minimizing harms. Some of the key advocacy issues will include stigma/discrimination; addressing gender issues that affect women; religion and culture. To address these, the communication strategy provides a roadmap on engagement with the communities while taking into consideration issues of cultural sensitivity in the packaging and delivery of the messages.

7. Interventions.

The Ministry of Health has been instrumental in the provision of safe male circumcision services but on a limited scale. The roll out of male circumcision services is dependent upon the resources available at various levels of the health care delivery system to provide voluntary, safe and accessible services. The government, jointly with development partners and other stakeholder in health care, has developed the Kenya National HIV/AIDS Strategic plan (KNASP) covering the period 2005-2010 to provide an action framework for HIV/AIDS prevention interventions. The goals of the KNASP are: 1) to reduce the spread of HIV, by focusing on the prevention of new infections in both vulnerable groups and the general population; 2) improve the quality of life for those infected and affected and 3) to mitigate the socio-economic impact of the epidemic in Kenya. Underpinning this strategy are the core principles that include a multi-sectoral approach which enhances advocacy, building strategic partnerships and mainstreaming of HIV/AIDS within key sectors; the targeting of evidence based interventions for the groups most vulnerable to infection and empowerment of stakeholders to participate effectively in the national response. [May be you can introduce the NHSPP II here – briefly –]. These documents therefore form the basis for the scaling up of HIV prevention care and treatment services within the ambit of health care delivery in Kenya.

To facilitate the introduction of male circumcision services for HIV prevention, the Ministry of Health developed a National Guidance for Male Circumcision in Kenya document, for policy makers and implementers, to provide a framework to ensure the provision of safe, accessible and sustainable male circumcision services in the country. Also the national task force on male circumcision headed by the National AIDS Control Council (NASCOP) has the responsibility to spearhead the appropriate national communications strategy. Partners involved in delivery of male circumcision have assisted the Ministry of Health in mobilizing resources for efficient service delivery. The provincial task forces will oversee the implementation of the communication strategy at the regional levels to ensure sensitivity to the local needs.

8. Implications of the findings about MC to the communication strategy

Information from the situational analysis presents a number of communication concerns around the introduction of male circumcision services. The non-circumcising communities form the key target group for communication initiatives to break the barrier created by misinformation and myths around MC. These include pain, cost of the procedure, time taken to heal, the procedure not being culturally acceptable to the community, and that circumcision reduces male libido among others. Besides addressing such concerns, the communications strategy will focus on the health benefits of the male circumcision for HIV prevention strategy. It will emphasize the message that the HIV prevention aspect of MC is for both traditionally circumcising and non-circumcising communities thus disabusing the notion that the service is targeting certain communities.

One of the key issues that will need to be addressed is the key evidence behind the roll-out of the services namely the partial protective effect with regard to acquisition of HIV. This needs to be effectively done in order

for the consumers of the message not to get an impression of wholesome protection with a resultant dis-inhibition effect. This message will also be directed at traditionally circumcising communities where the cut is seen as a rite of passage to manhood. There is an implicit giving of licence to engage in sexual activities to newly initiated young men with the attendant risk of acquiring HIV infection which will be highlighted.

Women are an important constituency that will be targeted by the communication strategy. A cornerstone of the strategy is prevention of the acquisition of HIV by men from women. In the process of passing on the reduction of acquisition of HIV message, one concern that needs to be addressed will be the viewing of women as "vectors" of the disease and therefore increase blame and stigma directed at HIV positive women. Another concern that women would have relates to dis-inhibition, with men feeling at decreased risk (more protected) and as a result engaging in behaviour that puts them and their female partners at increased risk of HIV. One other facet that would need to be factored in regarding women, relates to engaging them in discussions of what having their male partners circumcised implies for their sexual lives. Of immediate concern is the prolonged period of abstinence that is necessary post-circumcision and the risk of acquiring HIV in the event that sexual activity is resumed early in the event that one of them is already infected. The communication strategy will also address the question of FGM and the need to distinctly differentiate it from MC with the information that FGM is illegal and is not an intervention for HIV prevention.

The purpose of the strategy is to raise the level of awareness and concerns for individuals and communities and to empower them to make appropriate choices that reduce their risk of HIV infection; alter the prevailing socio-cultural context in a manner that supports positive/preventive sexual, reproductive health options; advocates for effective implementation of appropriate activities and mobilization of resources through-out the roll-out process. This is intended to be achieved through multidimensional, multi-component and multilevel methodologies targeting individual, community and policy levels. The communication strategy will be strong on the fact that the male circumcision services are only one of a spectrum of HIV prevention strategies and that its presence does not put away the need to continually practice the other aspects.

The strategy will take cognizance of the WHO/UNAIDS technical consultations Committee (2007) that made the following conclusions and recommendations with regard to male circumcision and HIV prevention [WHO/ UNAIDS Technical Consultation, 2007]:

- Correct communication and information on male circumcision are critical. This is important to dispel potential misconceptions about MC and undermine its partial protection. For example, people seeking MC may do so for other purposes than for HIV risk-reduction. Others may conflate it with female genital mutilation, which does not offer any medical benefits

- Socio-cultural contexts should inform male circumcision programming. The historical context, the socio-cultural determinants and practices of MC in each community widely vary. This indicates the need for broad-based community engagement in introducing or expanding access to safe MC services. The messages on the benefits and risks of MC ought to be correct, clear, appropriate and relevant to their contexts. The local needs should be fitted within the broader national health goals

- Human rights, legal and ethical principles must guide service delivery. Male circumcision should be promoted within a framework of good medical practice that will ensure it is provided safely under conditions of informed consent and confidentiality, without discrimination both at community and individual levels

Communities where MC is being introduced as well as their individual members have a right to clear and comprehensive information about what is known and not known about MC and HIV prevention

- Gender implications of MC as an HIV intervention must be addressed. The MC promotion programs must be monitored for potential harms to women such as unsafe sex, sexual assault/violence, conflation of male circumcision with female genital mutilation. Male circumcision services should be considered as apt opportunity to promote and address broader issues of the frequently neglected sexual and reproductive health needs of men; enhance shared decision-making; to minimize potential harm to women and to address gender equality

- Promoting MC for HIV positive men is not recommended. There is no conclusive evidence that male circumcision of HIV positive men may limit their chances of HIV transmission to their sexual partners. Since persons with severe immuno-suppression may be at an increased risk of complications post surgery, male circumcision for HIV-infected men should only be recommended when medically indicated. If male circumcision is requested by men with HIV following extensive counseling on known risks and benefits, it should not be withheld unless medically contradicted. This implies that men seeking MC should be encouraged to undergo testing to ascertain sero-status

- Research is needed to guide development, implementation and monitoring MC program as part of the scale-up in order to identify and prioritize services and information package

Given the different social settings across different segments of societies, the messaging will need to be clear, correct, comprehensive, focused, appropriate and relevant to the contexts of the intended audiences. This design process will be critical in getting the right messages across and achieving the acceptability and support for MC as a medical method for HIV prevention by both the circumcising and non-circumcising communities. Key to the success of the communication strategy will be the development of an effective feedback mechanism to ensure that the information that is learnt in the delivery of messages is fed back in the design of new messages. Implied in the feedback mechanism is the involvement of the community in the communication development process to increase the trust level within communities for the initiative as well as ensuring sustainable capacity for the information.

Part 2

The Communication Strategy.

1. Aims and Objectives

The Communication Strategy for Voluntary Medical Male Circumcision aims at defining the framework, guiding principles and key elements that focus on the participant needs related to male circumcision and sexual reproductive health. The guiding principles will be based on the national policy on male circumcision and is congruent with the available national documents on HIV prevention. The strategy also conforms to the basic principles of communication including transparency and timeliness, sufficiency and meaningfulness of information. The strategy will run initially for five years, with a mid-term review and evaluation.

The goal of the program is to contribute to the reduction of incidence of HIV infections among men through the application of integrated, safe and accessible voluntary male circumcision services. Ultimately, the communication strategy aims to help in raising awareness, creating and maintaining demand for MC as a medical method to reduce the risk of heterosexual acquisition of HIV infection by men, within a comprehensive HIV infection risk- reduction framework. The specific objectives of this strategy are:

1. To increase the level of awareness of MC as a safe and voluntary HIV prevention strategy

2. To promote MC as part of a comprehensive HIV prevention strategy

3. To create and maintain demand for comprehensive MC services for HIV prevention

4. To improve the attitudes and communication skills of health workers and other players in the sector to deliver quality MC services.

2. Audience Analysis

2.1 Core (Primary) Audiences.

1. Males aged between 18 and 49

This is the core primary audience. They have reached the age of majority and are sexually active. They take individual decisions about their sexual lives and are mostly married or about to get married. This group is most affected by HIV/AIDS and other sexually transmitted infections mainly as a result of the level of sexual activity and propensity to risky sexual behaviours. Most in this group have basic level education and are exposed to a variety of media.

2. Males between 12 and 17:

They consist of males in the pubescent and adolescent stages of maturity. They are impressionable, and capable of putting pressure on their parents and guardians to facilitate decisions that will favour their choices. Some are sexually active and quite susceptible to peer pressure. They can form a large swathe of early adopters that converts to the early majority. They are in various stages of their primary and secondary schooling and are exposed to a variety of local and international media.

3. Parents of Young Boys.

Parents of young boys have the responsibility of deciding to circumcise their boys at an early age which is a key strategy in the campaign. They have to decide to make decision on behalf of and in the best interest of their sons giving more consideration to the medical benefits rather than traditional requirements. This usually would require consensus between the parents.

4. Males in Discordant Relationships.

Cases of HIV negative men in relationships with HIV positive women has been noted to be in the rise. They stand high risk of acquiring HIV. They may not be knowing their HIV status or that of their partners and seem to live normal lives as that of their other age mates.

2.2. Secondary Audiences

1 Parents and guardians:

Kenyan societies are patriarchal. Fathers are the ultimate decision makers on most issues in the home, including the choice on whether or not their children should be circumcised. They perceive themselves the custodians of tradition and both in circumcising and non-circumcising communities hold the key to making in-roads into the communities. Mothers are usually most concerned about their children's health and indeed, it is mothers who initiate doctor visits and accompany their children to health centers for periodic checks. Mothers are also critical in making decisions about the introduction of male circumcision at infancy.

2. Opinion leaders:

Are members of the communities in political, social, economic and religious leadership. Some of the leaders who would have influence on MC include:

a) ***Religious leaders: -*** In most cases hold sway over the moral behaviour of their members. However, they shy away from discussing sexual issues, at-least from the medical standpoint. Even though the bible talks about circumcision, it is largely seen as a religious tradition rather than a medical necessity.

b) ***Community elders:-*** For instance, among the Turkana, community elders are the guardians of culture and the community's traditions. They preside over the community's cultural rites and are, therefore, seen to have a great influence on decisions regarding male circumcision.

c) ***Local politicians:-*** Opinion shapers in their various communities. They are however shy to discuss issues that run contrary to the beliefs and practices of their community members. In a majority of cases would not talk about sexual issues in public gatherings.

d) ***Administrative officials:-*** Most are members of the communities and do not take strong positions on issues of sexuality. They are important players in organizing forums to educate members of the public.

e) ***Teachers:-*** Most are members of the communities and are held in high regard especially by their

students. They are in constant contact with the younger members of the community and exert influence over them.

f) ***Community change agents:-*** Include mobilizers for social programs. They are trained in areas such as health and have the capacity to reach out to some sections of the community that are not ordinarily accessible.

3. Health workers:

They are respected and trusted members of the community, and can therefore influence individual and community decision about health related life choices such as male circumcision. However even though the majority of them are familiar with the MC procedure and its health advantages, they are still not able to clearly pinpoint their role in its promotion. Further some health workers still feel strongly bound by cultural perspectives on MC despite their knowledge on its medical importance. In the infotrak survey, some health workers demonstrated reservations towards being advocates of a practice that is alien to the cultural practices of the community they come from/ work in. Health workers would thus need to be empowered as good advocates of MC.

4. Women and girls:

As sexual partners and mothers, women are influential as affirmers of men. Women, in the infotrak study, were found to have a high level of acceptability for men who are circumcised. Of all the women interviewed, over 60 per cent claimed that they had no problem marrying a man who is circumcised. The highest incidence of acceptance was noted in Teso and Nairobi where 75 per cent and 72 per cent of the women interviewed respectively claimed that they would marry a man who was circumcised. As mothers, women play an equally important role in the decision making and in influencing the key decision maker in the home, usually the man.

5. Male Peers:

Male peers especially those who have undergone MC, can be important ambassadors in the MC campaign. They can play a critical role in quelling myths about pain, excessive bleeding and mutilation. Peers tend to trust each other and advocacy from a fellow man/friend can be quite influential.

6. Editors and media owners, rural based media correspondents in target areas, specialist writers,/ reporters, photographers:

As purveyors and gate keepers of information, they play a crucial role in transmitting information on MC and correcting perceptions that may have been created by misinformation. Radio is key in the delivery of messages as it transcends education and economic barriers. The advent of community stations and vernacular broadcasts make radio an even more powerful medium. Editors rely to a large extent on correspondents who are opinion shapers in their own right.

The messages developed will be carefully tailored, culturally sensitive, draw on local language and symbols, and appeal to both men and women. Key messages will be designed to speak to the overall communication objectives. They should command attention, clarify central messages, communicate a benefit, create trust in the target audiences, call target groups to action, and cater for the heart as well as the head.

Campaign messages will be delivered in a manner that minimizes the stigma associated with circumcision status and should ensure that men opting for the procedure and where possible their partners are counseled that MC is only partially protective against HIV. Both messages and counseling shall stress that sexual relations should only resume after six weeks when the wound is completely healed.

Specific messages for the campaign should derive from the following generic messages:

HIV Prevention: Male circumcision lowers the risk of acquiring HIV by about 60 per cent in men and is therefore desirable as a preventive measure against sexually transmitted infections.

Continuing vigilance: Men who get circumcised must know that it is only part of the comprehensive HIV and STI prevention package and must be used together with the other known strategies. MC does not replace other known HIV preventive measures such as Abstinence, Faithfulness, Proper use of Condoms, Testing and counseling.

Cultural neutrality: Male circumcision is a health intervention to reduce the chances of acquiring HIV and has no bearing on one's identity or culture.

Safe: Male circumcision performed under sterile conditions and local anesthesia is available at the nearest health facility or local hospital at an affordable cost.

The messages will respond to some of the key issues that have been identified and will continuously be updated to respond to emerging issues. Some of the issues that will inform the design of messages will include:

1. **Why has it taken the government so long to find out that MC is an effective intervention?**
2. **Why haven't policies and services been made available sooner?**
3. **What is the HIV prevalence in other provinces?**
4. **Does MC reduce the sexual urge? This would cause problems in families.**
5. **Different scientists disagree on how much protection MC provides. Doesn't this show that there isn't adequate proof?**
6. **How can something be only partially effective? What does that mean?**
7. **What are the dangers of male circumcision?**
8. **How can you reduce men's fears about getting the cut?**

10. **How soon can a man resume sex after MC?**

11. **Why is MC protective if communities that practice MC get AIDS?**

12. **How about older men, should they get circumcised?**

13. **When can a man resume work after having the procedure?**

14. **What brings about a post-operative wound infection?**

15. **How do women stand to benefit from male circumcision?**

16. **Should men who are already HIV-positive get circumcised?**

17. **Why is it that uncircumcised men are at greater risk of HIV infection?**

18. **What is the ideal age for a male to be circumcised?**

The key messages to be emphasized in this context include:

- That male circumcision reduces the risk of men acquiring HIV infection by 60% and that this protective effect is only partial as well as the fact that the procedure is additional but not a substitute for other proven HIV prevention methods

- That men should not resume sexual intercourse for at least 6 weeks after circumcision to ensure that the healing process is complete and that ideally sex should only recommence once a medical assessment confirms that the healing is complete. The prolonged duration of abstinence indicates the need to involve the sex partners in the decision making before and after opting for male circumcision services

- 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 that the procedure is done by well-trained practitioners in aseptic settings under conditions of informed consent, confidentiality, risk-reduction counselling and safety

- 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. Female genital mutilation is an outlawed practice in sec 14 of the Childrens Act 2001

- It is recommended that male circumcision should not be promoted for men who are already infected with HIV but it should not be denied unless medically contra-indicated. 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. HIV positive men who become circumcised benefit directly from reduced genital ulcer disease

Message Production and Pre-Test Plan

Materials will be pre-tested on a sample drawn from the target population before final production and mass dissemination is undertaken.

Pre-test criteria should include the following:

- Check for comprehension and recall
- Cultural appropriateness/acceptability
- Credibility
- Personal involvement
- Compatibility with the communication strategy
- Clarity
- Call to action

Part 3

1. Strategy Implementation.

The implementation of the communication strategy for voluntary male circumcision will be done at different stages. It will take cognizance of the fact that there are several implementing partners and that circumcision as a practice is viewed differently among traditionally circumcising and non-circumcising communities in Kenya. This will require the development of an integrated action plan that will provide a framework for coordinating the implementation of the strategy at various levels in the country. The national task force on MC in consultation with the district and provincial task forces will be responsible for the development of such an action plan.

The implementation of the strategy will be based on multidimensional approaches which are mutually reinforcing. These would include advocacy, social mobilization, behavior change communication (BCC), capacity building and research evaluation. The latter two are cross-cutting through the process.

Advocacy will help to create or strengthen social norms by garnering political commitment and policy change that would facilitate positive behavior change. It will help to mobilize resources and services, and to accelerate the implementation of programs. It will also be undertaken to cement political and social commitment to the program.

Advocacy programs will be undertaken with communication participants at all levels to develop positive attitudes and behavior in areas of MC among all partners, allies and gatekeepers to help create an enabling environment and increase resources. Some key advocacy strategies will be to:

- Lobby at the national, district, community and household levels for increased MC/male sexual health resources
- Establish and support coordinating committees and coalitions for MC under MoH in areas under the program
- Advocate for decision-makers and other partners to increase access to quality MC services
- Advocate for the government to address Male Circumcision /Sexual Reproductive Health related issues

Social mobilization will be initiated with implementing partners at the national, provincial, district, local government and community levels, involving civil society, non-governmental organizations, community-based organizations, religious groups, and the private sector. It will involve capacity building and intersectoral collaboration, from national to community levels. Capacity building as a cross-cutting strategy will be implemented in all program areas.

Building the community mobilization capacity of government officials, civil society, local and community-based organizations (CBOs) / NGOs, public and private sector service providers is critical to achieving the objectives of National Communication Strategy for MC/SRH. Cooperation and participation among all partners is essential to support and conduct program activities in a coherent and effective manner.

Behavior Change Communication (BCC) will help individuals and communities gain the knowledge and skills to change or develop their own behavior and will augment the roles of advocacy and social mobilization.

Audience Analysis Implementation Matrix

Audience	Activities	Medium	M 1	M 2	M 3	M 4	M 5	M 6	M 7	M 8	M 9	M 10	M 11	M 12
Males aged between 18 and 30 years	Branding: Logo and slogan promoting MC Logo/ colours display	Mementos – T-shirts, watch-straps, caps, stickers												
	Talk shows Call-in programmes	National and local language radio -Endorsement from opinion leaders												
		Television stations -Endorsement from opinion leaders												
	Persuasive editorials Specialised articles on best practices Discussion forums- Print	Newspapers												
Males between 12 and 18 years	Below the line communication Branding	Brochures posters Billboards Pamphlets Mementos -caps, T-shirts, pens												
	Education	-School competitions -Kenya Schools and Colleges Music and Drama festivals -Do a dip stick survey on the perceptions on circumcision												
	Persuasion	Community theatre												
	Sponsorship	Sponsor young boys for circumcision												

Audience	Activities	Medium	M 1	M 2	M 3	M 4	M 5	M 6	M 7	M 8	M 9	M 10	M 11	M 12
Fathers	Branding	Logo/colours display												
	Mass Media: Electronic (Radio, TV)	Talk shows / Call-in programmes												
	Mass Media: Print	Specialised articles on best practices Discussion forums-Letters to the editor Persuasive editorials												
Opinion leaders: Church leaders Community elders- tribal leaders Local Politicians Administrative officials	Branding	Mementos: caps, calendars, key chains, T-shirts												
	Advocacy	Direct community contact Community forums through peer educators												
	Lobbying	Churches Chief's barazas												
	Persuasion	Theatre for education/ development programmes												
	Education/ training Education/ Persuasion	Schools, adult education classes and churches												
	Mass media	Television news and documentary programmes												

Audience	Activities	Medium	M 1	M 2	M 3	M 4	M 5	M 6	M 7	M 8	M 9	M 10	M 11	M 12
Health workers	Branding	Mementos – T-shirts, watch-straps, caps												
	Lobbying	Training workshops												
	Training	Training workshops Manuals ocumentation]												
	Mass media	Newspapers National and Local language radio/ TV stations												
Women and girls	Branding	Mementos – khangas, T-shirts, caps												
	Advocacy	Opinion leaders' endorsement Workshops/ seminars												
	Mass media	Newspapers National and local language radio/ TV stations												

Audience	Activities	Medium	M 1	M 2	M 3	M 4	M 5	M 6	M 7	M 8	M 9	M 10	M 11	M 12
Male Peers	Branding	Logo/colours display												
	Advocacy	Discussion forums Workshops Seminars												
	Mass media	Talk shows Call-in programmes Specialized articles on best practices Persuasive editorials -Interviews with beneficiaries -Interviews with proponents of circumcision												
Editors and media owners, rural based media correspondents in target areas, specialist writers, reporters, photographers	Advocacy	Media Training workshops seminars Media tours -Interviews with MCC Spokes person												
	Training	Key messages to be communicated for the MCC campaign Inception report for the communication strateg Communication strategy Information press packs Media round table – Event logistics MCC Launch of the communication materials Information resource centre on male circumcision												

Notes