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Executive Summary.

Sub-Saharan Africa remains the region most affected by HIV/AIDS. The priority to find effective, acceptable and affordable methods that would confer long-term preventive health benefits to the general population is therefore critical. In view of the observed benefits of male circumcision as an intervention method in HIV prevention, the World Health Organization (WHO) and UNAIDS endorsed MC in March 2007 as a viable method of HIV risk reduction intervention.

In spite of its proven efficacy, the adoption of male circumcision as a strategy for prevention against HIV infection remains a challenge. On one hand, there are communities that do not traditionally circumcise and who see such campaigns as an affront on their culture. There are also concerns on how to package the MC information to avoid misconceptions, false sense of security, safety, ethics and need for continual engagement at the community level. In such situations, the campaign is affected by lack of proper information leading to rumors, fears, misinterpretation of facts and sometimes political interference. On the other hand, there are serious questions on the hygiene and effectiveness of the traditional circumcision among the circumcising communities. Added to this is the challenge of meeting the demand for male circumcision created by the campaign as a result of overstretched resources.

To overcome these challenges, there is need for comprehensive communication initiatives that will address the challenges posed mainly by resistance to MC in non-circumcising communities as well behavioral issues in both circumcising and non-circumcising communities. The overall objective of the strategy is to raise awareness, create and maintain demand for MC as a medical method to reduce the risk of heterosexual acquisition of HIV infection by men, within the framework of comprehensive HIV infection risk- reduction interventions.

The strategy takes 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 communication strategy at various levels in the country. The national task force on MC in consultation with the provincial and district 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 expected outcomes of the strategy implementation will include: raised awareness of MC as a strategy in HIV prevention; increased demand for MC as a medical method for HIV prevention; increased flow of sufficient and accurate information about voluntary MC as a HIV risk reduction method; a coordinated and effective communication process; and improved access to safe voluntary MC in appropriate settings.

Part 1 of the strategy provides an overview of MC globally, the intervention in Kenya and the current environment in which the program is operating. Part 2 outlines the strategy framework and isolates the audiences, channels and messages. Part 3 sets the steps for strategy implementation; the implementers and their expected roles while part 4 discussed the monitoring and evaluation of the program.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavior Change Communication
CBO	Community Based Organization
CHWs	Community Health Workers
CORPs	Community Owned Resource Persons
CSO	Civil Society Organization
FBO	Faith Based Organization
HIV	Human Immuno-Deficiency Virus
HMIS	Health Management Information System
HWs	Home Workers
IEC	Information, Education and Communication
KAP	Knowledge, Attitude & Practices
MC	Male Circumcision
M&E	Monitoring & Evaluation
MOH	Ministry of Health
NGO	Non-Governmental Organization
RHD	Reproductive Health Division
SRH	Sexual Reproductive health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Program on HIV and AIDS
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

Part 1

1. Background to Medical Male Circumcision for HIV Prevention.

Although global commitment to control the HIV/AIDS pandemic has significantly increased in recent years, the level of spread and impact of HIV infection have remained relatively high in most regions. The priority to find effective, acceptable and affordable methods that would confer long-term preventive health benefits to the general population is critical. Sub-Saharan Africa remains the region most affected by HIV/AIDS, although some of the countries have achieved important advances in curbing its transmission through diverse efforts and methods of approach.

Male circumcision, which is the surgical removal of the foreskin of the penis, is one of the oldest surgical procedures worldwide. It is an emerging technology for primary intervention in HIV prevention that has been conclusively shown to proffer significant effectiveness in reducing heterosexual HIV-1 and HIV-2 acquisition to men, particularly among the high risk groups. Recent randomized clinical trials in Africa, besides numerous observational studies have provided substantial evidence that male circumcision is effective in reducing the risk of female-to-male HIV transmission during penile-vaginal intercourse.

Randomized controlled trials which make it possible to adjust for potential causes of biases such as behavioral or socio-cultural factors that may be associated with circumcision status and risk of HIV, carried out in Uganda, Kenya and South Africa showed that MC reduces male acquisition of HIV in penile-vaginal intercourse by an average of 60%. The evidence from these trials supports the findings of numerous observational studies that have also suggested that the geographical correlation long described between lower HIV prevalence and high rates of male circumcision in some countries in Africa is, at least in part, a causal association.

Modeling methods have shown that high public health impact (herd immunity phenomenon) from MC roll-out is more likely to be realized if majority of the population is circumcised within the shortest time. With 80% male circumcision uptake, the reduction in prevalence observed in models ranged from 45% to 67% whereas with 50% MC uptake, the reduction ranged from 25% to 41%. More resources and intensive efforts will be required to ensure successful implementation of the initial phase of the roll-out.

In view of the observed benefits, the World Health Organization (WHO) and UNAIDS endorsed MC in March 2007 as a viable method of HIV risk reduction intervention. In the endorsement, the two organizations noted that "the efficacy of male circumcision in reducing female to male HIV transmission has now been proven beyond reasonable doubt," and that male circumcision should be considered as part of a comprehensive HIV prevention package.

Because MC as a method for HIV prevention is partial, it has to be considered alongside the other intervention strategies, which include abstinence, being faithful, consistent and correct use of condoms, delaying onset of sexual relations, avoiding penetrative sex, reducing the number of sex partners, avoidance of multiple concurrent sexual partnerships and counseling and testing to know ones sero-status. This means that, operationalizing male circumcision scale-up as an intervention program in HIV prevention must ensure effective communication process; sufficient, valid information to the target audience; integration of the program within the existing sexual and reproductive health programs; the procedure is done in safe aseptic settings by professionally trained and certified personnel; confidentiality, informed consent and voluntariness.

Increases in risk behavior due to decrease in perceived risk may potentially cancel the benefits of male circumcision. Although there is concern over the possibility for risk compensation among the circumcised, most studies show no tendency for increased risky sexual behaviors following MC, in terms of number of partners, non-spousal sexual contacts or unprotected sex, if comprehensive counseling on risk reduction is provided. Even so, additional issues that may be correlated to risky behavior still require further exploration in different contexts as the program is scaled up. Efficient feedback mechanism will facilitate opportunities to refine or redefine messaging about the partial protection against the risk of HIV infection offered by male circumcision. The public health message must clarify that MC directly reduces the risk for infection for men only but does not completely eliminate it. Thus, men may still become infected with HIV after being circumcised; infected circumcised men can and do transmit HIV to their sex partners. Male circumcision provides no direct protection to women against HIV infection, although women and uncircumcised men will indirectly benefit as prevalence of HIV decreases among circumcised men. Consequently, men and women must be fully educated about partial protection provided by MC and the need to continue with additional protection measures and safer sex practices.

2. Policies and Strategies.

Based on the results of the three clinical trials and other accumulated evidence showing that male circumcision reduces the risk of HIV acquisition, the World Health Organization (WHO) and UNAIDS in their recommendations on male circumcision and HIV prevention issued in March, 2007 stated that, "the efficacy of male circumcision in reducing female to male HIV transmission has now been proven beyond reasonable doubt," and that male circumcision should be considered as part of a comprehensive HIV prevention package.

In recognition of the recommendations, the Ministry of Health developed the 'National Guidance for Voluntary Male Circumcision in Kenya," to provide a framework for the integration of MC in the existing HIV prevention programs. It offers general principles to ensure that MC services are offered in safe settings and are accessible and sustainable within the available resources as an integrated program in sexual and reproductive health. This fits within the overall HIV and AIDS prevention strategy that aims to reduce the risk of new HIV infections and the prevalence to below 5% by 2010.

The guiding principle of the 'National Guidance for Voluntary medical Male Circumcision in Kenya are to:

- Ensure that male circumcision is performed by well trained practitioners in antiseptic settings under conditions of informed consent, confidentiality, risk reduction counseling and safety.
- Ensure that male circumcision is promoted and delivered to males of all ages in a manner that is culturally sensitive to minimize stigma that may be associated with circumcision status.
- Ensure that male circumcision does not replace other known effective HIV prevention methods and is always considered as part of a comprehensive prevention package.
- Ensure that community and individual education programs provide sufficient and correct information on the partial protection provided by male circumcision and the continuing need for other HIV and sexually transmitted infection prevention measures.
- Ensure that appropriate laws, regulations and supervisory mechanisms are developed so that male circumcision services are accessible and provided safely without discrimination.

- Establish a male circumcision task force, appointed by the Minister for Health, to advise on the management of integrated reproductive and sexual health and HIV prevention programs providing male circumcision services.

- Strengthen health systems to ensure that male circumcision programs do not interrupt or divert resources from other primary health care services.

- Improve the general health care service delivery through adequate and appropriate strengthening of health care programs.

- Ensure the monitoring and evaluation of male circumcision services for quality control and planning purposes.

- Ensure operations research to strengthen male circumcision services and to implement effective, comprehensive HIV prevention programs in the context of sexual and reproductive health.

- Ensure that partners involved in the delivery of male circumcision services operate within the framework of the National Sector Strategic Plan II and promote male circumcision as an added strategy to other HIV prevention methods. The National Male Circumcision Taskforce serves as an advisory body for the MoH on plans and development programs within the national health structure.

The National Health Sector Strategic Plan II (2005 – 2010) and the Kenya National HIV/AIDS Strategic plan (2005 – 2010) are the essential strategic documents that highlight the need and basis for strengthening of health care delivery and the scaling up of HIV prevention, care and treatment in Kenya.

3. Situational Analysis.

Globally, about 34% of the males are circumcised, mainly for religious and cultural reasons. The common determinants of circumcision in Africa include ethnicity, perceived health benefits, religion and pressure to conform to the social/group norms. In Kenya, about 84% of males are circumcised but wide variations exist among the tribes who traditionally practice male circumcision and those who don't. More than 90% of the men are circumcised in North–Eastern, Eastern, Coast and Central Provinces; more than 80% in Nairobi, Rift Valley and Western provinces. In Nyanza, the average proportion is 46%, but varies within districts from 17% - 99%. The national prevalence of HIV is estimated at 5.1%. The prevalence exhibits similar regional variations with a low of <1% in North-Eastern province and peaking at 18% in Nyanza. Data from the 2003 Kenya Demographic and Health Survey indicates that a lower proportion of men aged 15 – 19 (72%) compared to 84% of the older ages are circumcised. This may imply a decline of the practice, although it is possible some men do not go through the male circumcision until they are above 20 years.

The Teso, Turkana and the Luo ethnic groups have lower male circumcision rates because they traditionally don't practice it. Among the circumcising communities, the age at circumcision is not constant across the groups and there is no consensus on what the minimum age should be, though it is traditionally associated with initiation rites. In such circumstances, circumcision is carried out by a traditional circumciser without anesthesia in circumcision camps. While the government in its policy is silent on traditional circumcision, the challenge is in ensuring safety and eliminating the possibility of HIV transmission through the use of unsterelized equipment. Traditionally performed circumcisions have been associated with higher complication rates. There is also the

Research & Consulting'(2008) and 'Firmlinks Consultancy' (2008)

added danger of some of the circumcised men resuming sex early before healing is complete. This can potentially increase the risk of HIV infection from open wounds. Appropriate system measures to address the limitations in the settings and context of performing MC and follow up activities will be required. The communication strategy will provide the framework, measures and methods on how to handle the challenges.

The evidence for providing MC routinely to neonates to reduce risk of penile infections is complex and controversial, although most studies show a benefit of lower rates of urinary tract infections in infants. Also, evidence for benefits of MC in adolescents and young adults is mixed and scanty. The case for performing MC in children must be considered on the basis of risk-benefit ratio and the best interest of the child. Studies have shown that the circumcision of infants is simpler and carries fewer medical risks than when performed later. In high HIV prevalence settings, optimum public health benefit and long-term cost effectiveness may be realized from prioritizing scale-up of MC services among children and young adults among whom HIV prevalence may still be low[Weiss et al., 2007; WHO/UNAIDS Technical Consultations, March 2007]. This indicates that parents considering circumcision of their children must be furnished with sufficient facts so they can determine the best interest of the child. Given that HIV-related benefits of MC only arise in the context of sexual activity and because MC is an irreversible procedure, parents may consider that the child should be given the choice of opting for the procedure when he has the capacity to do so [UNAIDS, June 2007].

Conceptual understanding and perception of MC among traditionally circumcising and non-circumcising communities in Kenya are varied. Quantitative and qualitative research done by 'Infotrak Research & Consulting' among the non-circumcising people-groups in Kenya show that majority are aware of MC as a procedure, but associate it largely with initiation rites. About half of those interviewed among the traditionally non-circumcising areas do not understand well the benefits of MC. Most people in the non-circumcising communities considered MC as alien, foreign and an affront to their culture. People who are circumcised or born with shortened foreskin are labeled adversely as being different, which stigmatizes them. Some consider MC as painful, reduces penile sensitivity and libido, risky and likely to encourage pre-marital sex. Nevertheless, majority of the people indicate willingness to accept it were it to be offered as a medical intervention against HIV. Pain, cost of the procedure and long duration required for abstinence to complete healing after circumcision, lack of education, potential post-operative complications such as loss of penile sensitivity were perceived as greatest barriers to uptake of MC services among the traditionally non-circumcising communities [Bailey, 2006]. Among the circumcising communities, the perception about MC are that it is hygienic; limits the chance of getting STIs; circumcision status makes one fit well with the peers; it is a sign of maturity; source of pride; and is a religious requisite.

Acceptability of male circumcision determines the potential number that would be circumcised to achieve acceptable 'herd immunity'. Sufficient numbers circumcised would ensure adequate protective effect to the partners from infections, but this is less clear if levels are less. A review of five qualitative and eight quantitative studies in Sub-Saharan Africa was done and Westercamp and Bailey (2007) established that: the median proportion of uncircumcised men willing to be circumcised was 65%. Similarly, 69% of women favored the circumcision of their partners, while 71% and 81% of men and women respectively were willing to accept the circumcision of their sons [Weiss, 2007].

Health workers are commonly perceived as the custodians of health within the community. They play an extremely critical role in advising members on various health related issues. However, the study by Infotrack indicated that some health workers still do not consider MC as a viable HIV preventive method for various reasons including cultural and professional bias. The communication package to this group would target attitudes, knowledge and practice and advocacy for updated practice guidelines.

Opinion leaders for example chiefs, political leaders, religious leaders, parents, counselors, traditional circumcisers are usually very influential and powerful members of the community especially in rural Kenya. The youth who are generally susceptible to peer-pressure and influence could easily adopt MC if their peers recommended the practice as worthwhile. Generally there is no consensus among Christian religious groups on the compatibility of MC with Christian beliefs. Among Muslims MC is not obligatory but it is strongly encouraged. It is regarded as a traditional practice but not universally done. Also there is no universally acceptable minimum age of circumcision for men, though traditionally it is practiced at or about puberty, for cultural reasons. Traditional positions or ambivalence to MC practices would influence roles of the potential key players and the target groups. Also, various rites associated with MC as a traditional practice, gender constructs, spirituality and existing discrimination on the basis of circumcision status at individual and regional level may distort the intended health messages and the information process.

4. Media Coverage of Male Circumcision in Kenya.

An analysis of the media coverage of male circumcision issues conducted to get an understanding of the social and political environment in which MC campaign is being undertaken underlines the need for a focused strategy to reach out to the various categories of stakeholders. Print media coverage for six months from late 2008 to early 2009 was analyzed in terms of the key issues being discussed and the major players in the MC campaign. The analysis highlights some of the major challenges facing MC and isolates some of the issues that need to be addressed by the communication strategy.

The formal adoption of male circumcision as a medical intervention against HIV infection by the government policy initially met with resistance mainly from elders in traditionally non-circumcising communities. In Nyanza, the Luo Council of Elders initially came strongly in condemnation of the promotion of male circumcision considering it to be an affront on the Luo culture. But they were also concerned with the potential for risk compensation and how best the messages would be packaged to avoid chances of misconceptions. Subsequently, after discussions and proper presentation of facts, the Council supported the initiative. There has been an upsurge of young men willing to undergo male circumcision in government and private hospitals and clinics. This was particularly so after the political leadership made a public appeal for the Luo to embrace male circumcision as one of the effective methods in preventing HIV transmission. However, there is need for continual engagement with the community at all levels.

Questions on the efficacy, practice and intention however still linger with suggestions from some that the government is using the issue of circumcision to humiliate the Luo. There are comments to the effect that 'the reason for the high HIV prevalence rate in Nyanza is not because of absence of circumcision but rather because of poverty'. The argument has been that while the Turkana is a traditionally non-circumcising community, the HIV prevalence rate among the community is significantly lower.

Cases of misinformation on the efficacy of male circumcision in reducing chances of HIV transmission have been recorded. There have been cases where some member of the target population have been recorded as understanding the information that 'male circumcision reduces chances of HIV transmission by up to 60% to mean that one can not get HIV in six out of ten sexual encounters.

Individuals with no surgical training have taken advantage of the rise in demand for male circumcision to perform operations. In one or two cases, serious complications have been reported as a result of botched operations leading to fears of increased complications and unhygienic operations. There has been the question about

the preparedness of government and other hospitals to meet the demands for male circumcision and the conviction by some medical personnel about the efficacy of male circumcision in reducing HIV transmission.

Among the mainly circumcising communities, increased rates of forced circumcision among adults have been reported with perpetrators citing the government drive to rationalize their actions. The level of hygiene in traditional circumcision ceremonies remain a case for concern even as questions are being raised on whether the circumcisers provide the correct information to the initiates about HIV and AIDS.

Deliberate misinformation of FGM as a HIV preventive measure has gained ground in areas that traditionally practice it. Proponents of the practice have argued that FGM reduces a woman's sexual desire and the likelihood that she will have sexual partners thus reducing the chances of contracting the HIV virus. They have used this to lure more girls into the practice in-spite of the known dangers of the practice and the fact that it is illegal.

5. Challenges to MC.

The male circumcision campaign is faced with a variety of challenges. The challenges vary mainly between the traditionally circumcising communities and the non-circumcising ones. Among the circumcising communities, male circumcisions often occur in non-clinical settings. Traditional surgeons who are not medically trained, provide most of the circumcision services during prescribed seasons. Methods used, age of circumcision and amount of skin removed vary from one region to the other. The concerns with traditional circumcision include:

- The nature of operation in some instances may not meet the medical requirements for male circumcision for HIV prevention due to the amount of skin removed
- Complications arising out of non-medical surgery with adverse effects ranging from death due to septicemia (overwhelming systemic infections), loss of the penis due to gangrene (from lack of blood supply), stricture due to severance of the external urethral meatus/opening and loss of penile function due to amputation or partial loss of glans penis. Also excessive bleeding, infections, slow healing rates, excessive pain, swelling and scaring/keloid formation occur more commonly when male circumcision is performed traditionally
- Early resumption of sex before healing is complete have been reported, potentially increasing the risks of HIV infections from wounds. The mean healing period in most cases is six weeks. The complication rates vary according to the methods used, skill and background education of the surgeon, instruments used and the clinic setting
- Mass circumcision may potentially compound exposure of participants to more complications. Cases where one un-sterilized knife is used on several initiates has the potential of increasing HIV infections if one of the initiates is infected
- In-spite of the advantages offered by infant circumcision, there is the difficulty of convincing parents from traditionally circumcising communities to adopt it as the process is not seen as a medical rather than a traditional requirement
- Possible conflation with female genital mutilation

Among non-circumcising communities, the challenges are numerous and range from issues of perception to logistical issues. Among the major challenges include:

- Increase in demand for male circumcision among the previously non-circumcising communities is likely to increase the resource burden for the already constrained health care system especially the reproductive health programs
- The potential danger of misconceptions about MC among target groups for example some understanding MC to mean a total prevention against HIV infections
- Level of acceptability among the target population with perceived barriers including: pain; cost of procedure; duration of healing and abstinence from sexual activity; potential surgical complications; cultural hindrances; difficulty in accessing health facilities
- Opposition and political interferences especially from opinion leaders in the community

The challenge is to package information to address the varied positions in different contexts

6. Human Rights, Ethical and Legal Implications

An ethical obligation exists for the government to provide an enabling environment for the promotion and progressive realization of universal access to health services, including health education. This includes developing appropriate health systems and structures to ensure implementation and policing of health services. The best proven interventions should be provided routinely as an option to the public.

The Government of Kenya government adopted MC as part of the comprehensive strategies to reduce risks of HIV infection in line with the goals of the Political Declaration on AIDS and the Declaration of Commitment on HIV to make available to the public HIV related goods, services and information. Because its protective effect is partial, it is to be provided as part of a minimum package of the comprehensive HIV prevention and risk reduction strategies and as part of a broader male sexual and reproductive health promotion program. This includes making available all effective sexual and reproductive health options accessible to all communities and individuals in an acceptable manner. The service providers will ensure that the process of providing male circumcision services is safe and voluntary. Also, they will ensure the principles of informed consent, including accurate and sufficient information that is understandable to the client; assessment of capacity of the client/ audience to understand given information; confidentiality; assurance of non-coercion and assisting those categorized in law as children to make informed decisions [WHO/UNAIDS June 2007].

The regulatory framework for the health sector is being reviewed and developed to make it relevant and appropriate for the provision of comprehensive male circumcision services as indicated in the policy for MC provision in Kenya. Community consultations as part of engagement with them to ensure acceptability and ongoing respect is part of the MC promotion and education roll-out process. Although the decision to opt for male circumcision will be made by individual men, adolescent boys or parents, the decision-making process will be influenced by the attitudes and opinions of the immediate social networks, such as sexual partners, peers, family members and the socio-cultural disposition. It is assumed that education principles require participation of citizens in a democratic manner, and that the information is only accurate and non-manipulative. The ultimate expected output is to ensure high uptake within a short period to ensure maximum impact of the benefits while

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.

Individual and community multi-media participatory approaches will be adopted. Multi-channel, multilevel communication approach will be designed to help influence changes in people's knowledge, attitudes and behavior. Approaches for BCC will be in the form of a multimedia entertainment-education campaign that can include mass media or take the form of community-level communication and folk media.

Some of the key activities will include designing and developing mass media campaign for the general population in the form of radio programs and spots, television serials and spots, or newspaper articles including adoption of the materials/products into the local languages; promote community-level communication and folk media, including folk dramas, songs, street theatre, dance, storytelling, games, group talks, flip charts, posters, billboards, comic books or individual counseling; develop Radio-Based distant education programs for community-level health providers; enhance health workers skills in inter-personal communication and counseling; empower CHWs / CORPs (community owned resource persons) to fulfill their role; promote communication between spouses on MC/SRH issues; strengthen medical training and school health curricula to include MC/SRH issues; address disadvantaged and marginalized segments of the populations; promote the increased use of quality health services; reduce the gap between service providers and clients and influence delivery of quality health services with clients rights approach as stipulated in the National Health Sector Strategic Plan II (2005 – 2010).

Communication Approaches and Activities.

Given the psychographic and demographic differences of the primary target audiences, the campaign should employ a mix of communication approaches at each implementation step for maximum effect. The following communication approaches, channels and activities are proposed.

1. **Interpersonal communication** involving interpersonal exchanges of information among peers, professional groups, within the family and other closely linked groups are ideal in aiding the initial stages of awareness creation, and the following stage of stimulating interest in the individual to want to try male circumcision as a new innovation to prevent HIV infection among men. Informal channels like chiefs' barazas, health centre open days, public rallies would be useful.

2. **Communication campaigns;** Audio Visuals including mobile cinema would be an effective medium of communication especially with men who happen to be the most frequent visitors of these cinemas. Being a powerful medium that uses voice, visuals and even text, very effective messages can be designed.

3. **Media advocacy campaigns** through print media newspapers would be effective in areas where literacy levels are high and newspaper reach is relatively good like in Nairobi. Nyanza and Teso.

4. **Advocacy campaigns** targeting opinion leaders.

5. **Persuasion;** using messages through the radio and television to support the adoption stages the strategy. Vernacular FM radio stations are ideal for this task.

6. **Dialogue:** Among groups, peers, workers, medical staff and their clients etc. The vernacular FM stations have gained immense popularity amongst their target audiences in the various communities. Because they broadcast in languages widely understood by community members, their messages & programmes tend to resonate better with the audiences. Furthermore, radio listernership in Kenya is quite high as it breaks the education barrier presented by many other media.

7. **Entertainment:** To create interest, stimulate a level of mental engagement as well as giving the campaign momentum, messages should be presented in a form that also entertains. Interactive channels like road shows and community theatre would play a critical role in capturing the attention of the young people.

8. **Education:** Overall goal should be to increase knowledge through a process of education.

9. **Identification, documentation and dissemination** of best practices.

The communication channels and activities to support the approaches shall be varied and will depend to a large extent on the targeted groups. A multi-media approach shall be used to ensure optimal reach of the target audiences. The activities will seek to respond to the communication objectives as presented in the following table:

Communication objective	**Activities**
Increase level of awareness of MC as a safe and voluntary HIV prevention measure	▪ Branding: Logo and slogan that summarises male circumcision and its benefits. ▪ One-on-one communication between clients and health workers. ▪ Below-the-line communication through brochures, posters, billboards, pamphlets using simple language available at health centres, social halls (this should be produced and used throughout the campaign). ▪ Above-the-line advertising – radio, television and print. ▪ Vernacular radio programmes and discussion forums. ▪ Placement if articles in vernacular and national newspapers as well as websites. ▪ Television news and documentary programmes. ▪ Promotion through cultural, religious and political leaders. ▪ Theatre for education/development programmes covering the critical areas targeted for adoption of male circumcision.
Promote MC as part of comprehensive HIV prevention strategy	▪ Branding: Logo and slogan that summarises male circumcision and its benefits. ▪ One-on-one communication between clients and health workers. ▪ Below-the-line communication through brochures, posters, billboards, pamphlets using simple language available at health centres, social halls (this should be produced and used throughout the campaign). ▪ Above-the-line advertising – radio, television and print. ▪ Vernacular radio programmes and discussion forums. ▪ Placement if articles in vernacular and national newspapers as well as websites. ▪ Television news and documentary programmes. ▪ Promotion through cultural, religious and political leaders.
Create and maintain demand for comprehensive MC services for HIV prevention	▪ Theatre for education/development programmes covering the critical areas targeted for adoption of male circumcision. ▪ Community forums and training of peer educators. Direct personal contacts with the community, holding forums/information sessions inside the club/group/church is preferred. ▪ Public debates and forums with media spin-offs. ▪ Provision of Information schools, adult education classes, churches and mosques. ▪ Recruitment and training of opinion leaders to advocate male circumcision. ▪ Obtaining and broadcasting testimonials from early adopters - men who have adopted male circumcision to address fears, misconceptions, myths and negative attitudes.
Improve attitudes and communication skills of health workers and other players in the sector to deliver quality MC services.	▪ One-on-one communication between clients and health workers. ▪ Community forums and training of peer educators. Direct personal contacts with the community, holding forums/information sessions inside the club/group/church is preferred.

2. Management, Coordination and Partnerships

The Ministry of Health has the mandate to provide quality accessible and affordable health care in Kenya. As the male circumcision service is primarily being provided within the health services, the Ministry of Health plays a central role in the oversight of the scaling up of these services. The Ministry is the convenor of a multi-sectoral taskforce whose functions include oversight responsibility for the male circumcision services as spelt out in the National Guidance for Voluntary Male Circumcision in Kenya document. The principal mandate of the national taskforce is to advise the MOH on the plans and development of programmes for the expansion of safe, accessible and sustainable voluntary medical male circumcision services.

Given that the male circumcision in question is primarily for the purpose of HIV prevention, the National AIDS Control Council (NACC), a body that is mandated by an act of Parliament to coordinate HIV Prevention, Care and Treatment in Kenya, is responsible for ensuring the participation of the various stakeholders in this process. NACC is a member of the National Male Circumcision Taskforce.

It is envisioned that there will be similar lower level taskforces especially at the provincial level to carry out similar tasks to the national body but with a bias to the delivery of services. The provincial task forces shall feed off from work developed at the national level such as service delivery standards, guidelines, communication strategies and shall also help inform the development of such instruments by way of their field experiences.

Both the national and provincial taskforces for voluntary medical male circumcision will endeavour to ensure that standardized services that are safe, accessible and sustainable are available for as large a proportion of the population as possible. They will operate within the guiding principles of the NHSSP II and KNASP in achieving these objectives.

While they will give direction and oversight for the male circumcision for HIV prevention activities, it is not intended that the task forces should take on functions that are currently being undertaken by existing bodies in the health infrastructure but should involve as necessary these structures in the roll-out of the services.

One of the issues the taskforce will need to address from the initial phase is the evolution of traditional circumcision from being purely a rite of passage to adulthood to a process that takes on the HIV preventive slant while retaining the engagement with young males on issues of sexuality. The issue of safety will be a core one to be addressed as part of this evolution.

Partners involved in the delivery of MC services are expected to assist the Ministry of Health in mobilizing resources for efficient service delivery. They shall operate within framework of the National Health Sector Strategic Plan II. They shall ensure that male circumcision is promoted as an added strategy to other HIV prevention efforts. Below is a summary of the key players in the delivery of MC services and their expected roles.

National/District/Community Levels

National/District/Community Levels

Partners and stakeholders	Roles
Parliament/Members of parliament	▪ Promote legislation that will support voluntary male circumcision in Kenya ▪ Promote the practice of male circumcision among their constituents ▪ Allocate resources for MC including development of physical facilities such as dispensaries ▪ Counter negative information on MC among politicians
Ministries of Health	▪ Provide financials and other resources ▪ Provide policies, guidelines and standards for quality integrated service delivery ▪ Provide technical support for MC service delivery ▪ Conduct routine support supervision of MC programs ▪ Integrate MC activities into other reproductive health and HIV programs ▪ Coordinate and conduct operational research.
National AIDS Control Council	▪ Overall Coordination of HIV Prevention, care and treatment. ▪ Coordinate involvement and participation by stakeholders in MC interventions ▪ Spearhead communication strategies on MC targeting communities
• National Male Circumcision Task Force • Provincial and District Task Forces.	▪ Advise MOH on plans and development programs for expanding safe, accessible, sustainable male circumcision services in Kenya ▪ Ensure professional, technical, and administrative excellence in the provision of MC services. ▪ Promote pre/in-service education of relevant health personnel ▪ Ensure accurate and appropriate dissemination of information to individuals, communities and the media regarding MC services.
Development partners	▪ Provide financial and other resources ▪ Provide technical guidance
Implementing partners/ NGOs/Faith-Based Organizations	▪ Implement MC activities at community levels. ▪ Implement communication initiatives at community levels ▪ Integrate MC programs into other programs
Media	▪ Prioritize delivery of accurate and competent MC information and messages through their media outlets.
Community leaders	▪ Integrate MC activities into community based programs ▪ Disseminate messages on MC ▪ Lobby for provision of facilities for MC at local levels ▪ Encourage and support communities to use MC services ▪ Participate in monitoring MC services for availability, accessibility and quality.
Women and youth groups	▪ Disseminate messages on MC ▪ Counter misinformation on MC ▪ Encourage and support communities to use MC services.
Administrative Officials	▪ Mobilize community members to participate in and support MC activities ▪ Provide education and discussion forums for MC activities ▪ Ensure conducive, secure environment for MC activities.

1. Monitoring and Evaluation.

In order to measure the success of the National Communication Strategy for Voluntary Medical MC in Kenya, a strong monitoring and evaluation component is needed. Evaluation will measure outcomes and impact tied to key objectives and specific indicators identified in the strategy. Also it will provide information on the direction, pace and magnitude of change as well as unanticipated changes. Monitoring is a process that routinely tracks a program's activities. Regular monitoring helps to measure the effectiveness of activities and the continued relevance of activities. The results enable corrective actions to be taken, if needed. Evaluation is used to assess the overall effectiveness and outcomes of the strategies employed, largely in terms of changes to knowledge, attitudes, beliefs and behavior based on the individual and community responses.

Monitoring and evaluation of the communication program of the campaign shall be undertaken by the Ministry of Health through the Provincial and National task forces which are tasked with the responsibility of ensuring accurate and appropriate dissemination of information to individuals, communities and the media regarding male circumcision services. Collaborative links will need to be established with other institutions and partners such as the National Aids Control Council which has the mandate of ensuring stakeholder involvement and participation in male circumcision interventions and to spearhead appropriate communications strategy targeting communities as a member of the task force.

The evaluation of the strategy will focus on both the process and impact of the communication interventions. It is proposed that a mid term and end term evaluation be conducted as appropriate during the life cycle of the strategy. The mid-term evaluation will focus on the process and keep track of the deliverables or outputs of the strategy while the end term will be a focus on the impact or outcomes of the various interventions.

Primary assessment tools shall be developed from the available program data including information from the National Health Management Information System (HMIS) that will help in providing valuable baseline data.

Communication objective	Data sources	Outcome indicators
• To increase the level of awareness of MC as a safe and voluntary HIV prevention measure	• MOH records • Media scans • KAP Surveys	• Exposure to MC messages. • % increase in demand for MC services. • Knowledge of benefits and risks of MC. • % increase in knowledge of MC. • Proportion of adolescents and young adults (age 15 – 49 yrs) with correct knowledge of male circumcision and sexual reproductive health issues.
• To promote MC as part of a comprehensive HIV prevention strategy	• Surveys • Media scans/reviews • Group discussions	• % increase in demand for MC services. • % increase in demand for HIV preventive measures. • Increased knowledge of MC as part of a comprehensive strategy. • Number of communication documents produced and adopted for distribution. • media support, measured by the time and space allocated for education on MC/SRH. • Proportion of individuals who are provided with risk reduction and post-operative risk reduction counseling.
• To create and maintain demand for comprehensive MC services for HIV prevention	• Ministry records • Surveys	• Level of unmet need for male circumcision • Percentage of males receiving circumcision, disaggregated by age. • % increased demand for MC services. • Increase in demand for other HIV preventive methods including testing. • Additional new sites for integrated MC/SRH services per district per year. • Number of mobilization activities and other social functions organized in collaboration with the communities. • Number of NGOs / CBOs involved in ensuring MC/SRH services in rural and urban areas. • Number of men who seek MC while accompanied by their wives/female sex partners.
• To improve the attitudes and communication skills of health workers and other players in the sector to deliver quality MC services.	• Surveys • Media scan	• % increase in satisfaction with service provision. • Increase in exposure to information on MC from medical facilities. • Proportion of providers trained on how to ascertain correctly and manage post-operative adverse events that may be related to male circumcision.

Audience Strategy Matrix

Target Audiences	Key Audience Characteristics	Activities	Approaches	Message Themes	Channels/	Expected Outcomes
Males aged between 18 and 30 years	- Sexually active - Can make individual decisions - Married or about to get married - Have some level of formal education - Group most affected by HIV/AIDS and other STDs.	Design of logos and colors for MC and display of the same colors display Talk shows Call-in programs Specialized articles on best practices Discussion forums Persuasive editorials	Branding, education persuasion Mass Media	Health benefits of MC Continuing vigilance – use of other methods of preventing HIV infections Safety Cultural neutrality	Mementos, Mementos – T-shirts, watch-straps, caps, stickers Endorsement from opinion leaders Newspapers National and local language radio -Television stations - Billboards - Posters - Pamphlets	MC concept captured and made memorable, acceptable and easy to remember Increased awareness of MC and more people persuaded to undergo circumcision. Fears and negative perceptions about MC addressed. Increased awareness on MC procedures and questions on availability, efficacy etc answered. Acceptability created and questions on MC addressed Demand for MC created. Medical concerns addressed and need for continued vigilance re-emphasized
Males between 12 and 18 years	- Pubescent and adolescent stages of maturity - Impressionable Capable of putting pressure on their parents to favor them - Some are sexually active - Susceptible to peer pressure - Can form a larger percentage of early adopters of VMMC	Design of logos and colors for MC and display of the same Sponsorship programs and use of discussions by early adopters Essay-writing in schools Sponsorship of categories of plays and music during festivals. Working with youth groups to train peer educators	Branding, education persuasion Mass Media	Health benefits of MC Continuing vigilance Safety Cultural neutrality	Mementos [caps, T-shirts, pens] School competitions Kenya Schools and Colleges Music and Drama festivals sponsorship. Community theatre	Increased acceptance of MC Increased demand for voluntary MC at clinics Increased discussions among teenagers of HIV/AIDS and prevention methods including MC. More open discussions on MC and other methods of HIV prevention.

Target Audiences	Key Audience Characteristics	Activities	Approaches	Message Themes	Channels/	Expected Outcomes
Males aged Fathers	Ultimate decision makers on most issues in the home	Logo/colours display	Branding	Health benefits of MC	Mementos – T-shirts, watch-straps, caps, stickers	Acceptance and endorsement of MC for sons
		Talk shows		Continuing vigilance	Opinion leaders' endorsement	Increased discussion of MC, its benefits and risks
		Call-in programs Specialized articles on best practices		Safety Cultural neutrality	Newspapers National and local language radio	
		Discussion forums			Television stations	
		Persuasive editorials				
Opinion leaders ***- Church leaders*** ***- Community elders*** ***- tribal leaders*** ***- Local politicians*** ***- Administrative officials***	- Seen as keepers of traditions and cultural practices - Have assumed role of community spokespersons - Advanced in age	Logo/colours	Branding	Health benefits of MC	Mementos [caps, calendars, key chains, T-shirts]	Endorsement of MC campaign
		Formal briefings with local opinion leaders such as elected leaders, administration officials, social leaders		Continuing vigilance	Direct community contact	Adoption of MC as community practice
		Direct information	Advocacy	Safety	Community forums through peer educators	
				Cultural neutrality	Theatre for education/ development programmes.	Increased discussion of MC, its benefits and risks
			Lobbying		Schools, adult education classes and churches Chief's barazas	
			Persuasion		Television news and documentary programmes Churches	
			Education/ training			
			Education/ Persuasion			
			Mass media			

Target Audiences	Key Audience Characteristics	Activities	Approaches	Message Themes	Channels/	Expected Outcomes
Health workers	Respected and trusted in the community Can influence individual and life choices such as male circumcision Majority familiar with MC Most not able to pinpoint their role in its promotion Still bound by cultural perspectives on MC Hold reservations about being advocates of alien practice (MC)	Logo/colours display Skills-building [education]	Branding Lobbying Training	Health benefits of MC Continuing vigilance Safety Cultural neutrality	Mementos – T-shirts, watch-straps, caps Training workshops Manuals ocumentation] Newspapers National and local language radio Television stations	Wear out resistance to MC. Recruit health workers as MC advocates Empower health workers to provide comprehensive information to clients on MC
Women and girls	Sexual partners or mothers to core target audience Have high acceptability of circumcised men Concerned about their children's health Initiate doctor visits- Critical in introducing MC in infancy	Logo/colours display Talk shows Call-in programmes Specialized articles on best practices Discussion forums Persuasive editorials	Branding Mass media Advocacy	Health benefits of MC Continuing vigilance Safety Cultural neutrality	Mementos – khangas, T-shirts, caps Opinion leaders' endorsement Newspapers National and local language radio Television stations	Affirmation for men who undergo MC Acceptance and adoption of MC for boys 12 to 18 years as well as adolescence

Target Audiences	Key Audience Characteristics	Activities	Approaches	Message Themes	Channels/	Expected Outcomes
(Early Adopters/ Innovators)		Talk shows Call-in programmes Specialized articles on best practices Discussion forums Persuasive editorials	Advocacy	Continuing vigilance Safety Cultural neutrality	Opinion leaders' endorsement Newspapers National and local language radio Television stations	Increased discussion of MC, its benefits and risks
Editors and media owners, rural based media orrespondents in target areas, specialist writers,/ reporters, photographers		Lobby the media to adopt a positive attitude towards MC and set a positive agenda		Health benefits of MC Continuing vigilance Safety Cultural neutrality	Training workshops Media breakfast for editors	

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	Brochures posters Billboards Pamphlets												
	Branding	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