UNAIDS Guidance Note on Developing a Communication Strategy for Male Circumcision

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1 Background

Since early 2007, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have recommended that countries with high prevalence of human immunodeficiency virus (HIV) and low prevalence of male circumcision should "scale up" male circumcision as part of a comprehensive package for HIV prevention. To this end, a number of eastern and southern countries in Africa have begun to develop policies, strategies and implementation plans.[1]

In the course of this work, a number of countries have begun to recognize the need for normative guidance and technical guidelines on how to develop, implement and evaluate communication programming, so that the scale-up of male circumcision is supported. Clearly, there is a need for comprehensive communication programming to support the expanded provision of services.

Some governments already have national policies and strategies for male circumcision; a few countries have already developed communication strategies. This document draws on the lessons and experiences of developing these communication strategies, and on expertise and guidance from a range of health communication experts.

2 Purpose

2.1 Why communication about male circumcision is important

Accurate and appropriate information about male circumcision can address misconceptions and myths about the procedure. Misinformation and strong opinions about male circumcision can have an effect on whether national scale-up efforts are effective and whether there is an increased demand for services.

These challenges should be acknowledged and addressed in scale-up plans. Particularly in the early stages, the development of national guidance documents and plans are needed to provide a framework in which countries can develop their communication strategies and messages.

2.2 Who this document is for and how to use it

The aim of this document is to provide strategic guidance on developing communication strategies on voluntary male circumcision for HIV prevention. It outlines the practical steps to develop a comprehensive evidence-informed communication programme that can be used by anyone. For policy and decision makers in government, civil society and international collaborating partners, it provides an overview of general issues related to male circumcision, and some specific communication issues.

For communication practitioners, this document outlines the steps to be followed in developing a strategy and gives an overview of the required activities at each step. A

more detailed document, *Communications toolkit for male circumcision*, accompanies this document, and describes the strategy-development process in more detail with supporting examples and illustrations.

This is not just a document about creating demand for male circumcision. A number of social and behavioural outcomes are required before male circumcision for HIV prevention can make a difference, and men seeking circumcision services are just one of these. It is also important that men protect themselves and their partners from HIV, both before and after circumcision; undertake an HIV test before male circumcision; and pay proper attention to the different aspects of safe healing. A comprehensive communication strategy needs to include all these elements and more.

3 Overview of male circumcision for HIV prevention

3.1 Scientific evidence

Male circumcision is the removal of the male foreskin. It is a common surgical procedure that has been done for thousands of years.[2] Male circumcision may be undertaken for traditional, religious, social and health-related reasons. In certain communities, the practice has cultural significance associated with a rite of passage, marking the transition from boyhood to manhood. In other settings, being circumcised or uncircumcised is an important symbol of identity and belonging to a community.

Observational studies since the mid-1980s in different countries and regions around the world have reported a relationship between high levels of male circumcision and low prevalence of HIV. It was not until 2005–2006 that three large-scale randomized controlled trials conducted in Orange Farm (South Africa), Kisumu (Kenya) and Rakai District (Uganda) demonstrated a clear protective effect of circumcision on heterosexual males. These trials made it possible to separate the effects of male circumcision from other factors that might explain the lower HIV incidence or prevalence rates, such as differences in sexual behaviour, number of partners or religious practices. The results of these trials showed that following circumcision, the rate of new HIV infections was reduced by up to 60%.

A plausible biological explanation for the higher levels of HIV infection seen in men who are not circumcised is that the inner mucosal surface of the foreskin is fragile and is susceptible to minor trauma and sores, which facilitate entry of pathogens (germs), including HIV. Also, the area under the foreskin is a warm, moist environment that may enable germs to multiply, especially when hygiene of the penis is poor. This can make uncircumcised men more vulnerable to some sexually transmitted infections, which, in turn, make them more vulnerable to HIV. Furthermore, some cells under the foreskin are susceptible to HIV infection. These cells (Langerhans cells) are removed or made less accessible through circumcision, thus reducing vulnerability to HIV.

With the new evidence of the impact of male circumcision on HIV prevalence, increasing numbers of boys and men around the world may undergo circumcision for its health

benefits. There is a low chance of complications when male circumcision is performed under aseptic conditions by properly trained staff. However, when circumcision is done within a traditional setting by non-clinically trained practitioners, there is limited information about the safety of the procedure. It can be assumed that full circumcision when performed by traditional providers is equally effective in reducing the risk of HIV infection in men.

For communicators, it is important to note that the health benefits of male circumcision relate not only to HIV, and apply to men and women, as set out in the male circumcision information pack.[3]

3.2 Cost effectiveness

Research indicates that circumcision is a highly cost-effective way to prevent HIV infection in areas with high HIV prevalence.[4] For maximum population-level benefit and cost effectiveness, male circumcision needs to be scaled up rapidly. It is projected that many more lives will be saved if large numbers of men are circumcised within the short term than if the same numbers of men are circumcised over a longer time period. Thus, communication strategies need to respond to this issue and include effective advocacy components.

3.3 Male sexual and reproductive health

The expansion of male circumcision services provides an opportunity to strengthen and expand all HIV prevention and sexual health programmes for men. It also provides a means to reach a population that is not normally reached by existing services. Male circumcision service provision should be used as an opportunity to address the sexual health needs of men, and such services should actively counsel and promote safer and more responsible sexual behaviour.

3.4 Women and male circumcision

There are no known direct benefits of male circumcision for women; however, data suggest that there are important indirect health benefits for women. For example, indirect benefits may result for women as a consequence of men receiving more HIV-related messages and services. Additionally, circumcised men are less likely to be infected with penile human papillomavirus, including the virus types most likely to cause cancer in men and women.

As with all HIV-prevention interventions, there is concern that circumcised men will be more likely to forgo other risk-reduction strategies (e.g. correct and consistent use of condoms) or engage in risky sex (e.g. have multiple partners). Furthermore, the perceptions and attitudes of both women and men towards risk and protective behaviours could conceivably shift, leading to reduced use of condoms. Limited evidence indicates that this has not occurred among participants in clinical trials. However, service delivery programmes have less intensive counselling and follow-up than clinical trials. There may

be very different effects on men's and women's behaviour now that male circumcision is known to reduce the risk of HIV infection in men.

Efforts are needed to ensure that a scale-up of male circumcision does not lead to any additional vulnerability in women. In some countries, the message that male circumcision is very different from female genital mutilation also needs to be emphasized. Female genital mutilation has serious adverse effects on the health of women and on obstetric outcomes and, unlike male circumcision, has no demonstrated medical benefits.

3.5 Traditional male circumcision

Traditional male circumcision is conducted for rites of passage, religious rites, health and hygiene, and other social and cultural reasons. In a number of cultural groups, traditional male circumcision is a small incision on the foreskin or the partial removal of the foreskin. These procedures do not provide the required protection from HIV infection. Clinical circumcision is the complete removal of the male foreskin by trained staff under aseptic conditions.[5]

In countries where there are groups that traditionally circumcise, there are often cultural institutions associated with the procedure. In these settings, clinical male circumcision should be promoted with sensitivity and respect for traditional concepts of health, illness and masculine identity. Due to these and many other social factors relating to male circumcision, most national communication on the topic has tended simply to highlight the recent clinical data, relying heavily on scientific explanations of the protective benefit of male circumcision, and avoiding any association between cultural identity and male circumcision.

3.6 Men who have sex with men

There are currently no clinical trial data that show that male circumcision provides protection from HIV during anal intercourse.

4 Overall approach

Once countries have developed their male circumcision goals and objectives, the task for male circumcision communication programming is to determine the role of communication and to develop a communication programme to support the national strategy. To this end, a number of specific communication outcomes (which are more specific than national male circumcision objectives) should be developed. The sections below outline how to plan communication activities to achieve these outcomes.

4.1 Situation analysis

A situation analysis is recommended, by WHO and UNAIDS, before male circumcision scale-up, to determine:

- the current status and scale of male circumcision in the country
- whether male circumcision is practised, capacity to perform safe male circumcision in various clinical settings and capacity gaps
- the willingness of populations to support and come forward for male circumcision
- whether and how male circumcision can be scaled up.

The *Male circumcision situation analysis toolkit*[6] sets out a thorough situation analysis process, ranging from guided desk reviews and stakeholder meetings, to in-depth interviews and focus groups with various audience members.

Although a situation analysis is not a substitute for audience research and analysis for communication planning, it can be a good first step, particularly if it includes key informant interviews or focus groups. If these are to be included in the situation analysis, communication planners must be involved, so they can influence the design of the audience research and the questions to be asked. In this way, later audience research can build on the outcomes of the situation analysis.

4.2 A conceptual framework for communication about male circumcision

Annex 1 is a conceptual framework for communication about male circumcision. It shows how communication programming can tackle issues around male circumcision and sexual risk in various contexts – in sociopolitical domains, health care settings, and at the level of the community and the individual.

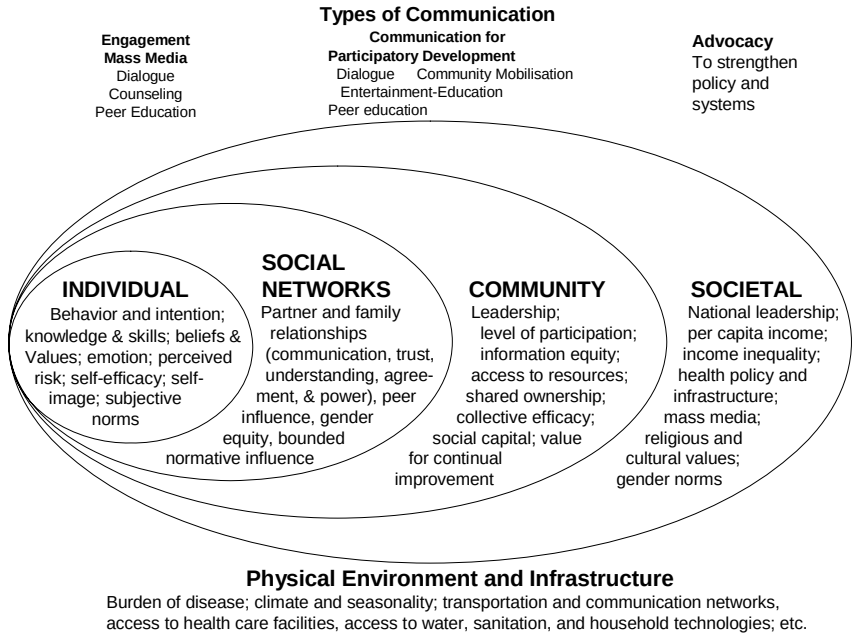
This conceptual framework can be used throughout communication planning and is intended to provide a holistic approach to social communication around male circumcision. It is based on the integration of existing frameworks adopted by UNAIDS and WHO, and takes into account the different channels and modes of communication in operation at each of these levels, and the kinds of objectives appropriate to each. The outcomes associated with those objectives are listed in Annex 1, provide a useful level of specificity and a concrete sense of what needs to be achieved for the process of effective communication.

4.3 Social ecology model of communication and behaviour

The strategic guidance outlined here is based on a framework that identifies causal pathways to health behaviour outcomes, using an ecological approach. This framework places male circumcision within a broad social and biomedical context, and helps show how interventions support change at the sociopolitical, health-care sector, community and

individual levels (Figure 4.1). The ecological approach shows that individuals need community support, effective health-care delivery systems and enlightened health policy, to make good individual health decisions.

Figure 4.1 Social ecology model of communication and behaviour



Source: Johns HopkinsBloomberg School of Public Health Center for Communication Programs

The ecological model reinforces the male circumcision communication framework provided in Annex 1. It recognizes that individual change is linked to change in other domains. All four domains need to be recognized when male circumcision communication strategies are planned:

1. The sociopolitical domain (policies and policy makers, information gatekeepers, such as the media)

2. The health-care setting domain (health-care systems and workers)

3. The community domain (formal leaders, informal opinion leaders, social diffusion, local media)

4. The individual domain (individuals who choose male circumcision; friends, family and social networks that influence them directly)

4.4 Key messages

Messages should be developed for broad use with key audiences. The following key messages may be considered for local adaptation:

- **Male circumcision works** – evidence clearly shows that male circumcision reduces the risk of HIV infection, and has additional sexual and reproductive health benefits for both men and women.
- **Male circumcision cannot replace other HIV prevention methods** – whether men are circumcised or not, limiting the number of sexual partners and using condoms consistently and correctly will ensure maximum protection from HIV infection.
- **Healing period** – newly circumcised men and boys should abstain from sex until their penis is fully healed – usually after about six weeks – as they could be at increased risk of infection during this time.
- **Safety** – it is recommended that circumcision takes place in certified health facilities; however, whether the procedure takes place in a clinical setting or in a cultural, traditional or religious context, it is vital to ensure and demand safety.
- **Informed choice** – all possible information should be made available so that men, boys and parents can make informed decisions about male circumcision.

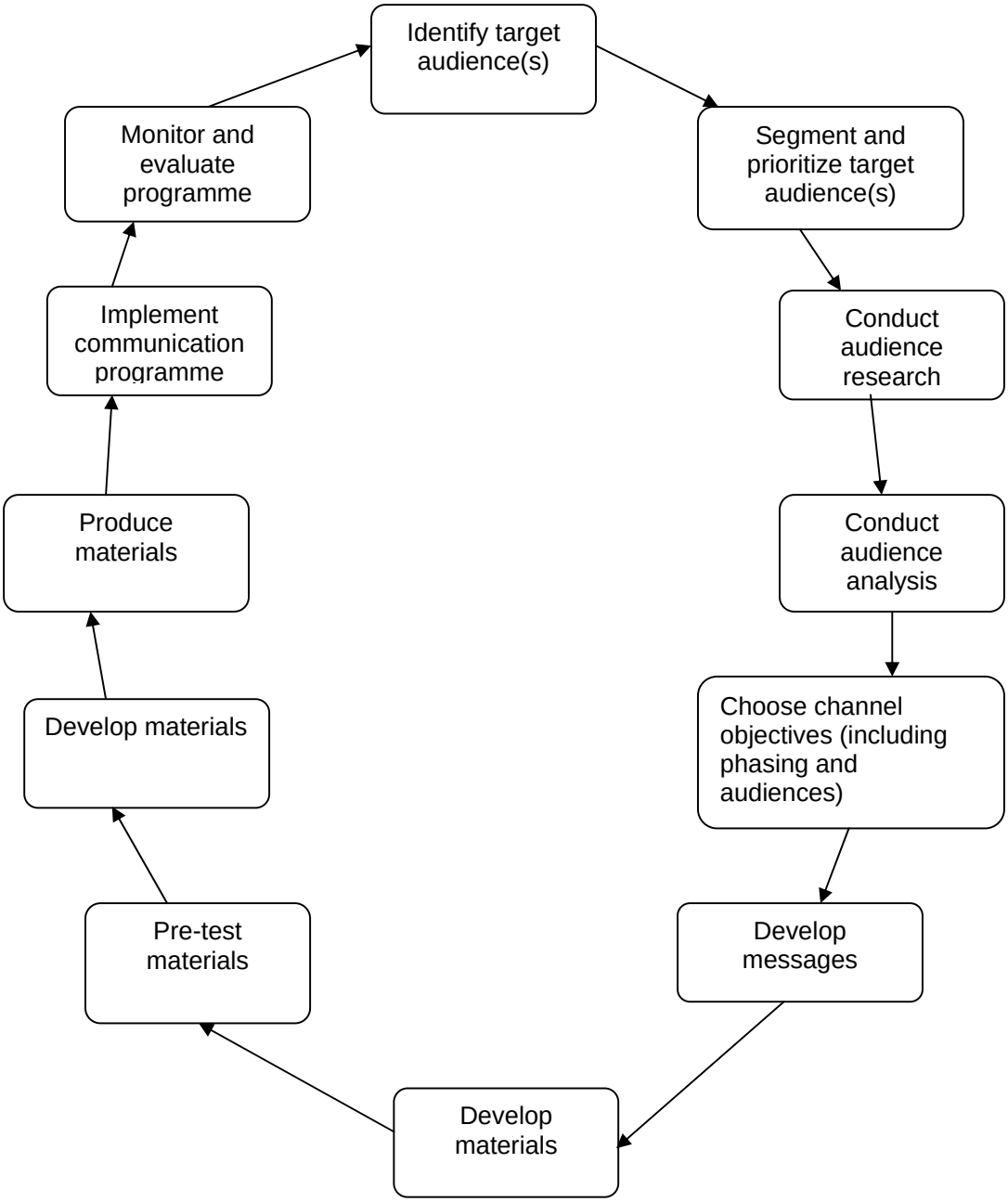
Programme managers should be prepared to correct misinformation that may arise during scale-up. Messages must be clear. Mangers should plan to address possible "danger areas" as they arise. In addition to local level communication challenges, three areas of concern have already emerged within the male circumcision discourse:

- **Male circumcision and female genital mutilation/cutting** – distinguish clearly between male circumcision and female genital mutilation/cutting, which must be discouraged as a harmful practice with no health benefits.
- **Risk compensation** – some men may not have internalised the message that circumcision offers only partial protection against HIV; as a consequence, they could relax their attitude towards safer sex out of the misinformed belief that limiting partner numbers and consistent condom use are no longer required.
- **Circumcision and HIV-positive men** – there is currently no evidence that circumcising HIV-positive men will reduce the likelihood of HIV being transmitted to their sexual partners; a circumcised man who becomes HIV positive is just as likely to transmit HIV as an uncircumcised male with the virus.

4.5 Steps in a strategic communications programme

Once the situation analysis is complete, there are 11 essential steps to developing effective communications for any audience (Figure 4.2). These are described briefly below and in depth in the *Communications toolkit for male circumcision*.

Figure 4.2 Cycle of a planning communications programme



Step 1 Identify the target audience(s)

Task for the communication planner

Select the audiences to be targeted by the communication, to ensure that the male circumcision objective is achieved.

In communicating for change, the target audience is identified by asking who needs to change to achieve the programme objectives. In the case of male circumcision, the development of a communication plan starts with identifying the audiences with knowledge, attitudes or behaviour that needs to change in order for the male circumcision programme to be successful. These audiences may come from any or all of the four domains: sociopolitical, health-care setting, community or individual.

Although the discussion here emphasizes programming communication to meet the needs of individuals, this is not intended to suggest that the individual domain is more important, or that communication does not need to be developed for the sociopolitical, health-care setting or community domains. All four domains are important and need communication interventions.

Step 2 Segment and prioritize the target audience(s)

Task for the communication planner

Divide the audiences into appropriate groups for the most effective communication.

Once the most important target audiences have been chosen, they may need to be segmented (or subdivided) into specific target audiences, for purposes of communication. There is no definitive rule about how to segment an audience. The basis for segmentation is simply to group people according to certain criteria (e.g. age), so that each audience is exposed to the communication most appropriate for them.

Step 3 Design and conduct audience research

Tasks for the communication planner

Make a research plan and conduct research to find out what information is essential for communication on male circumcision for each audience segment.

Once an audience has been chosen and segmented appropriately, it is time to learn the essential facts about each audience segment so that effective communication about male circumcision can be developed for each one. This type of research is called “formative research” because it is used to form or shape an intervention or communication campaign. Much information may already have been gathered on the different target audiences during the situation analysis.

Step 4 Conduct an audience analysis

Task for the communication planner

Interpret the information gathered during audience research so it can be used to shape communication with each audience segment.

The audience research should provide the most essential information to inform the development of a communication campaign. This should include how each audience segment is positioned with regard to the male circumcision objective and the change goal it implies for them (i.e. the preferred change in behaviour or attitude).

Research into the diffusion of new behaviours in a community has identified the process that communities and individuals go through in adopting a new behaviour (Table 4.1). Diffusion researchers have named these steps:

- awareness
- knowledge
- persuasion (or attitude formation)
- decision to try
- trial (or implementation)
- confirmation.

For a discussion on this research see *Diffusion of innovations*.[7] Note that this is a general process of change, not the well-known stages of change model proposed by Prochaska, which is oriented to how individuals change addictive behaviours.[8]

Table 4.1 Diffusion of innovation

Diffusion of innovation	Awareness	Knowledge	Persuasion or attitude formation	Decision to try	Trial (or implementation)	Confirmation
Male circumcision (Population Services International model)	Awareness of male circumcision	Knowledge of benefits of male circumcision	Counselling/persuasion		Procedure	Adherence (to safer sexual procedures)
Stages of change	Pre contemplation	Contemplation	Preparation	Action	Maintenance	Relapse?

To understand what communication is required, it is essential to identify where a given target audience fits in with regard to this change process. Gathering this information through audience research is relatively simple. Once this is done, barriers to change – and subsequently, communication needs – become clear.

Analyses must include barriers to change and communication needs, motivation to change, positive deviance and preferred communication channels.

Step 5 Develop communication objectives

Task for the communication planner

Define the expected outcome in detail and the desired effect of the communication on audience members.

Communication objectives are not the same as the male circumcision programme objective or the behaviour change goal. Rather, they reflect the audience analysis and inform how communication activities will affect the target audience – how it might help them overcome their present barriers to change so that they can progress through the innovation-decision process towards the change goal. Communication objectives may also address myths and rumors, so that expectations for male circumcision are realistic.

Communication objectives should be written in this specific manner for two important reasons. First, this will focus the efforts of communication planners on the needs of each target audience, so that they will develop effective messages and materials.

Second, communication objectives provide an accurate milestone for measuring communication effectiveness. Too often, communication campaigns are judged by big behaviour change goals and are found lacking, while the real – but often small and subtle – changes they bring about are overlooked. Communication is a gradual process; small changes in audiences' knowledge, attitudes and decisions to try a new behaviour are worth noting. These small changes could mean a fundamental shift in behaviour change and social norms regarding male circumcision. Small changes are important to build on as an male circumcision campaign evolves.

Step 6 Choose channel objectives

Task for the communication planner

Select a communication channel that matches the target audience's needs and preferences.

The choice of communication channels should be made carefully, based on the audience analysis. Several factors need to be considered:

- the audience's stated preferences
- the realistic possibilities of the communication environment (e.g. the available media, staff availability and budget)
- where the target audience is situated in the innovation-decision process.

Research shows that different communication channels can be more or less effective for different age groups and for audiences at different stages of the innovation-decision process.

Mass media formats include television and radio, such as talk shows or "magazine" shows, or integration into existing drama series, spot advertisements; print formats, such as newspaper news or feature articles; and display formats, such as billboards, advertisements on transport routes or posters.

Targeted media is media for limited distribution to a certain group. These include mobile video, audio recordings, posters, brochures and messages on apparel (hats, T-shirts), or key chains and other practical objects.

Interpersonal communication formats are many and varied, including door-to-door outreach, facilitated discussions in various settings, community forums, counselling, peer communication, theatre events, information booths at fairs and community events of various types.

Mass and targeted media can also be used to target individuals, but peer communication is of primary importance in this domain.

Step 7 Develop messages

Task for the communication planner

Determine key message content required for the target audience and tailor it to their needs and interests.

Messages should be developed for an audience based on an analysis of its place in the innovation-decision process – in this case, in terms of the male circumcision change goal. Barriers to change and motivating factors have the potential to attract them to take part. Messages need to be developed for a specific audience. It is usually not enough to copy messages from a successful campaign run elsewhere; instead; new messages should be crafted to fit the audience and pre-tested with that audience to assess effectiveness (see Step 8).

Messages have two aspects:

- The key message is the message content an audience needs to hear. Key messages convey factual content and essential attitudes, and the content does not change.
- Literal messages are the specific words and images that convey the key message most effectively to the target audience.

Developing effective messages about male circumcision that will appeal to a specific target audience depends on good qualitative audience research and skillful analysis. Sometimes, messages come directly from audience research as ideas, images or phrases, especially if interviews are recorded and then transcribed. This can capture a great deal of information and facilitate the use of procedures to analyze the content as a whole.

Step 8 Pre-test materials with the target audience

Task for the communication planner

Find out how the target audience responds to the messages or materials, and revise them accordingly.

Pre-testing with the target audience is essential for good communication. A pre-test may take place after message development, to test message content or tone, or later, after materials are designed, to test their reception. Pre-testing it may take place several times, depending on the type of message and scale and cost of the materials to be developed.

When materials are relatively simple and cheap to develop (e.g. posters and brochures), a pre-test may be conducted at a late stage because changes can be made without excessive cost. For high-cost media, such as video, pre-tests should be conducted early, because changes at a later stage of development are expensive to make.

While materials may be submitted first to expert review (with technical specialists) or to gatekeeper review (with government or other authorities responsible for the campaign), neither of these is a substitute for pre-testing with the audience segment for whom the materials have been designed and with whom they will ultimately be used.

Pre-tests can be done relatively easily with focus groups. Although it is also possible to do a quantitative pre-test, qualitative pre-tests typically offer better insights. Male circumcision may be a sensitive topic; however, pre-tests are typically not sensitive. Most people enjoy the opportunity to express an opinion on messages and materials and are not shy to do so. It may also be useful to pre-test with different audiences based on their status within the innovation-decision process – people still thinking about undergoing the procedure will provide a different point of view from those who have already been circumcised and are already clear about the benefits and issues.

Step 9 Develop materials

Task for the communication planner

Organize the production of all needed materials according to the communication plan.

Whether the pre-test is conducted on messages or on draft materials, the pretest feedback should be taken into account when materials are developed and revised.

Step 10 Implement the communication programme

Task for the communication planner

Put together an action plan to get the right messages to the right target audiences at the right time.

In considering an overall plan for communication about male circumcision, planners may want to consider a phased approach.

If a country has not yet scaled up the provision of male circumcision services, but wants to avoid creating unmanageable demand, a phased approach to communication may be appropriate. A phased approach allows a country to develop a strategy for managing communication around male circumcision before scaling up services, and also to be prepared when there is wide distribution of services. This is essential preparation, because it can reassure those responsible for shaping national health services that sufficient planning is in place.

For a phased approach, communication channels are selected to ensure that specific audiences receive the required information according to a planned timeline. It is important to clearly identify the communication objectives for each phase of programming (Table 4.2), and to choose the most appropriate channel.

Table 4.2 A simplified illustration of objectives within a phased approach

Before scale-up	During scale-up	Scale-up in place
Population is aware of the benefits and limitations of male circumcision	Demand is created within a few geographically bounded areas	National-level demand is created
Health-care workers are educated about male circumcision	Health-care workers are supported in providing male circumcision	Health-care workers know where to access information about male circumcision
Policy-makers are informed and supportive of male circumcision	Policy-makers are supported in shaping male circumcision services	Policy-makers are equipped to guide ongoing services

There is no single model for designing a phased approach to communication about male circumcision. Often, the model will be determined by the timelines and outcome targets of policy and strategy, where these exist, and by the actual delivery of services.

Step 11 Plan for monitoring and evaluation

Task for the communication planner

Ensure that the action plan includes ample opportunities for audience feedback, and for monitoring and evaluation of the communication programme.

To ensure that an intervention is on track, communication planners should build into the plan opportunities for audience feedback, and monitoring and evaluation activities. Analysis of monitoring and evaluation can enable a communications plan to evolve and change over time, based on the real requirements of the target audience and the national programme.

Monitoring enables communication programme managers to track the implementation of communication interventions and to assess progress. The types of indicators include:

- **Process indicators –** these track progress of the implementation of a communication programme (e.g. quarterly reports and milestones reached).
- **Output indicators** – these may include the number of materials produced; people trained; or newspaper, radio or television programmes that address the issue of male circumcision.
- **Outcome indicators** – these measure the number of people reached through the communication intervention and overall targets achieved (e.g. number of procedures undertaken).

Evaluation seeks to understand the impact of the various communication interventions and of the programme as a whole. A thorough evaluation of a communication programme about male circumcision may include surveys that explore knowledge of male circumcision intervention, the efficacy of the media used and the audience's interpretation of the messages.

Monitoring and evaluation should be tracked over time, together with epidemiological data (such as incidence and prevalence) before the intervention and then after the intervention to assess overall impact.

A further possibility for monitoring and evaluation is an overall impact evaluation for the programme. Although this is not strictly a communications evaluation, the phasing of communications and the demand that is generated may need to be re-examined based on whether impact is to be measured. In addition, communications planners may need to review plans that are in place for process and cost effectiveness evaluations – these will have an impact upon communications.

Readers may refer to the *Communication toolkit for male circumcision* for more detailed information on each of these steps.

5 Principles of quality communication about male circumcision

The rationale for the rapid scale-up of male circumcision for HIV prevention is powerful. Funds are increasingly available to those working on male circumcision programmes, particularly when they can show sound progress in relation to the central indicator: numbers of men being circumcised. However, the full impact of such programmes will not be realized unless there is appropriate attention to other outcomes; for example, HIV preventative behaviours that protect the circumcised and also their sexual partners, and a range of behaviours in relation to the healing process once the procedure is performed.

The following guidelines will be helpful in ensuring that all preferred outcomes are achieved within a communication framework for male circumcision:

- Communication programming around male circumcision should fit with, and be directed by, national HIV-prevention strategies that are overseen by national governments.
- Communication should tackle individual behaviours and factors at the level of society that are driving the behaviour, as best practice in social and behavioural change communication make clear (e.g. *UNAIDS technical update on social change communication, 2009*).[9]
- Knowledge, attitudes and practices around male circumcision should be studied, to provide baseline information that can be used to guide programming and, subsequently, to assess changes as communication about male circumcision proceeds.
- Mass media messages on male circumcision should complement community outreach, peer education and other mobilization and interpersonal communication methods. The mass media can be used to sensitize, and raise interest in male circumcision, but other methods will be needed to ensure that a full understanding of the benefits and limitations of male circumcision are widespread and accepted within local communities.
- Appropriate messaging should accompany the delivery of all services. Particular emphasis should be placed on linking male circumcision to broader prevention messaging including an emphasis on gender issues.
- A clear effort should be made to identify and address the most appropriate audiences for communication about male circumcision, including primary and secondary audiences (i.e. not just clients of services, but also health-care workers and local government officials).
- In all communication programming, there should be a link between demand-creation activities and the availability of male circumcision services supply. Demand should not be created where there is no supply; however, general information on male circumcision for HIV prevention can be distributed widely, as long as overtly promotional elements take into account local supply levels.
- The communication plan for each of the partners implementing the programme should include appropriate channel selection. Channels should be chosen for specific audience characteristics and preferred outcomes.
- Communication for social and behavioural change is more effective through multiple channels, and this is the best option for communication about male circumcision. This may involve organizations partnering with existing local communication agencies, where viable.
- Communication about male circumcision should be developed with adequate pre-testing, undertaken by an external and independent agency.
- Monitoring and evaluation of communications activities around male circumcision needs to take place on an annual basis at least, by an independent agency (that is not contracted by the service provider or by the partner developing the communications material). Monitoring and evaluation activities will draw on the baseline knowledge, attitude and practices studies.

WHO, UNAIDS and partners will provide technical assistance to help achieve these outcomes.

6 Implementation

6.1 Integration

We need to continue the global focus on, and advocacy for, HIV prevention to foster a political environment in which the scale-up of male circumcision and other prevention strategies can take place.

Some of the audiences identified within the strategic communication process may be "audiences for advocacy" and have a great impact on the success of scaling up male circumcision as part of an HIV prevention approach:

- political decision-makers – heads of state, ministers of health, technical experts in relevant ministries, national AIDS councils
- medical practitioners – nurses and doctors
- social and traditional decision-makers – traditional and community leaders, and traditional healers in both circumcising and non-circumcising communities; social activists; civil society organisations
- spiritual decision makers – heads of major faith-based organizations at global, regional, national and community levels
- organizations and sectors with a high proportion of men – police, prisons, armed forces
- organizations and sectors with a high proportion of women – nursing, teaching and child-care professionals
- social leaders – news media, celebrities (e.g. musicians, sports players)
- opponents of male circumcision.

6.2 Intensity

Much of the evidence for the preventative impact of male circumcision is based on three randomized controlled trials in South Africa, Kenya and Uganda. These trials not only showed that male circumcision gives effective partial protection from HIV to men, but also that the communication programming (particularly client counselling, community outreach and active follow-up of clients) during the trials produced a number of positive behavioural outcomes. Notably, the trials showed that trial participants did not adopt risky behaviours once they were circumcised, and men also adopted healthy behaviour in relation to the healing period.

Key elements for success in these trials seemed to be intensive counselling for participants, active follow-up within the communities (e.g. if a participant did not return for a check-up) and strong community mobilization efforts.

Analysis of the randomized controlled trials provides a glimpse of the communication programming associated with certain behavioural outcomes. The trial in Kenya used the following sequence of communications, and similar approaches were used in South Africa and Uganda:

1. The client receives a visit from a community mobilization officer and is engaged in one-to-one or group interaction.
2. At this point, the client receives a brochure outlining the benefits of male circumcision.
3. The client comes to the clinic and engages with any information, education and communication materials displayed there.
4. The client is given counselling, lasting around 40 minutes, on male circumcision and HIV prevention.
5. The client is offered an HIV test. If the client accepts the offer, he is given a further 20 minutes of pre-test counselling.
6. The client receives the results and is given post-test counselling.
7. Within the clinic, local anesthetic is used, and commonly the client is engaged in conversation about HIV prevention during the surgery.
8. The client is given basic printed information to help him understand the male circumcision procedure and the healing process.
9. After day three, the client returns to the clinic. If he does not show up, he is actively followed up by community outreach workers. His healing is checked and he is given more one-to-one interaction with a healthcare worker.
10. After day eight, the client again returns to the clinic (and if he does not come he is followed up). Again the client receives one-to-one interaction on healing and HIV prevention with a health-care worker.
11. After six months, the client returns for an HIV test. He receives pre and post-test counselling with all the normal HIV-prevention messages.
12. After another six months, the client returns for another HIV test, again with counselling and HIV-prevention messaging.
13. Every six months until the end of the study, the client returns for an HIV test. For each test, he receives the full one-to-one HIV testing and counselling with all the associated information about HIV risk and prevention.
14. Throughout this process, the client may be engaged by researchers with surveys and other parts of the study, which further reinforces sexual health messages. As this trial was geographically focused, the client is surrounded by other community members who may be reinforcing the sexual health messages received through the process.

Clearly, a randomized controlled trial demands many resources. Such trials present a proactive HIV-prevention approach that traces participants within their communities if they do not turn up for counselling or clinical appointments. This leads to an intensity and scope of communication programming far in excess of that received by most communities in Africa, where most sexual health information comes from the mass media and occasional outreach programmes. This illustrates a number of points:

- Within a randomized controlled trial, participants are advised that it is not known whether circumcision protects them from HIV infection. However, after the trial results and during programme scale up, it is known that circumcision protects. So risk compensation is a real issue and the experience from the RCTs (which demonstrated that risk compensation did not occur), while reassuring, cannot predict what will happen in the general population.
- The same kind of impact on behavioural outcomes that is seen in the context of a randomized controlled trial requires scaled-up communication programming. Scaling up the clinical elements of male circumcision without scaling up communication elements may have unpredictable consequences.
- Male circumcision needs to be integrated within existing national HIV-prevention strategies to ensure that issues, such as multiple and concurrent partnerships, condom use and sexual health, can be covered at an appropriate frequency and intensity by mass media and outreach programmes.
- Scaled-up communication programming has the advantage of economy of scale. The mass media can be used (it was not used during the randomized controlled trials), and synergies between mass media and community mobilization work can be maximized.
- The best evidence about appropriate channels and frequency of programming must be used in each setting. It is crucial to follow established communication principles to achieve good results – use multiple channels simultaneously, carefully segment audiences (e.g. by age), pre-test media, and target social and behavioural factors underlying risk and vulnerability.
- HIV counselling and testing is a crucial component of scaling up male circumcision services. HIV testing provides opportunities for additional one-to-one client interactions, together with all the other benefits for the client in finding out his status. For communicators, promoting voluntary counselling and testing is integral to the promotion of male circumcision.

Randomized controlled trials are rich in one-to-one interactions between clients and health-care workers – a particularly effective, but also costly, communication intervention. The simulation of large numbers of health-care interactions may be possible using group interventions (e.g. counsellors visiting community meetings periodically).

6.3 Coordination

As with the development and implementation of any strategy, coordination of various partners and stakeholders is important in the communication of male circumcision. The coordination will need to be at various levels – national, regional and site levels – and involve clear linkages between the national policy and strategic plan on communications for male circumcision and HIV prevention as a whole.

Coordination of communications would generally rest on a male circumcision task force, or similar body.

6.4 Collaboration

Effective communication is most often a collaborative venture. Key expertise can be harnessed when designing, implementing and evaluating a communication programme, either as suppliers or partners. These may include:

- HIV prevention and reproductive health experts
- nongovernment organizations and community-based organizations
- traditional community units or tribal leaders
- international partners and donors
- private sector organizations
- faith-based organizations
- social scientists
- medical organizations and associations
- strategic communication practitioners, including
    - script writers
    - designers
    - advertising and public relations experts
    - journalist groups.

6.5 Continuity

Continuity of messaging is important in communication about male circumcision – there can be no 'launch and leave' approach. Following on from the decision-making process or stages of change approach, the target audience needs to be communicated with at each of the different stages of their male circumcision experience; from pre-contemplation through to the maintenance of safer sexual behaviours. Continuity need not be the premise of just the male circumcision communications team, but can be achieved through integration with other male health programmes and national HIV-prevention programmes.

6.6 Costing

Costing of the development and implementation of a communications strategy should be included as part of the costing of the implementation plan for the scale-up of male circumcision services. Communication needs to begin at a very early stage in the scale-up.

The current global economic crisis presents both opportunities and challenges for effective HIV-prevention communication. The global economic crisis naturally has

required reprioritization of the allocation of resources for work on HIV, from the perspectives of donors and implementing organisations. Preventing new HIV infections is the most cost-effective intervention, since it ultimately results in significantly lower total costs for care, treatment and support for people living with HIV.[10]

7 Conclusion

It is clear that male circumcision is an important and effective intervention to be considered and included within broader HIV-prevention strategies.

Communication and advocacy that is strategic and well coordinated can effectively support increased uptake of male circumcision in eastern and southern Africa as part of the region's broader HIV-prevention strategies.

Decisions on whether to be circumcised or not occur within a complex social and political context, and may be influenced by numerous interacting factors, including the attitudes of men, their sexual partners and the cultural and religious context. Political concerns, particularly around resource mobilization and allocation, also influence the chances of accelerated scale-up. Advocacy should be a key component of broader communication strategies.

For circumcision to be considered as a viable and sustainable option for communities tasked with reducing rates of HIV transmission, there is a need to ensure that men and women, communities, and policy and decision-makers all have the opportunity to participate in developing supportive communication interventions.

Annex 1 Conceptual framework for communication about male circumcision

Underlying conditions	Domains of communication	Objective	Outcome	Goal
Societal level (these are the broad societal-level factors that determine male circumcision outcomes)	Societal level (these are the areas of communication associated with each of these broad societal-level factors)	Societal level (these are the objectives that can be realized in each of these areas of communication)	Societal level (these are the outcomes that relate to these objectives)	(these are the overall goals met by these objectives)
Government policy Socioeconomic status Culture Gender relations	Media communication environment Civil society communication environment Policy environment	Enhance media coverage of male circumcision Enhance civil society engagement with male circumcision issues Enhance the political engagement on male circumcision Enhance political support for male circumcision Ensure male circumcision is firmly integrated into other prevention, health and social interventions	Media: positive media coverage of male circumcision Media: integration of male circumcision into national 'storylines' Media: national dialogue and debate around male circumcision Civil society: each constituency is engaged with male circumcision Civil society: networks support male circumcision Programme managers develop/ improve/ adopt male circumcision policies and strategies Programme managers implement male circumcision programming Male circumcision integrated into other prevention, health and social interventions.	Reduction in HIV infections among males and females Reductions in other sexually transmitted infections for men and cervical cancer for women Increased number of safe male circumcisions Increased number of people who know their HIV status More men accessing the health services Increased number of individuals who are aware of partial protection of male circumcision
Health-care setting (these are the factors within the health-care setting that affect male circumcision outcomes)	Health-care setting (these are the areas of communication associated with each of these factors within the health-care setting)	Health-care setting (these are objectives for each of these areas of communication relating to the health-care setting)	Health-care setting (these are the outcomes that relate to these objectives within the health-care setting)	
Provision and distribution of male circumcision services Quality of male circumcision services Accessibility of male	Communication between health-care workers Communication between health-care workers and patients	Improve skills and knowledge of service providers Improve motivation of service providers Improve counselling and	Health-care workers have the required knowledge and skills for male circumcision Health-care workers accept the partial protective status of male circumcision	

circumcision services		clinician–client interaction Develop effective clinic-based information, education and communication materials (leaflets, posters) for clients and partners	Health-care workers are motivated to provide scaled-up delivery of quality services Clients of clinical facilities have good understanding of male circumcision issues Clients have appropriate information during health-care worker visits	
Community level (these are the factors within the community level that affect male circumcision outcomes)	Community level (these are the areas of communication associated with each of these factors within the community setting)	Community level (these are objectives for each of these areas of communication at the community level)	Community level (these are the outcomes that relate to these objectives at the community level)	
Community attitudes and norms Traditional health practices Traditional rites of passage Acceptability of male circumcision services	Public meetings Festivals, burials and other public events Community media Social, political, labour-based, business and faith-based networks Traditional health-care interactions	Build social cohesion around male circumcision Foster public engagement and positive attitudes towards male circumcision Support community leadership around male circumcision Ensure peer networks and sexual partners of male circumcision clients informed of male circumcision benefits and limitations Improve male circumcision outcomes in relation to traditional health care	Communities support and promote male circumcision Increased community discussion on male circumcision Increased acceptance of male circumcision for HIV prevention	
Individual level (these are the factors that influence male circumcision outcomes for an individual)	Individual level (these are the areas of communication that relate to each of these factors)	Individual level (these are objectives for each of these areas of communication at the individual level)	Individual level (these are the outcomes that relate to these objectives at the individual level)	
Individual knowledge, behaviours, self-efficacy	Peer education Interpersonal communication Media messaging Participating in interactive media	To improve knowledge on male circumcision To increase uptake of services To encourage safe healing To decrease vulnerability and risk after male circumcision	Increased uptake in male circumcision services Increased tested for HIV before male circumcision Reduced risky behaviour after male circumcision	

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