# SOUTHERN AND EASTERN AFRICA REGION MALE CIRCUMCISION COMMUNICATION MEETING

## A JOINT UNAIDS & PEPFAR SPONSORED MEETING

## SEPTEMBER 22-24, 2010

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

**APRIL 2011**

This publication was produced by the AIDS Support and Technical Assistance Resources (AIDSTAR-One) Project, Sector 1, Task Order 1, USAID Contract # GHH-I-00-07-00059-00, funded January 31, 2008.

# SOUTHERN AND EASTERN AFRICA REGION MALE CIRCUMCISION COMMUNICATION MEETING

A JOINT UNAIDS & PEPFAR SPONSORED MEETING

SEPTEMBER 22-24, 2010

**AIDS Support and Technical Assistance Resources Project**
AIDS Support and Technical Assistance Resources, Sector I, Task Order 1 (AIDSTAR-One) is funded by the U.S. Agency for International Development under contract no. GHH-I-00–07–00059–00, funded January 31, 2008. AIDSTAR-One is implemented by John Snow, Inc., in collaboration with Broad Reach Healthcare, Encompass, LLC, International Center for Research on Women, MAP International, Mothers 2 Mothers, Social and Scientific Systems, Inc., University of Alabama at Birmingham, the White Ribbon Alliance for Safe Motherhood, and World Education. The project provides technical assistance services to the Office of HIV/AIDS and USG country teams in knowledge management, technical leadership, program sustainability, strategic planning, and program implementation support.

**Recommended Citation**
Bertrand, Jane T., L. Evanson, et al. 2011. *Southern and Eastern Africa Region Male Circumcision Communication Meeting: A Joint UNAIDS & PEPFAR Coordinated Meeting, September 22-24, 2010*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

**Acknowledgments**
The meeting was organized by the PEPFAR Technical Working Group for Male Circumcision (MC TWG), in collaboration with UNAIDS. The organizers would like to acknowledge all the support that ensured this meeting's success.

**Technical design:** The PEPFAR MC TWG members and UNAIDS were heavily involved in the meeting's design and implementation. The MC TWG is co-chaired by Naomi Bock, Emmanuel Njeuhmeli, Caroline Ryan, and Anne Goldzier Thomas. The members of the MC TWG are Funmi Adesanya, Melanie Bacon, Delivette Castor, Sekai Chideya-Chihota, Suzanne Leclerc-Madlala, Patrick McElroy, Jason Reed, Brian Rettmann, Carolyn Williams, and Sheryl Zwerski. UNAIDS support came from Catherine Hankins and Precious Lunga. Other contributors include Melissa Adams, Wendy Benzerga, Elizabeth Berard, Jane Bertrand, Stephanie Cook, Kim Dickson, and Sharon Stash.

**Administrative support:** Bongeka Chili, Leigh Ann Evanson, Sian Long, and Amy Pepin.

**Chairpersons, presenters, small group facilitators and resource persons:** Isaac Abuya, Kawongo Agot, Naomi Bock, Cal Bruns, Sekai Chideya-Chihota, Henry Chimbali, Kelly Curran, Richard Delate, Beth Deutsch, Roy Dhlamini, Faith Dlamini, Mphikeleli Dlamini, Adebayo Fayoyin, Bennet Fimbo, Catherine Hankins, Ndungu Kiriro, Pamela Kisoka, Tara Kovach, Cheryl Lettenmaier, Emma Llewellyn, Precious Lunga, Hally Mahler, Maria de Gloria Meque, Mpolai Moteetee, Zebedee Mwandi, Gertrude Ncube, Emmanuel Njeuhmeli, Luke Nkisi, Ayanda Nqeketo, Athanasuis Ochieng, Cate O'Kane, Peters Roberts, Caroline Ryan, Julie Samuelson, Suleiman Shifaw, Beth Skorochod, and Anne Goldzier Thomas.

Critical in-country support to the meeting was provided by the South Africa National Department of Health (NDOH), and NDOH Deputy Director Yogan Pillay, the South Africa PEPFAR team: Wendy Benzerga, Mary Fanning, Thurma Goldman, Roxana Rogers, and Chalone Savant; and Consul General Jill Derderian.

**Cover photo:** The UNAIDS–PEPFAR Southern and Eastern Africa Region Male Circumcision Communication Meeting brought together 117 participants from 14 countries.

**AIDSTAR-One**
John Snow, Inc.
1616 Fort Myer Drive, 11th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
E-mail: info@aidstar-one.com
Internet: aidstar-one.com

# CONTENTS

# ACRONYMS

| | |
|---|---|
| ACHAP | The African Comprehensive HIV/AIDS Partnerships |
| AED | Academy for Education Development |
| BMGF | Bill & Melinda Gates Foundation |
| CCP | Center for Communication Programs |
| CDC | Centers for Disease Control and Prevention |
| CHAPS | Culture and Health Programme for Africa |
| DOD | Department of Defense |
| HTC | HIV testing and counseling |
| JHHESA | John Hopkins Health and Education South Africa |
| JHU | John Hopkins University |
| JSI | John Snow, Inc. |
| MC | male circumcision |
| MOH | Ministry of Health |
| MOHCW | Ministry of Health and Child Welfare |
| NASCOP | National AIDS and STD Control Programme |
| NERCHA | National Emergency Response Council on HIV and AIDS |
| NRHS | Nyanza Reproductive Health Society |
| OGAC | Office of the U.S. Global AIDS Coordinator |
| PEPFAR | U.S. President's Emergency Plan for AIDS Relief |
| PITC | provider-initiated testing and counseling |
| PSI | Population Services International |
| TWG | Technical Working Group |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| USAID | U.S. Agency for International Development |
| VCT | voluntary counseling and testing |
| VMMC | voluntary medical male circumcision |
| WHO | World Health Organization |

# EXECUTIVE SUMMARY

**Background.** The rapid roll-out of male circumcision (MC) programming is crucial to halting the further spread of the HIV epidemic in countries with generalized epidemics and low rates of MC. This is an urgent public health challenge; if the 14 target countries reach the goal of 80 percent coverage by 2015, an estimated 4 million adult infections will be averted.

Modeling indicates that reaching these targets faster will avert even more new infections than a gradual scale-up. However, the communication challenge of reaching 80 percent coverage for MC is daunting in terms of increasing uptake of services, addressing firmly held cultural beliefs and gender issues, and avoiding unintended consequences, such as greater risk taking by circumcised men.

Creating demand for adolescent and adult MC is essential to the success of scale-up. To consolidate what the HIV community has learned to date and advance MC communication, the Male Circumcision Technical Working Group for the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Joint UN Programme on HIV/AIDS (UNAIDS) organized the first regional meeting on MC communication from September 22 to 24, 2010. Held in Durban, South Africa, the meeting brought together 117 health professionals from 14 countries in east and southern Africa (including representatives of the military from 9 countries) and international experts from Europe and North America.

**Objectives.** The meeting aimed to advance knowledge and to share promising experiences and communication materials for adolescent and adult MC in three key areas: demand creation, client counseling, and advocacy.

**Overview of the agenda.** The three-day program provided participants with an overview of current work in MC communication and fostered interactive and in-depth discussion of key issues in small group settings. The first two days consisted of plenary sessions in the mornings, with small group work on different topics in the afternoons. The final day included reports from all of the small working groups, as well as a late-breaking panel discussion on the role of incentives for clients and providers.

A Materials Marketplace, held on the first day, gave countries and organizations an opportunity to informally display and share printed materials, videos, and other communication materials on MC. During the afternoon of the third day, representatives of health ministries met with donor agencies to discuss next steps regarding MC communication and other issues relevant to their specific country situations (these discussions are not covered in this report).

**Key points from the plenary sessions.** Speakers on the first day gave participants an overview of current programming in MC, with several key messages:

- Countries are at very different stages in their MC communication programming.
- Many of the tools used in behavior change communication can be easily modified for MC.
- Epidemiological projections underscore the potential power of and urgent need for MC scale-up.

- Achieving scale-up and saturation requires a communication strategy tailored to each country context that segments audiences, addresses existing and potential barriers, and reaches prospective clients with persuasive, accurate information.

The plenary session on the second day included presentations on promising experiences and ongoing challenges from Kenya, Tanzania, Swaziland, and Zimbabwe. The speakers provided useful insights about integrating MC into existing medical facilities, incorporating medical MC into traditional circumcision ceremonies, recruiting clients for services through innovative mobilization techniques, and scaling up to meet ambitious targets and timetables. Another plenary on the same day discussed whether demand creation is different for MC than for other public health services. The panelists noted more similarities than differences and discussed the unique challenges in effective communication for the key elements of MC.

The plenary on the third and final day reviewed the role of provider and client incentives for MC and identified a need for greater guidance on this issue from UNAIDS. There seemed to be fairly widespread consensus that reimbursements for transport and provision of meals, snacks, or soft drinks do not constitute a financial incentive. Finally, rapporteurs from the small groups reported back to all participants on the key findings from the working sessions.

**Key points from the working sessions.** The small group format was designed to foster discussion of key topics, with 12 to 20 persons in each group. The subjects covered included advocacy, demand creation strategies, counseling, elements of a communication toolkit, and research/program evaluation related to MC. One group discussed the specific challenges facing Swaziland's ambitious Accelerated Saturation Initiative in achieving the targeted coverage of 80 percent of men aged 15 to 49 years old circumcised in one year. The key points from each working session are summarized in this report.

Many of the small groups found it valuable to apply techniques used in other public health interventions to MC scale-up. In contrast, the group addressing client counseling identified issues that need special attention in the context of MC programs (e.g., how best to take advantage of this "once-in-a-lifetime" encounter with men in a clinical setting, and how to integrate messages on risk reduction and gender into preoperative and postoperative counseling). The small groups also summarized the key points from the Swaziland case study and provided recommendations for those charged with developing an MC communication toolkit.

**Conclusions.** The meeting emphasized the need for well-designed communication interventions that will create the demand for adolescent and adult MC, especially among non-circumcising populations.

During the early phases of MC scale-up, attention focused on 1) developing and strengthening the clinical aspects of service delivery to ensure highly efficient, high-quality service provision, and 2) engaging in advocacy efforts with government officials and community leaders to pass policy that enables MC scale-up. In contrast, demand creation in the early days of the scale-up was relatively ad hoc.

This meeting underscored the need to apply to MC what the public health community has learned about communication strategies from other health issues (e.g., family planning, malaria control, and HIV prevention), and to apply a systematic approach to the design, implementation, and evaluation of MC communication. It will be important to compile and communicate the evidence and experience of those involved in the initial scale-up efforts to inform the expansion of MC programming in the target countries.

Operations research will be useful for testing new approaches to MC communication, and more widespread monitoring and evaluation will identify the most effective approaches and channels to increasing adoption of MC. One area ripe for process evaluation and operations research is counseling (both HIV counseling and testing, and counseling related specifically to MC). Potential research topics include the quality of counseling in high-volume settings, off-site counseling and testing (prior to the day of the MC procedure), and improving the efficiency of counseling to avoid bottlenecks.

Finally, the HIV community needs to address gender concerns (both in terms of the known positive biological effects of MC, as well as potentially negative social impact), understand the woman's role in the man's decision to get circumcised, and ensure against sexual risk compensation among circumcised men at different ages and in different cultural contexts. Also, MC offers an opportunity to address the sexual health needs of men, and the need for healthy gender norms.

The Durban meeting provided a springboard for exploring MC communication. It established a common base of knowledge among countries and organizations working in MC for HIV prevention. It afforded participants from 14 countries the opportunity to share their experiences, identify successful strategies, and gain greater insight into the technical skills needed in communication (e.g., design and program evaluation). Of particular note was the opportunity for exchange between military and civilian programs; providing a valuable discussion of models and approaches for promoting MC in different contexts.

Meeting organizers recommend that future meetings on this topic include findings from operations research and program evaluation that measure the effectiveness of communication interventions.

The report that follows elaborates on each of the topics mentioned in this summary. In addition, it includes the final agenda for the meeting (Appendix A), a list of all participants (Appendix B), and illustrative examples of MC communication materials (Appendix C).

# INTRODUCTION

## MEETING OVERVIEW

The Male Circumcision (MC) Technical Working Group (TWG) for the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) joined with the Joint UN Programme on HIV/AIDS (UNAIDS) to design and host the first UNAIDS–PEPFAR Southern and Eastern Africa Region Male Circumcision Communication Meeting from September 22 to 24, 2010. Held in Durban, South Africa, the meeting brought together 117 health professionals from 14 countries with expertise and interest in using communications to improve the efficiency and effectiveness of scale-up of MC in eastern and southern Africa. The meeting's primary focus was demand creation, but there were also dedicated sessions on other MC topics that rely heavily on effective communication, namely counseling and advocacy. Gender was also a key topic that was interwoven into many of the sessions.

## BACKGROUND

In 2005 and 2007, three randomized controlled trials demonstrated that MC reduces the heterosexual acquisition of HIV by men by approximately 60 percent.[1] Since then, several countries in eastern and southern Africa have been working to scale up delivery of MC services. The experience to date suggests that many adult men are in fact interested in having the procedure for a variety of reasons, including HIV prevention, hygiene, appearance, and the perception that women prefer circumcised men. To date, MC scale-up has mostly focused on service delivery and surgical techniques to improve efficiency in the clinical context. However, effective communications are essential to meet the ambitious targets established to achieve MC coverage. Well-designed demand creation campaigns help ensure a steady flow of clients into MC facilities. Appropriate counseling ensures voluntarism and consent; links MC into the continuum of HIV prevention, care, and treatment services; and provides information about sexual risk for MC clients. Effective advocacy messages generate political support for MC activities that ensures country ownership and sustainability of MC programs.

## OBJECTIVES AND AGENDA

The meeting's objectives were to advance knowledge and share promising experiences and materials relating to communication in the scale-up of adolescent and adult MC in eastern and southern Africa.

---

[1] Auvert, B., et al. 2005. Randomized, Controlled Intervention Trial Of Male Circumcision for Reduction of HIV Infection Risk: The ANRS 1265 Trial. *PLoS Medicine*, Vol. 2, e298.

Bailey, et al. 2007. Male Circumcision for HIV Prevention in Young Men in Kisumu, Kenya: A Randomised Controlled Trial. *The Lancet*, Vol. 369, 643-656.

Gray, R.H., et al. 2007. Male Circumcision for HIV Prevention in Men in Rakai, Uganda: A Randomized Trial. *The Lancet*, Vol. 369, 657-666.

More on these trials is available on AIDSTAR-One's HIV Prevention Knowledge Base at http://www.aidstar-one.com/focus_areas/prevention/pkb/biomedical_interventions/male_circumcision?tab=introduction.

Specifically, the meeting addressed the following key issues (see Appendix A for the complete agenda):

- Demand creation
  - Strategy, channels, techniques, and tools for mobilizing demand
  - Calibrating demand (number of men seeking services) with supply (capacity of the system to deliver MC services)
  - Targeting the "right age" for clients
- Counseling
  - Types of counseling
    - Information on the surgical procedure, including informed consent and insuring voluntarism
    - Risk reduction counseling
    - Counseling regarding HIV testing and knowing one's status
    - Related topics: men's health, male norms, and other gender-related topics
    - Counseling during follow-up visit
  - Essential content to communicate in each type of counseling
  - Strategies to improve uptake of HIV testing prior to MC
- Gender (as it relates to communication in the MC scale-up)
  - Human rights and women's rights
  - Promotion of positive male norms to prospective clients, women, and the general population via multiple channels
  - Gender-specific barriers and facilitators in the MC scale-up
- Advocacy
  - Types of changes sought: political, structural
  - Strategy, channels, techniques, and tools/materials
  - Audiences for advocacy initiatives.

The PowerPoint slides from all sessions are available at www.aidstar-one.com.

# PARTICIPANTS

Attending the conference were 117 communication and public health professionals representing 14 eastern and southern African countries, in addition to a number of international experts working in MC. In contrast to meetings held earlier in 2010 in Johannesburg and Arusha, Tanzania, attended by those responsible for MC service delivery, the Durban meeting targeted professionals who play a lead role in the HIV communication programs of their country.

Representatives from the military of nine PEPFAR partner countries also participated in the meeting. This was the first time that such a large contingent of military personnel had attended an MC conference sponsored by UNAIDS and PEPFAR.

# ORGANIZATION OF THE PROGRAM

The three-day program was designed to provide participants with an overview of state-of-the-art developments in MC communication while allowing for ample interaction and in-depth discussion of key issues in small group settings. For the first two days, the mornings consisted of plenary sessions; the afternoons consisted of small group work on a series of different topics (detailed subsequently). The final day included reports from the small working groups, including recommendations on the different topics covered. Finally, at the request of participants, the organizers rearranged the program on the third day to include a panel on the topic of incentives for providers and clients. During the afternoon, representatives of Ministries of Health (MOHs) met with donor agencies to discuss the relevance of the meeting to their specific country situations.

One highlight of the meeting was the Materials Marketplace, held in the early evening on the first day. The Marketplace gave countries and organizations an opportunity to display and share printed materials, videos, and other MC communications materials. These materials are being uploaded to the Male Circumcision Clearinghouse (www.malecircumcision.org) and should be available shortly. The materials are currently found on the AIDSTAR-One website at www.aidstar-one.com/male_circumcision_communication_materials.

# KEY POINTS FROM THE PLENARY SESSIONS

## DAY 1: SEPTEMBER 22, 2010

The plenary session of the first day gave participants an overview of the state-of-the-art in MC communications and addressed the following question: What do we need to do in MC programming to have a public health impact?

- Jane Bertrand presented preliminary results from a survey conducted among organizations from 11 countries on current practices in communication and counseling for MC. Respondents reported that community mobilization is the most effective means of increasing demand but that many find it challenging to find time to participate in such activities. They also noted a lack of government support for MC.
- Athanasius Ochieng promoted the idea of working in partnership across organizations in the public and private sector in Kenya, keeping the focus on the objectives for Kenya's national MC program.
- Catherine Hankins touched on key aspects of gender and ethics, emphasizing the need for simultaneous scale-up of MC and encouraging a broader conversation about the role of gender equality within these public health campaigns.
- Julie Samuelson updated the participants on the Male Circumcision Clearinghouse (www.malecircumcision.org), a website designed to expand global access to information on MC for HIV prevention.
- Sekai Chideya-Chihota described the plans of PEPFAR/U.S. Centers for Disease Control and Prevention (CDC) for developing an MC communication toolkit for use in eastern and southern Africa, which was also the subject of one of the small working groups.
- Emmanuel Njeuhmeli presented recent data on the scale-up of MC, emphasizing the need to match demand and supply for better efficiency and productivity of MC programs and for better use of limited available resources. He underscored the urgency of the MC scale-up to halting the further spread of the HIV epidemic and emphasized that moving quickly will bring far greater gains in averting new infections than a more gradual approach to achieving coverage. He cited the case of South Africa, where a rapid, full-scale roll-out of MC could cause a 14 percent drop in HIV infection rates by 2025, based on modeling exercises.

## DAY 2: SEPTEMBER 23, 2010

The plenary on the second day included two lively panels. In the first, participants from four countries presented promising experiences with MC communication.

- Bennett Fimbo recounted recent successes in the non-circumcising region of Iringa, Tanzania, in organizing high-volume MC activities in coordination with MOH facilities in remote areas. The presentation highlighted efforts to build on the existing health facilities in these areas to service the demand for MC.
- In a talk entitled "Beyond 130,000 MCs," Kawango Agot discussed the communication techniques—largely interpersonal—used to motivate males in Kisumu, Kenya, to get circumcised.
- Ayanda Nqeketo presented the unique challenges facing Swaziland. Swaziland has set the ambitious target to increase the coverage of circumcised men aged 15 to 49 years old to 80 percent in less than one year, which reflects the urgency of slowing the epidemic quickly in this high HIV prevalence country. For this country of 1.3 million inhabitants, this represents a target of 152,000 men 15 to 49 years old who are to be circumcised in 12 months. (This topic was also pursued in greater depth in the afternoon sessions on both the first and second days.)
- Gertrude Ncube shared the experiences of MC providers in Zimbabwe who worked alongside traditional circumcisers to bring services to locations near the traditional camps established as part of initiation rites for young men. This integration allows local communities to respect many of the elements of traditional MC 'camps' while ensuring a safe procedure conducted under sterile conditions for these adolescent boys.

The second panel addressed the following question: Is demand creation for MC different than for other public health services? The five panelists (Tara Kovach, Cheryl Lettenmaier, Cal Bruns, Hally Mahler, and Ndungu Kiriro) represented implementing partners engaged in the development of health communication materials. They generally agreed that there are more similarities than differences, but discussed the unique features of materials for MC. For example, MC is more painful than most public health interventions, which may make it a "harder sell." Additionally, MC affects not only the man but also his partner (given the six-week period of abstinence). There was considerable discussion about the abstinence period and how to counsel clients and their partners. In addition, it is difficult to convey the concept of partial protection (MC does not offer 100 percent protection from HIV infection for a man). On the positive side, MC "only needs to be performed once," in contrast to other public health behaviors that require repeated action on the part of the beneficiary.

All programs offer MC voluntarily, with an informed consent form that is signed before the procedure. However, during this panel, the issue of incentives arose in connection with the experience of family planning programs in the 1970s, which ran into political problems when incentives were given to either clients or providers offering permanent contraceptive methods (e.g., vasectomy in India). Two types of incentives were discussed: provider incentives (including extra payments for clinical staff who work overtime in this program and payments—in cash or in kind—to mobilizers for the number of persons recruited) and client incentives (consisting of reimbursement of transportation costs or clothing). This topic inspired such spirited discussion that the organizers rearranged the program on the third day to include a panel on the subject.

# DAY 3: SEPTEMBER 24, 2010

The panel on the use of incentives in MC programming consisted of four persons representing governments and four representing nongovernmental organizations from Kenya, Swaziland,

Tanzania, and Zambia. Key points expressed by panelists or other participants included the following:

- Paying government workers to perform MC during hours outside the regular schedule is simply paying overtime and does not constitute an unethical incentive. While the panelists asserted payment should not be based on number of procedures completed, others stated that it was acceptable to base payment on number of operations performed.
- Incentives for motivators—if used—should be based on number of men who come to the clinic rather than the number who actually get circumcised (thus allowing for "defectors" who change their mind).
- The distribution of underwear should not be viewed as an incentive but rather as a means of reducing adverse postoperative effects (because clean underwear ensures a hygienic cover that assists with wound healing).
- The World Health Organization (WHO)/UNAIDS provides limited guidance on the use of incentives in MC.
- If perceived to be coercive, incentives could be politically detrimental to MC scale-up in a given country.
- The group recommended that WHO/UNAIDS develop clear guidance on this issue.
- The PEPFAR MC TWG also decided to develop policy guidelines around voluntarism, informed consent, and incentives for PEPFAR-funded MC programs.

Although not on the original program, Dr. Maria de Gloria Meque presented on the topic, "Minor Surgery and Male Circumcision Demonstrative Program at the Maputo Military Hospital in Mozambique." Data from November 2009 through August 2010 show an increasing number of MC procedures performed (reaching 527 per month) at the hospital, with those aged 15 to 19 representing the largest age group. In addition, Dr. Anne Goldzier Thomas gave an overview entitled "Male Circumcision for HIV Prevention in Military Populations." Among other topics, she discussed the advantages that the military has in performing MC, namely the military is willing to scale-up and conduct research with cohorts of new recruits, has control over all aspects of their programs, can readily implement task shifting and task sharing in their work, and can establish MC sites that also provide antiretroviral therapy.

# KEY POINTS FROM THE WORKING SESSIONS

The program included five small group discussions during the afternoon hours of the first and second day. The topics covered included advocacy (one session), demand creation strategy (one session), counseling and testing (two sessions), development of a communication toolkit (two sessions), and program evaluation (two sessions). Participants selected their choice of sessions prior to the conference; enrollment for each group totaled 12 to 20 participants. Each session had a facilitator, one or more resource persons presenting on the topic, and one or two rapporteurs responsible for capturing the main conclusions. The groups each had a set of objectives to achieve during the session and outputs that were expected to result from the groups' deliberations.

The key findings and recommendations of each group are described as follows.[2]

## ADVOCACY FOR SCALE-UP OF MALE CIRCUMCISION

The objectives of this session were 1) to review a range of experiences to date with advocacy for MC scale-up; 2) to discuss ways to integrate gender into advocacy initiatives; and 3) to synthesize lessons learned from experiences to date.

The session included presentations on advocacy initiatives in Malawi and Lesotho. From these, participants identified a number of lessons learned and used them to formulate recommendations for other countries seeking to develop or strengthen their own advocacy efforts for MC. Their recommendations were the following:

- Design an MC advocacy strategy and define advocacy issues based on country context and evidence.
- Define and prioritize target audiences (supporters and detractors) for MC advocacy and understand the different concerns and needs of each audience.
- Listen and respond to target audiences, knowing that there may be underlying or unspoken issues.
- Identify and work through appropriate and multiple channels (especially methods that engage the audience in different forms of interactive communication).
- Address emerging concerns and manage expectations for all target audiences for MC (which is a continuous process).

[2] The recommendations presented are based on points presented in the plenary on the third day. The one exception is the session on demand creation strategy, in which the slides of Richard Delate, a resource person, served as the basis for the notes in this report.

# DEMAND CREATION STRATEGY: IMPORTANCE AND CONTENT

The objectives of the session were 1) to develop a common understanding of the importance and content of a communication strategy; and 2) to identify the challenges of designing and implementing a communication strategy for MC in participating countries.

Strategic communication for behavior change (including for MC) generally draws on the social ecological framework within which individual behavior occurs under multiple layers of influence: partner and family relationships, community, and society. Thus, communication interventions must promote change simultaneously at these different levels.

Strategic communication targets an identified audience and identifies other groups that influence the target audience in relation to a defined set of outcomes or objectives, such as peers, family members, or community leaders. It combines a series of elements: data, planning, stakeholder participation, creativity, high-quality programming, and linkages with other program areas. It uses mass media (television, radio, print, and mobile and outdoor media), interpersonal communication (community mobilization), and advocacy in an ongoing effort to promote behavioral and social change and increase service uptake.

High-quality service delivery is critical for successful strategic communication; if services fall below expectation (e.g., high rates of adverse events), word of mouth can undermine the intervention. Strategic communication uses symbols (such as logos) to connect mass media, interpersonal communication, and service delivery into one package that serves as a mark that guarantees the quality of services. It is unethical to promote a service or intervention that is not available.

Formative research as well as audience segmentation (primary and secondary audiences) drives strategic communication. Program planners should use SMART objectives (specific, measurable, achievable, realistic, and time-bound) to describe what the program expects to achieve. Participatory approaches to designing messages result in more effective communications that promote change, reinforce positive behaviors, and promote service uptake. Monitoring and evaluation demonstrate the extent to which the communication program meets its objectives.

MC messages need to:

- Draw on the evidence
- Provide a call to action
- Address the context
- Draw on realities of the target audience
- Use the visual and verbal language of the audience
- Entertain and educate
- Be clear and consistent.

Communication programs use both mass media, which reaches large numbers of people at a low cost per unit, and interpersonal communications, which allow face-to-face dialogue and greater interaction. Entertainment-education involving drama, sports, or interactive sessions can be highly effective in bringing about a personal reflective moment. Interpersonal approaches include peer

education, in-clinic facilitation, community events, telephone helplines, counseling, home visits, and workplace programs.

Advocacy falls within the broader realm of communication. It works to strengthen community response through community dialogues and media dialogues.

# COUNSELING

Given the high level of interest in counseling as it relates to MC and the range of issues to cover, the program included small group discussions on this topic on both the first and second days. The objectives of the first day session were 1) to identify the content that should be included in preoperative and follow-up counseling; 2) to discuss how best to integrate messages on risk reduction and gender into preoperative and follow-up counseling; and 3) to identify messages and content needed for those who are HIV-negative, those who are HIV-positive, and those of unknown HIV status. On the second day, the session on counseling continued with several additional objectives: 1) identify strategies for increasing uptake of HIV testing in MC services; 2) explore HIV testing and counseling (HTC) as a source of referrals to MC services; 3) examine the extent to which counseling activities represent a bottleneck in client flow at MC sites; and 4) identify the nature of the delays and possible solutions to this issue.

As men do not often or readily enter the health system, participants viewed MC services as a "once-in-a-lifetime opportunity to reach men" for HIV testing (as well as other health services).

To this end, participants made several recommendations to increase HIV testing uptake:

- Employ and expand provider-initiated testing and counseling (PITC) to increase uptake of HTC, including the following:
  - Establish effective referrals between MC services and PITC, voluntary counseling and testing (VCT), and home-based HTC services
  - Conduct testing via mobile outreach teams preceding an MC campaign
  - Create awareness among clients that HTC is part of MC before they come for services
- Avoid stockouts of test kits
- Identify private spaces for HTC when setting up the site
- Anticipate client load and provide enough counselors to manage it
- Train extra counselors before campaigns.

To avoid bottlenecks in MC services related to HTC, suggestions for non-surgical efficiency at service delivery include the following:

- Use outreach teams preceding an MC campaign
- Create awareness among clients that HTC is part of MC before they come for services, such as providing HTC/MC information one to two days prior to MC procedures.

The participants also addressed the issue of efficient client flow and discussed the following successful approaches:

- Anticipate client load and profile (e.g., younger ages during school holidays), and train and provide enough counselors to manage that load
- Schedule reviews and counseling in the morning and procedures in the afternoon
- Split the MC team and simultaneously have clinical staff doing reviews while counselors take new clients through group education sessions and counseling; new clients will be ready for surgery by the time reviews have been completed if these are well scheduled
- Schedule earlier arrival for counselors so some clients can be ready for the procedure when the surgical team arrives.

Several participants commented on experiences to date that indicate the need for more extensive training of counselors than indicated in current WHO/Jhpiego guidance.

Participants in this group identified a number of issues for further discussion:

- Does providing condoms at procedure or less than six weeks after the procedure send a confusing message?
- What is appropriate counseling for adolescents with or without their guardians?
- What is appropriate information about retesting HIV-negative clients?
- What is useful, accurate information on post-surgical erections, masturbation, and abstinence? What are the best ways to train providers to provide this information?
- What are best practices in creating efficiencies outside of surgical practices?

Because of the need for a balance between service and demand, participants suggested that a step-by-step expansion to counseling in service delivery should be considered, such as:

- Establish core services of good quality
- Improve referrals and linkages from MC PITC/VCT to appropriate services, including strengthening counseling and referral training of these providers
- Expand other counseling components as pertinent to the local population, such as alcohol use
- Link with other services doing PITC to further increase demand
- Expand to other outreach sites such as workplaces.

# DEVELOPING A COMMUNICATIONS TOOLKIT FOR MALE CIRCUMCISION

Following the announcement that the CDC would be issuing a call for proposals for the development of a communications toolkit for MC, this working session focused on the contents and audience for this product. Specifically, the objectives of the session were 1) to describe the purpose of a toolkit for MC; 2) to explain which agency(ies) are sponsoring the development of this toolkit; and 3) to identify the potential contents of such a toolkit. The group reformulated these objectives as needing to identify:

- Priority populations that communication templates provided in the toolkit will aim to reach

- Potential barriers to developing and implementing the contents of the toolkit, as well as ways to address these barriers
- Most effective channels for communications to reach target audiences
- Examples, materials, and case studies for inclusion in the toolkit.

To identify high-priority audiences for the communications in the toolkit, the group specified the following categories of individuals and organizations:

- Individuals
  - Potential clients
  - Non-circumcised men
  - Sexually active (partnered and single) men
  - Older men (e.g., 25 to 40 years old)
  - Groups with the highest rates of infection
  - Members of traditionally circumcising communities (where relevant)
  - Traditional and cultural leaders (circumcising and non-circumcising)
  - Cultural custodians (e.g., village elders)
  - Discordant couples
  - Parents
- Women
  - Sexually active partners of non-circumcised men
  - Mothers/guardians
  - Sisters/relatives
- Organizations
  - Religious
  - Media
  - Workplace.

The key barriers and influences that the toolkit will need to address include the following:

- At the individual level
  - Misconceptions and fear
  - Pain
  - Sexual performance (decreased pleasure or impotence)
  - Safety

  - Effectiveness
  - Stigma or rejection
  - Financial costs
  - Accessibility
  - Cultural norms
  - Fear of HIV testing
- At the partner level
  - Fear of infidelity
  - Fear of HIV testing
  - Abstinence during the healing period
- At the community level
  - Traditional practices
  - History
  - Accessibility
  - Politics and policy
  - Stigma
  - Health systems
- At the national level
  - Politics and policy
  - Political will
  - Commitment
  - Prioritization of finances
  - Lack of understanding about MC and HIV prevention
  - Cost-effectiveness
  - Health care systems
  - Burnout or skepticism about HIV and related topics.

Effective channels for disseminating the toolkit:

- Should be country-specific
- Each country should conduct an assessment to make an informed decision on the most effective channels.

The Kenyan team provided a useful example of toolkit development, including materials that could improve the toolkit. More information on the Kenya MC communication toolkit and its relation to the national and regional communication strategies are provided in Appendix C.

# CASE STUDY ON SWAZILAND: SCALING UP MALE CIRCUMCISION TO REACH AN ENTIRE COUNTRY

The objectives of the two sessions focusing on Swaziland were to:

- Articulate the objectives of MC scale-up initiatives in Swaziland
- Review progress to date as well as setbacks in MC scale-up
- Present available epidemiological, sociological, and other types of data needed to understand the challenge of the scale-up in Swaziland
- Identify factors that will facilitate the scale-up as well as barriers to the scale-up
- Discuss the role of gender in MC scale-up
- Outline key elements of a communication strategy for Swaziland.

The group identified multiple targets for the demand creation strategy in Swaziland: clients, service providers, community leaders (including royalty and traditional leaders), media, parents or guardians, and partners (wives, girlfriends). They recommended that those responsible for developing the communication strategy incorporate results from the formative research conducted to date (e.g., acceptability studies and consultation with professional medical and public health organizations) to better understand the target groups.

One key issue is working with the media. The group discussed the need to define an approach for working with the media, to establish a partnership with the media, to engage media personnel in the MC program, to devise a system to feed information to them, and to train journalists on MC issues. The strategy must also explore the best options for media use (e.g., paid or unpaid media space and timing of programs) and strategies for managing negative media publicity.

In terms of channels for MC communication, the group recommended the full range of available channels: mass media (radio, television, newspapers, magazines, billboards), interpersonal (group and individual counseling, call-in programs, road shows, promoting MC through sports, dialogues, and meetings), and new technologies (e.g., cell phones). Two key messages are the benefits of MC and where to find services.

# PROGRAM EVALUATION: FORMATIVE RESEARCH, PRE-TESTING, AND MONITORING SERVICE UTILIZATION

The objectives of the session on the first day were to:

- Identify the types of research needed to guide the design and implementation of an effective communications program
- Identify key issues to be addressed in formative research

- Present the state-of-the-art in monitoring demand creation.

The second day focused on measuring the effectiveness of communication programs. Key points were as follows:

- Formative research guides the development of a communication strategy. The following are taken into account during formative research:
  - Segment of the population affected
  - Knowledge, attitudes, beliefs, and practices
  - Channels of communication
  - Barriers to and opportunities for MC.
- Formative research can take a variety of forms:
  - Epidemiological and ethnographic work
  - Focus groups with key community stakeholders and clients
  - Desk reviews of existing data
  - Survey research (the group discussed that it is important to anticipate and allow time for the human subjects review process).
- Pre-testing is performed to obtain audience input to improve messaging. The following variables should be tested:
  - Likeability (Do you like the message?)
  - Clarity/comprehension (Do you understand what this message is about?)
  - Call to action/persuasion (Would you act based on this message?)
  - Acceptability (Is this message culturally appropriate for you?)
  - Note: The importance of testing and reviewing material with gatekeepers was highlighted (e.g., religious leaders, traditional authorities, and National AIDS Council officials).
- Monitoring MC uptake tracks the level and rate of increase in number of MC procedures. Monitoring MC uptake includes the following:
  - Collect service delivery data for real-time monitoring
  - Use MOH (or other) standardized tools for client intake
  - Train staff on use of the forms
  - Determine how best to integrate findings into programming.
- Monitor communication activities (e.g., program implementation) to ensure efficiency. The following are activities to monitor communication:
  - Tracking the number of MC communication materials produced and diffused (e.g., communication guides and materials for community mobilizers)

  - Identify salient issues as new activities and products are planned
  - Differentiate paid advertising from unpaid coverage
  - Explore the development of a media intensity index (i.e., a means of quantifying the volume of materials produced and disseminated).
- Evaluate the effectiveness of communication programs. The following are used to evaluate the effectiveness of communication programs:
  - Build the rigorous evidence base associated with communication programming
  - Track trends in service utilization, at a minimum
  - Consider more elaborate designs for large-scale programs with a mass media component
  - Carefully define outcomes of interest, develop appropriate measurement strategies, and study design
  - Think and plan strategically.

# CONCLUSION

To increase the pace of averting HIV infections, it is essential not only to expand MC services but also to keep supply and demand in balance for maximum efficiency. Dr. Emmanuel Njeuhmeli presented the comprehensive package of services endorsed by UNAIDS/WHO and the PEPFAR MC TWG that addresses MC, condom usage, risk reduction counseling, HIV and sexually transmitted infection screening with treatment as indicated, as well as surgical and clinical care. Programs must use approaches that identify and establish greater efficiencies in the operating theater that have demonstrated the potential for increases in the number of circumcisions performed. While keeping in mind the need to improve the supply side of MC service delivery, participants at the Durban meeting grappled with the issues of demand creation.

This meeting underscored the need for well-designed communication interventions that will create demand for adolescent and adult MC, especially among non-circumcising populations. Much of the initial attention in MC scale-up focused on developing and strengthening the clinical aspects of service delivery, accompanied by relatively ad hoc approaches to creating demand for these services. However, given the importance of MC in averting HIV infection and the urgency to avert infections as quickly as possible, the public health community must apply what it has learned about communication from other health topics (e.g., family planning, malaria control, and HIV prevention) to MC, but at the same time allow space for innovation.

This conference allowed participants to:

- Define best practices in terms of strategic communication for MC
- Provide useful suggestions for improving counseling services and enhancing uptake of HIV testing
- Identify gaps in existing communication strategies
- Advance thinking on the toolkit for MC that is currently under development
- Solicit expertise and experience to be applied to the rapid scale-up in Swaziland
- Define the types of formative research and program evaluation needed for MC communication
- Signal the need for additional guidance from WHO and UNAIDS on the issue of incentives in MC.

Whereas many of these topics are familiar to communication experts, they represent new territory for many of those leading the MC scale-up in eastern and southern Africa.

In terms of next steps, the HIV community must apply a systematic approach to the design, implementation, and evaluation of MC communication, similar to that used in other areas of public health. It will be important to compile the evidence from this natural experiment of scaling up MC to inform the expansion of MC programming across the target countries. Operations research will test new approaches to MC communication, and more widespread monitoring and evaluation will allow identification of the most effective approaches and channels to increase adoption of MC.

Counseling around MC (including HTC) is particularly ripe for process evaluation and operations research. Potential topics include content of counseling sessions, quality assurance and improvement for counseling in high-volume settings, potential for offsite testing and counseling (prior to the day of the procedure), and means of improving the efficiency of counseling to avoid bottlenecks. Finally, gender remains a cross-cutting issue: for MC to fulfill its promise as a significant HIV prevention intervention, its full potential needs to be realized for both men and women. The HIV community needs to better understand the potential effects of MC on women and how to determine if risk compensation is a real phenomenon and if so, how to counter risk behavior among circumcised men. The role of wives, partners, mothers, and grandmothers as key decision makers and advocates for MC has to be recognized and strengthened. The need to address harmful gender norms that continue to impede the uptake of all HIV prevention is ongoing, and the scale-up of MC presents an opportunity to address these norms and to promote male sexual health more generally. Linking and integrating MC services to community-based programs that address norms can enhance the effectiveness of all HIV prevention interventions. All of these issues should be reviewed with the understanding that there will be differences based on the age and cultural settings of the men coming for MC.

The Durban meeting began the important conversation to further explore and develop MC communication. It established a common base of knowledge among countries and organizations working in MC, and provided participants from 14 countries an important opportunity to share their experiences, identify successful strategies, and gain greater insight into the technical skills needed in communication. Moreover, the meeting introduced a number of military participants to the civilian approaches used in promoting circumcision (many of which can be easily adapted). This type of exchange should be repeated. Future meetings on this topic should present the findings from operations research and program evaluation that test the effectiveness of communication interventions and document the mechanisms that make them most effective.

# APPENDIX A

# AGENDA

## UNAIDS–PEPFAR SOUTHERN AND EASTERN AFRICA REGION MALE CIRCUMCISION COMMUNICATION MEETING

### SEPTEMBER 22-24, 2010

### DURBAN, SOUTH AFRICA

### SOUTHERN SUN ELANGENI

| ***Day 1 – Wednesday, September 22, 2010***<br>***Chair: Catherine Hankins, UNAIDS*** | | ***Facilitator*** |
|---|---|---|
| 07:00-08:00 | **Breakfast**<br>**Registration** | Leigh Ann Evanson and Amy Pepin, AIDSTAR-One |
| 08:00-08:30 | **Welcome**<br>Presentation of Participants<br>Presentation of the Meeting Agenda | Yagan Pillay, South Africa NDOH<br>Catherine Hankins, UNAIDS<br>Naomi Bock, CDC Atlanta<br>Emmanuel Njeuhmeli, USAID |
| 08:30-09:30 | **Male Circumcision Communication: Achievements and Challenges from the PEPFAR Program**<br>**Case Study: Successful Coordination of Partners in Designing a Communication Strategy for Male Circumcision** | Jane Bertrand, AIDSTAR-One<br>Athanasius Ochieng, NASCOP Kenya MOH |
| 09:30-10:30 | **Male Circumcision for HIV Prevention: What Do We Need to Have a Public Health Impact?**<br>Communications Update Including Gender and Ethics<br>MC Clearinghouse: Expanding Global Access to Information<br>Communication Toolkit: Principle, Purpose, Content<br>Calibrating Supply and Demand | Catherine Hankins, UNAIDS<br>Julie Samuelson, WHO<br>Sekai Chideya-Chihota, CDC<br>Emmanuel Njeuhmeli, USAID |
| 10:30-11:00 | **Break** | |
| 11:00-11:30 | **Advocacy in Support of the Male Circumcision Scale-Up** | TBD |

| *Day 1 – Wednesday, September 22, 2010*<br>*Chair: Catherine Hankins, UNAIDS* | | *Facilitator* |
|---|---|---|
| 11:30-12:30 | **Panel Discussion: HIV Counseling and Testing for the Male Circumcision Program: Voices from the Field**<br>Roy Dhlamini, PSI Zimbabwe<br>Bennet Fimbo, National AIDS Control Program Tanzania MOH<br>Emma Llewellyn, NRHS Kenya<br>Hally Mahler, Jhpiego Tanzania<br>Gertrude Ncube, Zimbabwe MOHCW<br>Athenasius Ochieng, NASCOP Kenya MOH | Chair of the Panel: Julie Samuelson, WHO |
| 12:30-13:30 | **Lunch** | |

**Small Group Sessions**

*Note: the organizers will ask some participants to attend a specific section; all other participants are free to select the session they prefer on Day 1 and Day 2. We request that once in a small group, the participant attends the whole session for that afternoon and does not "jump between sessions."*

| | | |
|---|---|---|
| 13:30-17:30 | **GROUP A: Communication Strategy for Demand Creation**<br><br>**Facilitator**: Pamela Kisoka, Tanzania DOD<br>**Resource Person**: Richard Delate, JHHESA; Adebayo Fayoyin, UNICEF South Africa<br>**Rapporteurs**: Melissa Adams, USAID; Roselyn Mutemi-Wangaho UNICEF Kenya<br><br>**Objectives of the session:**<br>• Develop a common understanding of the importance and content of a communication strategy<br>• Identify the challenges of designing and implementing a communication strategy for male circumcision in participating countries<br>**Expected output for the session:**<br>• Recommendations for developing a communication strategy for demand creation | |
| 13:30-13:50 | **Presentation**: Developing Communication Strategies for Demand Creation<br>• Purpose/importance of communication strategy for demand creation for MC<br>• Contents of a communication strategy<br>• Definition of strategy objectives | Richard Delate, JHHESA |
| 14:00-15:00 | **Facilitated Discussion:** Exchange of Country-level Experiences | |
| 15:00-15:30 | **Break** | |
| 15:30-16:15 | **Facilitated Discussion:** Aligning Strategy and Service Delivery, Addressing Gender and Cultural Norms | |
| 16:15-17:30 | **Small Group Work:** Developing Recommendations for Communication Strategies for Demand Creation for Male Circumcision to be Included in Meeting Report | |

| *Day 1 – Wednesday, September 22, 2010*<br>*Chair: Catherine Hankins, UNAIDS* | | *Facilitator* |
|---|---|---|
| 13:30-17:30 | **GROUP B: Counseling: Messages for Pre-op and Follow-up Counseling; HIV Testing Demand Creation and Update for HIV Testing**<br><br>**Facilitator**: Zebedee Mwandi, CDC<br>**Resource Persons**: Naomi Bock, CDC Atlanta; Roy Dhlamini, PSI Zimbabwe; Emma Lewellyn, NRHS Kenya; Hally Mahler, Jhpiego Tanzania<br>**Rapporteurs**: Sara Banda, WHO Zimbabwe; Kirk Lazell, USAID Washington<br><br>**Objectives:**<br>• Identify messages for pre-op and follow-up counseling<br>• Discuss how to integrate messages on risk reduction and gender into pre-op and post-op counseling<br>• Identify messages/content needed for negatives, positives and those of unknown HIV status<br>**Expected output:**<br>• Recommendations on the content that should be included in pre-op and follow-up counseling | |
| 13:30-13:50 | **Presentation**: Recommended Protocol and Content for Pre-op Counseling<br>• Pre-op: surgical information, treatment of wound, need for follow-up visit<br>• Follow-up counseling<br>• Partial protection, risk reduction, integration of gender | Naomi Bock, CDC Atlanta |
| 13:50-14:10 | **Presentation**: Integrating Pre-op and HTC Counseling Around Risk Reduction; Incorporating Gender into Counseling Sessions | Hally Mahler, Jhpiego Tanzania |
| 14:10-14:30 | **Presentation**: Pre-op Counseling Based on HIV Status | Emma Llewellyn, NRHS Kenya |
| 14:30-15:00 | **Small Group Work**: Recommendations of the Group on Content for Pre-op Counseling | |
| 15:00-15:30 | **Break** | |
| 15:30-15:50 | **Presentation**: Recommended Content for Follow-up Counseling | Roy Dhlamini, PSI Zimbabwe |
| 15:50-16:15 | **Facilitated Discussion**: Exchange of Country-level Experiences with Pre and Post-op Counseling | |
| 16:15-17:30 | **Facilitated Discussion**: Recommendations of the Group for Post-op Counseling to be Included in Meeting Report | |
| 13:30-17:30 | **GROUP C: Communications Toolkit for Male Circumcision: Mass and Small Media Elements**<br><br>**Facilitator**: Sekai Chideya-Chihota, CDC<br>**Resource persons**: Isaac Abuya, AED/C-Change Kenya; Beth Deutsch, USAID Malawi; Ndungu Kiriro, PSI Kenya; Peters Roberts, JHUCCP Malawi<br>**Rapporteurs**: Precious Lunga, UNAIDS; Duncan Onditi, USAID Tanzania<br><br>**Objectives:**<br>• Describe the purpose of a male circumcision toolkit<br>• Explain who will develop the toolkit<br>• Identify toolkit contents as it relates to mass and small media elements<br>**Expected output:**<br>• Recommendations on mass media elements of a toolkit | |

| *Day 1 – Wednesday, September 22, 2010*<br>*Chair: Catherine Hankins, UNAIDS* | | *Facilitator* |
|---|---|---|
| 13:30-14:00 | **Presentation**: Rationale for Toolkit | Sekai Chideya-Chihota, CDC |
| 14:00-14:30 | **Presentation**: Work to Date by C-Change and PSI-Kenya | Isaac Abuya, AED/C-Change, Kenya |
| 14:30-15:00 | **Facilitated Discussion**: Toolkit Contents, Mass Media Focus. Channels, Audiences, Materials | |
| 15:00-15:30 | **Break** | |
| 15:30-16:00 | **Facilitated Discussion**: Incorporating Gender (e.g. Addressing Male Norms, Gender-based Violence, Other) | |
| 16:00-16:30 | **Facilitated Discussion**: Additional Information or Research Needs | |
| 16:30-17:30 | **Small Group Work**: Develop Recommendations on Male Circumcision Toolkit. Focus on Mass Media and Small Media Elements to be Included in Meeting Report | |
| 13:30-17:30 | **GROUP D: National MC Scale-up: Case Study Swaziland: Part I of II**<br><br>**Facilitator**: Catherine Hankins, UNAIDS<br>**Resource person**: Cal Bruns, Matchboxology; Ayanda Nqeketo, Futures Group; Faith Dlamini, NERCHA Swaziland<br>**Rapporteurs**: Thembisile Dlamini, UNAIDS; Daryl Martyris, USAID Swaziland<br><br>**Objectives:**<br>• Articulate the objectives of the male circumcision scale-up initiatives in Swaziland<br>• Review progress and challenges<br>• Present available epidemiological, sociological, and other types of data needed<br>• Identify supportive factors for and challenges to national scale-up<br>• Discuss the role of gender<br>• Outline elements of a communication strategy for Swaziland<br>**Expected outputs:**<br>• Key points for a new communication strategy for Swaziland | |
| 13:30-13:45 | **Presentation**: Accelerated Saturation Initiative (ASI) Objectives | Faith Dlamini, NERCHA Swaziland |
| 13:45-14:00 | **Presentation**: Communication Strategy Overview | Cal Bruns, Matchboxology |
| 14:00-14:30 | **Presentation**: Advocacy and Involvement of Local and Traditional Authorities | Ayanda Nqeketo, Futures Group |
| 14:30-15:00 | **Facilitated Discussion**: Observations from Audience Based on Experiences in Other Countries | |
| 15:00-15:30 | **Break** | |
| 15:30-16:30 | **Small Group Work**: Refining Swaziland Communication Strategy | |
| 16:30-17:30 | **Small Group Work**: Outline for Swaziland Communication Strategy for Male Circumcision Scale-up | |

| *Day 1 – Wednesday, September 22, 2010*<br>*Chair: Catherine Hankins, UNAIDS* | | *Facilitator* |
|---|---|---|
| 13:30-17:30 | **GROUP E: Program Evaluation: Formative Research, Pretesting, and Monitoring Service Utilization**<br><br>**Facilitator**: Anne Goldzier Thomas, U.S. DOD<br>**Resource person**: Kayango Agot, Impact Research & Development Organization; Delivette Castor, USAID; Cate O'Kane, PSI Botswana; Suleiman Shifaw, Ethiopia AIDS Resource Center; Beth Skorochod, PSI<br>**Rapporteurs**: Stephanie Cook, USAID; Kanyanta Sunkutu, WHO Zambia<br><br>**Objectives:**<br>• Identify research needs for design and implementation of a communication program<br>• Identify key issues to be addressed in formative research<br>• Present the current state-of-the-art in monitoring demand creation<br>**Expected output:**<br>• Recommendations on the research needed for the design, implementation, and monitoring and evaluation of demand creation strategies | |
| 13:30-14:00 | **Presentation**: Formative Research to Guide the Design of Demand Creation | Delivette Castor, USAID |
| 14:00-15:00 | **Presentation**: Communication Experiences on Pretesting Communication Materials/Messages<br>• Ethiopia<br>• Kenya<br>• Botswana | Suleiman Shifaw, Ethiopia AIDS Resource Center<br>Beth Skorochod, PSI Kenya<br>Cate O'Kane, PSI Botswana |
| 15:00-15:30 | **Break** | |
| 15:30-16:00 | **Presentation**: Research for Monitoring Demand Creation:<br>• Monitoring Outputs<br>• Tracking Service Utilization | Kayango Agot, Impact Research & Development Organization |
| 16:00-16:30 | **Facilitated Discussion**: Challenges of Monitoring Demand Creation | |
| 16:30-17:30 | **Small Group Work**: Developing Recommendations for Formative Research and Monitoring Demand Creation to be Included in the Meeting Program | |
| 17:30-20:00 | **Marketplace Gallery of Male Circumcision Materials**<br>**Welcome Dinner** | |

| **Day 2 – Thursday, September 23, 2010**<br>***Chair: Caroline Ryan, OGAC*** | | **Facilitator** |
|---|---|---|
| 07:00-08:00 | **Breakfast**<br>**Registration** | Leigh Ann Evanson and Amy Pepin, AIDSTAR-One |
| 08:00-10:00 | **Promising Country Experiences With Male Circumcision Communication**<br>• Tanzania: Supporting public sector implementation of male circumcision program<br>• Kenya: Beyond 130,000 male circumcisions—Mobilizing the "right age" for public health impact<br>• Swaziland: Mobilizing the general population for male circumcision saturation<br>• Zimbabwe: Incorporating male norms under the male circumcision program | Bennet Fimbo, National AIDS Control Program Tanzania MOH<br>Athanasius Ochieng, NASCOP Kenya MOH<br>Ayanda Nqeketo, Futures Group<br>Gertrude Ncube, Zimbabwe MOHCW |
| 10:30-12:30 | **Expert Panel: Does Demand Creation for Male Circumcision Differ From Other Public Health Topics?**<br>Tara Kovach, AED/C-Change<br>Cal Bruns, MatchBoxology<br>Cheryl Lettenmeier, CCP<br>Ndungu Kiriro, PSI Kenya<br>Hally Mahler, Jhpiego Tanzania | Chair of Panel: Precious Lunga, UNAIDS |
| 12:30-13:30 | **Lunch** | |
| **Small Group Sessions**<br>*Note: the organizers will ask some participants to attend a specific section; all other participants are free to select the session they prefer on Day 1 and Day 2. We request that once in a small group, the participant attends the whole session for that afternoon and does not "jump between sessions."* | | |
| 13:30-17:30 | **Group A: Advocacy for the Male Circumcision Scale-up**<br><br>**Facilitator**: Precious Lunga, UNAIDS<br>**Resource persons**: Kelly Curran, Jhpiego; Beth Skorochod, PSI<br>**Rapporteurs**: Leigh Ann Evanson, AIDSTAR-One; Suzanne Leclerc-Madlala, USAID<br><br>**Objectives:**<br>• Review country experiences in advocacy for male circumcision scale-up<br>• Discuss strategies for integrating gender into advocacy initiatives<br>• Synthesize lessons learned from experiences to date<br>**Expected output:**<br>• Recommendations on designing and implementing advocacy for the male circumcision scale-up, for inclusion in the meeting report | |
| 13:30-15:00 | **Presentation**: Case Studies in Advocacy from Kenya, Swaziland, Malawi, and Lesotho | Athanasius Ochieng, Kenya MOH<br>Henry Chimbali, Malawi MOH<br>Mpolai M Moteetee, Lesotho MOH |
| 15:00-15:30 | **Break** | |
| 15:30-15:45 | **Facilitated Discussion**: Review of Male Circumcision Clearinghouse | Beth Skokochod, PSI<br>Kelly Curran, Jhpiego |
| 15:45-16:30 | **Facilitated Discussion**: Lessons Learned from Advocacy Initiatives Including Objectives, Audiences, Channels, Tools, and Materials | |

| **Day 2 – Thursday, September 23, 2010**<br>***Chair: Caroline Ryan, OGAC*** | | **Facilitator** |
|---|---|---|
| 16:30-17:30 | **Small Group Work**: Developing Recommendations on Male Circumcision Advocacy Strategies to be Included in the Meeting Report Strategies for Advocacy for Male Circumcision | |
| 13:30-17:30 | **GROUP B: Counseling: HIV Testing and Counseling in Male Circumcision Services and Efficient Client Flow**<br><br>**Facilitator:** Zebedee Mwandi, CDC Kenya<br>**Resource persons:** Roy Dhlamini, PSI Zimbabwe; Emma Lewellyn, NRHS Kenya; Hally Mahler, Jhpiego Tanzania; Mphikeleli Dlamini, PSI Swaziland<br>**Rapporteurs:** Kirk Lazell, USAID Washington; Sara Manda, WHO Zimbabwe<br><br>**Objectives:**<br>• Identify strategies to increase HIV testing uptake in male circumcision services<br>• Explore HCT referrals to male circumcision services<br>• Identify factors in HIV testing uptake in male circumcision services<br>• Analyze impact of HCT on client flow at male circumcision sites<br>• Identify delays and possible solutions<br>**Expected output:**<br>• Recommendations for improving HCT uptake in male circumcision services<br>• Recommendations for efficient client flow and quality assurance of counseling | |
| 13:30-13:50 | **Presentation**: Strategies for Increasing HCT Uptake in Male Circumcision Services | Hally Mahler, Jhpiego Tanzania |
| 13:50-14:30 | **Presentation**: Factors Related to the Acceptance Prior to Male Circumcision | Emma Llewellyn, NRHS Kenya |
| 14:30-15:00 | **TBD** | |
| 15:00-15:30 | **Break** | |
| 15:30-16:00 | **Presentation**: Bottlenecks and Other Issues for Efficient Client Flow | Mphikeleli Dlamini, PSI Swaziland |
| 16:00-16:30 | **Facilitated Discussion**: Experience from Other Countries | |
| 16:30-17:30 | **Small Group Work**: Developing Recommendations for Ensuring Efficient Client Flow to be Included in the Meeting Report | |
| 13:30-17:30 | **GROUP C: Developing a Male Circumcision Toolkit: Interpersonal Communication**<br><br>**Facilitator:** Sekai Chideya-Chihota, CDC<br>**Resource persons:** Isaac Abuya, AED/C-Change Kenya; Beth Deutsch, USAID Malawi; Ndungu Kiriro, PSI Kenya; Peter Roberts, JHU Center for Communication Programs<br>**Rapporteurs:** Precious Lunga, UNAIDS; Duncan Onditi, USAID Tanzania<br><br>**Objectives:**<br>• Review the toolkit purpose for male circumcision and agency(ies) involved<br>• Identify toolkit contents as they relate to interpersonal communication<br>**Expected output:**<br>• Recommendations on the interpersonal communication contents of the toolkit | |
| 13:30-14:00 | **Presentation**: Case Study on Experience with Interpersonal Communication in the Male Circumcision Scale-Up (Peer Educators, Satisfied Users, Wives of Satisfied Clients, etc.) | Isaac Abuya, AED/C-Change Kenya |
| 14:00-15:00 | **Facilitated Discussion**: Interpersonal Communication Elements for the Male Circumcision Toolkit | |
| 15:00-15:30 | **Break** | |

| **Day 2 – Thursday, September 23, 2010**<br>***Chair: Caroline Ryan, OGAC*** | | **Facilitator** |
|---|---|---|
| 15:30-16:15 | **Facilitated Discussion**: Incorporating Gender Into Interpersonal Communication Strategies | |
| 16:15-17:30 | **Small Group Work**: Develop Recommendations on Male Circumcision Toolkit. Focus on Interpersonal Communication to be Included in Meeting Report | |
| 13:30-17:30 | **GROUP E: Program Evaluation: Evaluating the Effectiveness of Demand Creation and Assessing the Quality of Counseling**<br><br>**Facilitator:** Anne Goldzier Thomas, U.S. DOD<br>**Resource person:** Jane Bertrand, AIDSTAR-One; Tara Kovach, AED/C-CHANGE<br>**Rapporteurs:** Stephanie Cook, USAID; Kanyanta Sunkutu, WHO Zambia<br><br>**Objectives:**<br>• Present the challenges in evaluating the effectiveness of demand creation<br>• Identify practical study designs for evaluating effectiveness in field settings<br>**Expected output:**<br>• Recommendations on appropriate study designs for evaluating the effectiveness of demand creation and for assessing quality of counseling in MC programs | |
| 13:30-14:00 | **Presentation**: Challenges and Possible Study Designs for Evaluating the Effectiveness of Demand Creation Interventions for Male Circumcisions | Jane Bertrand, AIDSTAR-One |
| 14:00-14:30 | **Facilitated Discussion**: Challenges in Evaluating the Effectiveness of Demand Creation | |
| 14:30-15:00 | **Small Group Work**: Recommendations on Study Designs for Measuring Effectiveness of Male Circumcision Demand Creation | |
| 15:00-15:30 | **Break** | |
| 15:30-16:00 | **Presentation**: Research Strategy for Monitoring the Quality of Male Circumcision Counseling | Tara Kovach, AED/C-Change |
| 16:00-16:30 | **Facilitated Discussion**: Country Experiences and Challenges with Monitoring Quality of Male Circumcision Counseling | |
| 16:30-17:30 | **Small Group Work**: Developing Recommendations for Monitoring the Quality of Counseling to be Included in the Meeting Report | |

| **Day 3 – Friday, September 24, 2010**<br>***Chair: Luke Nkinsi, BMGF*** | | **Facilitator** |
|---|---|---|
| 09:00-10:30 | **Key Recommendations From Each Group Rapporteurs**<br>• Development of a communication strategy<br>• Advocacy<br>• Counseling: content, quality, and client flow | <br>• Day 1, Group A<br>• Day 2, Group A<br>• Day 1 and 2, Group B |
| 10:30-11:00 | **Break** | |
| 11:00-12:15 | **Key Recommendations From Each Group Rapporteurs**<br>• Communication strategy for a saturation initiative<br>• Male Circumcision Communication Toolkit<br>• Program Evaluation | <br>• Day 1 and 2, Group D<br>• Day 1 and 2, Group C<br>• Days 1 and 2, Group E |
| 12:15 | **Meeting Close** | Precious Lunga, UNAIDS<br>Luke Nkinsi, BMGF<br>Caroline Ryan, OGAC<br>Julie Samuelson, WHO |
| 12:30-13:30 | **Lunch** | |
| ***Afternoon Programming For Representatives of the Ministries of Health and Donor Agencies only*** | | |
| 13:30-15:00 | **Roundtable Discussion with MOH Representatives only with PEPFAR, BMGF, WHO and UNAIDS representatives only**<br>• Solicit meeting feedback<br>• Review action items for individual countries<br>• Share recommendations with donors | |
| 15:00-15:30 | **Break** | |
| 15:30-17:00 | **Meeting of PEPFAR, BMGF, WHO and UNAIDS only for coordination**<br>• Discuss priorities for communication in the male circumcision scale-up | |

# APPENDIX B

# PARTICIPANTS

| First Name | Last Name | Organizational Affiliation | Work Country |
|---|---|---|---|
| Isaac | Abuya | Academy for Educational Development (AED)/C-Change | Kenya |
| Silas | Acha | FHI Kenya – MCC | Kenya |
| Melissa | Adams | United States Agency for International Development (USAID) | United States |
| Fayoyin | Adebayo | United Nation's Children's Fund (UNICEF) | South Africa |
| Kawango | Agot | Impact Research & Development Organization | Kenya |
| Venansio | Ahabwe | Johns Hopkins University Center for Communication Programs, Health Communication Partnership | Uganda |
| Irakoze | Ange Anitha | TRAC PLUS (Treatment and Research AIDS Center) | Rwanda |
| Bertran | Auvert | CHAPS | South Africa |
| Wendy | Benzerga | USAID | South Africa |
| Jane | Bertrand | Consultant, John Snow Inc. (JSI) | United States |
| Benjamin | Binagwa | The African Comprehensive HIV/AIDS Partnerships (ACHAP) | Botswana |
| Naomi | Bock | CDC | United States |
| Maud | Boikanya | MOH Lesotho | Lesotho |
| Mark | Breda | Makerere University Walter Reed Project | Uganda |
| Cal | Bruns | Matchboxology | South Africa |
| Lesego | Busang | ACHAP | Botswana |
| Delivette | Castor | USAID | United States |
| Kumbirai | Chatora | Population Services International (PSI) Zimbabwe | Zimbabwe |
| Sekai | Chideya | CDC | United States |
| Maureen | Chilila | Jhpiego | Zambia |
| Henry | Chimbali | MOH | Malawi |
| Ladislous | Chonzi | Jhpiego Botswana | Botswana |
| Farley | Cleghorn | Futures Group | United States |

| | | | |
|---|---|---|---|
| Shanti | Conly | USAID | United States |
| Stephanie | Cook | USAID | United States |
| James | Creighton | CDC | South Africa |
| Kelly | Curran | Jhpiego | United States |
| Cynthia Nhlapo | Cynthia | Society for Family Health | South Africa |
| Richard | Delate | Johns Hopkins Health and Education South Africa | South Africa |
| Shame | Dendere | Zimbabwe Defense Force | Zimbabwe |
| Beth | Deutsch | USAID/Malawi | Malawi |
| Roy | Dhlamini | PSI | Zimbabwe |
| Banele | Dlamini | Umbutfo Swaziland Defence Force | Swaziland |
| Faith | Dlamini | MOH Swaziland | Swaziland |
| Mphikeleli | Dlamini | PSI Swaziland | Swaziland |
| Thembisile | Dlamini | The United Nations Joint Programme on AIDS (UNAIDS) | Swaziland |
| Sam | Enginya | MOH Uganda | Uganda |
| Leigh Ann | Evanson | AIDSTAR-One, JSI | United States |
| Thato | Farirai | CDC South Africa | South Africa |
| Bennett | Fimbo | MOH/National AIDS Control Program Tanzania | Tanzania |
| Laura | Fitzgerald | Jhpiego | Swaziland |
| Sarah | Gibson | PSI Malawi | Malawi |
| Thulani | Grenville - Grey | Matchboxology | South Africa |
| Shannon | Hader | Futures Group | United States |
| Catherine | Hankins | UNAIDS | Switzerland |
| Ismael | Hassen | MOH Ethiopia | Ethiopia |
| Augustino | Hellar | Jhpiego | Tanzania |
| Helga | Holst | McCord Hospital | South Africa |
| Krishna | Jafa | PSI | United States |
| Bishagara Therese | Kagoyire | Jhpiego | Rwanda |
| Ndalambo Tshibola | Kanku | MoHSS Namibia | Namibia |
| Wezi | Kaonga | MOH | Zambia |
| Virgile | Kikaya | World Health Organization (WHO) | Lesotho |
| Ndungu | Kiriro | PSI Kenya | Kenya |
| Pamela | Kisoka | Department of Defense | Tanzania |
| Tara | Kovach | AED/C-Change | United States |
| Stephen | Kusasira | Uganda Defense Force | Uganda |
| C Kirk | Lazell | USAID | United States |
| Suzanne | Leclerc-Madlala | USAID | United States |

| | | | |
|---|---|---|---|
| Cheryl | Lettenmaier | Johns Hopkins University Center for Communication Programs | Uganda |
| Emma | Llewellyn | Nyanza Reproductive Health Society | Kenya |
| Precious | Lunga | UNAIDS Geneva | Switzerland |
| Robin | Maarman | St. Marys Hospital | South Africa |
| Glandson | Madziatera, | Malawi Department of Defense | Malawi |
| Samuel | Magagula | MOH Swaziland | Swaziland |
| Makojang | Mahao | USAID/Lesotho | Lesotho |
| Hally | Mahler | Jhpiego/Tanzania | Tanzania |
| Robert | Manda | CDC Botswana | Botswana |
| Patrick | McElroy | Peace Corps | United States |
| Bonginkosi | Mdluli | Centre for the AIDS Programme of Research in South Africa (CAPRISA) | South Africa |
| Maria da Gloria | Meque | Ministry of Defense Mozambique | Mozambique |
| Sibia Tracy | Mjumira | Department of Nutrition, HIV & AIDS | Malawi |
| Jonathan | Moalosi | MOH, Department of HIV/AIDS Prevention & Care | Botswana |
| Mbako | Molopo | Botswana Defence Force | Botswana |
| Mpolai | Moteetee | MOH Lesotho | Lesotho |
| Charles | Murego | Ministry of Defence Rwanda Defense Force | Rwanda |
| Roselyn | Mutemi | UNICEF Kenya | Kenya |
| Zebedee | Mwandi | CDC Kenya | Kenya |
| Robert | Mwandishi | CDC Tanzania | Tanzania |
| Fabian | Mwanyumba | UNICEF | Swaziland |
| Getrude | Ncube | Ministry of Health and Child Welfare | Zimbabwe |
| Nelson | Ndegwa | Tanzania Marketing and Communications (T-MARC) Company Ltd | Tanzania |
| Bongani | Ndlovu | Soul City Institute | South Africa |
| Kighoma | Nehemia | Rakai Health Sciences Program | Uganda |
| Emmanuel | Njeuhmeli | USAID/Washington | United States |
| Amon | Nkhata | MOH Malawi | Malawi |
| Luke | Nkinsi | Bill & Melinda Gates Foundation | United States |
| Ayanda | Nqeketo | Futures Group | Swaziland |
| Palesa | Nthakana | PSI Lesotho | Lesotho |
| Athanasius | Ochieng | National AIDS/STI Control Programme (NASCOP) MOH KENYA | Kenya |
| Cate | O'Kane | PSI Botswana | Botswana |
| Duncan | Onditi | USAID/Tanzania | Tanzania |

| | | | |
|---|---|---|---|
| Amy | Pepin | AIDSTAR-One, JSI | United States |
| Shungu | Phillips-Malikongwa | ACHAP | Botswana |
| Mannasseh | Phiri | PSI Zambia | Zambia |
| Paris | Pitsillides | Matchboxology | South Africa |
| Arthi | Ramkissoon | Maternal, Adolescent & Child Health [MatCH] | South Africa |
| Dino | Rech | CHAPS | South Africa |
| Benoit | Renard | PSI Swaziland | Swaziland |
| Peter | Roberts | Johns Hopkins University Center for Communication Programs | Malawi |
| Roxana | Rogers | USAID/Pretoria | United States |
| Douglas | Ross | St. Mary's Hospital, Mariannhill | South Africa |
| Caroline | Ryan | The U.S. Global AIDS Coordinator (OGAC) | United States |
| Tembo | Samson | Ministry of Defence | Zambia |
| Julia | Samuelson | WHO | Switzerland |
| Chalone | Savant | USAID/PEPFAR | United States |
| Agnes | Shabala | Soul City Institute | South Africa |
| Suleiman | Shifaw | Center for Communication Programs/AIDS Resource Center | Ethiopia |
| Thiopolina | Shivolo | Ministry of Defence | Namibia |
| Beth | Skorochod | PSI | United States |
| Helen | Struthers | Anova Health Institute | South Africa |
| Kanyanta | Sunkutu | WHO | Zambia |
| Dirk | Taljaard | CHAPS | South Africa |
| Christopher | Teleka | National AIDS Commission Malawi | Malawi |
| Joao | Teofilo | Mozambique Defense Force | Mozambique |
| Caroline | Teter | Futures Group | United States |
| Dlamini | Thembisile | UNAIDS | Swaziland |
| Anne | Goldzier Thomas | U.S. Department of Defense | United States |
| Aiesha | Volow | U.S. Peace Corps | Swaziland |

# APPENDIX C

# SAMPLES OF COMMUNICATION MATERIALS

In 2008, the Kenya MOH released the "National Guidance for Voluntary Male Circumcision in Kenya" to provide a framework for the integration of MC in existing HIV prevention programs. It offers general principles to ensure safe MC services are accessible and integrated into sexual and reproductive health programs. This contributes to Kenya's national HIV prevention strategy that aims to reduce the risk of new HIV infections and the prevalence to below five percent by 2010.

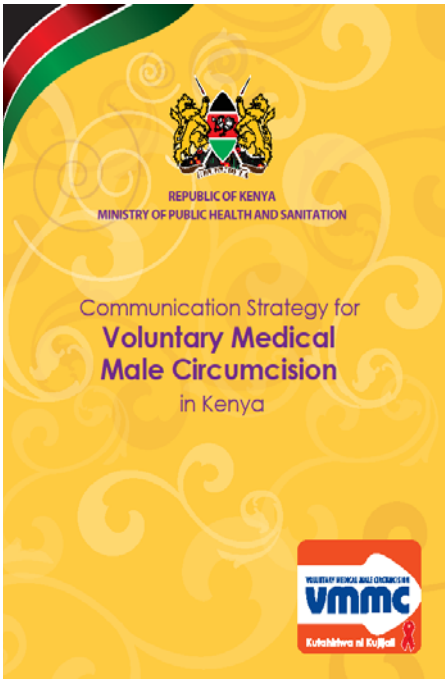
Realizing the complex communication needs associated with MC, Kenya also created a national Communication Strategy for Voluntary Medical Male Circumcision (VMMC) that defines the framework, guiding principles, and key elements related to MC. The process of developing the strategy brought together key stakeholders and, using high levels of consultation and interaction, produced a document that reflected the concerns and priorities of those involved in MC in Kenya.

The Communication Strategy for VMMC is designed to raise the level of awareness and concerns for individuals and communities, empowering them to make decisions that reduce their risk of HIV infection. The strategy also advocates for social and normative change that increases and sustains positive/preventive sexual and reproductive health options, recognizing that MC services represents only one of many HIV prevention strategies.

The five-year strategy was designed after a comprehensive situation analysis and policy review (which is summarized in the strategy document), and is aligned with national HIV strategy and guideline documents, as well as best practices and recommendations from international bodies like UNAIDS and WHO. The strategy document enumerates its aims and objectives, analyzes the audience, and identifies primary and secondary audiences for VMMC. The strategy outlines key general messages that must be conveyed directly or indirectly in any communication efforts. The strategy also reviews the process for developing messages, insisting on a careful pre-testing phase before any materials are produced en masse. The strategy also details plans for implementation for its multilevel, multipronged approach, notably approaches and activities in advocacy, social mobilization, and behavior change communication efforts. The strategy outlines the role of various actors in the management and coordination of communication activities at national and local levels. Finally, the strategy provides a monitoring and evaluation framework that will allow communication efforts to measure effectiveness and make changes to increase impact. The strategy will also be reviewed at its midpoint and have a final evaluation to determine its effectiveness.

Subsequent to the development of the national strategy, C-CHANGE—in partnership with the Nyanza Male Circumcision Task Force—developed a VMMC Communication Guide for Nyanza province. This document utilized the framework and guidance from the national-level document to adapt and operationalize the principles, objectives, and outcomes, which are derived for the specific context of Nyanza.

A broad range of VMMC communication materials were designed in accordance with the strategy, including radio spots targeting men and women, billboards, posters for men (including posters specifically to be posted in men's bathrooms), video vignettes, and brochures and booklets targeting men. Other materials included a booklet and poster targeting women, a post-operative brochure and poster, and even a supermarket TV screen. For service providers, the communication sub-committee of the National and Nyanza MC Taskforce developed flipcharts and posters for service delivery points. Community mobilizers were provided with guides and community dialogue cards. A series of brochures targeting key influencers (faith leaders, business leaders, and community leaders) were also developed. Samples of these materials are included on the following pages.

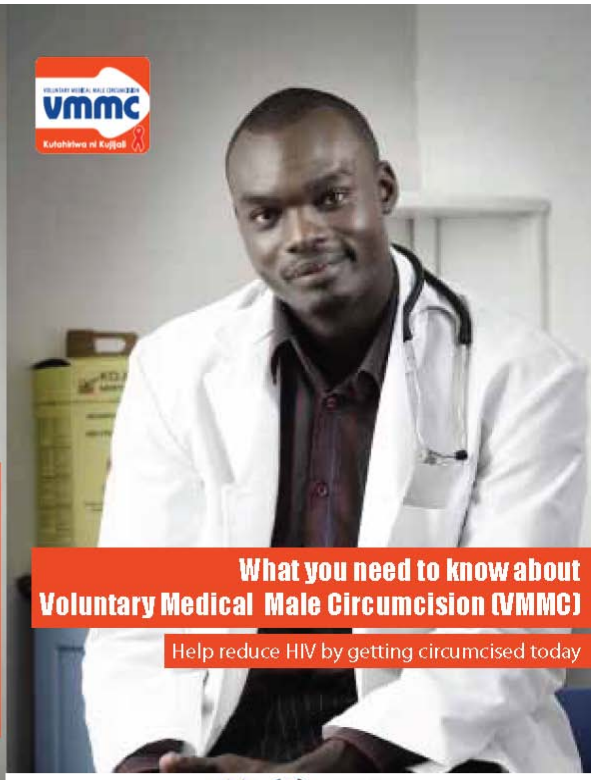


**Five Facts about Voluntary Medical Male Circumcision (VMMC)**

1. A circumcised man is up to 60% less likely to get infected with HIV.
2. It does not affect the size of your penis.
3. There is some pain, but not much.
4. After VMMC, you can do most things after just 2 or 3 days.
5. There is no proven effect on sexual pleasure.

**How male circumcision protects you against HIV:**

**Before circumcision:**
The inside of the foreskin is soft and moist and is more likely to get a tiny tear or sore that allows HIV to enter the body more easily. The foreskin itself contains many 'target cells' that allow HIV to enter the body easily.




# What you need to know about Voluntary Medical Male Circumcision (VMMC)

Help reduce HIV by getting circumcised today

USAID

## 1. What is Voluntary Medical Male Circumcision (VMMC)?

VMMC is the removal of a man's foreskin. It is a widely used, simple and safe procedure. Men can be circumcised at any age. While many men in Kenya have already undergone the procedure, only 10% of Luo men in Nyanza are circumcised today.

## 2. Why should men get circumcised?

VMMC can provide protection against HIV infection. A circumcised man is up to 60% less likely to get infected with HIV than an uncircumcised man.

## 3. What are other benefits of VMMC?

VMMC reduces the man's chances of getting other infections like syphilis and herpes. VMMC also gives some protection against penile cancer in men and cervical cancer in women.

## 4. How does being circumcised protect men from HIV?

The inside of the foreskin is soft and moist and is more likely to get a tiny tear or sore that allows HIV to enter the body more easily. The foreskin itself contains many 'target cells' that allow HIV to enter the body easily. After circumcision, the skin on the head of the penis becomes thicker and is less likely to tear.

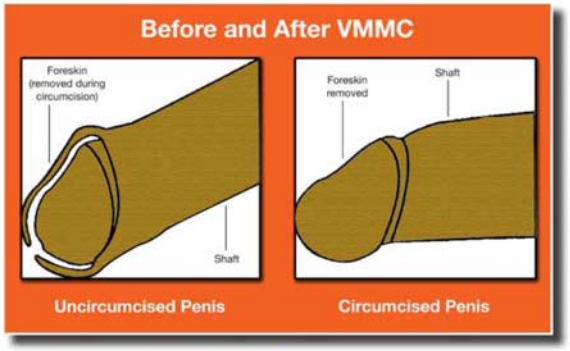
## 5. Why is it important to know your HIV status prior to VMMC?

Someone considering VMMC should know their HIV status in order to get the health benefits that VMMC provides. Clients who decline the test but still want to get circumcised must be respected for their decision. VMMC is not recommended for HIV positive men.

## 6. How is VMMC done?

The procedure takes a short time. An injection is given at the base of the penis to make it go numb, so that no pain is felt while the foreskin is cut off. The wound is then stitched, cleaned and bandaged.






## 7. What happens after the operation?

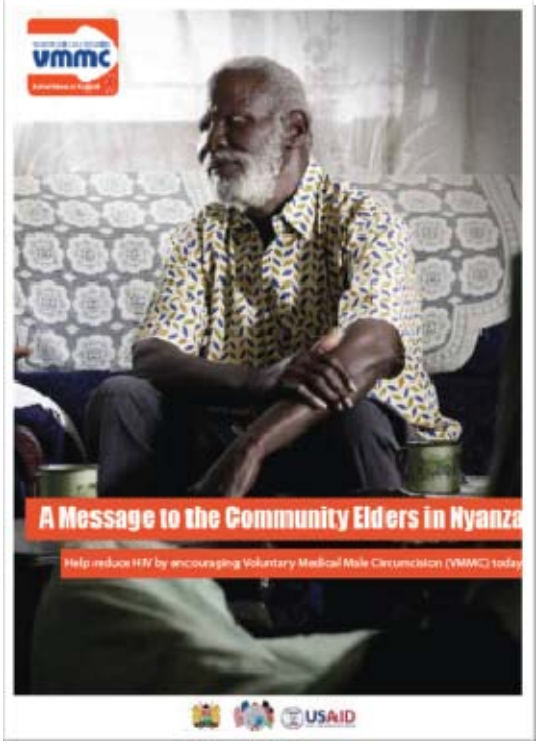
- The man rests a short while, and then goes home.
- After 3 days the bandage is removed. He cannot have sex for the next 6 weeks.
- For the next 7 days, it is important to keep the wound clean, and avoid heavy exercise.
- After 7 days, the man needs to return to the health facility for a check-up.
- If men experience any complications after surgery (like prolonged pain or bleeding), they should seek assistance at the clinic.

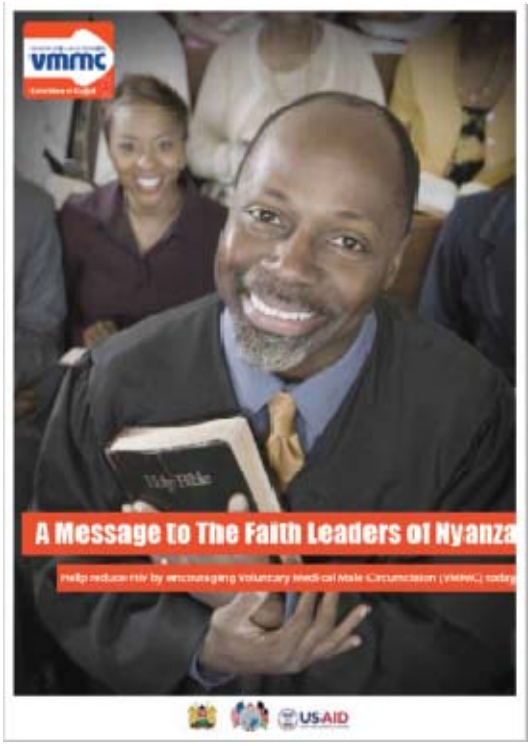
## 8. Does VMMC affect sexual intercourse?

Yes, because men cannot have sexual intercourse for 6 weeks after VMMC. The wound needs enough time to heal properly. VMMC does not affect sexual performance.

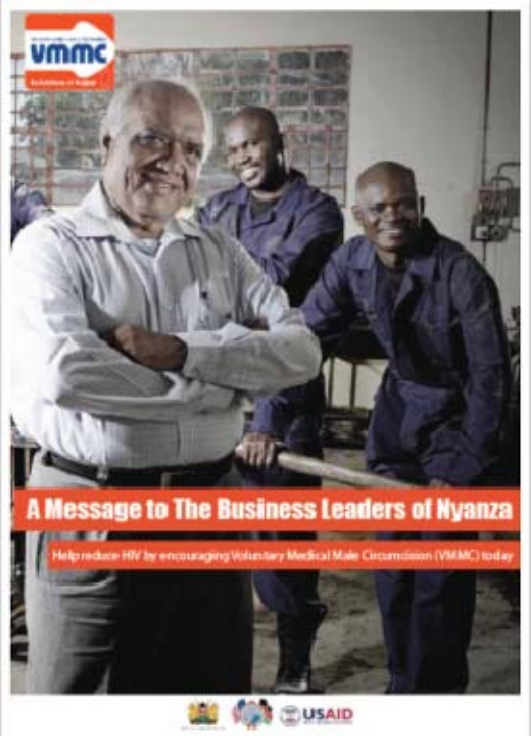
## 9. Why should I talk to my partner about VMMC?

VMMC has many benefits for both partners and both need to understand the procedure. It is best to openly discuss why you want VMMC. You can also visit a counselor or health worker together to discuss the matter.


vmmc
A Message to the Community Elders in Nyanza
Help reduce HIV by encouraging Voluntary Medical Male Circumcision (VMMC) today
USAID


vmmc
A Message to The Faith Leaders of Nyanza
USAID


vmmc
Our Future is in Your Hands
Help reduce HIV by getting circumcised today
USAID


vmmc
A Message to The Business Leaders of Nyanza
Help reduce HIV by encouraging Voluntary Medical Male Circumcision (VMMC) today
USAID



**Do not have sex or masturbate for 6 weeks after VMMC.**

| Reason | Risk |
| --- | --- |
| The wound needs time to heal properly. | Engaging in sex too early can damage the wound and delay the healing process. It can also increase your risk of getting HIV. |
| **Rights** | **Responsibility** |
| Even though it may look as though the wound has healed, it is still not safe to have sex until 6 weeks after circumcision.<br><br>Your partner also has the right to say 'no' to sex during those 6 weeks. | You have a responsibility to ensure that the wound heals properly and that you are not putting yourself or your partner at risk. |

For more information, please visit aidstar-one.com.

**AIDSTAR-One**
John Snow, Inc.
1616 Fort Myer Drive, 11th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Email: info@aidstar-one.com
Internet: aidstar-one.com