

March 2016 – March 2017



Sustaining
**Voluntary Medical
Male Circumcision
(VMMC)
Services and
Linkages with Adolescent
Sexual and Reproductive
Health (ASRH):**

The Zimbabwe Smart-LyncAges Project



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CONTENTS

Abbreviations and acronyms	4
Age group definitions.....	4
Executive summary	7
Lessons learnt.....	8
Section 1. Project background and overview	9
Background.....	9
Project rationale.....	9
Project objectives.....	10
Overall objective.....	10
Specific objectives.....	10
Start and end dates of this phase.....	10
Project sites and context: Mt Darwin district.....	11
VMMC services in Mt Darwin District.....	12
Source: Zimbabwe National Health Information, 2016.....	13
ASRH services in Mt Darwin District.....	14
Mount Darwin Youth Centre.....	14
Dotito Youth Centre.....	14
Project sites and context: Bulawayo.....	15
VMMC services in Bulawayo.....	16
Source: Zimbabwe National Health Information, 2016.....	17
ASRH services in Bulawayo.....	17
Bulawayo youth centres.....	17
Key programme stakeholders and their roles.....	17
.....	23
Project logical framework	21
Human rights perspectives.....	22
Availability.....	22
Accessibility.....	22
Affordability.....	22
Acceptability.....	22
Quality.....	22
Other key considerations.....	23
Gender.....	26
Ethical considerations.....	23
Participation.....	23
SECTION 2. Project components and implementation	25
Project planning process.....	25
Mapping of the current configuration of ASRH and VMMC	
Services in Mt Darwin and Bulawayo districts.....	25
Protocol to strengthen integration and linkages.....	26
Messages and messaging.....	27
Field test protocol.....	28
Evaluation protocol.....	28
Core components/activities.....	28
Objective 1	28
Objective 2	33
Objective 3	41
Summary of key achievements of the VMMC – ASRH linkage project	42
SECTION 3. Monitoring and results	44
Monitoring mechanisms.....	44
Coverage.....	44

CONTENTS

Peer educators.....	44
Peer educators' use of referral slips.....	45
Service delivery.....	47
VMMC services.....	47
ASRH services.....	48
Adaptations to services and delivery over the project lifespan.....	50
Services package to deliver transformative masculinity.....	50
Service delivery options.....	50
Project design and implementation.....	51
Service package.....	51
SECTION 4. Key lessons learnt and recommendations.....	54
Lessons learnt from implementation and recommendations.....	54
Sensitization and capacity building.....	55
IEC materials development and distribution.....	56
Community participation.....	57
Referrals and tracking.....	57
Joint demand creation and service delivery (service integration and outreach).....	58
Project coordination and partnerships.....	60
Seed funding.....	60
Use of social media.....	61
Peer educators.....	62
Monitoring and evaluation.....	62
Community dialogues and boys' fora.....	63
Challenges with cash and disbursements.....	63
Assessment of stakeholders' perceptions, March 2017.....	64
Background.....	64
Estimated project costs.....	65
Section 5. Implementation considerations for sustainability and scalability.....	68
Sustainability.....	68
Political sustainability.....	68
Sustainability of service delivery options.....	70
Options A and B.....	70
Options C and D.....	70
Peer education.....	70
Scalability.....	70
Possibilities for implementation in other settings.....	72
Vision for scale (governance, ownership).....	72
Pathway to scale and potential challenges that need to be addressed.....	72
Section 6. Next steps.....	74
Modified intervention.....	74

CONTENTS

Tables

Table 1. Age and sex distribution of the population of Mt Darwin, 2012.....	12
Table 2. VMMC coverage by age group in Mt Darwin District, 2016.....	13
Table 3. Age and sex distribution of the population of Bulawayo, 2012.....	16
Table 4. VMMC coverage: Bulawayo province, 2016.....	17
Table 5. Capacity-building sessions conducted.....	32-33
Table 6. Stakeholders that participated in sensitization meetings.....	34
Table 7. Self-perceived roles of stakeholders in the VMMC – ASRH project.....	34
Table 8. Transformative masculinity meetings conducted.....	40-41
Table 9. Dissemination of VMMC information by peer educators in Bulawayo and Mt Darwin, March 2016 – March 2017.....	45
Table 10. Estimated project costs in US\$ by category.....	65
Table 11. Resources contributed by partners (other than WHO).....	66
Table 12. Scalability of project aspects.....	71
Table 13. Modified VMMC – ASRH linkages intervention.....	74-87

Figures

Fig. 1. Map of Mt Darwin District.....	11
Fig. 2. Map of Bulawayo health and administrative districts.....	15
Fig. 3. VMMC and ASRH packages for integrated / linked services.....	26
Fig. 4. Referrals made with referral slips by peer educators, Bulawayo, November 2016 – January 2017.....	46
Fig. 5. Referrals made by peer educators, Mt Darwin, July 2016 – March 2017.....	46
Fig. 6. Numbers and age distribution of youths obtaining VMMC, Mt Darwin District, March 2016 – March 2017.....	47
Fig. 7. Numbers and age distribution of youths obtaining VMMC, Bulawayo, March 2016 – March 2017.....	47
Fig. 8. Numbers of condoms distributed by peer educators, Mt Darwin, January 2016 – March 2017.....	48
Fig. 9. Numbers of condoms distributed by peer educators, Bulawayo, January 2016 – March 2017.....	48
Fig. 10. Attendance at health and livelihoods talks, Bulawayo Youth Centre, January – December 2016.....	49
Fig. 11. Mt Darwin Youth Centre attendance, April 2016 – March 2017.....	49
Fig. 12. Numbers of young people reached through outreach, Mt Darwin District, April 2016 – March 2017.....	50
Fig. 13. Revised service package (particularly the Expanded option).....	51
Fig. 14. Distribution of estimated costs by project area.....	69

Annexes

ABBREVIATIONS & ACRONYMS

AA-HAI	Global Accelerated Action for the Health of Adolescents
AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ASCOP	Accelerated Strategic and Costed Operational Plan
ASRH	adolescent sexual and reproductive health
CWGH	Community Working Group on Health
FGD	focus group discussions
HIV	human immunodeficiency virus
HIMS	health information management system
HTC	HIV testing and counselling
ICPD	International Conference on Population and Development
IEC	information, education and communication
IPPF	International Planned Parenthood Federation
KII	key informant interview
MC	medical circumcision
MOHCC	Ministry of Health and Child Care
NAC	National AIDS Council
NGO	nongovernmental organization
OI	opportunistic infections
PCN	primary care nurse
PE	peer educators
POSM	programmatic options and support materials
PSI	Population Services International
QA	quality assurance
RGN	registered general nurse
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SGDs	Sustainable Development Goals
SOPs	standard operating procedures
SRH	sexual and reproductive health
STI	sexually transmitted infection
TOT	training of trainers
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VMMC	voluntary medical male circumcision
WHO	World Health Organization
YFC	youth-friendly centre
YMCA	Young Men's Christian Association
ZAPSO	Zimbabwe AIDS Prevention Support Organization
ZNAC	Zimbabwe National AIDS Council
ZNFPC	Zimbabwe National Family Planning Council
ZNNP+	Zimbabwe National Network of Positive People

Age group definitions

An adolescent is a person 10–19 years of age inclusive.

A youth is a person 15–24 years of age inclusive.

A young person is a person 10–24 years of age inclusive.

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The Report, Sustaining VMMC Services and Linkages with ASRH: The Zimbabwe Smart LyncAges Project March 2016- March 2017 represents strong collective effort from different stakeholders and organisations in the implementation of the Smart LyncAges project. The first phase of the Smart LyncAges project was implemented under the leadership of the Ministry of Health and Child Care, AIDS and TB Unit in close collaboration with the Family Health Department from March 2016 to February 2017 and it will inform the future of ASRH and VMMC programming in Zimbabwe.

The Ministry of Health and Child Care therefore wishes to acknowledge the different organisations and individuals who played a very pivotal role in the implementations of this pilot project in the different phases. The Zimbabwe National Family Planning Council (ZNFPCC) played a pivotal role as some of the project activities were implemented by and through its structures. Population Services International (PSI), the VMMC implementing partner in the two project sites (Bulawayo metropolitan province and Mt Darwin district) was key in both joint demand creation at community level and issuing out referrals to young people. This project would not have been successful without the financial and technical support from the World Health Organisation (WHO) and the Bill and Melinda Gates Foundation. Special acknowledgement and appreciation go to the team from the City of Bulawayo, namely the Department of Housing and Community Services, which coordinates the 15 youth centres in Bulawayo and the City Health Department for their unwavering support.

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FOREWORD

Adolescence is a period of rapid of physical change, psychological maturation, and social value acquisition. Adolescents and young people are faced with a myriad of challenges relating to their health, educational commitment, social behaviour, sexual development, familial conflicts, economic problems, and substance abuse. These factors may certainly modulate personality and individual behaviour. According to the Zimbabwe Demographic Health survey of 2015, the country has Adolescent Sexual Reproductive Health (ASRH) indicators showing risky behaviours among young people. Of greater concern are the age-disparity in HIV prevalence among young people, high rate of early sexual debut and low condom use indicating a gap in both ASRH and HIV prevention programming for adolescents. Nevertheless, Zimbabwe has implemented several programmes to limit HIV infection among young people with the two core strategies being Voluntary Medical Male Circumcision (VMMC) and provision of ASRH services.

The ARSH and VMMC programs have however been implemented as vertical health programs, despite an overlap in their respective packages. In 2016, the WHO supported the Ministry of Health and Child Care to pilot the Smart-LyncAges project to identify approaches to sustain VMMC and improve the linkages with ASRH services. Through the project, cross-referral mechanisms were established wherein adolescent boys from VMMC are linked to ASRH programmes and vice versa. Participatory approaches were introduced to engage and ensure participation of young people and their respective communities.

This report is aimed at sharing the lessons learnt from the first pilot project in Zimbabwe which sought to assess the feasibility and capacity strengthening requirements of linking and integrating ARSH and VMMC programmes for adolescent boys. These would also serve to inform transition to longer term VMMC and general HIV prevention services. The two projects sites that were involved in the pilot project; Mt Darwin and Bulawayo provided a balanced mix of lessons as models varying in context were tested, catering for both the urban and rural dynamics settings of Zimbabwe. The different and complementing stakeholders worked hand in glove to build models on how the once vertical programmes could be effectively and efficiently linked. The pool of

stakeholders included the Ministry of Health and Child Care (MOHCC), World Health Organisation (WHO), Zimbabwe National Family Planning Council (ZNFFPC), Bulawayo City Council and Population Services International (PSI) among other Community Based Organisations (CBOs) and Non-Governmental Organisations (NGOs) working in the two sites.

It is envisioned that these stakeholders and Zimbabwe at large will continue to harness and maximise benefits of linking VMMC and ASRH services, through building strong collaborations and partnerships that positively impact the health of adolescents and young people, thereby preventing disease and death in this important segment of the population. An early realisation by all key players across sectors of the importance of such integration and linkages would sustain the gains thus far made and produce a direct return on investment especially required in the resource limited setting like ours. Commitment at all levels is therefore required in building resilient health systems and providing the necessary leadership.

Finally I urge all stakeholders to utilise the report findings on how to improve VMMC and ARSH outputs and impact positively the HIV and reproductive health indicators among adolescents and young people. The strategic and operational direction for intergrating and linking ARSH and VMMC services provided for in this report is in everyone's best interest.



Dr A. Mahomva
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EXECUTIVE SUMMARY

Sexual and reproductive health and HIV prevention are top priorities for the Ministry of Health and Child Care (MOHCC) of Zimbabwe. To strengthen sustainable delivery of adolescent sexual and reproductive health (ASRH) and voluntary medical male circumcision (VMMC), the MOHCC conducted a participatory pilot project to initiate, inform and strengthen integration and linkages of these two programmes and services. The World Health Organization (WHO) provided technical and financial support through the Bill & Melinda Gates Foundation and the United States President's Emergency Plan for AIDS Relief /

and money for both the health system and the clients.

However, systematic and joint delivery of these services is new. Pilot-testing is needed to determine how best to realize these services and maximize their potential benefits. This report describes the design, implementation and findings of a participatory learning project that was conducted to explore implementation and inform scale-up of integrated VMMC and ASRH services in Zimbabwe.

In 2017 the VMMC programme was in the catch-up phase, addressing men of all ages as well as increasing the focus on those adolescents and adult men most at risk. Now it is entering a maintenance phase, serving mostly young men as or before they enter puberty. Thus, this project sought to inform the design of longer-term, sustainable VMMC services by bringing together the strengths of the ASRH and HIV/VMMC programmes. The objectives were to assess the feasibility and capacity-strengthening needs for enhancing linkages between ASRH and VMMC services and interventions, while incorporating interventions to transform young men's gender norms.

An assessment phase, undertaken in 2014–2015, included mapping of the available service delivery; information, education and communication (IEC) materials; and messages. Stakeholder engagement was key throughout the steps and the selection of districts for the pilot project. The pilot project followed this preparatory phase.

The participatory learning project was designed to test, within the current systems, what sustainable ASRH and MC services to deliver and how to deliver them.

Centers for Disease Control and Prevention.

Adolescent males already constitute a major proportion of all VMMC acceptors. This segment of the population otherwise has little contact with the health system. Thus, VMMC services provide an important opportunity to offer adolescent boys other HIV prevention and ASRH information and services and to link them with other interventions. An integrated and linked approach to VMMC and ASRH has many potential benefits. These include strengthening the competence of service providers, improving the quality and coverage of services for adolescents, making better use of resources by decreasing duplication and so saving time

The project was deliberately designed to test within current systems and services in order to determine feasibility and capacity building needs for sustainable services within current systems. The intent of participatory testing was to engage those involved from the beginning and develop a model that would later be more rigorously evaluated in the next phase of activity.

The interventions tested included community engagement, capacity-building of providers and peer educators, use of referral slips, joint demand generation activities for VMMC and ASRH, and use of social media to disseminate ASRH and VMMC information. UNICEF's U-Report messaging platform was also used to disseminate information and gather young people's opinions on various ASRH and VMMC topics. Project activities started in March 2016 with sensitization meetings and training of service providers and peer educators (PE) as well as to develop IEC materials with both ASRH and VMMC messages. The pilot phase ended in March 2017 with a meeting to review the implementation and to plan for the next phase. Among other impacts, the project contributed to a revision of the National ASRH Strategy 2017–2020 and the ASRH training manuals to incorporate VMMC in both.

Lessons learnt

The most feasible components of the project proved to be community engagement, including engagement of young people; aspects of capacity-building; provision of basic ASRH and VMMC information by both ASRH and VMMC service providers; development of IEC materials with joint messages; and using social media to disseminate information as well as to coordinate stakeholders.

Pilot implementation taught many lessons.

The five main lessons were that:

- 1. Integration and linkages should be undertaken from a systems perspective.** A strong, resilient health system is needed to facilitate and sustain integration and strong linkages. Without strong systems, the linkages are weak.
- 2. Collaboration within the health sector and across sectors, is key** for sustaining adolescent health services. Different departments offer health programmes in a

predominantly vertical manner. Partnerships are key to maximize the return on limited resources and increase impact on the overall health of adolescent boys.

- 3. Commitment by leadership is essential to ensure that staff time is dedicated to the intervention;** particularly to strengthen coordination with stakeholders across the health system and from national to subnational levels; and to identify sufficient funding.
- 4. Meaningful and active community engagement strengthens ownership and linkages** throughout the community (among community health workers, parents, peer educators, traditional leaders, opinion leaders and others). Youth engagement and participation is critical to assure age-relevant messaging and services, and engagement of other relevant community resources
- 5. Service delivery models need to be informed by context-specific issues.** Models vary with context, but youth-friendly service provision and appropriate referrals by competent providers are the foundation.

The participatory pilot project suggests that the project interventions are sustainable, but several issues need further policy, programme and research action. Evaluation of the project activities and interventions relied on routine data collection and feedback from stakeholders during monitoring visits. Going forward, quantitative evaluation and research methodologies are needed to better gauge impact. Research should explore key underlying issues, including costs, and test the validity of the observations from this participatory pilot project. The next phase of the project will further evaluate the interventions while continuing to support implementation in the initial districts as next step towards integrated programming.

SECTION 1.

Project Background And Overview

Background

Against the backdrop of both national and international recognition of the challenges that young people face concerning sexual and reproductive health, the Ministry of Health and Child Care (MOHCC), in partnership with the Zimbabwe National Family Planning Council (ZNFPC), undertook the Adolescent Sexual and Reproductive Health (ASRH) programme, guided by the National Adolescent Reproductive Health Strategy 2010–2015. The MOHCC and its partners have been implementing youth-friendly services through the Youth Friendly Corners and Youth Centres among other approaches. This has been run through different funding initiatives, mainly the Youth Responsibility Project 1996–2000, funded by the United States Agency for International Development (USAID), and the Urban Youth Project 2001–2005, funded by the Joint United Nations Programme on HIV/AIDS (UNAIDS). Currently, the ASRH programme is funded by the National AIDS Council (NAC), the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF).

In 2007 the World Health Organization (WHO) and UNAIDS recommended voluntary medical male circumcision (VMMC) as part of a comprehensive HIV prevention package in countries with a generalized HIV epidemic and low rates of male circumcision. WHO based this recommendation on evidence that male circumcision reduces men's risk of becoming infected with HIV through heterosexual intercourse by as much as 60%. In 2010 Zimbabwe officially launched VMMC as a core HIV prevention programme. The goal was "to contribute to the reduction of HIV incidence by scaling up VMMC to reach 80% of HIV-negative men between 13–29 years by 2017" (2007 Accelerated Strategic and Costed Operational Plan 2014–18). MC coverage was estimated to have reached 62.1% at the end of 2016, with ongoing scale-up underway that includes reaching adolescents and adult men.

In 2010 the WHO Department of Maternal,

Newborn, Child and Adolescent Health developed a draft document, Programmatic options and support materials (POSM): Linking male circumcision and adolescent sexual and reproductive health (ASRH), to guide improvements in linkages between programmes providing male circumcision and those offering ASRH. In 2013 a series of consultations with stakeholders on integrating ASRH and VMMC in Zimbabwe recommended actions in two broad areas, service delivery (including masculinity and life skills interventions) and messaging.

Service delivery recommendations focused on integration and linkage elements of both VMMC and ASRH service sites and on strengthening the competencies of service providers to deliver age-appropriate information about sexual behaviour, including masculinity, and life skills interventions.

Messaging recommendations focused on strengthening and improving VMMC messages to make them more age- and gender-appropriate; addressed gender-specific issues for adolescent boys; mainstreamed VMMC within ASRH information to broader community audiences; and sought to enhance girls' and parents' understanding of VMMC and the protection that it offers.

Project rationale

The MOHCC seeks to undertake projects to inform the delivery of health services for adolescents. Integration of ASRH and VMMC services has been proposed as an approach to increase adolescents' access to important health services and foster the sustainability of these services. The MOHCC received financial and technical support from WHO between April 2014 and March 2017 to prepare, through stakeholder engagement and assessment, explore and test in a participatory manner how integration of ASRH and VMMC services might be achieved. The rationale for strengthening integration and

linkages between VMMC and ASRH programmes for adolescent boys is as follows:

VMMC is important for HIV prevention.

HIV remains a major public health challenge in Zimbabwe. VMMC is one of the most effective HIV prevention interventions and is being promoted in the country.

Adolescent boys will be a priority client group for VMMC programmes.

Currently, VMMC is mostly provided in a vertical manner, in order to circumcise, as a priority, adult men as well as adolescents in as short a period of time as possible – dubbed the “catch-up” phase. However, beginning soon, VMMC implementation will require a more integrated strategy and will explicitly address adolescent boys, preferably before their sexual debut.

Integration offers important and unique opportunities for contact with adolescent boys.

Adolescent boys already constitute a major proportion of VMMC acceptors. The health system usually has very little contact with this section of the population. Therefore, VMMC provides an important opportunity to offer them other HIV prevention and ASRH information, services and other interventions.

ASRH and VMMC programmes may provide entry points for each other.

It is important that providers of adolescent health services and interventions are able to motivate adolescents to access VMMC services. At the same time, VMMC programmes provide opportunities to increase adolescent boys’ access to ASRH services.

VMMC and ASRH interventions are complementary and reinforcing.

Several services to be delivered under VMMC or ASRH are the same. These include HIV testing services, STI prevention, screening and treatment, and condom provision. Thus, stronger linkages between VMMC and ASRH facilities and service providers will likely benefit both programmes and help improve health outcomes for adolescent boys.

Linking VMMC and ASRH programmes has many potential benefits.

These benefits include strengthening the competency of service providers and improving the quality and coverage of services for adolescents, making better use

of available resources, decreasing duplication, and saving time and money for both the health system and its clients.

Strengthened VMMC – ASRH linkages can be an entry point for improving adolescent health, which also will affect their health and care seeking as adult men. The lessons learned from making district services and facilities, centres and nongovernmental organizations (NGOs) more responsive to adolescent boys’ VMMC and ASRH needs can help to improve all services and interventions for this segment of the population.

Project objectives

Overall objective

To assess the feasibility of ASRH – VMMC integration and/or linkages and the capacity-strengthening needed to do so in order to inform the transition to longer-term VMMC strategies and services along with addressing young men’s gender norms.

Specific objectives

1. to develop a resource package of effective materials for messaging and learning, service delivery protocols (SOPs) for providers and easy-to-use capacity-building manuals;
2. to strengthen communication and collaboration among various stakeholders at all levels on VMMC and ASRH linkages and integration;
3. to inform actions needed for the long-term sustainability of VMMC services beyond the catch-up phase, including identifying facilitators and barriers to integrating or linking elements of service delivery at both VMMC and ASRH sites and testing ways to address those barriers.

Strengthened VMMC – ASRH linkages can be an entry point for improving adolescent health.

Ultimately, the integration and linkages of VMMC and ASRH programmes should maximize contact with adolescent boys as the primary beneficiary group and adolescent girls as a secondary audience.

Start and end dates of this phase

March 2016 – March 2017

**Project sites and context:
Mt Darwin district**

The project was implemented in Mt Darwin district in Mashonaland Central Province and in the city of Bulawayo in Bulawayo Metropolitan Province.

5.1%. The proportion of 6–16 year-olds who have never been to school was 5.2%, and the proportion of 6–16 year-olds out of school was 10.7%. A significant proportion (44%) of 20–24 year-olds attained education only at the primary school level. Mt Darwin is, therefore, a relatively disadvantaged district socio-economically.

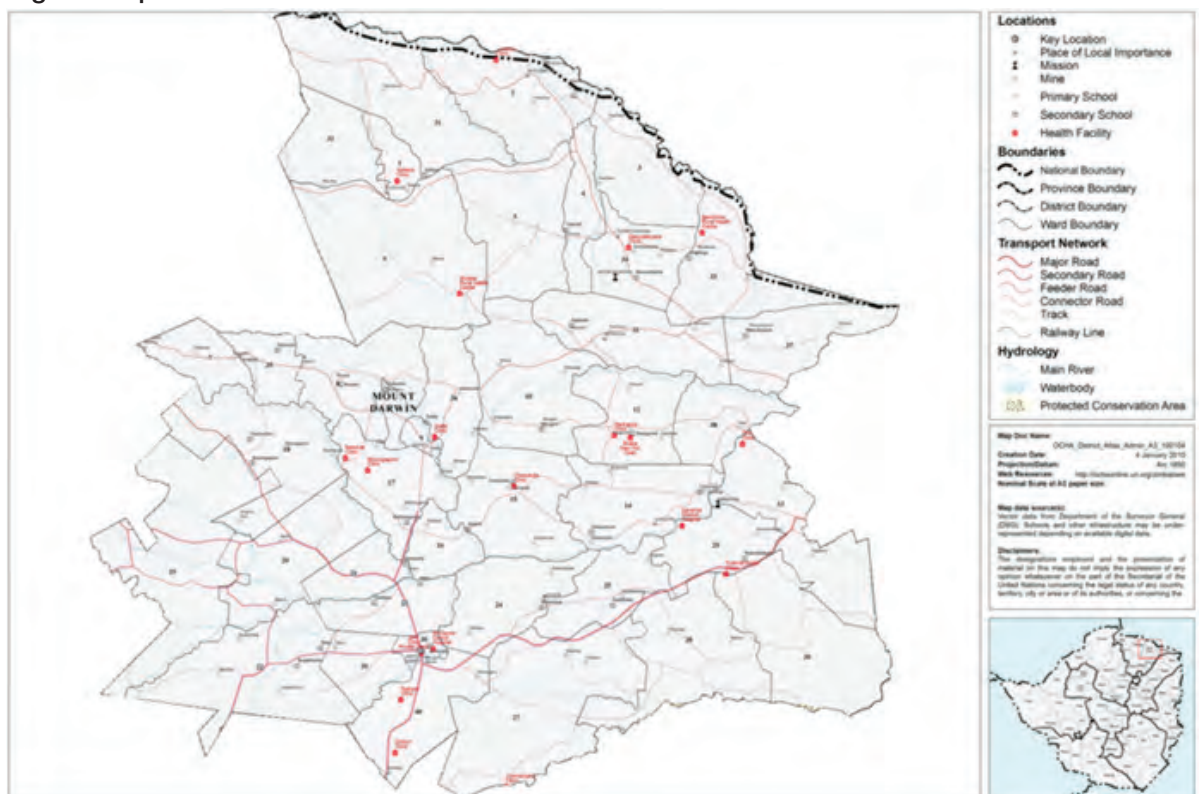
Mt Darwin is a relatively disadvantaged district socio-economically and lies in the province with the country's highest teen pregnancy rate.

Mt Darwin is one of seven districts in the Mashonaland Central province of Zimbabwe

Mt Darwin has been identified as one of the geographical hotspots for HIV, with medium to high risk factors for transmission (HIV Hotspot Analysis of Zimbabwe, 2014). In 2014 HIV prevalence in the district was among the highest in the country, at 11.5% among those ages 15–49 years. According to the National Adolescent Fertility Study 2016, Mt Darwin is in the province that has the highest teenage pregnancy rate in the country, with 28.1% of women ages 15–19 years reporting that they have ever been pregnant.

(Fig. 1). The district consists of rural communities that rely on subsistence farming. It is generally underdeveloped, with relatively high poverty levels. According to the 2012 national census, the district's total population was 212 725 (Table 1), and the youth unemployment rate was

Fig. 1. Map of Mt Darwin District



Source: United Nations Office for the Coordination of Humanitarian Affairs (OCHA), 2010

Table 1. Age and sex distribution of the population of Mt Darwin, 2012

Age group	Males		Females		Total	
	Number	Percent	Number	Percent	Number	Percent
Not stated	165	39.4	254	60.6	419	100
Under 1	3 699	50.1	3 681	49.9	7 380	100
1–4	13 068	49.8	13 154	50.2	26 222	100
5–9	14 876	50.1	14 798	49.9	29 674	100
10–14	14 919	50.5	14 640	49.5	29 559	100
15–19	11 806	52.7	10 576	47.3	22 382	100
20–24	8 750	47.6	9 647	52.4	18 397	100
25–29	8 098	47.9	8 821	52.1	16 919	100
30–34	6 415	48.4	6 831	51.6	13 246	100
35–39	5 601	47.9	6 104	52.1	11 705	100
40–44	3 758	50.2	3 733	49.8	7 491	100
45–49	2 045	44.6	2 540	55.4	4 585	100
50–54	1 908	33.2	3 836	66.8	5 744	100
55–59	1 666	37.1	2 823	62.9	4 489	100
60–64	1 745	39.6	2 657	60.4	4 402	100
65–69	1 367	44.4	1 714	55.6	3 081	100
70–74	1 272	46.7	1 449	53.3	2 721	100
75+	2 045	47.5	2 264	52.5	4 309	100
Total	103 203	48.5	51.5	212 725	100	

Source: Zimbabwe national census, 2012

VMMC services in Mt Darwin District

Mt Darwin District Hospital is the biggest health facility in the district. It provides referral and supervisory support to 19 clinics and rural health centres in the district. VMMC is primarily offered primarily at the hospital, with a few outreach sites such as Dotito Rural Hospital. Mobilization relies on a combination of IEC materials (posters and pamphlets), school-based demand generation initiatives and VMMC mobilizers who provide basic information on VMMC and the availability of services in the district. Through MOHCC, Population Services International (PSI) provides financial and technical support such as training, provision of sundries and IEC materials for the VMMC programme in the district. There is a VMMC team comprising six nurses and two doctors, but only two of those nurses had received ASRH training at the district hospital. The team provides VMMC services at static sites as well as through outreach. The team members are full-time employees of MOHCC, with other duties in the hospital; they perform VMMC

part-time. PSI pays them a performance-based allowance for performing VMMC procedures. The VMMC programme is well-funded and more vibrant than the ASRH programme.

The VMMC service package includes:

- HIV testing and counselling
- health education on HIV prevention and wound management
- STI diagnosis, treatment and management
- referrals to the antiretroviral therapy (ART) clinic for those who test HIV-positive
- family planning and distribution of male and female condoms.

By the end of 2016

Mt Darwin district was at 35% of the VMMC target of 62 730 medical

circumcisions among the 10–29 years age group. Coverage is highest (50%) in the 15–19 age group and lowest in older men, ages 55–59 years (Table 2).

VMMC coverage is highest (50%) in the 15–19 age group.



Mt Darwin Youth advisor disseminating information puberty and sex and sexuality at Tangenhamo secondary school on the 27/10/17



Mt Darwin youth advisor discussing VMMC and ASRH with a group of women at a community dialogue at the youth centre

Table 2. VMMC coverage by age group in Mt Darwin District, 2016

Age group (years)	10–14	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	10–29
Coverage (%)	21	50	42	29	19	15	13	11	10	9	35

Source: Zimbabwe National Health Information, 2016

ASRH services in Mt Darwin District

ASRH services in Mount Darwin District are offered primarily by the Zimbabwe National Family Planning Council (ZNFPC), which runs two static Youth Friendly Centres – the Mt Darwin and Dotito Youth Centres. These centres offer youth-friendly reproductive health services in line with the national ASRH strategy and manual. The ASRH programme in Zimbabwe focuses on 10 to 24 year-olds, although it also reaches other age groups. All services are offered on an outreach basis as well as at the centres. However, outreach depends entirely on availability of sufficient funding and is erratic, since there are no funds specifically allocated to outreach and funding must come from other budgets when available. Each youth centre is supposed to be staffed by a Youth Health Advisor (a registered general nurse), a Youth Facilitator (a social worker) and five peer educators.

Prior to the ASRH – VMMC pilot project, the youth centres offer the following services:

- **Health education talks.** These are presented mainly as group discussions. Topics covered include HIV prevention, VMMC, growing up, friendship, dating, how to negotiate safer sex, contraception, menstruation and basic hygiene, among others.

- **Counselling on youth issues.** Youth Facilitators provide counselling as needed to youth who visit the centre. In addition, one-on-one counselling services are provided to youth identified during health talks as possibly having problems such as substance abuse or family/relationship problems at home. Group counselling is also provided to young people as a way of helping them to confront challenges such as the changes in their anatomy that are a normal part of growing up. These topics are addressed mainly in the health educational talks and youth group discussions.

- **Edutainment services** are mostly film, drama and sport. These are often used to mobilize youth to seek services. Topics covered under these services are similar to those covered in group talks, with the only major differences being the delivery approach and methodology.

- **Indoor and outdoor games.** These include darts, soccer and snooker/pool. Centres often

receive games equipment from stakeholders such as the Youth Centre Committee, parents and the Zimbabwe National AIDS Council (ZNAC).

- **Library services.** The centres offer various books and hand-outs on ASRH as well as space for reading.

- **Distribution of IEC materials.** Various IEC materials are distributed to young people to ensure that they have accurate and comprehensive information on sexual and reproductive health. IEC materials are distributed at the youth centres and health facilities as well as in the community.

- **Life skills education.** Through counselling and group discussions, young people receive information on life skills, including negotiation skills and assertiveness.

- **Clinical services.** Both youth centres in the district offer basic clinical services such as STI screening and treatment as well as provision of contraceptives including male and female condoms.

- **Referrals for clinical and non-clinical services.** Clinical complications related to family planning, STI management and other conditions that cannot be managed by the Youth Health Advisor at the youth centres are referred to Mt Darwin Hospital. This includes referrals for VMMC. Before the project, however, these referrals were conducted in an unsystematic way, with no procedure to track them.

Mount Darwin Youth Centre

This centre is situated near Mt Darwin Hospital. In the first quarter of 2016, the centre was fully staffed. However, by the end of quarter 3, the peer educators and the Youth Facilitator had left, and they have not been replaced to date. Reasons for the departure of the peer educators included marriage and going to college. The Youth Facilitator found a more lucrative opportunity.

Dotito Youth Centre

This centre is located about 40 km from Mt Darwin Hospital. ZNFPC trained five peer educators in ASRH there in the first quarter of 2016. The centre also has a Youth Health Advisor. The Youth Facilitator was hired in the second half

of 2016. There is no electricity or water at the centre, and the building is deteriorated. ZNFPC planned to renovate it, but this has not been possible due to lack of funds. According to ZNFPC staff and peer educators, youth attribute their low attendance to the state of the building and furniture, which is unattractive to the young people.

**Project sites and context:
Bulawayo**

Bulawayo is the second largest city in Zimbabwe (Fig. 2). According to the last census, in 2012, it has a total population of 653 337 people, with the 15–19 year age group, at 78 205, constituting the largest 5-year age group (Table 3).

The municipality of Bulawayo is responsible for providing social services to the residents of the

of residents to adopt healthy life styles; continuous staff development, training and support; provision and maintenance of health services infrastructure; innovative interventions; and action-oriented health systems research. Static services are offered through the 19 City Council clinics under the city Health Services Department. The clinics provide curative services, rehabilitation, counselling, HIV testing and counselling; STI management; services for opportunistic infections and ART; family planning; cervical cancer screening; and tuberculosis, malnutrition, and antenatal and postnatal care. VMMC services are not offered, as council health staff members are not trained in VMMC, and they do not have the equipment required to provide the service. Clients, including young people, are expected to pay a consultation fee amounting to US\$ 5 to access services at these clinics.

Like Mt Darwin, Bulawayo has been identified as a geographical HIV hotspot, with an estimated prevalence of 19.8% among those ages 15–49 years (HIV Hotspot Analysis of Zimbabwe, 2014). Bulawayo Province has a relatively low teenage pregnancy rate, with 11.1% of women ages 15–19 years reporting that they have ever been pregnant, according to the National Adolescent Fertility Study 2016.

Bulawayo is an HIV hotspot but has a relatively low teenage pregnancy rate.

city. It is a local government run by a council of elected representatives. The city's Health Services Department (Council) is responsible for maintaining and promoting a healthy environment and for providing accessible, affordable and high quality services to residents. This is achieved through involvement of communities in health promotion activities and empowerment

Fig. 2. Map of Bulawayo health and administrative districts

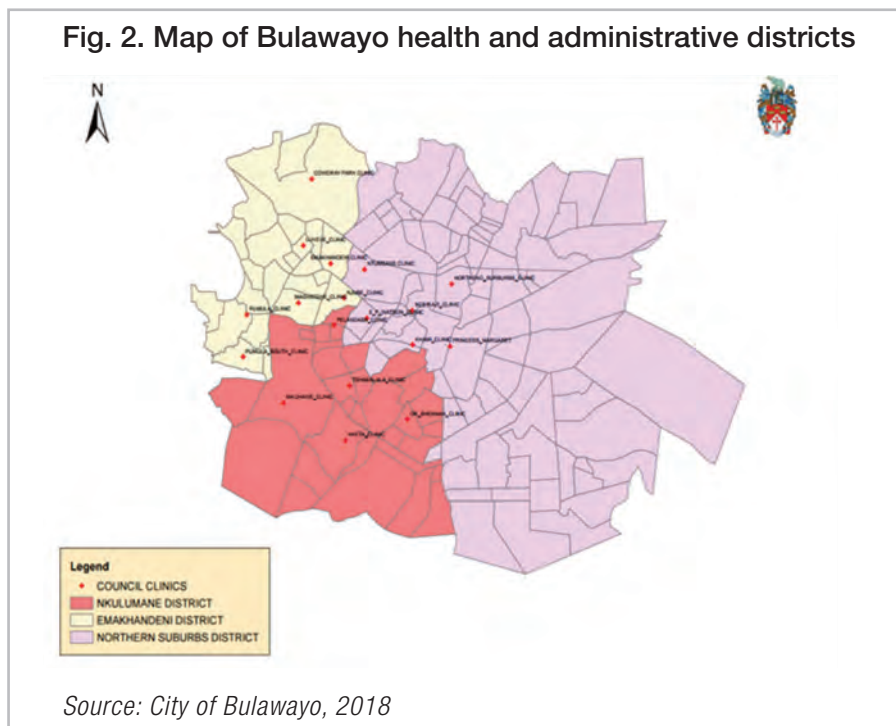


Table 3. Age and sex distribution of the population of Bulawayo, 2012

Age Group	Males		Females		Total	
	Number	Percent	Number	Percent	Number	Percent
Not stated	232	49.7	235	50.3	467	100
Under 1	9 425	50.0	9 436	50.0	18 861	100
1–4	32 610	49.5	33 238	50.5	65 848	100
5–9	32 980	48.7	34 699	51.3	67 679	100
10–14	32 940	47.4	36 570	52.6	69 510	100
15–19	33 923	43.4	44 282	56.6	78 205	100
20–24	31 803	43.4	41 436	56.6	73 239	100
25–29	28 817	45.0	35 261	55.0	64 078	100
30–34	23 831	47.0	26 829	53.0	50 660	100
35–39	18 691	47.9	20 304	52.1	38 995	100
40–44	15 119	49.0	15 729	51.0	30 848	100
45–49	10 475	45.1	12 776	54.9	23 251	100
50–54	9 945	44.9	12 180	55.1	22 125	100
55–59	8 144	48.4	8 668	51.6	16 812	100
60–64	5 392	48.2	5 794	51.8	11 186	100
65–69	3 375	44.1	4 277	55.9	7 652	100
70–74	2 266	41.2	3 233	58.8	5 499	100
75+	3 378	40.1	5 044	59.9	8 422	100
Total	303 346	46.4	349 991	53.6	653 337	100

Source: Zimbabwe national census, 2012

VMMC services in Bulawayo

There are two VMMC sites in Bulawayo, namely the Bulawayo MC site and the Lobengula MC site, both run by PSI. Both sites provide static and outreach services. Clients are mobilized by PSI-trained mobilizers and at community gatherings through collaboration with stakeholders, including the youth centres. With the implementation of the VMMC – ASRH pilot project, youth centre peer educators were recruited as VMMC mobilizers, and PSI VMMC teams began offering male circumcision outreach services routinely at the youth centres and City Council clinics. The VMMC teams are

composed of nurses, doctors, clerks and theatre assistants. The VMMC programme in Bulawayo is well funded and has better capacity to deliver services than the ASRH programme.

In contrast to Mt Darwin, VMMC coverage in Bulawayo is high, at 63% of the target of 155 328 for the 10–29 year age group. Like Mt Darwin, the 15–19 year age group in Bulawayo has the highest coverage, at 72% (Table 4).

In both project areas VMMC services are stronger than ASRH services.

Table 4. VMMC coverage: Bulawayo province, 2016

Age group (years)	10–14	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	10–29
Coverage (%)	62	72	66	53	41	32	26	22	21	18	63

Source: Zimbabwe National Health Information, 2016

ASRH services in Bulawayo

In Bulawayo sexual and reproductive health services are provided primarily through ZNFPC, which has two clinics, namely Lister Clinic and Mpilo Training Centre. UNFPA and IPPF fund the clinics for service provision and training. At times the clinics also receive project funding from ZNAC and UNICEF. Both clinics provide HIV testing and counselling, couples counselling and contraceptives such as intrauterine contraceptive devices and implants. ZNFPC services target primarily youth, ages 10–24 years. Services are free for adolescents. Only youth who can afford it are asked to pay; the nurse in charge assesses ability to pay by asking a set of questions. According to ZNFPC staff, youth can rarely afford to pay; almost everyone is treated for free. These facilities receive more female clients than male (70% and 30%), possibly because of their orientation towards family planning, which may be perceived as a concern only of females. ZNFPC trains peer educators for other organizations such as the Bulawayo City Department of Housing.

Bulawayo youth centres

The Bulawayo City Department of Housing coordinates 15 youth centres in the western suburbs of the district (low-income, high-density areas). During the colonial era youth centres were there to remove the youth from the streets and were a place where employers would go to recruit youths to work in factories. After independence the centres remained functional, providing recreational activities and livelihoods trainings. The youth centres are focussed primarily on recreation, the aim of which is to develop youths physically, mentally, spiritually and socially so that they become responsible citizens. These centres promote youth development through sports, other recreational services and life skills training. The youth centres also have a “moral development” aspect, focused on reproductive health programmes that encompass sexual development, counselling and sexually transmitted infections (STIs), with special emphasis on HIV. In collaboration with ZNFPC, the centres provide adolescent sexual and reproductive health services. Also, the centres send peer educators into communities to mobilize youths to participate in activities at the youth centres.

Key programme stakeholders and their roles

A list follows of stakeholders and their responsibilities in the VMMC – ASRH pilot project.

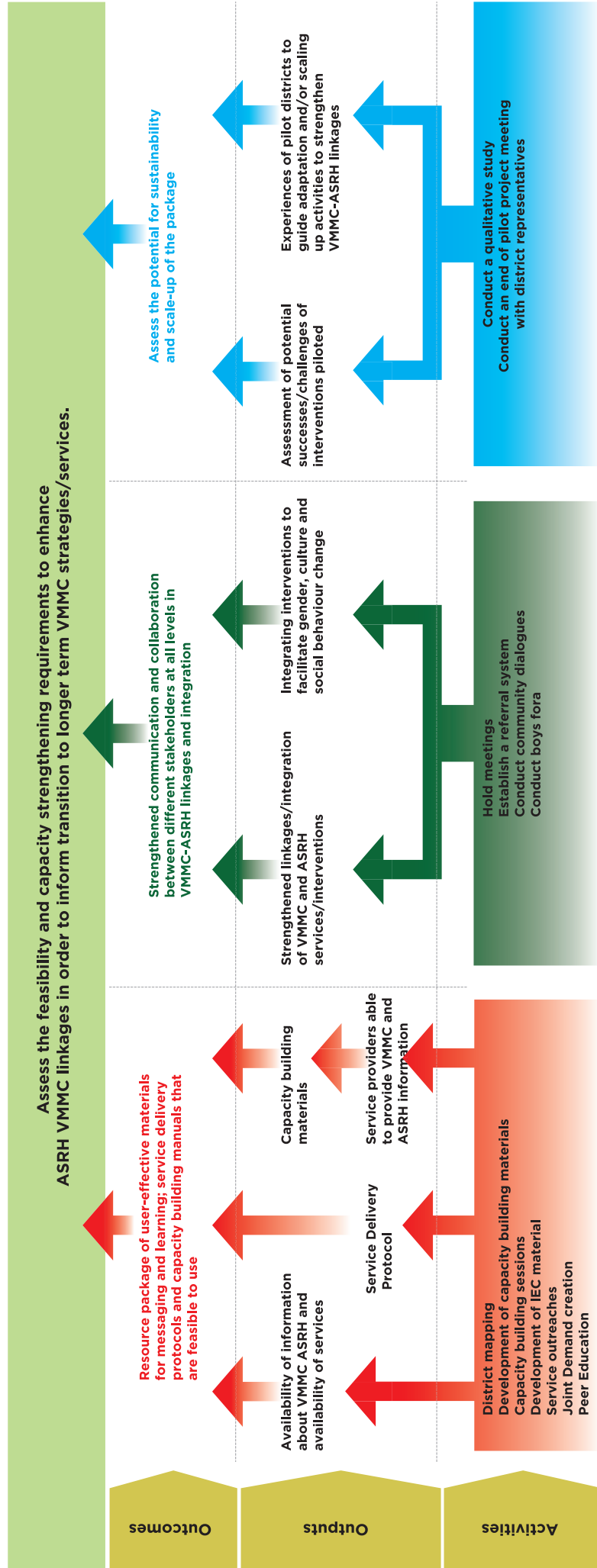
Stakeholders	Roles
MOHCC HQ	<ul style="list-style-type: none"> • coordinate the project; • develop project implementation plans and budgets in consultation with relevant stakeholders; • lead the development of IEC materials; • draft U-Report opinion poll questions; • facilitate meetings at national and district levels; • facilitate the capacity-building of service providers; • conduct monthly monitoring and support visits to districts.
MOHCC provincial, district and facility levels	<ul style="list-style-type: none"> • provide VMMC services; monitor and record data; • offer ASRH and VMMC information; • complete referral forms and track clients; • provide clinical services such as STI treatment; • promote and distribute condoms.

Stakeholders	Roles
ZNFPC	<ul style="list-style-type: none"> • coordinate and monitor the provision of integrated adolescent reproductive health and family planning services; • coordinate and deliver ASRH services; • train peer educators; • participate in project meetings, district monthly support visits and quarterly review meetings.
City of Bulawayo	<ul style="list-style-type: none"> • coordinate and supervise youth centre activities – recreational activities, vocational training; • provide venues for project meetings, for example, district review meetings, community dialogues, boys' fora.
<u>Youth centres</u>	
Youth Health Advisors	<ul style="list-style-type: none"> • promote safer sex practices, risk reduction counselling and social and behaviour change communication; • screen for and treat STIs; • make referrals; • provide integrated sexual and reproductive health (SRH) services, information and management of STIs, including HIV, and male circumcision; • encourage parent–child communication on male circumcision and sexuality education by capacitating both parents and youths to be able to discuss.
Youth Facilitators	<ul style="list-style-type: none"> • encourage parent–child communication on male circumcision; • integrate life skills and livelihood programmes into the SRH programme; • counsel for ASRH and male circumcision services; • promote HIV prevention, HIV testing and counselling (HTC), including promoting the benefits of VMMC to men and women; • promote safer sex practices and conduct risk reduction counselling and social and behaviour change communication; • promote and distribute male and female condoms; • conduct outreach health education talks and distribute IEC materials on ASRH and male circumcision.
Recreation leaders	<ul style="list-style-type: none"> • coordinate youth centre activities.
Peer educators	<ul style="list-style-type: none"> • coordinate youth centre activities.
Referral services	<ul style="list-style-type: none"> • refer youth where they can get the services or information they need for HIV testing and other ASRH care; • provide information to individuals and groups through discussions, video screenings, drama, sports events, games, music and demonstrations; • organize meetings and educational sessions, hold regular meetings and organize and conduct formal group discussions on reproductive health topics; • participate in IEC materials development, including materials on VMMC, and distribute IEC materials, display posters; • participate in the development of the referral system.

Stakeholders	Roles
Community Resources Centre	<ul style="list-style-type: none"> • stock VMMC and ASRH behaviour change materials and answer frequently asked questions; • motivate and support behaviour change: carry out one-on-one or small group discussions; • counsel, including support and help for problem solving. Also, teach peers how to negotiate safer sex and to assess their risk.
Community-based distribution	<ul style="list-style-type: none"> • distribute condoms and teach condom use skills; • participate in community activities such as commemoration of important health days – AIDS Day, TB Day, etc.; • carry out community services such as supporting people living with HIV and orphans; • may be involved in income generating projects.
Youths	<p>Youth activities are organized through the various youth centres, with the peer educators as the leaders.</p> <ul style="list-style-type: none"> • organize talk shows, music and sports galas on VMMC and ASRH and actively engage the community; • distribute IEC materials; • encourage each other to go to youth centres; • actively involve both youth in school and youth out of school in all activities; • participate in exchange programmes between the youth centres so that they learn from each other; • advocate active involvement of youths living with disabilities, for example, the deaf; • use community halls to disseminate more information.
Local community leaders	<ul style="list-style-type: none"> • continue supporting work being done at youth centres; <p>create an enabling environment for the adolescents to access more information on ASRH and VMMC.</p>
Community Health Workers	<ul style="list-style-type: none"> • offer youth-friendly services; • disseminate ASRH and VMMC information; • train adolescents on livelihood skills.
National AIDS Council (NAC)	<ul style="list-style-type: none"> • coordinate stakeholders at district level; • participate in project meetings; • support youth centre activities, for example, through provision of sports equipment.
Padare Enkundleni Men's Forum on Gender	<ul style="list-style-type: none"> • draft a manual to facilitate community dialogues and boys' fora; • participate in community dialogues and boys' fora preparatory meetings; • facilitate community dialogues and boys' fora sessions; • assist in report writing after each session.

Stakeholders	Roles
Young Men’s Christian Association (YMCA), Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) and the Ministry of Women Affairs, Gender and Community Development	<ul style="list-style-type: none"> • participate in community dialogues and boys’ fora preparatory meetings; • facilitate community dialogues and boys’ fora sessions; • participate in partners’ meetings.
WHO	<ul style="list-style-type: none"> • provide financial and technical support during design and implementation of the project; • participate in monthly monitoring and support visits to districts.
UNICEF/U-Report	<ul style="list-style-type: none"> • spearhead U-Report launches/campaigns in project districts; • conduct U-Report polls; • manage the U-Report database; • generate poll reports.
Funding sources	<ul style="list-style-type: none"> • Bill & Melinda Gates Foundation; <p>United States President’s Emergency Plan for AIDS Relief (PEPFAR) / Centres for Disease Control and Prevention (CDC), through WHO.</p>

Project logical framework



Human rights perspectives

The right to health is recognized in several core international and regional human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), and in national constitutions including the Zimbabwean Constitution. The section below focuses on aspects of health service that are essential to enjoyment of the right to health by all, including adolescents, as reflected in the VMMC – ASRH pilot project. These are rights to availability, accessibility, acceptability, affordability and quality.

Availability

While efforts were made to ensure that information and services were available for adolescents, the project experienced challenges, mainly due to health system issues beyond the scope of the project. For instance, staff shortages hindered the availability of clinical service at Dotito Youth Centre between May and August 2016, and youth centres in Bulawayo have no capacity to offer clinical ASRH services.

Accessibility

Adolescents often do not have full or easy access to services due to multiple barriers – for instance, distance to the service points. Access to project services was constrained by some health system issues as well. For example, in Mt Darwin there are only two youth centres for the whole district.

Measures were put in place to ensure that adolescents have greater access to both ASRH and VMMC services. In both districts the VMMC programme conducted routine outreaches, offering VMMC in hard-to-reach areas and areas where young people often gather, such as shopping centres. For ASRH, through financial support from this project, ZNFPC was able to go out into communities offering ASRH information and services. The services offered included contraceptives, HIV testing services and condom distribution. Although outreaches tried to address issues of accessibility, more needs to be done beyond the scope of this project to address these issues.

Affordability

The VMMC services are free to the user, including management of adverse events. The ASRH services are also free in specific facilities such as the youth centres. However, in Bulawayo city, where the youth centres do not offer clinical services, young people have to pay for clinical consultations in the clinics run by the municipality. This can adversely affect uptake of clinical ASRH services.

Acceptability

A project is better accepted when stakeholders are engaged at all stages, from planning to evaluation. In this project, stakeholders, including health authorities, youths and community leaders, were engaged during the background consultancy work as well as during the implementation of the project. Stakeholder and community sensitization meetings allowed the ideas and concerns of the various stakeholders to be addressed.

The participation of communities and stakeholders is key to the success of this project.

Community participation also improved acceptability. For instance, in the development of IEC materials, members of the intended audience for each material were involved in design and pretesting.

Quality

The VMMC programme has mechanisms in place to maintain the quality of the services offered. These include quarterly internal quality audits and mentors' support visits. SOPs are in place, and so are measures to ensure that these SOPs are followed. The ASRH programme also has quality assurance (QA) mechanisms, mainly focussing on clinical services, but implementation could be improved if more funding were availed. It is recommended that SOPs for linkages be developed and rolled out. In the Smart-LyncAges project, data quality was checked during support visits by the monitoring team.

Other key considerations

Several other key considerations informed project design. These included gender, ethical considerations and participation.

Gender

Although the project addressed primarily boys, girls were a secondary audience, given the influence that they may have on boys' decisions. Peer educators included girls, and they took part in demand generation activities for VMMC and ASRH. Project planners recognized that VMMC is not a boys-only issue and that girls and women need to be involved at all stages of the project. IEC materials were developed for girls and parents, including mothers, who have a key role in advising their sons and as care-givers.

Ethical considerations

It is important to observe ethical principles when offering services to adolescents. For this reason the project built the capacity of service providers to maintain confidentiality and *privacy* and to ensure informed consent. In the VMMC – ASRH referral system, maintenance of confidentiality was key. This was addressed in the training, and mentorship visits by the national project team addressed confidentiality and privacy, but these important principles need continuing emphasis.

Adolescents are always concerned about privacy and confidentiality. For example, this concern apparently motivated some youths to give intentionally incorrect contact details on referral slips. To enhance confidentiality, the referral

slips used codes to identify the services needed and the services offered. While the referral slips requested clients' names for easier tracking and follow-up, names were not mandatory, and pseudonyms were allowed.

Informed consent also is key *in service* delivery. For VMMC all clients have to sign informed consent forms indicating that they have understood the information given and agree to be circumcised. For clients below the age of 16, both the boy's assent and parental consent were sought. Routine programme checks sampled the signed consent forms to verify that informed consent processes were indeed done according to procedures.

Service delivery and referrals also were done so as to ensure protection from harm for all clients, particularly because clients who seek VMMC services are generally healthy.

Participation

The project was fully committed to the participation of the district communities, partners, health-care staff and stakeholders in the various stages of the pilot project. The participation of stakeholders was key to the success of this project, considering that one of its key objectives was to strengthen communication and collaboration among stakeholders at all levels in VMMC and ASRH programmes. Partners participated in monthly monitoring visits as well as in quarterly project review meetings.



VMMC services in Bulawayo



SECTION 2.

Project components and implementation

Project planning process

Planning for the project began in 2014 with the hiring of consultants to conduct the background assessments of services and messages. Key issues raised by the consultants were considered during implementation. However, some recommendations were not taken for various reasons ranging from policy, funding and time required to unforeseen changes in the implementation of the ASRH and VMMC programmes. The consultants developed five documents (reports and tools available separately):

- mapping of the current configuration of ASRH and VMMC services in Mt Darwin and Bulawayo districts;
- service delivery protocol to strengthen integration and linkages between VMMC and ASRH programmes in Zimbabwe;
- ASRH, gender and VMMC IEC materials: messages and messaging for adolescent boys and VMMC – ASRH integration and linkages;
- field test protocol;
- monitoring and evaluation protocol.

Mapping of the current configuration of ASRH and VMMC services in Mt Darwin and Bulawayo districts

A mapping exercise took place in Mt Darwin in May 2014 and in Bulawayo in June 2014. The mapping assessed current service configurations for ASRH and VMMC in order to inform a service delivery protocol that would promote better service linkages and integration and, thereby, reduce the vulnerability of young people.

Protocol to strengthen integration and linkages

The background work recommended various ways to strengthen integration and linkages. The following recommendations were implemented:

- Training more personnel to provide integrated services and ensuring that Youth Friendly Centres become “one stop shops” for services.
- PSI community mobilizers can mobilize in

- schools for both VMMC and ASRH services.
- Develop more adolescent-specific messages and IEC materials to further mobilize young people to take up VMMC.
- Focus ASRH messages on contextual challenges for both males and females and include VMMC to encourage linkage.
- Develop messages and IEC materials with more focus on females and embrace their influential roles as partners, peers and mothers.
- Support interpersonal communication to strengthen adolescents’ information and knowledge sharing on VMMC.
- Community nurses should routinely visit Youth Friendly Centres more often to ensure quality control and improve data management.

Some recommendations were not feasible:

- Develop and widely disseminate a clear strategy on ASRH and VMMC linkages, especially at the strategic level for resource mobilization and prioritization.

COMMENT: The MOHCC has yet to fully adopt the concept of ASRH and VMMC linkages. Thus, it would be premature to develop a strategy. The outcomes of this project will inform the adoption.

- Prioritize capacity building of Youth Friendly Centres in terms of both infrastructure and personnel with requisite competencies.

COMMENT: The project did not focus on infrastructure, although, through the seed fund, some youth centres completed minor infrastructure improvements. For example, Dotito repaired the youth centre furniture, and Mt Darwin Youth Centre constructed a snooker shade.

- Explore possible approaches for capacitating and motivating teachers to ensure that they teach life skills even though it is not an

examinable subject.

packages (Fig. 3).

COMMENT: In this phase schools were not directly engaged. There are plans to engage them in the next phase.

- Consider including VMMC and ASRH integrated services as part of the curriculum for midwives' and nurses' training, as this will be crucial for the VMMC sustainability phase.

COMMENT: This recommendation will be taken when ASRH – VMMC linkages is adopted as a national strategy.

Service delivery protocol: strengthening integration and linkages between VMMC and ASRH programmes in Zimbabwe

Following completion of the mapping exercise, a desk review and a national stakeholders' workshop were conducted to develop a menu of options for strengthening integration and linkages. The options identified were these:

Option A: One service provider or a team of service providers in the same facility provides both ASRH and VMMC services to adolescents.

Option B: Different health workers in the same facility provide both ASRH and VMMC services for adolescents, using an effective system of referral.

Option C: All the services that need to be integrated are provided in one facility by different organizations and service providers who are based in different facilities. They bring the services to a single facility through outreach. Effective referral within the facility is ensured.

Option D: VMMC and ASRH services are provided in different facilities and settings and through different providers. Adolescents access these different services through effective referral systems.

The service delivery protocol recommended three service

1. Minimum package of services for adolescents

This consists of providing young people basic information about ASRH and VMMC and on the availability of ASRH and VMMC services and interventions in the district.

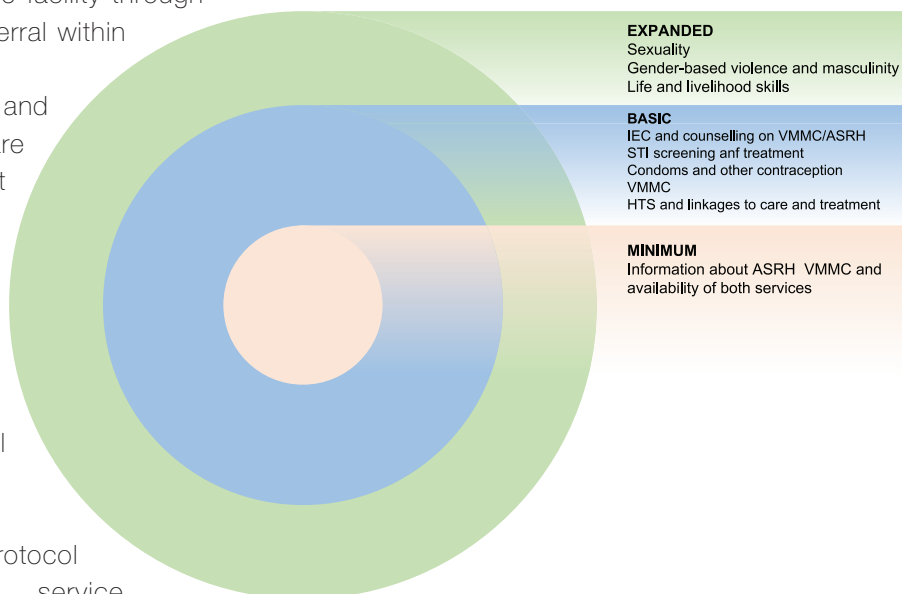
2. Basic package of services

This includes, in addition to the minimum package, STI screening and treatment, HIV testing and counselling (HTC) with linkages to prevention, treatment and care as necessary, IEC and counselling on VMMC and ASRH, the provision of condoms, different forms of contraception and VMMC.

3. Expanded package of services and interventions

Building on the minimum and basic packages, the expanded package also offers social and behavioural change interventions, including content on sexuality, masculinity, and life and livelihood skills training. These additional interventions will be provided mostly through youth-friendly centres and NGOs, with linkages and other approaches to improve access.

Fig. 3. VMMC and ASRH packages for integrated / linked services



Messages and messaging

This preparatory report presented messages that were developed in response to key recommendations from a series of consultations with stakeholders on integrating ASRH and VMMC. The recommendations focused on messaging, specifically on opportunities for strengthening and improving VMMC messages to make them more age- and gender-appropriate; addressing gender-specific issues for adolescent boys; mainstreaming VMMC within ASRH information to broader community audiences; enhancing girls' and parents' understanding of VMMC and the protection it offers against HIV; and helping health workers and others who work with adolescent boys to provide them with accurate and consistent information.

The key observations from this reported included these:

- There are limited messages on positive living for adolescents despite evidence of an increasing number of adolescents living with HIV and on treatment.
- Gender issues are not adequately addressed; They are considered only in terms of consequences, such as unplanned pregnancies, that have a more direct burden on females, whilst in terms of VMMC it is mainly the voice of older women that is captured.
- Current messages do not adequately explore issues of assertiveness, negotiation and ways that young people are abusing drugs and alcohol, such as binge drinking, that have implications for ASRH and HIV prevention. Messages and role models/champions gave the impression that VMMC is for older males and not for adolescent boys.
- The voices of mothers and girls need to be heard, given their power to promote male circumcision. Such messages can include mothers encouraging their sons to go for VMMC.
- Information and knowledge should also be shared with families, especially parents, so that they provide further support, particularly to decision-making, wound management and preventative behaviour.

Key recommendations included the following:

- Creation of more age-specific messages on VMMC, given that current messages are generalized and are assumed to apply to everyone. VMMC messaging for adolescent boys should emphasize how VMMC can help them to get the future that they want.
- For girls, messages should address why they should be interested in VMMC and why/how they could influence boys. The messages would focus on promoting personal hygiene amongst their future boyfriends/husbands and their reduced risk of cervical cancer if their partners are circumcised.
- Messages targeting health workers should help them understand that integration/linkages are easy and achievable.
- There is a need for specific materials, messages and interventions aimed at strengthening the capacity of parents. Strengthening capacities of parents will help them encourage adolescents to consider taking up VMMC.

The preparatory report noted that, for these suggestions of content and channels to be implemented, the following additional steps would need to be taken into consideration:

- Consideration should be given to whether there is need for branding the VMMC and ASRH demand generation campaign for adolescent boys to ensure its specific focus on this age group.
- Working with people and organizations already involved in VMMC and ASRH messaging, especially those focusing on demand generation, is essential, as this will ensure the project immediately benefits already on-going interventions. Such collaboration will also promote messages on VMMC – ASRH linkages and generate suggestions on how integration and linkages can best be adopted and adapted by the implementing organizations.
- The printing of materials for the pilot phase is urgent; this will include processes of layout and pre-testing. The key materials that should be printed include the pamphlet for adolescent boys, pamphlet for parents and poster for health workers. These materials should also be reviewed to inform other messages if this project is to be scaled up.
- There is a need to explore social networks and interactive media, especially those that

are already popular with young people. This will include linking with organizations targeting youth through bulk messages and social media to explore opportunities for collaboration. Suggestions of creating a stand-alone Facebook page for the campaign can also be considered, but this might require dedicated human resources to manage the account and collect relevant information.

Once the three documents described above – on mapping, strengthening integration and linkages, and messages and messaging – had been developed, the field test and evaluation protocols were drafted. These draft protocols outlined steps in pilot testing the three services delivery options and the IEC materials.

Field test protocol

The field test protocol outlined steps in pilot-testing the three service delivery options.

Steps outlined for implementation:

1. Advocacy and sensitization

- a. Engage all key stakeholders from the national, provincial and district levels and sensitize them to the pilot programme.
- b. Conduct 1-day orientation workshops for service providers in both districts for all VMMC and ARSH service providers and implementers.

2. Readiness appraisal

- a. stakeholders meet to appraise their readiness
- b. hire a VMMC – ASRH Project Coordinator

3. Implementation

- a. joint demand creation

- b. integrated service delivery
- c. continuous on-the-job training and mentoring of service providers

4. Monitoring and reporting

- a. participatory monitoring
- b. district exchange visits for sharing and learning

5. Evaluation focusing on (which was not undertaken):

- a. uptake of services and messages
- b. effectiveness
- c. efficiency
- d. sustainability

6. Dissemination of evaluation findings, lessons learnt and the way forward.

Evaluation protocol

The consultants recommended the following steps for carrying out the evaluation:

1. constitution of an evaluation steering committee
2. development of terms of reference
3. identification of an independent consultant
4. inception meeting with the selected consultant
5. inception report
6. data collection
7. data analysis and report writing
8. dissemination of results

However, evaluation was not conducted but instead is being proposed in a future phase of the project.

Core components/activities

The core components or activities carried out were based on the background consultancy work described above. This section applies the monitoring and evaluation (M&E) framework to describe how these activities were carried out. The time period covered is March 2016 to March 2017.

Objective 1

To develop a resource package of materials for messaging and learning that are effective and service provider delivery protocols and capacity-building manuals that are effective and usable.

Output 1.1. Availability of information about ASRH, VMMC and services

Activity	Frequency	By whom	Inputs	Achievement
Activity 1: Hire a consultant to develop document on messages and messaging	Once off	WHO and MOHCC	Consultancy fees for messaging report	Messages and messaging report produced

Comment: The consultant developed the messages and messaging report in 2014. The project started in March 2016.

Activity	Frequency	By whom	Inputs	Achievement
Activity 2: Plan, design and pre-test materials in both districts; print and distribute IEC materials and promotional materials	Once off	MOHCC	IEC and promotional material production costs	<ul style="list-style-type: none"> • Posters and flyers for boys, girls, parents, service providers • T-shirts, pens and wrist bands • Distributed 4 500 posters and 6 500 pamphlets

Comment: IEC materials were developed with guidance from the messages and messaging document and applying the method used by the MOHCC for all IEC materials, which involves making creative briefs with stakeholders' participation as well as pre-testing. An IEC materials development plan outlined the steps to be taken (see Annex 2). An IEC materials development workshop was held in Bulawayo (2–3 June 2016) for participants drawn from both pilot sites. The workshop produced several creative briefs, which guided the design process.

about the dangers of STIs, HIV/AIDS and unplanned pregnancies with your friends. Encourage all guys to go for circumcision TODAY!!

Previously, separate IEC materials addressed VMMC and ASRH. The project developed IEC materials with combined messages. Additionally, the new IEC materials more clearly highlight the roles of parents and girls in the health-seeking behaviour of boys. Previously, there were no VMMC IEC materials addressing service providers that highlighted the importance of youth friendliness in providing VMMC services. Samples of four English-language posters and a pamphlet were produced for pretesting (one poster for service providers, one for parents, one for adolescent girls, and a poster and a flier addressing adolescent boys) as well as a job aid for providers. The IEC materials were translated and then pretested in both districts. Pretesting yielded valuable feedback on the design, images and text of the materials. Final IEC materials were produced in the three major languages spoken in the districts – English, Shona and Ndebele. Local models (parents and youths) appeared on the posters (Annex 3). IEC materials were distributed to facilities during monitoring visits as well as disseminated via social media (Facebook and WhatsApp). Also, peer educators and parents distributed

Previously, separate IEC materials addressed VMMC and ASRH. The project developed IEC materials with combined messages.

The key messages included:

- For parents: Be responsible and smart parents. Talk to your children about the dangers of STIs, HIV/AIDS and unplanned pregnancy.
- For boys: Be the cooler, smarter generation. Cooler, smarter brothers take good care of their health.
- For health workers: "I have done my part... have you?" Be the cooler, smarter and youth-friendly service provider. Provide comprehensive information, services and referrals on ASRH and VMMC to all young people.
- For girls: Be the cooler, smarter sista. Talk

IEC materials in the communities. In addition, a job aid for service providers (Annex 4) served as a desk-top reference to facilitate provision of information on ASRH and VMMC. Thirty copies of the job aid were distributed.

distributed to service providers and peer educators. It showed the various service providers in each of the districts, the service they offered, their contact details and the hours they are open.

Also, a service directory was printed and

Output 1.2. Service delivery protocol

Activity	Frequency	By whom	Inputs	Achievement
Activity 3: (a) Hire a consultant to develop the service delivery protocol (b) Consultations with relevant stakeholders (c) Produce the service delivery protocol (d) Revise the protocol basing on lessons learnt	Once off	MOHCC	<ul style="list-style-type: none"> • Consultancy fees • Service delivery protocol printing costs 	<ul style="list-style-type: none"> • Service delivery protocol, version 1 available • Comments with proposed changes to service delivery protocol (version 2) available

Comment: A consultant completed the service delivery protocol in 2014. Project implementation started in March 2016.

Output 1.3. VMMC – ASRH capacity-building materials

Activity	Frequency	By whom	Inputs	Achievement
Activity 4: Develop capacity-building materials	Once off	MOHCC, WHO, ZNFPC	<ul style="list-style-type: none"> • VMMC training manuals • ASRH training manuals • VMMC – ASRH technical briefs • staff time 	Package of orientation/training materials, including guidance for facilitators and resources needed to conduct the orientation

Comment: The capacity-building materials were adapted from the existing VMMC and ASRH training materials as well as from the VMMC – ASRH linkages technical briefs and service delivery protocol. The materials focused on provision of youth-friendly services giving

participants basic information about both VMMC and ASRH. The MOHCC, WHO and ZNFPC developed the materials jointly, with input from trainers in both the ASRH and VMMC programmes (Annex 5).

Activity	Frequency	By whom	Inputs	Achievement
Activity 5: Contribute to the revision of the national ASRH strategy and training manuals and guidelines on youth-friendly service provision to include VMMC	Once off	MOHCC	<ul style="list-style-type: none"> • VMMC training manuals • ASRH training manuals • VMMC – ASRH technical briefs • staff time 	Inclusion of VMMC in the National ASRH strategy 2017–2020, training manuals and guidelines on youth-friendly service provision

Comment: The VMMC – ASRH linkages team contributed to the revision of the National ASRH Strategy 2017–2020 and the ASRH training manuals. Team members participated in stakeholder meetings and reviewed drafts at various stages of development. In the National Adolescent and Youth Sexual and Reproductive Health Strategy 2016–2020, the VMMC – ASRH linkages pilot project was

needs to increase. The new ASRH training manual incorporates more information on VMMC. The previous training manual simply mentioned VMMC as one method of HIV prevention. The new manual has a 30-minutes slot for VMMC and PrEP, which includes basic information on VMMC, a video demonstration of the VMMC procedure and information on where young people can be referred for VMMC services. Also included in the manual is a VMMC hand-out with details of the procedure, a list of benefits and answers to frequently asked questions for service providers. The new VMMC training manual recognizes that VMMC is an entry point for adolescents and young adults to health-care services. It places special emphasis on youth-friendly services.

To increase affordability of quality ASRH services, youths’ access to services, including VMMC, needs to increase.

noted as one of the key achievements of the ASRH Strategy 2010–2015. The new ASRH Strategy 2017–2020 recognizes that, in order to increase affordability of quality ASRH services, youths’ access to services, including VMMC,

Output 1.4. Service providers able to provide VMMC and ASRH information

Activities	Frequency	By whom	Inputs	Achievement
Activity 6: a) capacity-building sessions	a) once off	MOHCC, ZNFPC	<ul style="list-style-type: none"> • training stationery • handouts • venue • facilitators • allowances for facilitators and participants 	<ul style="list-style-type: none"> • Bulawayo: 4 capacity-building sessions (150 participants trained) • Mt Darwin: 2 capacity-building sessions (101 participants trained) • 2 peer educators trained in basic ASRH • monthly support visits to both districts
b) refresher workshops	b) as needed			One refresher session conducted in each district

Comment: A capacity-building plan guided implementation of the trainings (Annex 6). The plan specified the topics, intended participants, facilitators and duration of the various sessions. Facilitators came from the MOHCC, ZNFPC and PSI. No training-of-trainers was conducted; facilitators focused on their respective areas of practice, with MOHCC and WHO making

presentations on the [linkages](#) aspect of the project. The capacity-building sessions were designed and delivered differently for service providers and others such as facility support staff and peer educators. That is, the orientation for non-service providers did not cover in detail the different VMMC and ASRH service delivery models and reporting systems. Capacity-building

sessions took one day for service providers and half a day for others. In both Mt Darwin district and Bulawayo City, the capacity-building sessions took place at youth centres. The time for capacity building was allocated as follows: 15% to VMMC, 15% to ASRH, 15% to youth-

friendly service provision and the rest to ASRH and VMMC linkages, including project reporting, referral system and plenary. Table 5 details the capacity-building sessions conducted in the two districts.

Table 5. Capacity-building sessions conducted

Date	Activity	Participation	Participant composition
Bulawayo			
14 June 2016	Full-day orientation	47 of expected 51	Peer educators and youth centre recreational leaders
15 June 2016	Full-day orientation of health services providers	26 of expected 60 (competing priorities and staff shortages limited participation)	VMMC surgical nurses, ZNFPC clinic nurses, Bulawayo Council nurses, guidance and counselling teachers
16 June 2016	Half-day orientation of non- health service providers	46 of expected 60	Community-based workers and clinic auxiliary staff (clinic attendants, nurse aides, janitors, administrative clerks, receptionists, theatre assistant, cleaners)
Mt Darwin			
5 July 2016	Full-day orientation of peer educators and youth centre staff and health services providers	26 of expected 25	5 Dotito peer educators 4 Mt Darwin peer educators 1 Youth Health Advisor 2 Youth Facilitators 6 Mt Darwin hospital health-care providers (5 registered general nurses (RGNs) and 1 acting nutritionist) 1 primary care nurse (PCN), Chahwanda clinic 1 RGN, Mutungagore clinic 1 provincial VMMC officer 1 health promotion attaché 1 PCN, Chitse clinic 1 state-certified nurse (SCN), Tsakare clinic 1 PCN, Bveke clinic 1 National AIDS Council district officer

Date	Activity	Participation	Participant composition
6 July 2016	Half-day orientation of community-based health cadres and health facility auxiliary staff	40 of expected 40	9 village health workers 8 behaviour change facilitators 1 community-based distributor 4 child care workers, auxiliary support staff (2 nurse aides, 1 accounting assistant, 2 security guards, 2 health information officers, 2 human resources officers, 1 rehabilitation technician, 1 primary care counsellor) 3 youth centre committee members, 1 traditional healer, 3 ward development committee members
7 July 2016	Half-day orientation of non- health service providers	34 of expected 40	20 village health workers 4 behaviour change facilitators 1 district youth coordinator 2 child-care workers 3 youth centre committee members 3 youth centre support staff 1 VMMC mobilizer

Objective 2

To strengthen communication and collaboration among stakeholders at all levels on VMMC – ASRH linkages and integration.

Output 2.1. Meetings with stakeholders

Activity	Frequency	By whom	Inputs	Achievement
Activity 7: a) Identify key stakeholders b) conduct meetings	a) quarterly/ as needed b) quarterly/ as needed	MOHCC	a) staff time b) transport and allowances for participants and facilitators in sensitization meeting	a) List of stakeholders was updated quarterly b) 6 advocacy and sensitization meetings held in the two districts

Stakeholder meetings were key to obtaining buy-in, particularly from communities.

Comment: Key stakeholders were identified from both the mapping exercise and consultation with local health authorities (Table 6). An advocacy and sensitization plan guided the activities (Annex 7). Stakeholder meetings were key to obtaining buy-in, particularly from

communities (Table 6). Stakeholders also identified the gaps and needs of the youth centres, and some pledged resources. For example, in Mt Darwin a community member pledged to provide transport to peer educators for outreaches. The meetings also were held with provincial and city health authorities.

Table 6. Stakeholders that participated in sensitization meetings

Bulawayo	Mt Darwin	Dotito
<ul style="list-style-type: none"> • parents' association members • recreational leaders • councillors • Ministry of Primary and Secondary Education • nurses from City Council and private clinics • social workers from City of Bulawayo • peer educators • community-based distributors • nongovernmental organizations (NGOs): • Grassroots Soccer • Children's Christian Network • Dot Youth • Youth Ahead • You Have It In You organization • religious leaders • artists • parents • youths 	<ul style="list-style-type: none"> • Ministry of Youth, Indigenization and Economic Empowerment • Ministry of Women's Affairs, Gender and Community Development • Department of Social Welfare • Zimbabwe National Network for Positive People (ZNNP+) • Zimbabwe AIDS Prevention Support Organization (ZAPSO) • parents • local government, represented by Ward 12 councillor • Youth centre committee members • youths • VMMC mobilizers 	<ul style="list-style-type: none"> • Ministry of Local Government • 1 headman (Nohwedza), 10 village heads • 3 councillors • Dotito, Pfura Rural District Council • Ministry of Youth, Indigenization and Economic Empowerment • Ministry of Primary and Secondary Education • National AIDS Council • Department of Social Welfare • ZNFPC Dotito Youth Centre staff • Youth centre committee members • religious leaders • parents • youths

During the sensitization meetings stakeholders were asked to highlight what they perceived as their potential roles in the project (Table 7).

During the project stakeholders were able to carry out most of their perceived roles.

Table 7. Self-perceived roles of stakeholders in the VMMC – ASRH project

Stakeholder group	Perceived role	Comment
Peer educators and youth	<ul style="list-style-type: none"> • share information about the VMMC, ASRH and the linkages project with their peers; • mobilize and refer adolescent boys for VMMC and ASRH; • participate in door-to-door campaigns informing parents about the project; • participate in development of IEC materials to help take into consideration youths with special needs – for example, the blind; • actively involve youth living with HIV in all their youth centre activities; 	<ul style="list-style-type: none"> • The peer educators and youth carried out most of their perceived roles. Peer educators have been providing information and mobilizing youths for ASRH services but had limited capacity to discuss VMMC since it was only a small part of their training. • In Bulawayo 30 peer educators were trained as VMMC mobilizers. • The project did not have a defined component for youths living with HIV, and they were not addressed as a separate group.

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Parents and other community members	<ul style="list-style-type: none"> • be role models in VMMC and HIV testing; • distribute IEC materials; • support their children by attending VMMC – ASRH meetings; • ensure open communication with their children on VMMC, ASRH and HIV issues. 	<p>Parents carried out their perceived roles, particularly ensuring open communication, as shown by attendance and active participation in community dialogues.</p> <p>Parents also distributed some IEC materials to their peers.</p>
Stakeholders/ service providers	<ul style="list-style-type: none"> • actively participate in all ASRH and VMMC meetings and programmes; • participate in development and distribution of IEC materials for the VMMC – ASRH linkages project; • develop an algorithm to be followed by all stakeholders/service providers in the district; • advocate on behalf of VMMC ASRH programmes; • churches to give teachings on ASRH and VMMC; • ZAPSO to continue offering video and pictorial materials on ASRH; • Mt Darwin hospital to refer all those circumcised to the youth centre. 	<p>Most stakeholders carried out their perceived roles. However, some activities were not actively tracked – for example, whether religious leaders discussed VMMC and ASRH in their churches.</p>

Activity	Frequency	By whom	Inputs	Achievement
Activity 8: Conduct district quarterly review meetings	Quarterly	MOHCC	a) staff time b) transport and allowances for participants and facilitators in sensitization meeting	3 quarterly review meetings held in each district

Comment: Review meetings discussed lessons learnt during implementation of the pilot project. Meetings took place at youth centres with representation from all stakeholders. Youth centre staff chaired the half-day meetings, with support from WHO and MOHCC. Review meetings were an important platform for partners to update

each other on their plans and achievements. They improved coordination of the ASRH and VMMC programmes in the districts.

Review meetings were an important platform for partners to update each other, and they improved coordination.

Output 2.2. Strengthened linkages and integration of VMMC and ASRH services and interventions

Activity	Frequency	By whom	Inputs	Achievement*
Activity 9: VMMC service providers provide ASRH information	Every time they provide VMMC services	VMMC service providers	Staff time	Bulawayo: 6212 adolescents reached. Mt Darwin: 4239 adolescents reached.

* Assumption: All adolescents circumcised received ASRH information, as providers signed on the consent form that they had given this information to every client circumcised.

Comment: Sexual and reproductive health information is part of the minimum package given to all clients who access VMMC services. This includes information on STIs, the importance of HIV testing and counselling and the importance of abstinence or condom use for the sexually

active. This information is provided during group and individual counselling sessions on the day of the VMMC procedure and during follow-up visits. Through the VMMC – ASRH district service providers directory, the project enhanced the capacity of VMMC service providers to also provide ASRH information and make appropriate referrals to facilities where young people can obtain ASRH services.

Activity	Frequency	By whom	Inputs	Achievement
Activity 10: Youth centre staff and peer educators provide VMMC information to adolescents	Every time they are in contact with adolescent boys	Youth centre staff and peer educators	Staff time	Bulawayo: 1025 adolescents reached. Mt Darwin: 239 adolescents reached.

Comment: In the 2009–2015 ASRH manual, VMMC was mentioned only as one HIV prevention methods, giving no details on the procedure or other benefits. This limited the ability of ASRH providers to give information on VMMC. Through this project ASRH service providers were capacitated to provide basic VMMC information and to answer frequently asked questions. The job aid facilitated this (Annex 4). Service providers and VMMC

mobilizers provided information in individual and group counselling sessions as well as during events such as sports galas.

In Bulawayo PSI recruited and trained 30 peer educators as VMMC mobilizers. On a monthly basis peer educators reported on the number of youths they had reached with information on different topics, including VMMC.

Activity	Frequency	By whom	Inputs	Achievement
Activity 11: Referrals	As needed	<ul style="list-style-type: none"> Youth centre staff VMMC service providers peer educators 	<ul style="list-style-type: none"> Referral slips Peer educators' allowances Personnel time 	<p>ASRH to VMMC</p> <ul style="list-style-type: none"> Bulawayo – 425 referrals Mt Darwin – 77 referrals <p>VMMC to ASRH</p> <ul style="list-style-type: none"> Bulawayo – 5 referrals Mt Darwin – 12 referrals <p>ASRH referrals by peer educators</p> <ul style="list-style-type: none"> Bulawayo – 104 referrals Mt Darwin – 333 referrals

Comment: Referrals were made between the different service providers and facilities. The service provider directory for each district showed the locations and contact details for all VMMC and ASRH service providers. With extensive participation of all stakeholders, a referral form was adapted from the existing MOHCC community referral form and finalized in July 2016 (see Annex 8). The form both referred and tracked clients. Referrals also were tracked using mobile phones as well as social media such as WhatsApp. In some instances peer educators accompanied the referred youths to the service to which they had been referred.

In most cases, however, referral consisted of giving out referral slips and information on the location and availability of the other services. Qualitative interviews were carried out to explore the facilitating factors and challenges of the referral system (Annex 13). Among the main challenges was the health workers' perception that completing referral slips was too much additional work. This was clear among VMMC service providers, who already have many forms to complete. Introduction of an allowance for peer educators increased motivation to make more referrals.

Activity	Frequency	By whom	Inputs	Achievement
Activity 12: Carry out support visits to project districts	Monthly	WHO, MOHCC, ZNFPC	Fuel and allowances for support team	7 monthly support visits carried out in each district

Comment: Implementation was monitored monthly by a joint team comprising MOHCC, WHO and ZNFPC. The other partners were engaged from time to time depending on the objectives of the visit.

Quarterly review meetings took place in each district, which brought together all stakeholders and discussed progress toward implementation, including successes, challenges and lessons learnt. Various tools supported monitoring progress. These included the monthly support visit form and the project evaluation forms (Annex 9). Data from these were then used to compile

Monitoring visits used a participatory approach involving discussions with various stakeholders.

support visit reports. The monitoring visits were also used to mentor service providers and peer educators. Aspects of the work that were not fully clear to providers, such as completion of

the referral forms, were revisited, as were the key VMMC and ASRH messages. Monitoring visits were also used to distributed IEC materials.

Activity	Frequency	By whom	Inputs	Achievement
Activity 13: Conduct VMMC – ASRH outreaches	Monthly (December 2016- March 2017)	ZNFPC, PSI	Fuel and allowances for service providers	6 outreaches conducted in Bulawayo. 12 outreaches conducted in Mt Darwin.

Comment: Outreaches were introduced to the project in December 2016 to enhance accessibility of both ASRH and VMMC services. PSI had been conducting VMMC outreaches in both districts but started conducting outreaches at youth centres as part of this project in January 2017. VMMC outreaches were conducted with resources from PSI including transport, commodities and staff time. ZNFPC had plans to conduct ASRH outreaches in both

districts. However, these were not conducted as frequently as planned due to the limitation of financial resources. The project provided financial support to the ASRH outreach services. In Bulawayo youth centres do not provide ASRH clinical services; the ZNFPC team provided the services as outreach at the youth centres. ASRH outreaches in Mt Darwin addressed the community level. Outreaches provide information as well as clinical services.

Activity	Frequency	By whom	Inputs	Achievement
Activity 14: Joint demand creation activities	Bimonthly	ZNFPC, PSI	Fuel and allowances for service providers to facilitate participation in demand creation activities	<ul style="list-style-type: none"> • 4 sports galas in Bulawayo • 2 sports galas in Mt Darwin

Comment: Youth centres in Bulawayo have a larger focus on recreation and have been offering sporting facilities to youths. In Mt Darwin the youth programme has a smaller recreation component, focusing mainly on indoor games. It was observed from the experience of other programmes that sport and music bring together a large number of young people and provide an opportunity to disseminate information and provide services. Thus, in partnership with other stakeholders, the project supported sports

galas in both districts. The support included capacitating the peer educators to be able to integrate ASRH and VMMC information and service provision into the sports galas. The National AIDS Council and Community Working Group on Health funded the sports galas. Service providers and peer educators from youth centres and the VMMC programme provided services, including condom distribution, distribution of IEC materials, VMMC and contraception. There were no specific reporting tools for the galas.

Activity	Frequency	By whom	Inputs	Achievement
Activity 15: Disbursement of seed fund	Quarterly	MOHCC	Funds (US\$ 100 per youth centre per quarter)	Bulawayo: Sporting equipment and 12 sign boards Mt Darwin: Refurbishment and 1 sign board

Comment: Each youth centre received US\$ 100 per quarter as a seed fund. The fund was to be used at the discretion of each youth centre to meet needs not directly met by the project but considered high-priority. The Dotito youth centre used the seed fund to refurbish their chairs, and the Mt Darwin youth centre used theirs to construct a shed for a snooker table donated by

NAC. In Bulawayo the seed fund was used to buy sporting equipment and sign boards for each of the youth centres that showed the opening times and services offered, as recommended in the ASRH manual. In Bulawayo youth centre staff made the decisions on using the seed funds in consultation with the youths, while in Mt Darwin the youth centre committee decided.

Output 2.3. Integrating interventions to facilitate gender, culture and social behaviour change

Activities	Frequency	By whom	Inputs	Achievement
Activity 16: Conduct U-Report polls to gather adolescents' views and opinions	Monthly	MOHCC, UNICEF/ U-Report	U-Report questions	Results of 10 polls used to inform programme planning and implementation

Comment: With support from UNICEF, the project used the U-Report platform to poll youths. A proposal was developed to incorporate the U-Report platform into the VMMC – ASRH linkages project (Annex 10). The focal point for U-Report from UNICEF conducted an orientation session on the platform with peer educators from Bulawayo. Youths joined the platform by subscribing to a free SMS service and

were able to add on other youths. The project team generated the survey questions. Reports appeared on the U-Report website (at <https://zimbabwe.ureport.in/polls/>). U-Report sent the polls to Bulawayo and Mashonaland Central Province, where Mt Darwin is located, and UNICEF analysed the data. The results provided input to project planning as well as lessons learnt.

Activities	Frequency	By whom	Inputs	Achievement
Activity 17: Identify stakeholders and conduct community dialogues and boys' fora	Monthly (December 2016-March 2017)	MOHCC, ZNFPC, youth centres	<ul style="list-style-type: none"> • facilitators and allowances • venue • refreshments • stationery 	Bulawayo: 15 dialogues and for a. Mt Darwin: 6 dialogues and fora.

Boys' fora and community dialogues were introduced into the project in November 2016. Their objective was to provide a platform to discuss gender and transformative masculinity

issues. In Bulawayo three organizations were already working in the area of masculinity. These were the Young Men Christian Association (YMCA), SAfAIDS and Padare Enkundleni Men's

Forum on Gender. These organizations provided guidance to facilitators for some of the dialogues and fora. In Mt Darwin staff from the Ministry of Women Affairs, Gender and Community Development provided guidance for some of the discussions. Other than Padare Enkundleni Men's Forum on Gender, none of the partners

had a manual to guide discussions. In Bulawayo recreational leaders facilitated some discussions and peer educators facilitated others. The meetings took place at youth centres, and the project provided refreshments. Table 8 lists meetings held.

Table 8. Transformative masculinity meetings conducted

Date	Venue and meeting	Attendance	Facilitators
Bulawayo			
1 February 2017	Indlovu Youth Centre community dialogue on "Boyhood to manhood"	41 males 14 females	<ul style="list-style-type: none"> • Kana Media • recreation leader
8 February 2017	Sizinda Youth Centre community dialogue on "Boyhood to manhood"	48 males 10 females	<ul style="list-style-type: none"> • Padare Enkundleni Men's Forum on Gender • Ministry of Youth, Indigenization and Economic Empowerment • recreation leader • Khaya Arts Production
9 February 2017	Phumelela Youth Centre boys' forum. Topic: "My body, my pride"	24 males 5 females	<ul style="list-style-type: none"> • recreation leader • peer educators
10 February 2017	Lobengula Youth Centre community dialogue on the "Smart Talk" (VMMC)	42 persons	<ul style="list-style-type: none"> • recreation leaders • peer educators
10 February 2017	Magwegwe Youth Centre community dialogue on "My health, my responsibility"	40 persons	<ul style="list-style-type: none"> • recreation leaders • peer educators
10 February 2017	Mzilikazi Youth Centre community dialogue on "What is manhood?"	32 males 13 females	<ul style="list-style-type: none"> • Dot Youth • recreation leader • peer educators
10 February 2017	Vulindlela Youth Centre boys' forum on VMMC	48 males 4 females	<ul style="list-style-type: none"> • ZNFPC • Dot Youth • recreation leader • YMCA
13 February 2017	Luveve Youth Centre community dialogue on STIs and VMMC	28 males 14 females	<ul style="list-style-type: none"> • recreation leader • peer educators
20 February 2017	Isilwane Youth Centre youth dialogue on relationships and also VMMC	19 males 27 females	<ul style="list-style-type: none"> • community health worker • DREAMS coordinator • senior peer educator
28 February 2017	Thabiso Youth Centre boys' forum on drug and alcohol abuse	38 males 6 females	<ul style="list-style-type: none"> • recreation leader • Padare Enkundleni Men's Forum on Gender • parents' association member
Mt Darwin			
8 February	Mt Darwin boys' forum on barriers	21 males	<ul style="list-style-type: none"> • Ministry of Youth

Date	Venue and meeting	Attendance	Facilitators
2017	for boys to accessing health services	3 females	Empowerment and Indigenization and Economic Empowerment • ZNFPC
13 February 2017	Chakoma Ward 8 community dialogue on parent-to-child communication on HIV/AIDS and VMMC Service outreach	36 males 11 females (19 were tested for HIV and received their results)	• Ministry of Youth, Indigenization and Economic Empowerment • ZNFPC
15 February 2017	Chaminuka Vocational Training College boys' forum on STIs	89 males	• AFRICAID • ZAPSO • ZNFPC
17 February 2017	Mangware in-school youths dialogue: HIV and VMMC	52 males 46 females	• ZNFPC • Ministry of Primary and Secondary Education
17 February 2017	Mangware out-of-school youths dialogue: STIs and VMMC	9 males 3 females	• ZNFPC

Objective 3

To assess the potential for sustainability and scale-up of the package.

Output 3.1. Assessment of potential successes and challenges of interventions piloted

Activities	Frequency	By whom	Input	Achievement
Activity 18: Key informant interviews (KIIs) and focus group discussions (FGDs) with service providers and peer educators	Once off	Research consultants	Consultancy fees	<ul style="list-style-type: none"> • 3 FGDs, 10 KIIs conducted • research reports produced

Comment: In both districts key informant interviews (KIIs) and focus group discussions (FGDs) were conducted in March 2017 to gather stakeholders' perceptions of the different components and aspects of the linkages project. KIIs were held with ASRH and VMMC facility managers; FGDs participants were peer educators (Annex 11).

Output 3.2. Experiences of the pilot districts to guide adaption and/or scaling up of activities to strengthen VMMC – ASRH linkages

Activities	Frequency	By whom	Input	Achievement
Activity 19: Documenting activities and processes	Monthly and at end of pilot project	MOHCC	Staff time	<ul style="list-style-type: none"> • reports on all district visits • monthly reports • lessons learnt documents

Activities	Frequency	By whom	Input	Achievement
Activity 20: End of pilot project review meeting with district stakeholders	Once off	MOHCC	<ul style="list-style-type: none"> venue transport allowances for participants, facilitators stationery 	Meeting held; report available.

Comment: An end-of-pilot meeting took place in March 2017. Participants came from all stakeholders including the MOHCC AIDS and TB Unit, ZNFPC, district staff from youth centres, peer educators, ZNFPC and VMMC facility managers and service providers, PSI Zimbabwe (PSI/Z) and three NGOs working on masculinity and gender (SAfAIDS, YMCA, and the Padare Enkundleni Men's Forum on Gender). A large

stakeholders' workshop was held 21–22 March 2017. This was followed by a core group meeting 23 March 2017 to further discuss aspects of the project, including a refocusing of the work on a pathway to scalable and sustainable services rather than a short-term project, documenting the processes and outcomes, refining the service delivery protocol and initial research questions, and expansion (Annex 12).

Summary of key achievements of the VMMC – ASRH linkage project

Messaging materials and capacity building

- Production of combined ASRH and VMMC IEC materials in three languages addressed to different audiences encouraged boys to obtain VMMC and ASRH information and services.
- The desk-top job aid facilitated service providers' provision of VMMC and ASRH information and services.
- The package of capacity-building material supported district-level implementation. The package consisted of the service delivery protocol, a technical brief series and training materials. Some 253 services and non-services providers attended capacity-building orientation and training.
- Monthly implementation support visits to project sites focused on reflecting on the activities implemented.
- On-going capacity building (and coordination) meetings with all stakeholders through quarterly review meetings resulted in improved coordination.
- The new National ASRH strategy 2017–2020 and training manual contain more content on VMMC and referral requirements.

meetings brought in a wide range of partners, all committed to roles within the pilot project.

- The free SMS service U-Report was used innovatively to increase interaction and engagement of adolescents.
- Youth centres used seed funds for improvements that increased their attractiveness and helped generate demand.

Service delivery and demand creation

- ZNFPC conducted 18 outreach visits in response to adolescent's access challenges. Each visit provided clinical services and information.
- Providing VMMC as an integrated service at youth centres in Bulawayo reduced barriers to access.
- Six sports galas showcased joint VMMC and ASRH demand creation activities.
- A total of 21 boys' fora and community dialogues focused on gender and transformative masculinity, VMMC and ASRH.
- Key informant interviews, focus group discussions, and monthly and final end-of-pilot meetings identifies lessons learnt and implications for sustainability (see Section 5).

Communication and collaboration for linkages and integration

- Stakeholder engagement and coordination



SECTION 3.

Monitoring and results

Monitoring mechanisms

Implementation of the project was monitored monthly by a joint team comprising MOHCC, WHO and ZNFPC. The other partners were involved from time to time depending on the objectives of the monitoring visit. These visits used a participatory approach; discussions with various stakeholders addressed key aspects of the project. In addition, quarterly review meetings in each district brought together all stakeholders to discuss progress, including successes, challenges and lessons learnt. Various tools supported monitoring. These included the monthly support visit form and the project evaluation forms (Annex 9). Data from these forms were used to compile the support visit reports.

Coverage

The project reached a total of 11715 young people with VMMC and ASRH information. Approaches included peer educators' interpersonal contacts, outreaches and enhanced efforts at health and youth facilities. It is estimated that 502 referrals were made to VMMC service and 454 referrals to ASRH services. The project increased condom distribution, particularly during ASRH outreaches. VMMC procedures were being performed prior to the project, but the project may have enhanced uptake. Numbers of youth health talks increased, and the talks included issues of gender and transformative masculinity. Boys' fora and community dialogues engaged 567 adolescent boys and 156 adolescent girls.

Peer educators

Peer educators are youths identified by their communities as role models and capacitated

by ZNFPC to provide information on ASRH to other youths. In this project, in addition to giving information, peer educators made and tracked referrals, distributed condoms and mobilized clients for VMMC.

Peer educators play a critical role in dissemination of information and making referrals for young people. On a monthly basis peer educators reported on the number they had reached with information on different topics, one of them being VMMC (Table 9).

The number of youths reached with VMMC messages by peer educators in Bulawayo increased, from none in March and April 2016 to 342 in March 2017, with a peak of 487 in February 2017 (Table 9). Although the number of Bulawayo peer educators that were submitting statistics increased in November 2016 following incorporation of 11 more youth centres into the project, it is clear that the peer educators became more confident to talk about VMMC after the sensitization meetings and capacity-building sessions held in May and June 2016. Monthly support visits and mentorship also contributed to the increase. Sharp declines are observed in both districts in September and October 2016. During review meetings this was attributed to decreased motivation among peer educators due to lack of allowances. Notable monthly increases in figures are observed from November 2016, when the project started providing allowances following submission of reports. In addition, there was an increase in both districts in the number of youths reached with ASRH messages by peer educators.

Table 9. Dissemination of VMMC information by peer educators in Bulawayo and Mt Darwin, March 2016 – March 2017

Month	Number of youths reached with VMMC messages by peer educators in Bulawayo	Number of youths reached with VMMC messages by peer educators in Mt Darwin
Mar 2016	0	8
Apr 2016	0	22
May 2016	6	48
Jun 2016	6	37
Jul 2016	11	53
Aug 2016	105	40
Sep 2016	2	26
Oct 2016	0	40
Nov 2016	193	28
Dec 2016	222	32
Jan 2017	406	30
Feb 2017	487	22
Mar 2017	342	55

There was a further increase in the number of young people reached with VMMC information from January 2017 to March 2017, as the project capacitated the peer educators to provide VMMC information and introduced an

allowance in November 2016. The number of youths reached monthly by peer educators with VMMC messages in Mt Darwin was relatively constant throughout

Peer educators' use of referral slips

Peer educators referred youth to youth centres for more information, clinical service and recreational activities. Referrals were made with referral slips. Confirmed referrals are those where the referred youths went to the referral destination. Referral slips were not immediately effective at either centre, for different reasons, but in the last quarter of the project they were often used.

In Bulawayo peer educators reported at first making verbal referrals, although no data on this were systematically collected. Use of referral slips in Bulawayo did not start immediately after capacity building because recreation leaders

thought that peer educators should not keep written personal information about other youths at their homes. This concern was later resolved through dialogue and the realization that peer educators were already collecting personal information in their daily report forms. Use of referral slips then started in November 2016. In January 2017 there was a sharp increase in the numbers referred and for whom feedback was received – that is, confirmation that the client went to the referral destination (Fig. 4). Mentoring improved peer educators' confidence in using the referral slips, which explains this increase.

Fig. 4. Referrals made with referral slips by peer educators, Bulawayo, November 2016 – January 2017

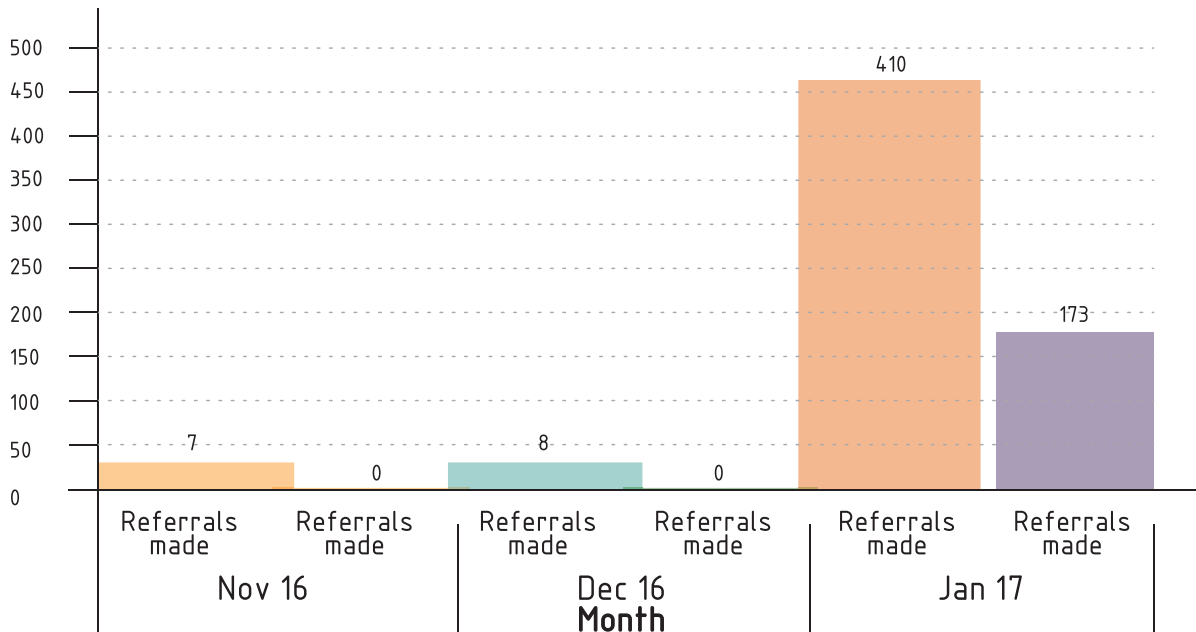
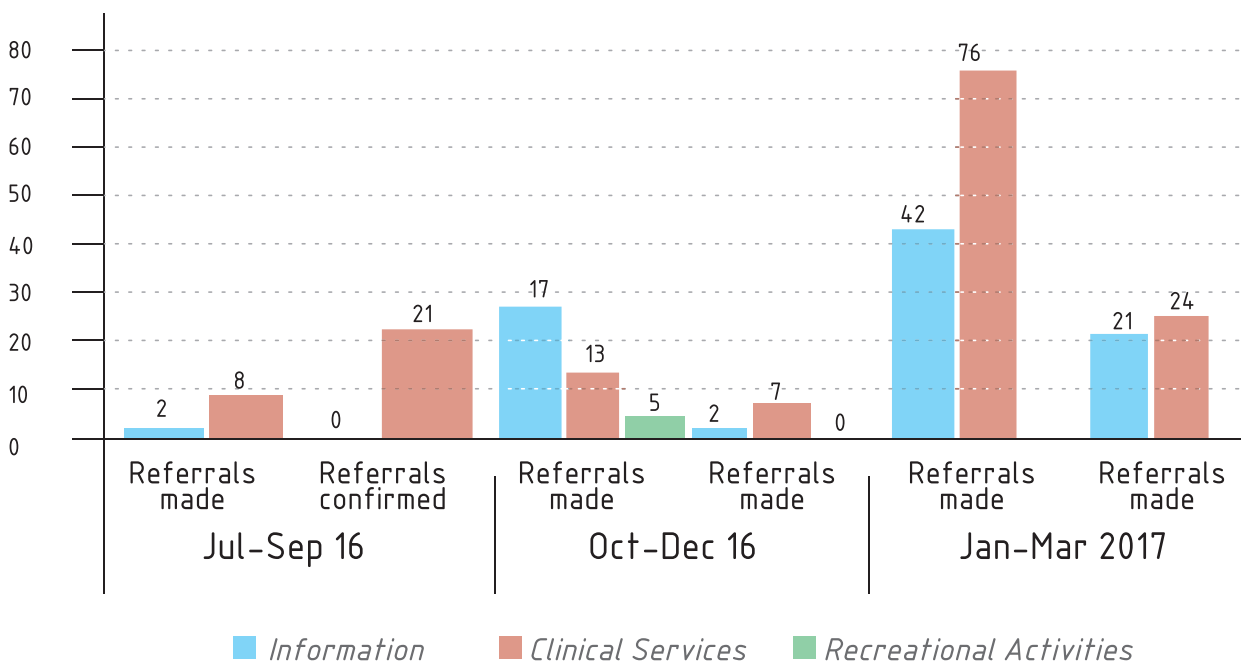


Fig. 5. Referrals made by peer educators, Mt Darwin, July 2016 – March 2017



In Mt Darwin referral slips were accepted earlier than in Bulawayo. Referral slips were made available in July 2016 followed by a sensitization session on their use. Peer educators and service providers in Mt Darwin started using the referral slips immediately. However, the numbers

referred between July 2016 and December 2016 remained low. This was discussed during monitoring visits and review meetings. Once peer educators began receiving allowances, their use of referral slips increased substantially in January–March 2017 (Fig. 5).

Service delivery

VMMC services

Between March 2016 and March 2017, 5187 young men were circumcised in Mt Darwin district. The majority of them, 56%, were in the 15–19 year age group. Over the project period there was a generally upward trend on the numbers of young men circumcised, with

a peak of 1200 in the month of March 2017 (Fig. 6). In Bulawayo over the same period, 6784 young men were circumcised, with a peak of 802 in August 2016. In contrast to Mt Darwin, the largest number circumcised (42%) were in the 10–14 year age group (Fig. 7).

Fig. 6. Numbers and age distribution of young men obtaining VMMC, Mt Darwin District, March 2016 – March 2017

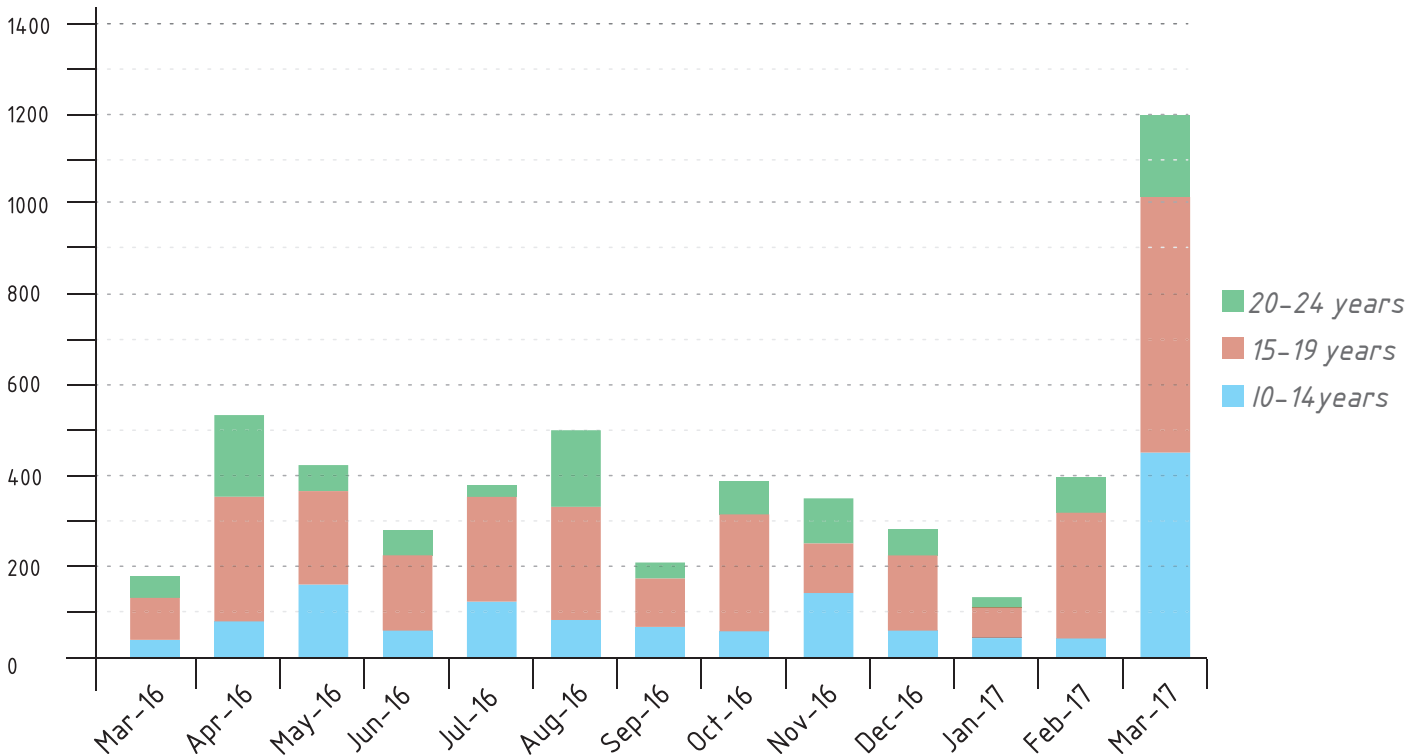


Fig. 7. Numbers and age distribution of young men obtaining VMMC, Bulawayo, March 2016 – March 2017

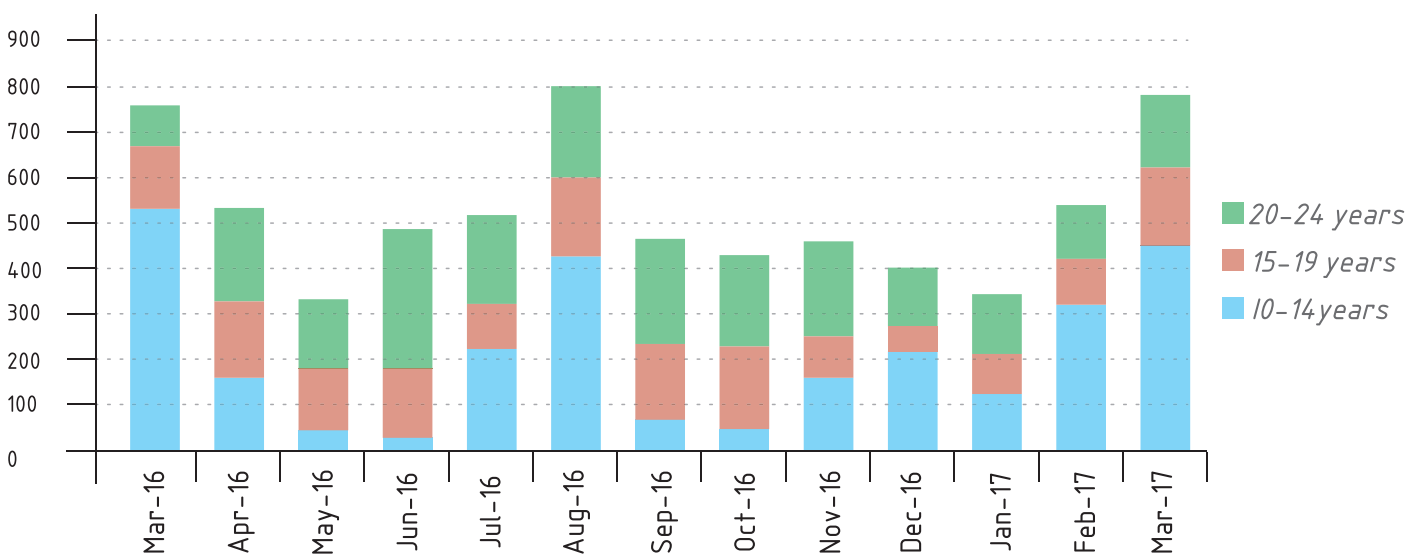
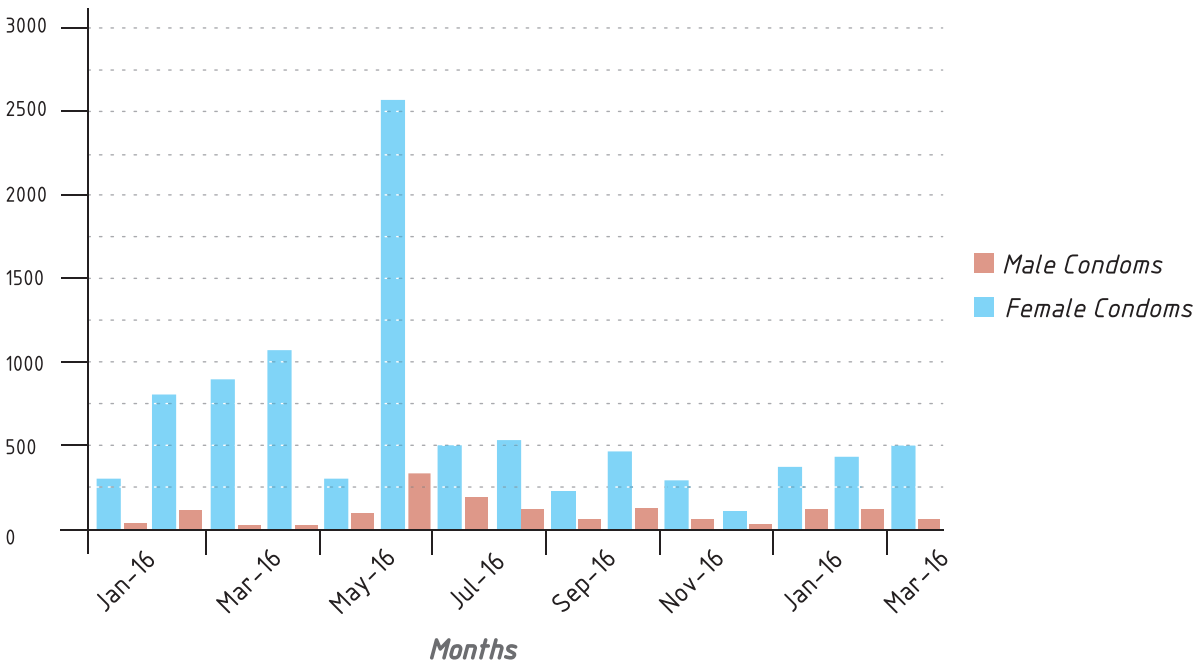


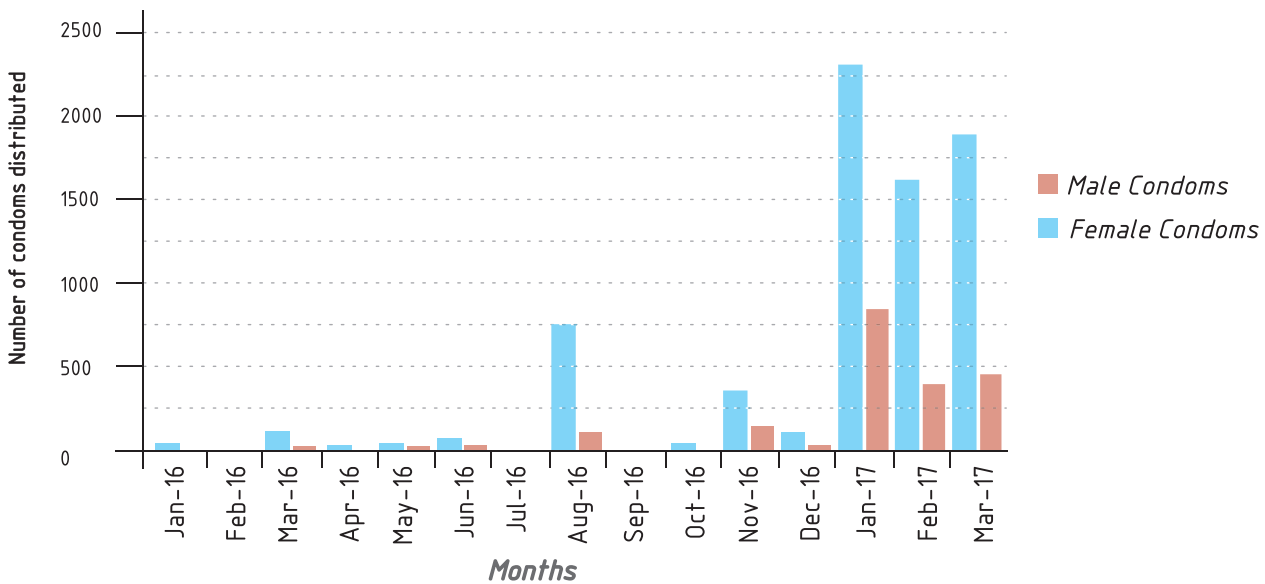
Fig. 8. Numbers of condoms distributed by peer educators, Mt Darwin, January 2016 – March 2017



In Bulawayo condom distribution started on a low note during the first half of 2016 but increased gradually as the year went along (Fig. 9). This trend was attributed to the fact that, unlike in Mt Darwin, the youth centres in Bulawayo are focused mainly on recreational activities, and the

ASRH component needed strengthening. Peer educators were distributing condoms before the pilot. With the project, distribution increased, including during ASRH outreaches and sports events. (Condoms distributed at VMMC sites are not included.)

Fig. 9. Numbers of condoms distributed by peer educators, Bulawayo, January 2016 – March 2017

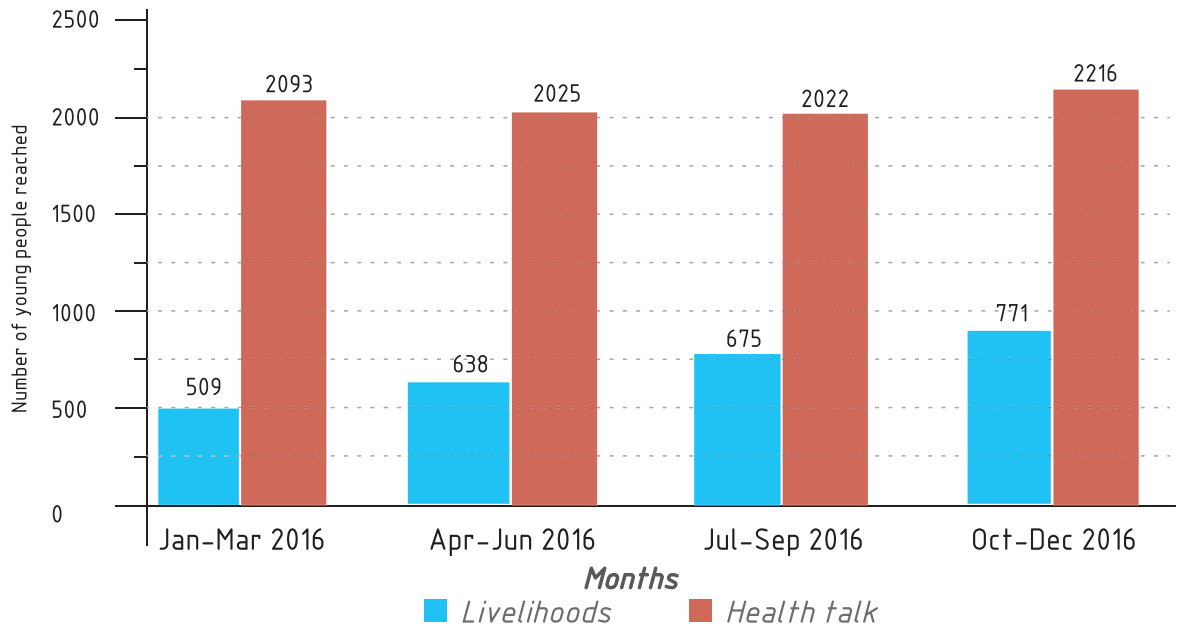


Health talks

In Bulawayo attendance at health talks slightly increased throughout 2016 (Fig. 10). The number of youths reached with livelihood information also increased somewhat. Of note

is that the health talks also incorporated talks on gender and transformative masculinity for the first time. The health talks were held once daily on week days.

Fig. 10. Attendance at health and livelihoods talks, Bulawayo Youth Centre, January – December 2016



In Mt Darwin district, following the introduction of the linkages project in March 2016, there were notable increases in the number of adolescents receiving health information and clinical and recreational services between April and September 2016 (Fig. 11). However, significant drops occurred in the first quarter of 2017. This was due largely to staffing issues: At the start of

2017, only four peer educators remained of the 10 who were available at the beginning of 2016. The high attrition rate was attributed to lack of motivation before the introduction of allowances. The Youth Facilitator and the Health Advisor at Mt Darwin also left; their replacements are yet to be confirmed.

Fig. 11. Mt Darwin Youth Centre attendance, April 2016 – March 2017

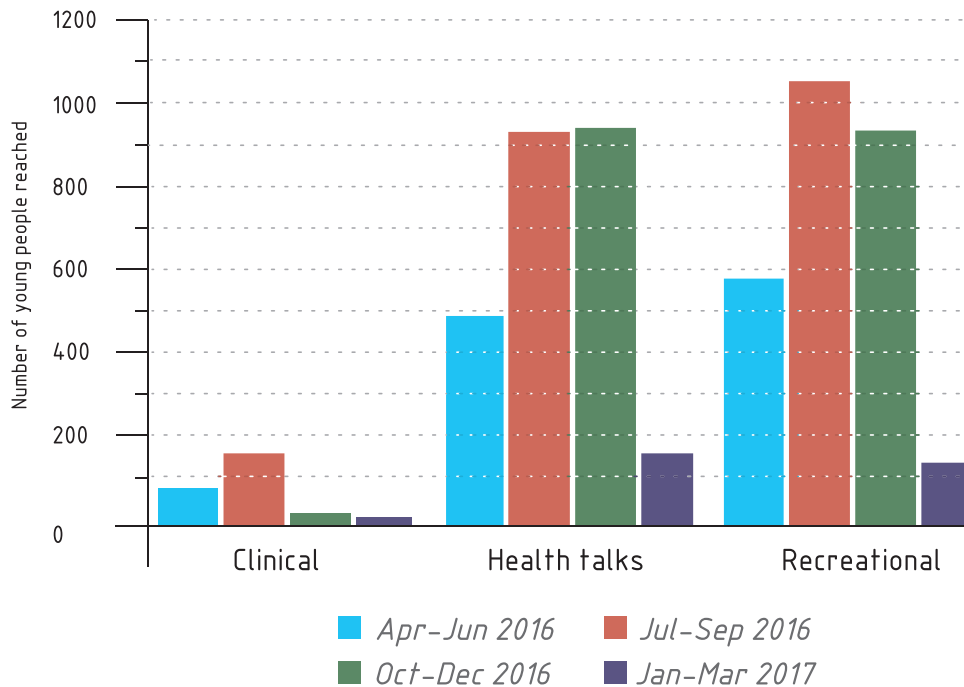
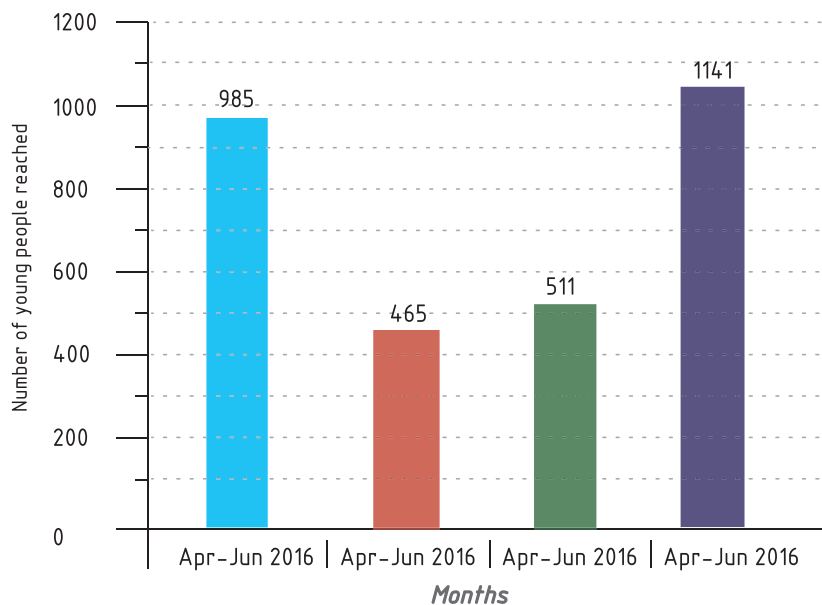


Fig. 12. Numbers of young people reached through outreach, Mt Darwin District, April 2016 – March 2017



Outreaches conducted in Bulawayo were different from those in Mt Darwin. Geographical access was not major issue in Bulawayo, and youth centres there do not offer clinical services. Therefore, outreach involved ZNFPC going to offer clinical services at the youth centres. Outreach in Bulawayo started only in the first quarter of 2017 and reached 473 young people.

Adaptations to services and delivery over the project lifespan

The VMMC – ASRH project learned and adapted over the course of the activities in a number of ways.

Services package to deliver transformative masculinity

For this project “transformative masculinity” was defined as a masculinity that seeks to transform the manner of being a man, changing how respected men will behave in their relationships with other men, women and children. It was envisaged that this would be the focus of the boys’ fora and the community dialogues. However, the transformative masculinity component on the project plan was not implemented until December 2016. Stakeholders lacked a clear understanding of the rationale and content of the intervention. It was taken on board later (Fig. 13), after further discussions and clarifications with the stakeholders. In addition, there was limited capacity and experience among the stakeholders at that point. Therefore, organizations with transformative masculinity experience – Padare Enkundleni Men’s Forum on Gender, SAfAIDS and YMCA – were brought on board. These three organizations, together with other stakeholders, facilitated boys’ fora

and community dialogues on transformative masculinity topics.

Service delivery options

The service delivery protocol provided a good framework for implementation of the project. Some of the proposed options were not implemented due to feasibility issues, however. Those implemented are noted below. (Page 18 describes the options in more detail.)

Options A and B. These “integrated” options were implemented only in VMMC facilities but without the gender transformative masculinity interventions, which was included later. In addition to providing VMMC services, the same or different providers in the same facility offered other SRH services such as STI treatment and condom provision.

However, ASRH facilities were not able to offer VMMC services because of lack of necessary skills and absence of requisite infrastructure. This resulted in ASRH facilities implementing Option C in Bulawayo and Option D in Mt Darwin. During the mapping exercise Mt Darwin Hospital was offering both ASRH and VMMC services,

however, at the time of project implementation, the Youth Friendly Corner at the hospital was no longer functional.

Option C, integrated outreach, was implemented in Bulawayo, where ASRH and VMMC service providers conducted service delivery outreaches to the youth centres.

Option D, linked delivery through effective referral, was implemented in both districts.

Option D – service delivery through linkage and referral between separate sites – was widely implemented since it was the most feasible.

Option D was widely implemented since it was the most feasible.

However, this

does not meet the request of the adolescents for a one-stop shop.

Project design and implementation

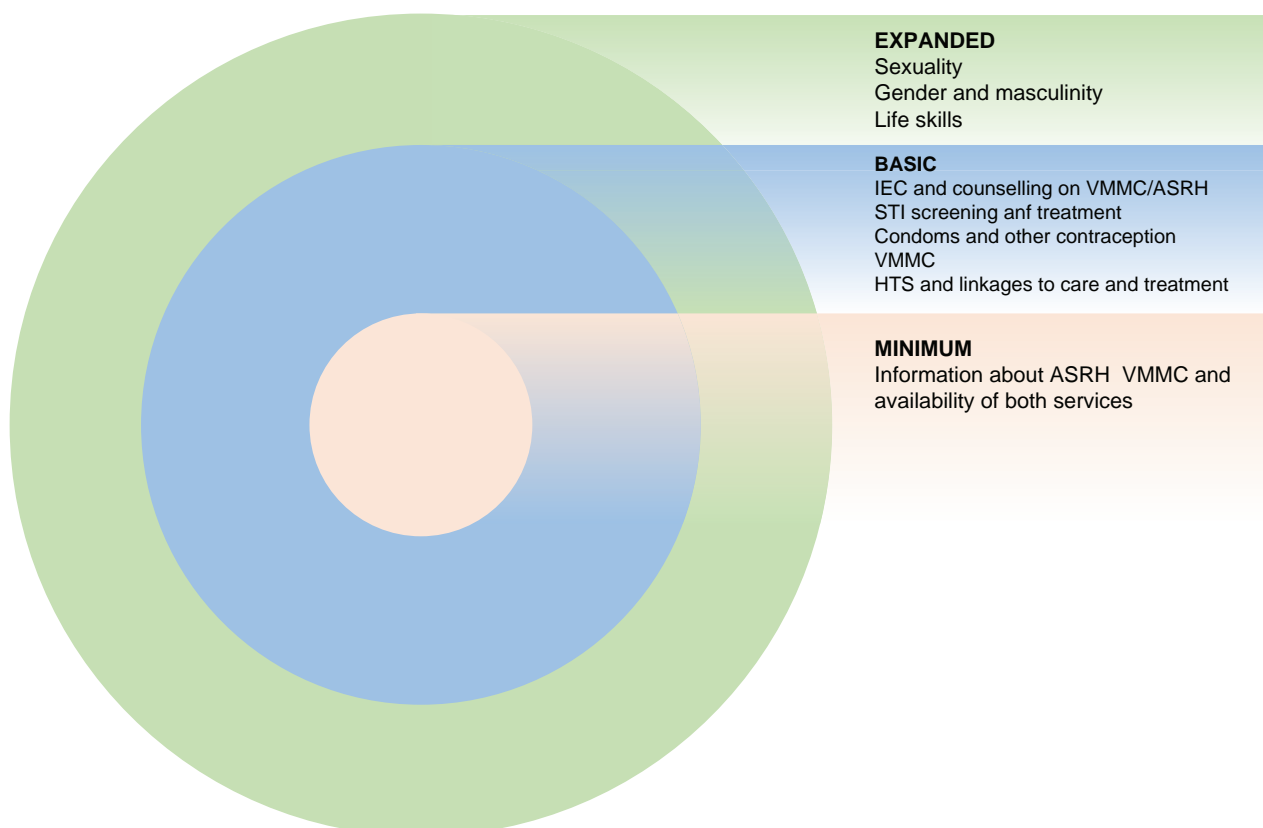
The evaluation protocol envisaged that a research organization could conduct a baseline and, after 9 to 12 months of implementation, an end-point assessment. There were delays, and project execution began in 2016, with funds available for only nine months (March–November 2016) and without the external evaluation. During

implementation significant delays were also encountered in the administration of funds and procurement of project materials, and therefore the project was extended from December 2016 to March 2017 with additional funding.

Service package

From March to November 2016, the project managed to implement fully the Minimal and Basic packages. Once consensus was reached to include the masculinity component, it was added in December 2016. The consensus was to provide not only the gender-based violence information as covered by the ASRH manual but also comprehensive gender and transformative masculinity information (Fig. 13). As envisaged in the service delivery protocol, NGOs offered the additional activities of the Expanded package with funds provided by the project for the boys' fora and community dialogues.

Fig. 13. Revised service package (particularly the Expanded option)



The revised package made some changes to the Expanded option for integrated/linked services after assessing what had been implemented in the pilot phase. Comprehensive information on gender and masculinity was provided in addition

to information on gender-based violence. Additionally, the project could not provide livelihood skills but instead provided information on livelihoods and life skills.

Summary of key results of the VMMC – ASRH linkage project

Coverage of messages and services

- The number of young people reached with VMMC and ASRH messages increased over the project timeframe, reaching monthly highs of 487 adolescents in February 2017 in Bulawayo and 55 in March 2017 in Mt Darwin.
- Similarly, the numbers of referrals made were at their highest in the final quarter of the pilot project, with 583 made in Bulawayo and 118 in Mt Darwin.
- Numbers of VMMCs increased. This increase may be associated with the project, but the association could not be assessed with methods that would permit greater certainty of cause-and-effect.
- Increasing numbers of young people over the course of the pilot project received health talks, clinical and recreational services at youth centres.
- Transformative masculinity content was adopted into health talks, boys' fora and community dialogues through advocacy, improved stakeholder understanding and the identification of appropriate programme partners.

Peer educators

- Peer educators seemed to play a critical role in disseminating information and making referrals to services. Through capacity-building activities, peer educators became more confident in discussing, and referring their peers to, VMMC and ASRH services.
- Outreach services were important to

improve young people's access to services. Steep increases were noted in the number of adolescents accessing services in Mt Darwin (where there are geographical barriers to access) after ZNFPC provided outreach services through this project. Outreach provided at youth centres also had a positive effect.

- Other fora such as the boys' fora and community dialogues and sports and music events provided additional opportunities for joint delivery of messages and services.

Health-care providers

- Lack of allowances for peer educators and concerns regarding the confidentiality of referral slips affected the types and effects of referrals. Staffing issues such as limited time for in-service training, resources limitation, seasonality of VMMC and unclear understanding of rationale for the transformative masculinity component affected implementation and, therefore, outcomes.

Accomplishments

- Through services linkage and referral, this project provided the Minimum and Basic packages for adolescent boys and young men.
- Given additional partnerships with local NGOs, the Expanded package was provided in the project's last quarter, yielding additional lessons.

RELATIONSHIPS:

- umfambelzane
- kuqanisa
- ku mirana
- ku noveruwa
- ku duka
- Uzama
- Kungqawirirano

S.R.H:

- SCBV
- family planning
- TI net
- level of the r

Kinds / types

- * love relation
- + * aqaple
- * mediocre
- romantic rel
- marriage
- family
- Community
- * Friendships



PEER EDUCATOR

SECTION 4.

Key lessons learnt and Recommendations

Lessons learnt from implementation and recommendations

The lessons learnt and recommendations discussed in this section should form the core of the follow-on project. They were compiled over the duration of the pilot project. They are based on observation of the project team, discussions in review meetings, monitoring visits and the end-of-pilot meeting (see Annex XX for reports). Also, some lessons were compiled through an assessment conducted in March 2017 at the end of pilot project implementation. This was a qualitative study, involving focus group discussions (FGDs) and key informant interviews (KIs) with key stakeholders from Bulawayo and Mt Darwin, the project sites. KI and FGD guides were developed that explored the stakeholders' views and perceptions of the project's key

components – sensitization and capacity building, IEC materials development and distribution, community participation, referrals and tracking, joint demand creation and service delivery (service integration and outreach), project coordination and partnerships, seed funding, use of social media, peer educators, monitoring and evaluation, community dialogues and boys' fora and challenges with cash and disbursements. Experienced independent research consultants, fluent in both Shona and Ndebele, were hired to conduct and transcribe the KIs and FGDs. Another consultant was hired to analyse the transcripts using Nvivo software to group together similar themes.



Lessons learnt

Sensitization meetings and capacity-building sessions may be duplicative. But one day of capacity building is not enough to cover all topics.

Sensitization meetings preceded capacity-building sessions. The content of the two activities was very similar and varied only in that the capacity-building sessions were more in-depth. Staff members who had attended the sensitization meetings did better in the pre-test during the capacity-building sessions than those who had not attended the sensitization sessions.

VMMC needs more emphasis in the capacity-building sessions. From the post-training feedback and review meetings, it was evident that one day for capacity building was not enough to comprehensively cover all sessions on the programme, especially VMMC, as participants had many questions regarding the procedure and myths and misconceptions about it.

When services are short-staffed, it is difficult to make staff members available for training. On-site mentorship visits can help. In Bulawayo the turnout of health service providers at the capacity-building sessions was low (26 attended against a target of 60). The main reason given for this low attendance was that facilities were understaffed and could not afford to release many providers. This adversely affected the number of service providers who were reached and could confidently deliver ASRH and VMMC information.

Subsequent mentorship visits were conducted at each project site. More staff members were reached with minimal disruption of their daily duties, and individual concerns were addressed more effectively. Mentorship built on the capacity building and sensitizations that had been done initially.

Capacity building focused on how to provide basic VMMC and ASRH information and to make referrals. In Bulawayo recreational leaders requested more capacity building in youth-friendly service provision. The recreational leaders had no ASRH background, since the youth centres focus mainly on recreation and vocational training.

Recommendations

- **Sensitization and capacity building can be combined**, since the two are similar. The two days would then ensure adequate time to discuss all issues exhaustively. The capacity-building sessions might also need to be spread over two days to include more practical sessions and field practice – for example, practice filling out referral slips.

- **Develop a training-of-trainers (TOT) course** so that facilitators are better able to deliver both ASRH and VMMC messages as well as linkages messages. ASRH and VMMC should be integrated into the current TOTs for VMMC and ASRH following their inclusion in the respective training manuals.

- **Trainers can be assigned at the district level**, which will reduce the cost of travel incurred by using national-level trainers.

- There is need in the next phase to start engaging nurse educators to **advocate inclusion of ASRH and VMMC linkages in pre-service training for nurses.**

- **Mentorship and support after the capacity-building sessions should be continued in all project sites** since this appears to be more efficient and effective than classroom-based training in building service providers' capacity. In the case of a wider roll-out, district trainers will conduct mentorship together with district VMMC and ASRH focal persons.

- There is need to **explore other capacity-building methods** that minimize disruption of service delivery – for example, blended learning, e-training/m-health, training of trainers or incorporating ASRH and VMMC linkages trainings into pre-service training and other pre-existing HIV and ASRH trainings and onsite mentored learning.

- **Integrate ASRH and VMMC linkages into both ASRH and VMMC training manuals.** Although this has already happened to some extent, future versions of the manuals will need to be updated based on the lessons learnt in implementing the VMMC – ASRH Linkages Project.

- **Develop an advocacy plan to promote the inclusion of VMMC – ASRH integrated services in the pre-service curricula** for nurses and midwives. Inclusion of VMMC – ASRH in the curricula will be crucial to sustainability.

IEC materials development and distribution

Lessons learnt

Planning underestimated the time required for design, pretesting and printing. Two months (March and April 2016) were planned for developing IEC materials. However, the process took almost six months. The delays were due to procurement procedures, suppliers' lag time and time for pre-testing the English and translated vernacular versions.

Pre-testing of IEC materials: Perceptions differed between rural and urban sites, making consultation particularly important. Stakeholders in the two project sites had quite different perceptions and views on the acceptability of messaging in the IEC materials. For example, the Mt Darwin parents and youth centre committee members considered the initial designs of the IEC materials using youths from Bulawayo to be "too urban". The Mt Darwin stakeholders thought the dress of the youths was inappropriate, and so was some of the wording – for example, the phrase "cool parents". However, the participatory approach used made it possible to address these concerns early by reaching a compromise that made the materials acceptable in both areas.

Local people make good models for photographs on posters. The use of local youths, parents and service providers as models was seen in a positive light at both project sites, making the materials seem appealing to people they knew. Additionally, the models volunteered, which cut the cost of IEC materials development. Part of the project team from the MOHCC provided photography services, which also saved money.

Various people play important roles in youths' health-seeking behaviour. IEC materials should address each of these important audience groups. Stakeholders greatly appreciated the production of materials targeting specific groups – parents, service providers, boys, and girls. This pointed clearly to the valuable contribution each group can make to overall improved health and lives of adolescent boys and also addressed the specific concerns and interests of each audience.

Recommendations

Adequate time should be scheduled for materials development, taking into account the time required for pretesting and issues that are out of the control of the project, such as procurement procedures.

Development of IEC materials should be a consultative process and be sensitive to cultural and regional differences. However, at the same time audiences should not over-segmented, since this would likely increase the cost of producing the IEC materials.

Use of local models should be continued. In the case of wider roll-out, the same messages might be used but different models for each local area. The cost implications of this will need further exploration.

IEC materials should continue to address the various specific audiences that influence youths' health-related decisions.

Community participation

Lessons learnt

Community participation is crucial. In both districts community involvement contributed to the success of the project. There was a strong sense of community ownership following the initial sensitization meetings.

Involvement of local organizations facilitates smart partnerships and sustainable resource mobilization.

For example, in Bulawayo peer educators conducted a community dialogue on drug and sexual abuse with resources from community organizations, including a church and a funeral parlour. In Mt Darwin a youth centre committee member offered their vehicle for an outreach event.

The involvement of local leadership enhances acceptability to local communities and their buy-in.

Local leaders have been actively involved in both districts. The District Administrator's office always had representatives at the meetings in Mt Darwin. In Bulawayo the local members of Parliament attended functions held by the youth centres, such as the sex and sexuality workshop and modelling contest hosted by Inyathi Youth Centre.

Recommendations

Involvement of the community, particularly the young people and their parents, should be continued.

Mapping of local organizations working in ASRH and VMMC should be continued as well as networking with them.

Local leaders should continue to be involved.

Referrals and tracking

Lessons learnt

Referral forms were little used at first, but the reasons varied. At first, use of the referral forms was not widely accepted. This was more marked in Bulawayo than in Mt Darwin. Different groups raised various issues:

Service providers: Some health workers perceived the referral forms as too much additional clerical work. This was particularly the case in Bulawayo, where council clinics are reportedly under-staffed and any additional work is not welcome.

Also, VMMC service providers are paid per client circumcised; some felt that filling out the referral forms took too much time; therefore, they did not record any referrals. In addition, some VMMC service providers felt that there was no point in referring youths to the youth centres from their outreach points, especially in Mt Darwin, where the distances to youth centres are long. ASRH service outreaches were introduced in November 2016 to address this, but there was no improvement in the number of referrals made.

Recommendations

Referral slips provide the best opportunity for tracking referrals. **Less detailed slips can be considered.** However, this will limit collection of information on the nature of the referrals.

Underlying issues with referrals and how to optimize the system deserve further exploration.

All respondents and FGD participants suggested ways to strengthen referrals, including:

- use of an electronic referral system;
- more sensitization of stakeholders and service providers on the referral system, to facilitate buy-in;
- allowing people with referral slips to get free or subsidized assistance for services sought;
- conduct a survey to ascertain reasons that young people are not taking up referrals.

These recommendations require careful exploration, including monitoring and implementation research. They should be considered as part of the health systems response to meeting the needs of adolescents*¹.

**Recommendations marked with an asterisk have implications beyond this specific Smart LyncAges project. These issues will need to be resolved within the broader context of strengthening national efforts to improve the quality and coverage of services and interventions for adolescents and youth, as part of universal health care. They raise a number of potential implementation research questions.*

The MOHCC felt that the referral forms have not been in use long enough to consider revising them yet.

Bulawayo recreational leaders' view: Recreational leaders in Bulawayo felt that the forms contained personal information, and, therefore, it was not appropriate for peer educators to take them home. They told the peer educators to leave the referral slips at the youth centre and collect them whenever they needed to make a referral. The peer educators considered this logistically difficult. This was later resolved by dialogue and the realization that peer educators were already collecting personal information on their daily forms, which they kept at home. Peer educator training covers issues of privacy and confidentiality.

Peer educators' view: Peer educators reported no concerns with the information collected on referrals slips. However, they reported challenges with tracking referred youths. Challenges included lack of mobile telephone airtime to track the referred adolescents and youths who were using mobile phones. They also reported that some youths gave incorrect contact details, which made tracking impossible. Youth gave misinformation mainly because they were worried about their privacy.

Some adolescents do not want to be referred for VMMC, as they think that the peer educators will receive financial benefit from the referral, as the VMMC mobilizers do.

Note: It appears that other MOHCC programmes that use referral slips have faced challenges like these, except for the VMMC programme, where mobilizers are paid for each completed referral.

Provide mobile phone airtime for peer educators to track referrals. Mobile service providers may be willing to donate airtime.

Joint demand creation and service delivery (service integration and outreach)

Access challenges. Geographical inaccessibility and user fees led to low follow-through on peer educators' referrals.

Geographical inaccessibility of services. Outreach is necessary to bring services to areas far from youth centres. In Mt Darwin the geographical inaccessibility of services to which clients were referred posed a huge challenge. One peer educator from Dotito referred 12 clients in October and November 2016 to the youth centre, but none of them could follow through because the youth centre is 15 km away, with poor road access. The youths had been referred mainly for clinical ASRH services. Findings of the U-Report poll made clear that adolescents in rural areas had limited access to the youth

Explore longer-term, sustainable options for bring services to where the young people are. In the short-term outreach can improve accessibility of services, but this is not sustainable. *

In the long term all youth centres need to be capacitated to offer clinical services, including those in Bulawayo.

Explore and strengthen innovative and sustainable integrated service delivery models – for instance, revival of Youth Corners at the hospitals and routine offering of male circumcision at youth centres.

centres. ASRH outreaches were introduced in December 2016. This increased utilization of services.

Recreational leaders at youth centres in Bulawayo have little or no capacity to provide comprehensive ASRH services.

Health workers' attitude hampered young people's access to services. Young people were concerned also about the attitude of some service providers, who are not youth-friendly, at the facilities to which they were referred.

User fees. User fees can be a barrier to access for youth. In Bulawayo user fees have been noted by the youths to be a barrier to clinical services. The youth centres in Bulawayo, unlike those in Mt Darwin, do not offer clinical services. Instead, young people are referred to municipally owned primary health care clinics. These clinics charge a consultation fee of US\$ 5, which is a barrier to youth accessing services. (In contrast, in Mt Darwin clinical services at youth centres are free to the user.) ZNFPC offers free services in Bulawayo, but young people have to pay transport fares to get there. ZNFPC is not well capacitated to conduct service outreaches. The City of Bulawayo is willing to consider a waiver of user fees if there is a funder who can take up the cost. In previous projects a donor-funded coupon system covered user fees.

The integrated service model. Young people prefer having both ASRH and VMMC services offered in one facility. Young people greatly appreciated the offer of VMMC and HTS on site at the youth centres during events such as sports galas. This saved them time and transport fares.

ZNFPC youth centres in Mt Darwin already offer clinical services, including HTS, STI treatment, contraception/condoms and pregnancy testing.

Service providers should be capacitated to provide a comprehensive package of services, especially in Bulawayo, where recreation leaders at the youth centres needed the full five-day ASRH training course. This has much wider implications for MOHCC and ZNFPC.

Attitude issues among health workers should be addressed through training and mentorship. However, there is need for innovative approaches to address cultural perceptions that determine health worker attitudes

The MOHCC should consider whether user fees can be dropped for adolescents. This is an important policy decision for the MOHCC, with significant implications for adolescents' use of services more generally.* The follow-on project should plan to present its experience as part of advocacy for dropping user fees.

To the extent feasible, ASRH and VMMC services should be offered in the same facility.

Project coordination and partnerships

Lessons learnt

Dedicated personnel. Recruiting dedicated personnel both at WHO and MOHCC greatly facilitated the take-off and implementation of the project. Otherwise, MOHCC staff members are usually overwhelmed in a system with many vertical programmes, and it can be difficult for them to prioritize activities.

Competing priorities for other MOHCC units. Competing priorities limited the involvement of the MOHCC Reproductive Health Unit. The public health system in Zimbabwe is composed of vertical programmes. This leaves the MOHCC personnel with many competing priorities.

Importance of partnerships. Partnerships among different organizations contributed to the success of the project. The project was led by MOHCC; partners included WH, UNICEF (U-Report), PSI, ZNFPC, NAC), CWGH, the City of Bulawayo and several other, local NGOs. NAC and CWGH have been supporting youth initiatives and made monetary contributions to events where joint demand creation/service integration for ASRH and VMMC took place.

Recommendations

Hire dedicated staff at the national level. Dedicated staff time is required to strengthen coordination of the project at the national level. How this can be sustained and/or integrated with support for a wider set of responsibilities for services/interventions for adolescent health needs to be explored.*

Coordination at the subnational level can be strengthened through existing MOHCC or ZNFPC structures but needs to be incorporated into existing job descriptions.

Move toward more integrated administration at the national level. The long-term solution would be a system that is more integrated and less dependent on vertical funding. This has implications for responsibilities and structures for adolescent health generally within the MOHCC.*

For sustainability partnerships with national and local organizations should be developed and or strengthened.

A resource mapping exercise should be conducted to ensure that available resources are distributed equitably and are used efficiently.

Both of these recommendations have implications for VMMC – ASRH linkages and for broader strategies to improve adolescent health in Zimbabwe.*

Seed funding

Lessons learnt

The seed fund helped to build relationships with all stakeholders. Each of the youth centres was given a seed fund of US\$100 per quarter, which they could use according to their priorities. In both settings the youth centres have many needs that cannot be addressed by a project with limited resources, such as the VMMC – ASRH linkages project. Most youth centre infrastructures are run-down, and the seed fund was used mainly to address this (refurbishing furniture, buying sporting equipment). However, there is need to manage expectations.

Recommendations

The seed fund could be continued. However, this requires further discussions within the MOHCC and ZNFPC, and with key stakeholders/funders, and would require careful monitoring and evaluation, as it would have significant resource implications in the case of wide-scale roll-out. It needs to be seen within the context of other efforts to strengthen youth centres.*

Use of social media

Lessons learnt

WhatsApp platform

Need for moderating. Use of the WhatsApp platform was a success, but content shared from other online sources was not always accurate. WhatsApp groups for peer educators and for stakeholders were created, and the platform was actively used to disseminate information and to discuss various ASRH and VMMC issues. Stakeholders used the group to share calendars and coordinate activities. The platform was also useful in obtaining feedback during the development of IEC materials, T-shirts and hats, through chats and exchanging images among the designer, peer educators and stakeholders: Ideas on colour, text and designs could be discussed and finalized.

Despite the positive contributions of the WhatsApp platform, some of the content included in the groups, especially content obtained from other online sources, was shared as facts but was inaccurate.

Privacy issue. Young people would prefer a “youths-only” space. The groups consisted of young people, recreational leaders, stakeholders, the MOHCC linkages officer and the WHO officer. This broad participation was felt to be important because these were the first groups of this nature, and there was a need to observe/monitor the use of the platform. However, some expressed concerns that this creates a sense of lack of privacy.

Facebook

Low utilization of the Facebook platform. The peer educators created a Facebook page as a platform to share ideas and experiences. **The Facebook platform proved to be less popular than the WhatsApp platform.** It was used for similar purposes but received much less demand. This could be attributed to easier access to WhatsApp, which does not require opening a web page and logging in, and consequently uses fewer data. Young people in rural Mt Darwin, in particular, have limited access to the Internet.

U-Report platform

Information dissemination. The U-Report platform proved a powerful vehicle for reaching young men. U-Report was used to disseminate information, for example, on VMMC campaign dates. This was successful: About 13 000 young men from the two project districts received SMSs on the July/August VMMC campaign dates.

Opinion polls. The U-Report platform has been used to

Recommendations

The WhatsApp groups should have a moderator or moderators, with sound understanding of ASRH and VMMC issues, who continuously check the accuracy and quality of the content. Young people can use articles from credible sources such as WHO to initiate discussions. **The project can partner with organizations, such as the Young People’s Network, that have experience in youth engagement via social media.**

Regulation and monitoring will need to be balanced with young people’s privacy.

Use of this platform will need **further exploration with youths to develop a set of guidelines for use of the WhatsApp groups.**

In every context young people’s social media preferences should be considered.

There are pre-existing ASRH social media platforms nationally. For larger scale roll-out, integrating VMMC – ASRH linkage messages into these pre-existing platforms should be considered.*

Wider use of the U-report platform can be promoted during review meetings and through promotional and IEC materials such as T-shirts and posters, which are available through UNICEF.

Ask fewer questions on the opinion polls to improve the response rate.

conduct opinion polls and gather valuable data on young people's experiences and perceptions. When the poll had many questions, the response rate dropped sharply with each follow-up question. Polls with a maximum of just three questions had a better response rate. U-Report was also used to collect data on the main challenges faced by boys. This information helped to identify topics for the boys' fora.

Peer educators

Lessons learnt

Overall. Peer educators played an important role in many aspects of the project, such as making and tracking referrals and developing and distributing IEC materials. However, ZNFPC reports that they have not been able to pay the peer educator allowances consistently due to funding challenges. During review meetings stakeholders raised the issue of the sustainability of the peer education component, particularly the allowances.

Attrition. There was high rate of attrition of peer educators at both Mt Darwin youth centres for a variety of reasons, such as getting married, going to school and lack of motivation due to the absence of allowances for the greater part of 2016. While both centres had a full complement of peer educators in the first quarter of 2015, only two were left by the last quarter of the year.

Incentives. Allowances increased peer educators' reporting. Reporting improved after the project introduced allowances for submitting reports. The peer education programme had been giving allowances erratically due to funding challenges.

With capacitation, peer educators can perform other duties. For example, in Bulawayo some peer educators were trained as VMMC mobilizers.

Monitoring and evaluation

Lessons learnt

M&E data/indicators. Project M&E requires robust existing M&E systems. Inherent weaknesses in the M&E systems of the two programmes, particularly the ASRH programme, hampered project M&E. In Bulawayo, for example, not all peer educators reported their data to the programme, due to non-payment of allowances. Monitoring visits helped with following up on statistics. However, at times these visits took place after the cut-off dates for submission of information, and so the reports could not be accepted into the ZNFPC data collection system.

Data collection tools. Existing M&E tools were not sufficient. To minimize the workload, the project used

Recommendations

The implementation of the whole peer education component of the project, including its sustainability, needs further exploration.*

Given the high attrition rate, the feasibility and value of the peer education component of the project need further consideration.

Allowances for peer educators should be continued. A number of incentives were explored: Hats and T-shirts are a good non-monetary incentive for peer educators and should be continued.

Approaches to remuneration and incentives should be standardized across projects in Zimbabwe to avoid unrealistic expectations and competition.*

Recommendations

Since data are necessary to demonstrate effectiveness, **the linkages project should explore ways of strengthening the M&E systems of the programmes.** For example, incentives to peer educators to submit reports improved the rate of submissions.

VMMC should be seen as an inherent part of ASRH, and in the long term M&E tools should be revised to reflect

the existing data collection tools already used by the two programmes. However, these tools recorded only attendance and therefore they could not adequately assess the impact of the strengthened linkages.

The national ASRH and VMMC M&E systems have no indicators that are specific to linkages since linkages have not been of interest to the two programmes.

The coverage and effectiveness of IEC materials needed specific assessment. There was no comprehensive evaluation of the coverage and effectiveness of the various IEC materials to inform scale-up.

this.*

The project should propose M&E indicators that would help to demonstrate the outcomes and impact of strengthening integration and linkages, taking into consideration relevant indicators already included in the national M&E system.*

IEC materials should be monitored and evaluated to optimize their distribution and usage.

Community dialogues and boys' fora

Lessons learnt

Masculinity package. The packages used by Padare Enkundleni Men's Forum on Gender were adapted from a manual developed for adult men. There is no specific package for adolescent boys. In some of the dialogues and forums, all ages of boys and men were mixed, which resulted in poor participation by younger adolescents.

Overall, **the boys' fora proved to be a great platform for boys to freely discuss issues that affect them.** The boys preferred having male facilitators during these fora so that they could freely express their views and feel comfortable asking questions.

Recommendations

Masculinity packages should be developed to address different age groups – that is, 10–14 years, 15–19 years and young adults.

Dialogues and fora should separate young people according to their age groups so that issues specific to a particular age group can be discussed. At a minimum, young people should not be mixed with adults.

Selected male facilitators should be capacitated to deliver gender and masculinity messages in boys' fora. These facilitators can be service providers, peer educators or youth centre committee members.

Challenges with cash and disbursements

Lessons learnt

Disbursement of funds. Delayed disbursement of funds can slow project activities. Administrative delays in the disbursement of funds to MOHCC delayed some activities at every stage of the project. For example, the Bulawayo sensitization meetings with the Parents' Association and community members and the advocacy meeting with local leaders were planned for May but held in June for this reason.

Cash shortages. Cash shortages in Zimbabwe led to postponement of June training/orientation meetings in Mt Darwin because there was no cash for participants' allowances.

Recommendations

Innovative and rapid, flexible solutions will be critical for cash disbursements in order to minimize delays in project implementation – for example, using mobile transfers to pay peer educators' allowances.

Assessment of stakeholders' perceptions, March 2017

Background

As called for in the M&E framework of the pilot project, an assessment was conducted at the end of project implementation in March 2017. This was a qualitative study, involving focus group discussions (FGDs) and key informant interviews (KIs) with key stakeholders from Bulawayo and Mt Darwin, the two project sites. KI and FGD guides were developed to explore the stakeholders' views and perceptions of the project's key components. These guides covered: joint demand creation, service integration, service outreaches, community dialogues and boys' fora, the referral system, youth centre seed funding, mobile phone airtime allowances and IEC material. Experienced independent research consultants, fluent in both Shona and Ndebele, conducted and transcribe the KIs and FGDs. Another consultant analysed the transcripts using Nvivo software to group together similar themes.

Participants

Participants were drawn from both Mt Darwin and Bulawayo. In Mt Darwin one FGD was conducted with five peer educators from Mt Darwin and Dotito Youth Centres. The key informants were the Mt Darwin Hospital Matron, one hospital VMMC team member, one ZNFPC Provincial IEC Officer, and two Youth Health Advisors, each representing Mt Darwin and Dotito Youth Centres. In Bulawayo two mixed FGDs were conducted with peer educators, with an average of eight participants in each group. Two PSI VMMC facility managers, three youth centre recreation leaders and one ZNFPC Provincial IEC Officer were the key informants.

Roles in the project

Key informant interviews

Key informants in both districts were asked to state their roles in the project. The key roles highlighted were:

- coordination and planning of community-based programmes on ASRH and VMMC
- coordination of youth centre activities
- overseeing the implementation/integration of the VMMV and ASRH.
- compiling the project report
- making referrals for young people
- networking young people.

Due to the differing nature of the Youth Centres in Bulawayo and Mt Darwin, KIs in Mt Darwin also highlighted the following service delivery roles:

- conducting needs assessment of ASRH services
- developing and reviewing project material for relevance
- offering counselling and VMMC services to young people
- offering health education to young people on VMMC and ASRH
- advocacy at national and community levels.

FGDs

Peer educators reported their roles as follows:

- advocacy
- planning and facilitation of project activities
- mobilizing young people for VMMC and ASRH services
- information dissemination on the VMMC – ASRH Linkages
- referring young people for VMMC and ASRH services.

Overall view of the project

Responses from the FGD participants point to the conclusion that the VMMC – ASRH Linkages Project has been a good project, as it is promoting access to information and services of the two aspects at one go, incorporating HIV prevention.

Excerpts from key informant interviews

"We also ensure that we engage influential leaders in the community and make them aware of the programme, its aims and its objectives so that they may also have an understanding and may also be the advocates of the programme."

~male

key informant

"My favourite role has to do with advocacy on SDGs [the Sustainable Development Goals], especially SDG Number 3, Universal access to health for all people. The economic system in Zimbabwe does not support youths. It is hard for us as youths to get money to go and get treated, so VMMC provided platforms for unemployed youths to get access to treatment through referrals."

~male

peer educator

"My role has been to ... look for facilitators when we had events. I have been working with my youth recreation leader to identify people who can assist us on any activity we wanted to embark on."

~female

peer educator

Respondents saw the project mainly in a positive light:

- The project has strengthened the ASRH programme as a whole.
- It is a more comprehensive and integrated project, addressing the ASRH gaps that exist in the population.
- The project has increased stakeholders' interaction.

- Quite useful to the young people who have been exposed to it.
- Quite useful in terms of its referrals component.

At the same time, respondents noted some short-comings. These include the fact that the project started slowly and late.

Estimated project costs

THE project consisted of two funding phases. The estimated expenditure for the project from March 2016 to March 2017 totalled US\$ 140 811. Costs from March through November 2016 were US\$ 69 905 and from December 2016 through March 2017, US\$ 70 906, including costs of the end-of-pilot meeting. Table 10 shows project costs by category, while Table 11 shows the contributions of the partners. On a monthly

basis, costs were greater in the December–March period, even with costs of the end-of-pilot meeting excluded. March–November 2016 cost per month was US\$ 7 767 compared to US\$ 12 483 for the December 2016 to March 2017 period. Among the major cost drivers in the later period was the introduction of the peer educators allowance, community dialogues and boys' fora and community outreaches

Table 10. Estimated project costs in US\$ by category

Cost category	Mar–Nov 2016	Dec 2016–Mar 2017	Total*	% of total cost
IEC materials (including referral slips)	9 320	9 013	18 333	13.0
Support and supervision	25 480	7 880	33 360	23.7
Capacity building	8 870	3 195	12 065	8.6
Advocacy and sensitization	3 335	2 550	5 885	4.2
Seed fund	2 400	1 700	4 100	2.9
Peer educator allowances	—	4 800	4 800	3.4
Mobile phone airtime for youth centres	720	1 360	2 080	1.5
Community dialogues and boys' fora	—	5 600	5 600	4.0
Community outreaches	—	4 760	4 760	3.4
Project officer allowances	15 300	6 300	21 600	15.3
Review and planning meetings	4 480	2 775	7 255	5.2
End-of-pilot meeting	—	20 973	20 973	14.9
Total	69 905	70 906	140 811	100

* All costs are estimated expenditure

Table 11. Resources contributed by partners (other than WHO)

Partner	Project aspect supported	Contribution
MOHCC and other government ministries	All aspects	Technical input on all project aspects, staff time
Community members	Outreaches	Transport for peer educators Refreshments, tent, public address systems for community dialogues
CWGH	Sports galas	Financial resources
NAC	Sports galas	Financial resources
Padare Enkundleni Men's Forum on Gender	Community dialogues and boys' fora	Staff time
PSI	VMMC outreaches in youth centres	Staff time and VMMC supplies
SAfAIDS	Community dialogues and boys' fora	Staff time and IEC materials
UNICEF	U-Report	U-Report polls and staff time
YMCA	Community dialogues and boys' fora	Staff time
ZNFPC	Community dialogues and boys' fora	Staff time and IEC materials

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SECTION 5.

Implementation considerations for sustainability and scalability

Sustainability

Political sustainability

Leadership in the MOHCC and key partners such as ZNFPC have demonstrated strong commitment to enhancing access for adolescent boys to SRH services through VMMC. This has been demonstrated by the inclusion of VMMC in both the ASRH strategy and training manual. Similarly, ASRH has been included in the VMMC training manuals. This has created an environment that helps to sustain the linkages.

Social sustainability. The project has received social support, as evidenced by strong community participation in sensitization and review meetings, including the participation of traditional leaders and some political leaders such as councillors. The communities largely accepted the project, owing to their involvement at various stages of the project including production of IEC materials addressing parents. Also, youth centre committees have recommended its expansion to more centres.

Ownership. In both districts there was already significant community ownership of the ASRH / youth centres programme. This was demonstrated by community involvement in running the youth centres through youth centre committees in Mt Darwin and parents' associations in Bulawayo. The VMMC – ASRH Linkages Project took advantage of this pre-existing acceptability and buy-in. Local leaders such as the District Administrators, chiefs, headmen and village leaders actively participated in the sensitization meetings, community dialogues and district review meetings. Local community members contributed personal resources to some project activities — for example, in Mt Darwin a parent provided transport for peer educators to go to outreaches, and in Bulawayo local businesses contributed some resource towards community dialogues. This demonstrates strong ownership of the project that can enable some of the services to continue even when donor funds are no longer available.

Technical sustainability. For the most part, the project used systems and tools that were already in use in the ASRH and VMMC programmes. The M&E tools that were used were already being used, with a few additional reports to capture project-specific data. The existing reporting channels were used as well, as were mechanisms for support and supervision at the district level. By and large, the project was not a new intervention but rather the strengthening of what was already in place and enhancing opportunities for linkages.

Skills and capacity of local stakeholders.

Through the capacitation of service providers and sensitization of communities undertaken by the project, there is potential for the linkages activities to continue even when the funding for the pilot project is no longer available. It appears that service providers are now equipped to provide basic ASRH and VMMC messages, and peer educators, too, are capacitated to provide information and to refer and track their peers. (Evaluation of the knowledge and skills of peer educators and service providers will be needed in the future.)

Through wide stakeholder involvement at all stages of the project, there was extensive buy-in.

Effectiveness of stakeholder organizations.

The capacity of district-level stakeholders to coordinate has also been improved through review meetings in both districts. Coordination platforms such as WhatsApp, which require only modest financial resources, have been set up and can be maintained beyond the project. The effectiveness of MOHCC and WHO has also been improved by recruitment of personnel dedicated to project activities.

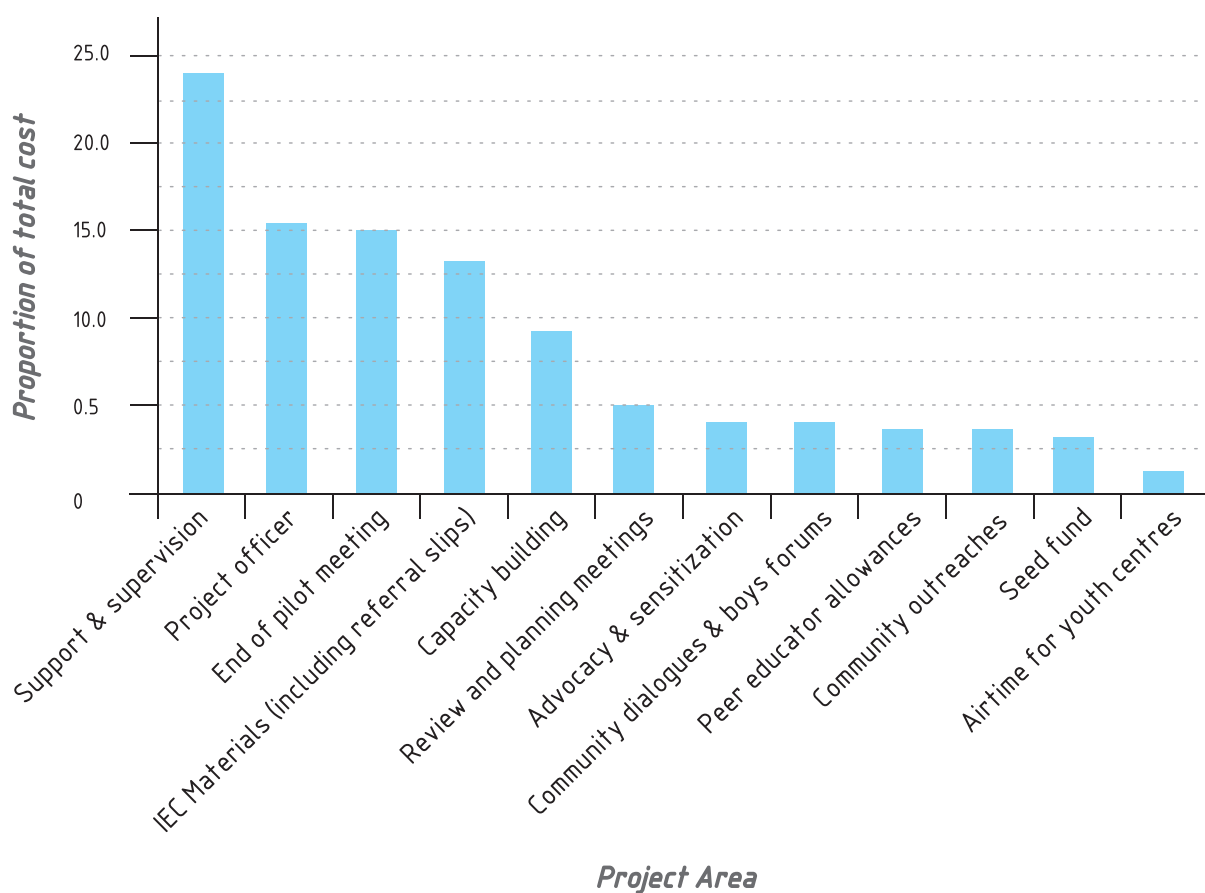
Sustainability of financing models. The project was financed largely by WHO. However, various organizations contributed directly and indirectly to the financing of the project (see Table

11). Routine systems and pre-existing staff were used, as the project was deliberately designed to work within current systems and to inform feasibility and needs to achieve sustainable services within current systems.

Of the funds that WHO provided, the largest proportion went to support and supervision (Fig.

14). The greater part of the cost for support and supervision was incurred during the initial stages of the project, when there were numerous meetings and capacity-building missions. The cost for the project officer was the second highest cost; the greater part of this was non-recurring costs such as equipment and job aids for the project officer.

Fig. 14. Distribution of estimated costs by project area



Some project costs, such as support and supervision, can be integrated into the pre-existing VMMC and ASRH support and supervision budgets in the longer term. This will be feasible when the intervention is fully adopted into the national ASRH and VMMC programmes. Specific

indicators will then be integrated into the existing M&E and support and supervision tools. Costs such as those for community dialogues can be taken up in part by community members and community-based organizations.

Sustainability of service delivery options

Options A and B

Options A and B were feasible only in VMMC facilities. The facilities in Bulawayo are owned and directly run by PSI. Thus, continued operation there depends on PSI funding. In Mt Darwin the physical infrastructure is provided by MOHCC, while PSI funds the operations.

Options C and D

Option C involves outreach. With funding from PSI the VMMC programme had been carrying out regular outreaches before the linkages project was introduced. The ASRH programme, in contrast, had not been able to carry out planned outreaches due to lack of funding. Sustainability depends on continued funding for the VMMC programme as well as for the outreach component of the ASRH programme.

Option D is the most feasible and probably most sustainable. However, its effectiveness needs further exploration, given the system challenges such as user fees and long distances to facilities that make it difficult for young people to follow up on their referrals.

Peer education

The project sought to strengthen peer education

by providing capacity building, mentorship and allowances for the peer educators. Each peer educator receives an allowance of US\$ 15 per month. Reporting has improved, and the numbers reached with information increased. A review of the ASRH programme, conducted in 2015 by the Johns Hopkins Bloomberg School of Public Health and commissioned by UNFPA, concluded that peer education approaches may be a useful adjunct to other approaches but that evidence did not support significant investment in this area as a primary strategy to improve ASRH. The peer education effort faces the challenge of high attrition of the youths as they enter colleges or get married. This was seen at Dotito Youth Centre during the pilot project.

Scalability

The project is deemed to be scalable due to its success in the current sites and the fact that it used the pre-existing systems of the VMMC and ASRH programmes. Still, systems issues need to be addressed and research on key issues is needed. Table 12 comments on specific aspects of scalability. It analyses the scalability of the project aspects using the "CORRECT" attributes (Credibility, Observability, Relevance, Relative advantage, Ease of transfer/installation, Compatibility and Testability), as described in the 2010 WHO publication

Nine steps for developing a scaling-up strategy.¹

¹Geneva: World Health Organization; 2010. http://www.who.int/reproductivehealth/publications/strategic_approach/9789241500319/en/.

Table 12. Scalability of project aspects

Attribute	Comments
Credibility	Results of the pilot project suggest improvements in the capacity of service providers to provide information and make referrals. The factors underlying this observation need exploration. In addition, the project should consider more quantitative indicators and methodology to collect evidence on the effect of capacity building.
Observability	Stakeholders observed results in both project sites. The results include increased reporting by peer educators in Bulawayo and increased collaboration between VMMC and ASRH stakeholders in both districts, among others. Going forward, the project will need to measure changes in service uptake, as well as changes in knowledge and attitudes, among parents, recreation leaders and service providers.
Relevance	The need for this intervention is felt at all levels of the health system. All agree that VMMC has created an unprecedented opportunity for adolescents to come in contact with the health system, making an opportunity to deliver comprehensive SRH services. Teenage pregnancy and HIV remain significant public health concerns in Zimbabwe. Factors that influence HIV transmission, such as harmful perceptions of masculinity and cultural practices, also affect teenage pregnancy rates and need to be addressed. This intervention creates the opportunity to foster transformative masculinity and gender norms in adolescent boys at a younger age.
Relative advantage	The project has created an opportunity for efficient utilization of both ASRH and VMMC resources. At the district level existing programme staff participated and additional staff was hired. Joint VMMC and ASRH outreaches were conducted. Although implemented in a vertical manner at the moment, there is an opportunity to integrate project activities into existing ASRH and VMMC programme systems and structures. This is a key consideration for long-term implementation of both ASRH and VMMC programmes. Partnership among the different organizations working on ASRH and VMMC will create synergies.
Ease of transfer/installation	The project did not lead to major changes in the way that ASRH and VMMC services were being delivered. Rather, it identified opportunity for service linkages among ASRH, VMMC and other adolescent health services and for improving the efficient use of resources. The project mainly used the tools already used in the two programmes, with some adaptation – for example, of the community referral tool. Additional staff was required at the national level at MOHCC and WHO. Delivery approaches need to be further specified to enhance the ease of transfer.
Compatibility	The project is compatible with the MOHCC drive to ensure that all services are integrated for reasons of efficiency. Some components, such as the seed fund, will need further exploration to demonstrate impact and local adaptation to ensure sustainability.
Testability	Before being fully adopted, the VMMC – ASRH intervention can be tested using implementation research / operations research and through more systematic routine monitoring.

Possibilities for implementation in other settings

The VMMC programme is being implemented in all 62 districts in the country. While the ASRH programme is implemented in all districts as well, only 16 districts have youth centres. The process and main activities of the pilot project can be easily introduced and adapted in the 16 districts with youth centres. However, adjustments to the service delivery model would be needed in districts with no ZNFPC youth centres. Partnerships with other youth-serving organizations should be developed and strengthened.

Vision for scale (governance, ownership)

The MOHCC envisages a situation where young people have access to integrated ASRH and VMMC services in a youth-friendly environment with minimal barriers to access and most efficient use of available resources.

Pathway to scale and potential challenges that need to be addressed

The project has been implemented in two districts (one rural and one urban). There are differences in culture and health systems issues in various settings that can affect implementation of ASRH and VMMC services. Therefore, we propose gradual scale-up of the intervention while continuing to learn lessons. Potential barriers to scale-up and their solutions are discussed in Section 4, under lessons learnt. Still, they will need further exploration applying implementation research methods. The points below highlight actions on policy change, programme and partnerships, and service delivery that are based on the project lessons, the assessment of feasibility and capacity strengthening needs.

Policy changes to consider include:

- improving pre- and in-service training on adolescent-friendly services to expand the number of competent providers (nurses, counsellors and doctors)
- removing user fees for adolescents
- supporting staff to serve as coordinators of this work from national to subnational levels.
-

Strategy for the future needs to be clarified, as the long-term solution would be a system that is more integrated and less dependent on

vertical funding. VMMC and ASRH should be incorporated into a delivery system that works for adolescents, but it may also be the platform upon which other services can be provided, since no such specific platform currently exists. This project serves as one step to identify that systematic approach to delivering the relevant services to adolescent boys (and girls).

Partnerships among different organizations for implementation and advocacy must be enhanced (and recognized). The partnerships in the pilot project contributed to its success and must be built upon further at all levels from national to local. It is recognized that adolescent health is not just an issue of the health sector; other sectors have roles in programming for adolescent health, as described in the strategy for Global Accelerated Action for the Health of Adolescents (AA-HA!).

Line ministries engaged in the initial phases of VMMC implementation, in addition to the MOHCC, should participate in a working group or steering group that is officially tasked to take forward the transition to sustainable and broader services for adolescent boys. Involvement of other nationally relevant sectors is in line with WHO's A framework for voluntary medical male circumcision. Effective HIV prevention and a gateway to improved adolescent boys' & men's health in eastern and southern Africa by 2021.¹

Advocacy will be needed for full implementation in a landscape of limited resources.

Programmes will need to consider the readiness of service delivery platforms, as recommended by the AA-HA! guidance. These will likely include school health services and community-based platforms for service delivery. The package of services is clearly indicated, based on the Zimbabwe-defined ASRH and VMMC packages and expanded based on experience. (Additionally, many adolescent disease and injury burdens are preventable or treatable but are often neglected, as the AA-HA! guidance points out). During the pilot project school health services were not fully engaged other than involving the teachers in sensitization meetings. Advocacy will be needed for full implementation in a landscape of limited resources.

Geneva: World Health Organization; July 2016. <http://www.who.int/hiv/pub/malecircumcision/vmmc-policy-2016/en/>.
http://www.who.int/maternal_child_adolescent/topics/adolescence/framework-accelerated-action/en/



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SECTION 6.

Next steps

Modified intervention

The end-of-pilot meeting in March 2017 prioritized activities for future implementation based on the lessons learnt in the pilot project. Changes to the current interventions were proposed. Table 13 shows the activities that will be continued and the changes that will be introduced. The underlying issues affecting implementation of all the activities will need further exploration of effectiveness, feasibility and scalability, using implementation/service delivery research. The modified intervention will be implemented in Bulawayo and Mt Darwin as well as in three new districts, which will be identified through consultation with stakeholders.

In this next stage the VMMC – ASRH Linkages Project aims to:

1. further enhance collaboration and coordination multi-sectorally and identify and engage interested stakeholders at all levels;
2. use the developed materials for capacity building and assess their effectiveness (in new and current districts);

3. prioritize and undertake research on key challenges;
4. assess the effectiveness of service delivery approaches for coverage, including which adolescent age sub-groups should be the focus for sustained services.

These aims may be met by:

- making use of previously developed products and protocols;
- coordinating stakeholders to undertake joint activities and develop products;
- monitoring and documenting key activities to explore effectiveness, feasibility and scalability;
- partnering with other organizations currently undertaking ASRH and VMMC activities and supporting these partners to undertake tasks or activities through financial assistance or capacity building.

The modified intervention will be implemented in Bulawayo and Mt Darwin as well as in three new districts.

Table 13. Modified VMMC – ASRH linkages intervention

Programme area	What is being continued	What is new	Undertaken by whom
Project coordination	<ul style="list-style-type: none"> • Coordinate project through dedicated project officer at MOHCC 	<ul style="list-style-type: none"> • Develop terms of reference that include VMMC – ASRH linkages to strengthen adolescent health 	<ul style="list-style-type: none"> • VMMC – ASRH Linkages Project
IEC materials	<ul style="list-style-type: none"> • Use already developed IEC materials (posters, flyers, job aids) • Partner with UNICEF to use U-Report for information dissemination and for conducting polls • Support peer educators to use social media to provide VMMC and ASRH information 	<ul style="list-style-type: none"> • Coordinate and support expansion of IEC delivery platforms, especially at the district level – for example, the Young People’s Network social media platforms • Coordinate the development of a pocket-size job aid for service providers on ASRH, VMMC and masculinity • Coordinate the development of age-specific IEC materials based on the recommendations of the messaging documents • Coordinate the development of flow diagram charts outlining referral pathways, including a service directory, in a wall chart 	<ul style="list-style-type: none"> • VMMC – ASRH Linkages Project • The project will look for synergies with development of IEC materials in the national VMMC and ASRH programmes as well as other youth social media platforms such as the Young People’s Network.

Programme area	What is being continued	What is new	Undertaken by whom
		<ul style="list-style-type: none"> Support youth centres to be hubs of information to disseminate IEC materials 	
Demand creation and health education	<ul style="list-style-type: none"> Partner with local performing arts groups to provide information Support youth centres in strengthening parents' involvement in demand creation Support youth centres to undertake activities that create broader youth participation – for example, sports galas Support consultation with young people on preferred demand creation activities Support peer educators as drivers of demand generation 	<ul style="list-style-type: none"> Encourage youth centres to offer a variety of activities (such as quizzes and talent shows) that engage young people, especially young men Encourage parents' groups to work with youth centres to organize the community demand creation activities Monitor, document and analyse data on the effectiveness and feasibility of peer educators to generate demand and to provide information and health education as well as referrals to services 	<ul style="list-style-type: none"> VMMC – ASRH Linkages Project The project will look for synergies with other partners, such as Grassroots Soccer, that are working in demand generation for youth health services as well as health education.
Referral and tracking	<ul style="list-style-type: none"> Support providers to effectively handle referrals 	<ul style="list-style-type: none"> Coordinate revision of the referral slip <ul style="list-style-type: none"> Explore further with providers the acceptability and usability of the referral forms Prioritize the most critical fields to keep on the form Learn from other programmes' use of referral systems Integrate referral slips into the existing MOHCC referral tool Monitor and document the added value of referrals through further documentation and analysis of data on effectiveness and feasibility. 	<ul style="list-style-type: none"> VMMC – ASRH Linkages Project
Services for adolescent boys	<ul style="list-style-type: none"> Partner with implementers to provide VMMC through static and outreach sites Partner with implementers to provide ASRH services through static and outreach sites – including condoms Support and partner with implementers to provide gender norm and transformative masculinity interventions 	<ul style="list-style-type: none"> Monitor and document ASRH and VMMC outreach effectiveness, feasibility and gaps Advocate changes in policy on user fees for adolescents in the long term and district-level solutions in the short to medium term Support identification of most vulnerable adolescents with help from the child protection department Coordinate the development of a standard package of information and tools for gender norms and transformative masculinity for adolescent boys <ul style="list-style-type: none"> Use the comprehensive sexuality education manual, MOHCC ASRH manual and materials from other organizations to inform content Support and collaborate with partners working on age-specific transformative masculinity interventions for ages 10–14 years and 15–19 years 	<ul style="list-style-type: none"> National VMMC programme National ASRH programme with support from the VMMC – ASRH Linkages Project to conduct outreaches regularly Padare Enkundleni Men's Forum on Gender and other NGOs working in the area of gender, with technical and financial support from the VMMC – ASRH Linkages Project

Programme area	What is being continued	What is new	Undertaken by whom
		<ul style="list-style-type: none"> • Monitor and document the effectiveness and feasibility of the gender norms and transformative masculinity interventions 	
M&E	<ul style="list-style-type: none"> • Use already developed reporting tools from the VMMC and ASRH programmes 	<ul style="list-style-type: none"> • Reduce reporting requirement • Coordinate the development of a revised monitoring framework with reduced reporting requirements, and define new indicators • Standardize monthly visits by adapting existing ASRH and VMMC checklists to add linkages aspects 	<ul style="list-style-type: none"> • VMMC – ASRH Linkages Project with support from MOHCC M&E unit
Stakeholder collaboration	<ul style="list-style-type: none"> • Coordinate regular meetings with key stakeholders <ul style="list-style-type: none"> ◦ Update the list and map of stakeholders 	<ul style="list-style-type: none"> • Engage new relevant stakeholders, especially other government ministries – for example, the Ministry of Gender, Women Affairs and Community Development 	<ul style="list-style-type: none"> • VMMC – ASRH Linkages Project
Community engagement	<ul style="list-style-type: none"> • Support youth centres to engage community stakeholders, including community and religious leaders • Support youth centres to increase parental engagement • Support youth centres to engage young people through activities and community dialogues • Collaborate with schools 	<ul style="list-style-type: none"> • Support youth centres to develop a community engagement plan in all districts • Coordinate and support the engagement of school health masters to provide comprehensive ASRH and VMMC information and make referrals 	<ul style="list-style-type: none"> • Youth centre • VMMC – ASRH Linkages Project
Capacity building and mentorship	<ul style="list-style-type: none"> • Continue using materials that were adapted from the ASRH and VMMC manuals 	<ul style="list-style-type: none"> • Coordinate the review of the content and length of capacity-building trainings <ul style="list-style-type: none"> ◦ Explore other capacity-building methods that disrupt minimally service delivery, for example, blended learning, e-training/m-health, training of trainers (TOT) ◦ Consider merging the capacity-building training and sensitization into a two-day training focusing on more practical sessions and field practice – for example, filling out referral slips • Coordinate the development of a district TOT for the minimum package • Advocate inclusion of ASRH and VMMC linkages in existing pre-service training and in-service HIV and ASRH trainings for nurses and doctors • Advocate inclusion of ASRH, VMMC and their linkages in national training manuals, including lessons from the pilot project • Support ASRH and VMMC trainers to deliver training for both components in the long term 	<ul style="list-style-type: none"> • VMMC – ASRH Linkages Project

Programme area	What is being continued	What is new	Undertaken by whom
		<ul style="list-style-type: none"> • Support organizations to deliver masculinity training with a focus on adolescent boys • Document experiences of trainers and trainees to inform continuing trainings and mentorship and to assess how they have contributed to this project 	

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ANNEX 1.

List of Stakeholders

Annex 1: List of stakeholders

Facilitators	Description of organization	Responsibilities in project
Africaid	Africaid is a community based organization in Zimbabwe which, through its Zvandiri programme, provides community and health facility based prevention, treatment, care and support for children, adolescents and young people living with HIV.	Facilitated discussion in Boys For a and Community Dialogues
Ministry of Youth Empowerment and Indigenization	Government ministry whose mandate is to formulate, review and execute policy on youth development and empowerment of indigenous citizens; and monitor and evaluate compliance with the National Indigenization and Empowerment Act.	Facilitated discussion in Boys For a and Community Dialogues and participated in project planning and review meetings
Young Men's Christian Association (YMCA)	Worldwide organization Christian humanitarian organization. The focus of it work in Bulawayo is Transformative Masculinity	Facilitated discussion in Boys For a and Community Dialogues
Zimbabwe Aids Prevention and Support Organization (ZAPSO)	Local NGO that promotes HIV/AIDS prevention at the workplace	Facilitated discussion in Boys For a and Community Dialogues
Dot Youth	Local NGO implementing the PEPFAR DREAMS Project	Facilitated in community dialogues
Kana Media	Local NGO that promotes health and wellbeing through arts mainly music	Facilitated in Boys Forum
Khaya Arts Production	Local NGO that promotes health and wellbeing through arts mainly music	Facilitated in Boys Forum
Ministry of Primary and Secondary Education	Government ministry that administers the system of primary and secondary school education in Zimbabwe catering mainly for the age groups 5-18 years	Participated in project planning and review meetings
Zimbabwe Republic Police	National police service	Through its victim friendly unit facilitated on gender based violence topics in Boys For a and Community dialogues



ANNEX 2.

IEC Material Development Plan

VMMC- ASRH LINKAGES PILOT PROJECT
IEC material development plan

Contents

1.0 Introduction.....	80
2.0 Purpose.....	80
3.0 IEC material development workshop.....	80
4.0 Pretesting drafts/ prototypes.....	94
Annex 1: IEC material drafts - Pre-test data collection tool.....	94

1.0 Introduction

1. The objective of the project is to assess the feasibility and capacity strengthening requirements to enhance ASRH VMMC linkages in order to inform transition to longer term VMMC strategies/services. The project seeks to determine how the respective strengths of the ASRH and VMMC programs can be harnessed to increase uptake of service for either of the programs.

2.0 Purpose

The purpose of this document is to outline the plans for developing IEC materials, including referral forms for the linkages project.

3.0 IEC material development workshop

Date: 2-3 June 2016

Location: Inyathi Youth Centre, Bulawayo

Workshop agenda: To develop IEC material, referral system forms and SOP.

Participants: *those already engaged in demand generation for VMMC and ASRH as well as health providers and staff at youth centres

Structure: The workshop will be held over 1 ½ days. The workshop will comprise

of presentations, group work and plenary discussions.

Tools: Workshop agenda, Messages and messaging report, VMMC ASRH service delivery protocol.

Materials required: Meeting agenda, attendance register, bond paper, flip charts, markers, printer, current ASRH IEC material, VMMC IEC material.

Workshop outputs:

By end of workshop, the following samples/ prototypes should be available:

1. Social media –VMMC ASRH linkages
Facebook page, WhatsApp group, Twitter.
2. Leaflet/pamphlet for adolescent boys
3. Leaflet/pamphlet (x2) for adolescent girls
4. Leaflet/pamphlet & poster for parents
5. Leaflet/pamphlet for service providers
6. Poster for service providers
7. Job aid for service providers

***Leaflets/pamphlets to be translated into Shona & Ndebele. However, no translation might be necessary for service providers. Development of material in Sign language and Braille will also be considered.*

Workshop agenda

DAY 1		
TIME	ACTIVITY	FACILITATOR
08:00-08:15	Registration	MoHCC
08:15-08:30	Introductions, welcome remarks, housekeeping issues, objectives of the workshop	Youth Centre Rep
08:30-08:45	Key findings from the messages and messaging report	MoHCC
08:45-09:15	Points to consider when developing IEC material	MoHCC
09:15-10:00	Break away sessions	
	Group A -IEC material for adolescent boys	ZNFPC
	Group B - IEC material for adolescent girls	ZNFPC
	Group C - IEC material for parents	ZNFPC
	Group D - IEC material for service providers	MoHCC
10:00-10:30	TEA BREAK	ALL
10:30-13:00	Group work – Development of prototypes: IEC materials for adolescents, parents, health workers, referral forms & tracking tools	ALL
13:00-14:00	LUNCH	ALL
14:00-16:00	Cont' Group work	ALL
16:00-17:00	Group work presentations of e-version samples/prototypes	ALL
17:00	Close of day	

DAY 2		
TIME	ACTIVITY	FACILITATOR
08:00-08:15	Registration	MoHCC
08:15-08:30	Recap of day 1	ZNFPC
08:30-09:00	Introduction to the referral system SOP	MoHCC
09:00-09:30	Service directory	WHO
09:30-10:00	Referral OUT form	MoHCC
10:00-10:30	TEA BREAK	ALL
10:30-10:50	Referral IN form	MoHCC
10:50-11:10	Referral register	MoHCC
11:10-11:25	Ways to strengthen and monitor the referral system/process	MoHCC
11:10-11:45	Plenary	ZNFPC
11:45-12:00	Way forward and closing remarks	YC Rep
12:00	Lunch and Departure	

A. Day 1

1. Registration

Materials required – Registration form, Attendance register

Time – 15 minutes

- Ensure that all participants fill in the registration form and attendance register as they arrive.

2. Welcome remarks, introductions, objectives of the workshop

Materials – Flip chart, markers

Time – 15 minutes

- Introduce yourself and other facilitators. Get participants to make self introductions giving their names, designation and station/organization.
- Allow participants to suggest ground rules for the workshop. Write these down on the flip chart. Display them where they can easily be seen during the discussions
- Welcome the participants, state the workshop objectives and the importance of everyone's full participation.

3. Points to consider when developing IEC material

Materials – Flip chart, marker,

Time – 30 minutes

- Discuss points to consider when developing IEC material.

Talking points:

IEC material should:

- Be appropriate for the target population;
- Provide information that increases knowledge amongst adolescent boys;
- Influence attitudes and behaviours; and
- Generate demand for services and influence health seeking behaviours.

The following should be considered:

- Which material or materials best fit the audience's learning style / preference?
- What are the literacy and educational levels of the target audience?
- Are there any culturally-specific values and beliefs that might impact on the acceptance of certain material types or designs?
- What are the communities impression's of past, similar health promotion and health education programs and products?

Discuss how to generate a creative brief

A creative brief should provide the following information:

- **Target Audience.** Describe who is intended to be reached with the IEC material? What are their characteristics – that may affect the way they react to the IEC material? Do other groups make up a secondary audience?
- **Communication Objective(s).** What will the IEC material make the target audience feel, think, believe, do, or not do?
- **Obstacles.** What beliefs, cultural practices, pressures, and misinformation stand between the target audience and the objectives of the IEC material?
- **Key Message / Advice.** Emphasize the benefit of doing, thinking, or feeling what the IEC material will promote? Why should they follow this advice?
- **Support Statement/Reasons Why.** Why does the key promise outweigh the obstacles?
- **Tone.** What feeling should this communication have? What tone works best with the target audience? Are they emotional about this issue? Religious? Do they listen more to authority?
- **Creative Considerations.** What additional points need to be considered while designing the IEC material?

Qualities of Effective IEC Materials

Effective IEC materials should attempt to:

1. Create a distinct look and personality – Effective IEC materials are vivid, having an appealing personality that helps them stand out from other materials. They should stimulate the target audience with a distinctive look and sound, making them stand out from the “clutter” of competing materials and messages. Messages and design all must speak with the same voice – in design, color, text and narrative.

2. Stress the most compelling benefit. Effective IEC materials should address real needs and problems facing the target audience. The information they provide should be specific and single-minded. The main message and benefit to the target population should be clear.

3. Generate trust. IEC materials that are

simple, direct, and technically correct generate trust in what they say. Credibility should never be replaced by creativity.; a straightforward design is a better basis for trust than extravagant or fancy IEC materials. Trust is generated by tone, presentation, believable images, and a solid information foundation.

4. Appeal to both the heart and the head.

A decision on the part of the target audience to try something new is not made entirely in the mind — trials are often decided in part by an emotional response. Thus, effective IEC materials and messages should be designed to appeal to both the heart or emotions, and the head or reason.

Rules of thumb:

- Include only a few concepts and only information that enables the user to follow the message.
- Use short sentences and words. Use active language. Use words and phrases familiar to the target audience. In narratives, be sure the pace and intonation are appropriate.
- Use visuals that reinforce text and / or

narrative. Visuals should make sense to the target audience. Visuals and text should be clearly related.

- Make messages believable and practical. Promote behaviors that are appropriate in the cultural, social and economic setting.
- Choose photographs or drawings that are clear and easy to understand. Use visuals that show specific examples of the behavior described. Cartoons and drawings should be life-like. Avoid diagrams, graphs and other complicated visuals.
- Limit the number of visuals in order to emphasize the most important points. Place them in a logical sequence.
- Illustrations and symbols should reflect the ethnic and cultural background of the intended target audience. Place people in everyday settings, using familiar belongings and wearing familiar cloths.
- Do not overcrowd printed materials. Leave space between text and visuals to allow the eye to move easily from one to the other. Place related messages and illustrations together. Use colours appropriate and acceptable to the target. audience

4. Presentation of Key findings from the messages and messaging report

Materials - Messages and messaging report

Time- 15 minutes

Facilitator's Notes/ Taking points

- **Creation of more age specific messages on VMMC is important**, given that current messages are generalised and are assumed to apply to everyone.
- There are few materials that carry the voices of adolescents themselves on the topic of VMMC.
- There is little role modelling on good ASRH behaviour
- Most messages about VMMC do not adequately cater for the worries of adolescents whose concerns are not primarily fear of HIV.
- There are limited messages on positive living for adolescents despite evidence of an increasing cohort of adolescents living with HIV and on treatment.
- Gender issues are not adequately addressed, they are only considered in terms of consequences such as unplanned pregnancies which have a more direct burden on females, whilst in terms of VMMC it is the voice of older women that is mainly captured.
- Issues of assertiveness, alcohol abuse, negotiation and other ways that young people are abusing drugs and alcohol such as binge drinking, that have implications for ASRH and HIV prevention are not adequately explored in current messages.
- Messages and role models/champions that are used give the impression that VMMC is for older males not adolescent boys.
- There is little role modelling on good ASRH behaviour. Given that young people normally learn through positioning themselves against people that they admire, the failure of most of the IEC materials to utilize role modelling

is a key gap.

- There were no materials designed to mobilise adolescents to make use of ASRH services. This limits the use of ASRH services to those adolescents who are already enduring the negative consequences of ASRH and seeking curative service.
- Most messages about VMMC do not adequately cater for the worries of adolescents whose concerns are not primarily fear of HIV.
- The need to capture the voice of mothers and girls given their power to promote male circumcision. Such messages can include mothers encouraging their sons to go for VMMC.
- Information and knowledge should also be shared with families especially parents so that they provide further support especially on decision making, wound management and emphasising preventative behaviour.

Materials – Flip charts, current VMMC IEC material, current ASRH IEC material

Time – 1 hr 15 min

- Divide participants into 4 groups. Each group will have a facilitator who will make a presentation before members work on a creative brief and how to package the messages/design the IEC material samples.

Group A - IEC material for adolescent boys

- Facilitator lead discussion on points to consider when developing materials for adolescent boys
- After the presentation group to brain storm on material concept/sample

Facilitator's Notes/ Talking points

The differences between adolescent boys and adult men that have implications for messages and messaging include:

- **A low risk perception** which makes HIV prevention a lesser motivating factor – however, although they are less concerned about future problems, they have positive dreams for the future;
- **Not all adolescent boys are having sex** and if they are it is often not with a regular long-term partner;
- **Hygiene is a key motivating factor** (for both adolescent boys and girls), and as such hygiene should come first before discussion on sex and the HIV prevention benefits of VMMC;
- **Adolescent boys have unique channels for accessing information** – in particular peers, both boys and girls, so they need messages and stories from their peers. Adolescents are also increasing their use of **interactive and social media** to obtain information;
- They **do not make the decision to get circumcised in “isolation”** and as such there is need to reach the parents and other family members, including messages from mothers - women are not simply wives or

partners, as is mostly presented in current campaigns;

Main themes

Low risk perceptions - One of the most important key themes to pay attention to in developing messages for adolescents is their low risk perception to HIV. This low risk perception should mean that messages should focus on other concerns for adolescents such as being more desirable boyfriends and better husbands in the future. The low risk perception will therefore require messages to continue emphasising consistent and correct use of condoms for those that get circumcised.

Not yet having sex - the fact that most adolescents are not yet having sex is critical in crafting messages on VMMC, as it demands that attention be put on how the adolescents can benefit from VMMC in the future as well as the present looking at benefits such as hygiene.

Influence of peers - The theme of peer influence is important in messaging as well as channel selection. It is important to consider the voices and images of adolescents speaking on VMMC as a way of influencing their counterparts to consider the same. This influence also

extends to female counterparts

Implications for messaging, content, channels and message linkages for adolescent’s boys

- Emphasis for adolescent boys should be placed on how VMMC can help them to get the future that they want.
- The use of the analogy of going to school to be ready for a good job can be used for VMMC, which makes one ready for a good relationship (a good boy-friend).
- A key message for linkages can outline how VMMC is a first step towards taking responsibility for one’s own health, including making good sexual and reproductive health choices.

Messaging for adolescent boys should consider age appropriateness and ensure that other non-health related benefits are mentioned before the health benefits. The materials should also feature the voice of the adolescent boys especially sharing their experience of getting circumcised. Having pictures of the adolescent themselves is more appealing, and this should be considered in current posters of celebrities who can be featured with adolescent boys.

The key thread that should be maintained in messages for adolescents is how VMMC will be a key decision for a better future. It has been noted that adolescents are concerned about their future, but not necessarily about diseases that they might get in the future. This might entail the use of the analogy of going to school to be ready for a good job and in the case of VMMC: it makes one ready for a good relationship. “Helping you get the future that you want” can be a key message for adolescent boys. Key Message for linkages with ASRH can be on how VMMC becomes a first step towards taking responsibility for your health, including reproductive health.

For the adolescent boys, a leaflet with quick facts about VMMC was suggested as important. This should be something that they can share with peers and influence them to consider VMMC. The same will also emphasise some general information on ASRH and VMMC. Social media is another important low cost but high impact channel that was suggested to promote the VMMC and ASRH linkages project.

- Develop a creative brief and brain storm on concept and sample for the following:

Channels	Content
Leaflet/Pamphlet	<ul style="list-style-type: none"> ▪ Basic ASRH information ▪ What is VMMC ▪ Benefits of VMMC ▪ VMMC and ASRH linkages and where to get services
Facebook page	<ul style="list-style-type: none"> ▪ General information on ASRH ▪ What VMMC is ▪ Benefits of VMMC ▪ Different materials on VMMC ▪ Testimonies and Pictures of circumcised adolescents ▪ Pictures of celebrities and VMMC champions including some with circumcised adolescents ▪ Post discussion topics on key questions and worries of adolescents on VMMC ▪ Information on where to get ASRH and VMMC services ▪ Updates of VMMC campaigns ▪ Share information on the VMMC and ASRH minimum package ▪ Share the benefits of linking VMMC and ASRH <p>Share updates on the VMMC and ASRH linkages initiatives in the pilot sites (including number of those accessing services, case stories, service providers testimonies etc)</p>

Channels	Content
	* The Facebook page will also be open for adolescent girls given their influence to the decisions that their male counterparts take. They will also have access to post pictures and updates on how they are mobilising for VMMC.
WhatsApp & Twitter	<p>“Securing your Future through”/ “Smart Menu For a Healthy Lifestyle”</p> <ul style="list-style-type: none"> • Abstaining • Using a condom • Getting Tested For HIV and • Getting Circumcised (and still using a condom) <ul style="list-style-type: none"> ▪ *Sharing VMMC Campaigns via text messages ▪ Where and times to get ASRH and VMMC services

Group B - IEC material for adolescent girls

- Facilitator lead discussion on points to consider when developing materials for adolescent girls
- After the presentation group to brain storm on material concept/sample

Facilitator’s notes/ Talking points	
<ul style="list-style-type: none"> • Highlighting the importance of VMMC in reducing the risk of cervical cancer. • Similarly, while some VMMC messages and material target women, none of the materials target the younger females, especially those that are not yet sexually active. • For girls, messages should address why they should be interested about VMMC and why/how they could influence boys. The messages will focus on promoting personal hygiene amongst their future boyfriends/ husbands and their reduced risk to cervical 	<p>cancer if their partners are circumcised.</p> <ul style="list-style-type: none"> • Adolescent girls can be used to positively influence their male counterparts to consider getting circumcised. The primary focus for messages targeting girls should address why they should be interested about VMMC and why they should influence the boys. The messages will focus on promoting personal hygiene amongst their future boyfriends/ husbands and the reduced risk to cervical cancer for women who eventually marry circumcised partners.

- Develop a creative brief and brain storm on concept and sample for the following:

Channel	Content
Leaflet/pamphlet	<p>What is your role on the general Health of adolescent boys and their sexual and reproductive health?</p> <ul style="list-style-type: none"> • Adolescents are the future of tomorrow and as such healthy adolescents are a prerequisite for a better future. • Adolescence is also the same time were life-long health related behaviors are initiated. • Evidence is showing that some young people are having sex whilst they do not have knowledge of negative

Channel	Content
	<p>consequences related to sexual contact in general and early sexual activity in particular;</p> <ul style="list-style-type: none"> • If you do not have accurate information, refer boys to where they can get correct information. ▪ Basic information on VMMC ▪ What are the benefits of VMMC (including those for women) ▪ How safe is VMMC ▪ Where can one get circumcised
Leaflet/pamphlet	<p>“Your brother or boyfriend is more hygienic if he considers to get circumcised”</p> <ul style="list-style-type: none"> ▪ Basic information on ASRH and VMMC ▪ There are future benefits for girls to consider marrying a circumcised partner! ▪ Girls play an important role in convincing their male friends, boyfriends and future husbands to go for VMMC. ▪ If your future husband is circumcised husband, he will have a lower risk of contracting HIV and thereby increasing possibilities of a healthy family; ▪ Circumcision reduces the risk of cancer of the opening of the womb if one marries a partner who is circumcised; <p>Circumcision facilitates access to HIV testing, counseling and general health seeking behaviors so boys who go for circumcision are concerned about their health and their future.</p>

Group C - IEC material for parents

- Facilitator leads discussion on points to consider when developing materials for adolescent girls. Highlight key issues from the messaging and messages exercise.
- After the presentation group to brain storm on material concept/ sample
- Although most of the parents knew the health benefits of VMMC, they noted that some are not comfortable because of culture and tradition as well as limited knowledge of the program as currently offered by government. The overall recommendation focused on the need for specific materials, messages and interventions aimed at strengthening the capacity of parents. Strengthening capacities of parents will ensure they will be better able to actively mobilise adolescents to consider taking up VMMC.
- **Messaging on VMMC:** Parents and guardians further noted that messages should cover other aspects and move beyond the current focus on “HIV”. Qualitative insights showed that current messaging over-emphasizes protection against HIV and parents felt that accepting VMMC seem to suggest that they would have admitted that their children are vulnerable to HIV. There is still resistance, especially as parents do not want to accept their children are engaging in sex. The recommendation was that HIV prevention benefits therefore should be part of broader messages that promote VMMC as a decision for healthy living, which parents need to promote amongst their children. Additional recommendations focused on the need to ensure messages consider using local role models and local languages. Issues of pain and what happens to the foreskins after MC were cited as key concerns which need to be addressed through appropriate messaging efforts.
- **Messaging on ASRH:** Parents and guardians noted that although messages for adolescents should continue to emphasise delayed sexual debut, there should also be a dual focus on informing children about the negative consequence of early sex. Further suggestions were made towards prioritizing

parent-child communication to counter potentially negative information from peers, the Internet and other unreliable sources.

- Influence of mothers and involvement of parents - The influence of mothers on the decision that their sons
- make is an important theme. The influence of mothers can be used as an important mobilising tool as well as an important factor to address the fear that is associated with VMMC. Mothers are known for caring for the health and welfare of the family and their endorsement of VMMC will have much influence among adolescents as well as other mothers and general members of the community.

Implications for messaging

Mothers and parents are critical in decision making of the adolescent and should be

specifically targeted with comprehensive information that makes them understand the benefits of circumcision and why they should consider it for their sons. Messages should present women as mothers, who have been noted to have considerable influence on the decision that is taken by their sons. Such messages should also explore how mothers of circumcised adolescents can share experiences to dispel the worries of other mothers and assure adolescent boys that the procedure is safe with manageable pain.

Mothers and parents have an important influence on the decisions that adolescent boys make, and should therefore be specifically targeted with comprehensive information that helps them understand the benefits of circumcision and be in a position to discuss VMMC in an informed way with their sons (and daughters).

- Develop a creative brief and brain storm on concept and sample for the following:

Channel	Content
Leaflet/pamphlet	<p>What is your role on the general Health of young people and their sexual and reproductive health?</p> <ul style="list-style-type: none"> • Adolescents are the future of tomorrow and as such healthy adolescents are a prerequisite for a better future. • Adolescence is the period between the ages 10 – 19 years. It is a period of rapid growth and development as well as increased risk-taking. It is a key period in the life of a person, where they develop potential and start making contribution at the same time. It is also the same time were life-long health related behaviors are initiated. • Evidence is showing that some young people are having sex whilst they do not have knowledge of negative consequences related to sexual contact in general and early sexual activity in particular; • As parents and the family you have influence and young people need your guidance on how to make good health choices including delaying sex, getting circumcised, having safe sex; • Your role is not to judge young people but to provide them with enough information to allow them to make informed choices; • If you do not have accurate information or your cultural context does not promote discussions with young people about sex, refer them where they can get correct information. <ul style="list-style-type: none"> ▪ Basic information on VMMC ▪ What are the benefits of VMMC (including those for
Poster	

Channel	Content
	<ul style="list-style-type: none"> ▪ What are the benefits of VMMC (including those for women) ▪ How safe is VMMC ▪ Why they should consider it for their sons ▪ Where can one get circumcised

Group D - IEC material for service providers

- Facilitator to lead discussion on points to consider when developing materials for adolescent girls. Highlight key issues from the messaging and messages exercise.
- After the presentation group to brain storm on material concept/sample

Facilitator's notes

Messages targeting health workers should help them understand that linkages are relatively easy and achievable, and can be done well with current resources and capacity, especially as this relates to offering the Minimal package. Messages should also focus on the benefits of linkages and making referrals to services they cannot offer.

For health workers, a poster that will be in

the waiting room was identified as essential to remind both the service providers and the clients seeking services on the minimum package and the importance of making referrals. Another option will be to include a poster with tick boxes that will act as a checklist of the essential elements that the service providers needs to consider for establishing VMMC and ASRH linkages (the Minimal package).

- Develop a creative brief and brain storm on concept and sample for the following:

Channel	Content
Poster	<p>“This is why I did it...This is how I did it...This is what I told the adolescent...This is what I told the parents...”</p> <p>I provided information on both VMMC and ASRH to ensure adolescents get maximum benefits for their health</p> <p>I provided basic information on ASRH and VMMC and made referrals for services I could not offer</p> <p>I told the Adolescent to consider VMMC for a healthy future and a happy marriage</p> <p>I told the parents to consider VMMC for their adolescent sons and ensure they continue talking about hygiene and responsible behaviour after circumcision</p>
Tick box/ Job Aide	<ul style="list-style-type: none"> • Gave him basic information on ASRH • Gave him basic information on VMMC • Told him where to get ASRH and VMMC services, • Gave him a pamphlet to share with friends, • Gave him a pamphlet to share with parents

Channel	Content
Leaflet/pamphlet	Provision of information on: <u>ASRH and VMMC, and about the availability and location of ASRH and VMMC services</u> <ul style="list-style-type: none"> • ASRH <ul style="list-style-type: none"> ○ Male and female anatomy ○ Puberty ○ Genital health and hygiene ○ HIV/STI risk ○ Condom use including female condoms ○ Signs and symptoms of STI's ○ HTC ○ Available types of contraception including emergency contraception • VMMC <ul style="list-style-type: none"> ○ Basic of the procedure – method, time, healing, follow up required ○ Benefits including safety and efficacy ○ Consent requirements • Availability of other services (time, location, how to make appointments) including: <ul style="list-style-type: none"> ○ Condoms ○ HTC ○ VMMC ○ Contraception including emergency contraception

6. Group work presentations of e-version samples/prototypes

Time – 1hour

- Give each group 15 minutes to present creative briefs and concept/ sample(s)
- Discuss and capture feedback from the participants. Creative briefs and concepts/ samples revised accordingly.

DAY 2

1. Registration

Materials required – Registration form, Attendance register

Ensure that all participants fill in the registration form and attendance register as they arrive.

2. Recap of day 1

- 2 volunteers to give a recap on Day 1

3. Introduction to the referral system SOP

Materials – VMMC ASRH Service delivery protocol, Draft Referral system SOP

Time – 30 minutes

- Give participants copies of the draft referral system SOP
- Review and capture feedback from

participants

4. Service directory

Time – 30 minutes

Materials – Draft Service directory tool

- Give participants copies of the draft service directory tool
- Review and capture feedback from participants

5. Referral OUT form

Materials – VMMC ASRH Service delivery protocol, Draft Referral OUT form

Time – 20 minutes

- Give participants copies of the draft Referral OUT form
- Review and capture feedback from participants

6. Referral IN form

Materials – VMMC ASRH Service delivery protocol, Draft Referral IN form

Time – 20 minutes

- Give participants copies of the draft Referral IN form
- Review and capture feedback from

participants

7. Referral register

Materials – VMMC ASRH Service delivery protocol, Draft Referral register

Time – 20 minutes

- Give participants copies of the draft Referral register
- Review and capture feedback from participants

8. Ways to strengthen and monitor the referral system/process

Time: 15 minutes

- Discuss ways on what can be done to increase the likelihood of adolescent boys taking up a referral
- Discuss how to strengthen monitoring of the referral system

9. Plenary

Time – 20 minutes

- Question and answer session
- Matters arising

9. Way forward and closing remarks

Time – 15 minutes

- Thank the participants for their active participation
- Discuss way forward and any action points
- Close the workshop

4.0 Pretesting drafts/ prototypes

Pretesting is testing the draft materials or concepts and messages with representatives of your target audience before the materials are produced in their final form. Pretesting of draft IEC material ensures that the material is “right” from the audience’s perspective.

The following steps are going to be carried out in pre-testing the IEC material drafts:

1. Preparing draft material for the pre-test – The drafts will be first reviewed by VMMC specialists and ASRH specialist. This will be done to make sure the technical content of the message has no errors, and is in line with procedures and processes promoted in VMMC and ASRH.
2. In-house pre-testing – MoHCC, WHO and ASRH staff in the office and those based at Youth Centres will review the drafts before they are taken to the field.
3. Selection of the pre-test sample – the sample will be drawn from communities around Youth Centres and hospitals/clinics providing ASRH and VMMC services. Proposed sample:
 - Mount Darwin – 20 adolescent boys, 20 adolescent girls, 20 parents & 5 service providers
 - Bulawayo: 40 adolescent boys, 40 adolescent girls, 40 parents & 10 service providers
4. Peer Educators will be oriented on the pre-test instrument (Annex 1) and collect data through individual interviews.
5. Pre-test data analysis will be done by the project staff and a report produced.
6. IEC material will be revised accordingly. If 70 percent of the target audience understands the IEC material and message, the draft will be revised accordingly. For any IEC material draft that will be understood or accepted by less than 70 percent, the IEC material development team will consider changes to the design of material and message.

All approved materials will be printed and distributed in the project sites.

Annex 1: IEC material drafts - Pre-test data collection tool

Date: _____		Material name: _____		Language _____		Location _____			
Interviewer _____									
	Picture	Text				Picture		Text	
Respondent #	What do you see?	What do the words mean to you?	How do you feel about the picture, words?	Is the message asking you to do anything? What?	What would you change? Why?- Suggestions for improvement	OK	Not OK	OK	Not OK
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

ANNEX 3. **IEC Materials**



Be the Responsible and Smart parents



Talk to your children about the dangers of STIs, HIV & AIDS and unplanned pregnancies.

Allow your children to visit the nearest Youth Centre, Hospital or Clinic today for more information and services.



Be the Cooler, Smarter *generation..*



**Cooler, Smarter brothers take
good care of their health.**

**Pinda muSmart!
Ngena kuSmart!
Get Circumcised!**

**For more information and services, visit your
nearest Youth Centre, Hospital or Clinic today.**



I have done my part... have you?



**Be the cooler, smarter and
youth friendly service provider.**

**Provide comprehensive information, services
and referrals to all young people on:
Adolescent Sexual & Reproductive Health (ASRH)
And
Voluntary Medical Male Circumcision (VMMC)**



Be the Cooler, Smarter Sista



**Talk about the dangers of STIs,
HIV & AIDS and unplanned
pregnancies with your friends.**

**Encourage all guys to go for
circumcision TODAY!!**

**For more information and services, visit your
nearest Youth Centre, Hospital or Clinic today.**



Be the Cooler, Smarter generation..



How can I be Cooler and Smarter?

- Respect yourself
- Say No to alcohol and drug abuse
- Abstain from sex until married
- Get tested for HIV
- Get circumcised

What are the advantages of abstaining or delaying sex?

- It gives you pride because you are in control of your life.
- You can explore a wider range of friendships and relationships.
- You can develop real friendship based on mutual respect.
- You build a firmer foundation for self-respect and self-control.
- You can complete your education and achieve financial independence before marriage or parenting.
- If already sexually active use condoms correctly and consistently.

What is Voluntary Medical Male Circumcision (VMMC)?

- It is the complete removal of the skin that covers the "head" of the male sexual organ through surgical procedure or use of devices e.g. Preper Ring. Both methods are SAFE and FREE.

As a young man, why should I be circumcised?

- Your male organ will be smart and clean.
- Your chances of getting HIV and STIs are reduced.
- It proves that you are a responsible person and willing to take up new challenges to ensure good health and hygiene.
- Going for VMMC provides an opportunity for you to access more information and services relating to your sexual and reproductive health.

REMEMBER to use condoms correctly and consistently even after circumcision!

If I get circumcised are there any benefits to my future girlfriend/wife?

Yes there are benefits.

- She will enjoy a healthier and hygienic sexual relationship because your organ is smart.
- She will have lower chances of getting infected with the virus that causes cervical cancer.
- She will also have lower chances of acquiring HIV and other STIs like genital ulcers.

Where can I go for further information and services?

- Talk to Peer Educators in your area.
- Visit your nearest Youth Centre, Hospital or Clinic TODAY.
- REMEMBER to share the information with your friends.



ANNEX 4.

VMMC ASRH Job Aid



VMMC ASRH LINKAGES

JOB AID



World Health Organization

1 Voluntary Medical Male Circumcision & Adolescent Sexual and Reproductive Health Linkages

Name of facility/Youth Centre:.....

Address:.....

Contact number.....

Email.....



World Health Organization

Purpose of this Job Aid

This job aid has been designed as a reference guide in VMMC ASRH service delivery.

- **Who can use this Job Aid?**

This job aid can be used by all people involved with providing a broad range of ASRH and VMMC services to adolescents. This includes

Nurses, Doctors, Counsellors, Recreational Leaders, Youth Health Advisors, Youth Facilitators and Peer Educators e.t.c



World Health Organization

Service Directory

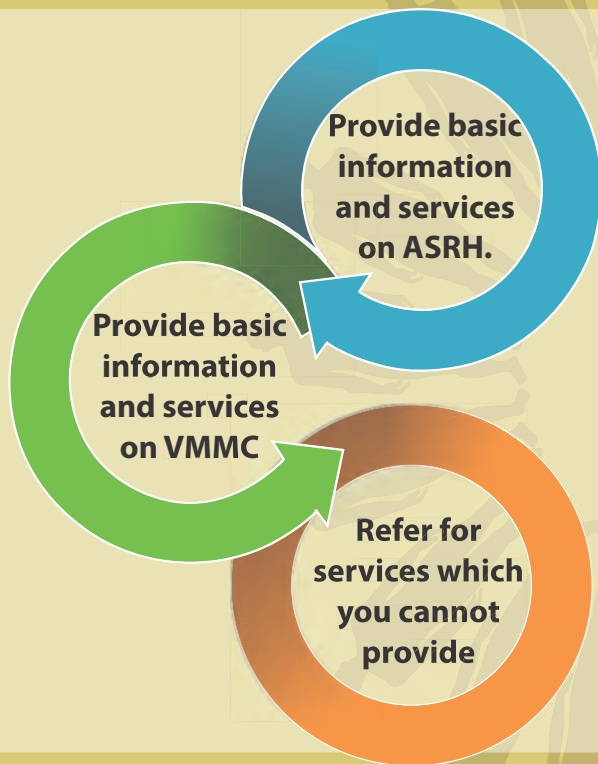
List service providers in your area providing VMMC and ASRH information and services (Note- opening time, how to make appointments & any other important information)

Service Area	Organisation	Address	Contact No.	Notes

Notes

A large rectangular area with horizontal lines for writing notes, set against a background of silhouettes of people in a circle.

VMMC ASRH Minimum Package



1



Categories of adolescents

- **Not yet sexually active:** Provide information on life skills to postpone sex, how to handle relationships with the opposite sex and the benefits of circumcision.

2



- **Sexually active but have not yet experienced negative effects of their actions:** Provide information on negative consequences of pre-marital sex, negotiating safe sex, condom use, STIs and benefits of circumcision.

3



- **Experienced negative consequences of their sexual activities:** Provide information about where to access appropriate information and services that would respond to the negative effects.

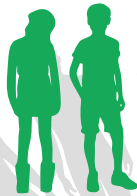
4



- **Adolescents with special needs or in difficult circumstances:** Provide information relating to the special need and refer for further services.

PROVIDE LIFE SKILLS INFORMATION TO ALL ADOLESCENTS

1



**Early Adolescence:
10-13 years old**

2



**Middle Adolescence:
14-16 years old**

3



**Late Adolescence:
17-19 years old**

**The physical,
psychological
and social
changes**

SEXUAL BEHAVIOURS

1

Why adolescents engage in pre-marital sex

2

Consequences of pre-marital sex

3

Advantages of delaying sexual debut

4

How adolescents can delay sexual debut

5

How adolescents who are sexually active can keep themselves healthy (and avoid STIs, HIV and pregnancy)



CONTRACEPTIVE OPTIONS FOR ADOLESCENTS

1



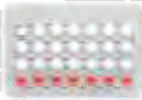
Male & Female Condoms

6



Emergency Contraception

2



Oral Contraceptives (Pills)

3



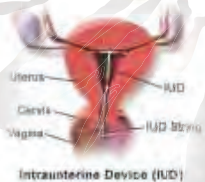
Injectables

4



Implants

5



Intra Uterine Devices (IUDs)

- Advantages and disadvantages of each
- Suitability for adolescents
- Dual protection

Demonstrate how to use a male and a female condom

Emphasise the need to continue using condoms even after circumcision

HIV Testing Services

- HIV Transmission
- Prevention
- Benefits of testing to adolescents
- ART

**PREVENTION
TREATMENT
CARE**

Refer for services which you cannot provide

VMMC Reduces risk by 60% but must continue to use condoms

Sexually Transmitted Infections

Types of STIs	Preventing STI	Signs and symptoms	Management of STIs
---------------	----------------	--------------------	--------------------

Infection with other STIs, in particular those that cause sores in or around the sexual parts, makes it easier for a person to get HIV.

- Encourage young people to seek STI treatment early
- Encourage adolescents to bring their partners for treatment
- Treat or refer young adolescents for treatment

VMMC reduces the chances of contracting ulcerative STIs like Genital Ulcers

Gender Based Violence

TYPES OF VIOLENCE



COUNSELING GBV CLIENTS

- Be empathetic and nonjudgmental
- Help client understand their options, and let them make their own decisions about what to do
- Providing practical care and support without intruding on a survivor's autonomy
- Listen without pressure for the survivor to respond or disclose
- Offer comfort and help to reduce anxiety
- Help survivors of GBV create a plan that ensures their own safety and – when appropriate – the safety of their siblings.
- Provide information about and help survivors connect to services in the community.

Voluntary Medical Male Circumcision



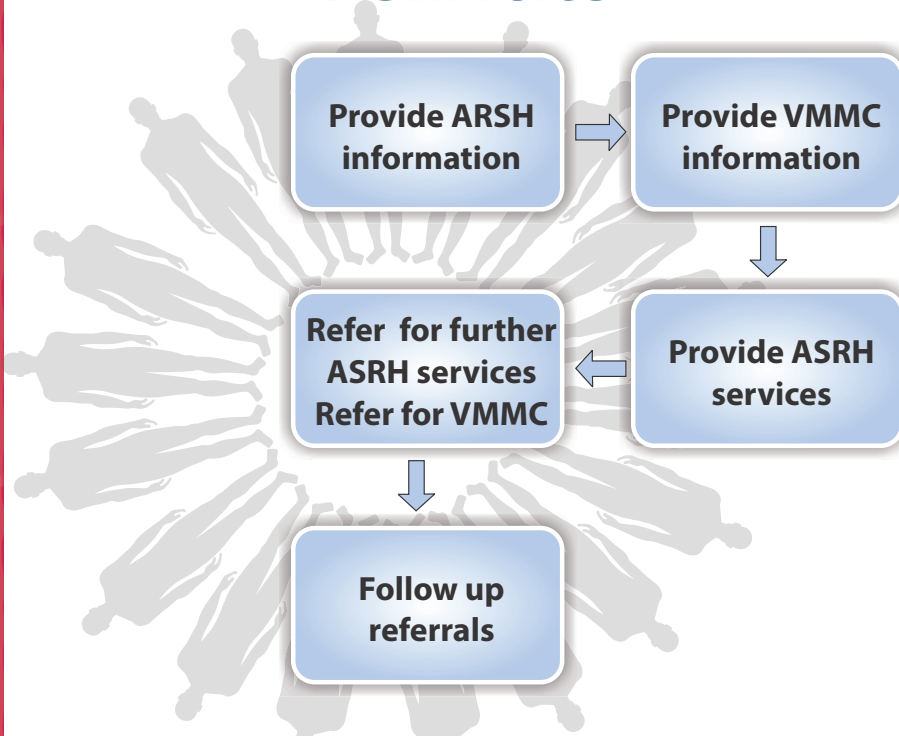
- **What is VMMC**
- **Types of procedures**
–Surgical and Non-surgical (e.g. Prepex ring)
- **Wound care**
- **Benefits of male circumcision**
- **Eligibility and Consent**
- **Address any barriers or fears**

REMINDE THE CLIENT:

- MC only offers partial protection to HIV and has to be used together with other methods
- They need to prevent HIV & STIs infection, and seek early treatment
- Follow all wound care instructions including abstaining from sex until the wound has completely healed

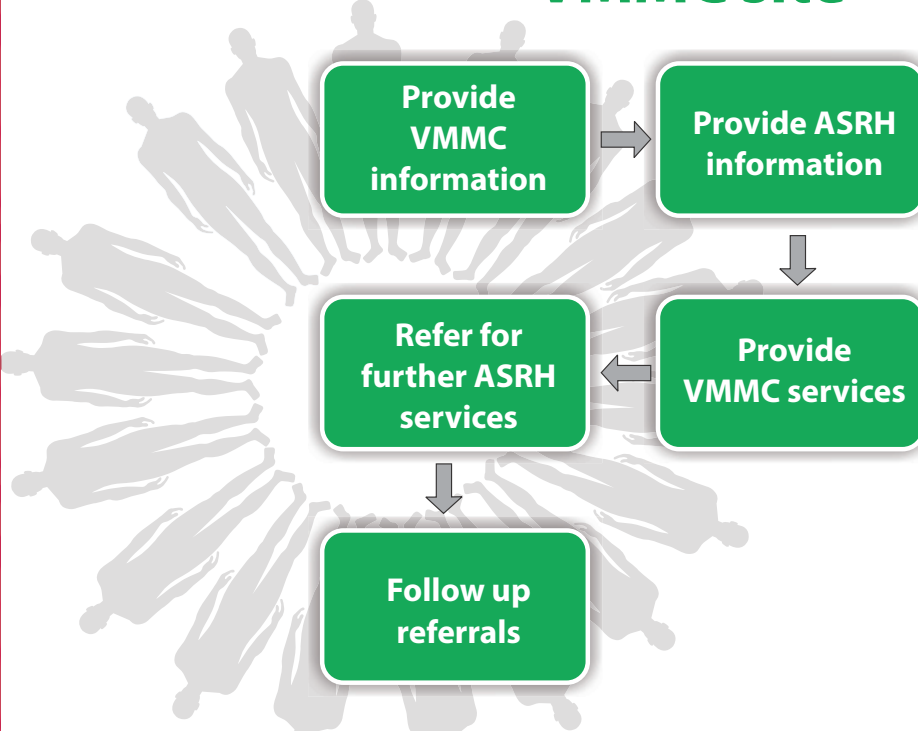
ASRH and VMMC Linkages

ASRH site




VMMC and ASRH Linkages


VMMC site




Conditions for Youth Friendly Service Provision




1. Affordability



2. Accessibility


















3. Acceptability



4. Provider competence

- **Make sure there is privacy when you provide services to adolescents. Tell the client that confidentiality will be maintained**

Communicating with Adolescents

DO	AVOID
 Be truthful about what you know and what you do not know	 Giving inaccurate information (to scare them or to make them 'behave').
 Be professional and technically competent	 Threatening to break confidentiality 'for their own good'.
 Use words and concepts which they can understand and relate to. Assess if they understand. Use pictures and flip charts	 Giving them only the information that you think they will understand  Using medical terms they will not understand
 Treat them with respect in terms of how to speak and how you act . Listen in a non-judgemental way	 Talking down to them, shouting, getting angry, or blaming them
 Give all the information/choices and then help them decide what to do	 Telling them what to do because you know best and they a 'young'.
 Treat all adolescents equally. Be understanding and supportive even if you do not approve of their behaviour	 Being judgemental about their behaviour, showing disapproval, or imposing your own values
 Accept that they may choose to show their individuality in dress or language	 Being critical of their appearance or behaviour, unless it relates to their health well-being

REMEMBER!!

- Encourage the client to visit the Youth Centre or nearest health facility for more information or services on VMMC and ASRH
- Give the client information on location and opening hours of the health facility/youth centres
- If you make a referral, fill in the referral form and give it to the client
- Make follow-up for all referrals made
- Document all referrals and referral outcomes

CHECK LIST

Activity	Done: Y/N
Made the client feel comfortable	
Gave client basic information on ASRH	
Gave client basic information on VMMC	
Told client where to get ASRH and VMMC services	
Gave client a pamphlet to share with friends	
Gave client a pamphlet to share with parents	
Encouraged the client to come back if need be	



ANNEX 5.

Facilitators' guide for capacity Building

VMMC- ASRH LINKAGES PILOT PROJECT
**Facilitators' guide for capacity
building**

[VMMC ASRH Training manual and handouts](#)

Facilitators' guide outline

Section A – Capacity building for service providers

Section B – Capacity building for non-service providers

Section C - Trainers' manual

Section A – Capacity building for service providers

Participants – Youth Centre staff, Peer Educators, healthcare providers

Objectives:

By the end of the orientation participants should be able to:

- Have some basic knowledge about VMMC and ASRH, about the availability of services and interventions in their locality.
- Understand the rationale for linking VMMC and ASRH
- Understand what the project is trying to achieve, and why
- Have the skills to communicate with adolescents in a supportive way and refer

them to other services as appropriate.

- Understand adolescents, adolescent health and the importance of engaging them in health services
- Understand the referral system and how the referral forms should be completed
- Appreciate that the project is not “something separate” or “something extra to be done”, but is something that could easily be incorporated into their current work, and would improve the quality of the services that they provide and the outcomes that they are trying to achieve.

Proposed Program

Time	Topic	Facilitator
08:55	Registration	MoHCC
09:00-09:05	Welcome remarks, introductions	Youth Centre representative
09:05-09:15	Expectations and Objectives of the meeting	MoHCC
09:15-09:40	Pretest	MoHCC
09:40-10:00	ASRH program	ZNFPC
10:00-10:15	Break	ALL
10:15-10:45	VMMC program	MoHCC/PSI
10:45-11:00	Why link ASRH and VMMC?	MoHCC
11:00-11:45	How to strengthen ASRH and VMMC linkages and integration	MoHCC
11:45-12:30	Working with adolescents, Youth Friendly ASRH, VMMC services & service provision	ZNFPC
12:30-13:00	VMMC & ASRH Demand Creation	ZNFPC/PSI
1300-1400	Lunch	ALL
1400-14:30	VMMC ASRH linkages referral system	MoHCC
14:30-15:00	ASRH/VMMC proposed reporting	MoHCC/ ZNFPC
15:00-16:00	Plenary	ZNFPC
16:00-16:20	Post test	MoHCC
16:20-16:30	Way forward	MoHCC

Time	Topic	Facilitator
16:30-16:40	Wrap up & closing remarks	Youth Centre representative

Section B – Capacity building for non-service providers

Participants: Community health workers, Youth Centre and Clinic ancillary staff

Objectives:

By the end of the orientation participants should be able to:

- Have some basic knowledge about VMMC and ASRH, about the availability of services and interventions in their locality.
- Understand the rationale for linking VMMC and ASRH
- Understand what the project is trying to

achieve, and why

- Have the skills to communicate with adolescents in a supportive way and refer them to other services as appropriate.
- Understand adolescents, adolescent health and the importance of engaging them in health services
- Understand the referral system
- Appreciate their roles in the VMMC and ASRH linkages project

Proposed Program

Time	Topic	Facilitator
08:55	Registration	MoHCC
09:00-09:05	Welcome remarks, introductions	Youth Centre representative
09:05-09:15	Expectations and Objectives of the meeting	MoHCC
09:15-09:40	Pretest	MoHCC
09:40-10:00	ASRH program	ZNFPC
10:00-10:15	Break	ALL
10:15-10:45	VMMC program	MoHCC/PSI
10:45-11:00	Why link ASRH and VMMC?	MoHCC
11:00-11:15	How to strengthen ASRH and VMMC linkages and integration	MoHCC
11:15-11:45	Working with adolescents, Youth Friendly ASRH, VMMC services & service provision	ZNFPC
11:45-12:00	VMMC & ASRH Demand Creation	ZNFPC/PSI
12:00-12:20	Plenary	ZNFPC
12:20-12:40	Post test	MoHCC
12:40-12:50	Way forward	MoHCC

Time	Topic	Facilitator
12:50-13:00	Wrap up & closing remarks	Youth Centre representative
1300	Lunch & Departure	ALL

Section C - Trainers' manual

1. Registration

Materials required – Registration form, Attendance register

Ensure that all participants fill in the registration form and attendance register as they arrive.

2. Welcome remarks, introductions

Materials – Flip chart, markers

Time – 15 minutes

- Introduce yourself and other facilitators. Welcome the participants. Get participants to make self introductions giving their names, designation and station/organization.
- State the workshop objectives and the importance of everyone's full participation.
- Allow participants to suggest ground rules for the workshop. Write these down on the flip chart. Display them where they can easily be seen during the discussions

3. Expectations and objectives of the workshop

Time – 15 minutes

- Participants to state their expectations of the workshop
- Briefly explain the VMMC ASRH linkages pilot project and outline the objectives of the workshop.

4. Pretest

Time - 10 minutes

A pre-test is administered to participants to obtain a baseline level of knowledge, attitudes, and skills (or perceived skills) regarding the issues to be covered in this training. The facilitator should encourage the participants to answer the questions from their own perspectives

- Hand out the Pretest questions and encourage participants to answer the questions from their own perspectives.
- Once the participants finish writing the test of the facilitator should mark the papers and return to participants.

5. ASRH program

Session objectives

- Participants to have some basic knowledge about ASRH and the availability of services and interventions in their

Section C - Trainers' manual

1. Registration

Materials required – Registration form, Attendance register

Ensure that all participants fill in the registration form and attendance register as they arrive.

2. Welcome remarks, introductions

Materials – Flip chart, markers

Time – 15 minutes

- Introduce yourself and other facilitators. Welcome the participants. Get participants to make self introductions giving their names, designation and station/organization.
- State the workshop objectives and the importance of everyone's full participation.
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questions from their own perspectives

- Hand out the Pretest questions and encourage participants to answer the questions from their own perspectives.
- Once the participants finish writing the test of the facilitator should mark the papers and return to participants.

5. ASRH program

Session objectives

- Participants to have some basic knowledge about ASRH and the availability of services and interventions in their locality.
- For participants to understand adolescents, adolescent health and the importance of engaging them in health services

Time – 25 minutes

- Define what ASRH is and the objectives of the program
- Discuss the core elements and services of ASRH packages
- Highlighted the importance of engaging adolescents / ASRH in fighting HIV
- Adolescents living with HIV
- Give a brief background of the program- target group & categories of adolescents
- Explain the physical development of the body
- Highlight organizations available in the area which provide ASRH services

- Allow participants to ask questions at the end of the presentation

6. VMMC

Session objective - Participants to have some basic knowledge about VMMC and about the availability of services and interventions in their locality.

Time – 20 minutes

- Define what VMMC is and the objectives of the program
- highlight the importance of VMMC in fighting HIV infection
- Provide participants with core information about VMMC
- Different methods used in MC, procedures, pain, AEs
- Highlight the VMMC services and organizations/ clinics where these can be accessed in the respective districts
- Allow participants to ask questions at the end of the presentation

7. Why link VMMC and ASRH?

Session objective – Participants to understand the rationale for linking VMMC and ASRH

Time – 15 minutes

- Explore the importance of linking VMMC and ASRH

Talking points

- VMMC is important for HIV prevention
- Adolescent boys will be a priority target group for VMMC programmes
- Important to take advantage of having contact with adolescent boys
- ASRH and VMMC programmes provide entry points for each other
- VMMC and ASRH interventions are complementary and reinforcing
- Linking VMMC and ASRH programmes is in everyone's best interests
- Strengthened VMMC - ASRH linkages can improve adolescent health

- Allow participants to ask questions at the end of the presentation

8. How to strengthen ASRH and VMMC linkages and integration

Session objective – Participants to have an appreciation of the intervention packages and models in linking ASRH and VMMC

Time – 45 minutes

Materials – service delivery protocol

15 minutes presentation on:

- Discuss the intervention packages
- Discuss the different models for linking ASRH and VMMC

ASRH and VMMC

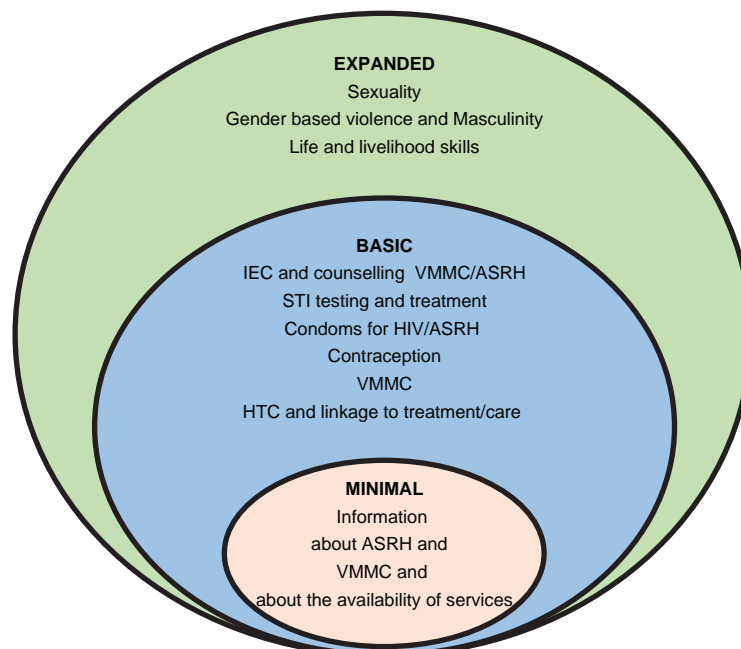
30 minutes group work and feedback:

Divide participants into smaller groups according to their service areas/ organizations. Each group should explore how they can deliver the intervention packages; and how they can adopt the different models of linkages/integration and . Give each group 3 minutes to make their presentation.

Talking points/notes

- Intervention packages
- The Minimal package, which consists of the provision of essential information about VMMC and ASRH, and the availability of services in the district where these VMMC and ASRH services/interventions can be obtained;
- The Basic package, which includes a range of clinical services that are core components of both VMMC (provided immediately before, during and immediately after the circumcision) and also of ASRH for adolescent boys;
- The Extended package, which will generally be provided some time before or sometime after VMMC, and includes some of the broader interventions that contribute to ASRH

Packages of services and interventions ASRH/VMMC



Two main models are going to be explored for strengthening linkages:

Option 1: VMMC is offered through outreaches at Youth Centres.

Option 2: Adolescents who go to youth centres are referred to the male circumcision clinics for

VMMC. Likewise, adolescents circumcised at MC clinics are referred to youth centres for more ASRH and other life-skills services at youth centres.

9. Youth Friendly ASRH, VMMC services & service provision

Session objectives

– To equip participants with skills to communicate with adolescents in a supportive way and refer them to other services as appropriate.

Time – 45 minutes

- Quick overview of what YFS
- Define Youth Friendly SRH Services
- Conditions for Friendly ASRH Service Provision
- Interpersonal communication with adolescents
- What to do and what not to do when communicating with adolescents
- Divide participants into 4 smaller groups; give each group a flip chart and markers.
- Groups to discuss how they can improve their services to be more YF and draft a workplan on this.
- Give groups 10 minutes to discuss and 4 minutes for each to present.

10. ASRH & VMMC demand creation

Session objective – To equip participants with skills on how to carry out ASRH & VMMC community mobilisation

Time – 30 minutes

Materials – IEC materials and the distribution forms

- Define what community mobilisation is and the skills required
- Discuss strategies for successful mobilization – door to door, small group sessions, road shows
- Divide the participants by the different types of cadres of community workers available (e.g Peer Educators, Village Health Workers e.t.c.)
- Each group to come up with activities and work plans on how they will carry out demand creation activities on different audiences, indicating the support they might require and how they will distribute IEC material.
- Each group given 3 minutes to present.
- Peer educators to create WhatsApp group and Facebook page

11. VMMC ASRH linkages referral system

Session objective - familiarise participants with the referral system SOP and forms

Time – 30 minutes

Materials – referral system SOP, service directory forms, referral forms and registers

- Explain that this is not anything new but is something that could easily be incorporated into their current work, and would improve the quality of the services that they provide and the outcomes that they are trying to achieve
- Give participants the referral system SOP. Explain how the system will work outlining how forms & registers are to be completed. Also highlight the client follow up/ tracking system.
- Role plays - Participants to form groups of 3 – one will be the client, one is the sending/ referring the client and the other will receive the client. Each will fill in appropriate sections of the referral form and register.
- Encourage participants to exchange roles to ensure all practice completing the different sections.
- Collect the completed forms & registers and check for correctness and completeness.
- Discuss with participants their experiences.

12. ASRH/VMMC proposed reporting and discussion

Time – 30 minutes

- Routine reporting and monitoring of data

13. Plenary

Time – 1 hour

- Question and answer session

14. Post training test

Time – 20 minutes

- Hand out the Pretest questions and encourage participants to answer the questions from their own perspectives.
- Once the participants finish writing the test of the facilitator should mark the papers and return to participants.

15. Way forward

Time – 10 minutes

- One card from each participant: "When I return to my workplace I will ..."

16. Wrap up & closing remarks

Time – 10 minutes

- Congratulate and thank participants for their involvement
- Collect all presentations made by participants
- Highlight action points
- Close workshop

HANDOUT 1: ASRH

Defining sexual and reproductive health

Sexual Health: In broad terms, sexual health is a personal sense of sexual well-being as well as the absence of disease, infections or illness associated with sexual behaviour. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. Sexual health can be described as the positive integration of physical, emotional, intellectual and social aspects of sexuality. (World Health Organization, 2002).

Reproductive health: Is the state of complete physical, mental and social well-being of an individual in all matters relating to the reproductive system and its processes and functions but not merely the absence of disease or infirmity. It also includes sexual health and suggests that people with adequate reproductive health have a satisfying and safe sexual life, can have children, and can make a choice as to whether they would like to have children and if so, when and how to have them. (ICPD Program of Action, para 7.2).

The ASRH package as per national asrh strategy (2010-2015) includes

- Counselling for ASRH services;
- Condom promotion and distribution (male and female condoms);
- Provision of Youth-friendly reproductive health services (including contraception, STI and HIV prevention/diagnosis/treatment, pregnancy prevention and management, menstrual hygiene);
- Referrals; and
- Health Education talks, distribution of IEC materials, edutainment services (film, drama and sport), life skills education, recreation, library services.

Defining adolescents

Adolescence begins at puberty. It is a period in which an individual undergoes major physical, psychological and emotional changes. It is a period characterised by exceptionally rapid growth and development. During this stage, the

body develops in size, strength and reproductive capabilities, and the mind becomes capable of more abstract thinking. It is a phase in an individual's life, rather than a fixed age band, and is perceived differently in different societies. Adolescence is defined by the World Health Organisation (WHO) as the period between the ages of 10 – 19 years. It is broken down into three stages (which in some literature, overlaps):

- Early adolescence: 10 - 13 years
- Mid adolescence: 14 - 15 years
- Late adolescence: 16 - 19 years

Young person refers to anyone between 10 – 24 years (United Nations)

Youth: The African Youth Charter describes a youth as anyone between the ages of 15 and 35 years. However, the United Nations define Youth as anyone between 20 – 24 years.

Categories of adolescents

- Not yet sexually active: This group needs support and life skills to postpone sex, and how to handle relationships with the opposite sex.
- Sexually active but have not yet experienced negative effects of their actions: This is a vulnerable group, which needs protection and empowerment.
- Experienced negative consequences of their sexual activities: These are at great risk and need help to abstain from sex or receive services to prevent pregnancy, STIs, HIV and AIDS and cancer of the cervix.
- Adolescents with special needs or in difficult circumstances

Boy and girl changes at puberty

PUBERTY is a time of change. During this time many changes occur as girls become women and boys become men. These changes are natural, caused by hormones--oestrogen and progesterone in girls and testosterone in boys. It can be a frustrating time for boys and girls as they begin to look different from their friends. Puberty in girls begins at about age 10, while in boys it begins a year or two later. These changes are signs that one is sexually maturing.

Common changes

Both boys and girls will experience these changes but at different times and in varying degrees.

1. Physical	2. Psychological and emotional
<ul style="list-style-type: none">• Rapid growth both in height and weight• Skin problems such as pimples/acne• Hair development in the pubic area and armpits• Increased sweating leading to stronger body odour• Voice changes	<ul style="list-style-type: none">• Attraction and preoccupation with the opposite sex• Sensitivity to self image• Unpredictable moods• Rebellious tendencies

Specific Changes

Boys	Girls
<ul style="list-style-type: none">• Voice breaks• Broad shoulders and muscular body• Proportionate growth in the reproductive organs• Wet dreams, also called nocturnal emissions• When a boy begins experiencing wet dreams, he is capable of making a girl pregnant. Some boys will have more wet dreams than others.	<ul style="list-style-type: none">• Breast develops• Hips widen• Proportionate growth in the reproductive organs• Menstruation starts – also known as monthly periods• A girl who has undergone these changes can fall pregnant.

Going through puberty means that girls and boys should know how to relate to each other in healthy ways, because irresponsible sexual behaviour may lead to pregnancy, and/or sexually transmitted infections and HIV.

Adolescent Psychological and Social Development
Characteristic Behaviours of Adolescence

Developmental Stage	Early Adolescence (10 to 13 years old)	Middle Adolescence (14 to 16 years old)	Late Adolescence (17 to 19 years old)
	Transition to adolescence Characterized by puberty	<ul style="list-style-type: none"> • Essence of adolescence • Strong peer-group influence 	<ul style="list-style-type: none"> • Transition to adulthood • Assumption of adult roles
Independence	<ul style="list-style-type: none"> • Independence • Challenges authority, parents, and other family members • Rejects things of childhood • Desires more privacy 	<ul style="list-style-type: none"> • Moves away from parents and toward peers • Begins to develop own value system 	<ul style="list-style-type: none"> • Is emancipated: begins to work or pursue higher education • Enters adult life • Reintegrates into family as emerging adult
Cognitive Development	<ul style="list-style-type: none"> • Finds abstract thought difficult • Seeks to make more decisions • Has wide mood swings 	<ul style="list-style-type: none"> • Starts to develop abstract thought • Begins to respond based on analysis of potential consequences • Has feelings that contribute to behaviour but do not control it 	<ul style="list-style-type: none"> • Firmly establishes abstract thought • Demonstrates improved problem solving • Is better able to resolve conflicts
Peer Group	<ul style="list-style-type: none"> • Has intense friendships with members of the same sex • Possibly has contact with members of the opposite sex in groups 	<ul style="list-style-type: none"> • Forms strong peer allegiances • Begins to explore ability to attract partners 	<ul style="list-style-type: none"> • Is less influenced by peers regarding decisions and values than before • Relates to individuals more than to peer group
Body Image	<ul style="list-style-type: none"> • Is preoccupied with physical changes • Is critical of appearance • Is anxious about menstruation, wet dreams, masturbation, breast or penis size 	<ul style="list-style-type: none"> • Is less concerned about body image than before • Is more interested in looking attractive 	<ul style="list-style-type: none"> • Is usually comfortable with body image • Accepts personal appearance
Sexuality	<ul style="list-style-type: none"> • Begins to feel attracted to others • May begin to masturbate • May experiment with sex play • Compares own physical development with that of peers 	<ul style="list-style-type: none"> • Shows an increase in sexual interest • May struggle with sexual identity • May initiate sex inside or outside of marriage 	<ul style="list-style-type: none"> • Begins to develop serious intimate relationships that replace group relationships as primary relationships

Adapted from Youth-Friendly Services: A Manual for Service Providers by EngenderHealth 2002

Adolescents living with HIV

Essentially, there are two specific groups of adolescents living with HIV:

- adolescents who acquired HIV perinatally during pregnancy, labour and delivery, or postpartum through breastfeeding;
- adolescents who acquired HIV during adolescence, usually through unprotected sexual intercourse or injecting drug use, or less frequently through blood transfusion or sharing instruments used for tattooing or skin piercing.

HANDOUT 2: VMMC

What is Voluntary Medical Male Circumcision?

Voluntary Medical Male circumcision is the complete removal of the skin covering the head of the penis (foreskin). It is done by trained doctors and nurses in clinical setting at Ministry of Health and Child Welfare certified sites.

Voluntary medical male circumcision does not provide 100% protection against HIV, but is part of a comprehensive HIV prevention package which includes the following:

- Knowing one's HIV status (get tested for HIV)
- Correct and consistent use of condoms
- Reduction of sexual partners
- Faithfulness to one sexual partner
- Abstinence

VMMC Program Goal

- To reduce the incidence of HIV infection and other STIs, penile and cervical cancer through provision of safe and voluntary medical male circumcision services.

Benefits of male circumcision

1. Benefits to younger boys

- The male organ will be smart and easy to keep clean. One needs not worry about being smelly.
- Going through VMMC helps to access information on how to stay healthy and smarter.
- Being healthy increases chances of one achieving their dreams.
- Proves to oneself and peers that one is a brave person and willing to take up new challenges to ensure good health and hygiene
- It prevents urinary tract infections and tight

foreskin problems (in younger boys)

- It gives a future lifelong 60% protection from HIV infection

2. Benefits to men

- Taking pride in maintaining good penile hygiene
- Assurance of a safer and satisfying sexual experience after reducing risk of bruising and tearing during sex.
- Love and concern for your partner as it reduces risk of acquiring and passing on Human Papilloma Virus which is one of the causes of cervical cancer for the female partner.
- Going for MC reflects a man's strong values for health and quality life as it reduces risk of HIV by 60% as well as reducing risk of acquiring other STIs like gonorrhea and syphilis. Culturally, as head of the family, reduced risks will help one to stay healthier to look after their family and watch them grow.
- MC provides an opportunity for men to access information regarding their sexual and reproductive health while still healthy to prevent diseases and continue to provide for the family.

3. Benefits to women

- Assurance of a safer and satisfying sexual experience after reducing the male partner's risk of bruising and tearing during sex.
- Healthier and hygienic sexual relationship with a partner who is circumcised as he can keep his organ clean.
- MC provides an opportunity for men to access information on their sexual and reproductive health while they are still healthy in order for them to prevent diseases and continue to provide for the family.
- Though one abstains for 6 weeks MC is a once off procedure and that has lifelong benefits.
- MC reduces risk of acquiring and passing on a virus which is one of the causes of cervical cancer (cancer of the mouth of the womb). A man's decision to get circumcised shows his love and concern for his partner.
- MC for one's partner means health and quality life as it reduces risk of HIV by 60% as well as reducing risk of acquiring other STIs like gonorrhea and syphilis.

Barriers and motivators to VMMC

The following is a list of the possible barriers to VMMC and possible explanation to reassure potential VMMC clients and females:

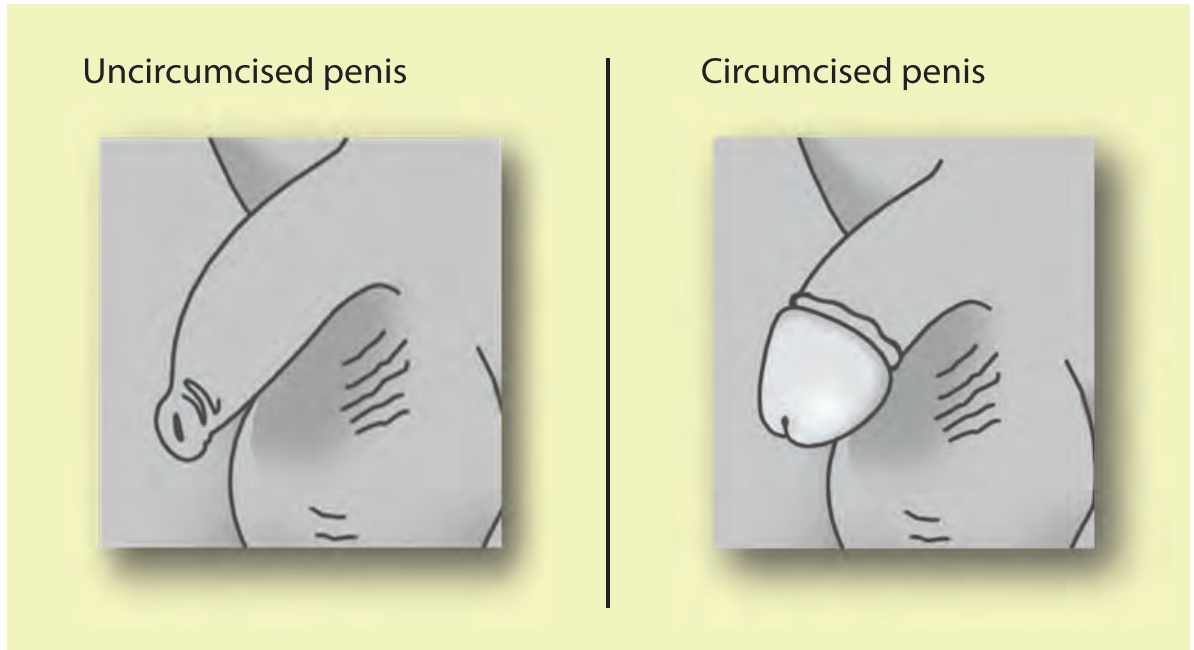
Potential Barrier	Possible Explanation
Safety concern	Procedure done by trained professionals in MOHCW certified centres
Pain from the Surgical procedure	Procedure done under local anaesthetic and after procedure the pain is manageable by over the counter pain killers. The lifelong benefits outweigh the pain. Pain level on a scale is 2/10 from reports from people circumcised and this varies from person to person depending on the individual's pain threshold.
Pain during healing period	Pain which is manageable with painkillers may be felt during the first few days after circumcision. Most men have reported no pain by the end of the first week
Healing period is too long	By the second week the outer wound has healed and complete healing that can withstand the pressure and friction of sexual activity takes six weeks.
Abstinence from sex for 6 weeks	Ensures complete wound healing inside. A lot of friction is often experienced during sexual intercourse and this may disturb wound healing.
Reduced sexual performance	Circumcision itself does not negatively affect sexual activity and many men circumcised have confirmed this.
Refusal by the female partner	Before circumcision a man should find the right time and way to introduce the subject, explain the benefits and encourage partner to accompany him to VMMC clinic for more information. Men should also highlight that VMMC also has benefits of reduced risk of cervical cancer for the female partner.
Fear that VMMC can be harmful	This common and natural. Counseling precedes procedure and procedure is done by qualified professionals under ethical conditions
Fear of knowledge of HIV status	Done confidentially by trained counselors after counseling. Allows referral and access to care if test is positive.
VMMC not seen as part of culture	Culture changes with generations. Explain the benefits and relevance in an era of HIV.
Time away from work	One is encouraged to take one or two days off from work after circumcision and thereafter go to work as normal.
Attitude that VMMC is for promiscuous men	VMMC offers men an opportunity to get advice on men's reproductive health issues. Men who go for VMMC are responsible and are concerned with their personal hygiene, and their partner and family's health. The benefits of VMMC also go beyond protection from STIs, including HIV. It helps ensure general good health for the man and the family.

Motivating Factors for VMMC

The following is a list of the possible facilitators to VMMC and possible explanation to reassure potential VMMC clients and females:

- **Knowledge** that VMMC reduces the risk of acquiring HIV
- **Social support** from partner, friends, and family respectively
- **Hygiene** – the male organ will not have dirt that normally accumulates under the foreskin
- **Belief that it improves sexual appeal and performance** – as they know that the organ will be hygienic and risk of transmitting the virus which is one of the causes of cancer of the opening of the womb is reduced.
- **Other medical reasons** like cracked and tight foreskin problems are resolved.
- **Sexual Performance**- improved by the peace of mind from reduced risk factors

Structure of Circumcised and Uncircumcised Penis



The nature of the foreskin

- The shaft of penis and outer part of the foreskin has normal skin (keratinized) which is strong and not easily torn or bruised. When the male organ is erect the inner part of the foreskin will be seen as the pinkish area before the head of the organ
- Inner part of the foreskin is less strong than normal skin so it easily tears or bruises during sexual intercourse (compare skin inside your mouth with that of the outside).
- It is rich in blood supply, hence can easily bleed during intercourse, especially with “dry sex” practices (common in Southern Africa)
- This foreskin is also rich in cells that are easily affected by HIV.
- Very small tears can also occur on the foreskin fold underneath the male organ (frenulum). This fold is rich in blood supply.
- The area under foreskin is warm and moist an environment suitable for growth and multiplication of germs. If one of the partners is infected with a sexually transmitted infection, these multiply and can be passed on to the other partner.
- Because the area under the foreskin is closed most of the time and warm and moist, dirt can easily accumulate there and eventually cause a foul smell, particularly if the man does not properly and regularly bath.
- Wound producing STIs like herpes (HSV-2), gonorrhoea and syphilis, which are more common in uncircumcised men, provide entry for HIV infection.
- After circumcision, the skin on the head of the penis becomes harder and less likely to tear or bruise, making it difficult for HIV to enter.

The Voluntary Medical Male Circumcision Procedure – What to expect

The client who has accepted to undergo VMMC is tested for HIV and counseled. Female partners are encouraged to go with their men for the circumcision.

The following is a summary of the procedure that a client goes through for male circumcision services: -

1. Client goes through HIV testing and counselling
2. Client goes for counselling before the male circumcision procedure
3. The Doctor or Nurse physically assesses the client before circumcision
4. Circumcision is done and it generally takes about 20 minutes under a local anaesthetic. This means that the client will be awake during the whole procedure and will not feel any pain.
5. Client receives counselling after the procedure and given pain killers to take when necessary
6. Client comes back at Day 2 review for assessment and removal of bandage
7. Client begins salt baths after Day 2 review, using coarse salt
8. Client continues salt baths
9. Client goes for Day 7 review
10. Client goes for last review at Day 42

Wound care Instructions for VMMC Clients

The client needs to rest at home for one to two days. This will help the wound to heal quickly. Bathing is normal the day after the procedure, but one needs to take care not to get the bandages wet.

The Does and Don'ts after Circumcision: -

- Do not remove bandages and expose wound before review date.
- Do not show the wound to your peers to avoid infection of the wound
- Do not pull or scratch the wound as this disturbs wound healing.
- Erections may cause some pain. Urinating can usually help but do not masturbate. This can damage the wound.
- Return to the clinic for the two-day, seven-day and forty two- day post-procedure reviews without fail. The MC provider will remove the bandages on day 2 and examine the wound to make sure it is healing properly.

Return to the clinic or call your VMMC provider if you have any of the following problems: -

- Bleeding that does not stop or gets worse
- Severe pain
- Inability to urinate
- Pus coming out of wound
- Increased swelling
- A fever within one week of your procedure
- Severe lower abdominal pain

Sexual intercourse or masturbation must not be done for six weeks after circumcision. Take any medications as directed by your VMMC provider.

HANDOUT 3: Why link VMMC and ASRH?

VMMC is important for HIV prevention

HIV remains a major public health challenge in Zimbabwe. Voluntary medical male circumcision (VMMC) is one of the most effective HIV prevention interventions and is being promoted in the country.

Adolescent boys will be a priority target group for VMMC programmes

Currently VMMC is mostly provided in a vertical manner, in order to circumcise as many men as possible in a short period of time: the catch-up phase. However, in the future it is likely that VMMC will require a more integrated strategy, and will explicitly target adolescent boys, preferably before their sexual debut.

Important to take advantage of having contact with adolescent boys

Adolescent boys already constitute a major proportion of VMMC acceptors. This is a section of the population with whom the health system usually has very little contact, and VMMC therefore provides an important opportunity to link them with other HIV prevention and adolescent sexual and reproductive health (ASRH) information, services and other interventions.

ASRH and VMMC programmes provide entry points for each other

When adolescent boys come into contact with people providing adolescent health services and interventions it is important that they are able to motivate them to access VMMC services: ASRH programmes provide opportunities to increase adolescent boys' access to VMMC services, and VMMC programmes provide opportunities to increase adolescent boys' access to ASRH services.

✓ **VMMC and ASRH interventions are complementary and reinforcing**
Having stronger linkages between VMMC and ASRH facilities and service providers will therefore benefit both programmes, and help improve health outcomes for adolescent boys: several ASRH interventions could make important contributions to HIV prevention.

✓ **Linking VMMC and ASRH programmes is in everyone's best interests**
An integrated approach to VMMC and ASRH has many benefits, including the potential to strengthen the skills of service providers and improve the quality and coverage of services for adolescents: integrating/linking could make better use of available resources, decrease duplication and generate savings (e.g. time and money) for both the health system and the clients.

✓ **Strengthened VMMC - ASRH linkages can improve adolescent health**
The lessons learned from making district services/facilities and centres/NGOs more responsive to the ASRH/VMMC needs of adolescent boys can help to improve the overall delivery of services and interventions for this segment of the population: improving communication, referral and care.

HANDOUT 4: How to strengthen ASRH and VMMC linkages and integration

Intervention packages

- **The Minimal package**, which consists of the provision of essential information about VMMC and ASRH, and the availability of services in the district where these VMMC and ASRH services/interventions can be obtained;
- **The Basic package**, which includes a range of clinical services that are core components of both VMMC (provided immediately before, during and immediately after the circumcision) and also of ASRH for adolescent boys;
- **The Extended package**, which will generally be provided some time before or sometime after VMMC, and includes some of the broader interventions that contribute to ASRH

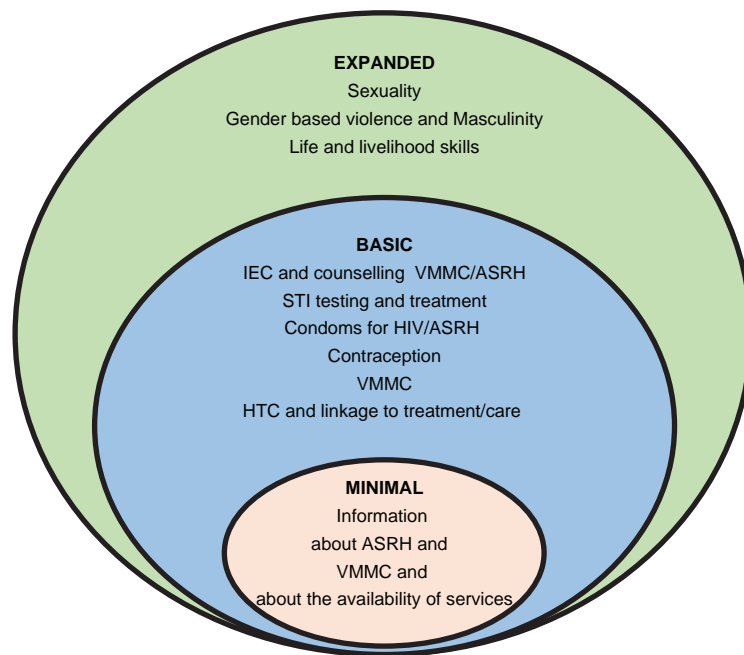
Everyone should be able to provide the Minimum package i.e. provide information about ASRH and VMMC, and about availability of services.

Two main models are going to be explored for strengthening linkages:

Option 1: VMMC is offered through outreaches at Youth Centres.

Option 2: Adolescents who go to youth centres are referred to the male circumcision clinics for VMMC. Likewise, adolescents circumcised at MC clinics are referred to youth centres for more ASRH services and life skills at youth centres.

Packages of services and interventions ASRH/VMMC



HANDOUT 5: Youth Friendly services & service provision

Defining youth friendly services

Youth Friendly Services (YFS) are services that are accessible, acceptable and appropriate for young people. They are in the right place, at the right time, at the right price (free where necessary) and delivered in the right style to be acceptable to young people. It meets the needs of young people and are able to retain their youth clientele for follow up and repeat visits.

Conditions for Youth Friendly Service Provision

1. Affordability. Services should be provided for free. In cases where there are charges for certain services, the charges should be affordable and exemptions for poor young people should be guaranteed.

2. Accessibility. Services are required to be accessible to young people at a low cost (both financially and timeously), without any form of discrimination. Special times and convenient hours need to be set aside for provision of SRH services to young people, apart from the general health facility opening hours (0730 – 1630 hours). These include late afternoons, after schools/work, during weekends or holidays. There is need to publicise the location of services, for example through sign posts and labels.

3. Acceptability. There is need to assure privacy and confidentiality as a right for adolescents/

young people.

4. Provider competence. Health workers and other service providers (e.g. Recreational leaders) need to be sensitive and have appropriate skills (including communication) to competently deal with adolescents. Trained peer educators need to complement health workers in reaching out to young people.

Communicating with adolescents

There are a number of techniques the provider can use to facilitate good communication with youth. These include: -

1. Active Listening/Attending Behaviour

Providers let the youth know through verbal and nonverbal expressions that they are listening. Facial expressions and posture should show the youth that he/she is interested and paying attention.

Some examples are maintaining eye contact, nodding as client speaks, saying 'um hmm'.. (however, avoid to irritate your client)

2. Summarizing and Paraphrasing

The provider restates what the youth has said in her own words. This assures the youth that she has heard and understood what the youth has said. For example:

Youth: 'I don't know what is the matter. I just

don't feel well today'.

Provider: 'You are feeling sick and not sure what is the matter'.

Summarizing usually restates many thoughts in a shorter form.

3. Reflecting Feelings

By observing and listening, providers imagine how youth feel. Then they tell youth what they think those emotions are. For example, when a youth sounds and acts confused, the provider can point this out saying, 'You seem confused'. This serves three purposes: -

- It makes the youth think about how he or she feels and why,
- The provider finds out whether or not the youth is confused, and
- If there is confusion, the youth and provider can clear it up through discussion.

4. Questioning

The provider encourages youth to talk about themselves by asking questions. Questions can be open or closed ended.

Open-ended questions gives provider a wide range of information from the youth without influencing his/her responses. Open-ended questions usually begin with the words 'how', 'what' or 'why'. For example, 'how have you been?'

Closed-ended questions are leading and limit possible youth responses. They may cause youth to give answers he/she thinks the provider wants to hear. For example, 'have you been well?'

Closed-ended questions can be used to shorten a discussion. But, if used too often, the provider might miss important information.

Probing questions or statements are used to elicit further details form the youth. They can be open or closed-ended, but are usually open-ended, e.g.: -

'Tell me more about...'

'And?'

'Um hmm,' followed by silence.

'Is there anything you left out?'

When probing, get information the youth might feel is personal or private. Probes should be worded carefully.

5. Making Positive Statements (Praise/Encouragement/Reassurance)

Making positive statements can help youth to feel good about themselves. When a youth is in a crisis, it can help him/her get control of his/her own situation. Avoid giving false praise. Some examples are:

Praise: 'You are looking well today'.

Encouragement: 'You did the right thing by coming here'.

Reassurance: "Being HIV positive does not mean that it's the end of the world for you..."

6. Giving Information

When giving information, explanations should be simple, clear, and in language the youth understands.

Use visual aids whenever possible.

Part of giving information is assessing whether youth have understood the message. Do this by asking questions, having youth repeat instructions.

Barriers to Communication and Strategies to Overcome Them

Barriers Created by Service Providers

Sometimes service providers can create barriers to communication. Here are a few examples, including strategies to overcome them.

1. Knowledge – This may be important if you are speaking on a topic you do not know a lot about.

Strategies: Make sure your knowledge is up-to-date. If you do not know something, it is okay to tell youth that you do not know at present, but that you can find out for them.

2. Attitude – Negative attitudes can affect the impact of the message. Good communication must be non-judgmental.

Strategies: Be aware of your attitudes and biases, and keep them out of your communication. Never impose your opinions on controversial topics.

3. Age – Some youth do not feel comfortable with people either younger or older than themselves.

Strategies: Show proper respect. Identify yourself as a health worker who deals with sensitive topics. Explain that when there are serious health consequences, there is a need to discuss issues – that are sometimes personal.

4. Religion and Culture – Sometimes youth may feel uncomfortable sharing their thoughts and feelings with a person from another culture or religion.

Strategies: It helps to have background information on the religious and cultural beliefs of youth. Try to identify times when religious and cultural values might interfere with

communication, and work with them (do not ignore them). Respect people's values, even when you do not agree with them.

5. Sex – Some prefer to communicate with people of the same sex (especially about personal subjects)

Strategies: Again, acknowledge that the discussion might be embarrassing but explain that it is necessary to discuss personal topics for health reasons. Acknowledging embarrassment usually helps youth to overcome it.

6. Language – Technical words can be too difficult to understand. It is important to speak in terms that people understand and to use acceptable names for things.

Strategies: Keep language simple. Confirm whether terms are familiar and understood by youth. If not, explain the terms or use more familiar words.

7. Economic Status – Youth might find it hard to relate to a person who appears to be of another economic status.

Strategies: Show respect no matter how poor the adolescent might appear. Avoid fancy dress. Sit among group members, instead of standing over them or sitting apart from them.

8. Time – Adolescent might not be interested in talking with providers if they are busy doing something else.

Strategy: When possible, let the adolescent choose the time for discussion. Remember, good communication can occur even when little time is available.

9. Venue – Noise, excessive temperatures, and poor seating facilities can make good communication difficult.

Strategy: Make sure the venue is suitable and in a location that is accessible.

What to do and what to avoid when talking to adolescents.

DO	AVOID
✓ Be truthful about what you know and what you do not know	➤ Giving inaccurate information (to scare them or to make them 'behave').
✓ Be professional and technically competent	➤ Threatening to break confidentiality 'for their own good'.
✓ Use words and concepts which they can understand and relate to. Assess if they understand. Use pictures and flip charts	➤ Giving them only the information that you think they will understand ➤ Using medical terms they will not understand
✓ Treat them with respect in terms of how to speak and how you act	➤ Talking down to them, shouting, getting angry, or blaming them
✓ Give all the information/choices and then help them decide what to do	➤ Telling them what to do because you know best and they are 'young'.
✓ Treat all adolescents equally? Be understanding and supportive even if you do not approve of their behaviour	➤ Being judgemental about their behaviour, showing disapproval, or imposing your own values
✓ Accept that they may choose to show their individuality in dress or language	➤ Being critical of their appearance or behaviour, unless it relates to their health well-being



ANNEX 6.

VMC ASRH Capacity Building Plan

Outline

1.0 Introduction

2.0 Purpose

3.0 Mount Darwin trainings

3.1 Training of Peer Educators

3.2 Training/orientation for Community Health Workers

3.3 Training/orientation for Youth Centre staff and Nurses from the District Hospital

4.0 Bulawayo trainings

4.1 Training of Peer Educators

4.2 Training/orientation for Recreation Officers and Nurses

4.3 Training/ orientation for Youth Centre and Clinic Ancillary staff

1.0 Introduction

The objective of the project is to assess the feasibility and capacity strengthening requirements to enhance ASRH VMMC linkages in order to inform transition to longer term VMMC strategies/services and gender norming intervention. The project seeks to determine how the respective strengths of the ASRH and VMMC programs can be harnessed to increase uptake of service for either of the programs.

2.0 Purpose

The purpose of this document is to outline the training/ orientation of Peer Educators, Youth Centre staff, Health care providers, Ancillary staff, Community based health workers and mobilisers in Mt Darwin and Bulawayo.

3.0 Mount Darwin trainings

Several trainings will be conducted in Mt Darwin; these include training of Peer Educators; Community Health Workers; Youth Centre staff and Nurses from the District Hospital. The trainings will be carried out as outlined below.

3.1 Training of Peer Educators

Training dates: TBD

Participants: 2 newly recruited Peer Educators

Training Location: TBD

Training staff: TBD

Training structure, tools and curriculum

The ZNFPC basic Peer Educators ASRH training structure, tools and curriculum will be used. Training will also include sessions on VMMC Demand Creation and VMMC/ASRH Integration.

3.2 Training/orientation for Community Health Workers

Training dates: TBD

Participants: 80 Community Health Workers (i.e. Peer Educators; Village Health Workers; VMMC Mobilizers; Family planning Community Based Distributors and Ancillary staff).

Training Location: TBD

Training staff: TBD

Training structure, tools and curriculum

Structure: The orientation will be conducted in 1 day beginning at 09:00 to 16:00 Hrs. Methods of training will include interactive lectures, PowerPoint presentations, Question and Answer sessions and group discussions.

Tools: Training tools will include the training agenda and the training manual.

The curriculum: The curriculum of the training will cover, but will not be limited to VMMC Demand Creation and VMMC/ASRH Integration.

3.3 Training/orientation for Youth Centre staff and Nurses from the District Hospital

Training dates: TBD

Participants: 5 Youth Centre staff and 20 Nurses from the District Hospital

Training Location: Mt Darwin Youth Centre

Training staff: TBD

Training structure, tools and curriculum

Structure: The orientation will be conducted in 1 day beginning at 09:00 to 16:00 Hrs. Methods of training will include interactive lectures, PowerPoint presentations, Question and Answer sessions and group discussions.

Tools: Training tools will include the training agenda and the training manual.

The curriculum: The curriculum of the training will cover, but will not be limited to VMMC Demand Creation and VMMC/ASRH Integration. Youth Centre staff will also be trained on how to acquit discretion funds/ seed money.

4.0 Bulawayo trainings

Several trainings will be conducted in Bulawayo; these include training of Peer Educators; Recreation Officers and Nurses; Youth Centre and Clinic Ancillary staff. The trainings will be held as detailed below.

4.1 Training of Peer Educators

Training dates: TBD

Participants: 36 Peer Educators

Training Location: Inyathi Youth Centre

Training staff: TBD

Training structure, tools and curriculum

Structure: The orientation will be conducted in 1 day beginning at 09:00 to 16:00 Hrs. Methods of training will include interactive lectures, PowerPoint presentations, Question and Answer sessions and group discussions.

Tools: Training tools will include the training agenda and the training manual.

The curriculum: The curriculum of the training will cover, but will not be limited to VMMC Demand Creation and VMMC/ASRH Integration.

4.2 Training/orientation for Recreation Officers and Nurses

Training dates: TBD

Participants: 15 Recreation Officers and 60 Nurses from the respective clinics, including PSI

Training Location: TDB

Training staff: TBD

Training structure, tools and curriculum

Structure: The orientation will be conducted in 1 day beginning at 09:00 to 16:00 Hrs. Methods of training will include interactive lectures, PowerPoint presentations, Question and Answer sessions and group discussions.

Tools: Training tools will include the training agenda and the training manual.

The curriculum: The curriculum of the training will cover, but will not be limited to VMMC Demand Creation and VMMC/ASRH Integration. Recreation Officers will also be trained on how to acquit discretion funds/ seed money.

4.3 Training/ orientation for Youth Centre and Clinic Ancillary staff

Training dates: TBD

Participants: 60 Youth Centre and Clinic Ancillary staff (Nurses Aides; Clerks; General Hands)

Training Location: TDB

Training staff: TBD

Training structure, tools and curriculum

Structure: The orientation will be conducted in half day beginning at 09:00 to 13:00 Hrs. Methods of training will include interactive lectures, PowerPoint presentations, Question and Answer sessions and group discussions.

Tools: Training tools will include the training agenda and the training manual.

The curriculum: The curriculum of the training will cover, but will not be limited to VMMC Demand Creation and VMMC/ASRH Integration.

ANNEX 7.

VMMC ASRH Advocacy and Sensitisation Plan

Outline

1.0 Introduction

2.0 Purpose

3.0 Mount Darwin activities

- 3.1 Sensitisation of MOHCC and ZNFPC
- 3.2 Sensitization of Mt Darwin community

4.0 Bulawayo activities

- 4.1 Sensitisation of City of Bulawayo Directors- Housing & Community services department; Health Department; ZNFPC
- 4.2 Advocacy meeting with local community leadership
- 4.3 Sensitisation meeting with Parents Association for Bulawayo Youth Centres
- 4.4 Sensitization of Bulawayo community

1.0 Introduction

The objective of the project is to assess the feasibility and capacity strengthening requirements to enhance ASRH VMMC linkages in order to inform transition to longer term VMMC strategies/services. The project seeks to determine how the respective strengths of the ASRH and VMMC programs can be harnessed to increase uptake of service for either of the programs.

2.0 Purpose

The purpose of this document is to outline the project advocacy and sensitisation plans for Mount Darwin and Bulawayo.

3. Mount Darwin

3.1. Sensitisation of MOHCC and ZNFPC

Date: 18 March 2016

3.2 Sensitization of Mt Darwin community

The community sensitisation dates, venues and participants will be as follows:

	Date	Centre	Meeting venue	Participants
1	TBD	Mt Darwin Youth Centre	TBD	50 community members
2	TBD	Dotito Youth Centre	TBD	50 community members

Sensitisation Team composition: WHO x 2 people; ZNFPC x 1; SRH x 1; VMMC x 1; Project Officer x 1; Driver x 1.

Meeting structure and agenda

Structure: Sensitization will be done through one day meeting that will be convened with the assistance of Youth Centres staff and peer educators. The project will be presented and the support of the parents will be sought to ensure that the objectives are achieved.

4. Bulawayo

4.1 Sensitisation of City of Bulawayo Directors- Housing & Community services department; Health Department; ZNFPC

Date: 23 March 2016

Sensitisation Team composition: WHO x 2 people; ZNFPC x 1; SRH x 1; VMMC x 1; Project

Sensitisation Team composition: WHO x 2 people; ZNFPC x 1; SRH x 1; VMMC x 1; Project Officer x 1, Driver x 1.

Location: Mashonaland Central PMD's office, ZNFPC Provincial office, Mt Darwin District hospital.

Meeting agenda: Introduction of the VMMC/ ASRH Linkages officer & NPO, project update and plans.

Structure: Sensitization will be done through a meeting jointly attended by all stakeholders-WHO, MOHCC VMMC & ASRH and ZNFPC. Site visits will be made to Mt Darwin Youth Centre and Dotito Youth Centre.

Officer x 1, Driver x 1.

Location: City of Bulawayo offices, ZNFPC Provincial office,

Meeting agenda: Introduction of the VMMC/ ASRH Linkages officer & NPO, project update and plans.

Structure: Sensitization will be done through a meeting jointly attended by all stakeholders-WHO, MOHCC VMMC & ASRH and ZNFPC. Site visits will be done at Inyathi, Magwegwe, Mzilikazi and Indhlovu Youth Centres.

4.2 Advocacy meeting with local community leadership

The advocacy meetings will be carried out as follows:

	Date	Centre	Meeting venue	Participants
1	TBD	Inyathi Youth Centre	TBD	20 community leaders
2	TBD	Magwegwe Youth Centre	TBD	20 community leaders
3	TBD	Indhlovu Youth Centre	TBD	20 community leaders
4	TBD	Mzilikazi Youth Centre	TBD	20 community leaders

Advocacy Team composition: WHO x 2 people; SRH x 1; VMMC x 1; Project Officer x 1; ZNFPC x 2; Driver x 1.

Meeting structure and agenda: This will be a half day advocacy meeting done to encourage stakeholders to buy into project and get stakeholders' perspectives on the project processes.

4.3 Sensitisation meeting with Parents Association for Bulawayo Youth Centres.

The sensitisation meetings will be carried out as follows:

	Date	Centre	Meeting venue	Participants
1	TBD	Inyathi Youth Centre	TBD	8 association members
2	TBD	Magwegwe Youth Centre	TBD	8 association members
3	TBD	Indhlovu Youth Centre	TBD	8 association members
4	TBD	Mzilikazi Youth Centre	TBD	8 association members

4.4 Sensitization of Bulawayo community

The community sensitisation dates, venues and participants will be as follows:

	Date	Centre	Meeting venue	Participants
1	TBD	Inyathi Youth Centre	TBD	50 community members
2	TBD	Magwegwe Youth Centre	TBD	50 community members
3	TBD	Indhlovu Youth Centre	TBD	50 community members
4	TBD	Mzilikazi Youth Centre	TBD	50 community members

Sensitisation Team composition: WHO x 2 people; SRH x 1; VMMC x 1; Project Officer x 1; ZNFPC x 2; Driver x 1.

Meeting structure and agenda: Sensitization will be done through one day meeting that will be convened with the assistance of Youth Centres staff and peer educators. The project will be presented and the support of the community members will be sought to ensure that the objectives are achieved.

ANNEX 8.

Client Referral Form

VMAC ASRH LINKAGES		CLIENT REFERRAL FORM	
Part A: Referral Slip: To be filled out by the Organisation/Health facility/ Youth Centre making the referral			
Date:			
Client Name:		Age:	Gender: M / F
Address:		Contact number:	
Referred from:			
Person:		Organisation/Health facility/ Youth Centre :	
Contact number:		Address:	
Referred to:			
Person:		Organization:	
Address/phone number:			
Services Needed (please use codes):			
Tick in the box when feedback is received (to be completed of the original copy)		<input type="checkbox"/>	Date feedback received _____

Part B: Services Provided: To be filled out by the Organisation/Health facility/ Youth Centre fulfilling the referral (slip to be given to the person referring so that they tick referral as complete)	
Date:	Organisation/Facility/Youth Centre name:
Services Provided:	
<input type="checkbox"/> Services provided (please use codes): _____	
<input type="checkbox"/> Services completed as requested ____ Yes ____ No	
<input type="checkbox"/> Follow-up needed: services: _____ Date for follow-up: _____	
Name of person who provided service: _____ Signature _____	
Additional Comments:	

CODES

- | | |
|---|----------------------------------|
| 10 – Boy/girl relationships | 24 – Sexuality |
| 11 – Social and family problems | 25 – Child abuse |
| 12 – Education/ career | 26 – Puberty |
| 13 – Drug/Alcohol abuse | 27 – HTS / VCT |
| 14 – Stress | 28 – VMMC |
| 15- Life skills | 29- Abortion |
| 16 – Unemployment | 30 - Music, Dance & Drama |
| 17- Male condoms | 31 - Sports & Games |
| 18- Female condoms | 32 - Talk Shows |
| 19- Pregnancy (prevention & Management) | 33 - Computer Courses |
| 20- SGBVC | 34 - Cancer screening |
| 21- Family planning | 35 - Vocational training courses |
| 22 – STIs | 99- Other (specify) |
| 23- HIV & AIDS | |

ANNEX 9.

VMMC ASRH U report system proposal

Developed by UNICEF, the U-Report is a user-centered social monitoring tool based on simple Short Message Service (SMS) messages designed to strengthen community-led development, citizen engagement and positive change. Registration is voluntary with SMS free to the users across all networks. To become a U-Reporter, users equipped with even basic mobile phones text the word “join” to a toll-free short-code and within moments, they can receive information and share their opinions. This information is instantly mapped and analyzed, yielding vital information and real-time insights about how young people see their world and what they think is most important. Data received can be disaggregated by age, gender and place of residence real time.

In the VMMC/ASRH linkages project the platform can be used for communication, advocacy and monitoring & evaluation. Table 1 below outlines why and how the U report can be incorporated in the current project.

U report launches can be held in the project districts and adolescents register to join. A separate database for the project (geo-fencing) will be created and will be used in sending information and opinion polls. The UNICEF Country Office also develops and distributes IEC material on the U Report. There is an opportunity to partner and include VMMC/ASRH messages on some the posters and T-shirts.

Table 1: Why and how to incorporated the U Report in the linkages project

Use	Why	Possible information to send out / collect
1. Communication	<ul style="list-style-type: none"> • Disseminate information on ASRH/VMMC linkages • Inform adolescents about upcoming VMMC campaigns/ outreach dates 	<ul style="list-style-type: none"> • Information on different service providers/ organisations in ASRH and VMMC in Mt Darwin & Bulawayo • VMMC campaign dates • VMMC outreach dates and sites • Incorporate the typing tool into U-report
2. Advocacy	<ul style="list-style-type: none"> • Disseminate information on ASRH/VMMC • Baseline & routine monitoring of the adolescents' perceptions about VMMC & ASRH 	<ul style="list-style-type: none"> • Adolescent boy's perceptions on IEC material
3. Monitoring and Evaluation	<ul style="list-style-type: none"> • Baseline & Endline evaluation- qualitative & quantitative data • Routine monitoring 	<ul style="list-style-type: none"> • Demographic data • Adolescents knowledge levels at baseline and Endline points • Perceptions of the adolescents the linkages project/ processes • Their perception of the U report platform

Roles and responsibilities

MoHCC/WHO/ZNFPC

- Participate in U report launches/campaigns in project districts
- Provide key messages to be sent out
- Draft opinion poll questions
- Participate in VMMC/ASRH & U Report IEC material development

UNICEF

- Spearhead U report launches/campaigns in project districts
- Participate in VMMC/ASRH & U Report IEC material development
- Manage the database
- Generate preliminary poll reports

ANNEX 10.

Key Informant Interview with VMMC Team Member - Mt Darwin

Key Informant Interview with VMMC Team Member- Mt Darwin

01 March 2017

SECTION A: ROLES

1. To begin, can you tell me about your role in the VMMC/ ARSH program?

In the VMMC I was first trained as a counsellor and I was later trained as a circumciser and now I am both a counsellor and a circumciser. In the ASRH I was involved in the trainings and development of IEC material. I attended some training in the youth centers and some organised by ZNFPC. I was also involved in the initial stages of the pilot project on VMMC /ASRH linkages.

SECTION B: VMMC ARSH LINKAGES

2. What is your overall impression of the VMMC and ARSH linkages project?

As was planned, initially the idea was good, linking the two services was a noble idea but there are some difficulties in the districts that hinder the actual function of the project. Locally the Mt Darwin urban youths /adolescents are already circumcised hence we are having a challenge of getting new cadres. In other rural areas we are having more of the youths but the problem is that we have only two youth centres which is Mt Darwin and Dotito. As such referring someone to a youth centre becomes hard due to long distances travelled and as such youths don't show up even when referred.

3. What do you think have been the main successes and main challenges in:

- **Joint Demand Creation (e.g.VMMC offered at Youth Centre activities like sports galas)**

Successes

We held the meetings with the communities and stakeholders and I think everybody and most people are aware of the linkages project between VMMC and ASRH. The community mobilisers are hands on in the project and are referring youths for VMMC.

Challenges

One of the challenges we are facing in the project is that some of the mobilisers are not making efforts to refer youths for VMMC because they are not receiving some incentives. In the VMMC side we have PSI as a partner fortunately they work with the mobilisers to refer clients for services. As I said earlier, locally in the urban

area, only a few youths are uncircumcised and we are having a challenge to access the hard to reach areas. Even after we refer youths to centers for ASRH, after offering them VMMC they normally do not go because of transport challenges as we have only two youth centers. The referral is either way, it can be from the youth centre to us or from us to the youth centre.

- **Service Integration (e.g. routine offering of VMMC at Youth Centres)**

Successes

Some are saying they now clearly understand the linkages project but this is from the word of mouth.

Challenges

Sometimes pressure of work becomes too much when the youths come in huge numbers for VMMC they do not go back to get ASRH services. It would be a few cadres that we manage to refer back to the youth centre

- **Service Outreaches (VMMC /ASRH services at Youth Centres and in the community)**

Successes

We do community services to hard to reach areas like Dande Valley far from the centres. After conducting such we see a big turnaround in the numbers for clients for circumcision. More people are coming for VMMC services especially adolescents between the ages of 13 to around 26. More numbers are being observed although we have hard nuts to crack areas and at times we also face resistance due to cultural beliefs and practices.

Challenges

In Mt Darwin urban we have not done any outreach since we communicate with the centre that if they have a certain number of clients they should tell us. At Dotito youth centre if they found possible clients they also tell us to come for the services.

At Dotito the chief said the procedures were against the cultural practices. The issue was however solved by the counsellors whosensitised the whole community on the benefits of circumcision but still the numbers are very low although better than before.

- **Community dialogues and boys fora**

Successes

Some boys were shy to talk about VMMC and reproductive issues. In some areas you will find that these discussions encourage them to open up. Parents are now forthcoming and are receiving the programs. We have seen large numbers coming for the programs. We have seen some coming with the underage boys around 8 to 9 years for the service. The community is so supportive for the program except for those hard to reach areas like Nyamutsenzere.

4. How has been the referral system been working within the 2 services?

First of all we formed a whatsapp group for all the stakeholders involved in the linkages project. These are the community mobilisers, the counsellors, the circumcisers, peer educators from youth centers, behaviour change facilitators, Ministry of education and Ministry of Youth.

- **How has the referral system been working? Main successes, main challenges?**

Challenges

Sometimes pressure of work becomes too much when the youths come in huge numbers for VMMC they do not go back to get ASRH services. It would be a few cadres that we manage to refer back to the youth centre

- **Service Outreaches (VMMC /ASRH services at Youth Centres and in the community)**

Successes

Whenever there is a function or an outreach we communicate that VMMC team will be at such a place from this time to this time and everybody starts to mobilise for the service. As a result this activity increases the coverage and reach. We also have the referral slips where after a session at the youth centre the eligible youths are given slips that they carry to service provision centers.

Challenge

More of the adolescents who are uncircumcised are in the hard to reach areas. The issue of transport is making the processes hard and I am not sure why we are receiving few referrals from the centers but they said they are making frantic efforts. We are not sure whether the adolescents are afraid to come for services or there is another reason for that.

- **Do you follow up clients to check if they received the service?**

Follow ups are a challenge from both our side and from the centers that refer clients to us. If you conduct follow ups you realise that only a few that were referred would have come for the service.

- **In your opinion, does VMMC ARSH linkages/ referral system affect workers work load?**

I would say the referral system does not increase the work load because it is part and parcel of the job. Referring a client to specific service provider should be improved by referring to a specific person because if a youth comes to the facility and finds no one to attend to him he disappears and will never come back.

were referred would have come for the service.

- **In your opinion, does VMMC/ARSH linkages/ referral system affect workers work load?**

I would say the referral system does not increase the work load because it is part and parcel of the job. Referring a client to specific service provider should be improved by referring to a specific person because if a youth comes to the facility and finds no one to attend to him he disappears and will never come back.

5. What is your view on the community dialogues and boys fora?

It is a good program and should continue as it is engaging for both the parents and the youths. It closes the communication breakdown gap. Youths should be attended where they are i.e. the youth centres if that is possible to avoid those that are lost to follow up.

6. How has the linkages project assisted or positively impacted on your daily work?

As for now not much has been done. We still have a long way to go with the linkages project because the referred clients are still few. I will say not much has been done.

7. What innovations do you think will increase / strengthen the VMMC and ARSH linkages services or interventions?

I think since most of our adolescents are school going, if schools would allow us to visit them for mobilisation once a week it can increase our impact. We are yet to discuss about this and see how it works. More work should be done in schools and strengthen school health programs

SECTION C: ANY OTHER COMMENTS

8. Are there any final thoughts you have about the ARSH VMMC linkages project?

VMMC /ASRH linkages project will benefit much if we are able to get a good number of referrals and if possible those hard to reach areas have a youth centre established there because in Dande Valley there are a lot of youths who are idle .You find that a 17 year old is already a father and a 12 year old being the mother.

ANNEX 11.

ASRH VMMC BYO Draft Meeting Report



*Contributing to improved interventions for the health of adolescent boys:
Scaling-up stronger linkages between VMMC and ASRH*

HOLIDAY INN, BULAWAYO, 21-23 March 2016

Contents

Background and rationale.....	3
End of pilot phase workshop.....	3
Day 1 key discussion points.....	5
Day 2 key discussion points.....	7
Day 3 (Core planning group meeting) key discussion points.....	8
Annexe 1: Meeting agenda.....	13
Annex 2: Group work instructions.....	22
Annex 3: List of participants.....	25

Background and rationale

HIV remains a major public health challenge in Zimbabwe. Voluntary medical male circumcision (VMMC) is one of the most effective HIV prevention interventions and is being promoted in the country. In the future it is likely that VMMC will require a more integrated strategy, and will explicitly target adolescent boys, preferably before their sexual debut.

Adolescent boys already constitute a major proportion of VMMC acceptors. This is a section of the population with whom the health system usually has very little contact, and VMMC therefore provides an important opportunity to link them with other HIV prevention and adolescent sexual and reproductive health (ASRH) information, services and other interventions.

ASRH and VMMC programmes provide entry points for each other. They are complementary and reinforcing. Having stronger linkages between VMMC and ASRH facilities and service providers will therefore benefit both programmes, and help improve health outcomes for adolescent boys.

In March 2014, Zimbabwe MoHCC with the support of WHO, undertook a consultative work to explore integration and linkages between ASRH and VMMC for adolescent boys. The pilot set out to assess/addressed the question of how to link the two services. The implementation of the pilot project activities started in March 2016 with sensitisation meetings and training of service providers and peer educators, as well as IEC materials development. The interventions that were tested include using referral slips, use of IEC materials with both ASRH and VMMC messages, joint demand generation activities for VMMC and ASRH and use of social media for ASRH and VMMC information dissemination. The U-Report platform was also used to disseminate information and gather young people's opinions on various ASRH and VMMC topics.

The initial implementation period of 9 months (March –November 2016) was extended to March 2017 to ensure adequate time for results and understanding given significant delays/ time spent in the preparation phase. The programmatic lessons so far have been documented and further monitoring activities/ final end of pilot monitoring have been planned.

In order to inform future scaling up of the interventions included in the pilot project and demonstrate the effectiveness of the linkages there was need to review the work done so far, and incorporate more robust measurement using implementation science approaches to ensure quality. Therefore a 2 part workshop was held to review the current implementation of the ASRH VMMC Linkages project and plan for the next phase.

End of pilot phase workshop

Dates:

A larger workshop was held on the 21th and 22nd of March 2017. This was followed by a core group meeting on the 23rd of March 2017 to further discuss the project aspects, including a refocusing of the work on a pathway to scalable and sustainable services rather than a short term project, documenting the processes and outcomes, refining the service delivery protocol and initial research questions and expansion.

Venue:

Holiday Inn Hotel, Bulawayo, Zimbabwe

Participants:

Participants were drawn from all stakeholders including from the Ministry of Health and Child Care (MOHCC) AIDS and TB Unit, Zimbabwe National Family Planning Council (ZNFFPC), district staff from youth centres, Peer Educators, ZNFFPC and VMMC facility managers and providers, and NGO Population Services International Zimbabwe (PSI/Z) and more recently three NGOs working on masculinity and gender (SAfAIDS, Young Men's Christian Association (YMCA), Padare Enkundleni Men's Forum on Gender).

Approach:

Presentations and Participatory group work

Objectives and expected outcomes of the end of pilot workshop meeting

Objectives

- To provide an overview of adolescent sexual and reproductive health interventions for boys
- To synthesize the lessons learned from the two pilot districts that would help strengthen

- VMMC-ASRH linkages to scale with quality
- To outline priority actions to accelerate improved VMMC-ASRH linkages
- To define priority implementation science key question that if answered would support improved linkages between VMMC and ASRH interventions at scale with quality

Expected outcomes

- A synthesis of lessons learned from the pilot projects to support accelerated VMMC-ASRH linkages
- A list of key implementation science questions to support VMMC-ASRH roll-out
- A plan for improving VMMC-ASRH linkages, at scale with quality

Objectives and expected outcomes of core group planning

Objectives

- To discuss the outcome of the workshop and finalize next steps
- To devise detailed plans outlining action for both pilot and new districts – including what, where, who, and when
- To further define the implementation research methodologies required

Expected outcome of core group planning

- A refined plan for improving VMMC-ASRH linkages
- A plan for the implementation research phase

Day 1 key discussion points

I. Overview of adolescent reproductive health programs and interventions for boys

- Zimbabwe has developed a new ASRH Strategy for 2016 to 2020 which gives the package of interventions for both adolescents boys and girls
- ASRH VMMC linkages programming should take into consideration the interventions in this strategy
- At the end of 2016 coverage for VMMC in the 10-29 years age group was 63% and 35% for Bulawayo and Mt Darwin respectively
- There is need to strengthen the collaboration between ASRH and VMMC if the target of 80% is to be reached
- After catch up, VMMC services for adolescent boys will be needed for the

longer term

- There is need to identify approaches to reach new cohorts of adolescents; refine the service delivery package and services; integrate into youth-friendly sexual and reproductive health services; liaise with school, sports and other programs
 - o It was noted that there were no specific service delivery approaches that targeted vulnerable adolescents and there is need to identify who is vulnerable and revise the service delivery approaches
- Three partners (Padare Enkundleni Men's Forum on Gender, Young Men's Christian Association (YMCA) and SAfAIDS) who have been working on the gender norms and transformative masculinity component of the project presented their work focusing on what they are doing, how they are doing it and any results of evaluations carried out:
 - o All 3 organizations have facilitated Community Dialogues and Boys Forums in the ASRH/VMMC Linkages project
 - o Padare and YMCA used manuals and have meeting evaluation forms they used to evaluate their dialogues while SAfAIDS did not
 - o The content of their intervention packages varied but hinging around provision of information on gender, HIV, Gender Based Violence and addressing harmful cultural practices
 - o The interventions for all three organizations seem to be driven at any point by the demands of organizations who will be funding them at that particular time
 - o There is no standard masculinity package and it was expressed that going forward this would be needed
 - o It was noted that for community acceptability facilitators for the dialogues could also come for the local communities. There is need to capacitate these community facilitators to deliver the correct messages

II. Lessons learned from the two pilot districts

- Lessons learnt in the implementation of the ASRH VMMC pilot project include:
 - o Community involvement at all stages

- o of the project is key
- o Capacity building and continuous mentorship contribute towards improved service delivery including referrals
- o Using local role models on IEC material is greatly appreciated by communities
- o Partnerships and synergies with different organizations contributed to the success of the project.
- o Referral slips should be easy to complete with minimal clerical work requirements
- o Some adolescents provide inaccurate information making it difficult to track referred clients.
- o Barriers exist for adolescents in following referrals e.g. distance to services, user fees, unfriendly attitudes of service providers
- Successes noted from the group work included
 - o Collaboration
 - Having a multi-sectoral approach
 - Involvement of all stakeholders
 - Strengthening of relationships between stakeholders
 - o Community engagement and demand generation activities that improved acceptability of the project included Boys' forums & community dialogues.
 - Sports galas
 - However, there is need to improve data collection for galas including registration of attendees by age groups to determine who is reached by SRH and VMMC messages during these events
 - o IEC materials for the project visible, available in multiple languages and in both VMMC and ASRH settings
 - o Increasing access to services through mobile, outreach and referrals
 - o Mentoring and support improved feedback and communication through monthly meetings at all levels
- Challenges noted in the group work included
 - o Access challenges
 - Distance from services to the community: in Mt Darwin district where youths travel long distances to facilities and in Bulawayo youths do not have bus fares to get to the facilities where services are available free of charge (ZNFFPC Clinics)
 - User fees at Bulawayo City Council clinics
 - Restrictions on engaging with schools where most of the younger adolescents are found
 - o Service delivery challenges
 - Unavailability of commodities and services – Sometimes medicines are out of stock
 - Unfriendly attitudes of service providers
 - o Quality challenges
 - Insufficient time spent training service providers including M&E training
 - Stock outs of national program ASRH reporting forms
 - o Limited resources to make the youth center infrastructure more attractive to young people
 - o Referral mechanisms
 - Peer educators are unable to track referrals because they do not have airtime
 - Young people are reluctant to give their contact details because they are concerned about confidentiality
 - o IEC materials challenges
 - Delays in production and distribution of IEC materials
 - Text on one of the posters is not very clear

III. Recommendations

- Recommendations from group work (Proposed activities for strengthen intervention)
 - o Improve quality through continued training and mentorship of services providers and peer educators
 - o Reduce access barriers through outreach, mobile clinics and provision of one stop shop services
 - o Generate demand through:
 - Strengthening youth centers i.e. providing resources/seed funds for improving the infrastructure
 - Offering incentives and income generating projects / livelihood programs (at the least provide

- information)
 - Providing interactive activities such as edutainment, sports, road shows
- o Strengthen IEC through:
 - Using different platforms such as youth centers as information hubs and social media to provide information and advertise events to a wider audience
- o Continue community engagement through:
 - Community dialogues and outreach
 - Increasing parental engagement in the project to obtain buy in and use parents for information and other resources
- o Strengthening gender norms component through:
 - Continued boys forums
 - Establishing and developing a standardized manual for adolescent boys on gender norms defining age specific interventions and M&E for the activities
 - Maximizing opportunities to deliver gender norms components for example during follow up visits for VMMC (Day 2, Day 7 and Day 42)
 - Training youth center staff and VMMC nurse counselors to deliver gender norms interventions
- o Enhance referrals and reporting through:
 - Minimizing the reporting requirements- Continue using the program reporting tools already in place
 - Adapting the referral form (demand information that is absolutely necessary for tracking only)
 - explore adolescent and health care workers acceptability
 - Harmonizing community tools and reporting systems – MOHCC has a community referral tool from which the current referral tool is adapted

from

Day 2 key discussion points

IV. Defining priority implementation science key question that if answered would support improved linkages between VMMC and ASRH interventions at scale with quality

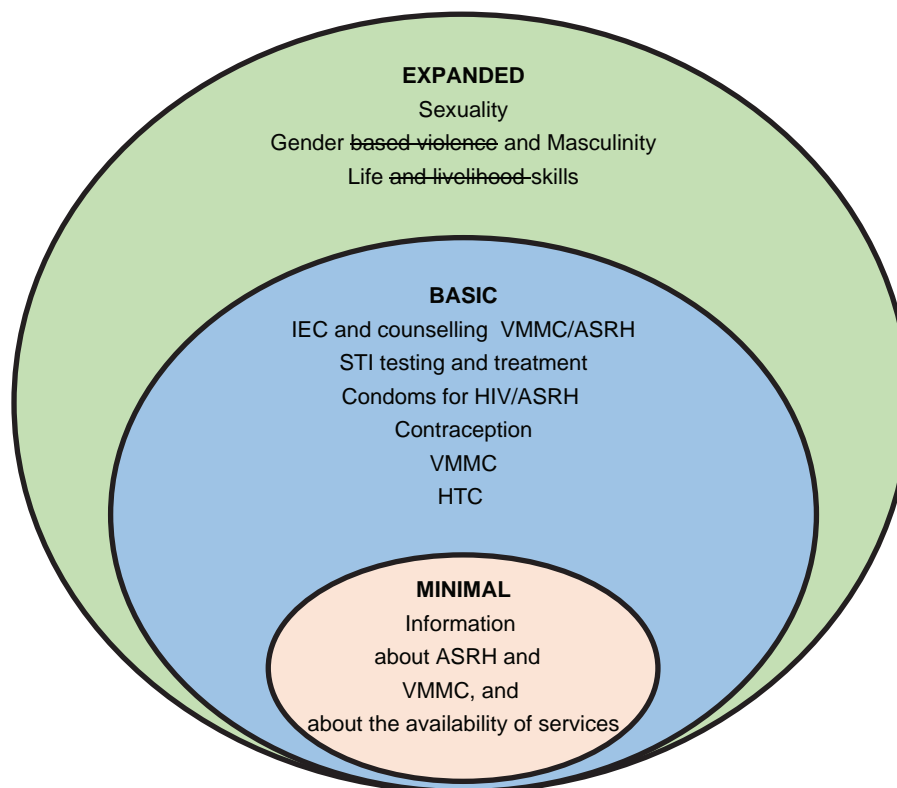
- Implementation research was introduced to the participants
- There are no single solutions to complex problems – there are no ‘magic bullets’ and one size fits all solution for implementation
- Sometimes decision-making and implementation are not highly rational processes – Implementation is inherently political
- Steps for identifying implementation research questions
 - o Step 1: define the intervention and vision for scale up
 - o Step 2: Develop a story line about what is going on in the system and why the change is not occurring (barriers? systems failure?)
 - o Step 3: identify what you would need to know to develop a strategy to address the systems failure
- Group work was conducted to identify the underlying causes of the current challenges to enable understanding and formulation of research questions.
- Possible visions for scale up were proposed and almost all of them focused on provision of a comprehensive ASRH package using a “ONE STOP SHOP” model
- Youths do not have resources required to access services (transport, user fees)
- There are structural challenges to addressing these resource limitations for example the Bulawayo city council depends on the revenue from the clinic and cannot consider waiving payment for youths unless there is a third party willing to take up the cost.
- It was noted that due to the varied backgrounds of the participants understanding of what Implementation Research was and what it intended to achieve was similarly varied

Day 3 (Core planning group meeting) key discussion points

I. Redefining the package

The package of services and interventions was refined based on what has been happening in the pilot

Packages of services and interventions ASRH/VMMC



It was noted that the project was providing information on gender norms and transformative masculinity and not just Gender Based Violence. However, the project was not providing livelihood skills but life skills only and could provide information on livelihoods.

II. Institutionalizing linkage/ VMMC for adolescent boys

It was discussed that the following key strategic questions need to be considered fully for scale up:

- How to scale up an expanded package for VMMC services as part of ASRH for adolescent boys?
- How to enhance political ownership of the linkages intervention?
- What are the financing options for scale up including domestic resources?
- What synergies for leverage across programs can be exploited?
- How to institutionalize linkages for the

expanded package to enable sustainability?

- o Generate evidence to inform policy
- o With a view to institutionalization / sustainability, how will we strengthen the linkages?

III. Implementation Research next steps

- Define core components of the current implementation:
 - o Define the aim of each of the interventions
 - o Describe/analyses how things have been and are working
- Conduct mapping in the current districts of services, events, linkages and data
- Define vision for scale (Governance, ownership etc.)
- Define pathway to scale and potential challenges that need to be addressed

*** There is need to define research questions under each of these areas**

It was discussed that next implementation should cover the period of April – September 2017 and priority activities for that period are outlined in Table 1.

I. Table 1: Priority activities

Program area	What is being continued	What is new
IEC Materials	<ul style="list-style-type: none"> Continue with provision of IEC materials (posters, flyers, job aids) Continue using U report for information dissemination and for conducting polls Use of social media to provide information 	<ul style="list-style-type: none"> Expand delivery platforms including using Young People's Network social media platforms for dissemination of messages Develop a pocket size job aid Flow diagram charts for referrals (service directory in wall chart version) Use Youth Centre as information hubs maximizing existing opportunities
Demand creation	<ul style="list-style-type: none"> Local performing groups to provide information Strengthen parents involvement in demand creation Strengthen engagement of community and religious leaders Continue activities that allow broader participation e.g. sports galas Consult young people on preferred demand creation activities 	<ul style="list-style-type: none"> Take up other activities that attract young people (quiz, talent shows) Set up core groups of parents to organise the community demand creation activities Develop a community engagement plan in both districts Include linkages messages on ZNFPC Radio slots Use role models and local celebrities for demand creation
Referral and tracking	<ul style="list-style-type: none"> Capacitate providers to effectively handle referrals 	<ul style="list-style-type: none"> Revise referral slip <ul style="list-style-type: none"> What is the information on the referral form being used for? Prioritize the most critical to keep on the form (that which is necessary and substantial) Learn from experience of other programs using referral slips Consider how to integrate referral slips into existing referral tools
Services for adolescent boys	<ul style="list-style-type: none"> Continue Peer education with the following considerations <ul style="list-style-type: none"> Are Peer Educators doing more than education? Is peer education improving access for adolescents? What else are the peer educators doing? Document contribution of PEs 	<ul style="list-style-type: none"> Gender norms and transformative masculinity <ul style="list-style-type: none"> Explore what is already in place in the Comprehensive sexuality education module, MOHCC ASRH Manual and what are other organizations are offering? Define standard package for gender norms and transformative masculinity Capacitate partners working on masculinity Service delivery platforms <ul style="list-style-type: none"> Demand creation prior to ASRH outreach (Explore evidence for outreach) Document and analyze data on outreach (effectiveness, efficiency), Document the gap
M&E	<ul style="list-style-type: none"> Use of reporting tools from both programs 	<ul style="list-style-type: none"> Reduce reporting requirements Define indicators (Uptake by adolescent boys, referrals made, referrals received, information received, services received) Standardize monthly visits- use a check list – adapt from existing ASRH and VMMC check lists and add linkages aspects
Stakeholder collaboration	<ul style="list-style-type: none"> Continue and keep updating the list/map of stakeholders 	<ul style="list-style-type: none"> Need to engage the Ministry of Gender, Women Affairs and Community Development at national level
Community engagement	<ul style="list-style-type: none"> Continue and increase parental engagement Maintain continuous engagement of community stakeholders, local leaders Youth engagement <ul style="list-style-type: none"> Continue utilizing community dialogues 	<ul style="list-style-type: none"> Include more stakeholders especially schools
Capacity building and mentorship	<ul style="list-style-type: none"> Review content and time of trainings 	<ul style="list-style-type: none"> District TOTs for the minimal package Capacitate ASRH and VMMC trainers to deliver training for both components in the long term Capacitate organizations to deliver Masculinity training with focus on Adolescent boys Document experiences of how to continue trainings and how they have contributed to this project

- **Publication**
 - o Country team to lead development of Case studies and peer reviewed journal articles for publication
- **Timeline for project**
 - o Plan for up to September 2017
- **“Scale up”**- There was discussion regarding whether or not to add more districts. It was highlighted that more information from the

current implementation is needed. Scale up would depend on

- o Service delivery model to be scaled up
- o Research questions that need to be answered
- o Cost for each of the categories e.g. for IEC materials, support and supervision etc.

Annexe 1: Meeting agenda

Day1:

Time	Topics	Speaker	Format	Details
08.00 08.30	– Registration	Secretariat		
Chair: JB Mhlanga, Bulawayo City				
Objective 1: To provide an overview of adolescent reproductive health programs and interventions for boys				
08.30 09.00	– Opening session Introductions Welcome remarks Meeting objective and agenda	JB Mhlanga, Bulawayo City Nonhlanhla Zwangabani, ZNFPC Simba Mabaya, WHO Zimbabwe	Plenary	Time: 30 mins: 15 mins per presentation
09.00 09.50	– Plans for accelerated action for adolescent health in Zimbabwe: ASRH with a particular focus on adolescent boys VMHC and HIV prevention Q&A	Nonhlanhla Zwangabani, ZNFPC Sino Xaba, MoHCC	Plenary and Q&A	Time: 50 mins: 15 mins per presentation, 10 mins Q&A Objectives: An opportunity for the MOHCC and ZNFPC to provide an overview of their current plans to strengthen HIV prevention programmes and ASRH programmes in Zimbabwe, to set the scene
09.50 10.30	– Interventions for adolescent boys: what are the priorities, what works? Social and behaviour change programmes for boys: Masculinity programmes and community engagement. Q&A	Munyaradzi Nhengo, Padare; Maphosa, YMCA; TBC, SAfAIDS	Plenary and Q&A	Time: 40 mins: 10 mins per presentation, 10 mins Q&A Objectives: For partners to present their program (what they are doing, how they are doing it and any evaluation done of their work, including key lessons/ recommendation)
10.30 11.00	– Morning Tea Break			
Chair: Busi Mzyche, ZNFPC Bulawayo				
Objective 2: To synthesize the lessons learned from the two pilot districts that would help strengthen VMHC-ASRH linkages to scale with quality				
11.00 11.30	– Background and rationale for strengthening VMHC-ASRH linkages/integration Global perspective including the new VMHC2021 Framework National pilot perspective	Julie Samuelson, WHO HQ Sino Xaba, MoHCC	Plenary	Time: 30 mins: 15 mins per presentation Objective: To provide an overview of the background and history to the development of the project and the work in the pilot districts
11.30 12.45	– Lessons learned from the pilot projects: National overview Mount Darwin Bulawayo	Sandra Kokera, MoHCC Mt Darwin representative Bulawayo representative	Plenary and Q&A	Time: 75 mins: 10 mins per presentation, 15mins Q&A, 35mins panel Objectives: To provide an opportunity for the pilot projects to outline what has helped and what has hindered strengthening VMHC-ASRH linkages.

11.30 12.45	Lessons learned from the pilot projects: National overview Mount Darwin Bulawayo Q&A Panel Discussion of user perspectives	Sandra Kokera, MoHCC Mt Darwin representative Bulawayo representative Panel – peer educator, parent, provider, and partner and hosted by Simba	Plenary and Q&A Panel	Time: 75 mins: 10 mins per presentation, 15mins Q&A, 35mins panel Objectives: To provide an opportunity for the pilot projects to outline what has helped and what has hindered strengthening VMMC-ASRH linkages. Preparation: Panellist questions
12.45 13.45	Lunch Break			
Chair: P Kushure, ZNFPC Mt Darwin				
13.45 14.45	Strengthening VMMC-ASRH linkages: opportunities and challenges for HIV prevention, ASRH and adolescent health	Instructions for group work: Sandra	Group work Participants will self-select which group to join	Time: 60 mins: 5 mins instructions, 5 mins to make groups, 50 mins group discussion (30 mins brainstorming, 20mins prioritisation) Objectives: For participants to discuss the feedback from the pilot projects and reflect on their own experiences and perspectives with integrating/linking different programmes Divide groups into the following topic areas: IEC development Demand creation Referrals and tracking What interventions/service do boys need (minimum and broader) Service delivery models/approaches M&E Sensitisation and capacity building Stakeholder and community engagement Each group will discuss what went well and what did not go well. Successes
14.45 15.15	Feedback and synthesis	Sandra to facilitate Simba to assist with 'on the spot' synthesis	Plenary	Time: 30 mins Each group will report back on 3 things to do, 3 things not to do on coloured card for synthesis.
Objective 3: To outline priority activities for an action plan to accelerate improved VMMC-ASRH linkages				
15:15 – 16:15	Strengthened linkages between VMMC and ASRH: what and how?	Instructions for group work: Simba	Group work	Time: 60 mins: 5 mins instructions, 55 mins group discussion Objective: To-identify key activities that will need to be implemented and possible resources/innovations to support the actions proposed. Divide groups into: MOHCC/ ZNFPC - HQ staff District managers and service providers Young people / peer educators Partners Parents and community members Each group will discuss the following: What is needed for adolescent boys (big thinking) What needs to be taken forward that we have been doing in the pilot project What needs to be done differently for VMMC/ASRH linkages version 2 (remember: focus on <u>what is feasible?</u>)?
16.15 – 16:45	Feedback and synthesis	Simba to facilitate Sandra to assist with 'on the spot' synthesis	Plenary	Time: 30 mins Groups to report back on priority activities based on discussions from questions 2 and 3 on coloured card for synthesis.
16:45 – 17:00	CLOSE OF DAY & TEA BREAK			

17:00 – 17:30	Facilitators meeting	Simba		Time: 30 mins Develop slides of outcomes for group work 1 for Nhan Develop slides of outcomes for group work 2 for Sino wrap up
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Day 2:

Time	Topics	Responsible /Speaker	Format	Details
08.00 – 08.30	Registration	Secretariat		
08.30 – 09.00	Day 1 Recap	Lawrance and Trust		
Chair: Peer educator				
Objective 3: To define priority implementation science key question that if answered would support improved linkages between VMMC and ASRH interventions at scale with quality				
09:00 – 09:40	Introduction to the next phase of the VMMC ASRH project What is implementation science? Q&A	Sino Xaba, MoHCC Nhan Tran, WHO HQ	Plenary and Q&A	Time: 40mins: 5 mins intro, 20mins presentation, 15 mins Q&A Objective: To provide an opportunity for participants to understand how implementation science could support the roll-out of efforts to strengthen VMMC-ASRH linkages
09.40 – 11.00	A focus for implementation research to support VMMC-ASRH linkages scale-up	Instructions for group work: Nhan	Group work Same groups as previous	Time: 80 mins: 10 mins instructions, 70 mins Objectives: Participants to brainstorm on key implementation research questions that need to be answered to support scale-up with quality Allocate participants in randomly into 6 groups except one group of peers. Each group discusses key implementation science questions.
11.00 – 11.15	Morning Tea Break			
Chair: Simba Mabaya, WHO				
11.15 – 12.00	Feedback and synthesis	Nhan to facilitate Alice to assist with 'on the spot' synthesis	Plenary	Time: 45 mins Groups to report back on cards for clustering. Each person is then allocated 3 sticky dots to place on the cards with questions they feel are most important.
12.00 – 12.30	Next steps: what needs to be done Interventions and scale up Implementation science	Sino Xaba, MoHCC Nhan Tran, WHO HQ	Plenary	Time: 30 mins: 15 mins each Objectives: To identify core elements for an action plan, commitments and partnerships
12.30 – 12:45	Presentation of awards	Sino Xaba, MoHCC Julie Samuelson, WHO HQ	Plenary	Time: 15 min
12:45 – 13:00	Vote of thanks and close	Bulawayo City Council Julie Samuelson, WHO HQ	Plenary	Time: 15 min
13:00 – 14:00	Lunch Break			
14:00 – 15:30	Project site visits			

Core Group Planning Workshop

Participants: MoHCC, ZNFPC, District managers, WHO

Chair: Simba				
Time	Topics	Facilitator	Format	Details
14.00 – 14:30	Objectives	Sino		Time: 30 mins
14.30 – 15.30	Recap of stakeholder meetings outcomes Strengthened intervention: discussion and consensus – what	Sandra Alice		Time: 60 mins Focus on the outcomes of the second group work Consensus and prioritising
15.30 – 16.00	Scale up parameters: discussion and consensus – when and where	Simba		Time: 30 mins By when Include aspects of a step wise approach
16.00 – 17.00	Key implementation science questions discussion and consensus	Nhan		Time: 60 mins Include how to prioritize and involve partners

Day 3:

Time	Topics	Responsible /Speaker	Format	Details
08.00 – 08.10	Registration	Secretariat		
08.10 – 09.00	Recap of conclusions from the afternoon of the previous day	Sino/Sandra		Time: 50 mins
09.00 – 10.00	Revisit Implementation Science: How and who (including partners)	Nhan/Simba		Time: 60 mins
10.00 – 10.30	Completing the work plan (MOHCC template)	Simba/Sandra		Time: 30 mins Develop a draft work plan and budget, identify technical support needs, etc.
10:30 – 10:45	Tea Break			
10:45 – 11.45	Work plan	Simba/ Sandra		Time: 60 mins
11.45 – 12.15	Work plan	Simba/ Sandra		Time: 30 mins
12:15 – 12:45	Resources and publication	Alice /Sandra		Time: 30 mins
12:45 – 13:15	Way Forward and Recommendations	Sino and Julie		Time: 30 mins
13:15 – 13:30	Vote of thanks & Closing remarks	MoHCC		Time: 15 mins
13:30	Lunch and departure			
14:30	Site visits (optional)			

Annex 2: Group work instructions

Group work 1: Strengthening VMMC-ASRH linkages: Opportunities and challenges for HIV prevention, ASRH and adolescent health

Objectives

- To discuss the feedback from the pilot projects
- To reflect on your own experiences and perspectives with integrating/linking

Forming groups (Approx. 7 people per group)

- Select one of the following topic groups:
 - IEC development
 - Demand creation
 - Referrals and tracking
 - What interventions/service do boys need (minimum and broader)
 - Service delivery models/approaches
 - Monitoring & Evaluation

- Sensitisation and capacity building
- Stakeholder and community engagement

Process

- Identify a facilitator and rapporteur
- In your groups discuss the lessons learnt within your topic area:
 - Successes - What went well?
 - Challenges - What did not go well?
- Explore the reasons/drivers behind the successes and challenges
- Record these on the flip chart paper

Report back

- Decide as a group the top 3 successes and the top 3 challenges
- Report these back to the group on the colour card provided

Group work 2: Strengthened linkages between VMMC and ASRH: What and how?

Objectives

- To identify key activities that will need to be implemented
- To possible resources/innovations to support the actions proposed

Forming groups

Divide into the following stakeholder groups:

- MOHCC/ ZNFPC - HQ staff
- District managers
- Service providers
- Young people / peer educators
- Partners
- Parents and community members

Process

- Identify a facilitator and scribe
- In your stakeholder group discuss the following:
 1. What is needed to improve the health outcomes for adolescent boys?

****Think big****

2. What have been doing in the pilot project that needs to be taken forward?
3. What needs to be done differently for VMMC/ASRH linkages 2.0?

Remember to focus on what is feasible

- Record ideas on the flip chart paper

Report back

- Report back to the larger group your priority activities for question 2 and question 3 on coloured card

Group work 3: A focus for implementation research to support VMMC-ASRH linkages scale-up

Objectives

- To brainstorm on key implementation research questions that need to be answered to support scale-up

Forming groups

- Divide into groups of 6
- Mixture of stakeholders and districts

Process

- Identify a facilitator and scribe
- In your group discuss key implementation science questions
- Record these on the flip chart paper

Report back

- Decide which X questions are highest priority
- Report back to the larger group your key implementation science questions on coloured card

Prioritisation

Using your white dot stickers indicate which questions are the most important

Annex 3: List of participants

A. Participants to the main meeting

NO	NAME	INSTITUTION	POSITION	TELEPHONE/CELL	EMAIL
1.	Mr Samson Hwende	MOHCC	DRIVER	0774 039 502	N/A
2.	Julia Samuelson	WHO	Technical Officer		samuelsonj@who.int
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6.	Miss Tholakele R. Moyo	Lobengula Youth Centre	Peer Educator	0776 099 420	tholakelo@email.com
7.	Mr Sibusiso Vundhla	Magwegwe Youth Centre	Secretary	0777 011 886	sibusisovundhla@gmail.com
8.	Mr Sinokuthemba Xaba	MOHCC	National MC Coord.	0776 072 731	xabasino@gmail.com
9.	Mrs Sandra Kokera	MOHCC	VMMC ASRH Linkages Offr	0772 307 473	sandrakokera@gmail.com

NO	NAME	INSTITUTION	POSITION	TELEPHONE/CELL	EMAIL
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13.	Mrs Sifiso Dube	Social worker	Bulawayo City Council	0772 862 660/09 202444	sifdube@citybyo.co.zw/ sifisodubet@gmail.com
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20.	Mr Preachard Dzimbini	Indlovu Youth Centre	Peer Educator	0776 411 123/ 0773 247 444/ 09 490325	preachhardy@gmail.com
21.	Mrs Maginasi Moyo	Sizinda Youth Centre BCC	Recreation Leader	0773 722 359	maggiemoyo3@gmail.com
22.	Ms Sichelesile Dladla	Indlovu Youth Centre	Recreation Leader	0772 747 270/ 0715 318 141	chele.dladla@gmail.com
23.	Ms Nanziwe Dube	Magwegwe Youth Centre	Recreation Leader	0771 537 687/ 0713 204 841	nanziwedube2017@gmail.com
24.	Mrs Catherine Sibanda	MOHCC	Provincial VMMC Officer (Mash. Central)	0772 897 382	catherinesibanda@gmail.com
25.	Mrs Veronica Nyamudoka - Katsande	National AIDS Council	District AIDS Coordinator	0772 701 576	vyamudoka@nac.org.zw
26.	Mr Trust Matafini	ZNFPC	Youth Facilitator	0775 549 596	trustmatafini@gmail.com
27.	Mr Percival Kushure	ZNFPC	Provincial Marketing & Communications Officer	0772 627794	pkushure@znfpc.org.zw
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29.	Dr Moses Macheka	ZNFPC	Medical Officer	0779 637 262	mmacheka@znfpc.org.zw
30.	Mr Forbes Makamba	Mt Darwin District Hospital	Senior Nursing Officer	0773 522 860/ 0276 3232	makambaforbest@gmail.com
31.	Jabulani Mhlanga	Bulawayo City Council	Senior Community services Assistant (Recreation)	09 411270	jbokamhlanga@gmail.com
32.	Dr. Nonhlanhla Zwangobani	ZNFPC	Director Technical Services	0716 377 550	nzwangobani@znfpc.org.zw
33.	Mr Joseph Mutemani	Bulawayo City	Acting Health Promotion Officer	0772 370 521	jmutemani@citybyo.co.zw
34.	Tarisai Katanda	ZNFPC -Dotito Youth Friendly Centre	Youth Health Advisor (Nurse)	0779 138 725	tarisaiKatanda@gmail.com
35.	Ms Sinatra Nyathi	National AIDS Council	Provincial AIDS Coordinator	0773 481 741/ 09 884077	snnyathi@nac.org.zw
36.	Miss Thandeka Sibanda	Phumelela Youth Centre	Peer Educator	0717 935 505	teejibsibbs@gmail.com
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38.	Mr Nemisio Shoniwa	ZNFPC	Provincial manager	0774 644 093	nshoniwa@znfpc.org.zw
39.	Mr Itai Mushambadzi	ZNFPC – Dotito Youth Centre	Peer Educator	0779 466 664/0736 043 302	itaimush@outlook.com
40.	Pastor Maxwell Jiri	Mt Darwin Youth Friendly Centre	Centre Chairperson	0773 304 549	maxwelljiri9@gmail.com
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42.	Mr Promise Nqwababa	Thabiso Youth Centre – Makokoba Bulawayo	Chairperson Parental Ass.	0774 402 022	N/A
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44.	Angeler Ngunete	Mt Darwin Youth Friendly Centre	RGN- Youth Health Advisor	0784 942 490/ 0772 684 701	N/A
45.	Mr Dumisani Dube	BCC – Mzilikazi Youth Centre	Recreation Leader	0772 322 543	dubed@citybyo.co.zw
46.	Mr Obey Mataba	ZNFPC – Dotito Youth Centre	Peer Educator	0777 961 029	obeymataba@gmail.com
47.	Mr Mhedziso Chitoro	ZNFPC- Dotito Youth Centre	Chairperson	0776 643 276	N/A
48.	Mr Walter Sihwa	Bulawayo City Council	Recreation Leader	0775 323 152	sajulie07@gmail.com
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B. Core planning group participants

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3.	Sandra Kokera	MOHCC	VMMC ASRH Linkages Officer	0772 307 473	sandrakokera@gmail.com
4.	Simbarashe Mabaya	WHO	NPO/HIV PREV	0772 739 479	mabavas@who.int
5.	Sifiso Dube	Social worker	Bulawayo City Council	0772 862 660/09 202444	sifdube@citybyo.co.zw sifisodubet@gmail.com
6.	Lawrance Nyazema	MOHCC-ATP	M & E Officer	0776 294 285	nyazemalarry@yahoo.com
7.	Mr Percival Kushure	ZNFPC	Provincial Marketing & Communications Officer	0772 627794	pkushure@znfpc.org.zw
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ANNEX 12.

Summary of Key Recommendations

Results from the qualitative study

Overall impressions of the project

1. Project has strengthened the ASRH project as a whole
2. Project has increased stakeholders interaction
3. More comprehensive and integrated in addressing the ASRH gaps that exist within the population
4. Quite useful in terms of its referrals component
5. Too much work load on peer educators

Successes	Challenges
Demand for ASRH and VMMC services created among young people	Project publicity not aggressive
Young people getting a lot of information on VMMC, ASRH and HIV at one go	Myths and misconceptions which hinder project implementation at community level especially uptake of VMMC
Sports galas are crowd pullers and youths easily get influenced when they see their peers getting involved	Slow service delivery on referred clients and a repeat on some processes conducted at youth centres at the hospital (referral site). Limited staff to attend to attend to young people needs and follow ups
Increased number of young people taking up VMMC	Transport challenges amongst youths to go and access services once they have decided to do so.
Improved stakeholder interaction-	Lack of funds to coordinate youth activities and acquire equipment for youth activities
Young people accessing services from trained professionals	
HIV testing and counselling on the increase amongst young people.	
Young people accessing services easily	
VMMC was a male dominated area. Incorporating the two enables women to talk about VMMC issues and ASRH issues and a whole lot of prevention strategies against HIV	

Service integration

Successes	Challenges
Young people taking up VMMC and other ASRH services at offer	Limited project staff on the ground-
Good coordination with other relevant stakeholders on ASRH and VMMC	Distances covered by young people to get to referred services
The referral system has been incorporated and accepted by the communities	Busy community and family schedules
Project has managed to penetrate the difficult populations like the church	Limited participation of other line ministries
Meaningful participation of parents, guardians and community leaders	Young people having to pay for services they have been referred for

Service outreaches

Successes	Challenges
Great support from stakeholders	Limited reach to young people in hard to reach areas
A greater reach to young people especially those in school	Project component started late in most areas
Key knowledge imparted to young people on ASRH and VMMC	Busy community schedules
Reaching out to influential community leaders, figures and parents	Young people's knowledge of services not being translated to uptake
Uptake of services offered during outreaches	

Community dialogues

Successes	Challenges
Adults and young people sharing a common understanding on VMMC and ASRH issues	Existing myths and misconceptions on VMMC
Young men opening up and able to influence each other towards service uptake	Late disbursement and funds
Bridging the VMMC and ASRH information gap that existed amongst young people	Non availability of service provisions on such days-
High turnout at community meetings/fora and services uptake	Postponed implementation of activities due to busy community schedules
Females enlightened on VMMC and its benefits extended to them as well	
Community requesting for dialogues after realization of their importance	
Misconceptions and myths on VMMC cleared	

Referral system

Successes	Challenges
Coordinated communication amongst stakeholders	Loss of follow ups on referrals
Confidentiality observed on referrals	Some service providers not well versed with system of referrals
Young people aided in accessing services	Young people having to pay for some referrals
Young people fulfilling referrals	Distances covered by young people to referral centres

ANNEX 13.

Revised Package of Services & Interventions

Options for integration/linkages		Packages of services and interventions			Comments
		MINIMAL	BASIC	EXPANDED	
		Information about ASRH and VMMC, and about the availability and location of ASRH and VMMC services	Minimal plus: IEC and counselling VMMC/ASRH; STI screening and treatment; condoms for HIV/ASRH; contraception; VMMC; HTS and linkage to treatment/care	Minimal and Basic plus: Sexuality; gender based violence and masculinity; life and livelihood information	
Integrated - multiple services in one clinic visit/ location	A. Provided by one service provider	Feasibility: High Requirement: Minimal training	Feasibility: Low/Medium Requirement: VMMC and ASRH training; clinical SRH skills; and sufficient time and equipment/resources	Feasibility: Low/Medium Requirement: Significant skills and training; sufficient time and multiple clinic visits.	The basic package has been offered within VMMC clinics where all VMMC nurses provide STI screening and treatment, HTS, Condoms and Linkage to ART. The package was not implemented in the ASRH setting because the facilities were not able to offer VMMC services because of lack of the necessary skills and absence of requisite infrastructure.
	B. Provided by multiple providers	As above	Feasibility: High/Medium Requirement: Collaboration between service providers; VMMC and ASRH training; clinical SRH skills and sufficient time and equipment/resources, mechanism for information sharing.	Feasibility: Medium/Low Requirement: Established collaborative partnerships with NGO's, youth organizations or outreach workers; sufficient time and space within facilities to provide multiple sessions for long term interventions.	This option was implemented only in VMMC facilities. In addition to providing VMMC services other SRH services such as STI treatment and condom provision were offered by the same or a different provider. ASRH facilities were not able to offer VMMC services because of lack of the necessary skills and absence of requisite infrastructure. During the Mapping exercise Mt Darwin Hospital was offering both ASRH and VMMC services however, the Youth Friendly Corner at the hospital was no longer functional at the time of project implementation.

Linked – multiple services in multiple locations and/or visits.	C. Referrals within one facility/ setting	Feasibility: High Requirement: Minimal training, established clear referral pathways	Feasibility: High/Medium Requirement: Collaboration between service providers; VMMC and ASRH training; clinical SRH skills; sufficient time and equipment/resources; established clear referral pathways.	Feasibility: Medium/High Requirement: Established collaborative partnerships with NGO's, youth organizations and outreach workers; clear referral pathways; sufficient time and space within facilities to provide multiple sessions for long term interventions.	This package was implemented. Feasibility however, depends on availability of resources for outreach services. This appeared to be the most feasible option which reduces the access barriers for youths.
	D. Referrals between multiple facilities/ settings	As above	Feasibility: High/Medium Requirement: Collaboration between service providers; VMMC and ASRH training; clinical SRH skills; sufficient time and equipment/resources; established clear referral pathways and linkage mechanisms (i.e buddy system)	Feasibility: Medium Requirement: Established collaborative partnerships with NGO's, youth organizations, and the educational sector; clear referral pathways and linkage mechanisms to provide multiple	This option was implemented however, youths at times could not access the services they were referred to because they did not have money for bus fares or user fees that were charged by some of the service providers.



ANNEX 14.

Messages and Messaging

Developed for VMMC and ASRH linkages.

19 December 2014

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Table of Contents

Acronyms and abbreviations.....	2
1. Introduction.....	3
2. Background.....	4
3. Summary: messages & messaging for adolescent boys and vmmc/asrh integration and linkages.....	4
4. Methodology.....	7
5. Key findings.....	8
6. Key themes from the message development workshops.....	12
7. Implications for messaging.....	13
8. Next steps for implementation.....	18
9. Conclusion.....	18
10. Annexes.....	19
Focus group discussion guide for mixed adolescents (iec material & messages).....	19
Focus group discussion guide for adolescent boys and girls.....	20
Vmmc/asrh messages and information analysis framework.....	21
Adaptation of materials and messages development tools.....	22
Adaptation of materials and messages development workshops.....	24
Service providers' workshop.....	25

Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescent Sexual and Reproductive Health
FGD	Focus Group Discussion
HIV	Human immunodeficiency virus
IEC	Information, Education and Communication
MC	Male Circumcision
MOHCC	Ministry of Health and Child Care
POSM	Programme Options and support Materials
PSI	Population Services International
SRH	Sexual and Reproductive Health
VMMC	Voluntary Medical Male Circumcision
YFC	Youth Friendly Centre/Corner
ZDHS	Zimbabwe Demographic Health Survey
ZNFPC	Zimbabwe National Family Planning Council

1. Introduction

Evidence from research and studies such as the Zimbabwe Demographic Health Survey (ZDHS 2010-2011) have indicated continued high rates of unprotected sex, unintended pregnancy and sexually transmitted infections among young people. For some time now, there has been a wide variety of programs that seek to reduce adolescent sexual risk-taking. One of the critical elements of these programs is the promotion of health seeking behaviors and demand generation. This has been achieved through the development of social and behavioral change communication products that share information that is relevant to the young people.

The advent of Voluntary Medical Male Circumcision (VMMC) as an additional HIV prevention strategy has meant renewed attention on messaging. Social and behavior change communication is a central component of any VMMC campaign. A successful VMMC program targeting adolescent boys requires policy makers and program implementers to frame their VMMC strategy on the beliefs, values, and needs of their target audiences. Reaching the expected ambitious targets for VMMC will depend on creating and maintaining persuasive and compelling demand creation activities and messages. This will be especially important for adolescent boys, to emphasise the benefits of VMMC, and also for adolescent girls and people who can influence them in their decisions about VMMC.

This report presents messages that were developed to fulfil key recommendations from a series of consultations with stakeholders in Zimbabwe on integrating ASRH and VMMC. The recommendations focus on messaging, specifically focusing on opportunities for strengthening and improving VMMC messages to make them more age and gender appropriate; addressing gender specific issues for adolescent boys; mainstreaming VMMC within ASRH information to broader community audiences; enhancing girls' and parents understanding of VMMC and associated protection; and helping health workers and others who work with adolescent boys provide them with accurate and consistent information.

2. Background

The Ministry of Health and Child Care (MoHCC) [AIDS and TB Unit and the Reproductive Health Unit], the Zimbabwe National Family Planning Council (ZNFP) with assistance from the World Health Organisation (WHO) is implementing a pilot project on VMMC and ASRH linkages. This project is informed by the potential for scale up and improved reach if VMMC interventions are well integrated and linked with existing ASRH interventions in the country.

Although VMMC has been mostly run as a vertical programme in Zimbabwe during the roll out phase, as a result of the need to rapidly increase the coverage of this important HIV prevention intervention, for sustainability and better results, VMMC needs to be linked and integrated with other services. Given the fact that adolescent boys account for the most number of those that have been circumcised to date (61% are adolescent boys aged 13-19 years – MoHCC 2013), it is important for VMMC and ASRH interventions targeting the same target group to mutually reinforce each other.

3. Summary: messages & messaging for adolescent boys and VMMC/ ASRH integration and linkages

3.1 VMMC and ASRH integration and linkages are important because the two interventions are complementary and mutually reinforcing. Strengthening VMMC and ASRH linkages is a gateway to developing equitable gender relationships between individuals. Having stronger linkages between VMMC and ASRH will ensure improved benefits from both programmes and better health outcomes for adolescent boys, through increased access to information, services and social and behavioural change interventions. These linkages will ultimately ensure that there is better use of available resources.

3.2 Messages and messaging should:

- Be appropriate for the target population;
- Provide information that increases knowledge amongst adolescent boys;
- Influence attitudes and behaviors; and
- Generate demand for services and influence health seeking behaviors.

¹Young people referring to adolescents (10-19 years), youth (15-24 years), young people (10-24 years)

3.3 The differences between adolescent boys and adult men that have implications for messages and messaging include:

- A low risk perception which makes HIV prevention a lesser motivating factor however, although they are less concerned about future problems, they have positive dreams for the future;
- Not all adolescent boys are having sex and if they are it is often not with a regular long-term partner;
- Hygiene is a key motivating factor (for both adolescent boys and girls), and as such hygiene should come first before discussion on sex and the HIV prevention benefits of VMMC;
- Adolescent boys have unique channels for accessing information – in particular peers, both boys and girls, so they need messages and stories from their peers. Adolescents are also increasing their use of interactive and social media to obtain information;
- They do not make the decision to get circumcised in “isolation” and as such there is need to reach the parents and other family members, including messages from mothers - women are not simply wives or partners, as is mostly presented in current campaigns;

3.4 Implications for messaging, content, channels and message linkages for adolescents boys

Emphasis for adolescent boys should be placed on how VMMC can help them to get the future that they want.

The use of the analogy of going to school to be ready for a good job can be used for VMMC, which makes one ready for a good relationship (a good boy-friend).

A key message for linkages can outline how VMMC is a first step towards taking responsibility for one's own health, including making good sexual and reproductive health choices.

3.5 Implications for messaging for adolescent girls, parents (specifically mothers)

For girls, messages should address why they should be interested about VMMC and why/how they could influence boys. The messages will focus on promoting personal hygiene amongst their future boy friends/husbands and their reduced risk to cervical cancer if their partners are circumcised.

Mothers and parents have an important influence on the decisions that adolescent boys make, and should therefore be specifically targeted with comprehensive information that helps them understand the benefits of circumcision and be in a position to discuss VMMC in an informed way with their sons (and daughters).

3.6 Implications for Health Workers

Messages targeting health workers should help them understand that integration/linkages are easy and achievable.

Focus for initial core messaging for health workers should be on the Minimal package/Basic package, which involves offering information on both VMMC and ASRH and offering referrals.

The essential materials to promote VMMC and ASRH linkages through health facilities include:

- Pamphlet for boys with core content on basic ASRH information and basic HIV/VMMC information and where one can go to access VMMC services.
- Pamphlet for parents with core content on the benefits of Voluntary Medical Male Circumcision and why as parents they should consider it for their sons.
- Poster for Health Worker with core content on why referring adolescents and how to refer (exploring opportunities for related services).

3.7 Next steps

- Branding of VMMC demand creation campaign for adolescent boys.
- Link with people/organisations already involved in VMMC and ASRH messaging especially those focusing on demand generation, to support them to begin to include messages for adolescent boys (and girls) as a specific target group.
- Print materials: do layout and pre-test the messages before printing of the messages. (Pamphlet for adolescent boys, pamphlet for parents and poster for health workers).
- Explore ways to use social networks and

interactive media more effectively, especially those that are already popular with young people.

4. Methodology

This document presents draft messages and considerations for messaging developed from information gathered through a desk review, mapping study, various FGDs and content development workshops. The specific objectives of the activities that were undertaken in developing this document were to:

- Identify possible messages for adaptation and development on SRH (including gender) and VMMC to be delivered to adolescents;
- Outline the channels/methods for delivering messages;
- Create materials to support service providers integrate/linked ASRH and VMMC services; and
- Develop materials to inform the community about the services (ASRH and VMMC) and issues surrounding these services.

Message mapping was done to gather existing information on both VMMC and ASRH in the 2 districts of Mt Darwin and Bulawayo that will be targeted in the pilot project. During the mapping study, four Focus Group Discussions (FGDs) were held to contribute to analysis of current messages and gaps. The FGDs were facilitated using the tools attached in annex. These FGDs included one with 10 parents and guardians whose inclusion criteria was having an adolescent boy at their home, two with both adolescent boys and girls in the age groups of 13-15 and 16-19, and another one with teachers (who were randomly sampled).

A desk review on available materials including the unmet information needs for adolescents, parents and providers was done to identify and articulate gaps, in order to inform potential modifications to support the explicit targeting of adolescent boys and strengthen the proposed linkages.

Two message development workshops were held with adolescent boys and girls and one with technical experts. In each district, 1 workshop was held engaging 5 boys and 5 girls aged

between 13 and 19 years as a mixed group. The 10 Adolescents were identified by ZNFPC from their peer educators, those still in school and some randomly sampled within the communities that they operate in. The workshops were designed to identify information needs, gaps, relevant appeals, ideal channels and formats of messages that would be effective for adolescents using discussion guides in annex.

To further consolidate on the information gathered, a message development workshop of technical experts was organised for 15 service providers from the two pilot districts and some that operate at national level. The service providers included nurses and youth officers from sites within the pilot districts, IEC officers from Populations Services International (PSI), the Zimbabwe National Family Planning Council (ZNFPC) and programme implementors from organisations such as SAYWHAT, Zimbabwe National Network of People Living with HIV and Africaid whose work involves working with young people.

The different approaches were finalised by a process of summarising and analysing key themes, gaps and opportunities for developing messages and messaging to strengthen the VMMC and ASRH linkages.

5. Key findings

This section outlines the findings of all the activities undertaken in establishing current messages and messaging on VMMC and ASRH as well the existing gaps and opportunities to strengthen the linkages of VMMC and ASRH.

The various activities noted the need for:

- Creation of more age specific messages on VMMC, given that current messages are generalised and are assumed to apply to everyone.
- There are limited messages on positive living for adolescents despite evidence of an increasing cohort of adolescents living with HIV and on treatment.
- Gender issues are not adequately addressed, they are only considered in terms of consequences such as unplanned pregnancies which have a more direct burden on females, whilst

in terms of VMMC it is the voice of older women that is mainly captured.

- Issues of assertiveness, alcohol abuse, negotiation and other ways that young people are abusing drugs and alcohol such as binge drinking, that have implications for ASRH and HIV prevention are not adequately explored in current messages.
- Messages and role models/champions that are used give the impression that VMMC is for older males not adolescent boys.
- The need to capture the voice of mothers and girls given their power to promote male circumcision. Such messages can include mothers encouraging their sons to go for VMMC.
- Information and knowledge should also be shared with families especially parents so that they provide further support especially on decision making, wound management and emphasising preventative behaviour.

5.1 Desk review and mapping of messages

During the mapping of messages, very few messages were identified in relation to VMMC and ASRH for adolescent boys. There are some messages that feature celebrities or VMMC champions encouraging the old and young to go and get circumcised, but none that specifically target the adolescents. More importantly there are few materials that carry the voices of adolescents themselves on the topic of VMMC. On ASRH the messages are generalised and speak on the negative consequences of alcohol abuse and wrong decision making. Most of the ASRH messages have a bias on targeting the female and less focus is put on their male counterparts. Besides mention of VMMC in the Adolescent Sexual and Reproductive Health Strategy and a few posters, there are no materials that have been specifically developed to link VMMC and ASRH.

On ASRH, the desk review identified that the messages are mainly in one format (print, mainly pamphlets and posters) and according to the literature review as well as the findings from the mapping study, these traditional formats may no longer appeal much to adolescents and so there is need to consider other formats such as social media and internet based platforms for reaching

adolescents.

There is little role modelling on good ASRH behaviour. Given that young people normally learn through positioning themselves against people that they admire, the failure of most of the IEC materials to utilize role modelling is a key gap. Although there are two posters on ASRH demand creation that were produced by the MOHCC and ZNFPC for service providers and adolescents, in the two pilot districts there were no materials designed to mobilise adolescents to make use of ASRH services. This limits the use of ASRH services to those adolescents who are already enduring the negative consequences of ASRH and seeking curative service.

On VMMC the “Be smart” media campaign was noted as being effective amongst adolescent boys. To address the predictive factor of social support, the program tailored messages for adolescents and young men by working with a local, popular artist who developed radio jingles and appeared on television, billboards and print materials promoting the hygiene aspect of VMMC. VMMC messages have also been customized for women by highlighting the importance of VMMC in reducing the risk of cervical cancer, improving men’s hygiene and enhancing men’s sexual appeal.

However, the desk review noted that current messages do not primarily focus on adolescent boys and girls. Although there are a few materials with images of adolescents, the messages do not specifically target this age group. Similarly, while some messages and material target women, none of the materials target the younger females, especially those that are not yet sexually active. Most messages about VMMC do not adequately cater for the worries of adolescents whose concerns are not primarily fear of HIV.

5.2 Summary of messages mapping FGDs with parents and guardians

As part of the messages mapping exercise in the two districts, focus group discussions were conducted with parents and guardians of adolescents. The following key issues emerged from the discussions:

- **Parents’ capacity:** Although most of the parents knew the health benefits of VMMC, they noted that some are not

comfortable because of culture and tradition as well as limited knowledge of the program as currently offered by government.

The overall recommendation focused on the need for specific materials, messages and interventions aimed at strengthening the capacity of parents. Strengthening capacities of parents will ensure they will be better able to actively mobilise adolescents to consider taking up VMMC.

- **Messaging on VMMC:** Parents and guardians further noted that messages should cover other aspects and move beyond the current focus on “HIV”. Qualitative insights showed that current messaging over-emphasizes protection against HIV and parents felt that accepting VMMC seem to suggest that they would have admitted that their children are vulnerable to HIV. There is still resistance, especially as parents do not want to accept their children are engaging in sex. The recommendation was that HIV prevention benefits therefore should be part of broader messages that promote VMMC as a decision for healthy living, which parents need to promote amongst their children. Additional recommendations focused on the need to ensure messages consider using local role models and local languages. Issues of pain and what happens to the foreskins after MC were cited as key concerns which need to be addressed through appropriate messaging efforts.
- **Messaging on ASRH:** Parents and guardians noted that although messages for adolescents should continue to emphasise delayed sexual debut, there should also be a dual focus on informing children about the negative consequence of early sex. Further suggestions were made towards prioritizing parent-child communication to counter potentially negative information from peers, the Internet and other unreliable sources.

5.3 Summary of messages mapping FGDs with adolescents

An FGD with adolescents in school aged 13 to 15 years was held, and the following are some

of their comments that relate to VMMC and ASRH messages and IEC materials:

- Adolescents felt that VMMC is better addressed through Interpersonal communications because it allows interaction and provides opportunities to ask questions and understand.

“Interpersonal communication is better than the IEC materials which sometimes is too brief and do not give comprehensive information and an opportunity to ask questions,” said one male adolescent during an FGD in Bulawayo.

In line with this, the adolescents suggested the need for strengthening parent to child communication. Parents were noted as key decision makers, especially given that for the young adolescents they are the one that will eventually give consent.

- They further outlined that more information is required on how the procedure is done.
- In answering to a question on whether they felt they are at risk of HIV during the FGDs, the younger adolescents said that they were not worried about HIV because they are not currently engaging in sexual activity.

Another FGD with **16 to 19 year old** adolescents was conducted along with another discussion with males who took up VMMC. The following are some of the key issues from the two discussions:

- There was an almost universal awareness of VMMC and its benefits (health, hygiene and benefits to female partners). Amongst those who were circumcised there was a general thinking that MC ensures that one has delayed ejaculation and this then is one of the driving motivations of some of the young men who shared that they would eventually want to satisfy their sexual partners when they start engaging in sexual relationships.
- The main sources of information noted included ZNFPC, peers, posters, community mobilization as well as school

outreach. However, some of them solely focus on adolescents who are in the secondary school going age groups. This leaves out the primary school going age.

- Key motivating factors for VMMC uptake included role modelling (wanting to emulate the champions), health benefits, peer influence, as well as encouragement from sexual partners who note the benefit of reduced risk from cervical cancer.
- Further, the discussion noted that current messaging in the electronic media and IEC materials should be complemented with strong Interpersonal Communications that goes door-to-door mobilisation. Mobilisers were encouraged to be well informed so that they broaden their role to include provision of information transcending HIV.
- The FGD also established that in current messages the older women are left out, despite the fact that they are very critical as the mothers of adolescents.

5.4 Stakeholder Inputs

Stakeholders shared various suggestions on messaging for adolescents and emphasised the need to ensure that social media and the internet should be used effectively so as to provide accurate and comprehensive information to counter myths and misconceptions that could be propagated by some uninformed sources. Other suggestions for the long term include the development of audio-visual materials which have been noted as having a huge appeal among adolescent boys. Parent-to-child communication was also emphasised, although caution was made on the need to empower the parents so that they can provide accurate information to the adolescent boys. Stakeholders, also, noted that there is an opportunity for utilising existing resources to develop messages that highlight linkages, as long as there are clear guidelines.

6. Key Themes from the Message development workshops

In all the activities that were done to develop

messages and capture key issues on messages some key themes emerged and they are summarised in this section.

Low risk perceptions - One of the most important key themes to pay attention to in developing messages for adolescents is their low risk perception to HIV. This low risk perception should mean that messages should focus on other concerns for adolescents such as being more desirable boyfriends and better husbands in the future. The low risk perception will therefore require messages to continue emphasising consistent and correct use of condoms for those that get circumcised.

Not yet having sex - the fact that most adolescents are not yet having sex is critical in crafting messages on VMMC, as it demands that attention be put on how the adolescents can benefit from VMMC in the future as well as the present looking at benefits such as hygiene.

“The mobilisers are so desperate to look for the one with the foreskin, forgetting the one whose decision can either influence uptake or hinder it” Female FGD participant

Influence of peers - The theme of peer influence is important in messaging as well as channel selection. It is important to consider the voices and images of adolescents speaking on VMMC as a way of influencing their counterparts to consider the same. This influence also extends to female counterparts.

Influence of mothers and involvement of parents - The influence of mothers on the decision that their sons make is an important theme. The influence of mothers can be used as an important mobilising tool as well as an important factor to address the fear that is associated with VMMC. Mothers are known for caring for the health and welfare of the family and their endorsement of VMMC will have much influence among adolescents as well as other mothers and general members of the community.

“You can convince me to get circumcised but if you don’t convince my mother then you will not get me circumcised” said one male adolescent during a discussion in Bulawayo.

6.1 Channels for messages

The various activities engaged in developing this document indicate that channel selection

is as important as the message itself. For the purposes of the pilot phase prioritisation had to be done to identify critical channels that will make the most impact.

For mothers, adolescent girls and the family, a pamphlet was suggested given the fact that they need something that can provide detailed information and that can influence discussion.

“I need something I can take home for my parents and the family to read and understand before I introduce the topic of VMMC which is new to some of them”

lamented one male adolescent in a discussion on what forms of material do they consider important in the promotion of VMMC.

For the adolescent boys, a leaflet with quick facts about VMMC was suggested as important. This should be something that they can share with peers and influence them to consider VMMC. The same will also emphasise some general information on ASRH and VMMC. Social media is another important low cost but high impact channel that was suggested to promote the VMMC and ASRH linkages project.

For health workers, a poster (detailed in the table on content, target and channels) that will be in the waiting room was identified as essential to remind both the service providers and the clients seeking services on the minimum package and the importance of making referrals. Another option will be to include a poster with tick boxes that will act as a checklist of the essential elements that the service providers need to consider for establishing VMMC and ASRH linkages (the Minimum package).

The current “Be Smart” multi-media campaign that engages celebrities as champions for male circumcision was noted as effective and something that should continue. Some however felt that these could become more appealing if adolescents are also featured under the same campaign, both adolescent celebrities or simply adolescents who have been circumcised.

7. Implications for messaging

In light of all the information gathered through the various activities the following are the key implications for messages, messaging and channel selections:

7.1 For Adolescent boys:

Messaging for adolescent boys should consider age appropriateness and ensure that other non-health related benefits are mentioned before the health benefits. The materials should also feature the voice of the adolescent boys especially sharing their experience of getting circumcised. Having pictures of the adolescent themselves is more appealing, and this should be considered in current posters of celebrities who can be featured with adolescent boys.

The key thread that should be maintained in messages for adolescents is how VMMC will be a key decision for a better future. It has been noted that adolescents are concerned about their future, but not necessarily about diseases that they might get in the future. This might entail the use of the analogy of going to school to be ready for a good job and in the case of VMMC: it makes one ready for a good relationship. “Helping you get the future that you want” can be a key message for adolescent boys. Key Message for linkages with ASRH can be on how VMMC becomes a first step towards taking responsibility for your health, including reproductive health.

7.1 For adolescent girls:

Adolescent girls can be used to positively influence their male counterparts to consider getting circumcised. The primary focus for messages targeting girls should address why they should be interested about VMMC and why they should influence the boys. The messages will focus on promoting personal hygiene amongst their future boyfriends/husbands and the reduced risk to cervical cancer for women who eventually marry circumcised partners.

7.3 For parents (especially mothers):

Mothers and parents are critical in decision making of the adolescent and should be specifically targeted with comprehensive information that makes them understand the benefits of circumcision and why they should consider it for their sons. Messages should present women as mothers, who have been noted to have considerable influence on the decision that is taken by their sons. Such messages should also explore how mothers of circumcised adolescents can share experiences to dispel the worries of other mothers and assure adolescent boys that the procedure is safe with manageable pain.

7.4 For Health Workers

Messages targeting health workers should help them understand that linkages are relatively easy and achievable, and can be done well with current resources and capacity, especially as this relates to offering the Minimal package.

Messages should also focus on the benefits of linkages and making referrals to services they cannot offer.

The table below summarises the critical target groups, content and channels for the pilot phase of the VMMC and ASRH linkages project.

Target	Content	Channels
Boys	<ul style="list-style-type: none"> ▪ Basic ASRH information ▪ What is VMMC ▪ Benefits of VMMC ▪ VMMC and ASRH linkages 	Leaflet/Pamphlet
	<p>To develop a “Smart Guys” facebook page that will share information on:</p> <ul style="list-style-type: none"> ▪ General information on ASRH ▪ What VMMC is ▪ Benefits of VMMC ▪ Different materials on VMMC ▪ Testimonies and Pictures of circumcised adolescents ▪ Pictures of celebrities and VMMC champions including some with circumcised adolescents ▪ Post discussion topics on key questions and worries of adolescents on VMMC ▪ Share information on where one can get circumcised ▪ Updates of VMMC campaigns ▪ Share information on the VMMC and ASRH minimum package ▪ Share the benefits of linking VMMC and ASRH ▪ Share updates on the VMMC and ASRH linkages initiatives in the pilot sites (including number of those accessing services, case stories, service providers testimonies etc) <p>*This page can have dual administration of Ministry of Health, ZNFPC, PSI and allows young people to join in. The page can also be shared and linked with organisational facebook pages for those already working in young people and VMMC and ASRH.</p>	Social Media

	<p>“Securing your Future through”/ “Smart Menu For a Healthy Lifestyle”</p> <ul style="list-style-type: none"> • Abstaining • Using a condom • Getting Tested For HIV and • Getting Circumcised (and still using a condom) <p>*Sharing VMMC Campaigns via text messages</p>	<p>Short Text Messages & Twitter</p>
<p>Family and girls</p>	<p>What is your role on the general Health of young people and their sexual and reproductive health?</p> <ul style="list-style-type: none"> • Adolescents are the future of tomorrow and as such healthy adolescents are a prerequisite for a better future. • Adolescence is the period between the ages 10 – 19 years. It is a period of rapid growth and development as well as increased risk-taking. It is a key period in the life of a person, where they develop potential and start making contribution at the same time. It is also the same time were life-long health related behaviors are initiated. • Evidence is showing that some young people are having sex whilst they do not have knowledge of negative consequences related to sexual contact in general and early sexual activity in particular; • As parents and the family you have influence and young people need your guidance on how to make good health choices including delaying sex, getting circumcised, having safe sex; • Your role is not to judge young people but to provide them with enough information to allow them to make informed choices; • If you do not have accurate information or your cultural context does not promote discussions with young people about sex, refer them where they can get correct information. <ul style="list-style-type: none"> ▪ Basic information on VMMC ▪ What are the benefits of VMMC (including those for women) ▪ How safe is VMMC ▪ Why they should consider it for their sons ▪ Where can one get circumcised 	<p>Leaflet/Pamphlet</p>

	<p>The “Smart Guys” Facebook page will also be open for adolescent girls given their influence to the decisions that their male counterparts take. They will also have access to post pictures and updates on how they are mobilising for VMMC.</p>	<p>Social media (for girls)</p>
	<p>“Your brother or boyfriend is more hygienic if he considers to get circumcised”</p> <ul style="list-style-type: none"> ▪ Basic information on ASRH and VMMC ▪ There are future benefits for girls to consider marrying a circumcised partner! ▪ Girls play an important role in convincing their male friends, boyfriends and future husbands to go for VMMC. ▪ If your future husband is circumcised husband, he will have a lower risk of contracting HIV and thereby increasing possibilities of a healthy family; ▪ Circumcision reduces the risk of cancer of the opening of the womb if one marries a partner who is circumcised; ▪ Circumcision facilitates access to HIV testing, counseling and general health seeking behaviors so boys who go for circumcision are concerned about their health and their future. 	<p>Pamphlet</p>
<p>Service Providers</p>	<p>“This is why I did it...This is how I did it...This is what I told the adolescent...This is what I told the parents...”</p> <p>I provided information on both VMMC and ASRH to ensure adolescents get maximum benefits for their health</p> <p>I provided basic information on ASRH and VMMC and made referrals for services I could not offer</p> <p>I told the Adolescent to consider VMMC for a healthy future and a happy marriage</p> <p>I told the parents to consider VMMC for their adolescent sons and ensure they continue talking about hygiene and responsible behaviour after circumcision</p>	<p>Poster</p>
	<ul style="list-style-type: none"> • Gave him basic information on ASRH • Gave him basic information on VMMC • Told him where to get ASRH and VMMC services, • Gave him a pamphlet to share with friends, • Gave him a pamphlet to share with parents 	<p>Tick Box</p>

Minimum package Materials for service providers

Provision of **information** on:

ASRH and VMMC, and about the availability and location of ASRH and VMMC services

- ASRH
 - Male and female anatomy
 - Puberty
 - Genital health and hygiene
 - HIV/STI risk
 - Condom use including female condoms
 - Signs and symptoms of STI's
 - HTC
 - Available types of contraception including emergency contraception

- VMMC
 - Basic of the procedure – method, time, healing, follow up required
 - Benefits including safety and efficacy
 - Consent requirements

- Availability of other services (time, location, how to make appointments) including:
 - Condoms
 - HTC
 - VMMC
 - Contraception including emergency contraception
 - STI testing and treatment
 - HIV treatment and care
 - Psychosocial support

Provide leaflet and encourage decision with family and peers.

8. Next steps for implementation

It is important to note that for these suggestions of content and channels to be implemented the following additional steps will need to be taken into consideration.

- I. Consideration should be made on whether there is need for branding the VMMC and ASRH demand generation campaign for adolescents boys to ensure that specific focus is placed on this age group.
- II. Working with people and organisations already involved in VMMC and ASRH messaging, especially those focusing on demand generation, is essential, as this will ensure the project immediately benefits already on going interventions. Such collaboration will also promote messages on VMMC/ASRH linkages and suggestions on how best integration and linkages can be adopted and adapted by the implementing organisations.

- III. The printing of materials is urgent for the pilot phase and this will include processes

of layout and pre-testing. The key materials that should be printed will include the pamphlet for adolescent boys, pamphlet for parents and poster for health workers. These materials should also be subjected to review to further inform other messages would this project be scaled up.

- IV. There is need to explore social networks and interactive media especially those that are already popular with young people. This will include linking with organisations targeting youth through bulk messages and social media to explore opportunities for collaboration. Suggestions of creating a standalone Facebook page can also be considered for the campaign, but this might require dedicated human resource to manage the account and collect the relevant information to make it feasible.

9. Conclusion

Based on the various activities that were

undertaken, this report has presented some messages and considerations for messaging that can be adapted and created for the VMMC and ASRH integration/linkages project. The next steps will be essential in ensuring that the envisioned messages are developed and utilized within the pilot phase in the two districts. The messages are as important as the protocols and menu of options that have been developed separately to guide the implementation of the VMMC and ASRH pilot project.

possible linkages between VMMC and ASRH. The project's thrust is to improve and maintain the uptake and quality of both voluntary medical male circumcision (VMMC) and Adolescent Sexual and Reproductive Health (ASRH) services delivered to adolescents (10-19).

As part of this mapping study we are kindly requesting you to participate in this FGD so that you provide us with information that will aid in the implementation of this project.

Our discussion will be completely confidential. Your name will not be written anywhere, and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer. However, free, frank and open discussions will help us better understand issues related to VMMC and ASRH. We would greatly appreciate your participation. The discussion will take about 45 minutes.

10. Annexes

Focus Group Discussion Guide For Mixed Adolescents (IEC Material & Messages)

The Ministry of Health and Child Care (MoHCC) with support from the World Health Organisation (WHO) is conducting a mapping study to review the available VMMC & SRH services (Information, Skills building & Health services) so as to inform

Number of Discussion.....

Participants.....MALES.....FEMALES.....

District:Name of facility:

Facilitator.....

Note taker.....

1. What are your general thoughts of these materials? (each material will be displaced one after the other)
2. Which one do you find attractive and why?
3. Which one do you find easy to understand? (Probe why)
4. Which one gives you information that you really need?
5. Which material will make you take action after reading?
6. Do you consider any of these materials to be gender sensitive and if so which ones?
7. What do you think should be done to enhance the effectiveness of these materials?
8. What other messages and materials would you want on this subject?

Focus Group Discussion Guide for Adolescent Boys and Girls

Information on VMMC

- What do you know about VMMC?
- Where do young men get information on VMMC?
- What do you think motivates adolescents to get circumcised?
- What is your perception of VMMC?

Use of SRH services

- What SRH services do you and other adolescents your age use in your community? Probe: do you get SRH services from your school
- Where do you usually receive SRH information or services? Probe: condom, gender messages,
- Did you find it easy to access the services? What was it like to access the services?
- Have there been situations that some young people have failed to access the services? What might stop other young people from using the health facility?

More services- Linkages

- Where will you like to receive additional services?
- How might SRH information and other services at the health facility be made easily accessible?
- What is your view on combining ASRH services and VMMC services?
- What should be done to make it easy for young people to get both ASRH and VMMC services?

Messages and Materials

- What do you think of the current materials and messages currently used for VMMC and SRH information? Probe: Which one do you find attractive and why? Which one do you find easy to understand?
- How do you think VMMC affects relationships between boys and girls?
- What type of messages do you want on VMMC and ASRH and how do you want them delivered?
- Where will you like to receive these messages?
- Who do you want providing this information?
- What do you think should be done to improve these materials?
- What other messages and materials would you want on this subject?

VMMC/ASRH Messages and Information Analysis Framework

Focus	Key Question	Checklist
Existing Message Inventory	<ul style="list-style-type: none"> ▪ What IEC and SBCC materials are currently available at the facility? ▪ What type of materials? ▪ What issues are the materials covering? ▪ What topics/key Issues are being addressed? 	<ul style="list-style-type: none"> ▪ Pamphlets, posters, audio-visual materials, IPC sessions or educational curriculum ▪ VMMC/ASRH or both ▪ Services, efficacy of VMCC, aspects/elements of ASRH, prevention and management, BC
Appropriateness of Messages	<ul style="list-style-type: none"> ▪ Who is the target audience (Primary and Secondary)? ▪ What types of materials exist and in what format are they? (These can be assessed against) ▪ Length of IPC sessions if any? ▪ What is the number of interactions per each client? ▪ How is the information delivered or packaged? ▪ What are the Methods of learning? 	<ul style="list-style-type: none"> ▪ Age, gender, in school/out of school, rural/urban, literacy levels ▪ Young people, parents, SPs, Community ▪ Youth friendliness ▪ Thrust/Tone (informative, educative, mobilization or behavioural change Awareness, addressing Attitude, providing referrals) ▪ Participatory, Instructive or educative

Consistency of messaging	<ul style="list-style-type: none"> ▪ Who provides information? ▪ What are the competencies needed to provide this information? ▪ When is information provided in the client flow? ▪ Is there a curriculum or standard content manual? ▪ How are gender issues addressed? ▪ Are there information and knowledge provision protocols/guidelines? 	<ul style="list-style-type: none"> ▪ Trained service providers or peer educators ▪ Trainings on key messages ▪ Availability and utilization of communication strategies or any other standardization tools ▪ Utilised opportunities in client flow and opportunities
Message effectiveness?	<ul style="list-style-type: none"> ▪ How are the materials developed? ▪ Do the materials cater for different settings? ▪ What language is used in the materials? ▪ Has there been an evaluation of materials? 	<ul style="list-style-type: none"> ▪ Participation of service providers and the target ▪ Prior research for message development ▪ Rural/urban, in and out of school youth, different levels of literacy, youth with disability ▪ Are local and indigenous languages used ▪ Evaluation reports

Adaptation of Materials and Messages Development Tools

Tool 1: Designing messages and developing Materials worksheet

Primary/Secondary Audience

1. Audience Analysis

What are your needs and priorities?
What do you care deeply about or fear?
What is your knowledge level (on VMMC/ASRH) and what do you know? (Is there a starting fact that might cause you to rethink your position or to move to Action?)

2. Message Development

My Audience is (sex, age, health status)

They will (do, complete, learn) the following (a clear call to action)

For this they will receive (a definable benefit or solution for performing that action/whether relating to material gain, emotional reward or value or fulfilment.

Tool 2: Day in the Life

Target Group:		
Time of day	Location & Activities	Communications opportunity
Early Morning		
Mid Morning		
Midday		
Early Afternoon		
Late Afternoon		
Early Evening		
Dinner		
Late Evening		
Social Events		
Seasonal Opportunities (holidays etc)		

Adaptation of Materials and Messages Development Workshops

Adolescents Workshop Program Bulawayo and Mt Darwin Districts

Time	Topic/session	Description
830-845	Introductions and Welcome	
845-900	Sharing objective of workshop and the linkages project	
900-930	Presentation on mapping and desk review	ASRH, VMMC and Linkages Messages and Information Needs
930-1000	Plenary discussion	Establishing further messages and information needs
1000-1030	Health break	
1030-1130	Group work (using template one)	Categorising information needs by age, gender, settings (clinic, community, schools)
1130-1230	Group work: Selection of key audiences	Defining and describing target audiences
1230-1300	Group work: Audience profiling (a life in the day of tool)	Using the identified age groups and gender issues this session will result in the development of key audience profiles
1300-1400	LUNCH BREAK	
1400-1500	Plenary Discussion: Channel selection	Identifying material types and formats to address information needs for audiences profiles.
1500-1515	Presentation: How to develop effective messages	To provide basic information that guides the adolescents in creating effective messages
1515-1415	Group work: Key Message development (per audience segment)	To develop messages that answer the following questions: -What messages can appeal to adolescents (motivations) What are the key barriers that messages need to address
1415-1430	Way forward and closure	

Service Providers' workshop

Time	Topic/Session	Description
830-900	Registration	
	Welcome and Introductions	
900-915	Objectives and background of workshop	
915-1000	Presentation of Profile Briefs	Based on the adolescents workshops
1000-1030	HEALTH BREAK	
1030-1130	Presentation of proposed key messages and channel mix	Based on the adolescents workshops
1130-1200	Plenary discussion	Comments on the profile briefs, key messages and channel mix
1200-1300	Group work: Identifying further messages to strengthen linkages	This will include review of the adolescents submissions but will mainly focus on the service provider's perspective
1300-1400	LUNCH BREAK	
1400-1500	Plenary Discussion	How to leverage existing communication resources?
1500-1515	TEA BREAK	
1515-1600	Adaptation of Current Messages and Materials for service providers	<ul style="list-style-type: none"> -Identifying material or templates for adoption -Deciding on the changes to be made -Creating briefs for suggested materials
1600-1630	Plenary Discussion	When and how to collaborate with Civil Society Organisations



Sustaining
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March 2016 – March 2017