Male Circumcision & HIV PREVENTION in Eastern & Southern Africa

Communications Guidance

Acknowledgements

This document has been developed over several months and is now being made available for local adaptation and use.

Appreciation is extended to the staff of CADRE and Constella Futures Group for invaluable inputs and suggestions.

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

JOHNS HOPKINS
Health and Education in South Africa

unicef

UNFPA

World Health Organization

Contents

Introduction

Male circumcision is an important intervention that is increasingly being incorporated into national HIV prevention programmes – especially in settings where HIV prevalence is high and the prevalence of circumcision is low. Effective communications is a vital component of any scale-up strategy.

This document offers guidance to programme managers and policy-makers on how to plan and manage communications to support the scale-up of male circumcision in Eastern and Southern Africa.

A number of key issues require strong communications support to ensure clarity about the relationship between male circumcision and HIV prevention.

Misinformation about male circumcision and strong opinions, both for and against the procedure, present challenges that should be acknowledged and addressed in scale-up plans. In this context it is vital that the following points are clearly emphasized:

• Male circumcision reduces the risk of HIV infection for men but only provides partial protection. It is not a substitute for other proven HIV prevention methods.

• Men should not resume sexual intercourse for at least six weeks after circumcision to ensure the healing process is complete. Ideally sex should only recommence after a medical assessment confirms the healing process is complete.

• All males, whether circumcised or not, should seek to reduce the risk of HIV transmission through using condoms correctly and consistently and limiting their number of sexual partners.

• Whether circumcision takes place in a clinical or a traditional setting it is important to ensure safety.

• Information on HIV risk reduction and other benefits for male sexual and reproductive health need to be widely available to ensure individuals make informed choices about male circumcision.

• It is important to clearly distinguish between male circumcision and female genital mutilation/cutting which must be discouraged as a harmful practice with demonstrated adverse health effects and no health benefits.

• Male circumcision is not recommended for men who are already infected with HIV. For HIV positive men there is no demonstrated public health benefit for reduced HIV transmission to their partners and men with severe immunodeficiency are at an increased risk of complications following surgery.

What is male circumcision?

Male circumcision is the removal of the foreskin. The foreskin is the fold of skin that covers the head of the penis. It is often performed within two weeks of birth or during adolescence. In many places it has an important symbolic, cultural and religious meaning. For example, in certain communities of Eastern and Southern Africa young men are circumcised in their early to late teens as a rite of passage that marks their transition from 'boyhood' to 'manhood'. Circumcision may also be performed for medical or health reasons when there are problems involving the foreskin.

The case for scaling up

Sub-Saharan Africa remains the epicentre of the global AIDS epidemic with an estimated 22.5 million people living with HIV at the end of 2007. HIV prevention remains a major challenge. Scientific studies have shown that circumcised men are less likely to have HIV infection than uncircumcised men. Three randomised controlled trials in South Africa, Uganda and Kenya, between 2002 and 2006, demonstrated that male circumcision reduces the risk of HIV acquisition in men by about 60%. The evidence that male circumcision reduces the risk of HIV infection is compelling.

The prevalence of circumcised men varies greatly, from as low as 15% in parts of Southern Africa, to more than 70% in parts of Eastern Africa.

Male circumcision offers additional protection from HIV because it reduces the possibility of tear and injury to the penis during sex and removes cells that are vulnerable to HIV infection. A circumcised penis also dries more quickly after sex. This may reduce the life-span of any HIV present after sex. Male circumcision reduces the risk of ulcerative sexually transmitted infections, such as syphilis, and reduces the risk of penile cancer. It has also been shown to reduce the risk of cervical cancer in women.

The circumcision of adolescents and young adults provides an important opportunity for health care practitioners to discuss broader HIV prevention and sexual health issues including: the promotion of correct and consistent condom use; reducing the number of sexual partners; HIV testing and counselling; prompt treatment for sexually transmitted infections; and, respect for women's sexual and reproductive health needs and concerns.

In addition to saving lives there are strong economic arguments for scaling-up. Investing in male circumcision as part of a comprehensive HIV prevention package could save on future treatment costs. In Zambia it has been estimated that US $96.8 million is needed to scale-up male circumcision over eight years. By comparison the treatment costs for those who would go on to be infected without this added level of protection is estimated at US $161.7 million.[1]

UNAIDS and WHO recommend that countries with hyper-endemic HIV epidemics, where prevalence exceeds 15% in the general population, and generalized HIV epidemics consider scaling up access to male circumcision services.

As with any surgical procedure there are risks associated with male circumcision. Complications are rare, usually minor and quickly resolved when circumcision is performed by trained and well-equipped providers under aseptic conditions.

However more serious complications have been reported when male circumcision is performed by unqualified practitioners without the appropriate equipment or hygienic conditions. Ensuring the safety of male circumcision services is critical to successful scale up.

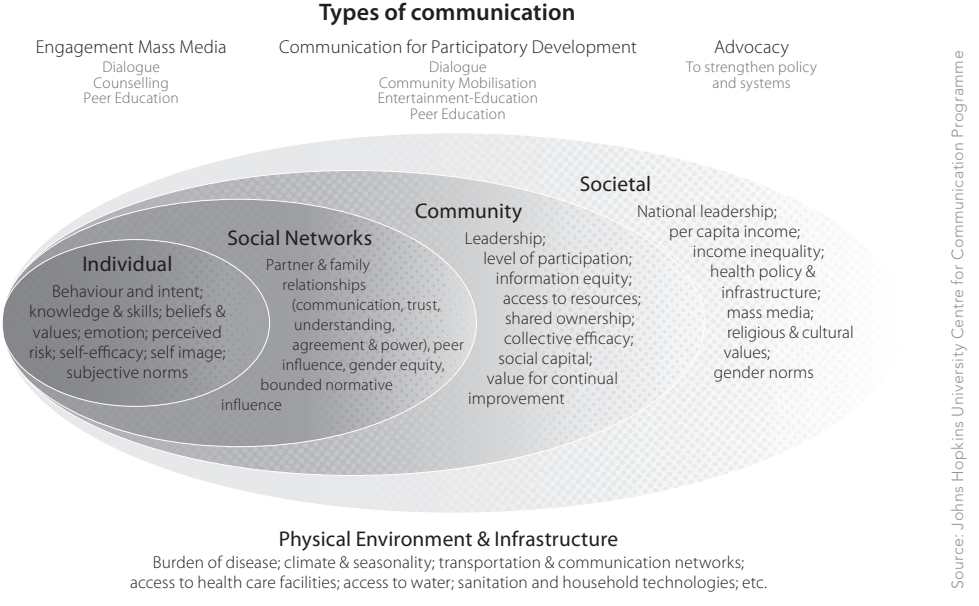
[1] *Cost of Male Circumcision and Implications for Cost Effectiveness of Circumcision as an HIV Intervention, Martin, G; Stover, J; Relebohile T. et al. (2007) USAID: Health Policy Initiative. Presentation to the PEPFAR Implementers Meeting (2007)*

Communication approaches

A combination of communication approaches are traditionally used in supporting the roll out of any development or health programme. These approaches can range from social mobilization, advocacy, behaviour and social change communication, social marketing, advertising, film and theatre.

Communication programmes generally produce the best results when they work at multiple levels. The decisions, actions and behaviours of individuals are influenced by family and community networks as indicated in the model below.

SOCIAL ECOLOGY MODEL OF COMMUNICATION AND BEHAVIOUR



Source: Johns Hopkins University Centre for Communication Programme

The decision on whether or not to be circumcised will often be made by individual men, adolescent boys and parents. This decision will be influenced by the attitudes and opinions of their immediate social networks that include their sexual partners, peers, and family members that they interact with on a daily basis.

Access to appropriate information at community level may not only affect the decision of a man to undergo circumcision but also his behaviour after being circumcised.

This guidance document focuses on two areas critical to the start of the scale-up phase: advocacy and strategic communication.

Advocacy

Advocacy is a strategic process designed to affect or influence change. In the context of male circumcision advocacy should be used to create the social and political environment needed to support the rapid scale-up required in order to achieve desired HIV prevention gains. Male circumcision poses a number of advocacy challenges including addressing negative media coverage, misinformation and resistance from some groups.

Advocacy is particularly important at the start of integrating male circumcision into HIV prevention programmes. It should be used to make a clear case for ensuring individuals and communities access the evidence-based information they need to make informed choices about the procedure and it should also provide important contextual information that presents the case for scale-up. This should include information on:

- HIV prevalence
- The number of men circumcised at different ages
- Estimated number of infections to be averted with scale-up
- Estimated financial cost and benefits of an expanded male circumcision programme
- The health and HIV prevention benefits of male circumcision
- Actions required to support scale-up needed to achieve impact

Besides men, critical targets for male circumcision advocacy include policy-makers, politicians, programme managers, medical practitioners, other health care providers, women's groups, women's and men's health advocates, community and social leaders and the media. An overall policy framework that describes the rationale and process for scaling up male circumcision will

be a crucial instrument to inform advocacy. Advocacy tools should be developed to support work with key advocacy targets and partners and can include:

- Briefing notes
- Presentations and meetings
- Media packs and fact sheets
- Special events and conferences
- Cabinet briefings

Strong advocacy will help underpin strategic communication and public information efforts.

Strategic Communication

Strategic communication is an evidence based approach to the design and implementation of communication interventions with linkages to other programmatic elements. When planning strategic communication the following steps may prove useful:

Eight Steps to effective male circumcision communication

1. Conduct a situation analysis
2. Set goals and objectives
3. Segment key audiences
4. Develop key messages
5. Identify communication channels
6. Identify key partners for collaboration
7. Develop and pre-test tools and materials
8. Monitor and evaluate progress

The same steps can and also be used as the key chapters or sections of any communications plan.

1. CONDUCT A SITUATION ANALYSIS

A good situation analysis may include a literature review of existing published studies, policies, guidelines, materials, surveys, and focus group discussions. Interviews with key informants can be useful especially when there is a lack of published material. In most cases a situation analysis will have been conducted as part of the broader scale-up plan. It should seek to:

- provide insight into how individuals and their social networks respond to male circumcision
- highlight possible barriers and challenges
- explore knowledge of the potential benefits of male circumcision including reduced risk of HIV infection
- provide insight into the meanings that men derive from male circumcision
- identify the potential for risk compensation (possible unsafe sex practices following circumcision)
- provide the basis for identification of audiences and development of interventions and messages

2. SET GOALS AND OBJECTIVES

A communications plan needs a clear goal supported by SMART objectives (specific, measurable, achievable, realistic and time bound). Goals and objectives that are agreed through the participation of all partners will help secure the broad ownership needed for success. An example of a goal might be:

Ensure 80% of all adolescents and sexually active men make an informed choice to be circumcised by 2012.

An example of an activity supporting an objective could be:

Develop and disseminate flyers in all local languages describing the benefits of male circumcision to the parents of all 12 and 13 year old males in school by the end of 2009.

3. SEGMENT KEY AUDIENCES

Segmentation of audiences allows messages to be framed and targeted. Audiences are often segmented into two parts:

• Primary audiences are those that are directly targeted to act or respond – for example, in the case of male circumcision, boys and men and parents.

• Secondary audiences are those in regular contact with the primary audience that can either facilitate or impede the desired action – for example the parents and partners of men and boys. Women are an important secondary target audience.

Recognising that countries will seek to focus on different age ranges the following broad categories are important primary audiences for male circumcision:

- Adolescent males
- Young adult males
- Adult males
- Parents (especially of newborns and young boys)

All should be exposed to broad HIV prevention messages that include the benefits of limiting the number of sexual partners, knowing one's HIV status and using condoms consistently and correctly, seeking prompt treatment for sexually transmitted infections, and reducing the number of sexual partners. In addition adolescent males should be encouraged to delay starting sexual relationships.

Secondary audiences include:

Women – can encourage their male sexual partners, sons or other male relatives to be circumcised. Women also should be targeted to ensure they also fully understand risks around male circumcision and HIV prevention.

Families – make decisions affecting the well-being of their children during infancy, childhood and adolescence. They need to understand both the health benefits of male circumcision and the importance of safe circumcision procedures.

Circumcised males – need to be reminded that although circumcised they are still at risk of HIV infection.

Health care providers – need to have comprehensive knowledge about male circumcision and its relationship to HIV and be able to manage questions and enquiries. A later section of this document offers more detail.

4. DEVELOP KEY MESSAGES

A number of core key messages should be developed for broad use with key audiences. The following key messages have been developed for use in all contexts and should be considered for local adaptation:

Male circumcision works
Scientific evidence clearly shows that male circumcision reduces the risk of HIV infection – providing partial protection against HIV for men. Studies show that male circumcision reduces the risk of HIV acquisition in men by about 60%.

Male circumcision does not replace other HIV prevention methods
Whether circumcised or not, men are at risk of HIV infection during sexual intercourse. It is important that they limit their number of sexual partners, use condoms consistently and correctly and seek prompt treatment for sexually transmitted infections to further reduce their risk of infection.

Healing period
Newly circumcised males should abstain from sex for about six weeks to ensure the penis is fully healed as they could be at increased risk of infection during this time.

Safety
Circumcision should be done in health facilities with appropriately trained providers, proper equipment and under aseptic conditions. However whether the procedure takes place in a clinical or traditional setting safety is of paramount importance.

Informed choice
Evidence-based information on male circumcision should be made available so that males and their parents can make an informed decision on whether or not to go ahead with the procedure.

In addition to promoting key messages programme managers should also be prepared to correct misinformation that may arise during scale-up. Clarity in messaging and the anticipation of potential problem areas are essential to effective communications.

In addition to local communication challenges the following areas of concern have already been raised in discussions on scaling up male circumcision for HIV prevention:

Male circumcision and female genital mutilation/cutting
It is important to clearly distinguish between male circumcision and female genital mutilation/cutting which must be discouraged as a harmful practice with no health benefits.

Importance of continued adherence to HIV prevention
Some men and their partners may relax their attitude towards safer sex after circumcision. Action to limit partner numbers and use condoms correctly and consistently is still required alongside other HIV prevention approaches.

Circumcision and HIV positive men
There is currently no evidence that circumcising men already living with HIV will reduce the likelihood of HIV being transmitted to their sexual partners.

5. IDENTIFY COMMUNICATION CHANNELS

Combining the different platforms offered by mass media communication, interpersonal communication and the health care setting offers maximum impact in supporting male circumcision programmes.

Mass media – messages can be integrated into mass media formats such as local television and radio drama series; advertising through television, radio, print, outdoor and mobile media (billboards, cinema and posters); radio and television talk shows and feature articles within the news media.

Interpersonal Communication – techniques include door-to-door outreach; facilitated discussions in settings such as workplaces, bars, community dialogues, peer education; counselling and community events. These techniques are often supported with print and/or audio-visual materials, in local languages, facilitated by trained field workers.

Health care setting – health care providers are a critical source for information and therefore need to have comprehensive knowledge about male circumcision and its relationship to HIV and be able to manage questions and enquiries.

• Service managers may want to consider the creation of a brand, logo or symbol to help identify the service. Associating interventions with a trusted authoritative brand or symbol can nurture the confidence needed for increased service uptake.

• Medical practitioners need to be trained to ensure that male circumcision is provided safely under conditions of informed consent to all parents of infants, adolescents and adult men that may request it.

• Nurses, midwives and social workers are often the first point of enquiry for individuals considering male circumcision and so should need to know what is available and how to respond to enquiries about risks and benefits.

6. IDENTIFY PARTNERS FOR COLLABORATION

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

- HIV prevention and health providers and experts
- NGOs and community based organizations
- international partners and donors
- private sector
- faith based organizations
- social scientists
- health professionals' organizations and associations
- strategic communication practitioners, including
    - script writers
    - designers
    - advertising and public relations experts
    - journalist groups

7. DEVELOP AND PRE-TEST TOOLS AND MATERIALS

Successful public information and communication efforts require a number of different materials and tools targeting different groups identified in the planning process. Involving the target audience from the start of the design phase is important in ensuring materials respond to the local environment and are culturally sensitive, non-stereotyping and non-judgemental. All materials should be pre-tested prior to use to ensure their effectiveness.

8. MONITOR AND EVALUATE PROGRESS

Programme managers should develop a monitoring and evaluation plan to track communications efforts. Monitoring and evaluating progress can involve the use of process, output and outcome indicators.

• Process Indicators may include number of consultations held, milestones reached and quarterly reports.

• Output Indicators may include the number of materials produced, the number of people trained; the number of newspaper, radio or television programmes generated addressing male circumcision.

• Outcome indicators may seek to measure the number of people going ahead with male circumcision as a result of the communication intervention.

Evaluation seeks to determine the impact of any communication campaign. This may include surveys that explore changes in knowledge around male circumcision and the efficacy of the media being deployed. Research that tests how messages are received and interpreted is also important. Findings from the evaluation of communications can also often be applied to the broader programme.

Over a longer period monitoring and evaluating communications combined with tracking changes in epidemiology can determine whether the programme has contributed effectively to HIV prevention goals.

Conclusion

It is clear that male circumcision is an important and effective intervention for incorporation within broader HIV prevention strategies – particularly in hyper endemic countries with low prevalence of male circumcision. Communication and advocacy that is well-coordinated and strategic can effectively support an increased uptake of the procedure in Eastern and Southern Africa and ensure maximum benefits from expanding access to male circumcision services.

Decisions on whether or not to be circumcised occur within a complex social and political context and are influenced by numerous interacting factors including the attitudes of men, their sexual partners, their families and the cultural and religious environment.

In order for male circumcision to become a viable and sustainable programme there is a need to ensure that men and women, communities, policy and decision-makers and programme managers all have the opportunity to participate in developing supportive communication interventions.

Programme managers are advised to allocate appropriate time, human and financial resources to planning and implementing the communication support needed for the effective scale-up of male circumcision. They are strongly advised to identify a clear lead or focal point for managing the communication process from inception, through implementation and evaluation. The eight strategic steps highlighted in this document provide the basic structure for a successful communications plan.

Background documents and other useful links

Conclusions and Recommendations from the WHO/UNAIDS Technical Consultation on Male Circumcision and HIV Prevention: Research Implications for Policy and Programming Montreux, 6 – 8 March 2007 | **http://data.unaids.org/pub/Report/2007/mc_recommendations_en.pdf**

Programming Guidance for decision-makers on human rights, ethical & legal considerations on Safe, Voluntary, Informed Male Circumcision and Comprehensive HIV Prevention June 2007 Developed by the UNAIDS Secretariat with assistance from the AIDS Law Project, South Africa **http://data.unaids.org/pub/Manual/2007/070613_humanrightsethicallegalguidance_en.pdf**

Further background information on male circumcision and HIV prevention is available at: **www.unaids.org/en/PolicyAndPractice/Prevention/MaleCircumcision/default.asp**

A number of useful guides and toolkits on planning advocacy and communications have been developed. They include:

McKee, N; Bertrand, J & Becker-Benton, A. 2004. Strategic Communication in the HIV/AIDS Epidemic. Sage. New Delhi.

Piotrow, P.T; Kincaid, D.L; Rimon II, J.G. & Rinhart, W. 1997. Health Communication: Lessons from Family Planning and Reproductive Health. Praeger, Westport.

References

Male Circumcision: Global trends and determinants of prevalence, safety and acceptability, Weiss, H & Polonsky, J. WHO, London School of Hygiene and Tropical Medicine & UNAIDS. (2007)

Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. Geneva: UNAIDS 2007. Geneva

Risk Compensation the Achilles Heel of Innovations in HIV prevention, Cassel, M.M; Halperin, D.T; Shelton, J.D; Stanton, D. (2006) Accessed from: **http://bmj.com/cgi/content/full/332/7541/60#BIBL.**

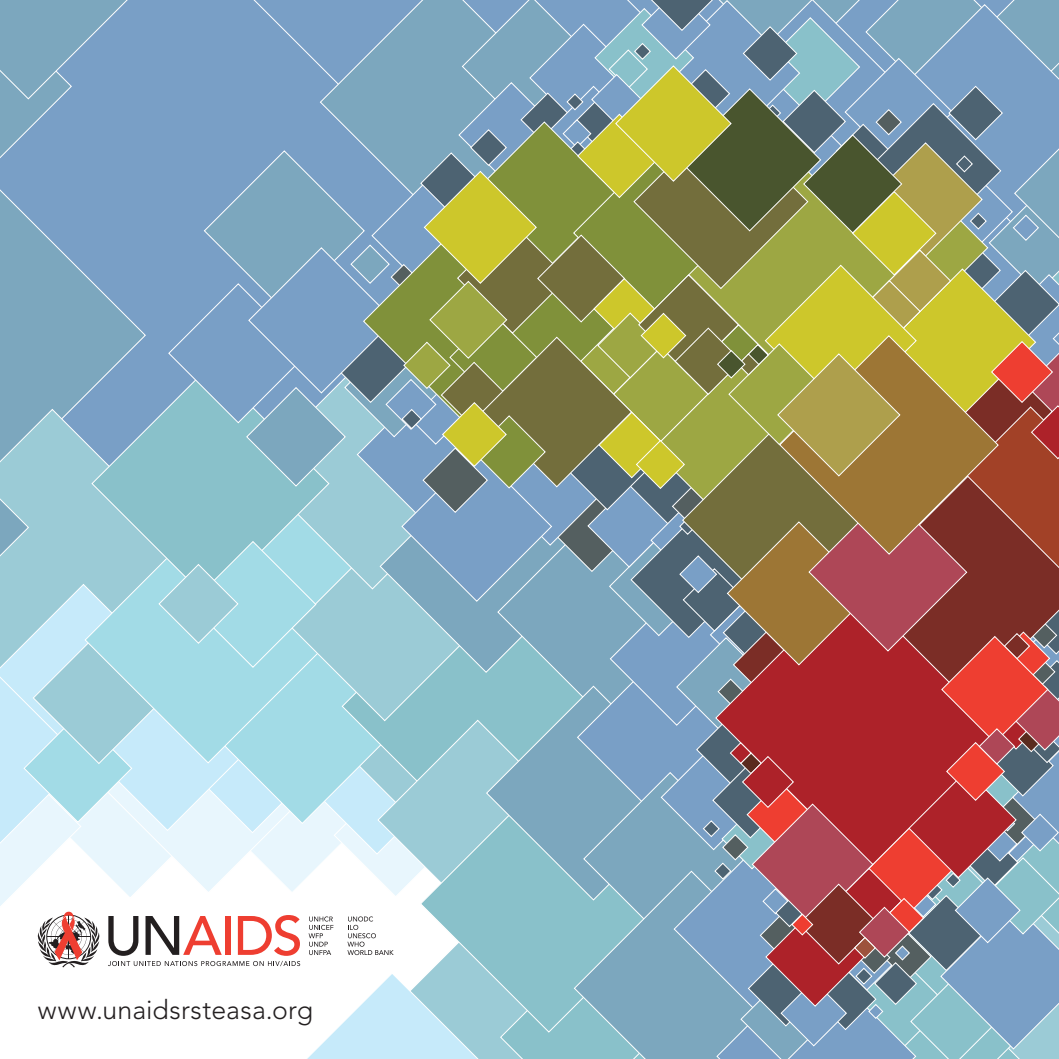
Social Science Perspectives on Male Circumcision for HIV Prevention: 18 – 19 January: Summary Report UNAIDS/CAPRISA (2007)

Strategies and Approaches for Male Circumcision Programming, WHO Meeting Report: 5 – 6 December 2006, Geneva

Why is HIV so severe in (Southern) Africa, and what works (and doesn't) for AIDS Prevention? Presentation to SADC Meeting on Social Change Communication, Halperin D. (2006)

A Social Ecology Model for Social and Behavioral Change Communication, D. Kincaid D.L; Figueroa M.E; Storey D (2007). Johns Hopkins Bloomberg School of Public Health Centre for Communication Programs

Cost of Male Circumcision and Implications for Cost Effectiveness of Circumcision as an HIV Intervention, Martin, G; Stover, J; Relebohile T. et al. (2007) USAID: Health Policy Initiative. Presentation to the PEPFAR Implementers Meeting (2007)



UNAIDS

JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNHCR
UNICEF
WFP
UNDP
UNFPA
UNODC
ILO
UNESCO
WHO
WORLD BANK

www.unaidsrsteasa.org