor media including billboards mobile media are placed in high population transit areas such as commuter junctions, shopping malls and along major transport routes within the vicinity of sites to reinforce messaging delivered through mass media and interpersonal communication channels.
- Communication material such as brochures also distributed to reinforce messages and national resource such as the SMS line, Toll-free Life Line or the HealthSites Website used to refer people to their nearest facility.

Sub-question 3: What was the level of participation of stakeholders in the work of the VMMC programme to improve uptake of services?

- Chaired by NDOH with participation of partner organisations, a national technical working group ensures on-going coordination and collaboration, and to engage women and men, and do referrals to nearby services and follow-ups for surgical procedures and checkups.
- VMMC programme coordinators work with all stakeholders and in close collaboration with districts and provincial health authorities, which results to cost sharing. Administrative structures at provincial and district levels, support implementation and monitoring and evaluation.

- Field mobilisation teams play an important role in reinforcing messages delivered through mass media, community dialogues and other VMMC awareness-raising activities.
- Advocacy activities are conducted to engage gatekeepers including; traditional councils, churches, universities, high schools, workplaces, and sports leagues for advocacy activities are engaged.
- Dedicated full-time staff with clear roles and responsibilities; and coordination mechanisms that bring stakeholders together on a regular basis, drive decision making and ensure accountability
- Provincial advocacy forums convened to train and equip church groups; workshops on development of content of IEC, training for radio spots, and monthly "Demand Creation Group" communication meetings held with community mobilisers
- Primary Health Care teams undertaking home based visits are capacitated to engage women and men around MMC and provide referrals through maintaining lists that can be provided to service providers for follow-up with interested clients.
- Community action teams also render similar tasks with a specific focus to promote the uptake of MMC through engaging with men in communities and maintaining lists of interested clients that can be provided to service providers for follow-up
- Health Care Workers trained around the district hospitals, community health care centers and high volume sites to promote the uptake of MMC as part of their household assessments
- Mobile teams conduct high volume of circumcisions in district hospitals, and community health centres
- Traditional leaders and partners lead demand activities at the provincial and district level
- Teams of field mobilisers support males to access MMC clinical services by seeking out those who are eligible and interested in the procedure and linking them to support services.
- Teams of field mobilisers deployed into community settings surrounding available MMC clinical services, and where large numbers of eligible uncircumcised men can be found (workplaces, schools, churches, community gatherings, etc.) also assist with promotion of MMC.
- The provincial technical teams consisting of 3 to 5 members are tasked with the responsibility of communicating and monitoring implementation and reporting.

Appendix 4 – Presentation of raw data on interviews with communicators

Question 1: Do you participate in decision-making processes for communication campaigns?	
P1	Sometimes, I do participate in decision-making processes when invited to make an input which must relate to my job description but refer decisions with financial implications to my supervisor for inputs. I do not have authority to make decisions with financial implications without a brief from my supervisor.
P2	I am indirectly involved with the VMMC programme. I often accompany my supervisor to attend planning meetings for events or to represent my supervisor. My inputs on decisions are guided by a brief from my supervisor. I have no influence on decisions. My involvement is limited to a brief or my job description.
P3	I attend meetings to provide inputs on communication support. My authority to make decisions is limited to my job description. My involvement also extends to strategy planning and formulation of communication plans, but I was not involved in the development of the V MMC strategy. I assist to distribute messages to the pubic but I do not participate in writing those messages. We use mass media to communicate to the public and external partners assist with advocacy and social mobilisation work.
P4	I attend meetings and make inputs on issues relevant to the brief. The authority I have to make decisions is related to my job descriptions. I refer technical decisions and those with financial implications to my supervisor. I also help with information distribution during communication campaigns. My involvement in content development is through formulation of media alerts or media statements based on information supplied to me by the programme and the final copy must be approved by my supervisor before distribution.
Question 2: How do you access information about health campaigns and which channel do you prefer to receive information?	
P1	Internal communication channels including internal magazine, screen-saver messages, email group messages and pop-up messages, Intranet, Website and social media platforms, are also used to share information with staff. These channels do not permit feedback from staff. Email surveys are used for staff surveys but this is also restricts interaction on general issues. I would prefer a meeting.
P2	Information about communication campaigns was easily accessible if you were involved with that campaign. The newsletter is very useful to distribute information about campaigns, and meetings are very empowering in terms of access to information and engagement. But, we need to use to develop a link on the Intranet where internal information such as strategies including communication plans, progress reports and presentations to management meetings could be uploaded to improve access to information on various campaigns and management decisions.
P3	There are many ways of getting information about what is going on in the department but the most useful channel would be to attend a staff meeting or receive feedback on management meetings. Information on other people's campaigns is not easily accessible unless you are involved with that campaign.
P4	My involvement in any campaign is limited to my job description or a brief of my supervisor. I want to be involved more in writing and testing messages. This will increase my access to information and efficient use of my writing skills.
Question 3: Were you involved in the development of strategies for VMMC communication campaigns?	
P1	No, I was not involved. Development partners developed the strategies but my supervisors were invited to make inputs.
P2	No, I was not involved but was requested to support the HCT and Calendar Health campaigns through an exhibition which also included distributing information about VMMC.

P3	No but I was aware that a high level meeting took place to develop the strategy with the support of development partners.
P4	No. The VMMC programme relied on external technical support to develop the strategies, as well as for the production and dissemination of messages to create the demand for the services. I have supported a number of campaigns where material on VMMC was distributed but I did not have a specific role that related to assisting the VMMC programme.

Appendix 5 – Presentation of raw data on interviews with programme managers

Approaches and platforms used to engage stakeholders?	
P 1	• A multi stakeholder technical structure involving VMMC funders, implementing NGOs, service demand generation partners, etc) held monthly **meetings** to consult on decisions, review progress and share lessons learned and challenges experienced. • Technical committees for quality assurance, monitoring and evaluation, demand generation, research developments, etc., were used to engage cooperating partners. • Annual multi-stakeholder meetings (involving private implementers like medical schemes with GPs, provinces, Traditional initiation guardians, i.e. house of traditional leaders and CONTRALESA were held. • Electronic **media campaigns** (Radio & TV adverts and interviews including talk-back shows. print media, etc) were used • Programme campaign launched outreach **events** involving Minister, Deputy President, etc, to engage communities on updates and feedback. • Stakeholder involvement happens from planning stages and throughout implementation and through feedback sessions (the degree of involvement is from **planning to delivery**).
P2	• The Department held **meetings** to engage stakeholders on implementation and to review implementation of activities to achieve communication goals such as to increase the uptake of services. • We conducted **outreach campaigns** to raise awareness and distribute information. • We involved partners during the **early planning stages** to consult on campaign ideas because they possess scientific knowledge on what works and does not work, and their inputs were based on scientific methods on how to reach the national targets.
P3	• **Technical meetings** were used for planning and sharing of scientific knowledge, and to review implementation and discuss new interventions. **Community dialogues** were conducted to consult on decisions and give feedback on services. • We involve them during **planning stages and throughout the campaign** so that they could assist with evidence-based communication approaches to attain our communication objectives. We use consultation and planning meetings to solicit their inputs and technical advice.
Level of their participation	
P 1	▪ Monthly technical meetings are used to **shared experience** and ideas about demand generation mechanisms ▪ Communication partners and researchers **provided feedback** about gaps in our messages, effective communication mechanisms ▪ Funded demand generation NGOs assisted with the **mobilisation of communities** to utilise available services ▪ **Engagement of gatekeepers** such as traditional leadership also help with mobilizing of communities ▪ Engagement of **VMMC implementers** in other countries share ideas and **lessons learnt** regarding what works
P 2	▪ The VMMC is a **partner-driven** initiative, and the Department provides oversight on all collaborative efforts and introduced campaign concepts by defining and communicating the need and the benefit of each campaign to stakeholders for **technical inputs** on what worked and did not worked. After deliberating, negotiating and trying to reach consensus on best practices, partners help to formulate **evidence-based** communication plans and messages. ▪ Partners also assist to conduct **needs analysis** to inform all planning and implementation, they do so by desktop research or direct interaction with communities who were affected. Not all communicators possessed the necessary **communication expertise** but communication objectives could be achieved by working with development communication experts or outsourcing some of the communication functions to get the best possible results.

P3	• Communication is a support service that cuts across many programmes, which compels us to work with different people within and outside the Department. In this way, we learn from each other by **sharing experiences** and knowledge, which helps to redefine the way we do things. Campaigns such as VMMC are driven by teamwork. • Work-streams are therefore identified and tasks allocated according to job descriptions and expertise, and engagements with stakeholders assist to address knowledge and **skills gaps** within the Department. So, we partner with external experts to augment a lack of scientific knowledge in communication and behaviour change methods within the Department. • Representation of all affected parties in decision making processes or implementation, is beneficial in terms of **buy-in**, ownership of decisions, support for implementation and **accountability**. Stakeholders also assist with **expansion of services** and monitoring and evaluation of implementation. Stakeholders also assist with formulation of **evidence-based strategies and messages**, as well as with outreach community campaigns and with testing messages with communities before production and distribution of communication materials. • Communication partnerships assist to address the shortage of skills and **limited funding**. The external partners also assist with **social mobilization** to empower people with knowledge and to ensure that they act on that knowledge. Communication platforms are created to achieve this and to engage the public through dialogues. Community participation in policy processes and decisions that affect their lives is a fundamental human right, which is protected by the Constitution. Programmes also benefit from these processes through increased buy-in and ownership of ideas. It is important though to consider people's lifestyle, culture and socio-economic conditions when engaging them, because these could pose obstacles to stakeholder engagement. One should also be mindful of the fact that women and men sometimes need to be consulted separately, because culture does not allow women to speaking in a gathering of men. Field work experience and research assist with **effective methods** of stakeholder engagement and promote the **inclusion of the voiceless** in decision-making processes. • Participatory approaches allow all stakeholders including communities to be partners in the implementation of programmes in their communities. It also assist **effective consultations** on campaign including planning, identification of appropriate communication channels, conducting needs analysis, testing messages and formulation of evidence-based plans. • So, our stakeholders are **technical experts** as well as receivers of communication messages, and they all have a role to play, in the achievement of communication objectives.
	Approaches and platforms for community mobilisation
P1	• Social mobilisation teams across different provinces have foot soldiers doing **door to door** • Community mobilisation partners, for example; Brothers for Life, run **community awareness** and education campaigns where direct engagement with men happens • Utilisation of VMMC champions, that is; men who underwent medical circumcision share experience and **recruit other men** • **Partnership with traditional leaders** ensure continued community representation • **Funding of civil society structures** promotes direct community involvement for inputs **Consultation with communities** in areas targeted for VMMC services

P2	• Social mobilization: - Activities are conducted to disseminate information and to interact with communities. **NGOs are contracted to do advocacy**, communication and social mobilization, in consultation and partnership with the DoH as well as provinces and districts. We rely on **outreach campaigns** to mobilize and engage communities. For example, in KZN, they conducted **youth camps** with the targeted audience, to impart knowledge and to get feedback from the public. In these camps, a number of activities were conducted, as well as dialogues, and provision of comprehensive health services on-site services **including health screenings** for HIV, TB, and other communicable diseases, to promote healthy living. We distributed IEC materials at these events, to empower communities to make informed decisions about their health. • Media: - Various media channels including digital and outdoor media, both national and **community media** are used for public awareness. More emphasis is on community media to mobilize communities through radio adverts and **radio call-in shows**, and to create access to the media for the public, in order to for them to air their views and engage policymakers. We worked in partnership with GCIS, through their 60+ community radio stations, to increase reach and coverage of our target audience. • Events: - We **utilize DoH's calendar and publicity events**, as well as participate in health exhibitions, under the HCT umbrella, of which MMC is a component. The provision of comprehensive HIV and AIDS services, include the MMC. We targeted these events to increase our visibility and to provide both communication materials and on-site services, which included counselling and testing for TB, HIV and other lifestyle conditions such as high blood pressure. During these activities, we also involved not only our implementing partners and NGOs, but also benefited from our **long-standing partnerships** with the private sector and institutions of higher education, to provide on-going workplace and on-site awareness campaigns and health screening services. We conducted outreach campaigns as build up to a national event, such as the World AIDS Day. • Implementing partners, who include development partners and NGOs, support the Department with the production and **distribution of IEC materials** through various communication channels, such as community events, exhibitions, radio, TV and social media, etc, as well as on the NGO sector to engage with communities. • We also **funded radio drama and edutainment activities**, and **radio interview campaigns** to maximise our impact. We have a **cadre of community health teams** (for example Ward-Based Outreach Teams [WBOTS] in Gauteng), who support our national communication, advocacy and social mobilization efforts (ACSM) efforts. We also have **task teams**, to help plan community events, in **partnership with implementing partners**. • As this is a partner-driven campaign, stakeholders drive the information, communication and education campaigns for VMMC and other campaigns, and we provide oversight to ensure coordination and alignment of all efforts with national priorities.

P 3	• We support all health campaigns, but always **involve external partners** to effectively communicate. The department adopted an **integrated perspective to communication**, which includes stakeholder engagement, to ensure access to information and increased knowledge levels, and communication cohesiveness, coordination and synchronisation of public information activities. • A well-coordinated communications and media strategy help to inform the public about health services and avail **mass media platforms** to give them an opportunity to comment on service delivery and on their experience on how best these services can be improved. • The Department's new approach integrated strategic **approach is people centred** and facilitative. It encourages communities to be active participants in finding solutions to their problems. In this way, we can take properly informed decisions based on public feedback and ensure that our services are well anchored in and are accountable to the communities we serve. This entails both one-way and two-way communication channels. • This approach encourages interaction with target communities, through various means including **radio call-in shows** and **TV talk-shows,** and **interaction through social media** forums, such as Facebook and Twitter. One of the key measurable objectives of the integrated approach related to the participatory approach is design and deliver communication that speaks to stakeholders; **dialogue effectively with stakeholders** to learn what is important to them; **work with stakeholders** to identify the key **strategic messages** to achieve communication goals, and to listen to the public and provide them with opportunities to voice their concerns and influence decisions and service provision. • In order to carry out our constitutional responsibility of developing public health policies properly, we have to **engage and communicate with communities** and other stakeholder in the healthcare sector. • So, I have no confidence in any strategy or campaign that **targets communities** but does not involve them in the processes of decision-making, whether directly by going out to the communities to talk to people or indirectly by consulting community leaders who should also consult with their constituencies to ensure proper representation of their interests and fears. We can only achieve our goals from understanding people's experiences on what works or does not work for them. • When you impose something on people without consulting or involving them, you are in violation of their human rights. It is their constitutional right to have a say about decisions that are going to affect their lives. Of course, it is not possible to **consult or engage everybody** on everything and at all levels of the programme or campaign, which is why one should establish task teams and forums to represent various sectors directly or indirectly affected who should also ensure that decisions are made in consultation with those they represent. • It is important to **consult and engage communities** because of our diverse cultural differences, which means that what works for one province, district or community may not work for the other. While men are the target audience for VMMC, **women, are very influential on decisions** on whether to circumcise or not. So, our messages should address them as enablers as well as possible inhibitors. Therefore, when educating men, women should be included as well as because they are part of the equation.

Appendix 6 – Presentation of raw data on interviews with development partners

1. Involvement in the development of VMMC strategies:

CHAPS	• Yes, we were involved on an **advisory capacity**. We attend the strategic planning meetings and our advice has heavy weight **as a major implementing agency**. o Service Delivery, Research, QA, Capacity Building, Demand Creation
CCI	▪ CCI through our former CEO, was involved in the development of the strategy for the MMC programme. Our involvement was mainly on an **advisory role** on demand creation and communication strategy to improve the MMC uptake.
SCI	▪ No were **not involved** in the development or revision of the VMMC strategy
CMT	• Yes, we were involved in the revision and consultation focusing on creation of demand and strengthening community mobilisation **as the lead demand creation partner** of the TB and HIV Consortium.

2. Provision of advisory and technical support

CHAPS	• Performed approx. 400,000 circumcisions since 2010 - Service Delivery – clinic coverage and penetration along with enhanced span of GP providers and QA on all. - Capacity Building – Training program - M&E - Research - New methods such as non-surgical (Prepex/CircumQ), EIMC, and the efficient use of Mobile Clinics. o Also piloted PrePex and EIMC
CCI	▪ CCI has been developing campaigns to drive demand creation since 2011, 2012, using the mass media and interpersonal communication channels such as community dialogues, focus group discussions, etc to help improve the uptake of the MMC services. ▪ CCI, supports MMC programme through the implementation of the demand creation strategy, using the USAID grant. Our approach is informed by a social ecology model (P-Process) when we interact with individuals, peers, families and communities. ▪ To implement the P-process approach, we use formative research to do situational analysis to understand to understand the environment that influences men's decisions to circumcise or not to circumcise, that is; challenges and enablers of MMC uptake. ▪ These strategies also cover the P-Process which supports evidence-based communication and participation [other partners, beneficiaries, communities, etc in processes and efforts to empower them with information]. ▪ The P-Process is a 5-step-by-step guide to strategic communication, and includes; inquire, design strategy, create and test, mobilise and monitor, and evaluate and evolve, to fulfil a requirement that strategies must be based on **theory** and to involve **participation** of stakeholders and **build capacity**. This road map guides you from a loosely defined concept about changing behaviour to a strategic and participatory programme that is grounded in theory and has measurable impact. ▪ We use strategic communication which is supported by mass media and interpersonal communication channels; such as community dialogues, focus group discussions, etc, with a strong outdoor media presence, to help improve uptake of MMC services. Our approach was informed by a social ecology model (P-Process) when we interacted with individuals, peers, families and communities. ▪ The campaign to drive demand creation is supported by mass media activities and interpersonal communication to engage communities. We used mass media as a point of kicker (to introduce the message) for conversations and to establish knowledge base for meaningful discussions. We then went out to the communities to conduct focus group discussions and road-shows to add the local voice.
SCI	▪ We making use of mass media communication vehicles that span prime-time TV, radio drama across all languages and high quality glossy booklets, the internet and new media ▪ We used the TV cut-down DVD with stories about MMC and questions to stimulate discussion and learning about MMC. It worked well as an edutainment vehicle to engage men and their mothers and partners. We still have a DVD with stories about MMC and questions to stimulate discussion and learning. ▪ In the past, we promoted MMC through our television series and holding community dialogues in communities to discuss the value of MMC. We developed a fact sheet on MMC. We also held radio talk shows. This, however, was terminated in 2013 when the funding ran out.
CMT	▪ CMT was supported by the Centre for Disease control in 2015/2016 to **increase uptake** of VMMC in the Eastern Cape and Kwa-Zulu Natal.

	- **CMT's current VMMC work for 2016 - The Soka Campaign** Soka is specifically aimed at two districts in Kwa-zulu Natal using demand creation and social mobilisation. CMT has developed, tested and implemented the Soka campaign in Ethekweni and Umgumgungdlovu districts and campaign elements consists of mobilisers working in communities, branding, outdoor media, radio and an active social media campaign. This campaign is targeted at older men (over 24) – with a specific focus on men aged between 24 and 36 and aims to reach both Living Standards Measures (LSM) 1-4 and 5-8 and will popularise and increase demand for VMMC. All media elements of Soka use a "please call me" number to refer potential clients to our partner CareWorks which offers more information via a call centre and makes bookings for circumcisions. - CMT used the following communication elements to increase demand for uptake of VMMC: Branded mobilisers in the communities engage with community members directly at Soka events or community engagements, which allows the community members to ask questions, receive the latest educational and scientific information on VMMC in a way that is practical and easy to understand. Soka mobilisers also distribute branded fact sheets, pamphlets and condoms. The use of condoms is always an important part of CMT's VMMC communication. ▪ **CMT's future VMMC work:** CMT is part of a consortium which is led by TB HIV Care, funded by CDC, which will be continuing work in VMMC as the lead demand creation partner over the next five years. CMT will continue to work with the consortium and all relevant partners to design, develop, implement, evaluate and monitor a demand creation campaign to increase the uptake of VMMC.

3. Strategic approaches for community mobilisation to support VMMC

CHAPS	• We are a part of the CAB (Community Advisory Board) through CHAPS representatives • We take a multi-pronged to communications and demand creation. Utilising both local and national channels of communication, as well as workshops, community dialogues, house visits, TV and radio talk-shows. • We have close relationships with local leaders where required i.e. TMS in relevant districts. We used social mobilisation through targeted interventions to disseminate information and increase positive public perception. • We used MMC brand ambassadors to sensitize communities in which we work with. • We used local broadcasting and print material. Recruiter/community health workers implemented targeted campaigns at schools, taxi stands, prisons, hostels.
CCI	▪ CCI, supports MMC programme through the implementation of the demand creation strategy, using the USAID grant. Our approach is informed by a social ecology model (P-Process) when we interact with individuals, peers, families and communities. ▪ To implement the P-process approach, we use formative research to do situational analysis to understand to understand the environment that influences men's decisions to circumcise or not to circumcise, that is; challenges and enablers of MMC uptake. ▪ These strategies also cover the P-Process which supports evidence-based communication and participation [other partners, beneficiaries, communities, etc in processes and efforts to empower them with information]. ▪ The P-Process is a 5-step-by-step guide to strategic communication, and includes; inquire, design strategy, create and test, mobilise and monitor, and evaluate and evolve, to fulfil a requirement that strategies must be based on **theory** and to involve **participation** of stakeholders and **build capacity**. This road map guides you from a loosely defined concept about changing behaviour to a strategic and participatory programme that is grounded in theory and has measurable impact. ▪ We use strategic communication which is supported by mass media and interpersonal communication channels; such as community dialogues, focus group discussions, etc, with a strong outdoor media presence, to help improve uptake of MMC services. Our approach was informed by a social ecology model (P-Process) when we interacted with individuals, peers, families and communities. ▪ The campaign to drive demand creation is supported by mass media activities and interpersonal communication to engage communities. We used mass media as a point of kicker (to introduce the message) for conversations and to establish knowledge base for meaningful discussions. We then went out to the communities to conduct focus group discussions and road-shows to add the local voice.
SCI	▪ In the past, we promoted MMC through our television series and holding community dialogues in communities to discuss the value of MMC. We developed a fact sheet on MMC. We also held radio talk shows. This, however, was terminated in 2013 when the funding ran out. ▪ We trained other implementing partners in media advocacy and encouraged the partners to engage with their audience in the discussions. Community dialogues were held with the community to increase understanding and awareness of MMC. We also held jamborees bringing services to distant

	communities among these were enrolling men and boys for MMC. ▪ We used the TV cut-down DVD with stories about MMC and questions to stimulate discussion and learning about MMC. It worked well as an edutainment vehicle to engage men and their mothers and partners. • We develop education material through research and evaluation involving the communities we serve.
CMT	▪ CMT works closely with all other PEPFAR partners and provinces. In the continued work on VMMC through the consortium led by TB HIV Care, CMT will work with the consortium to plan the VMMC demand creation overarching campaign strategy and design. ▪ Focus group discussions will be held in the 5 target provinces which will inform and test brand name, look and feel, campaign materials, messaging etc. ▪ All CMT's work across all campaigns, media and mobilisation is carefully monitored and evaluated and these are documented in our reports to funders. ▪ We used the mass media approach and interpersonal and participatory channels with an emphasis on TV documentaries. The model of using field mobilisers and call centre to recruit and link up men with services by making bookings and follow-ups was a major success in terms of numbers recruited into the programme. ▪ Three community radio stations were identified, and live-shows happened every Wednesday, every Thursday and every Monday for a month. Outreach teams conducted door to door campaigns and large community awareness events and follow-ups made through the call centre to link them to MMC service providers, All logo design, images, colours and slogans to create demand including the name of the campaign were tested with target audience and relevant community members using focus group discussions, as well as regular consultation with the DoH and community leaders in two province.

4. Activities implemented to support VMMC

CHAPS	• Social mobilisation through targeted interventions to disseminate information and increase positive public perception. • Use of MMC brand ambassadors to sensitize communities in which we work with • Local broadcasting and print material • Recruiter/CHW implemented targeted campaigns at schools, taxi stands, prisons, hostels • Close relationships with local leaders where required ie. TMS in relevant districts.
CCI	▪ In 2015, we conducted community dialogues, focus group discussions involving both men and women, and other local stakeholders (such as traditional authority, organised community structures, community-based organisations, etc). Thereafter, we presented our ideas and findings to our creative agency, to advise on the best approach to use to achieve our ideas, and we went back to the communities (target audience) to pre-test ideas before we finalised planning a campaign. ▪ Recently, we also conducted a campaign involving women, because from our initial research we found that **women were influential in decisions** on whether to circumcise or not, and not just any woman, but those that men have long-term relationships with and respect. Our communication material, images and voices then included women. In our initial campaign, we sought to create awareness targeting men, and a male voice and image drove this approach. As the campaign matured, women got roles to play in helping to increase the MMC uptake. So, men are our primary audience, and women our secondary audience. ▪ The campaign to **drive demand creation** is supported by mass media activities and interpersonal communication to engage communities. We use mass media as a point of kicker (to introduce the message) for conversations and to establish knowledge base for meaningful discussions. We then go out to the communities to conduct focus group discussions and road-shows to add the local voice. ▪ According to the evaluation of our campaigns, there is direct linkage to the MMC uptake. ▪ Knowledge levels have also increased. For example, only **8%** talked about MMC and risk reduction in our initial research, and in 2012, the knowledge levels increased to **42%.** ▪ CCI work very closely with official from the NDoH on demand creations, through meetings and work sessions. These processes can **address knowledge gaps** within the DoH if any exists about development communication or how to implement this phenomenon through participation and communication. While CCI assists the DoH with technical support, we also learn A LOT from the DoH officials. This exchange of knowledge through meetings and working together is **empowering for both parties**. ▪ There are also **opportunities for training** on communication strategies, from which the DoH officials can benefit. These strategies also cover the P-Process which supports evidence-based communication and participation [other partners, beneficiaries, communities, etc in processes and efforts to empower them with information].
SCI	▪ We make use of mass media communication vehicles that span prime-time TV, radio drama across all languages and high quality glossy booklets, the internet and new media ▪ Television, radio, print booklets, dialogues, community jamborees including youth camps. ▪ We trained other implementing partners in media advocacy and encouraged the partners to engage with their audience in the discussions.

	▪ Community dialogues were held with the community to increase understanding and awareness of MMC. We also held jamborees bringing services to distant communities among these were enrolling men and boys for MMC ▪ Using a range of advocacy tools, including research, media, lobbying and social mobilisation, SCI advocacy programmes focuses on: • Focused advocacy campaigns. • Ongoing media advocacy to place health and development issues on the public agenda. • Advocacy training for NGOs and other civil society groupings with a focus on how to deal more effectively with the media. • Working with journalists to enhance media coverage of health and development issues.
CMT	▪ In 2015, CMT worked closely with all other PEPFAR partners and Provincial DOH on design and testing of the men's campaign. This campaign was initially developed as **"Man Up"** which was tested through focus group discussions with circumcised and uncircumcised men. It was well received and resonated with both groups and a logo plus taglines were selected. However, when this was presented to KZN Dept of Health where the campaign was due to rollout, there was concern expressed that Man Up had no direct isiZulu translation and the campaign was tweaked to SOKA / Circumcise. CMT is hoping to still roll out Man Up in other provinces with a future MMC demand creation grant, but this will be subject to further focus groups discussions and testing in different provinces. All logo design, images, colours and slogans were tested in both English and isi-Zulu with target audience and relevant community members in focus group sessions run by CMT, as well as regular consultation with DOH and community leaders in KZN. ▪ We also focused on demand creation and strengthening community mobilization aimed at two districts in KwaZulu-Natal and Eastern Cape. Campaign elements consists of mobilisers working in communities, branding, outdoor media, radio and active social media with specific focus on men aged between 24-36. All media elements of the campaign use a **'"please call me"** number to refer potential clients to our partner for more information via a call centre to book circumcisions, designed developed, implemented, evaluated and monitored the campaign to increase the uptake of VMMC. Radio live shows, at least one show on each station making use of documentary insert to introduce the topic and community journalists used to discuss the topic with a content expert guest from DoH. Telephone lines were opened for listeners to call in and ask questions and reached 1 013 000 listeners and have them answered and others sending questions by SMS and "What's App". Three community radio stations were identified, and live-shows happened every Wednesday, every Thursday and every Monday for a month. Two news articles were placed seven newspapers in English, isiXhosa and isiZulu, in approximately 88 000 copies in 2015. Public service announcements (PSAs), were written, recorded and broadcasted only in isiZulu, reaching approximately 240 000 listeners and approximately 561 responses were processed by the call centre in 2015. Outreach teams conducted door to door campaigns and large community awareness events and follow-ups made through the call centre to link them to MMC service providers, and reached 51 725 people with messaging on MMC and referred 6 801 men to MMC services. Digital marketing and social media was conducted and reached 233 653 which resulted in 779 "please call me" requests. A flip chart and training manual was produced for all VMMC mobilisers and partners. The campaign will be expanded to other provinces, and again focus group discussions conducted to inform and test brand name, look and feel, campaign materials, messages, etc. ▪ **Mass media campaign** - In 2015, CMT implemented the following demand creation activities for VMMC in the Eastern Cape and Kwa-Zulu Natal under our Siyayinqoba brand. The radio stations jointly have a reach of **1 013 000** listeners: - **Live radio shows** At least one show on each station for this season was dedicated to VMMC. The format of the live radio show makes use of the documentary insert to introduce the topic. CMT's Community Journalists discuss the topic further with a "Content Expert" guest who is usually from the Department of Health. The telephone lines are then opened for listeners to call in and ask questions and have them answered. The show lasted 30 minutes and listener response is usually good with many people calling in or sending questions via SMS and What's App. One show per station on the topic of MMC took place in the month of June for the following stations: o UCR FM, Inkonjane Radio and UMgungundlovu FM - – 25 March 2015 at 17h30 and every Wednesday thereafter o Vukani Community Radio and Alfred Nzo Community Radio – 26 March 2015 at 17h30 and every Thursday thereafter o Izwi Lomzansi FM – 30 March at 10h05 and every Monday thereafter. - **Newspaper articles -** Two articles on MMC were written. One was in isiXhosa and was placed in five community newspapers in the Eastern Cape. The other was in isiZulu and was placed in a newspaper in KZN. The articles were published in the following publications: o **Isolomzi Fever -** Covers the Butterworth, Cala, Centane, Cofimvaba, Elliot, Idutywa, Ngcobo, Nqamakwe, Tsomo and Willowvale areas **19 872 copies** o **Uvo Lwethu Fever -** Coverage is Lusikisiki, Bizana, Flagstaff, Mount Ayliff, Mount Frere,

	Ntabankulu and Port St Johns **19 912 copies** o **Mthatha Express** - Covers Mthatha, Elliotdale4, Libode, Mqanduli, Ngqeleni, Port St Johns, Qumbu, Tsolo **59 987 copies** o **Ikwezi Kokstad** - Covers Kokstad and surrounds **5000 copies** o **Ikwezi Lase Mthatha -** Covers Mthatha and surrounds **2500 copies** o **Maritzburg Echo** - Covers Pietermaritzburg, Camp's Drift, CBD, Dlaba, Dorpspruit, Ezithandeni, Foxhill, Happy Valley, Mason's Mill Industrial, Imbali, Sweet Waters & Willowfountain **34 699 copies** - **Public Service Announcement (PSA) -** A new public service announcement (PSA) was written for MMC in 2015. It was recorded and broadcast only in isiZulu on Izwi LoMzansi (Durban, KZN with a listenership of **181 000)** and **u**Mgungundlovu FM (Pietermaritzburg, KZN with a listenership of **59 000).** The PSA was aired in September and October 2015. ▪ **Social Mobilisation:** CMT's outreach teams in OR Tambo and Alfred Nzo in the Eastern Cape and EThekwini and UMgungundlovu in KZN include demand creation for MMC during ongoing social mobilisation activities (door to door campaigns and large community awareness events). All MMC leads in KZN are written up on the CareWorks lead register and submitted to CareWorks to follow up through their call centre in order to link them to MMC service providers. In the Eastern Cape, any males interested in taking up MMC are referred directly to TB/HIV Care Association. Over Year 4 (Oct 2014 through to Sept 2015) CMT reached **51 725** people with messaging promoting MMC and referred and linked **6 801** men to MMC services. Given the significantly reduced award allocated for Year 5, CMT has had to exit from the Eastern Cape at the end of September 2015 and all outreach activities in year 5 will focus on the 2 districts in KZN. ▪ **Materials development and Outdoor media -** CMT produced a host of IEC materials, experiential media such as gym towels and caps and outdoor media such as branded taxi's, billboards, street pole posters and branded DOH mobile clinic trucks under the Soka brand. ▪ **Radio -** CMT produced radio Public Service Announcement (PSA) focusing specifically on VMMC, with its own Soka tag lines and identifiable music / jingle which urged listeners to call the dedicated Soka number for more information or to make a booking. Three radio PSAs – made in English and isiZulu, but broadcast in Zulu only on Ukhozi FM and 4 Community Radio Stations (Umgungundlovu FM, Iswi Lomsanzi, Inanda FM, Jive FM.) A total of **433** unique numbers were processed by the call centre in July and 117 so far in August. ▪ **Digital Marketing and Social Media -** CMT managed a digital marketing and social media element of the Soka campaign, which includes content generation, purchasing of appropriate digital advertising space for our target audience, daily monitoring of comments and questions and urging users to leave the their details to be contacted for more information, or make a booking via a link. The social media campaign included Facebook, Twitter and the Siyayinqoba website. CMT managed to reach the target audience as well generate discussion and increases impressions and site visits across all platforms, for example in the period 25 July – 2 September the Facebook advertisements reached **233 653** results and **779** forms for call centre were filled in online. All of the above campaign elements will be used in our future work as part of the consortium led by TB HIV Care, with the addition of a demand creation flip chart and training manual for all VMMC mobilisers and partners to use.

5. Successes

CHAPS	• Ground breaking Orange Farm Research project laid the foundation for the MMC sector. • **Increased clinic coverage** to approx. 80 clinics/sites in 6 short years • **Strong relationships** and membership with leading implementing agencies in our Consortium with RTC, Match, CHAPS has resulted in efficient **resource sharing** and **heightened capacity** for demand creation • Have received **great support from key stakeholders** on a national, provincial and district level. • We performed approx. **400,000** circumcisions since 2010. We conducted service delivery which involves clinic coverage and penetration along with enhanced span of general practitioners (GP) providers and quality assurance on all. • We have a **training progr**amme for capacity building, and conducted monitoring and evaluation, as well as research for new methods such as non-surgical (Prepex/CircumQ), EIMC, and the efficient use of mobile clinics. We also piloted PrePex and EIMC • We used **social mobilisation** through targeted interventions to disseminate information and increase positive public perception. They benefited through sharing of knowledge.

CCI	• According to the evaluation of our campaigns, there is **direct linkage** to the MMC uptake. • **Knowledge levels** have also increased. For example, only **8%** talked about MMC and risk reduction in our initial research, and in 2012, the knowledge levels increased to **42%.** ▪ CCI work very closely with official from the NDoH on demand creations, through meetings and work sessions. These processes can **address knowledge gaps** within the NDoH if any exists about development communication or how to implement this phenomenon through participation and communication. While CCI assists the NDoH with technical support, we also learn A LOT from the NDoH officials. This exchange of knowledge through meetings and working together is **empowering for both parties**. • There are also **opportunities for training** on communication strategies, from which the DoH officials can benefit. These strategies also cover the P-Process which supports evidence-based communication and participation [other partners, beneficiaries, communities, etc in processes and efforts to empower them with information].
SCI	• Our 11th television series was successful in dealing with MMC and **engaged audiences** in some of the discussions and debates that were happening at the time. Use of the TV cut-down DVD worked well as an edutainment vehicle to engage men and their mothers and partners about MMC, and **dispelling the myths**. • We used the TV cut-down DVD with stories about MMC and questions to stimulate discussion and learning about MMC. It **worked well** as an edutainment vehicle to engage men and their mothers and partners • We continue to **supply MMC booklets** where we hold jamborees and to those asking for them, we also have some DVD's available. ▪ In the past, we promoted MMC through our television series and holding community dialogues in communities to discuss the value of MMC. We developed a fact sheet on MMC. We also held radio talk shows. This, however, was terminated in 2013 when the funding ran out. ▪ We **trained other implementing partners** in media advocacy and encouraged the partners to engage with their audience in the discussions. Community dialogues were held with the community to increase understanding and awareness of MMC. ▪ We also held jamborees **bringing services to distant communities** among these were enrolling men and boys for MMC.
CMT	▪ CMT has mainly experienced successful work in VMMC work in KZN, where the issue of medical male circumcision is not as contentious as in the Eastern Cape for example. In the past we had issues of creating demand, but not having enough availability of services in communities, but this model of using the Careworks call centre to make booking and direct clients to the most suitable service provider is showing results. • CMT's radio work on VMMC on both regional and **community radio has shown results quickly**, CMT has received positive and negative responses to the radio PSAs. The high number of "please call me's" sent **(1198)** in about 6 weeks of which only 24 were already circumcised shows the PSAs are on target and **reaching the intended audience**. We have had some challenges with complaints to the Advertising Standards Authority objecting to one of our PSA's, saying it will promote experimentation among young people. • Our campaign was developed and its name, logos tested through focus group discussions with circumcised and uncircumcised men. The name of the campaign reflected the language of the target audience. **Communities were empowered** through the sharing of knowledge in their own language and participation in face-to-face dialogues and discussions. A flip chart and training manual was produced for all VMMC mobilisers and partners.

6. Challenges

CHAPS	• Late adopters • Traditional Sector infiltration • Broadened age pivot • **Slight saturation** in initial targets now leaves us with the low hanging fruits.
CCI	• **Resources are declining** to fulfil our mandate. We are not only focussing on MMC but on other health programmes as well. We need to strike balance. • In the SA context, awareness about MMC is there but we need to link this awareness to challenges on the ground, so that is speaks to **men's challenges** that prevent them from circumcising. • The services offering MMC are also not enough. We receiving complaints that people have to walk **long distances** to reach the nearest services, and still join long queues, and then there is still negative attitudes towards medical circumcision. We need to convert the knowledge that is already out there into action. • There is a **culture of circumcising** only in winter in SA, and we need to shift that habit so that men can access services for MMC throughout the year, and not only in winter.
SCI	• Less successful was working through the PEPFAR Programme with their partners to encourage **enrolment into MMC programmes**. This was because the funding was very limited and we had to rely

	on the partners to implement many aspects of the programme. ▪ In the past, we promoted MMC through our television series and holding community dialogues in communities to discuss the value of MMC. This, however, was terminated in 2013 when **the funding ran out.**
CMT	▪ CMT has often experienced issues of **timing of deliverables**. **Stakeholder engageme**nt is important and necessary in order to implement accurate and useful communication campaigns, but they often take time and partners do not always respond with feedback timeously and CMT is under pressure to roll out the campaign in set time frames.

ANNEXURES

Annexure A Director-General's response to a request to access VMMC programme documents to review, and to speak to health officials and visit a health facility

DIRECTOR GENERAL
HEALTH
REPUBLIC OF SOUTH AFRICA

PRETORIA
Private Bag X828, PRETORIA, 0001 Civitas Building, Cnr Thabo Sehume & Struben Street, PRETORIA, 2001 Tel: 012 395 8000, Fax: 012 395 8422
CAPE TOWN
P.O. Box 3875, CAPE TOWN, 8001 9th Floor, Room 912, 120 Parliament Towers, Plein Street, CAPE TOWN, 8000 Tel: 021 461 1111, Fax: 021 461 8854

Dr Y Pillay
Head: HIV/AIDS, TB and Maternal, Child and Women's Health
National Department of Health
Private Bag X828
PRETORIA
0001

Dear Dr Pillay

PERMISSION TO REFER TO THE DEPARTMENT'S VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) PROGRAMME FOR ACADEMIC STUDY TO BE CONDUCTED BY MS C BHENGU IN 2016

The National Department of Health (NDoH) acknowledges the receipt of a request for approval to conduct a study on *The importance of participatory communication for the voluntary medical male circumcision (VMMC) project in Alexandra Township, Gauteng.*

In view of the above, kindly assist Ms C Bhengu with necessary project documents for her analysis of progress made thus far to achieve set project goals, including allowing her access to reports on the Strategic Plan for the Scale up of Medical Male Circumcision 2012-2016 as well as the project's communication strategy and its operational plans to assist the creation of demand for the service. In addition, kindly recommend relevant persons within the NDOH and key implementing partners for in-depth interviews about the implementation of the Strategic Plan.

Please note that this approval is subject to any other condition that the MMC programme managers of the NDoH may impose. Permission to present findings of this academic study or publish data from the study for other purposes other than to complete the Master's degree in Development Communication with Wits University, should be sought with the NDoH first.

Submission and presentation of the final report of the study with recommendations to the NDoH as feedback is crucial and encouraged.

Yours sincerely

MS MP MATSOSO
DIRECTOR-GENERAL: HEALTH
DATE: 04/02/2016

Annexure B Support letter from Head of Communication in the national Department of Health

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

Private Bag X828, PRETORIA, 0001 Civitas Building, cnr Struben and Thabo Sehume Street
Tel (012) 395 8020, Fax (012) 395 8015

10 October 2016

Health Facility Manager
Alexandra Health Centre
JOHANNESBURG
2000

Request to allow Ms Charity Bhengu permission to conduct Interviews for academic purposes

Dear Facility Manager,

With reference to the above subject matter

Charity Bhengu, is an employee of the national Department of Health as well as a student at Witwatersrand University. She is currently enrolled for Masters Degree in Journalism and Media Studies. As part of her study programme, she is expected to undertake research interviews to investigate the awareness of the residents of Alexandra Township about Medical Male Circumcision.

She has identified the MMC project at your clinic to conduct observational study of the activities and conduct interviews of people who visit your clinic.

Please allow her to spend time at your Clinic. Her activities can be arranged in such a way that she does not interfere adversely with your schedule and the clinic activities.

Participation in the study is voluntary. People can withdraw from the study at any time. Their identity will not be disclosed and all data will be available only to her, and her supervisor. The findings will be used for academic purposes

Your assistance in this regard will be appreciated.

Yours Sincerely

Mr Popo Maja
Head of Communication & Stakeholder Engagement
National Department of Health (NDoH)
Tel (012) 395 8591 / 072 585 3219
Date: 10/10/2016

Annexure C Approval letter of academic proposal to conduct study

Faculty of Humanities: Postgraduate Office

South West Engineering Building, Room 4, Ground Floor, East Campus, Yale Road, Braamfontein · Private Bag 3, Wits, 2050, South Africa · Tel: +27 11 717 4008 · Fax: +27 11 717-8259 · E-mail: veli.mongwe@wits.ac.za · www.wits.ac.za/humanities

Student Number: 0404099H

Ms. Charity Bhengu
166 Cnr 2nd Avenue & Short Street
Edenvale
1431
Gauteng
South Africa

22 April 2016

Dear **Ms. Charity Bhengu**

APPROVAL OF PROPOSAL FOR THE DEGREE OF MASTER OF ARTS BY COURSEWORK AND RESEARCH REPORT IN JOURNALISM AND MEDIA STUDIES.

I am pleased to advise you that the readers of the Graduate Studies Committee have approved your proposal entitled ***"The importance of participatory communication for the voluntary medical male circumcision (VMMC) in the Alexandra Township in Gauteng, South Africa"***. I confirm that ***Mr. Alan Finlay*** has been appointed as your supervisor.

The research report is normally submitted to the Faculty Office by 15 February, if you have started the beginning of the year, and for mid-year the deadline is 31 July. All students are required to RE-REGISTER at the beginning of each year.

You are required to submit 2 bound copies plus 1 CD in pdf (Adobe) format of your research report to the Faculty Office. **NB: The 2 bound copies go to the examiners and are retained by them.**

Please note that should you miss the deadline of 15 February or 31 July you will be required to submit an application for extension of time and register for the research report extension. Any candidate who misses the deadline of 15 February will be charged fees for the research report extension.

Kindly keep us informed of any changes of address during the year.

Note: All MA and PhD candidates who intend graduating shortly must meet your ETD requirements at least 6 weeks after your supervisor has received the examiners reports. **A student must remain registered at the Faculty Office until graduation.**

Yours Sincerely

VC Mongwe

Veli Mongwe
Postgraduate Division
Faculty of Humanities
Private Bag X 3
Wits, 2050

Annexure D A letter from the Health Facility Manager

VISIT TO ALEXANDRA COMMUNITY HEALTH CENTRE

To conduct an academic study of the importance of the participatory communication approach for the voluntary medical male circumcision (VMMC)

11-17 October 2016

To whom it may concern

This is to confirm that **Charity Bhengu,** an employee of the national Department of Health and a student at Witwatersrand University, visited the Alexandra Clinic to conduct a study from 11 to 17 October 2016. She was allowed to conduct her research to observe and interview people individually or in groups based on condition that written consent is obtained from the participants and that the confidentiality of the identity of the participants to her study would be protected.

Name: Mbulelo Ndimandwe

Designation: Facility Manager

Signature:

Date: 17 10 2016

Annexure E A letter from the VMMC Clinic supervisor

VISIT TO ALEXANDRA COMMUNITY HEALTH CENTRE

To conduct an academic study of the importance of the participatory communication approach for the voluntary medical male circumcision (VMMC)

11-17 October 2016

To whom it may concern

This is to confirm that **Charity Bhengu**, an employee of the national Department of Health and a student at Witwatersrand University, visited the Alexandra Clinic to conduct a study from 11 to 17 October 2016. She was allowed to conduct her research to observe and interview people individually or in groups based on condition that written consent is obtained from the participants and that the confidentiality of the identity of the participants to her study would be protected.

Name: Simisa Mnphumuzo

Designation: Supervisor Voma Clinic

Signature: .....

Date: 17/10/2016

Annexure F List of contributors to the development of the VMMC strategic and operational plans

Contents

ACKNOWLEDGEMENTS AND LIST OF CONTRIBUTORS

The National Department of Health would like to acknowledge the following contributors to the development of this plan:

Dayanund Loyk ssoonlal	National Department of Health
Collen Bonnecwe	National Department of Health
Carlos Toledo	Centers for Disease Control and Prevention, South Africa
Lisa Mulenga	Centers for Disease Control and Prevention, South Africa
Sara Hersey	Centers for Disease Control and Prevention, South Africa
Jonathan Cockburn	SACTWU Health Program
Dinc Rech	Center for HIV/AIDS Prevention Studies
Richard Delate	Johns Hopkins Health Education South Africa
Rebecca Fertziger	US Agency for International Development
Dirk Taljaard	Center for HIV/AIDS Prevention Studies
Jessica Greene	Right to Care
Nikk: Soboil	SACTWU Health Program
Eva Kiwango	UNAIDS
Miriam Chipimo	UNAIDS
Barbara Franken	Right to Care
Augustin Ntilivamunda	World Health Organization

SOUTH AFRICA

VOLUNTARY MEDICAL

MALE CIRCUMCISION

OPERATIONAL PLAN

FY 2016/2017 – FY 2018/19

April 2016

CONTENTS

ACKNOWLEDGEMENTS

We acknowledge and give special thanks to the following individuals who were actively involved in the development of this plan:

Department of Health

Dr Yogan Pillay Deputy Director General: HIV/AIDS, TB and MCWH

Dr Zuki Pinini

Chief Director: HIV/AIDS & STI

Mr Collen Bonnecwe

Director: MMC Programme

Mr Dayanund Loykissoonlal

Manager: MMC Manager

BILL AND MELINDA GATES FOUNDATION

Maaya Sundaram

Programme Officer

Dr Patrick Odawo

Africa MC Coordinator

CLINTON HEALTH ACCESS INITIATIVE (CHAI)

Jorge Quevedo

Acting Country Director

MMC SA team

Annexure G Examples of signed consent forms

CONSENT FORM

Wits School of Journalism and Media Studies

Academic research on the importance of the participatory communication approach for the voluntary medical male circumcision (VMMC) programme by Charity Bhengu 0404099f

Dear Participant

Charity Bhengu, is a student at Witwatersrand University and she is currently studying a Masters Degree in Journalism and Media Studies. As part of her study programme, she is expected to interview the resident of Alexandra Township, to understand the extent of their awareness and knowledge about the medical male circumcision (MMC), its benefits and limitations, and the source of their information.

She has identified the Alexandra Clinic to conduct her research. Participation in the study is voluntary. You can withdraw from the study at any time. Your identity will not be disclosed and all data collected will be available only to her and her supervisor. The findings will be used for academic purposes.

Participant's approval to be part of the interviews/questioning and/or focus group interviews

Permission is granted:

- ☐ To be observed
- ☐ To be interviewed/questioned
- ☒ To be part of focus group interviews

I agree to these conditions with the understanding that the confidentiality of my identity will be protected, as stipulated above.

Name: [redacted] (30 yrs)

Organization (optional) Unemployed

Designation: Alexandra Youth

Signature: [redacted]

Date: 12 October 2016

Annexure H Feedback for Member checking

Greetings

I hope that this correspondence finds you in good health:. Enclosed herein please find the document that gives an overview of the Ward-Based Outreach Teams (WBOTS) as requested.

I hope that the paragraph will give you an understanding about these community cadres.

Trusting that you will find this in order.

Warm regards

Mxolisi

MMC and other programmes, and [we provide direction and oversight to ensure proper coordination and alignment of all efforts]

Ward-Based Outreach Teams (WBOTS)

These are community cadres that include community health workers, health promoters, community caregivers, etc that are being trained to become generalists in communities. These cadres are deployed within various public health facilities for capacity building, mentorship, and supervision purposes.

The WBOTS are expected to perform the following functions among others:

- Community-Based Primary Health Care services;
- Health education and awareness;
- Door to door/ household visits in communities;
- Home/Community Based Care services; and
- Referrals to various Government Departments for appropriate services.

In Gauteng Province, for instance, these are some of the community stakeholders that we work with building up to various HIV and TB Outreach Campaigns including HIV Counselling and Testing (HCT), VMMC, and provision of comprehensive health services to identified communities.

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4

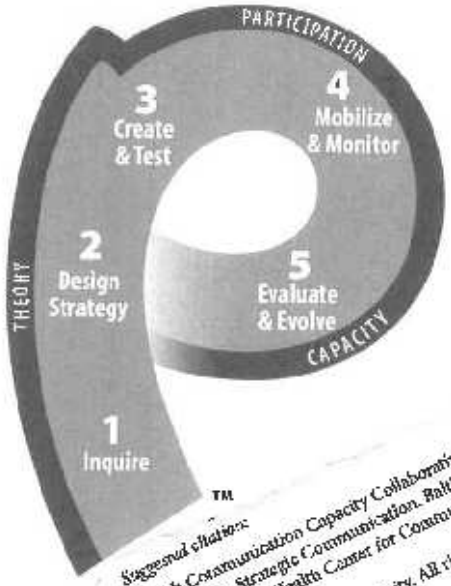
Please refer to this document on P. Process Steps to strategic communication as discussed during the interview

Introduction

The P Process is a step-by-step roadmap that can guide you from a loosely defined concept about changing behavior to a strategic and participatory program that is grounded in theory and has measurable impact.

Every day the P Process is used to design, implement and evaluate innovative and creative behavior change programs to reduce HIV transmission, promote family planning/reproductive health, reduce maternal mortality, promote child survival, prevent infectious diseases and protect the environment.

It doesn't matter what health area you are working in or how big or small your budget, by following the P Process, you can help people make healthy changes.



Suggested citation:
Health Communication Capacity Collaborative (November 2013). The P Process: Five Steps to Strategic Communication. Baltimore: Johns Hopkins Bloomberg School of Public Health Center for Communication Programs.

Photo credits:
Valerie Caldas (p. 7), Bonnie Gillespie (p. 11), Kajal Thaker (p. 13), Akinnade Akinleye/NURHI (p. 15) Diana Arsenikova/ Networks (p. 16), Courtesy of Photoshare

Annexure I Photographs of some of participants to focus group interviews.

FORM 10

chaps

DATE 11-10-2015 Paper

CODE	NAME & SURNAME	ADDRESS	DATE OF BIRTH	CONTACTS	WHO TOLD YOU ABOUT US	LANGUAGE
45	[redacted]	[redacted] 2nd Ave	05-10-1980	[redacted]	[redacted]	Xhosa
46	[redacted]	[redacted] Hlathi	30-08-[redacted]	[redacted]	[redacted]	Zulu
47	[redacted]	[redacted] A1	05-07-1986	[redacted]	[redacted]	Zulu
48	[redacted]	[redacted] Hlathi	[redacted] 1976	[redacted]	[redacted]	Zulu
49	[redacted]	[redacted] Hlathi	12-04-[redacted]	[redacted]	[redacted]	Zulu
50	[redacted]	[redacted]	18-04-1994	[redacted]	[redacted]	Zulu
51	[redacted]	[redacted] Hlathi	05-07-[redacted]	[redacted]	[redacted]	Zulu

Annexure K Photographs of some of participants to focus group interviews.

Focus group interviews in Alexandra Township in 2016

Annexure J Photograph of front door of VMMC clinic

Photo by the researcher: *This poster is the front entrance of VMMC clinic*

Annexure L Some of the posters found in and outside the clinic

Visual data on communication material

Compilation of posters about VMMC