MC Communication Strategy 2009 - 2013

The Kingdom of Swaziland

MALE CIRCUMCISISON

COMMUNICATION STRATEGY

2009 - 2013

SEPTEMBER 2009
MALE CIRCUMCISION COMMUNICATION STRATEGY

2009 - 2013
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# Abbreviations

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<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>FLAS</td>
<td>Family Life Association of Swaziland</td>
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<tr>
<td>HCW</td>
<td>Healthcare Worker</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</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>NERCHA</td>
<td>National Emergency Response Council on HIV and AIDS</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<tr>
<td>PSI</td>
<td>Population Services International</td>
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<tr>
<td>SDHS</td>
<td>Swaziland Demographic and Health Survey</td>
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<tr>
<td>SP</td>
<td>Service Provider</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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ACKNOWLEDGMENTS

It is with great pleasure and honour that we present the Male Circumcision Communication Strategy 2009-2013 which has been developed in line with the existing policies developed by the Ministry of Health.

The Ministry of Health acknowledges the following individuals for their immense contribution in developing this strategy: Dr. Magagula, Chairperson of the Male Circumcision Task Force; Ayanda Nqeketo, Male Circumcision Coordinator, Ministry of Health Muhle Dlamini, SNAP; Futhie Dennis, NERCHA; Jessica Greene, PSI; Mandla Malaza, PSI; Mz’wethu Nkambule, Lusweti; Vusie Dlamini, FLAS; Thembisile Dlamini, UNAIDS; Faith Dlamini, NERCHA; Thomas Scalway, Consultant; Donna Sherard, PSI; Sureyya Hornston, CDC, and Caroline Teter, USAID Health Policy Initiative, TO1.
EXECUTIVE SUMMARY

In *The Strategy and Implementation Plan for Scaling Up Safe Male Circumcision for HIV Prevention in Swaziland, 2009–2013* (Ministry of Health, 2009) the Government of the Kingdom of Swaziland outlined plans for integrating and scaling up male circumcision (MC). MC is to be delivered widely as part of a broad range of human immunodeficiency virus (HIV) prevention measures, as outlined in the *National Strategic Framework for Response to HIV and AIDS, 2009–2014* (Ministry of Health, 2009). The *MC Communications Strategy 2009–2013* is intended to support this initiative. It calls for a number of communication measures in the short term to meet the broader HIV prevention goals of MC scale-up. In the long term, it provides a broad framework for shaping MC communications.

This communication strategy is designed to be flexible to allow for adjustments over time. In this way, it can respond to changes ranging from the availability of resources and other support to new knowledge obtained about the target audiences and feedback generated throughout implementation. This strategy outlines the current efforts in MC scale-up, and lists some of the technical, political, and capacity-related issues underlying MC communication.

Following guidance from the Joint United Nations Programme on HIV/AIDS (UNAIDS)/World Health Organization (WHO) on MC communication, this strategy follows a rational process for identifying objectives, outcomes, and outputs, drawing on an ecological approach to communication that highlights the relationship between environmental and behavioural determinants of health. The approach recognizes that individuals and their health behaviour are impacted by social networks, the surrounding community, and overall societal norms.

To achieve this, the strategy follows a phased approach. In the first phase, a communications strategy will support MC providers who have begun service delivery and help prepare all stakeholders for population-level scale-up in the future. Criteria for a national MC provider “seal of quality” accreditation will be developed in preparation for its launch in phase 2. The second phase will direct a comprehensive communications strategy encompassing MC demand creation and associated prevention communications. This phase will guide national-level communication and align with the overarching NSF communications strategy. Communication channels and messages will be developed and implemented progressively to reflect this two-phased approach. Messaging on providers who meet the quality and training standards for the “seal of quality” brand will be linked to national demand creation.

Implementation of the MC communication strategy will require the commitment and involvement of many audiences and organizations. While a number of broad objectives and outputs are described, the strategy points to the importance of developing focused behaviour change communication (BCC) strategies for specific key audiences. A broad and preliminary segmentation of audiences, together with some communication objectives has been undertaken by the MC Task Force and is included in appendix 1.
INTRODUCTION

The Government of the Kingdom of Swaziland adopted a comprehensive prevention approach designed to address the multiple factors that fuel the spread of HIV infection. After the publication of results of three randomized controlled trials (Orange Farm, South Africa; Kisumu, Kenya; and Rakai, Uganda), which demonstrated that MC provided up to 60 percent protection from HIV for men, Swaziland joined the growing group of governments and stakeholders that recognize the importance of MC to HIV prevention efforts. As a result, the Swaziland Male Circumcision for HIV Prevention Taskforce (MC Task Force) developed The Strategy and Implementation Plan for Scaling Up Safe Male Circumcision for HIV Prevention in Swaziland, 2009–2013 (Ministry of Health, 2009).

Because effective and comprehensive communication is critical to the successful implementation of this strategy, Swaziland’s MC Task Force has also developed this MC Communication Strategy, 2009–2013. Designed to complement the draft “National Social and Behaviour Change Communication Strategy,” this strategy provides the framework for MC communication and can be modified as more information becomes available about MC acceptability and barriers and as service delivery scales up throughout Swaziland.

This communication strategy acknowledges that MC for HIV prevention can offer unprecedented gains in curbing HIV incidence within the country, but that it also presents significant challenges to effective communication. As a result, the communication strategy addresses the number of complexities of MC communication and presents MC as part of a comprehensive approach to HIV prevention, one that includes limiting the number of sexual partners, using condoms, and seeking prompt treatment for sexually transmitted infections (STIs).

MC also presents unique opportunities to improve the means for addressing men’s health. Effective MC communication provides an opening for increasing men’s involvement in their own reproductive health and that of their partners. MC also provides an opportunity to encourage greater communication between men and their sexual partners on health choices, including HIV status disclosure and STI prevention. Additionally, recognizing the unique social context of Swaziland, this strategy acknowledges the underpinnings of gender norms—both positive and negative—that promote and hinder access to health by both men and women. While MC is complicated by women’s social and economic vulnerability, male gender norms and concepts of masculinity limit what is considered acceptable for men, regarding sexual relationships, preventive behaviour, and access to care. This MC communication strategy provides guidance to address some of these concerns.

Two primary ideas underlie this strategy. The first is that MC communication will need to follow a phased approach. Communication should not create demand that is greater than available services. As a result, the strategy describes phase 1, which will guide communication during the early stage of implementation and be tailored specifically to initial service provider sites and advocacy in preparation for a national campaign. The second phase will concentrate on general demand creation and support. This national demand creation campaign will be linked to providers who have received a national “seal of quality” accreditation for adhering to quality and training standards.

The second guiding concept is the “Social Ecology Model of Communication and Behaviour.” This model describes the relationship between the individual or “primary audience” and the influencing factors that limit or support behaviour change. The strategy identifies audiences, communication objectives, and message points for audiences from each of the levels of this model.
While this strategy provides guidance for communication that targets carefully selected primary and secondary audiences, it is expected that the strategy will be modified as more information on MC in Swaziland is collected through a WHO assessment, graduate student research, and a planned household survey to be conducted later in 2010 by Population Services International (PSI).

The strategy was developed through a consultative process involving a range of stakeholders working in male circumcision throughout Swaziland. The following persons/organizations were consulted: the Ministry of Health (MOH); United Nations International Children’s Emergency Fund; UNAIDS; National Emergency Response Council for HIV and AIDS (NERCHA); the Church Forum; PSI; Marie Stopes International; Manzini Youth Project; Family Life Association of Swaziland (FLAS); Raleigh Fitkin Memorial Hospital; Swaziland National AIDS Programme (SNAP) and SNAP regional coordinators; WHO; Umbutfo Swaziland Defence Force; New Start, Dr. Adam Groeneveld, clinical coordinator of the MC Task Force; U.S. Agency for International Development/U.S. President’s Emergency Plan for AIDS Relief; healthcare workers (HCWs); taxi drivers; and a traditional healer.

HIV IN SWAZILAND: SITUATION ANALYSIS

Swaziland is facing a severe and generalized HIV epidemic. According to the 2006–2007 Swaziland Demographic and Health Survey (SDHS), HIV prevalence in Swaziland among men and women ages 15–49 years old is 26 percent. HIV prevalence among women is higher than among men. Prevalence among women in urban settings is 37 percent, compared with urban men at 26 percent. Prevalence among rural women is nearly twice that of rural men (29 and 17 percent, respectively).

Youth of ages 15–24 years are also highly at risk for HIV. Prevalence among this group is 14 percent. Additionally, HIV prevalence among young women is nearly four times higher than among young men: 23 percent compared with 6 percent (CSO and Macro International 2008). Coupled with a high rate of concurrent sexual partnerships, inconsistent condom use, and low prevalence of male circumcision, these prevalence rates among youth contribute to making Swaziland’s HIV prevalence the highest in the world.

In Swaziland, HIV is largely spread through heterosexual intercourse. While levels of awareness of HIV and AIDS are relatively high, comprehensive knowledge is low (CSO and Macro International 2008). Misconceptions persist about how the virus is transmitted and how the disease progresses. Swaziland HIV Prevention Response and Modes of Transmission Analysis (NERCHA 2009), provides useful insight into changing trends in the epidemic. About 68 percent of all new infections in the adult population occur in persons older than 25 years, many of whom are married or cohabit with a steady partner.

Polygamy and concurrent sexual partnerships are common in Swaziland and also likely contributors to the HIV prevalence rates (NERCHA 2009).

While gender inequality is a factor in women’s increased vulnerability to HIV, considerable evidence also exists that some women are knowingly engaging in risky behaviour at will. The Swaziland modes of transmission report notes that “while some women with risk behaviour fit the classic description of passively vulnerable, many others are ‘active agents’ in seeking multiple partners, especially among older men.”
Alcohol abuse may also be a social factor driving the spread of HIV. A recent systematic review of alcohol use and sexual risks for HIV in sub-Saharan Africa shows a consistent association between alcohol use and sexual risk taking (Kalichman, Eaton, and Pinkerton 2007). In Swaziland, alcohol consumption increases with age and out of school youth are more likely to consume alcohol than youth in school (NERCHA 2009).

AIDS is rarely the subject of public discourse in Swaziland. Stigma and denial are still widely prevalent with a range of repercussions; for example, only 36 percent of females and 17 percent of males ages 15–49 have ever been tested for HIV and received their results (CSO and Macro International 2008). Fear of getting tested for HIV is intense, which presents numerous challenges to access to treatment services and may present obstacles to widespread uptake of male circumcision for HIV prevention. Interestingly, while circumcision rates among men in Swaziland are low, the SDHS reports an unexpected inverse relationship between circumcision and HIV infection. Circumcised men have a slightly higher HIV infection rate (22 percent) than uncircumcised men (20 percent). It is suspected, however, that many of these circumcisions may not involve full removal of the foreskin.

In its NSF, the Swaziland government acknowledges that prevention is a key priority in the national response to AIDS. The MOH has formally adopted male circumcision as an additional HIV prevention intervention.

While efforts are being made to intensify programmes targeting concurrent sexual partnerships, services for the prevention of mother-to-child transmission and increased condom use, male circumcision is an important additional approach to reducing HIV incidence further.

POLICY FRAMEWORK FOR MALE CIRCUMCISION

The policy framework of MC for HIV prevention has been increasingly strengthened. The government established NERCHA in 2000 to coordinate Swaziland’s national response to HIV and AIDS. In 2006 the government adopted the National HIV and AIDS Policy. Subsequently, a number of other policies have been enacted to support the implementation of a comprehensive and integrated HIV response. The NSF provides overall guidance to improving and expanding effective prevention, treatment, and care to all Swazis. The NSF identifies 23 objectives for prevention and prioritizes five interventions to move prevention toward the national goal. Among the top priorities is male circumcision for HIV prevention. Specifically the government aims to “increase circumcision of all HIV-negative males, with special attention to infants and males ages 15–24.”

In 2007 the government drafted the National Policy on Safe Male Circumcision for HIV Prevention (Swaziland 2007). This policy, passed by Parliament in 2009, is to be implemented in the context of the National Health Policy, Second National Multisectoral HIV and AIDS Policy and Strategy, and the Health Sector Response Plan and is to be guided by the principles outlined in the National HIV and AIDS Policy.

The national MC policy has the following specific objectives:

- Create an enabling environment for scale-up of well-coordinated safe male circumcision services.
- Increase the number of health facilities providing safe male circumcision services in both urban and rural Swaziland.
- Increase the number of men ages 15–24 years accessing safe MC services.
Following UNAIDS/WHO guidelines, Swaziland’s MC policy does not discriminate against men living with HIV in the provision of MC services. The policy states that, “MC services shall be available to boys and men of all age groups who voluntarily request service. However, HIV-negative boys and men shall be prioritized to maximize the public health benefits in regards to HIV prevention” (Swaziland 2007). The MC policy further states that refusal to take an HIV test is not grounds for denial of service. Specific direction on handling MC for HIV-positive men was clearly outlined in the Swaziland Male Circumcision for HIV Prevention Clinical Protocol drafted by the MC Task Force and highlights that men who test positive can still receive circumcision services as long as they have no medical contraindication.

MC services are currently limited, but are expanding, primarily in urban areas. According to the Strategy and Implementation Plan for Scaling Up Safe Male Circumcision for HIV Prevention in Swaziland, 2009–2013, the MOH and Swaziland’s MC Task Force intend to use up to six of the government (“public” or “tertiary”) hospitals in the country to perform the majority of MC surgeries. The goal is to perform 144,688 MC surgeries by 2013. The work of public healthcare providers will be complemented by private providers, such as FLAS, PSI, Marie Stopes International, other non governmental organizations (NGOs), and private doctors. MC for neonates will start in two public hospitals in 2009–2010. Work toward expansion in additional hospitals and maternal and child health contexts will be made in subsequent years.

The Strategy and Implementation Plan for Scaling Up Safe Male Circumcision for HIV Prevention in Swaziland, 2009–2013 has the following objectives:

• Provide MC for HIV prevention services to 144,688 males during 2009–2013 (111,688 HIV-negative men ages 15–25 or 80 percent, and 33,000 male neonates or 33 percent).
• Provide safe MC services.
• Maximize safer sexual practices after MC among circumcised men, as well as women and uncircumcised men, throughout Swaziland.
• Always provide MC for HIV prevention as part and parcel of the minimum package of services. Complementing surgical care with HIV testing and counseling, STI screening (and treatment), and risk reduction counseling with provision of condoms will help maximize the impact of the HIV prevention intervention.

CURRENT KNOWLEDGE, ACCEPTABILITY, AND BEHAVIOURS ON HIV AND MALE CIRCUMCISION

General knowledge on HIV and AIDS is almost universal among Swazi men and women: nearly all men and women have heard of AIDS. Comprehensive knowledge is considerably lower: 52 percent for women and 51 percent for men (CSO and Macro International 2008).

Generally, male circumcision prevalence in Swaziland is low. The SDHS estimates that only 8 percent of men are circumcised and that men 35 years and older are more likely to be circumcised than younger men. Urban men are also more likely to be circumcised than rural men (13.3 percent, compared with 6.2 percent).

While considerable research on acceptability, attitudes, and behaviour regarding male circumcision has been conducted throughout the southern Africa region, Swazi-specific research is limited. In recent years, however, several acceptability studies have been conducted in Swaziland. Despite low MC prevalence, these studies indicate a considerably high acceptance of MC.
In 2007 a meta-analysis of 13 studies conducted in nine countries, including Swaziland, concluded that the median level of acceptability for MC at 65 percent (with a range of 29–87 percent) was fairly high (Westercamp and Bailey 2007). The SDHS reports that 43 percent of uncircumcised men ages 15–49 want to be circumcised with the highest number among men 30–34 years (51.3 percent), men in the highest two wealth quintiles (47 and 48 percent, respectively), and urban men (49 percent). Another study conducted by Tseli and Halperin (2006) in Manzini cited 71 percent acceptability of MC among men.

FLAS (2008) conducted a knowledge/attitude/practice study among men in urban Mbabane. Of all men surveyed, 98 percent were aware of MC. However, only 21 percent indicated they had access to MC information. Of the men interviewed, 68 percent were accepting of the practice. This same study revealed that 51 percent of men who were not circumcised would be willing to have the procedure. In contrast, 44.8 percent of men interviewed indicated they would not be willing to have the procedure. Most of the unwilling men were 45 years and older.

REASONS FOR MC ACCEPTABILITY

In the FLAS study, men interviewed indicated a number of advantages of MC: 46 percent believed that MC reduced the risk of STI infection. In comparison, only 21 percent recognized MC as a means of reducing HIV risk, followed by hygiene (16.7 percent) and sexual satisfaction (6.5 percent).

Hygiene as a mechanism of protection from STIs was often mentioned as a reason for MC by men (Bailey and others 2002). It was held that germs, dirt, bacteria, and viruses had a greater opportunity to proliferate in the warm moist environment beneath the foreskin.

In a Botswana study, 70 percent of study participants willing to circumcise their male child listed protection from STIs or HIV among their reasons for doing so (Kebaabetswe and others 2003). In South Africa, no association was found between willingness to be circumcised and perceived health benefits (Scott, Weiss, and Viljoen 2005). Rather, it was a belief about sexual pleasure that was the strongest predictor of being willing to undergo circumcision.

Sexual pleasure among circumcised compared with uncircumcised. How circumcision is perceived to influence sexual drive, sexual performance, and sexual pleasure for the man or his partner is likely to influence decisionmaking around MC. Participants in several studies reported a belief that circumcision enhanced sexual pleasure (Kigozi and others 2009).

Most studies assessed three factors associated with sexual activity based on circumcision status: sexual performance, sexual pleasure for men, and sexual pleasure for women. Fifty percent of circumcised and 30 percent of uncircumcised participants in South Africa believed that MC increased sexual performance, whereas only 21 and 14 percent, respectively, believed that MC decreased sexual pleasure (Rain-Taljaard and others 2003).

Women’s influence on MC uptake. Relatively little is known about the role of women in decisionmaking on MC. As the evidence base in this area grows, messages and communication approaches are expected to become more refined. Numerous studies in the region have indicated that women are in favour of MC, both for their male partners and for their children in the meta-analysis, women’s average reported acceptance of MC for their partners was 69 percent (Westercamp and Bailey 2007).
Limited evidence has indicated that some men are more likely to accept MC if they feel that they will be more sexually attractive to women. Other studies have also indicated that some women prefer men who are circumcised, as they are perceived to be cleaner and, some say, better sexual performers (Westercamp and Bailey 2007).

**Other Reasons to Circumcise**

Other reasons to be circumcised reported by participants included the belief that it was easier for circumcised men to use condoms (Bailey and others 2002), that MC proved manhood, that aim during urination was improved, and that not being circumcised brought bad luck (Rain-Taljaard and others 2003).

**Barriers to MC Acceptability among Men**

A comprehensive list of barriers to MC in the context of MC communication can be found in the table on page 14. Regionally, men have repeatedly reported “pain” as the most critical barrier to MC. In the FLAS study, 38 percent of men indicated lack of information as the reason they did not want to be circumcised. But this was followed closely by 34 percent of men who indicated pain as a reason for not getting circumcised.

It is widely accepted that if men and parents believe that circumcision leads to high rates of complications, including extreme pain, uptake of MC is likely to be low. Concerns for safety have also been noted in some research. Mothers were vocal in their concerns, especially in cases of infant and early childhood circumcision (Westercamp and Bailey 2007). Excessive bleeding was a major concern and this fear was heightened if the procedure was to be performed by a traditional circumciser outside the hospital setting (Westercamp and Bailey 2007). Infection and difficulty in healing were also stated as concerns, but were generally believed to be minimized in clinical settings (Bailey and others 2002).

Overall, studies seem to indicate a great deal of trust in medical practitioners and a strong preference for circumcision services being made available in public health facilities by trained health professionals.

Some studies also indicate concerns about cost as a prohibitive factor. While many reported that they believed that MC should be provided for free or at significantly reduced cost, others indicated that MC provided at public health facilities for free would be considered of low quality (Westercamp and Bailey 2007).

Despite the fact that circumcision is not widely practiced in Swaziland, only 10 per-cent of male Swazis mentioned tradition or religion as a barrier to MC (CSO and Macro International 2008). In the FLAS study, nearly 25 percent of men indicated that they were not aware of any reasons not to get circumcised (FLAS 2008).

Barriers to circumcision cited in other studies were lack of access to healthcare, required time away from work, the loss of penile sensitivity, reduction in penis size, decreased ability to satisfy women, excessive sexual desire, increased promiscuity by female partners during the period of healing (Bailey and others 2009), and the perception of circumcision as old-fashioned (Lagarde and others 2003).
Risk Compensation

There is some limited evidence of risk compensation or an increase in unsafe sexual behaviours after circumcision due to the perception that one is safer from HIV, among circumcised men; however, empirical evidence on this is inconsistent. A Cochrane review that assessed the evidence of the interventional effect of male circumcision conducted a meta-analysis of secondary outcomes measuring sexual behaviour in the Kenyan, Ugandan, and South African trials. The study concluded that there were no significant differences between circumcised and uncircumcised men in the Kenyan and Ugandan trials. In the South African trial, the mean number of sexual contacts among circumcised men was 5.9, compared with 5 in the control group, which was statistically significant. No other differences were observed (Siegfried and others 2009). A study in South Africa found a significant association between circumcision status and a higher reported number of nonspousal lifetime partners (Lagarde and others 2003). Circumcised men in Uganda were found to engage in more HIV risk behaviours than uncircumcised men (Bailey, Neema, and Othieno 1999). On the other hand, a prospective cohort study conducted in Kenya showed that circumcised men did not have more extramarital partners (Agot and others 2007). A randomized controlled study conducted in Kisumu, Kenya, provides evidence that circumcision did not result in increased HIV risk behaviour (Mattson and others 2008). Further research on this matter is needed.

Service Providers and MC

Except for the FLAS study, information is limited on service provider (SP) acceptance of MC. Eighty percent of SPs working in public and private settings in Manzini interviewed for the FLAS survey thought it was a “good procedure.” More than half of SPs (60 percent) were aware of the relationship between MC and HIV. The remaining 40 percent were not sure about it and added that more evidence was necessary to prove that MC reduces HIV infection among men.

Preferred Sources of Information for MC

According to the SDHS, radio is the most widely accessed media channel for both men and women ages 15–24. Eighty-two percent of young men ages 15–19 and 81.9 percent of young men ages 20–24 are exposed to radio on a weekly basis. Newspaper ranks as the second most accessed channel by both young men and young women ages 15-24. The FLAS study asked respondents where they would prefer to access information on MC. Nearly 28 percent indicated from a friend, followed by any source of media (27.4) and relatives (25 percent).

Future Research Questions

To date, the research conducted in Swaziland has focused on urban areas. It is essential to gain a better understanding of knowledge, attitudes, intentions, and behaviour related to circumcision on a national level. PSI is planning a national cross sectional survey that will help identify barriers and motivating factors for circumcision service use. The survey will also monitor MC prevalence and sexual behaviours. This survey will serve as a baseline for regular national cross-sectional surveys to track intervention progress.

A longitudinal study to measure the impact of MC on HIV and to determine levels of risk compensation is also necessary to measure the effectiveness of Swaziland’s MC programme on HIV prevalence and
There is also a need for qualitative research to understand beliefs and perceptions about male circumcision better among key stakeholders, including community leaders, religious leaders, women’s groups, PLHIV groups and traditional healers.

**Key Communication Issues for Male Circumcision for HIV Prevention**

The Strategy and Implementation Plan for Scaling Up Safe Male Circumcision for HIV Prevention in Swaziland 2009–2013 (Ministry of Health, 2009) describes the need for an ambitious communication strategy to ensure MC uptake for HIV prevention. It is important that this strategy help ensure that Swazis fully understand the benefits, limitations, and responsibilities of those seeking MC, those providing MC, and those supporting MC. As part of this process, the MC Task Force has identified priority challenges to MC communication. The following table presents the challenges to and considerations in MC communication.

<table>
<thead>
<tr>
<th>Challenge to MC Communication</th>
<th>Consideration</th>
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| Available MC services are currently limited with rapid scale-up planned. | • Timing communication messages is critical to avoid creating demand before services are available.  
• Criteria for a “seal of quality” must be developed for all providers and implemented during rapid scale-up. |
| Target audience has fairly poor knowledge on MC as a means to prevent STIs and HIV. | • It is crucial to ensure that key audiences understand the protective benefits of MC, the importance of HIV testing, and the importance of MC as a part of comprehensive prevention. |
| Key audiences need accurate information throughout each stage of the process. | • Individuals need to have information on MC to make informed demand.  
• Accurate and clear information on the procedure itself and what to expect should be made available to the key audiences.  
• Accurate information on the post-operative follow-up process and staying healthy should be made available to key audiences. |
| MC cannot be perceived as a stand-alone HIV prevention intervention. | • Messages on MC should be integrated into HIV testing and counseling, family planning, communication on concurrent partnerships and all clinic-based health education that targets the primary audiences. |
| Some cultural and traditional leaders hesitate to support MC. | • Traditional leaders must be considered key stakeholders in the MC programme.  
• Research is needed to understand perceptions on male circumcision and relevant social norms better to identify ways to increase involvement. |
| Men who are circumcised may think they can have risky sex. | • Communication should address issues of risk compensation and encourage consistent practice of safe sexual behaviour after MC. |
Underlying gender dynamics, such as polygamy and sexual violence, persist that make both men and women vulnerable to negative health outcomes.

| **Underlying gender dynamics, such as polygamy and sexual violence, persist that make both men and women vulnerable to negative health outcomes.** | **MC communication strategies and materials must be sensitive to negative gender norms and include this understanding in each approach**  
**Efforts must be made to design female-specific MC communication messages and materials.**  
**Limitations of MC should be communicated clearly, including that MC has limited benefits for men who are already HIV positive, that HIV-positive men who are circumcised can still infest their partners, and that MC is only 60 percent protective against HIV infection.** |

Many are not aware of the limitations of MC in terms of its protective value against HIV.

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### STRATEGIC APPROACH TO MC COMMUNICATION FOR HIV PREVENTION

The communication strategy will incorporate common communication models described below. These models target the individual, social networks, community and the society where the individual or group stays.

#### Social Ecology Model for MC Communication

The Male Circumcision and HIV Prevention in Eastern and Southern Africa – Communications Guidance (2008) recommends a strategically based ecological approach to communication. This approach suggests the need for a comprehensive social and behaviour change communication programme that targets individual behaviours, mobilizes the community, and helps address underlying societal factors that either promote or limit access to MC services. The following figure illustrates this model (UNAIDS 2008)

#### SOCIAL ECOLOGY MODEL OF COMMUNICATION AND BEHAVIOR

<table>
<thead>
<tr>
<th>Types of Communication</th>
<th>Social Networks</th>
<th>Community</th>
<th>Societal</th>
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<tr>
<td>Engagement Mass Media</td>
<td>Behavior and intention; knowledge &amp; skills; beliefs &amp; values; emotion; perceived risk; self-efficacy; self-image; subjective norms</td>
<td>partner and family relationships (communication, trust, understanding, agreement, &amp; power), peer influence, gender equity, bounded normative influence</td>
<td>national leadership; per capita income; income inequality; health policy and infrastructure; mass media; religious and cultural values; gender norms</td>
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<tr>
<td>Dialogue Counselling</td>
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<td>level of participation; information equity; access to resources; shared ownership; collective efficacy; social capital; value for continual improvement</td>
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<td>Peer Education</td>
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<td>Communication for participatory Development</td>
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<td>Dialogue</td>
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<td>Community Mobilisation</td>
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<tr>
<td>Entertainment Education, Peer Education</td>
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#### Physical Environment and Infrastructure

Burden of disease; climate and seasonality; transportation and communication networks, access to health care facilities, access to water, sanitation, and household technologies; etc.
This ecological strategy outlines specific guidance for audiences chosen by the MC Task Force from each concentric oval of the ecological model above.

**Individual.** At the level of the individual, the strategy is intended to improve knowledge of male circumcision, explain its advantages and limitations, and address risk compensation. Parents considering circumcision for their children will be directly targeted with basic information on MC as a means of HIV prevention. HIV-positive men shall also be targeted with specific information on the limitations of MC for HIV prevention and potential risk factors for HIV-positive men. Messages at the individual level will also communicate the value of seeking an MC provider accredited with the “seal of quality.”

Methods and approaches shall be culturally nonspecific and use value-free explanations of the pros and cons of male circumcision.

Key audiences at this level include the following:
- Uncircumcised males of ages 15–24 years
- Parents of uncircumcised young men under 18 years (including parents of neonates)
- HIV-positive men of ages 15–24 years

**Social networks.** Men rely on peers, parents, and sexual partners for information and encouragement. This strategy will improve the knowledge levels among these social networks and compel friends and influencers to encourage young eligible men to seek MC information and services from “seal of quality”–accredited providers. Female sexual partners of young men are targeted to increase their knowledge about the benefits and limitations of MC and to compel them to support their partners to seek services and abstain for six weeks after the procedure. Young men who are circumcised and exhibit safe HIV-related behaviours will be supported as role models.

Targeted audiences from this level include the following:
- Female sexual partners of males ages 15–24 years
- Parent(s) or guardian(s) (including caregivers and social workers) of males younger than 18 years old
- Peers of young men

**Community.** Engaging those with influence will be pivotal in providing an enabling environment for service access. Implementation will identify traditional leaders and encourage them to integrate HIV prevention and MC information into traditional ceremonies and practices that socialize men into manhood. It will be critical to engage the community in dialogue and debate about MC and the underlying factors of HIV.

At this level, the strategy will also seek to improve the level of knowledge, counseling, and referral capacity of health providers and ensure that a set of minimum standards for MC communication is applied. Providers who currently provide MC services and those who work in the referral chain in the public and private sector must meet the following “seal of quality” accreditation targets:
- Local leaders and individuals with influence at the community level
- Traditional healers
- Service providers providing MC services and information
- Service providers currently referring clients for MC services and information.
Societal. The need for an enabling environment is critical. An enabling policy environment for MC requires that policymakers have sufficient access to information and that the arguments for MC are made in a clear and compelling way to those that shape government policy. Creating an enabling environment will also include addressing harmful gender norms that limit access to MC and comprehensive HIV prevention. Journalists, editors, and other media gatekeepers need to be informed about MC. Advocacy around “seal of quality” facilities will take place with decision makers and media. All information will be made available, including critical or cautious perspectives.

Key audiences at this level include the following:
- National policymakers and influential leaders
- Media representatives: media owners, editors, and journalists

COMMUNICATION STRATEGY BY IMPLEMENTATION PHASE AND KEY AUDIENCE

The MC communication strategy also follows the principles laid out in the MC communications guidelines developed by WHO and UNAIDS. Because current MC service availability is limited, this strategy provides guidance on a two-phased approach to MC communication. The following graphic describes the key elements of each phase:

**Phase One**
- Intergrated Minimum Standards within all scale-up sites (eg FLAS, PSI etc)
- Preparatory work, research, priority early interventions.

**Phase Two**
- Generalised HIV campaign, linking MC with VCT, MCP, condom use and other prevention issues.

**Phase 1.** During this phase, MC services will be available at a limited number of facilities. Supporting communication activities will be implemented in the catchment areas of these facilities and among health centre staff.

These activities will be coupled with community- and national-level advocacy designed to gain increased stakeholder support for expanded MC service provision.

**Primary audiences for phase 1:**
- Young men ages 15–24 years in designated catchment areas
- Parent(s) or guardian(s) (including caregivers and social workers) of neonates
- Parent(s) or guardian(s) (including caregivers and social workers) of males ages 13–17 in catchment areas
- Healthcare workers currently providing MC services
- HIV-positive men
• Local leaders, traditional healers, women’s groups, people living with HIV/AIDS groups
• Media journalists, editors, as well as media house managers, correspondents, and photographers in the target areas
• National-level policymakers

Secondary (influencing) audiences:

• Sex partners of young men seeking MC
• Male peers of young men interested in MC

Key communication objectives for this stage include the following:

• Increase the level of knowledge in designated catchment areas among men 15–24 and parents considering MC for their children about the health benefits and limitations of MC for HIV prevention.
• Increase the awareness among target populations about where to go for MC and appropriate counseling services.
• Increase consistent practice of safer sexual behaviours post-MC.
• Increase MC knowledge relevant to HIV-positive men among this target audience.
• Improve counseling skills and knowledge regarding MC among current service providers and those making referrals for MC services.
• Improve understanding of quality assurance standards among service providers at relevant facilities.
• Increase knowledge about the health benefits and limitations for MC for HIV prevention among national, community, and religious leaders.
• Increase local and regional media coverage on MC.
• Increase the number of national policymakers and leaders who mobilize national stakeholders to support MC as a preparatory step for phase 2.

Phase 2. Phase two should begin only when services are adequately available to meet any increased demand generated by a national-level campaign. During this phase, communication activities will be expanded to a broader target audience as the national MC policy is adopted and MC services are expanded beyond the pilot sites. Phase 2 will comprise long-term, sustained communication campaigns designed to ensure those eligible to access services do so and that MC is integrated into the broader spectrum of HIV prevention options.

During this phase, MC communication will fall into four categories: demand creation (or conditioning), education around the MC procedure, promotion of safe healing, and promotion of sustained safer sexual behaviours following MC. This will be supported by communication activities that address the broader social context in which circumcision takes place. The following figure presents points of entry for communication activities for males ages 15–24 (PSI Zambia).
### 1. All healthcare workers in public and private sector
### 2. Media journalists/editors/media owners
### 3. Local- and national-level policymakers

**Secondary audiences for phase 2:**

1. Sex partners of men ages 15–24 who are interested in MC
2. Peers of young men interested in MC

**Primary audiences for phase 2:**

1. Men ages 15–24
2. Men ages 25–29
3. Parent(s) or guardian(s) (including caregivers and social workers) of neo-nates
4. Parent(s) or guardian(s) (including caregivers and social workers) of males ages 13–17
5. HIV-positive men
6. All healthcare workers in public and private sector
7. Media journalists/editors/media owners
8. Local and national level policymakers

**Secondary audiences for phase 2:**

1. Sex partners of men aged 15–24 who are interested in MC
2. Peers of young men interested in MC

Key communication objectives for this phase are the same as those outlined in phase 1, but will be scaled up to the national level. Communication about accredited facilities will be linked to national channel messages for MC demand creation.

See appendix 2 for a detailed table of key audiences and messages and communication goals, objectives, and channels/tools.
KEY MESSAGE POINTS

While the emphasis and focus of each message will change depending on the audience and intended communication outcome, some messaging will be common throughout (these are adapted from the UNAIDS/WHO guidance notes):

Male circumcision is a surgical procedure performed by a trained medical professional that removes the foreskin of the penis. Male Circumcision for HIV prevention is not the same as many traditionally practiced procedures.

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

Male circumcision only provides protection from HIV for the circumcised man.

Male circumcision does not reduce his sexual partner’s risk of HIV infection. Preliminary studies have confirmed that male circumcision does not reduce the risk of HIV infection among sexual partners if they have sex with an HIV infected circumcised man.

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

Circumcised men can be infected with HIV and can infect others. Not all men who are circumcised are HIV negative. Some circumcised men are HIV positive. Circumcised men who are HIV positive may still transmit HIV to their sex partners. Using a condom reduces this risk.

The healing period is important. Newly circumcised males should abstain from sex for six weeks to ensure the penis is fully healed, as there may be an increased risk of infection during this time.

Safety is paramount. Circumcision should be done in accredited, “seal of quality” health facilities with appropriately trained providers, and proper equipment and under aseptic conditions.

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

Male circumcision is available by providers who have been trained and are qualified to provide safe MC.

All those who do not know their HIV status should get tested for HIV before getting circumcised. HIV testing is recommended but not required for MC.
OPERATIONALIZING THE MC COMMUNICATION STRATEGY

Phase 1. In a context where coordination is essential and some service providers are moving forward faster than others with MC service provision, determining minimum operational standards and guidelines for MC Communication is necessary. This will help ensure that the following:

- All MC service providers engaging in communications abide by certain minimum standards of communication.
- MC communication messages are standardized and harmonized across the board as appropriate for consistency, quality, reliability, and effectiveness.
- Duplication of efforts is avoided due to coordination of communication activities among the implementing partners involved in MC communication.

The minimum guidelines are as follows:

- Continued operations of the BCC Subcommittee of the MC Task Force. The terms of reference of this committee should be clearly defined, provide oversight of communication activities, and identify any gaps that exist. This group should meet regularly to inform all parties involved and avoid duplication of efforts.
- Ensure that formative research informs the design of communication materials so that MC messaging can be built on research findings and more accurately address motivators and barriers to service use.
- **Messaging.** All print materials and communications in other formats (audio-visual, etc.) should include target audience–specific key messages listed in the table on appendix 2, as appropriate. It is important to develop target audience–specific “nuanced” messaging based on formative research while keeping the main information intact.
- **Pre-testing.** The communication work accompanying MC service provision should be developed with adequate pre-testing.
- **Ongoing monitoring and evaluation (M&E) activities.** These should be woven into MC communication activities from the outset. Evaluation findings should be fed into the communication programme activities to allow for adjustments along the way.
- **Demand and supply.** In all communication programming, there should be a link between demand creation activities and the availability of MC supply. Demand should not be created where there is no supply. However, general information on MC for HIV prevention can be distributed widely, as long as overtly promotional elements take into account local MC supply levels.

Phase 2. Operational guidelines for phase 2 include the following:

- Continued meeting and oversight by the MC Task Force BCC Subcommittee
- Compilation and analysis of all formative research (knowledge, attitudes, beliefs, and practices, etc.) results, M&E reports from the regions and localities involved in phase 1
- Development of a report that captures the best practices, lessons learned from the field, and next steps for MC communication in Swaziland
- Branding through an accreditation seal and development of target audience–specific communication materials/tools for use at the national scale
- Development of factsheets, success stories, lessons learned reports, and other documents that
can provide guidance to other countries in earlier stages of scale-up and that can be used to represent Swaziland’s programme in national and international forums.

- Continuation of formative research and M&E activities
- Reinforcing audience-specific MC messaging and the brand with the information obtained from ongoing knowledge, attitudes, beliefs, and practices M&E reports
- Sustained media outreach should also be an ongoing effort.
- Consideration of a national HIV prevention campaign that incorporates male circumcision as one of many tools to prevent HIV.

**Monitoring & Evaluation**

A strong M&E component is necessary to measure the success of the MC communication strategy during each phase. The evaluation of the strategy should focus on both the process and outcome of the communication interventions. Ultimately, an evaluation should be conducted to examine exposure levels and programme impact (behaviour change attributable to communication activities). Evaluation activities would track work performed, timeline progress, resource expenditures, participation of partners, etc. Tracking the number of radio talk shows aired within a given timeframe, the number of people who listened to these shows and the number of print materials given to local policymakers are good examples of process measures. Results of the process evaluation will allow assessment of whether activities are on track, target audiences are being reached, and some interventions are more successful than others. Therefore, based on this information, some aspects and activities of the strategy can be re-evaluated, effective interventions can be identified and strengthened, and other necessary adjustments can be made.

Evaluation activities would also assess exposure to campaign activities and assess changes in young men’s healthcare providers’ or leaders’ MC-related knowledge, attitudes, beliefs, and practices.

Progress reports must be scheduled at regular intervals to help keep the plan on target. In this way, MC communication activities can be tracked, providing information on the effectiveness of the interventions direction, pace, and magnitude of changes and any unintended results.

The following table outlines the necessary elements for phase 1 MC communication in Swaziland.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Outputs</th>
<th>Essential Elements</th>
<th>Schedule/ Timing</th>
<th>Roles and Responsibilities</th>
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<tr>
<td>Every site currently providing services provides a full package of MC communication.</td>
<td>Minimum standards for communication circulated; staff recruited to oversee these standards; communication M&amp;E framework exists.</td>
<td>Minimum standards developed with UN guidance; institutional administration of MC communications minimum standards are in place.</td>
<td>Minimum standards finalized by September 2009; mechanism for overseeing standard in place by September.</td>
<td>NERCHA to hire communication staff or communication agency for MC Task Force, through NERCHA; UNAIDS/WHO to assist on minimum standards.</td>
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<tr>
<td>All Swazi HCWs (including traditional HCWs) have good knowledge on MC and the status of service provision.</td>
<td>Regular news updates; policy group established; dialogues begun with traditional healers.</td>
<td>Rapid appraisal of healthcare workers, and traditional healthcare workers current views and practices on MC; communications programme building on appraisal.</td>
<td>Appraisal of HCWs’ knowledge undertaken in August; communications programme for HCWs undertaken September 2009 to January 2010.</td>
<td>MOH/SNAP to oversee this area of work; research/communication agency (e.g., PSI working with independent research partner) contracted and responsible to task force through MOH.</td>
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<td>HCWs and traditional healers know where to go for support on MC.</td>
<td>An advisory from the ministry, filters down to local level, identifying points of support and advice; outreach to traditional HCWs.</td>
<td>A nationwide outline of information points on MC required; a programme to reach out to traditional HCWs as equal partners and cultural experts instituted.</td>
<td>Outline for information points drafted in September 2009; programme for traditional HCWs instituted from September 2009 to September 2010.</td>
<td>SNAP to recruit organization/agency (e.g., PSI) to develop outline of information points within and to develop programme with traditional HCWs.</td>
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<tr>
<td>NGOs and community based organizations are mobilized to communicate effectively around MC.</td>
<td>National and regional coordination meetings; information, education, and communication materials; training.</td>
<td>Key messages are agreed on. MC Task Force agrees on roles of NGOs and service providers.</td>
<td>Key messages agreed in July 2009; NGO and community based organizations action plan developed in August 2009.</td>
<td>MC Task Force to oversee this work, probably commissioning assistance from another agency/organization (e.g., CANGO).</td>
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<tr>
<td>Media know policy situation relating to MC.</td>
<td>A press conference and brief policy update document.</td>
<td>MOH to release news of current progress of MC policy, protocols, and strategic plan.</td>
<td>Press release in July 2009.</td>
<td>MOH, working together with a local media NGO (e.g., Media Institute of Southern Africa (MISA)).</td>
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<tr>
<td>Media have the capacity to report on MC.</td>
<td>Media training activities; editor breakfast meetings; workshops; examples of good reporting; free materials.</td>
<td>An agency identified to work with the media; strong data on costing, sustainability, and other issues made available; a media liaison briefing to deal with difficult questions.</td>
<td>Media liaison briefing developed August 2009; consultant to assemble all required documentation to present as media package by October 2009.</td>
<td>MOH, working together with a local media NGO (e.g., MISA) supported by international agency/consultants (e.g., PSI).</td>
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<tr>
<td>Media can act as a platform for public debate on MC.</td>
<td>Work with talk-show hosts; readers’ letters pages; community media (from theatre to radio).</td>
<td>An agency identified to lead on this work; upfront approach to anticipated MC surgical complications and other challenges.</td>
<td>By August 2009 an agency or organization recruited to work on the media liaison; work ongoing through 2010.</td>
<td>MOH, working together with a local media NGO (e.g., MISA) supported by international agency/consultants.</td>
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<tr>
<td>Media starts covering MC issues in a way that sensitizes the public on the MC issues, benefits, and constraints and overall value of MC to the country.</td>
<td>A special 45-minute TV documentary made in which high-level Swazi spokespeople talk about MC; associated print and radio features commissioned.</td>
<td>Creative brief for factual/informative overview of MC benefits and limitations in Swaziland developed for media outputs; high-quality media production partner commissioned.</td>
<td>Creative brief developed in September 2009; creative products finalized and broadcast by World AIDS Day (December 1, 2009).</td>
<td>MOH, working with a local media NGO (e.g., MISA) supported by international agency/consultants; media production partner commissioned through competitive bidding process (through PSI).</td>
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<tr>
<td>Media are knowledgeable on MC pros and cons.</td>
<td>Accessible print materials; breakfast meetings; a film; a note on where to find information in government.</td>
<td>Agency identified to work with media; media liaison briefing drafted.</td>
<td>As above, by August 2009, agency contracted and media liaison briefing drafted.</td>
<td>As above; task force ultimately responsible.</td>
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<tr>
<td>Policymakers are supportive and informed on MC issues.</td>
<td>A film; special forums; advocacy; MC situational analysis; qualitative research; MC communication strategy.</td>
<td>A “no-spin” approach; nec-essary data and preparatory documentation (including this strategy) to be collected and presented in appropriate format.</td>
<td>As above, agency recruited in August 2010 overseeing media liaison.</td>
<td>Agency (e.g., PSI/ MISA to oversee media liaison); agency develops media committee for advice and technical expertise.</td>
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<td>Without creating demand where there is no supply, the public understands the benefits and limitations of MC.</td>
<td>Mass media reporting on MC; information in health services; information among traditional leaders; a film</td>
<td>Key agreed messages mainstreamed throughout; minimum standards closely adhered to</td>
<td>July 2009 to 2010 and beyond</td>
<td>MC Task Force oversees.</td>
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<td>The general public is updated on services.</td>
<td>Reaching out to traditional HCWs;</td>
<td>As above.</td>
<td>July 2009 to 2010 and beyond.</td>
<td>MC Task Force oversees.</td>
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<td>Clients exhibit no risk compensation in relation to MC.</td>
<td>Targeted multimedia and interpersonal campaigns among already circumcised males</td>
<td>Focused BCC programmes developed, with good theoretical basis, to address risk compensation</td>
<td>By October 2009, once minimum standards are instituted</td>
<td>MC Task Force oversees, with UN assistance.</td>
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<td>Targeted groups demand services.</td>
<td>Regional or population-based focused prevention strategies developed by communication partners, incorporating minimum standards.</td>
<td>MC demand creation, with minimum standards efficiently driving demand among targeted groups; special information and communication for positive adult men.</td>
<td>Communication partners provide their specific plans for activities by October 2009, once minimum standards are instituted; prevention for people who are HIV-positive; BCC campaign developed by October 2009 and implemented through 2010 and beyond.</td>
<td>MC Task Force oversees with UN assistance.</td>
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