Safe Male Circumcision
FOR HIV PREVENTION

NATIONAL COMMUNICATION STRATEGY
2010
Safe Male Circumcision
FOR HIV PREVENTION

NATIONAL COMMUNICATION STRATEGY
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>TABLE OF CONTENTS</td>
<td>i</td>
</tr>
<tr>
<td>FOREWORD</td>
<td>ii</td>
</tr>
<tr>
<td>ACRONYMS AND ABBREVIATIONS</td>
<td>iv</td>
</tr>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>v</td>
</tr>
<tr>
<td>1.0 BACKGROUND AND RATIONALE TO SMC FOR HIV PREVENTION</td>
<td>1</td>
</tr>
<tr>
<td>1.1. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>1.2. Evidence of Male Circumcision for HIV prevention</td>
<td>3</td>
</tr>
<tr>
<td>1.3. The communication strategy in line with the SMC policy 2010</td>
<td>4</td>
</tr>
<tr>
<td>1.4. Development of the communication strategy</td>
<td>5</td>
</tr>
<tr>
<td>1.5. Guiding Principles for the implementation of the communication strategy</td>
<td>6</td>
</tr>
<tr>
<td>2.0. GOAL AND OBJECTIVES</td>
<td>7</td>
</tr>
<tr>
<td>2.1 Communication Goal</td>
<td>7</td>
</tr>
<tr>
<td>2.2 Communication objectives</td>
<td>7</td>
</tr>
<tr>
<td>3.0. PRIORITY ISSUES AND AUDIENCES FOR SMC COMMUNICATION</td>
<td>7</td>
</tr>
<tr>
<td>3.1. Priority issues for SMC communication</td>
<td>7</td>
</tr>
<tr>
<td>3.2. Primary audiences for SMC communication</td>
<td>8</td>
</tr>
<tr>
<td>3.3. Secondary audiences for SMC communication</td>
<td>10</td>
</tr>
<tr>
<td>4.0. COMMUNICATION MATRIX</td>
<td>15</td>
</tr>
<tr>
<td>5.0. MESSAGE GUIDE</td>
<td>19</td>
</tr>
<tr>
<td>5.1. How to Use the Message Guide</td>
<td>19</td>
</tr>
<tr>
<td>5.2. Suggested Messages by Communication Issue</td>
<td>16</td>
</tr>
<tr>
<td>6.0. MONITORING AND EVALUATION</td>
<td>24</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>24</td>
</tr>
</tbody>
</table>
FOREWORD

It is more than a quarter of a century since HIV was first discovered in Uganda. It has since caused untold suffering of the population and burden to the health system. Almost every Ugandan knows someone or has a relative who has died of AIDS, and the infection rates, having dropped significantly during the 1990s, have stagnated and tended to increase in recent years. The initial HIV prevention approaches which emphasised abstinence, faithfulness and eventually condom use worked well to bring down the scale of the epidemic in the general population to a unique extent. However, the desire to halt and ultimately eradicate HIV, though dominant, has never been met and calls for constant adaptation of our prevention strategies.

HIV/AIDS is a complex biological, behavioural, and social phenomenon, and the science of its prevention requires a complex strategy. The science must be comprehensive and multidisciplinary, integrating biological, behavioural, and social science approaches and methods, including the adoption of proven, new technologies such as safe male circumcision (SMC). To be effective, HIV prevention strategies must be innovative, able to make use of research findings and thus adjust to the new scientific knowledge to deliver the desired public health benefits.

‘Knowledge is power’ and communication is a valuable tool for imparting knowledge and skills within the general population and service providers respectively. Effective communication will help to educate communities and health workers on various aspects of SMC, create demand for SMC, improve compliance with healing period after SMC, change society’s negative perspectives towards male circumcision and enable anti-HIV/AIDS campaigners to advocate for resource allocation for SMC. Therefore, this communication strategy is not only timely; it will also be a handy instrument for leaders of all respects to confidently and coherently articulate issues and messages about SMC and HIV prevention.
The development of this communication strategy was made possible by the tireless efforts of the Ministry of Health staff, the National Task Force on Male Circumcision, Makerere University School of Public Health, and the Johns Hopkins Centre for Communication Programmes / Health Communication Partnership. This is not to mention many other partners and stakeholders such as media practitioners, researchers, health workers, political leaders, and members of the public who, in one way or another, participated in communication strategy development sessions or commented in a way that provided raw material for this document. It is my hope that it will boost the implementation of the SMC policy for Uganda.

For God and My Country.

PAUL KAGGWA
ASSISTANT COMMISSIONER, HEALTH SERVICES
HEALTH EDUCATION AND PROMOTION
## ACRONYMS AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC</td>
<td>Abstinence, Being Faithful, Condom use</td>
</tr>
<tr>
<td>ABC+</td>
<td>Abstinence, Being Faithful, Condom use Plus</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immuno-Deficiency SYNDROME</td>
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<tr>
<td>CME</td>
<td>Continuous Medical Education</td>
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<tr>
<td>FAQ</td>
<td>Frequently Asked Questions</td>
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<tr>
<td>FHI</td>
<td>Family Health Interventional</td>
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<td>HCI</td>
<td>Health Centre One</td>
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<td>HCII</td>
<td>Health Centre Two</td>
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<td>HCIII</td>
<td>Health Centre Three</td>
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<td>HCIV</td>
<td>Health Centre Four</td>
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<td>HCP</td>
<td>Health Communication Partnership</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IEC</td>
<td>Information Education and Communication</td>
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<tr>
<td>LC</td>
<td>Local Council</td>
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<tr>
<td>MC</td>
<td>Male Circumcision</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NSP</td>
<td>National Strategic Plan</td>
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<td>NTV</td>
<td>Nation Television</td>
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<td>SMC</td>
<td>Safe Male Circumcision</td>
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<tr>
<td>SPH</td>
<td>Makerere University School of Public Health</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>TV</td>
<td>Television</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>VHT</td>
<td>Village Health Team</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<td>YEAH</td>
<td>Young Empowered and Healthy</td>
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EXECUTIVE SUMMARY

The Ministry of Health, in collaboration with key stakeholders, has developed this communication strategy to promote Safe Male Circumcision (SMC) in Uganda. The goal of the communication strategy is to contribute to the reduction in HIV and other Sexually Transmitted Infections incidences through increased safe male circumcision uptake. In order to promote safe male circumcision, the communication strategy primarily focuses on creating awareness and providing the necessary information to the public and other key stakeholders on safe male circumcision as an option of HIV prevention, elaborating the broader health benefits of safe male circumcision and advocating for support in the implementation of the SMC policy and scale-up programme.

The communication strategy presents guidance for implementing communication interventions in the context of five key principals: 1) A framework for organizations, projects, partners and stakeholders to develop specific information dissemination strategies, materials and activities, 2) ensuring that all SMC communication activities are in line with the relevant national policies and guidelines, 3) encouraging collaboration among all stakeholders in planning and implementing SMC communication activities at all levels in order to achieve maximum impact without duplication of efforts, and 4) ensuring that planning and implementation of all communication interventions are both evidence-based and culturally appropriate.

The communication strategy provides background information about the scale of male circumcision in Uganda and a brief review of the various studies that corroborate the potential of SMC to reduce risks of HIV infection in men. Giving a snapshot of the SMC policy, the communication strategy clarifies that all communication initiatives shall contribute to the realisation of the objectives of the policy i.e. to contribute to the reduction of HIV and STI incidence in Uganda. It gives brief profiles of the key audiences and also presents a communication matrix which systematically outlines: major communication issues, main target audiences, message themes, proposed communication activities, channels to be used and the indicators for monitoring progress and outcome of interventions.
Sample messages addressing various aspects of SMC are provided at the end of the communication strategy document. It should be emphasized that the sample messages are generic and have not been pre-tested. Implementers of the communication strategy can modify and tailor the messages for their specific needs.
1.0 BACKGROUND AND RATIONALE TO SMC FOR HIV PREVENTION

1.1. Introduction

In Uganda, an estimated 1.1 million people are living with HIV and 135,000 people became newly infected with the virus in 2006. At an average of 6.4%, the national HIV prevalence rate has reduced compared to 1991 when surveillance reports indicated a peak of 15% in the general population and 30% among pregnant women, these rates are still high. According to National HIV and HIDS Strategic Plan (NSP) 2007/8 – 2011/12, the incidence of HIV has a geographical heterogeneity with urban residents and people living in Kampala, and in the central and mid-northern regions, more affected.

A 2005/2006 survey conducted by the Ministry of Health indicates that boys and men aged 15 – 49 had an HIV prevalence of 6.4%, and that circumcised men are less HIV-infected, with a prevalence of 3.7% across all age groups, ethnicity, region and urban-rural residence.

However, only approximately one quarter (24.8%) of Ugandan men, 15 – 49 years old are circumcised (MOH Uganda, 2006). Circumcision rates vary widely within the country from a low of 2.4% in North-Central region to a high of 54.7% in Eastern region. Most of the circumcision is performed by traditional circumcisers as a cultural and religious rite among the Bagisu / Sabiny / Bakonzho / Bamba and Muslims respectively.
In settings where HIV prevalence is high and prevalence of circumcision is low, the World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS) have recommended male circumcision as an efficacious intervention for HIV prevention. The two organisations recommend male circumcision as an additional, important strategy for the prevention of heterosexually acquired HIV infection in men (WHO/UNAIDS 2007).

The NSP 2007/08 – 2011/12 recognises safe male circumcision as a cost-effective HIV prevention intervention. It also recognizes that it is not 100 percent effective in preventing new HIV infections. The challenges of rolling out safe male circumcision (SMC) to a full scale would require a simplified and disseminated national policy, an expanded infrastructure, human resource capacity and a strategic communication framework to ensure safe delivery of the intervention countrywide. The Ministry of Health, in partnership with key stakeholders, has developed this communication strategy in order to address the latter point.
1.2. Evidence of Male Circumcision for HIV prevention

Over 40 studies conducted worldwide to date reveal that male circumcision provides significant protection against HIV infection. In a meta-analysis of 27 observational studies of male circumcision (MC) in sub-Saharan Africa, 21 showed evidence of reduced risk of HIV and STI infection (Weiss, 2000).

Results from a randomised trial conducted in Rakai Uganda (2006), involving nearly 5,000 men revealed that new HIV infections among circumcised men were 50% less compared to the uncircumcised. This implies that HIV infections among sexually active men can be reduced by half if most are circumcised. Results from two other randomised clinical trials of male circumcision conducted in South Africa (2005) and Kenya (2006) provided similar compelling evidence. Taken together, these studies provide the strongest scientific evidence of the effectiveness of safe male circumcision in HIV prevention.

On the basis of the Uganda, Kenya and South Africa studies, WHO and UNAIDS issued guidelines in 2007 advising nations to include male circumcision in the available package of HIV prevention like abstinence, faithfulness to one sexual partner and using condoms (ABC). Given the permanence of male circumcision after the surgical procedure, it delivers lasting physiological benefits to a certain level.

It is estimated that over 80% of HIV infections worldwide occur through sexual intercourse. Removal of the foreskin not only reduces the surface area for possible entry of HIV into the body but also has numerous other benefits, such as:

- Minimising risks of injury resulting from small tears that can emerge during sex. After SMC, the head of the penis develops a tougher skin texture (keratin) that is not easily broken during sex.
- Allowing the head of the penis to remain dry and thus unfavourable for germs and viruses to stay and survive for a long time, and possibly enter the bloodstream.
• Improving a man’s penile hygiene by eliminating the cells that provide cover for dirt, smegma (cheesy substance), and other foreign objects within the foreskin.

• Reducing the risk of some sexually transmitted infections (STIs) such as Chlamydia, cancroids, syphilis, and gonorrhoea.

• Reducing the risk of penile cancer in men, and cervical cancer in women. SMC removes the foreskin which is a breeding ground for the human papillomavirus (HPV) that causes the cancers.

However, SMC is not 100% protective against HIV, and needs to be used in combination with safer sexual practices (including abstinence, faithfulness and sexual partner reduction, and correct and consistent condom use). SMC should also be reinforced with access to HIV counselling and testing (HCT) services, and treatment for other STIs.

1.3. The communication strategy in line with the SMC policy 2010

The SMC policy envisions a healthy and productive Ugandan population free from HIV infection. It provides a framework for increasing access and use of safe and sustainable male circumcision services as an integral part of HIV prevention. The goal of the policy is to contribute to the reduction of HIV and other STIs through SMC services. This will be achieved through, among others, integration of SMC service delivery in Uganda’s national health system, skills development of health workers for effective delivery of SMC services, effective provision of SMC in both public and private health facilities, promotion of SMC services through public education and mobilisation, as well as protection of human rights by ensuring freedom, voluntary access, and confidentiality of clients seeking SMC.

The policy (in section 4.6) stresses communication as a key aspect for promoting SMC through social mobilisation and public education based on a standard communication strategy. Therefore:

i. A wide range of individuals and organisations (public and private) may
provide communication in line with the communication strategy;
ii. Behaviour change communication messages to primary and secondary audiences would be designed in line with the communication strategy; and
iii. Male circumcision advocacy should reach leadership at the national, district, and community levels.

In promoting safe male circumcision, some groups should be ‘prioritised to maximise the public health benefit’, based on available resources. This communication strategy therefore identifies and prioritises audiences for effective communication.

1.4. Development of the communication strategy

The process of drafting this communication strategy on safe male circumcision for HIV prevention in Uganda involved participation of key stakeholders. Since 2007, the Ministry of Health (MOH), in collaboration with Makerere University School of Public Health (SPH) and Health Communication Partnership (HCP), organised stakeholder consultative meetings and seminars involving a wide range of partners to develop a communication strategy on SMC. They reviewed the available literature and status of male circumcision in Uganda and drafted the communication strategy through participatory plenary and group work sessions. This became a working document to guide communication initiatives until the SMC policy was finalised and inaugurated in June 2010.

With support from partners, the MOH and SPH conducted three studies about SMC in Uganda in terms of acceptability, availability of services at health centres, and factors that influence people to accept or reject the procedure. In addition, HCP and SPH conducted a nationwide media campaign that generated a lot of public feedback which was analysed and utilised in developing the communication strategy. The process ended with the review of the national SMC policy and revision of the interim document that translated into this national communication strategy.
1.5. Guiding principles for the implementation of the communication strategy

This national communication strategy aims to provide a framework for information dissemination and the implementation of communication interventions around SMC for HIV prevention.

Organisations, projects, partners and stakeholders will develop specific campaign strategies, materials and activities in line with the communication strategy. Implementation of all SMC communication activities will follow national policies and guidelines as specified in the National Health Policy, SMC policy, NSP and this communication strategy.

Implementation of this communication strategy will involve all partners in a manner where available resources are shared as widely as possible. All stakeholders will work collaboratively to plan and implement SMC communication activities at all levels in order to achieve maximum impact without duplication of efforts.

Strategic communication interventions around SMC for HIV prevention will follow the accepted process of analysis, strategic design, development and testing, implementation, monitoring and evaluation, and re-planning.

SMC interventions will implement communication activities based on clearly defined campaign strategies which define intended audiences, communication objectives, key message content, communication channels, and the monitoring and evaluation plan.

SMC communication interventions will be evidence- and theory-based, culturally appropriate, and use an appropriate mix of mass media, interpersonal communication, community mobilization and other communication approaches for behaviour change communication and/or advocacy efforts.
All communication interventions should contribute to enhancing knowledge and favourable attitudes, with the ultimate aim of increasing uptake of SMC in Uganda.

2.0. GOAL AND OBJECTIVES

2.1. Communication goal

The goal of the communication strategy is to contribute to the reduction in HIV and STI incidences through increased safe male circumcision in Uganda.

2.2. Communication objectives

- To create awareness and provide necessary information on safe male circumcision.
- To help people make informed decisions about safe male circumcision and HIV prevention.
- To increase demand and promote uptake of SMC in Uganda.

3.0. PRIORITY ISSUES AND AUDIENCES FOR SMC COMMUNICATION

3.1. Priority issues for SMC communication

The following are considered as priority issues to be handled through effective communication:

1. Lack of understanding of the relationship between SMC and HIV prevention.
2. Myths and misconceptions surrounding male circumcision.
3. The broader health benefits of safe male circumcision.
4. Need for operationalisation of the SMC policy through adoption, domestication and dissemination at all levels.
3.2. Primary audiences for SMC communication

The primary audiences in this communication strategy are men who are at risk of HIV infection in relation to SMC, namely, uncircumcised men and sexually active circumcised men. The audience profiles that follow outline the rationale for their selection, their demographic and social profiles, and communication objectives.

While the audiences are broadly defined for the purposes of this national communication strategy, communication campaigns should subdivide each audience into respective sections with specific demographic characteristics such as age, location, education level, socioeconomic status, religion, marital status, and/or culture, as the case may be. For each of the audiences given in this communication strategy, their peers should be treated as corresponding audiences, considering the significance of peer to peer influence on individual and community behaviour and decision making.

i. Uncircumcised men

Rationale for selection

Research shows that uncircumcised men are about eight times at greater risk of HIV infection than circumcised men. About three quarters of all men in Uganda, aged 14 – 55 are uncircumcised (MOH 2006). This provides a potential fertile ground for the spread of HIV. Most sexually active men in Uganda have little or no knowledge about the benefits of SMC, especially HIV prevention, which is a recent recommendation.

These are uncircumcised men and boys aged 14 – 55, mostly belonging to communities where circumcision is not a cultural practice, with a few others in traditionally circumcising areas. They comprise about 75% of sexually active men in Uganda. They regard lack of circumcision as a form of cultural or religious
identity, and hence view male circumcision as a threat to their own religions, cultures or traditions. They do not take seek male circumcision for fear of possible community ridicule for adopting a strange practice, as well as possible risks of pain, injury, prolonged healing period or side effects arising from male circumcision. Most uncircumcised men have little or no knowledge about the relationship between SMC and HIV prevention and other health benefits, and those who are interested in SMC are constrained by high costs and thus want it free of charge. Some uncircumcised men, however, support male circumcision for their sons but lack information about where to go for SMC.

This audience includes both married and unmarried men, in the low, middle and high-income classes, residing in both rural and urban areas. The decision on whether or not to be circumcised is often influenced by attitudes and opinions of their immediate social networks, which include sexual partners, peers, and family members with whom they interact on a daily basis. This audience also includes HIV-negative men, HIV-positive men and those whose HIV status is unknown.

**Communication objectives**

- To educate uncircumcised men about the health benefits of SMC, including HIV prevention.
- Promote communication among uncircumcised men and their peers and partners about the benefits of SMC.
- Direct uncircumcised men to SMC services.

**ii. Sexually active circumcised men**

**Rationale for selection**

Available evidence indicates that circumcised men might engage in increased risky sexual behaviour due to a false sense of security or protection known as ‘risk compensation’ or ‘behavioural disinhibition’. Volunteers circumcised during the
clinical trials in South Africa reported having more sex compared to the uncircumcised men, and at the end of the Kenya trial, circumcised participants reported more unprotected sex acts than their uncircumcised counterparts did, though both groups reported less unprotected sex than they had at baseline.

This audience includes circumcised men who are sexually active. They include those circumcised as an HIV preventive measure as well as for other benefits including hygiene, cultural and religious reasons. It includes newly circumcised men as well as those who have been circumcised a long time ago. They lack proper guidance and counselling before and after circumcision and hence engage in sex before their wounds are fully healed. They have more than one sexual partner but do not use condoms especially with partners they trust. They get incomplete information about the benefits of circumcision and its level of protection against HIV. They get much of their information about health and HIV/AIDS from the media (radio and newspapers).

**Communication objectives**

- To educate sexually active men about the need to abstain from sex for the recommended period of up to six weeks after circumcision.
- To promote other HIV prevention options among the circumcised men.

### 3.3. Secondary audiences for SMC communication

These secondary audiences are influencers of the primary audiences, and therefore require their own targeted communication. The audiences below are not mutually exclusive but are categorised for purposes of effective planning and delivery of appropriate SMC messages.
i. Health workers

Rationale for selection

A study conducted in Uganda revealed that health workers have a potentially significant role in influencing young men’s decisions to get circumcised (HCP 2010). Uncircumcised young men reported that they would go for male circumcision if recommended by a doctor or other trusted health worker. Other studies also showed that most health facilities in Uganda (68%) offer circumcision services, yet only a fraction of the clients (52%) are counselled about HIV or circumcision (MOH/HCP 2009). To maximize the benefits of male circumcision and ensure longer-term sustainability of services, SMC should be integrated, wherever possible, with other services, such as HCT, treatment for STIs, and promotion of safer sex practices (WHO 2007). All this puts health workers at the centre of promoting SMC.

Most health workers may not have the correct facts about SMC and its relation to HIV/AIDS, as it is a new development. Most of them work for health facilities that lack the capacity to provide SMC and yet they cannot refer clients due to lack of clear information on why and where it is offered. Some even view SMC as an additional burden to the already crammed workload; and as a result, they tend to become indifferent to any inquiries about SMC.

Communication objective

- To equip health workers with accurate information about SMC for HIV prevention to enable them answer clients’ queries.
- To prepare health workers to counsel clients and refer them to appropriate places for SMC services.
ii. Opinion leaders

Rationale for selection

Opinion leaders are listened to by the public and play significant roles in shaping public opinion. They are leaders in their communities and institutions and always provide authoritative and locally relevant guidance to their followers and/or fans. Opinions leaders may include politicians at different levels, religious and cultural leaders, teachers, the media and other influential members of society. The majority of these leaders lack full knowledge of the association between SMC and the reduced risk of HIV infection. They influence people and can guide them in making decisions regarding SMC.

Whereas some leaders are supportive of SMC as an additional HIV prevention measure, some have strong opinions against the intervention. They are cautious about publicly recognising SMC as a HIV preventive measure because of perceived cultural, religious and moral implications. Their attitudes and opinions are sometimes influenced by the position of their headquarters and executive centres of power. Their opinions are influenced by developments on SMC in other neighbouring countries. This audience, especially members of parliament and religious leaders, has the ability to influence the executive arm of government and big religious congregations if well equipped with the necessary information.

Communication objectives

- To provide opinion leaders with adequate information on SMC for HIV prevention.
- To educate them on the broader health benefits of SMC.
- To advocate for support in dissemination and implementation of the SMC policy and the scale up programme for SMC.
iii. Caretakers of uncircumcised boys

Rationale for selection

This audience include mothers, fathers, guardians and caretakers of male children. Evidence available indicates that parents in Uganda are supportive of circumcision of infants and young boys (MOH/FHI 2008). They are also more willing to provide care after circumcision to children other than adults whom they consider difficult to manage during the healing period (HCP 2010). A telephone survey to map SMC facilities and services in Uganda showed that the earliest age of circumcision clients received at health facilities was 1 month (HCP/MOH 2009).

Caretakers of uncircumcised male children have little knowledge about the health benefits of male circumcision including HIV prevention. They live both in rural and urban areas, among the high and low-income social class, and include both the educated and uneducated. They are responsible for the welfare of their male children including paying for school fees, medical care, feeding and providing other basics of life. They exercise significant control over their children’s choices, including decisions to be circumcised. Many of these caretakers are not circumcised themselves.

Communication objective

- To inform parents of young boys that a boy can be circumcised at any age, starting from infancy.
- To educate parents on the long-term benefits of SMC including HIV prevention.
- To encourage parents to take their sons for SMC.
iv. **Female sex partners**

**Rationale for selection**

This audience includes spouses, girlfriends, and other sexual partners. They are both educated and uneducated, in both rural and urban areas. They are low, middle and high-income earners. The majority, especially the uneducated and those in rural areas do not have access to the right information regarding SMC and HIV prevention. Majority of women support circumcision for their spouses and sons (FHI/MOH 2008 and HCP 2010). Many say that a circumcised man is a better partner sexually, while others believe that circumcised men are promiscuous.

Although SMC reduces men’s risks HIV infection, it does not protect wives and sexual partners of infected men from the virus (The Lancet 18 July 2009). Yet, available evidence suggests that if majority of men in a society are circumcised, the risk of acquiring HIV will be minimised and thus their sexual partners too will be safe from HIV infection. In the long run, the majority of women would be protected through SMC; which also provides other health benefits to women such as prevention of STIs and cervical cancer.

Communication on SMC for HIV prevention must target both women and men so as to maximize benefits and minimise potential harms, such as difficulties for women to negotiate safe sex or insist on condom use, particularly with a circumcised man (WHO/UNAIDS 2010).

**Communication objective**

- To educate women on the relationship between SMC and HIV prevention.
- To encourage safer sex practices even when relating with a circumcised man
## 4.0. COMMUNICATION MATRIX

<table>
<thead>
<tr>
<th>Target Audience</th>
<th>Communication Objectives</th>
<th>Communication issue</th>
<th>Barriers</th>
<th>Message Themes</th>
<th>Activities</th>
<th>Channels</th>
<th>M &amp; E Indicators</th>
</tr>
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<tbody>
<tr>
<td>A: Primary: (i) Uncircumcised men</td>
<td>To educate uncircumcised men about the health benefits of SMC, including HIV prevention. Promote communication among uncircumcised men and their peers and partners about the benefits of SMC.</td>
<td>Social stigma and fear of possible pain, injury or infection</td>
<td>Fear of criticism from the community and sexual partners when SMC is not their tradition. Misperceptions about SMC e.g. that it encourages promiscuity, or conversion to Islam. Lack of knowledge about how SMC prevents HIV infection. Fear of pain, injury or other side effects such as excessive bleeding. Lack of information about where to go for SMC services. Lack of awareness about other health benefits of SMC. High cost of SMC. Fear of HIV infection during the circumcision process. Concern about the perceived long period for complete wound healing.</td>
<td>SMC reduces the risk of HIV and other STIs. SMC offers partial protection against HIV. SMC improves the hygiene of a man’s reproductive organ. Circumcision is safe if performed by a trained service provider. Pain-reducing drug is given during SMC. SMC does not affect sexual performance. SMC does not affect penis size. SMC does not change one’s culture or religion.</td>
<td>Conduct public education &amp; mobilisation. Develop a special logo for accredited units offering SMC. Produce and disseminate IEC materials. Design and carry out mass media programs and messages. Edutainment on SMC.</td>
<td>Interpersonal /group meetings Mass media. Print material Outside media Drama Puppetry Use of celebrities</td>
<td>No of clients seeking SMC No of health facilities branded with SMC logo Proportion of men who know what constitutes SMC Proportion of men who decide to get circumcised No of men in traditionally circumcising areas who opt for SMC.</td>
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### 4.0 COMMUNICATION MATRIX

**Target Audience Communication Objectives**

<table>
<thead>
<tr>
<th>Communication issue</th>
<th>Barriers</th>
<th>Message Themes</th>
<th>Activities</th>
<th>Indicators</th>
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<tbody>
<tr>
<td><strong>A: Primary</strong></td>
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<tr>
<td>Uncircumcised men</td>
<td>Social stigma and fear of possible pain, injury or infection</td>
<td>SMC reduces the risk of HIV and other STIs</td>
<td>Conduct public education &amp; mobilisation</td>
<td>No of clients seeking SMC</td>
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<td></td>
<td>Fear of criticism from the community and sexual partners when SMC is not their tradition</td>
<td>SMC offers partial protection against HIV.</td>
<td>Develop a special logo for accredited units offering SMC</td>
<td>No of health facilities branded with SMC logo</td>
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<td></td>
<td>Misperceptions about SMC e.g. that it encourages promiscuity, or conversion to Islam.</td>
<td>SMC improves the hygiene of a man's reproductive organ.</td>
<td>Produce and disseminate IEC materials</td>
<td>Proportion of men who know what constitutes SMC</td>
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<td></td>
<td>Lack of knowledge about how SMC prevents HIV infection.</td>
<td>Circumcision is safe if performed by a trained service provider.</td>
<td>Design and carry out mass media programs and messages</td>
<td>Proportion of men who decide to get circumcised</td>
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<td></td>
<td>Fear of pain, injury or other side effects such as excessive bleeding.</td>
<td>Pain-reducing drug is given during SMC. SMC does not affect sexual performance.</td>
<td>Edutainment on SMC.</td>
<td>No of men in traditionally circumcising areas who opt for SMC</td>
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<td></td>
<td>Lack of information about where to go for SMC services.</td>
<td>SMC does not affect penis size.</td>
<td>Interpersonal/group meetings</td>
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<td></td>
<td>Lack of awareness about other health benefits of SMC.</td>
<td>SMC does not change one's culture or religion.</td>
<td>Mass media.</td>
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<td></td>
<td>High cost of SMC</td>
<td>SMC only offers partial protection against HIV.</td>
<td>Print material</td>
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<td></td>
<td>Concern about the perceived long period for complete wound healing.</td>
<td>Continue to practice ABC+ for HIV/STI prevention</td>
<td>Outside media</td>
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<td></td>
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<td>Traditionally circumcised men:</td>
<td>Drama Puppetry</td>
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<td>Risks of circumcision with unclean tools in unclean conditions</td>
<td>Use of celebrities</td>
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<td>The need to abstain from sex until healing is complete</td>
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<td><strong>B: Secondary</strong></td>
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<td>(i) Health workers</td>
<td>Lack of skills to provide SMC guidance and counselling</td>
<td>Limited knowledge about SMC and how it prevents HIV.</td>
<td>Refresher on SMC</td>
<td>No of CME sessions held</td>
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<tr>
<td></td>
<td></td>
<td>Limited access to the SMC national policy.</td>
<td>Orientation sessions on SMC/HIV counselling</td>
<td>No of basic information materials given out</td>
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<td></td>
<td></td>
<td>Lack of communication support materials.</td>
<td>Compiling FAQs &amp; providing relevant answers.</td>
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<td>SMC is complementary to ABC</td>
<td>Identifying all health facilities with capacity to</td>
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<td></td>
<td></td>
<td>SMC reduces the risk of HIV infection by 60%</td>
<td>Continuous medical education (CME) sessions</td>
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<td></td>
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<td>SMC reduces the risk of other STIs</td>
<td>IEC materials (booklets, flipcharts, posters, fact sheets, etc.)</td>
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<td>SMC reduces the risk of cervical cancer</td>
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<td>No of CME sessions held</td>
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<td>No of basic information materials given out</td>
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<td>Counselling sessions conducted</td>
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</tbody>
</table>

(ii) Sexually active circumcised men

To educate sexually active men about the need to abstain from sex for the recommended period of up to six weeks after circumcision.

To promote the practice of other HIV prevention options among the circumcised men.

<p>| Lack of knowledge about limitations of SMC in HIV prevention | False sense of security; assuming that SMC is immunisation against HIV. | SMC only offers partial protection against HIV. | Targeted sensitization of circumcised men | |
| | Having many sexual partners, yet not using condoms. | Continue to practice ABC+ for HIV/STI prevention | Mass media (print &amp; electronic) | |
| | Unprotected sex before full wound healing. | Traditionally circumcised men: | Interpersonal communication | |
| | Lack proper guidance and counselling before and after SMC | Risks of circumcision with unclean tools in unclean conditions | IEC materials | |
| | Unique barriers for traditionally circumcising areas: | The need to abstain from sex until healing is complete | (brochures, flyers, stickers, posters, fact sheets, etc). | |
| | Sharing circumcision knives. | | |
| | Using unclean tools for male circumcision. | | |
| | Belief that the vaginal fluids can help in wound healing. | | |
| | Infidelity after male circumcision | | |</p>
<table>
<thead>
<tr>
<th>Target Audience</th>
<th>Communication Objectives</th>
<th>Communication issue</th>
<th>Barriers</th>
<th>Message Themes</th>
<th>Activities</th>
<th>Channels</th>
<th>M &amp; E Indicators</th>
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<tbody>
<tr>
<td>(ii) Opinion leaders</td>
<td>To prepare health workers to counsel clients and refer them to appropriate places for SMC services.</td>
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<td>SMC Improves personal hygiene Information about the procedure and how it works to prevent HIV and other STIs</td>
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<td>To provide opinion leaders with adequate information on SMC for HIV prevention.</td>
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<td>To educate them on the broader health benefits of SMC.</td>
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<td>To advocate for support in dissemination and implementation of the SMC policy and the scale up programme for SMC.</td>
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<td>Limited knowledge about SMC for HIV prevention as well as cultural or religious misperceptions about SMC</td>
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<td>Limited knowledge about the relationship between SMC and HIV prevention.</td>
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<td>Fear of people whose religious or cultural beliefs may not approve of circumcision.</td>
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<td>Lack of disseminated national guidelines on SMC.</td>
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<td>Government bureaucracy, which delays provision of funding and guidance on programmes to inform the public and provide male circumcision.</td>
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<td>Leaders in traditionally circumcising cultures</td>
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<td>Belief that men who get SMC have not properly transitioned to manhood.</td>
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<td>Leaders have a key role to play in mobilization for SMC</td>
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<td>Male circumcision can only offer benefits to clients if it is safe</td>
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<td>Dangers of MC performed in unhygienic circumstances by untrained circumcisers</td>
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<td>Airing phone-in radio and TV talk shows.</td>
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<td>Outreach activities Sensitisation meetings</td>
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<td>Community dialogues</td>
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<td>Number of men reporting having received accurate information on SMC from health workers</td>
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<td>No of health workers oriented to the SMC guidelines</td>
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<td></td>
<td>No of health workers who counsel and educate clients about SMC.</td>
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</tbody>
</table>
(iii) Caretakers of uncircumcised boys

To inform parents of young boys that a boy can be circumcised at any age, starting from infancy.

To educate parents on the long-term benefits of SMC including HIV prevention.

To encourage parents to take their sons for SMC.

Lack of knowledge about the health benefits of SMC especially HIV prevention

Lack of information about benefits of SMC.

Unfavourable religious and cultural biases.

Fear that SMC is conversion of their sons to Islam

Lack of providers trained in SMC for infants.

Rarity of SMC services.

Poverty and high costs of SMC.

SMC reduces the risk of HIV and other STIs

SMC does not affect penis size.

Male circumcision is safe if performed by a trained service provider.

Pain-reducing drug is given during SMC.

SMC improves the hygiene of a man’s reproductive organ.

Effective wound healing needs correct and safe care.

Print and disseminate IEC materials

Counselling and educating parents/caretakers by health workers

Mass media

Community dialogues

Peer education

IEC materials

No of parents who have taken their sons for SMC

(iv) Female sex partners

To educate women on the relationship between SMC and HIV prevention.

To encourage safer sexual practices even when relating with a circumcised man

Lack of knowledge about benefits of SMC to women and its limitations in HIV prevention

Limited knowledge about the link between SMC and HIV prevention. Worry about the time & costs for care in addition to other needs.

Worried about complications that may arise from the operation.

Lack of skills to negotiate safe sex.

Support sexual partners to go for SMC

SMC reduces the risk of STDs.

SMC reduces the risk of cervical cancer

SMC Improves personal hygiene

Unprotected sex with HIV+ circumcised man leads to HIV infection.

Sensitization of women through women groups

Community dialogues. Mass media

Interpersonal communication

Mass media

Community dialogues

No of women who are aware of the benefits and limitations of SMC
5.0. MESSAGE GUIDE

This message guide is intended to serve as a reference for the delivery of standardized, accurate information about SMC for HIV prevention. Not all messages are intended for all audiences. At the same time, the messages are not exhaustive and may be re-enforced with other socially relevant, scientific and technical information, in line with the SMC policy and this communication strategy.

5.1. How to use the message guide

Refer to the ‘Message Themes’ in the Communication Matrix for guidance on which issues are most important for which groups. Message content should be adapted to the identified communication needs as well as social and demographic profiles of intended audiences.

5.2. Suggested messages by communication issue

SMC for HIV prevention

- Male circumcision is a procedure in which the foreskin of the penis is removed.
- SMC is a safe and effective way to reduce HIV infection among men who are not yet infected with the virus.
- SMC reduces the risk of HIV acquisition in HIV-negative men by about 60%.
- SMC does NOT provide complete protection from HIV infection. A circumcised man can still get HIV if he has unprotected sex with an HIV infected partner.
- After circumcision, a man should still use other HIV prevention methods such as abstinence, faithfulness, condom use, as well as get HIV counselling and testing.
- SMC does not protect women against HIV infection.
• HIV positive males can still transmit HIV to their sexual partners, even if they are circumcised.
• Having only one sexual partner who is faithful to you and who does not have HIV is an effective way of reducing the risk of HIV infection after SMC.
• Using condoms consistently and correctly every time you have sex will protect you from HIV infection.

Who can go for SMC
• SMC can be provided at any age from infancy to adulthood.
• Circumcision for babies requires a highly experienced medical worker.
• You can go for SMC if you are married or unmarried.
• Women CANNOT be circumcised.
• Male circumcision is not recommended for HIV+ men (WHO 2007).
• Some men or boys should not be circumcised. These include those with:
  - Wounds or infections around the genitals
  - Discharge from the urethra
  - Chronic disorders of the penis or foreskin (e.g. elephantiasis)
  - Anatomical penile abnormalities (e.g. hypospadias and episadias)
  - Sickle cell anaemia
  - Congenital bleeding disorders

Anyone with these conditions may not heal easily, or may get other physical complications.

SMC procedure
• SMC is best done by a trained medical provider in a health facility that has the proper medical tools.
• During the process of SMC:
  - The health provider counsels the client about SMC and HIV prevention.
  - The health provider examines the client to ensure that he is fit for circumcision.
- The client signs a consent form. For minors (children who are not yet 18 years old) a parent or guardian signs the consent form.
- The health provider cleans around the foreskin.
- The health provider gives an injection to prevent pain.
- The health provider removes the foreskin using a surgical blade.
- The wound is stitched for quick healing.
- The wound is dressed to prevent germs and dirt from reaching it.
- The client is given painkillers to minimize any possible discomfort.
- The health provider observes the client for a short period (e.g. 10 minutes).
- The client is given instructions about proper care for the wound and the entire healing process.

After SMC

- Most men can wear their trousers and go about their work normally after circumcision. Some may, however, need about 3 days to put on their trousers comfortably and return to work.
- The wound should be cleaned once a day with a clean piece of cloth and boiled water.
- After circumcision, the health worker will give advice on when one can return to the health facility for further treatment, wound cleaning, and redressing.
- The client should return to the health facility immediately in case of any difficulty e.g. if he experiences bleeding, excessive pain, or difficulty passing urine.
- Complications after circumcision are rare and generally not serious.
- Full healing takes about 6 weeks (42 days) during which a man should abstain from sex.
- Not having sex during this period helps to ensure that the wound is healed completely.
- Any sexual activity during the healing period can lead to injury or infections (including HIV), and may delay the healing process.
Talk to the health provider if you plan to engage in sex before the 6 week period is completed.

**How SMC reduces the risk of HIV infection**

- The foreskin increases a man’s risk of HIV infection in many ways:
  - The inner surface of the foreskin contains many special cells that are prime targets for HIV.
  - The cells inside the foreskin are normally wet with natural fluids.
  - Bacteria and viruses like HIV can survive in this moist environment, and eventually enter the bloodstream.
  - When the uncircumcised penis is erect, the inner layer of the foreskin is exposed. This provides more room (surface area) for HIV to gain access to the bloodstream.
  - SMC removes the foreskin and therefore reduces the surface area as well as the target cells through which the virus can enter the body.
  - The inner layer of the foreskin is delicate and can easily break (tear) or get bruised during sex. The virus can therefore enter the body through the small tears that are caused on the foreskin during sex.
  - After a man is circumcised, the head of his penis becomes dry and its skin becomes thicker and fairly hard to break during sex. This helps protect the penis from HIV and other STIs.

**Other benefits of SMC**

- A circumcised penis is easy to keep clean.
- In addition to reducing the risk of HIV infection in men, SMC also reduces the risk of:
  - Penile cancer
  - Prostate cancer
  - Urinary tract infections
  - Other STIs such as syphilis and gonorrhoea
- Although SMC has not been shown to reduce the risk of HIV in females with circumcised partners, it does have other benefits for women.
• Female partners of circumcised men have less risk of cervical cancer and some STIs, including Chlamydia, genital herpes, chancroid and syphilis.
• Some women prefer sex with circumcised men because they think a circumcised penis looks better, is cleaner, and provides more sexual satisfaction.

Availability of SMC services in Uganda
• Safe male circumcision services are available in health facilities where there are trained providers, adequate supplies and equipment.
• Most health facilities are able to carry out SMC. A telephone survey by the Ministry of Health (2009) showed that all private and public hospitals in Uganda and about 60% of health centre IVs are able to provide SMC.
• The Ministry of Health will set minimum standards for a health facility to provide SMC.

SMC and religion / culture
• Whereas some religions and cultures in Uganda promote male circumcision as part of their traditions, safe male circumcision does not lead to conversion into another religion or culture. SMC is simply promoted for its health benefits.
• Men and boys of any religious backgrounds can seek SMC without hindrance and still uphold their religious convictions and cultural practices.

Myths and misconceptions about SMC

HIV prevention
Male circumcision does not protect a man fully from acquiring HIV. It only reduces the risk of infection.

SMC and ABC
Male circumcision does not replace other HIV prevention strategies like abstinence, ‘zero grazing’, and condom use. SMC is not a natural condom. It only supplements the existing prevention strategies.
**Protection for women**
Women are not directly protected against the risk of HIV if they engage in unprotected sex with HIV+ circumcised men.

**Conversion**
SMC does not result into conversion to Islam or interfere with religious and cultural beliefs.

**Sexual performance / satisfaction**
There is no scientific evidence to show that male circumcision affects sexual performance in any way. It does not reduce or improve a man’s sexual performance.

**Age of circumcision**
A male can be circumcised at any age.

**Promiscuity**
A man does not become promiscuous simply because he has been circumcised.

**Healing period**
Complete healing after circumcision takes up to six weeks but after surgery, one can dress up normally and go about his daily work.

**Pain and SMC**
If male circumcision is performed by a well-trained health worker in a health facility, pain is controlled and minimal.

**6.0. MONITORING AND EVALUATION**
Communication campaigns based on this communication strategy should design and execute monitoring and evaluation plans along with communication activities. This will help to measure impact and results as well as guide re-planning and/or replication of communication campaigns.
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Safe Male Circumcision
FOR HIV PREVENTION

NATIONAL COMMUNICATION STRATEGY
2010

THE REPUBLIC OF UGANDA