IOSR Journal Of Humanities And Social Science (IOSR-JHSS)
Volume 22, Issue 9, Ver. 15 (September. 2017) PP 39-47
e-ISSN: 2279-0837, p-ISSN: 2279-0845.
www.iosrjournals.org

Strategic CommunicationFactors Affecting the Uptake of Voluntary Medical Male Circumcision (VMMC) Among the Traditionally Non-Circumcising in Kenya.

Dan Macho Okumu, Prof. Hellen Mberia, Dr. IdahMuchunku
JKUAT

ABSTRACT: Three randomized controlled trials in Africa indicated that voluntary medical male circumcision (VMMC) is an effective method to reduce a man's risk of becoming infected through sex with an HIV-positive female partner. The success of recent public health initiatives to increase numbers of circumcised men in Busia has been very limited. We conducted in-depth interviews (IDIs) and focus group discussions (FGDs) with men, women, and male adolescents from non-circumcising and circumcising communities in western Kenya to better understand their beliefs about male circumcision and the promotion of VMMC for HIV prevention. Empirical Results revealed that beliefs about male circumcision, in general, are strongly mediated by Samia culture and history. Participants have attempted to develop a new meaning for circumcision in light of the threat of HIV infection and the publicized risk reduction benefits of VMMC. Several study participants found it difficult to distinguish VMMC from traditional circumcision practices, despite awareness that the new form of circumcision was an expression of (western) modern medicine performed largely for public health purposes. Greater recognition of background cultural beliefs and practices could inform future efforts to promote medical male circumcision as an HIV prevention strategy in this context.

Keywords: Male circumcision, AIDS, HIV prevention, Busia, religion, cultural practices, sexuality

---

Date of Submission: 19-09-2017 Date of acceptance: 30-09-2017

I. BACKGROUND OF THE STUDY

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

Interpersonal communication is hailed as very central in the success of communication intervention. Preferred to the linear approaches, interpersonal communication can be traced to the development of the two step flow theory in the 1940s by Paul Lazersfeld, Berelson and Gaudet. The theory was later elaborated by two communication scholars Paul Lazersfeld and Elihu Katz. The theory suggests that information moves through two stages: from the media to relatively well informed individual (opinion leaders) who frequently attend to mass communications and from opinion leaders through interpersonal channels to individuals who have less direct exposure. The opinion leaders play important role in interpreting of issues. Opinion leaders are looked at in high regard and respectability by the masses and unlimited access to the media.

The proponents of the theory discovered that informal personal contacts were mentioned far more frequently than exposure to radio or newspaper as sources of influence on voting behavior (Lowery &DeFleur, 1995). This theory asserts that information from the media moves in two distinct stages. First, individuals [opinion leaders] who pay close attention to the mass media and its messages receive the information. Opinion leaders pass on their own interpretations in addition to the actual media content. In so doing, opinion leaders are quite influential in getting people to change their attitudes and behaviors and their personal influence seems more important in decision making than media (Flynn, Goldsmith & Eastman, 2001).

Brosius and Weimann (1996) explain one of the benefits of the two step flow theory as re-emphasizing the role of the group and interpersonal contacts. The most efficient media is word-of-mouth, and it is by reaching the influential's with other forms of media that this word-of-mouth is generated (Griswold, 2007). Some of the key approaches emanating from the interpersonal communication, which are central in promoting the success of SBCC strategies, are discussed below:

The policy/enabling environment level of the social and behavior change consists of policy, legislation, politics and other areas of leadership that influence health and development. A strategy used to address this level of the social system is advocacy. Advocacy is an organized effort to inform and motivate leadership to create an enabling environment for achieving program objectives and development goals. The purpose for advocacy is (1) to promote the development of new policies, change existing governmental or organizational laws, policies or rules, and/or ensure the adequate implementation of existing policies (2) to redefine public perceptions, social norms and procedures, (3) to support protocols that benefit specific populations affected by existing legislation, norms and procedures, and/or (4) to influence funding decisions for specific initiatives.

There are three common types of advocacy: Policy advocacy, to influence policymakers and decision makers to change legislative, social, or infrastructural elements of the environment, including the development of equity-focused programs and corresponding budget allocations; Community advocacy, to empower communities to demand policy, social, or infrastructural change in their environment, and Media advocacy to enlist the mass media to push policymakers and decision makers toward changing the environment.

Advocacy includes motivating different levels of decision makers (e.g. politicians, policymakers) to publically discuss important issues, defend new ideas or policies, and commit resources to action. The advocacy process requires continuous efforts to translate relevant information into cogent arguments or justifications and to communicate the arguments in an appropriate manner to decision makers.

The most common barriers to influencing leadership toward creating an enabling environment for SBCC programming can include: (1) political or institutional instability (e.g., high turnover of leadership and re-structuring) or lack of political will; (2) a lack of local evidence on overall program cost and cost effectiveness; (3) a lack of reliable data about the efficacy, effectiveness, or value of a program; (4) dissension among the leadership between health and other divisions of a government; (5) tensions or low capacity with regard to the use of various levels of health workers; (6) resistance from professional and/or regulatory bodies; (7) systems requirements (e.g., human resources, commodities); (8) contradictory policies; (9) culturally ingrained practices, social norms, and resistance to change; and (10) a lack of social accountability by policymakers.

A good way to approach developing an advocacy strategy is to identify key elements for different decision-makers, and examples of the concerns, activities and tools that suit these particular intended populations.

Social mobilization (SM) is a continuous process that engages and motivates various inter-sectoral partners at national and local levels to raise awareness of, and demand for, a particular development objective. These partners may include government policy makers and decision-makers, community opinion leaders, bureaucrats and technocrats, professional groups, religious associations, non-governmental organizations, private sector entities, communities, and individuals. This communication approach focuses on people and communities as agents of their own change, emphasizes community empowerment, and creates an enabling environment for change and helps build the capacity of the groups in the process, so that they are able to mobilize resources and plan, implement and monitor activities with the community.

Engagement is usually through interpersonal communication (i.e., face-to-face dialogue) among partners toward changing social norms and accountability structures, providing sustainable, multifaceted solutions to broad social problems, and creating demand and utilization of quality services. Other channels and activities for SM may include mass media awareness-raising campaigns, advocacy with community leaders to increase their commitment to the issue, and activities that promote broad social dialogue about the issues, such as talk shows on national television and radio, community meetings, traditional participatory theater performances, home visits, and leaflets. The outcomes are usually oriented toward developing a supportive environment for decision-making and resource allocation to empower communities to act at the grassroots level.

Social mobilization recognizes that sustainable social and behavior change requires collaboration at multiple levels, from individual to community to policy and legislative action, and that partnerships and coordination yield stronger impacts than isolated efforts. Key strategies of social mobilization include using advocacy to mobilize resources and change inhibiting policies, media and special events to raise public awareness and create public spheres for debate, building and strengthening partnership and networks, and motivating community participation.

Statement of the problem

Different countries have registered low uptake of VMMC services among the target populations.Some regions have registered much lower uptake levels than others especially among men 18 yearsoldandabove. Thereis very little literature availableonutilizationVMMC, especially among the older men who are prime targets for the intervention in the priority countries(Sabone et al., 2013).

From 2005 to 2007, three randomized controlled clinical trials in Sub-Saharan Africa (SSA) demonstrated that male circumcision reduces the risk of female-to-male HIV transmission by about 60% (Ashengo et al, 2014). In March 2007, the WHO and the Joint United Nations Programme on HIV/AIDS

(UNAIDS) recommended that voluntary medical male circumcision (VMMC) should be considered an important intervention for HIV prevention in settings with high HIV and low circumcision prevalence (WHO, UNAIDS, 2007). Mathematical models have estimated that VMMC scale-up across SSA could prevent up to 6 million new HIV infections and 3 million deaths by 2025 (Njeuhmeli et al 2011). VMMC has been rolled out in 14 African countries starting in 2009, and WHO estimates that 11.7 million men have been circumcised as of December 2015 (WHO, 2015).

Cultural and religious practices contribute to wide variation of circumcision prevalence (WHO, 2016). Several regions had close to universal prevalence, whereas 12 traditionally noncircumcising regions had lower circumcision prevalence, and constituted the Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) priority regions for VMMC (TACAIDS, 2013). The national VMMC programme was launched by the MOHCDGEC following a situational analysis from 2007–2008 that reported high acceptability for VMMC among men and women in both traditionally circumcising and noncircumcising communities (Mshana et al 2011). The MOHCDGEC developed a VMMC Country Operational Plan targeting 2.2 million men aged 10–34 years with circumcision between 2014 and 2017 in the priority regions (MOHSW, 2017).

Although the national strategy prioritized 10–34 year olds, modeling suggests that the most immediate reduction to HIV incidence may be achieved by circumcising men aged 20–34 years because of higher HIV incidence in this age group (Ashengo et al, 2014). To achieve the maximum number of HIV infections averted (3% of new infections) between 2011 and 2015, VMMC should reach sexually active men (Kripke et al, 2016). However, in Tanzania, the majority of clients are younger men; for example, 76% of VMMC clients in 2014 were under 20 years of age,Mberia (2009). Studies in Kenya, Zambia, and Tanzania have described strategies to increase VMMC demand among men aged 20 years or above (Kundi, et al 2013) but these strategies did not explicitly explore the relationship between a comprehensive demand-creation approach and uptake of services by older men. In addition, these studies did not explicitly focus on communication strategy. Communication strategy is used when targeting a large volume of VMMC clients,Nguzo (2012). Thus, strategies are needed to increase the number and proportion of male clients aged 20–34 years (Ashengo et al 2014).

II. LITERATURE REVIEW

Social change communication (SCC) is a purposeful and iterative process of public and private dialogue, debate, and negotiation that allows groups of individuals or communities to define their needs, identify their rights, and collaborate to transform the way their social system is organized, including the way power is distributed within social and political institutions. This process is usually participatory and is meant to change behaviors on a large scale, eliminate harmful social and cultural practices, and change social norms and structural inequalities.

While social mobilization (above) focuses on creating and sustaining action-oriented partnerships to create an enabling environment for positive health, SCC focuses on creating ownership of the process of change among individuals and communities. The emphasis of SCC is on creating empowered communities that know and claim their rights and become their own agents for changing social norms, policies, culture and environment (e.g., healthcare delivery infrastructure).

Multi-faceted communication interventions (e.g., using mass-, social-, and traditional media, information communication technology (ICTs), and/or *mHealth*) aimed at changing individual behavior play an important role as a foundation for SCC, with an emphasis on using local communication content that is socially and culturally appropriate to the community. Community members control the tools of communication directly, allowing for suitably tailored messages. Such interventions, however, must be reinforced by activities that encourage dialogue within the community to motivate people to shift toward desirable social/community beliefs, norms, and practices, and are often combined with advocacy.

Community dialogue for social change generally follows a pattern. The dialogue usually begins with a catalyst for change. The catalyst may be an individual within the community, a change agent working for a health organization who introduces a new innovation such as VMMC or a mass media message heard by individuals in the community. For example, a man might talk to another man about whether to take VMMC. The men might talk to, and ask questions of, others in their family and social networks about the problem, which may prompt someone to identify an opinion leader or potential champion (e.g., a community health worker) that can help to address the problem. Usually the person who takes up the cause calls a meeting to discuss the issues related to the problem and to achieve consensus about how to address the problem.

Communities that engage in this collective process of social change communication are likely to gain a sense of collective efficacy, feel a greater sense of ownership for their actions and outcomes, and believe in their capacity to engage in similar projects in the future.

Behavior change communication (BCC) is the strategic use of communication to promote positive health outcomes. BCC is a theory-based, research-based, interactive process to develop tailored messages and

approaches, using a variety of population-appropriate communication channels, to motivate sustained individual- and community- level changes in knowledge, attitudes, and behaviors. Formative research is used to understand current levels of knowledge, attitudes, and behaviors among individuals in a specified population in order to develop communication programs that move those individuals along a continuum of change (or through stages of change)toward the desired positive behavior(s).

Using the BCC approach can help to stimulate community dialogue and raise awareness about the problem; increase knowledge, for example, about the importance of taking the VMMC, promote attitude change, for example, about the risks associated with not undergoing the VMMC, create demand for information and services, advocate with policymakers and opinion leaders toward effective approaches to increasing the adoption of the innovation such as VMMC, improve skills and the sense of self-efficacy.

BCC is an essential part of comprehensive prevention and control programs that include both services (e.g., health, medical) and commodities (e.g., vaccines). Before individuals and communities can reduce their level of risk or change their behaviors, they must first understand basic facts about HIV health risks, adopt key attitudes, learn a set of skills and be given access to appropriate products and services. They must also perceive their environment as supporting behavior change and the maintenance of safe behaviors, as well as supportive of seeking appropriate prevention, treatment and support.

The above four approaches (advocacy, social mobilization, social change communication, and behavior change communication) are interrelated and interactive. When strategically combined, they produce a synergistic effect, that is, an increased intensity or effect with more efficient use of resources. BCC programs stimulate the most immediate preventive actions among individuals, families and communities for decreasing childhood pneumonia and diarrhea. Advocacy strategies can be used to create new laws or change existing policies to facilitate change. Multi-level approaches that help to change social, cultural, or institutional norms are most likely to result in sustained behavior change over time.

Since individuals exist in a social ecological system, changing individual-level behaviors and creating new social norms requires creating an enabling environment, that is, facilitating change and removing bottlenecks that inhibit change at the household, community, organizational, and policy levels.

Program managers and program planners should use the Social Ecological Model (1) to understand the complexity of, and possible avenues for addressing, the health problem, and (2) to prioritize resources and interventions that address the multiple facets of the problem, remove bottlenecks, and create an enabling environment for sustained behavior and social change. As described above, a preliminary tool that some program managers and program planners use to help them assess the social ecological landscape prior to developing a strategic program plan is the SWOT analysis. A SWOT analysis is one element of a strategic plan. The SWOT analyses is an inventory of resources and usually focuses on four key program management areas of (1) partnerships, (2) capacity development, (3) research, monitoring and evaluation, and (4) resource mobilization.

The SWOT analyses will highlight internal organizational strengths, internal weaknesses, external opportunities, and external threats or barriers to achieving your program's goal and objectives. Understanding the SWOT analysis will help to determine how to focus on high-priority vulnerable, marginalized, and hard-to-reach populations, where change is possible, and provide opportunities to change course or revise priorities as appropriate in order to reach your program goals. For example, an assessment of resources for a strategic SBCC program with a goal of increasing VMMC may allow (1) for advocacy activities toward a policy that assures that every male is circumcised, (2) for organizational capacity-building to develop a cadre of trained healthcare providers and promoters at the local level, (3) for community engagement activities to create demand for quality healthcare services where VMMC can be obtained at a reasonable cost, and (4) for a campaign to promote the importance, availability, skilled providers, and points-of-access for VMMC in an underserved community.

Strong partnerships and collaborations are at the core of effective SBCC programs. When partners take ownership of a program, it is more likely to succeed. A strong communication program should engage multiple partners at the national and local levels in a participatory manner; no single entity can achieve the results produced through multi-partner collaborations. Partners can provide program support through expertise, capacity building, and resource mobilization, can broaden the reach and profile of the program through network affiliations, and can help to avoid duplication of efforts.

A key strategy for developing and administering SBCC programs is to create an infrastructure or centralized mechanism for engaging partners in a participatory process to manage the program (e.g., SBCC Coordinating Committee). Such centralized mechanisms are more successful when partners create the mechanism together. The process for developing such a mechanism, and the ground rules by which it will operate, helps to create the culture of the partnership and develop working relationships.

The key to high-performance partnerships is continuous and open information sharing. There should be a mechanism for sharing information and communicating about the activities of the group and the program. For newly formed groups, it is useful to begin by clarifying a shared vision to help partners focus on the path to

achieving success and brainstorming about the limitations and challenges to realizing the vision and how the team of partners can overcome the limitations or challenges. The partners should also develop a common goal and objectives for the partnership and discuss the potential contributions of each individual, group, or organizational partner. Meetings should be held on a regular basis to share information, assess progress, re-visit program objectives and activities, and discuss next steps in the program steering process.

Capacity strengthening at the institutional and community levels is an important component for strong and effective SBCC programs. There are many strategies for developing capacities for the management and delivery of SBCC programs, including formal and informal skills training, mentoring, supportive supervision, and team building exercises. The type of strategy selected depends on the existing level of capacity, the type of strengthening required and the level at which the capacity needs to be strengthened (e.g., individual, group, community, organization/institution, or national level).

Individuals might benefit from topic- or skills- based trainings, demonstrations, study-tours, observations, and supportive supervision. Groups and communities might engage in participatory training workshops, group education meetings, and team-building exercises.

Organizations and institutions might gain insight into their capacities through special studies, for example a SWOT analysis, that engages members of the organization in an exercise to determine the strengths, weaknesses, opportunities, and threats facing the institution in such areas as partnerships, research, monitoring, and evaluation, and resource mobilization, and enable them to make recommendations for leveraging internal strengths, improving internal weaknesses, exploiting external opportunities, and minimizing external threats.

Strengthening capacity at the national level, for example, with government officials who are not clear on the contributions of SBCC for child VMMC programs, might involve briefings, study tours, focused trainings, invitations to participate in special events. It is useful to conduct an inventory of current skills and gaps in capacity to decide what type of capacity strengthening is needed and at what level. Program managers also need to be mindful of strengthening program staffing and institutional policies that can affect overall program capacity.

III. METHODOLOGY

This study will use mixed methods design comprising both qualitative and quantitative approaches (Creswell, 2009). Creswell observes that mixed methods are a powerful way of enhancing the validity of results. This view is also supported by Herbert &Shepherd (2001) who say that mixed methods are used to research the same issue with the same unit of analysis, thus cross-checking one result against another and thereby increasing reliability of the result. By using mixed-methods design, the researcher will better understand the issue being explored and also overcome the weaknesses or intrinsic biases and the problems that come from single method studies.

Nachmias&Nachmias (1992) and Nzioka (1994) concur with the scholars above that data produced by combined methods enhances the validity and reliability of the findings. The use of qualitative and quantitative in this study will help in getting confirmation of findings through convergence of different perspectives that affect the uptake of voluntary medical male circumcision in traditionally non circumcising community in Funyula. As a result of the combination, this study will benefit from the advantage of sample survey and statistical methods (quantification, representativeness and attribution) and the advantages of the qualitative and participatory approaches.

This study will be done in Funyula sub county, which is found in Busia County and which covers 1694.5 km2 (IEBC 2012). Funyula Sub-County has been chosen for this study because the residents are mainly Samia who are traditionally a non-circumcising community, and the rates of HIV infection is relatively high (KAIS 2012). The sub county has seven (7) constituencies namely Teso North, Teso South, Funyula, Nambale, Matayos, Budalangi and Butula. The 2012 population of Busia was estimated at 816,452 with females numbering 425, 622 (53.13%) and the males 390,880 (47.87%) respectively. Funyula Sub-County (formerly Samia) comprises of Nambuku, Namboboto, Odiado, Nangosio, Ageng'a, Nangumba and Bwiri locations. The study will target the sexually active male population aged between 20 years and above years from educational and social organizations from across all the seven locations and the HIV and AIDS specialists from Non-Governmental Organizations (NGOs), Faith Based Organizations (FBOs), and Community Based Organizations (CBOs), especially those that were involved with the VMMC programme implementation.

The estimated HIV prevalence in Busia District is 7.4%, compared to the national average of 6.3% (Central Bureau of Statistics, 2004 and the Daily Nation Tuesday March 29, 2011). Luhya comprises the main ethnic group in the area, with some Luo. The literacy level for the district by sex is 76% for males and 55.3% for females. Busia is the 67th poorest of Kenya's 71 districts (original district before the subdivision in 2007). Sixty six percent of the population earns less than US $1 per day (compared to 56% nationally).

On average, households earn Ksh 5,149 per month. Only 13.5% of those aged 18- 64 are in wage employment (KNBS 2009). The main causes of poverty include: lack of markets for farm produce (mainly

sugar cane) and fish, and poor communication and transport infrastructure. Busia and Samia have only one major road, a section of the Trans-African Highway connecting Mombasa and Lagos. This road is a factor in HIV transmission because of the long-haul truckers and the commercial sex workers they patronize. Truck stops are often where sex workers congregate, and Busia was identified as a hot-spots for commercial sex activity due to the high volume of trucks overnight. A GIS-based study conducted by the Strengthening STD/HIV Control Project in Kenya (SHCP) found that Busia received approximately one quarter of the trucks overnight at the Kenya-Uganda border (National Aids Control Council, 2005). Unlike sex workers in many developed countries and in urban areas of developing countries, many of the sex workers in Busia do not self' identify as commercial sex workers (CSWs). Many of the women are orphans, some are widowed, divorced, or separated, and most identify themselves as VsurvivorsV: women who engage in sex work in order to survive. Poor health is itself a major contributing factor to poverty in the district. High rates of malaria, TB, HIV and AIDS and childhood illnesses cause people to lose many workdays, and the cost of treatment has a significant impact on already meager family incomes. There are a number of organizations proving HIV and AIDS services in the sub-county, which is an indication of the efforts to address the HIV and AIDS problem here.

A sampling frame is a list from which the sample is drawn and is representative of the population. The sample frame will consist of two national polytechnic colleges, a technical college in the region, two beach resident organizations, one church organizations, one youth social organization and one provincial adminstration committee groups. Organizations that implemented the VMMC in Western regions will also be part of the sampling frame from where both HIV and SBCC specialists will be drawn.

Funyula Sub-County has been chosen because the residents are mainly Samia who are traditionally a non-circumcising community, and the rates of HIV infection is relatively high (KAIS 2012). There are alot of organizations fight HIV and AIDS prevalence in the sub-county. Additionally, the VMMC programme was rolled out in Funyula Sub-County in order to increase the uptake of VMMC for reduced heterosexually caused HIV prevalence. Specifically, the study will rely on participants selected from Nangina Youth Polytechnic, Namasali Youth Polytechnic, Bumbe Technical Institute, Sio Port Residents Association, Bumbe Beach Residents Organization, Sigalame Youth Social Hall, Bwiri SDA Group and Namboboto Chief's camps in Funyula. Also to be studied include County Public Health (Funyula), Population Service International, FHI 360 (C-Change Programme Department), the Impact Research and Development Organization, the Family AIDS Care and Educational Services, the Aphia II Western Programme (Engender Health) and the Catholic Medical Mission Board, in Funyula Town.

The study will be carried out from a carefully selected sample to represent the entire population (Slavin, 1984). Gay (1981) asserts that 20% of the population forms a representative sample for a descriptive study. Respondents from all the seven locations in Funyula Sub-County will be studied, especially by studying all the educational and social organization where all male populations in Funyula Sub-County are represented.

The total sample size for this study will be 384 respondents, made up of 384 sexually active male populations from Nangina Youth Polytechnic, Namasali Youth Polytechnic, Bumbe Technical Institute, Sio Port Residents Organization, Sigalame Social Hall, Bwiri SDA Youth Group and Namboboto Chief's Camp and eight key participants purposively selected from HIV and AIDs organizations such as Funyula County Public Health office, Population Service International, FHI 360, Nyanza Reproductive Health Society, Impact Research and Developpment Organization, Family AIDS Care and Educational Services, Aphia ii Western Programme (Engender Health) and Catholic Medical Mission Board in Funyula Sub-County.

The respondents based in organizational set up have been preferred because they are bound to be available to make the study much easier since they are controlled in the organizations. Also, the study seeks to survey the major institutions and organizations in the Sub-County in order to get representatives of the entire study site and the age 18-50 years required by the study.

Purposive sampling method will be used to choose seven educational and social organizations in Funyula Sub-County. Purposive sampling will be used since the research will be targeting respondents between 18-50 years, who are attached to these educational and social institutions. The sampling frame for the survey respondents will be developed with the assistance of the leaders (Deans of students in colleges, directors or heads of each organization where study participants will be drawn. Such a sampling frame enables the researcher to draw an adequate sample. Within the educational institutions, respondents will be selected using systematic random sampling strategy, where class registers will be used to select based on determined intervals. This is because in these institutions, students sit in class waiting for lessons. In other social organizations, systematic random method will be used, where the researcher will wait at specific locations and select respondents as they come in based on a determined interval.

Table 3.1: Sample size distribution

Institution/Organization	Population	Male Number	Female number	Sample
Nangina Youth Polytechnic	1500	1000 (87)	500 (43)	130
Namasali Youth Polytechnic	1500	1000 (87)	500 (43)	130
Bumbe Technical Institute	500	300 (30)	200 (20)	50
Sio Port Residents Association.	100	50 (10)	50 (10)	20
Sigalame Social Hall Organization	300	210 (28)	90 (12)	40
Bwiri SDA Church Group	140	100 (10)	40(4)	14
Namboboto Chief's Camp	100	60(6)	40	10
TOTAL	**4,140**	**2,720**	**1830**	**384**

(Source: Funyula Sub-County Department of Social Services, 2016)

The study will utilize mainly primary data. The data will be both quantitative and qualitative. Quantitative data will be collected by using questionnaires while qualitative data will be collected using Focus Group Discussions and In-depth Interviews with Key Informants from the listed organisations dealing with HIV and AIDS and SBCC in Funyula Sub-County. The researcher will develop all the primary data collection instruments.

The questionnaire will be used to collect quantitative data on personal, social, organizational, environmental and communication factors affecting the uptake of VMMC among sexually active members of the traditionally non-circumcising communities in Funyula Sub-County. These data will be obtained from 384 respondents usingself-administered structured questionnaires. The questionnaires will be administered because the population can read and write (Fisher &Foreit, 2002). Likewise, questionnaires are also expected to produce more accurate results on such sensitive topics as sexual behaviour and HIV and AIDS because they allow anonymity, which can encourage frankness when sensitive issues like Adopotion of VMMC are involved (Robson, 2002). Campbell et al (1999) note that the use of self-administered questionnaires is particularly useful in the collection of data on sensitive topics, such as sexual behaviour. The questionnaires content will be guided by the objectives of the study.

A total of two (2) focus groups emanating from the institutions/organizations will be used each comprising of 5 male participants. They will be drawn voluntarily from the selected institutions and organizations involved through volunteer method. Morgan (1988) notes that, where focus groups form a central and more substantive part of data collection for study, it would be difficult to justify fewer than this number. Focus Group Discussions (FGD) consists typically of 3 to 9 members who share certain characteristics relevant to the study with a moderator leading the discussions for about 2 hours on a particular topic, concept or product (Semakeran, 2006 ; Kombo, 2006).Wimmer (1993) notes that, a focus group has from 3-9 participants being interviewed simultaneously with a moderator leading the respondents in a relatively free discussion.

Focus Group Discussions (FGDs) will be used primarily to investigate the normative aspects of behaviour from respondents in groups of six from the seven research sites (institutions). The advantage of Focus Group Discussions will be the greater breadth of ideas, opinions and experiences that will be expressed by the participants. According to Morgan (1988), the hallmark of FGD is the explicit use of the group interactions to produce data and insights that would be less accessible without the interaction found in the group. Focus Group Discussions allow a group of participants to discuss subjects of common interest with the guidance of a facilitator or moderator.

In this study, only those who will respond to the questionnaires will be involved in the FGDs. Campell, et al (1999) argue that it is necessary for such a study to allow the youth to give their collective opinions and beliefs on the determinants of condom use behaviour change for the prevention of HIV and AIDS. This will enable to get the social norms of the youth.

A total of eight key respondents will also be purposively selected from HIV and AIDs-based projects and organizations within Funyula Sub-County such as Public Health (Funyula), Population Service International, FHI 360 (C-Change Programme Department), the Impact Research and Development Organization, the Family AIDS Care and Educational Services, the Aphia II Western Programme (Engender Health) and the Catholic Medical Mission Board, in Funyula town. They will participate in the in-depth interviews by shading light on the social and behaviour change communication factors that affect the uptake of VMMC among the traditionally non circumcising population in Western Kenya Region. Each of these participants will be individually interviewed to allow for detailed probing and privacy. The researcher will try to reduce the limitation of the interviews such as respondent's reservations by establishing a friendly atmosphere and positive attitude towards the respondents. According to Sekaran,(2003), the establishment of rapport between the researcher and the participant is a prerequisite for a successful interview. The key informants will be purposively selected based on active participation in the related projects or activities in the sub-county.

Campbell et al. (1999) observe that key informants interviews are a conversational style rather than a formal question-answer format. The informants will be provided with the issues to be covered during the interviews that include elements of personal, social, organizational, environment and communication factors that affect the adoption of VMMC as social and behaviour change process among the traditionally non-circumcising communities in Kenya.

Data is defined as the facts that are presented to the researcher from the research environment. This study will require the collection of both qualitative and quantitative data. Mixed method data collection will be employed comprising of three data collection methods of questionnaires, focus group discussions (FGDs) and In-depth interviews (IDIs). As Creswell (2009) puts it, collecting both quantitative and qualitative data assists in the triangulation of the result that ensures validity and reliability. Campbell et al (1999) asserts that while the survey is useful for measuring the incidence of a specified behaviour, it is often unsatisfactory for full investigation of motivations, beliefs and values that may have a major influence on behaviour.

Before the actual data collection, a research permit will be sought from the National Council for Science and Technology (NACOSTI) in the Ministry of Education, Science and Technology. Research assistants will then be recruited and trained. After that, directors and leaders of the research organizations and institutions will be approached. Participants of the study will first be informed about the purpose, procedure and benefits of the study and their consent will be sort. They will be assured of the confidentiality of the exercise by the researcher and his research assistants. They will also be informed that this is a voluntary process without any monetary gains. The respondents will each sign his consent form because they are 18 years and above. As for key informant interviewees and FGDs participants, they will be asked to consent to the audio recording of their discussions.

The study will be conducted when educational institutions are in session. Questionnaires will be self-administered using the drop and pick method. The structure of the questionnaire will be clear and easy to understand and straightforward ensuring that respondents answer questions with ease. The data collection instruments will be developed and organised by the research questions to ensure relevance to the research questions. The questionnaire will be divided into seven sections. Section A will be focused on general information while the other sections (C, D, E, F and G) will each section focus on the six specific objectives.
Testing validity and reliability will be done by carrying out a pilot study or pilot test. A pilot study is a feasibility study (trial runs), done in preparation for the major study (Polit et al, 2001:Mberia, 2009). Pilot testing will be carried out in Budalangi Sub-County with the primary purpose of checking content validity of the questionnaires. Bell (1993) emphasises the role of piloting in ascertaining the validity and reliability of research instruments. Pilot study helps in developing and pre-testing of the main research instruments (Baker, 1994).This study will provide feedback on the wording of the questions. After pilot testing, the researcher will make changes to the questionnaire to remove ambiguity.

Kombo and Tromp (2006) define data analysis as the process of examining what has been collected from the field, processing and managing it in a manner that permits easier deductions and inferences to be made based on the research data. It involves scrutinizing the acquired information and making inferences or generalizations based on it. Quantitative methods of data analysis attempt to draw meaningful results from a large body of quantitative data and provide a means of separating out the large number of confounding factors that often obscure the main quantitative findings (Abeyasekera, 2005).

Descriptive and inferential statistics will be used to interpret the quantitative data on the variables relevant to the study objectives.Descriptive statistics such as frequencies will be used to summarize categorical variables. Inferential statistics will be used especially the Pearson's Product Moment to establish the relationship between social and behavioral factors with VMMC. Qualitative data analysis can be defined as an iterative and reflexive process that begins with data collection rather than one that ends with data collection (Stake, 1995). Chambliss &Schutt, (2015) viewed qualitative analysis as an inductive process in which data is first organized into categories, pattern and connection identified and their influence on one another.

In this study qualitative, data will be collected from the Focus Group Discussions and the key informant interviews and will be transcribed and coded into common themes. The themes will be interpreted using thematic analysis. Then, a narrative report supplemented with quotations will be written. The written qualitative data report from the key informants and FGDs will be triangulated with the quantitative responses (survey data) to enhance the reliability and validity of the study.

IV. CONCLUSION

Kenya has integrated Voluntary Male Medical Circumcision (VMMC) as part of the HIV prevention interventions. The overwhelming evidence of the effectiveness of VMMC in reducing the risk of acquiring HIV in men is compelling. While, there has been so much progress on service delivery and strategic planning of the VMMC program in Kenya, there is also a need to ensure that the general public is aware of VMMC and its benefits and risks through a comprehensive communication strategy. Most

importantly is the partial protection that VMMC offers and also choices and decisions that couples should make to make certain that VMMC does not increase the risk but rather reduces the risk.

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

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

REFERENCES

[1]. Ashengo TA, Hatzold K, Mahler H, Rock A, Kanagat N, Magalona S(2012).Voluntary medical male circumcision (VMMC) in Tanzania and Zimbabwe: service delivery intensity and modality and their influence on the age of clients**.***PLoS One*Nguzo (2012); 9:e83642.

[2]. Campbell. Cleland J., Collumbien M., & Southwick K. (1999). *Social Sciences Methods for Research on Reproductive Health*. World Health Organization

[3]. Kundi GJ, Mphuru L, McMahan J, Mwakipesile P, Mwanasalli S, Simbeye. D, (2013). Increased uptake of voluntary medical male circumcision (VMMC) services among older men following mobile technology demand creation in Shinyanga and Simiyu, Tanzania**.** *-ISDS 2013*; 2013.

[4]. MOHSW. Ministry of Health and Social Welfare/National AIDS Control Program (2014). *Voluntary medical male circumcision country operational plan*. 2014-2017. Dar es Salaam, Tanzania: MOHSW; 2014.

[5]. Mshana G, Wambura M, Mwanga J, Mosha J, Mosha F, Changalucha J. (2011).Traditional male circumcision practices among the Kurya of North-eastern Tanzania and implications for national programmes**.***AIDS Care* 2011; 23:1111–1116.

[6]. Njeuhmeli E, Forsythe S, Reed J, Opuni M, Bollinger L, Heard N, (2011). Voluntary medical male circumcision: modeling the impact and cost of expanding male circumcision for HIV prevention in eastern and southern Africa**.** *PLoS Med* 2011; 8:e1001132.

[7]. TACAIDS, ZAC, NBS, OCGS, International I (2013). *Tanzania HIV/AIDS and malaria indicator survey 2011-12: key findings*. Dar es Salaam, Tanzania: National Bureau of Statistics, Ministry of Finance; 2013.

[8]. WHO, UNAIDS.New data on male circumcision and HIV prevention (2007): policy and program implications. WHO/UNAIDS technical consultation on male circumcision and HIV prevention: research implications for policy and programming**.***WHO meeting Montreux, Switzerland*.

[9]. WHO (2015). *WHO progress brief voluntary medical male circumcision for HIV prevention in 14 priority countries in East and Southern Africa*. Geneva, Switzerland: WHO; 2015.

Dan Macho Okumu. "Strategic CommunicationFactors Affecting the Uptake of Voluntary Medical Male Circumcision (VMMC) Among the Traditionally Non-Circumcising in Kenya." IOSR Journal Of Humanities And Social Science (IOSR-JHSS) , vol. 22, no. 09, 2017, pp. 39–47.