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# Communication Strategy

## Male Circumcision for HIV Prevention

Commissioned by the Male Circumcision Task Force of Namibia

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# 1. Executive Summary

This document serves as a broad frame of reference for the planning and implementation of communication programming around male circumcision for HIV prevention. It outlines how male circumcision (MC) communication programming should be integrated within both the broader Namibian MTP3 (and MTP 4) and the forthcoming National Namibian HIV prevention strategy, 2009.

This strategy has been developed in reference to what is known about emerging trends within the Namibian epidemic and guided by the MC Situational Analysis, particularly the qualitative research findings, commissioned by the National MC Taskforce.

A phased approach is recommended. A prioritized plan is outlined for responding to immediate needs, which include clear and comprehensive information for policymakers, service providers and the media. In the longer term, with the scale up of MC services, a broad set of further communication objectives and outcomes is listed. Communication issues relating to each of these longer term objectives are laid out, and some sample outputs are suggested, although until the modalities of scaling up MC provision are known, these suggestions remain generalized and tentative.

This strategy recommends the eventual launch of a broad combination prevention campaign, with the working title of "Prevention Max!"<sup>1</sup>. This is because MC needs to be communicated as just one part of a broader HIV prevention approach. Further, the introduction of MC requires a scale up in the intensity and reach of existing prevention efforts. A new campaign could help galvanise new energy, resources and action, as well as placing MC within the context of broader prevention approaches. However, a new campaign is not essential for achieving the objectives listed in this document, and most issues discussed and outputs and outcomes listed are relevant no matter how the resulting programming is presented.

A broad social and behavioural change communication framework is laid out which deals with the various different spheres of context around MC communication. Within this framework, efforts are required to target individuals, their social networks, and the broader community and societal contexts. In some instances, focused strategies and programming will be required for some specific groups. The principles for developing further focused strategies are outlined in order to minimize the risks associated with unplanned MC communications, and to maximize chances of success.

Tools and channels for programming are outlined and prioritized around each objective. Lastly, a list of requirements is outlined in terms of further research or information.

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<sup>1</sup> "Prevention Max!" is a working title. The identity, profile and official name of the campaign should be decided by the MOHSS with the National MC Taskforce

## **2. Introduction**

The Namibian Male Circumcision for HIV Prevention Taskforce have drafted a policy and action-plan for scaling up MC within the country. Recognising the importance of effective communication relating to MC, the Task Force has commissioned this strategy document. The aim is to address the needs for communication around MC both in the short and longer term.

A health communication consultant, Thomas Scalway, spent 4 weeks in Namibia, speaking to a range of stake-holders. At the end of the first fortnight the consultant presented initial findings in relation to the objectives and outcomes of the communication strategy. At this point, guidance and inputs on the broad parameters of the communication strategy were sought.

In the third and fourth weeks the consultant traveled to Gobabis and Ondangwa and spoke to further stakeholders in Windhoek. At the end of the fourth week a meeting was convened where a range of external partners gave initial impressions and inputs on the emerging strategy. In the fifth week, these inputs were incorporated into the first draft of this strategy document. Because plans are still being developed for scaling up MC within the country, this strategy document contains only very general notes about the kinds of partnerships and capacities required to implement the necessary outputs at different levels and in different regions.

This communication strategy acknowledges that male circumcision for HIV prevention can offer unprecedented gains in curbing HIV incidence within the country, but also carries significant issues and challenges. Because of the complexity of messages around MC, for example that it only offers partial protection from HIV, is only protective of men, and does not replace other preventative measures, MC communication will have to be comprehensive and sustained. Extra care will need to be taken to focus communications, to segment audiences, and to ensure that rights and participation remain paramount.

## **3. MC within Namibia's HIV Prevention Response.**

In its Medium Term Plan III (MTP III) for HIV/AIDS in Namibia, the Government acknowledges that prevention is a key priority for the national response to AIDS. The Ministry of Health and Social Services (MoHSS) is currently considering adopting male circumcision as an additional HIV prevention intervention.

Namibia is facing a generalised and hyper-endemic epidemic. The current evidence suggests that HIV is driven by multiple concurrent partnerships exacerbated by age disparate sex and low condom use, along with lack of male circumcision (presentations made to the HIV Prevention Consultation). While efforts are being made to intensify programmes targeting MCP, and to increase condom use, male-circumcision offers a useful additional approach to further slow infection rates.

In the HIV Prevention Consultation, November 2008, participants heard how MC should complement other prevention efforts in Namibia. Male circumcision is just one aspect of a Namibian “combination prevention” approach which uses a range of social and medical approaches to maximise impact on HIV. A Namibian Prevention Strategy is being developed which elaborates upon the prevention elements of the MTP 3/MTP 4. Crucial is that the communication programming for MC is integrated within the broader set of communications for HIV prevention, thereby avoiding dissonance, duplication or fragmentation.

#### **4. Responding to evidence**

The UNAIDS Practical Guidance for HIV Prevention emphasises that efforts should be informed by current information about the epidemic including a thorough understanding about emerging patterns amongst new infections. Currently the broadest information about HIV and risk behaviour comes from the Namibian Demographic and Health Survey. Information specifically about male circumcision for HIV prevention was compiled within the MC Situational Analysis. The next Demographic and Health Survey may be able to provide a useful set of indicators showing progress in prevention from the last 2008 DHS. Meanwhile a further population-based survey is planned, and this will further facilitate the collection of more nuanced information about circumcision and sexual risk.

The qualitative research commissioned as part of the MC Situational Analysis showed broad support for male circumcision for HIV prevention amongst general populations, including those belonging to language groups that do not traditionally circumcise. Further, this research showed that if the government of Namibia encourages male circumcision for HIV prevention, then many would seek services. However, attitudes and norms relating to MC and sexual risk vary greatly across the country, and it is clear that no one undifferentiated programme could meet the communication needs of all groups. The qualitative research illustrated diverse perceptions on the benefits and drawbacks of male circumcision centering around four areas. Participants within the research had different ideas about what the implications of MC would be for health and hygiene; some considered MC as an advantage, others not. There were very different ideas about MC depending on the culture and tradition of those spoken to. Thoughts about sexual pleasure and normative beliefs were also various, some saying that MC increased sexual pleasure, others saying that it detracted from it. From group to group, normative beliefs also varied. For some MC was advocated within the systems of norms, for others it was outside prevailing normative systems.

The diversities of views and experiences in relation to MC across the country highlight the need for localized and community originated efforts to compliment any national level programming.

## 5. Principles for programming

The following points were considered important by the MC Task Force and other people interviewed by the communication consultant:

Fighting disinhibition: Targeted communications ; Empowering sexual partners; Promoting circumcision as an inextricable part of broader HIV prevention approach.

Addressing myths and misconceptions: Providing full information; Ensuring minimum standards in service delivery; Developing a communication protocol for dealing with challenges.

Emphasising rights and gender issues: Involving women and PLHIV in the design of the communication strategy; Instituting standing civil society forum for MC (and wider prevention).

Strong monitoring and evaluation: Strong baseline data (from DHS or household survey) then yearly formative and summative assessments using quantitative and qualitative tools.

### **Further agreed principles emerging through Namibian MC Communication Consultations:**

Communication will need to address MC and HIV prevention at the level of the individual, social networks, the community, and at societal level.

Communication will be reinforced through a number of channels, from mass media through to interpersonal dialogue

Communication will be of a sufficient quantity, and regularity (“dosage”) to ensure social and behavioural change.

To ensure lasting prevention benefits, communication will be long term and considered within a multi year time-frame.

Communication will be coordinated and to some extent developed nationally, but there will be strongly nuanced regional elements to address geographical and cultural diversity in the country.

Communities will be active partners in shaping communication programmes around MC, particularly women, PLWHA and young men. At local level, efforts will be made to ensure full ownership of communication programming.

## 6. A phased approach

There are both short-term and long-term needs in relation to communication for Male Circumcision. This communication strategy outlines a phased approach to deal with these.

Phase One is everything that needs to happen now. This includes a range of outputs which respond to immediate priorities, outlined in the section. It also includes some preparatory work, strengthening partnerships and capacities in readiness for the future MC scale up. It is recommended that whilst still in phase one, the MC Task Force should convene a number of meetings at regional and national level to help clarify roles and responsibilities of different partners, and to identify what challenges will be anticipated at different programming levels.

Further, in phase one, it is recommended that in one site (probably Windhoek, but subject to implementing partners capacity) a focused set of efforts should target dis-inhibition. This will help identify what problems may arise, and will allow for the developing of materials which can later form the backbone of broader efforts. If this recommendation is accepted, more detailed plans would need to be developed jointly with local implementing partners.

Phase Two is everything that should happen as scale up begins. With the scale up of services a comprehensive array of communication outputs will be required to support those involved in guiding and implementing programmes, as well as to reach out to the general public to create and manage demand and to actively arrest MC related disinhibition. In reality, this phase is likely to be staggered, as pilot sites are selected and outputs are developed sequentially across different sites. However, for the purposes of clarity and brevity the likelihood of piloting MC scale up in select sites is encompassed within this simple two phase structure.

Further, in Phase Two, once MC services are widely available, the recommendation is that a broad HIV Prevention Campaign (Prevention MAX!) is launched to position MC alongside other necessary HIV Prevention measures. However, whether or not such a campaign is possible, the substantive content of this strategy remains largely the same.

## **7. Immediate priorities.**

There are already considerable demands for quality health communication around this issue. Male circumcision is already a reality in Namibia. Around 20 percent of Namibian men are already circumcised. Further, the news that MC has a protective effect against HIV transmission for men has already permeated into some areas of the population. For example, within some voluntary and counselling centres, clients are counselled about the benefits of MC. The Namibian military has also incorporated guidance around the role of MC in HIV prevention for its personnel. The issue has started to attract attention from the media and policymakers, and is entering into general popular discourse. Worryingly, there are already unverified, anecdotal accounts of changing attitudes, and possibly behaviours, among those men who are already circumcised and who believe they are now protected from the virus. A number of people and partners are reporting that there is considerable confusion around MC in different groups around the country.

In light of these issues, communication outputs are required immediately to provide accurate, accessible and comprehensive information on male circumcision to policymakers, the media and healthcare workers. These are briefly mentioned here below, but are more fully described in appendix 2. Particular outputs that are required are:

- 1) Fact sheets for policymakers, the media and healthcare-workers. These will have many common elements, and elements which are specific to each group.
- 2) An FAQ sheet for the media (which may also be adaptable for other audiences).
- 3) A basic brochure for those currently seeking MC services, explaining the procedure, the healing period, etc.
- 4) A basic leaflet for the large number of people currently working with the community on HIV prevention (including home-based carers and community mobilisers).
- 5) Generic content, including graphics and basic text, for adaptation by partners within their current work outputs. This could be presented on a CDROM.
- 6) Through the process of developing the above, further facilitation and dialogue at national and regional level around different partners roles and responsibilities for MC communication programming.

Also useful, resources permitting, would be a short 20 min video that gives an accessible overview of the benefits and limitations of MC to policymakers and service-providers currently working on HIV prevention.

## **8. Priorities for early and targeted programming.**

Using the messages, principles and approaches outlined in this strategy, specific targeted programming would be beneficial (dependent on resources).

### **8.1 Windhoek**

Windhoek could immediately benefit from a relatively opportunistic and small scale effort targeting the media, health care workers and those working within communities. This work would not promote MC (as services and policies are not yet fully in place) but would instead mainly promote comprehensive understanding of the benefits and limitations of MC. Through this work, some materials could now be developed with partners working in VCT units and out in the community. These materials, including broadcast quality video and possibly audio, could later serve as the back-bone for wider efforts.

### **8.2 The military**

The military is the first group in Namibia to whom MC services are being promoted as part of a broader HIV prevention effort. This work could be consolidated, with extra partners and investment bringing extra activities and materials. A priority within this work would be to establish strong research,

monitoring and evaluation processes. This would both improve the existing programme, but also would ensure that lessons learnt could be applied to broader populations. Strong partnerships between MoD and established communication partners would be the principal requirement for achieving an effective and focused programme.

### **8.3 Caprivi**

Investing in MC for prevention in the Caprivi region may be an efficient use of resources because of the high levels of HIV prevalence, and the region's relatively homogenous population. If services can be made available in the region, a focused effort could be beneficial by intensifying prevention efforts and driving MC demand amongst uncircumcised men. These efforts would mobilize localized media (particularly outdoor advertising and local language radio) complimented with strong community and interpersonal communication. Strong research and monitoring would be beneficial.

### **8.4 Gobabis**

In Gobabis the past gains in terms of prevention are now being reversed. Sentinel surveillance data in 2006 puts Gobabis HIV prevalence at 7.9%. In 2008 this figure was 13.1%. This could be due to anomalies in the sentinel surveillance data. However, there are strong signs that there is a need for clear accessible information for those shaping the regional response to HIV. Further, there are signs of confusion amongst sexually active and circumcised men about the protective benefits of MC, which is possibly leading to changing attitudes and behaviours. A focused prevention effort, mixing community outreach with interpersonal communication and supported with some IEC materials would be beneficial.

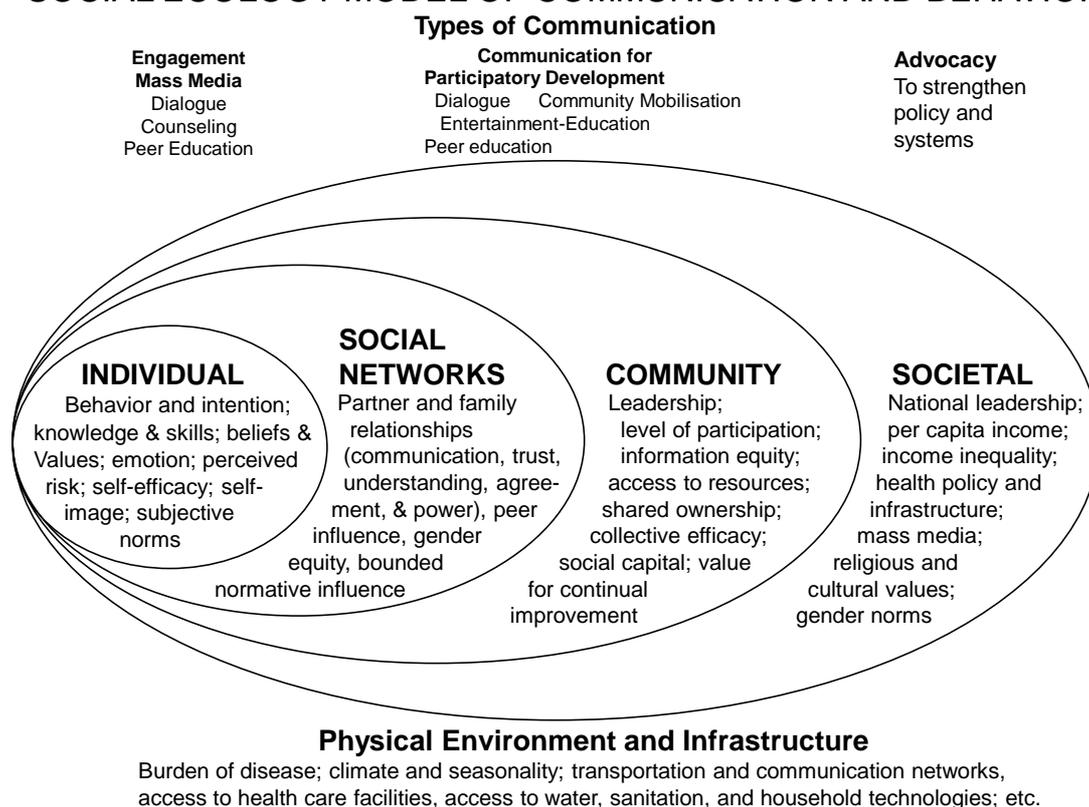
## **9. Social and behavioural change communication**

The UNAIDS Technical Guidance for Communications on MC recommends a strategic approach to communication, along with an ecological approach to the issue, systematically targeting different spheres of context around the individual. This is illustrated in the box below<sup>2</sup>:

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<sup>2</sup> Ref UNAIDS Southern Africa RST Communication Guidelines for MC and HIV Prevention.

## SOCIAL ECOLOGY MODEL OF COMMUNICATION AND BEHAVIOR



This ecological approach suggests the need for a comprehensive social and behavioural change communication programme. This will target individual behaviours, engage with the community, and help address underlying societal factors relating to male-circumcision for HIV prevention.

In the following section, some of the issues that the ecological approach helps highlight will be outlined.

### 9.1 The Ecological Approach

#### **Individual:**

At the level of the individual, a scaled up prevention communication strategy which incorporates male circumcision needs to improve knowledge of male circumcision, explaining its advantages and limitations. Young men, their sexual partners, and parents seeking neo-natal services need to be particularly equipped with knowledge on the basics of MC and HIV prevention.

Further, perceptions of risk from HIV are low among young men aged 15-24 in many parts of Namibia<sup>3</sup>. This needs to be addressed, along with men's sense of self efficacy in preventing HIV.

In Namibia, there is considerable cultural diversity in relation to sexuality and male circumcision. Beliefs and values vary across the country and within each community. At the level of the individual, it will be necessary to provide

<sup>3</sup> HIV/AIDS in Namibia: Behavioural and Contextual Factors Driving the Epidemic (MOHSS 2008)

culturally non-specific and value-free explanations of the pros and cons of male circumcision (for example through the national media). This should be supplemented by more localized and contextualized communication around the meanings of male circumcision to a specific cultural group (for example through locally tailored community theatre and peer-education interventions). Beyond the simple transmitting of knowledge to these individuals, mechanisms should be put in place to hear their views, concerns and needs and programming should be developed with sufficient flexibility to respond to this.

The qualitative research<sup>4</sup> on male circumcision in Namibia points to the issues of pain and fear of disfigurement as being central concerns for young men. Within communication, these issues, and related emotional responses to MC, will also need to be addressed.

In terms of targeting behaviours, particularly in terms of driving demand for MC and addressing disinhibition, efforts should be informed by behavioural prediction strategies, as well as behavioural change strategies. Behavioural prediction strategies, for example the health belief model, or the stages of change model, find application in showing what things influence a person to change behaviour. Behavioural change theories, for example the Stages of Change Model or Diffusion of Innovation Model, explain how a person changes their behaviour. In terms of male circumcision, it will be necessary to use the behavioural prediction theory to show, for example what might make a certain group of young men circumcise. It would be necessary to use the behaviour change theories to show, for example, what stage in the process of deciding to get circumcised that a certain group of young men are at.

***Social Networks:***

Communication efforts must address the immediate social networks of those seeking circumcision services. A specific priority would be to focus on sexual relationships, making an effort to reach out to the female partners of men either already circumcised, or those who would circumcise. According to the quantitative research, these women could have great influence with young men.

Young women in Namibia, often have a more realistic perception of risk than young men<sup>5</sup>, but may have a low sense of self-efficacy, in terms of negotiating safer sex with circumcised partners. In the context of scaled up circumcision, this issue of self-efficacy amongst young women needs to be particularly targeted. Also, supporting women in promoting MC to their sexual partners, or infant sons, needs to be recognized as a key element in individual level communications.

Young women will also be the primary group at risk from circumcision-related sexual disinhibition and may require information and ideas for approaching this area of sexuality. Current Namibian communication efforts on broader issues of trust, communication, power and joint decision making, for example within MCP work, may need re-enforcement, and orientating towards MC (for example

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<sup>4</sup> Report on Findings from Qualitative Research on Male Circumcision in Namibia, Sept 2008.

<sup>5</sup> Namibia Demographic and Health Survey, 2008.

through community theatre on MC, sports, comic strips on relationships and meanings around MC, interpersonal and peer-based activities on MC, and broadcast materials focusing on couples).

The family unit, including the mother, father and older siblings of those seeking neo-natal services should also be addressed, possibly through national mass media, or faith-based channels. Further, boys or young men who are circumcised and exhibiting safe HIV-related behaviours could be supported as role-models.

### **Community**

Much of the communication capacity required for effective communication work around MC is already to be found within the community and within those groups working within the community. Working with communities to define and implement communication programmes will be critical in building local ownership, participation and social capital. A number of organisations exist which can work to facilitate and support community based communication for social change. These have extensive reach within rural and urban Namibia.

Engaging those with influence will be pivotal. For young men, role models will be important, for example local sporting, entertainment or business celebrities. Additionally, working with traditional leaders will be key in accessing some communities, particularly in Northern regions. Also important would be to engage with traditional practices to explore healthier and more gender-equitable practices within those processes socializing young men into “manhood”.

Traditional circumcisers will also be key partners, particularly in terms of building linkages between the traditional and modern health systems. Understanding the role of traditional circumcisers will require discussion between medics and policy-makers, and should be clarified in the national policy on MC.

Community dialogues could be powerful processes for social change. Supporting dialogue and debate within communities could help identify challenges and opportunities relating to MC. Further, local community radio and print media may be able to provide a platform for popular engagement in MC issues.

### **Societal:**

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.

It is not yet clear what the financial implication will be for those living in poverty, and requiring MC services. It may be that some level of advocacy is required to promote free MC services, and that those services should be accessible to those living in rural areas.

Journalists, editors and other media gate-keepers need to be informed about MC. All information should be made available, including more critical or cautious perspectives. Diverse journalistic coverage will enhance the democratic process, and encourage policymakers to provide quality services with equity and care. While some PSAs and media materials will need to be sponsored by the

government and development partners, care should be taken not to distort the media market, and thereby undermine broader development processes.

Religion plays an active role in the life of many Namibians. Faith based organisations are playing an invaluable role in the national response to HIV. Working with religious organisations on HIV prevention could bring huge benefits, but will require sensitivity and pragmatism.

Gender norms in Namibia place women at disproportionate risk from HIV, and will play a role in the effectiveness of MC as a prevention measure. A comprehensive approach to male circumcision will require that harmful gender norms are addressed at a societal level, for example through mass media messaging and through policy and advocacy for more protective legislation for women.

## **10. Developing communications**

There is a great deal of literature available for those seeking guidance on developing focused communication programming, and there is considerable debate within the community of health practitioners about the merits and drawbacks of each approach. Increasingly, practitioners are tending towards pragmatism and using an eclectic approach, drawing upon a range of different approaches to create a comprehensive and integrated package of communications. This strategy document reflects this eclectic approach. While attention is paid within each strategic objective on issues of participation, equity and rights, the strategy is also informed by the need for rigorous, tested, and evidence informed programming similar to the strategic communication approach advocated in the UNAIDS RST Guidelines:

### ***Eight Steps to effective male circumcision communication<sup>6</sup>***

1. Conduct a situation analysis
2. Set goals and objectives
3. Segment key audiences
4. Develop key messages
5. Identify communication channels
6. Identify key partners for collaboration
7. Develop and pre-test tools and materials
8. Monitor and evaluate progress

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<sup>6</sup> Ref: UNAIDS RST MC Communication Guidelines, 2008.

## 10.1 Relations with other current Namibian health communication programmes.

Before any outputs are developed in either Phase One or Phase Two, effort needs to be directed towards ensuring sufficient integration with existing communication planning. A number of different campaigns exist within Namibia at present, including those working on alcohol, multiple concurrent partnerships, and voluntary counseling and testing. Once this strategy document is finalized, a meeting should be called with those planning and financing these campaigns to see how where synergies can be developed, and where messaging can be mutually reinforcing. Possibly, in Phase One, there will be limited strategic relationship between the outputs of each different campaign, but in Phase Two the opportunity exists for fundamental integration for many different HIV prevention communication efforts (see the section below on a combined prevention communication campaign "Prevention Max!").

## 11. Key messages:

While the emphasis and focus of each message will change depending to the audience and intended communication outcome, some messaging will be common throughout:

**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%.

**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 sexually transmitted infections to further reduce their risk of infection.

**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 about six weeks to ensure the penis is fully healed as there could be at increased risk of infection during this time.

**Safety is paramount:** Circumcision should be done in health facilities with appropriately trained providers, proper equipment and under aseptic conditions. However whether the procedure takes place in a clinical or traditional setting safety is of paramount importance.

**MC 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.

## 11.1 A Combined HIV Prevention Communication Campaign: “Prevention Max!”

A number of vertical HIV interventions exist or are currently planned around HIV prevention, for example targeting MCP, alcohol abuse, or promoting condoms and HIV-testing. Once MC services roll-out and availability increases (ie in phase two), MC communication can not be delivered as a vertical intervention, particularly on national media. Messages about MC always need to be embedded within a broader prevention approach.

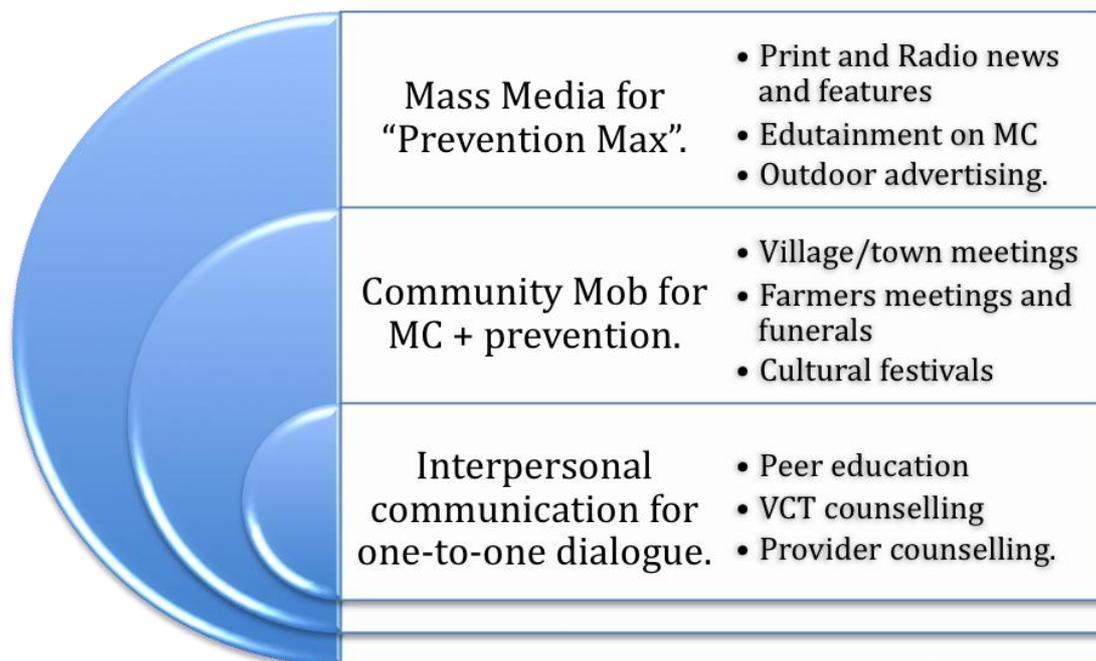
Here the recommendation is that a new integrated and comprehensive campaign for HIV prevention communication is launched.

Namibia has developed integrated prevention campaigns in the past through its national Take Control campaign (“Be your own Hero”/”Be there to care”) and can build on the experiences gathered during these interventions as well as on the mechanisms of the Take Control task force.

This campaign, representing a combination prevention approach, and incorporating all current existing HIV prevention methods (eg: partner reduction, increasing age of sexual debut, increasing condom-use, reducing age-disparate sex, PMTCT and prevention for positives) together with the added option of male circumcision will be delivered with renewed energy, new materials and new public profile.

A long term communication campaign promoting combination HIV prevention (“Prevention Max!”) will generate increased coverage, and address any risk compensation. Although the campaign may use the media vehicles of existing interventions, for example working through the channels and idioms of the MCP, condom promotion, and care and support campaigns, new media assets will be required, such as celebrity endorsements, edutainment modules strong graphics and images. It is recommended that there is some realignment of existing prevention efforts to allow them to integrate within a scaled up combination prevention programme.

This new campaign would ideally have a simple and integrated framework, with national media supporting an enabling environment for HIV prevention (including MC) communication, and other channels and tools being used to consolidate understanding, engage community mobilization and facilitate broader social change. A simplified graphic visualising of this approach is given below.



Within such a campaign, all communication going out to the general public would carry the overall theme of the prevention campaign (eg: Prevention just got bigger: PREVENTION MAX!). All channels that allow for more dialogue, and promote greater understanding, will explain how all these prevention techniques relate, and the benefits and limitations of each one.

A generalized prevention campaign would require further strategic planning, and should take place within the framework of the forthcoming National Namibian HIV prevention strategy, 2009.

## 12. Idioms and metaphors.

Some simple and effective ways need to be found to communicate the relatively complex messages laid out above. This will enable powerful graphic or video elements to be developed. Finding the most effective idiom would require a series of group discussions with a range of different audiences to uncover what idiom, or metaphor, or way of talking about male circumcision would be most effective. Graphical elements could be developed and then used as the raw products within a participatory process for developing communication materials, ensuring appropriate cultural adaptation. Ideally these materials could help frame one or two focus-groups or less formal group discussions in each region to help elucidate how best to present MC messaging.

These materials could use the following analogies, some of which have been suggested by colleagues outside Namibia:

**Football.** The virus is a ball, becoming infected is getting the ball into the net. Male circumcision can place a goalkeeper in front of the net, but every good team needs defenders also, and those defenders may be condoms (or other preventative measures).

**Militaristic.** Male circumcision is a lone warrior/body-guard keeping out HIV infection. But other warriors/body-guards are necessary to keep out this big enemy.

**Weather.** The condom is the rain-coat. Male circumcision is the umbrella or the boots: all are necessary.

**Air-flight:** The condom is the parachute. Male circumcision is the small back-up parachute. You definitely need the main parachute (condom) but nobody would jump from a plane without an emergency back-up parachute.

**House security:** The idea is that to keep a house safe you may have a guard dog as a last resort (IE, you may be circumcised). But you would also have a locked door (the condom). Further you may also have a fence and possibly burglar bars etc (further prevention measures).

### **13. Objectives, outcomes, outputs.**

In the following table, objectives and outcomes and some sample outputs are listed. This overall communication framework was developed in close consultation with a number of partners, and has itself been through a participatory communication development process. After the table, more narrative is offered around each objective, outcome and suggested programming.

<b>Immediate needs (before male circumcision scale up)</b>			<b>Long term needs (once MC scale up begins)</b>		
<b>Phase one</b>			<b>Phase two</b>		
<b>Objectives</b>	<b>Outcomes</b>	<b>Outputs</b>	<b>Additional Objectives</b>	<b>Additional Outcomes</b>	<b>Outputs</b>
<b>Service providers are prepared for MC scale up.</b>	Healthcare workers (HCWs) have good knowledge about MC	Accessible print materials.	<b>Service providers are supported in scale up.</b>	HCW understand how to provide quality MC services	Training, Clinical reference materials, networking events
	HCWs know where to go for support on MC	An advisory from the ministry, filtering down to local level, identifying points of support and advice			Updated advisory notes from Ministry of Health and Social Services (MoHSS).
	HCWs know the status of MC provision	Regular news updates			
	NGOs and CBOs are mobilized to communicate effectively around MC	National and regional coordination meetings, IEC materials, Training			Campaign materials, coordination meetings,
<b>The media plays an effective role in supporting MC scale-up for HIV prevention.</b>	Media knows policy situation relating to MC	A press conference and brief policy update document	<b>Media promotes combination prevention campaign (with MC as one element)</b>	Good coverage of campaign	Multimedia materials for scaled up prevention campaign
	Media has the capacity to report on MC	Workshops, samples of good reporting, free materials			Ensures all reporting discourages risk compensation.

	Media can act as a platform for public debate on MC	Work with talk-show hosts, readers letters pages, community media (from theatre to radio)			
<b>Policymakers are supportive of MC scale up</b>	Are knowledgeable about MC pros and cons	Accessible print materials, a film? A note about where in gov to find information.	<b>Policymakers are supported on scale up.</b>	A government able to direct MC provision.	Regular policy-briefs, strengthened health information systems
	Are supportive of MC, where appropriate	A film, special forums, advocacy		A government supportive of the campaign	Special forums, advocacy, explanations of campaign.
<b>General population are informed on MC, and Namibia's current position in relation to MC.</b>	No demand created, but public understands the benefits and limitations of MC	School curricula, information in health services, information amongst traditional leaders	<b>General population understand and are supportive of MC scale up</b>	Public understands roll-out and where services will be available	Radio and print PSAs, PSAs: government officials explain campaign on TV.
	Is updated on services	Information through health services only.		Public is supportive of campaign	targeted and sustained prevention outputs amongst circumcised men and their partners
	Exhibits no risk compensation in relation to MC	Targeted multimedia and interpersonal campaigns amongst already-circumcised males.		Exhibits no risk compensation in relation to MC	
			<b>Sexually active men incorporate MC within a broader set of HIV prevention behaviours.</b>	Full awareness of HIV prevention issues (eg MC in prevention context)	multimedia campaign materials (radio, tv, print), community mobilisation, community media, public discussion forums

	Demand MC services, as part of a healthy lifestyle	as above
	Exhibits no risk compensation in relation to MC	post-cut clubs?, radio products, targeted interpersonal campaigns, outdoor advertising
<b>Young people understand and benefit from MC within the broader context of issues of prevention, relationships and sexuality</b>	Full awareness and life skills for HIV prevention, including understanding MC in prevention context	Youth friendly educational materials, messages for existing youth channels, updated national curriculum
	Male youth demand MC services, as part of a healthy lifestyle	promotional materials and messages for a range of youth channels
	Youth exhibits no risk compensation in relation to MC	scaled up prevention interventions for youth in a variety of channels
<b>At scale up: Parents</b>	Demand MC services for children	Posters, leaflets distributed through ANC and primary health centres
	Know how to access services	Radio and print PSAs.
	Understand the benefits of MC for children	As above.

## 14. Phase one

In the next section of this document phase one objectives and outcomes are examined in relation to communication programming. For each objective an initial “problem statement” provides an overview of the key issues. Communication issues integral to achieving that objective are outlined. Then each outcome is discussed with some programming recommendations made. These sections give an idea of some of the communication modalities, but should be read in conjunction with the listing at the end of this document of different tools and channels (appendix 2) which together will make up a sound multi-level approach.

### 14.1 Objective: Service providers are prepared for MC scale up.

#### ***Problem statement:***

The situational analysis contained a Facility Readiness Survey which stated that the health services are currently already strained by staff shortages and infrastructural issues and need support and investment in able to accommodate MC. The MC Draft Action Plan, 2008 lists a number of measures to address these issues, including task-shifting and refining policy. For the purposes of this communication strategy, the outcomes required are that healthworkers have good knowledge of MC, know where to go for support on MC, and know the status of MC provision within the country.

Beyond the Namibian health system there is a large number of people providing services and information on HIV prevention. These people, and the NGOs and CBOs that support them, are loosely encompassed under the term service providers for the purposes of this document. They represent a sizable force for health communication on MC. From peer-educators through to home-based carers, a wide range of existing non-governmental actors require training, resources and encouragement around the issue of MC for HIV prevention.

#### ***Communication issues:***

Doctors, nurses and clinicians are a relatively simple group to reach, and they represent a fairly homogenous group in terms of literacy, training, and a commitment to public health. In the first phase, before scale up has commenced, more HCWs require a comprehensive understanding of MC issues for their own professional development and they need to know how to deal with the growing numbers of questions coming from their clients. For the sake of simplicity, VCT nurses and counsellors are incorporated within the category of health-care workers.

NGOs and CBOs working on HIV prevention outside of the health-care sector represent a much more diverse group. Ranging from Windhoek based managers of international agencies through to those living and working out in rural communities, all service providers require information, and materials outlining

basic issues relating to MC and HIV. Some probably require specific tools for working within their focus areas (eg community mobilization or education).

### **Achieving outcome: Healthcare workers have good knowledge about MC**

To respond to need HWCs require basic, accessible and comprehensive information on MC, including a very brief overview of MC, past and present in Namibia; examples of MC scale up in other countries; what MC entails and what the advantages and limitations of MC are. Although MC has strong cultural connotations, the presentations of this information should de-contextualise MC from its social and cultural context, and present it within the discourse of public health.

#### **Programming recommendations**

This should be presented in a straightforward way, akin to other technical updates, on a lasting media (quality print – eg booklet) for long term reference use in a busy health care setting.

More accessible media, (for example video), could be used to engage interest in MC and HIV prevention, particularly amongst those working in this area but who are less likely to access technical information disseminated by the MoH, for example those providing VCT from NGO providers.

### **Achieving outcome: healthcare workers know where to go for support on MC**

There should be a person available in every region who is able to deal with HCW's questions regarding MC, and who can provide support on questions as they arise. Where this person is not able to deal with questions, there should be a clear referral system, ie to the national level, so questions can be addressed.

#### **Programming recommendations**

Communication practitioners liaise with MoH to see what is necessary, if anything, to help all HWCs know where to get support on MC. This may result in a simple memo from district medical officers, which includes a contact list of local experts.

### **Achieving outcome: HCWs know the status of MC provision**

Healthcare workers should be updated on the current status of MC roll-out within Namibia. Within phase one this information should include the fact that a draft policy and action plan is going to parliament, but that MC is already being provided, at some level, in both the public and private sector.

#### **Programming recommendations**

This would be a relatively simple, low cost product (s), with a short shelf-life, presented in simple and accessible style from an official, government related source to ensure trustworthiness and reliability.

This update would probably use the already established system of memos from the MoH which are disseminated to the district level. This should be supported by information that could reach outside of the main clinical centres, including, for example, VCT units of non-governmental agencies. Placing information within the print and electronic special-interest media would be a useful approach.

**Achieving outcome: NGOs and CBOs are mobilized to communicate effectively around MC.**

NGOs and CBOs have been already mobilized around HIV. In towns and in the depths of many rural areas, various organisations are working with communities to promote HIV-related prevention, care, support and impact mitigation. Because MC communication needs to include work with communities and individuals, NGOs and CBOs with good presence on the ground become crucial allies.

NGOs and CBOs are diverse and numerous and they will have different needs in relation to communication for MC. However, most of these organisations are actively seeking the latest information about HIV prevention, and incorporating it into their work, so with just a few tools and resources it should be possible to engage with a large number of organisations and thereby reach a wide population through both community or interpersonal channels of communication (see communication tools reference in appendix 1).

Partners have noted that while disseminating information, tools and other resources may be relatively straightforward, coordinating those groups may be significantly more challenging. Possibly some form of loose, and dynamic coordination, for example on messaging, but not on communication modalities, will be more realistic and efficient than something more comprehensive.

**Programming considerations.**

Simple print materials, in different languages, would be able to reach most NGOs and CBOs, at least at district level. These could be supplemented with content, including graphics, for those developing their own material, for example those developing curriculums for training home-based carers. In phase one, holding information and preparatory meetings amongst CBOs and NGOs in each region could help bring people up to speed on the issues, and lay the foundations for phase two. These same meetings could help to develop or plan for pre or post testing of materials for specific language groups.

## 14.2 Achieving Objective: The media plays an effective role in supporting MC scale-up for HIV Prevention.

### Problem statement

Effective media coverage of MC is imperative for all objectives within this communication strategy, and ensuring strong and informed media engagement is probably the first priority for communication efforts both in phase one and phase two.

The media will play several roles around male circumcision in phase one, including providing accurate information, ensuring political accountability and enabling public debate.

Male circumcision for HIV prevention has already been a topic in the national media. Little is known about how male circumcision is being reported, for example in the local language radio stations. Samples of press reporting show recent coverage of MC has been mixed in terms of quality, accuracy and intensity. For example, There are many reports on MC which almost report back verbatim the language of different press briefings – portraying MC issues accurately but with little imagination. On the other hand, the consultant happened across one report where an agony-aunt advised readers that men who were circumcised were eight times less likely to get infected by the virus (the protective impact is actually much lower – around 60 percent).

AIDS can seem a “tired” topic to many journalists and media gate-keepers. While the media may be able to relay government-issued messages effectively, it is not certain that the media currently have the ability and/or interest to make MC newsworthy. This will be an issue to address in phase two, when demand should be created. In phase one, there does not need to be much national media exposure for MC-related issues. The essential issue in phase one is that MC should not be mis-reported, or that the balance of reporting should not be one-sided. Too much focus on some of the more negative literature and debates around MC could seriously hamper efforts.

The case for MC scale-up is compelling when presented with the evidence and facts. The issue does not need manipulation or overly careful management. Diverse voices and perspectives on HIV and MC circumcision should be aired on MC. Public commentary and feedback on ethical issues, rights issues and gender issues should be allowed frank, open and free expression. Crucial is that this discourse takes place within a framework where accurate information and the correct facts are all in place. People should be able to express their support, or lack of support, for circumcision, and should be supported in articulating their specific concerns on the issue. The emphasis should be on addressing inaccurate information and misconceptions, for example on the basic facts relating to circumcision. If all the facts are made available within the media discourse, any informed public debate will gravitate towards overall informed support of scaling up MC service provision.

## **Communication issues**

The media will benefit from official, “trustworthy” information about MC. Government or WHO sources will be particularly valuable. Information should be comprehensive and impartial, examining the challenges and complexities around MC, making sense of current critical perspectives, and ultimately laying out the evidence for journalists to interpret for themselves. It should be anticipated that journalists will access strongly critical literature and spokespeople on MC. FAQs and other resources for journalists should enable them to make sense of all the differing perspectives within a broad public health framework.

### **Achieving outcome: Media knows policy situation relating to MC.**

A number of activities could now be undertaken. A select number of journalists could be identified who work on MC. These could be approached, on a one to one basis, with updates and information about MC in the country.

Further, an accessible outline is required of the current position in relation to MC and HIV prevention in Namibia. This short media briefing note would emphasize that the Namibian government is supportive of MC and outline steps necessary to start national scale up and explaining the work undertaken in the mean-time. More information about this media briefing note is included in appendix 2.

### **Achieving outcome: Media has the capacity to report on MC.**

MC has only recently surfaced as an additional HIV Prevention measure and many journalists do not have the basic information about the issue. Further, reporting in Namibia on AIDS issues is often rather un-interesting. Work needs to be done to put MC, and other HIV Prevention issues, back within the media agenda.

## **Programming recommendations**

Journalists need to be given accessible information on MC to enhance accurate reporting. This should explain what MC entails, the history of MC in Namibia, current debates around MC together with guidance on how to interpret these.

In a longer term media development strategy, it would be useful to include elements on HIV prevention and MC within the national Namibian journalist training curriculum. Further, some ideas for how to frame discussion around MC, within the broader context of HIV prevention, could be shared. Associating HIV prevention to broader lifestyle, economic, sporting or entertainment reporting could make for more diverse coverage.

Information needs to be tailored to journalists needs, for example in terms of lasting reference tools accessible electronically or via desk reference tools. To ensure the topic is not dry and un-newsworthy, video materials, with dynamic graphics could be circulated (or streamed online). Information could be

presented associated to newspegs, for example key national holidays, World AIDS Days, Independence days etc.

### **Achieving outcome: Media can act as a platform for public debate on MC**

In Namibia, there are a reasonable number of interactive media channels, ranging from newspaper pages dealing with reader SMS entriesthrough to radio chat-shows. In each of these channels, care should be taken to ensure that expert advice is on-hand, and that any misconceptions that are aired can be addressed by those hosting the channel.

### **Programming recommendations**

Journalists and other media gate-keepers (editors) could be supported in facilitating interactive forums to enable public debate around MC. A static media reference tool is probably not enough, as the skills and principles of informed public debate probably require a certain amount of practice and engagement. A media workshop could be supported. Further, one or two interactive media forums (eg the reader SMS page in New Era newspaper) being given practical support, for example being temporarily partnered by an agency with technical capacity in this area.

## **14.3 Objective: Policymakers are supportive of MC scale up**

### **Problem statement**

There is broad support for scaling up MC within the government of Namibia, particularly within those ministries most engaged in HIV prevention. However, support for male-circumcision for HIV prevention may not be universal within parliament, and many policy-makers do not have enough information and understanding around MC to make any kind of informed assessment of the facts. As the MC policy moves through parliament it is likely to meet with mixed responses, particularly if discourses around MC and cultural tradition attract much attention. Meanwhile, negative media coverage around MC could predispose policymakers towards delaying or resisting MC scale-up.

A communication strategy for MC should not only aim to promote MC as a preventative strategy – but also to create an informed policy environment for strong leadership, responsiveness to changing conditions, and sound decision making, whether it results in either caution or aggressiveness in scale-up plans.

### **Communication issues**

Policymakers will be best influenced by authoritative and accessible information about male circumcision. Information associated with organisational brands such as UNAIDS and WHO will have particular influence. Reputable academic research institutions and local universities will also carry significant weight.

Most policymakers would appreciate information which is clear and succinct. Attracting policymakers interest in MC issues is likely to be a challenge – and for

this reason video, and attractive graphic presentations may be particularly useful.

### **Achieving outcome: Policymakers are knowledgeable about MC pros and cons**

Policymakers require comprehensive and accessible information about MC issues. These include the evidence for the protective impact of MC, benefits and limitations; an overview of MC in historical context (but with little emphasis on cultural associations); MC and HIV prevention experiences in the broader SADC region; and an introduction and outline to the current draft policy on MC with a special emphasis on the measures included to not create over-demand for services and the efforts intended to fight dis-inhibition.

#### **Programming recommendations**

Print materials with strong, authoritative institutional branding are required. Forums where policy-makers can discuss and ask questions about male circumcision would also be useful. Materials that are quick and easy to understand, such as a video may have greatest impact. More information is given on specific materials for achieving this outcome in appendix 2.

### **Achieving outcome: Policymakers are supportive of MC, where appropriate.**

For MC to be successful incorporated within Namibia's national HIV prevention strategy, it needs the understanding and backing of government. Policymakers need to support MC and to expedite the many processes that need to occur to achieve scale up. However, the information given to policymakers should be balanced and complete. Their caution and judgement is required to ensure that MC scale up is effective, safe and equitable.

#### **Programming recommendations**

The evidence relating to MC, showing all its benefits, should be laid out. This should include the economic case for MC and the associated policy issues relating to MC (ie less donor dependence). The emphasis should be on offering frames for understanding MC within a scaled-up prevention effort.

Further, a good measure of care and thought should be displayed in all strategy documents associated with MC scale up, including this communication strategy. MC is most likely to attract support when it is associated with a robust and measured approach, appreciative of the many issues and challenges latent with MC for prevention. Thorough, costed plans for implementing MC in a manner that presents a considered, balanced and cautious approach should be included.

#### **14.4 Objective: General population are informed on MC and Namibia's current position in relation to MC.**

##### **Problem statement**

The general public have mixed levels of knowledge about MC or what the government intends to do in relation to MC and HIV prevention. In the first phase of activity, it is necessary to avoid creating demand for services which are currently largely available. Yet MC is already part of popular discourse, at least in some areas. Sometimes this popular discourse may contain harmful and inaccurate elements. The qualitative research conducted as part of the MC Situation Assessment, and informal group discussions conducted as part of the development of this strategy, reveal a range of misconceptions about male circumcision, for example that MC alone provides adequate protection against HIV. There is a need to build more accurate knowledge and understanding and to arrest any unhealthy behaviours resulting from these mis-conceptions.

##### **Communication Issues**

With a culturally heterogeneous society and differing views and experiences relating to MC, supporting comprehensive communication will require a mix of localized and national level efforts. Already the national media has publicized issues of male-circumcision but full communication programming is yet to begin. National media may be useful in triggering interest in MC, but it is likely that in order to build comprehensive understanding of the benefits and limitations of MC one would need to mobilize different channels, including local community mobilization and interpersonal communication.

##### **Achieving outcome: No demand created but public understands the benefits and limitations of MC.**

Namibian populations have relatively good knowledge of AIDS issues and traditional HIV prevention measures, but the relatively recent move to incorporate MC for HIV prevention may have complicated this situation. A significant new element in HIV prevention knowledge is now required as part of a comprehensive knowledge of HIV prevention issues. Knowledge of MCs benefits and limitations for HIV prevention is needed within the generalized population before scale up actually begins. This is to address any misunderstanding or misconceptions that may have developed due to the partial information and communication on MC that has so far entered the country. At this stage, people already need to know that male circumcision, has a partial preventative benefit, but that other HIV preventative measures should be taken.

##### **Programming recommendations**

In order to not further spread misconceptions or to prematurely raise demands only certain channels should be used for this work, initially avoiding mass-media. This is an opportunity to mobilize those many groups and individuals already working with the community for HIV prevention. Accurate information

on MC, its benefits and its limitations needs to be circulated through channels which allow for full appraisal and understanding of the facts, for example through peer education and through participatory communication and community media approaches. Partners already exist in many areas who are active within these channels. The kinds of outputs that will help achieve this are relatively low cost and straight forward, and are outlined in the section on immediate priorities (and in appendix 2).

In all efforts for achieving this outcome, special emphasis should be placed on identifying and addressing misconceptions..

Further, a line of simple IEC materials, developed in appropriate languages, should be developed for distribution from clinical settings, for example for when a healthcare worker is asked by a patient about MC.

### **Achieving outcome: General public is updated on MC service delivery.**

While it is important to avoid creating further demand, it is necessary to update the public on when and how MC services should be available. Some communication partners are already urging that information should be circulated listing those clinicians who can already perform MC services.

### **Programming recommendations**

Simple, factual and upto date information. This should come through a channel that allows for regular updating, such as through a memo circulated via health-care workers and those working with communities.

### **Achieving outcome: General public exhibits no risk compensation in relation to MC.**

This is probably the most complex, and potentially the most resource intensive aspect of the phase one strategy. Already partial information about MC and HIV has spread to some groups throughout the country. For most, this is in the form of rumours and hearsay. Ensuring that this partial information does not lead to negative changes in attitudes and behaviours is a key priority moving forward.

The key messages, beyond the general ones listed earlier in this , is that MC only offers partial protection from HIV, and only for HIV negative men. Where men have already settled into attitudes or behaviours which exhibit risk compensation then these need to be reversed.

### **Programming recommendations**

Research is needed on levels of understanding around MC, and the prevalence of risk compensation in relation to MC. This would guide what interventions are necessary. At present it is recommended that a rapid assessment is carried out, possibly through partners working with community groups, to gauge these issues. Where harmful attitudes are prevalent, then focused BCC programmes

will probably be required. See sections on priorities and immediate needs, and appendix 2 for more information.

## **15. Phase two**

Because the details of the roll-out for MC are still unknown, and for the sake of brevity and clarity, little detail is given in the following descriptions of objectives, outcomes and recommended programming for phase two.

In the section that follows, each objective, together with its combined outcomes is listed and briefly discussed.

### **15.1 Objective: Service providers are supported in scale up**

#### **Outcome: HCW understand how to provide quality MC services.**

Health care workers, and those working on HIV Prevention within NGOs and CBOs will become the key agents in promoting, supporting and implementing MC services. They will also become an important interface between those providing services, and those benefiting from them. Building in listening mechanisms, where complaints, recommendations and other feedback from the community will be crucial.

With the scale up of MC as part of an accelerated HIV combination prevention programme, health care workers will require increased support, particularly in the initial period of training and skills building. For the training of health-care workers, the timing of the programming will be critical so that fresh skills and knowledge match the actual delivery of services and do not come too late, or too early. For those working in community outreach, managing and coordinating the timing of any communication efforts, particularly any promotion of services, will also be important. Demand should be created only when there are services to satisfy it. Expectant clients for early services may not return if disappointed by lack of availability.

#### **Recommendations for programming**

As scale up commences, networking events should be planned in various forums, possibly starting with a series of regional consultations around the country to solicit the communication needs, challenges and other issues may be in terms of HCWs role in MC scale up.

Training will be required for healthcare workers together with reference materials. These should be developed in consultation with HCWs, and may use a similar format to some of their current reference literature.

Similarly, the precise outputs required for informing HCWs about the status of service provision and how to access technical or clinical support will need to be developed in consultation with HCWs and those agencies currently supporting them. One obvious method will be to use the established system of memos and notes distributed from the national ministry, down to district centres.

For NGOs and CBOs, new materials and resources will be required to ensure that issues relating to MC are communicated effectively, always within the context of a broader set of HIV prevention approaches. See box on “A combined campaign: Prevention Max!”.

## **15.2 Objective: Media promotes combination prevention campaign (with MC as one element)**

**Outcome: All reporting discourages risk compensation.**

**Outcome: Good coverage of campaign**

As mentioned above, HIV prevention is perceived as a “tired” issue within Namibian media. Genuine news around AIDS is rare. Journalists need to understand that MC within combination prevention is new and newsworthy. There are many different story angles for combination prevention. Further, work with journalists needs to explore how combination prevention can be able to render attractive human interest stories.

Media personnel should be made aware of the risks and challenges of risk compensation. Drawing upon codes of professional ethics, it should be made clear that MC issues always need to be reported within the context of a combination prevention approach. The wider combination prevention campaign (Prevention MAX!) should enable journalists to easily integrate MC into broader prevention issues.

### **Programming recommendations**

The recommendation for a combined prevention campaign, with the working title “Prevention Max!” is offered for work with the media in this phase. Regular briefings, public events, and new media assets within this campaign will be supported by presentations and workshops for national media. Meanwhile, the importance of establishing and maintaining close personal contact with key journalists should not be underestimated.

## **Objective: Policymakers are supported on progress**

**Outcome: A government able to direct MC provision.**

**Outcome: A government supportive of the campaign**

As the scale up of MC commences, policymakers need to be supported in their role of guiding and leading the process. Their energy and commitment will be required throughout the process. Crucial is that the information systems are in place to allow for responsive and well informed decision making. Up to date information is required through accessible and authoritative channels. Opportunities need to be identified for sharing evidence with policymakers showing the success and accomplishments of MC scale up as activities accelerate. One component of these efforts should be to allow policymakers to see Namibia’s progress in international context, showing them that they are part of an

innovative phase in the HIV response and connecting them with their peers around the globe.

This strategy document, and any more refined documentation around the combination prevention campaign (Prevention MAX!), will also serve as important advocacy tools. They will reassure policymakers that sufficient thought, planning and care has gone into communication around MC.

### **Programming recommendations**

Updates will be required, in the form of policy-briefs, or through convening the appropriate parliamentary committees. As of Feb 2009, there is already enough information to report to justify some kind of a briefing note for policymakers. Accessible authoritative information which is up-to-date and accurate will be required throughout the scale up of operations. The precise nature of this information should be explored in consultation with key stakeholders within the government system, particularly MoHSS.

### **15.3 Objective: General population understand and are supportive of MC scale up**

**Outcome: Public understands roll-out and where services will be available**

**Outcome: Public is supportive of campaign**

**Outcome: Exhibits no risk compensation in relation to MC.**

In phase two demand can be created, and the emphasis should be on education, promotion and broad-based social change communication. The challenge will be to ensure that all MC information is embedded within broader prevention messages, and that no-one takes just part of the message away. The combination prevention campaign (Prevention Max!) is suggested for this purpose. Strong visuals, and clear succinct language within this campaign will be required that put across the messages rapidly and effectively, and these should be tested among a broad range of social groups.

Region-specific information needs to reach people in rural and urban areas on the availability of services. Regional meetings between key stakeholders will be required to guide the roll-out of the campaign, and to shape these more localized elements.

The levels outlined in the ecological framework depicted above need to be addressed with different types of activity in order to create an enabling environment for those seeking MC. This includes families, peers, traditional leaders, opinion leaders and all those playing a role at the level of social network, community and the broader society. The channels and tools reference guide in the appendices (appendix 1) highlight a number of options for programming across these different levels.

#### 15.4 Objective: At scale up: Sexually active men incorporate MC within a broader set of HIV prevention behaviours.

**Outcome: Group has full awareness of HIV prevention issues (eg MC in prevention context).**

**Outcome: Group demand MC services, as part of a healthy lifestyle**

**Outcome: Group exhibits no risk compensation in relation to MC**

Sexually active men represent the priority audience for MC related communications. These groups need to know all the basic messages relating to MC (outlined in section 11 above). They also need to understand that MC is good for them but to additionally understand that they will have to maintain or even improve their other preventative behaviours (eg condom-use). The key challenge will be to explain to sexually active men, why if they will have to continue to consistently and correctly use condoms during sex, which itself offers nearly complete protection from HIV, why they should *also* get circumcised. Here, some of the analogies depicted above (in section 12), for example the importance of defenders in a football match, should be particularly useful, although more work is required to identify the behavioural change processes and triggers required in order to adopt healthy behaviours.

Large numbers of men are already circumcised. All the information creating demand for surfaces will be irrelevant to these men, but one message that many men will take notice of is that their circumcised status offers them protection against HIV. Managing the behaviours and attitudes associated to this awareness will be one of the most fundamental challenges of the forthcoming period in the Namibian HIV prevention response. Promotional communication will need to be balanced with fuller information which outlines all the messages outlined above. There should be no men which are only exposed to MC promotional messaging without also being exposed to an adequate dosage and variety of broader supporting HIV prevention information. Identifying the kinds of scale of communication programming needed to illicit a positive result should be a continuing research priority.

Researchers and relevant service providers should identify and report risk-compensation as soon as it surfaces.

#### **Programming recommendations**

Reaching sexually active men will require a multi-channel set of efforts, both localised and supported by national media. Once again, the combination prevention campaign (Prevention Max!) is the recommended method for approaching this. Within this campaign, all available communication channels will need to be mobilised, from peer-educators through to TV (see channels reference guide for further information).

MC should be promoted within various discourses of masculinity, for example in relation to sport, paternity and financial success. Once again, research could help identify the current levels of knowledge amongst young men and what triggers

and processes are required for them to seek services. Here BCC theory and practice will become relevant.

Following current prevention best practice, efforts need to be shaped around an up-to-date understanding of emerging epidemiological and behavioural trends amongst sexually active men. Understanding male sexual risk, its drivers and the systems of meanings surrounding it, which will vary from group to group, is an immediate priority. The qualitative research commissioned as part of the MC situational analysis, marks a first step. Those working in similar areas could usefully convene and identify the state of current knowledge in the situation, and where gaps may exist.

Researchers, relevant service providers, and those working with health information systems should make an early report of any signs of risk compensation. Where risk compensation is found to be taking place, or where social attitudes and norms seem to be shifting in a way that may lead to increased risk, targeted BCC campaigns will need to be developed and applied. DHS and population based surveys will be particularly useful to track trends, but will need to be complimented with information and research mechanisms which allow for more frequent feedback.

There has been talk of couching MC within a gender transformative approach to masculinities. This is an exciting emerging school of thought, and it would be useful to commission a short strategic paper on this as part of the process for developing the combination prevention campaign (Prevention Max!).

### **15.5 Objective: Young people understand and benefit from MC within the broader context of issues of prevention, relationships and sexuality.**

**Outcome: Full awareness and life skills for HIV prevention, including understanding MC in prevention context**

**Outcome: Male youth demand MC services, as part of a healthy lifestyle**

**Outcome: Youth exhibits no risk compensation in relation to MC**

At this point it is not possible to make many recommendations in relation to communication amongst young people and circumcision. Further work needs to be undertaken to identify what the objectives and priorities are in terms of rolling out circumcision amongst younger group. If, as the Namibian Draft Policy on MC for HIV Prevention currently suggests, young people represent an age range between 10 and 24, a number of issues are raised in relation to parental consent, children's and young people's rights, and the need for child friendly services and communication.

Children and young people represent an extremely diverse set of groups within Namibia. Decision makers need to elaborate what kinds of outcomes are expected in relation to young people, male circumcision and HIV prevention amongst age-specific groups. Technical assistance and some strong facilitation may be required to develop a sufficiently strong policy framework for MC amongst children and young people.

#### **Programming recommendations:**

Depending on the policy in relation to young people, further segmentation will be required to enable suitable outputs to be delivered to specific age-ranges. What the precise age-range and segmentation should be depends upon the policy discussions, and should be decided upon in close consultation with the appropriate government ministries, including the Ministry of Education and MoHSS. Probably audiences should be segmented by age within at least 3 groups, varying from region to region, for example: 10 – 14; 14 – 18; 18-24. It should not be assumed that any of these groups do not have sexually active individuals amongst them, but communication should be sensitive to the different needs of each group.

### **15.6 Objective: Parents seek MC services for their infants.**

**Outcome: Demand MC services for children**

**Outcome: Parents Know how to access services**

Many of the challenges of scaling up male-circumcision amongst adults do not apply to infants. Once scale up has commenced, MC services for infants are clearly a priority for communication programming. Communication is required to explain the benefits of male-circumcision to parents and to allow for an airing of questions, concerns and inputs from different groups of parents, enabling two way communication between programmers and beneficiaries. Efforts should focus on creating demand amongst parents based on a full understanding of the benefits, but this should not preclude explaining to this group what the costs and whatever levels of risk may be involved.

The circumcision of infants carries diverse cultural meanings within Namibia. Localised efforts may benefit from engaging with local traditions and cultural discourses. However, efforts coordinated at national level will not introduce any cultural elements to communication efforts. These would not find support amongst national level leadership, and could have unintended consequences. At national level, the focus should be simply to lay out the medical and hygiene benefits of MC to parents. Regional and local leadership within the campaign should be encouraged to explore giving cultural adaptation to materials and tools, within a framework that ensures inclusion, consensus and that can achieve results.

### **Programming recommendations**

The combination prevention campaign (Prevention Max!) will probably mainly target sexually active adults and young people. However, elements could be included which include neo-natal circumcision.

It would be beneficial to bring together a number of representatives from health care workers, NGOs and CBOs who work with parents for infant health. These groups would help to identify the appropriate messages, channels and capacities necessary for scaling up neo-natal MC.

The products resulting from these consultations would almost certainly include a range of outputs for health care settings, particularly those which currently provide services for new mothers. Further work would ensure an integration of

MC messages into the relevant training, skills and IEC materials within currently existing community efforts servicing parents and infants. As scale up commences, a factual overview of where services are available for MC would be needed for all relevant health service providers.

## **16. Required research.**

Research is needed in a number of areas. Some of the questions that need answering include:

What have been the costs of MC communication programmes in other countries, and what have been the major communication lessons and experiences learnt.

What are the behaviour change processes and triggers in terms of accepting MC as an additional protective measure in Namibia. This could involve following a cohort of men that have had the procedure for HIV prevention purposes (eg military).

What is the current state of awareness about MC and related issues. Specifically, how prevalent are misconceptions about MC, and associated attitudes and behaviours (ie disinhibition).

What is the required dosage and numbers of channels to ensure circumcised men do not exhibit risk compensation. What lessons can be taken from other countries, eg Zambia on this.

What is the impact of women in communities where MC for HIV prevention is becoming the norm: lessons maybe required from countries such as Zambia and Swaziland, where services are currently being offered.

In terms of advocacy, it would be useful to ascertain levels of political support for MC scale up. It would also be useful to gauge possible resistance points, for example within the nurses council in relation to taking on extended duties with a task-shifting approach.

What is known about MC for men who have sex with men, specifically in an African context, and what are the implications for communication.

## Appendix 1: Channels and Tools for MC Communication.

There are numerous tools and reference resources to help planners choose which tools would be most effective. A more comprehensive, but by no means exhaustive list (adapted from Johns Hopkins University, Baltimore) is presented below.

Channels	Tools Used on the Channels	Materials/Activities
Interpersonal Communication	Peer Counselling on MC Service Provider Counselling	<i>MC training</i> for community field workers. <i>Support materials</i> for counseling on MC issues. <i>Training</i> on integrating MC into existing VCT and ANC counselling. <i>Support materials</i> , for example a reference guide incorporating MC for counsellors.
	Peer Education	<i>Training</i> for peer educators, incorporating MC. <i>Materials for peer-educators, incorporating MC</i>
	Health Clinic Enhancement	<i>Posters, pamphlets and videos</i> on MC used by client without personal interaction with provider, for example at New Start Centres.
Community Channels	Community Outreach	<i>Group meetings</i> (eg farmers meetings, funerals) and <i>rallies</i> . Supporting this, <i>speaker kits, press kits</i> for those able to work with MC in the community.
	Community conversations	<i>Community dialogues</i> within traditional structures.
	Community Mobilisation	<i>Radio listening clubs, community empowerment</i> on MC issues. <i>NGO/CBO training</i> on MC; <i>Materials</i> for MC distributed to those already involved in community mobilization.
	Community Media	<i>Community newspapers, local radio, community based edutainment</i> projects that could be adapted?; <i>A guide for producing local materials</i> on MC
Mass media, TV, Radio, Newspapers, Magazines, Billboards, Transit	Advertising for MC services	<i>Folk drama</i> , incorporating MC communication into <i>Namibian cultural festivals</i> on MC. <i>Print advertisements, TV spots, radio spots, outdoor posters</i> for MC.
	Publicity on MC issues.	<i>Press releases or a briefing on MC, video releases, commissioning articles on MC, radio press releases, press conferences, public service announcements, journalist training</i>
	Advocacy on MC issues.	<i>Targeted Interpersonal Communication</i> – encouraging a cadre of journalists to take interest in MC. <i>Simple fact-sheets</i> for the media; <i>Presentations/Video</i> on MC related issues.; <i>Print briefing and Training</i> for members of print and broadcast press on MC issues;
Media, Community	Event Creation and Sponsorship	<i>News conferences</i> about MC, celebrity appearances, grand openings of new MC centres, concerts including MC messaging, sporting events, for example incorporating MC into existing football programmes.
Media, Community	Entertainment Education Vehicles	<i>Incorporating MC</i> into existing Namibian <i>TV soap-operas and radio programmes, folk dramas, working with musicians to commission songs about MC. Bulding MC into games, for example football.</i>
Media, Community, IPC	Social Mobilisation	Use Political Leaders as Advocates on MC. Development of National Coordination Body of MC Communication. Participatory Planning Workshops at national and regional level. Supporting involvement in MC issues amongst key constituencies, for example PLWHA. Labour movement, women's movement.

## **Appendix 2: Outputs for immediate development.**

Within the MC strategy document, a number of outputs are suggested for immediate development. These outputs aim to not raise demand for MC but instead to raise basic awareness around basic MC issues with select audiences (for example the media and those working in HIV prevention). Most importantly, these outputs aim to counter any attitudes and behaviours that may related to misconceptions around MC.

The MC strategy document calls for coordination and strengthening of communication between partners at both national and regional level. Through the process of developing and testing these outputs there are opportunities for further facilitation and dialogue at national and regional level. This is an important by-product of all these materials.

### **1. Fact Sheets:**

Fact sheets for policymakers, the media and healthcare-workers. These will have many common elements, and elements which are specific to each group.

A problem statement and general communication considerations are documented in the MC Communication Strategy Document.

#### **Purpose:**

The purpose will be to inform policy-makers, the media and healthcare workers on the basics in relation to MC for HIV prevention to achieve the outcomes for Phase One listed in the MC Communication Strategy Document.

#### **Contents:**

This will include providing an update on the current situation in relation to MC scale up for HIV prevention within the country (ie that a policy and action plan have been prepared, together with a comprehensive national communication strategy). These fact sheets will also include the scientific evidence for the effectiveness of MC as a public health measure; simple biological explanations for the effectiveness of MC for HIV prevention; the other health and hygiene benefits of MC for both men and women. They would further include a brief overview of the prevalence of MC currently within the country. Very brief mention would be made of MC in cultural and historical context.

Further elements will be added to each pack depending on the audience:

*Policymakers:* Will receive more information about the current policy status in relation to MC; detailed information about the economic and other related benefits (eg: less future donor dependence). This group will receive more information about the process so far, for example the MC Situational Assessment, and the associated comprehensive strategy document: all of which aim to achieve careful progress, maximising chances for success.

*Media:* Will receive a listing of possible spokespersons on MC issues. They will also receive a brief distilled literature review covering different perspectives on the issue. A listing of possible story angles will also be circulated, together with any useful news-pegs. If some high-profile sports or entertainment figures can advocate for intensified HIV prevention, including MC, these will also be listed.

*Healthcare workers* will receive more information about the clinical benefits and limitations of MC. As the current principle interface with the public for MC issues, they will be provided with basic guidelines for dealing with questions from clients, for example from those requesting services, or from those living with HIV and who have general queries about MC. A listing of those currently providing services may also be distributed at this pre roll-out stage.

**Presentation:**

These fact sheets will be translated into the languages most appropriate in different regions. They will be short and succinct. The style will be simple and accessible. The tone will be matter of fact, and authoritative. No promotional or excessive branding elements will be used.

**Medium:**

The suggested medium is a simple standard A4 folder which will be filled with various A4 one page elements according to language group, and to the audience as differentiated above.

**Key considerations:**

Each sheet should be checked with various representatives of its intended audience, ensuring clarity and minimising misinterpretation. Extensive pre and post testing, given the need for speed, is not required, but some effort should be made to verify relevance, effectiveness and appropriateness to each audience.

The institutional affiliation, through logos and accompanying prefaces, should be agreed within the MC Task Force. Ideal branding identity would incorporate a few different organisations, most prominently the Government and its lead technical partners.

A covering letter should be included with each folder, giving a clear focal point for dealing with questions, and emphasising the fact the MC scale up is yet to begin.

## 2. Media FAQ

This resource is relatively short and easy to produce. It is simply a listing of frequently asked questions from the media, together with their corresponding answers.

### **Purpose**

The purpose of this output is to achieve the media objectives and outcomes outlined in the MC strategy document: principally to ensure the media plays an effective role in supporting MC scale-up for HIV prevention through being adequately informed and equipped to cover the issue.

### **Contents**

The precise questions will be developed in consultation with journalists. Provisional questions will include:

- What is MC?
- What is the evidence that MC works for HIV Prevention?
- Are we certain MC works for HIV Prevention?
- Why are some people in Namibia already circumcised and some not?
- How fast is MC being integrated into Namibia's HIV Prevention plans?
- What are the health and hygiene benefits of MC?
- What are the risks associated with MC?
- Why are their critics of male circumcision for HIV Prevention?
- Our health services are already strained, how will they carry the extra-burden of MC?
- What does MC do to benefit women?
- Is MC recommended for people living with HIV?

### **Presentation**

This should be translated into appropriate languages for journalists in different regions. The FAQ should be short, clear and succinct, once again written in an authoritative, matter-of-fact tone.

The source of the information should be official, and related to the government and its technical partners. Any institutional affiliation should be clearly non-partisan, or associated to any one overseas development partner.

### **Medium**

A simple, non-promotional document is recommended, with an authoritative but accessible look and feel, possibly in the form of a 4 side A-4 leaflet. This could also fit into the A4 folder mentioned above, which is intended to go to media partners.

### **Key considerations**

This document should be carefully presented in a way that clearly identifies it with the National Government of Namibia. The FAQ's should be expanded after discussion with journalists. The FAQ's should anticipate, and not avoid, more difficult questions, for example those stemming from a more critical stance on MC.

### **3. A basic brochure for those currently seeking MC services**

A basic resource is needed for those currently seeking MC services, both within the private and public health care sectors.

#### **Purpose**

The purpose of this brochure is to ensure that the growing number of those currently seeking MC services have access to the basic information they need to undergo the procedure, heal effectively, and maintain safe behaviours in the longer-term.

#### **Content**

This document will explain briefly some of the benefits relating to MC. Other contents include: outlining in very simple language the actual surgical procedure; explaining what pain relief measures will be taken during the process; explaining what will happen immediately after the process; explaining how and when dressings can be removed; explaining the healing period, and outlining what behaviors to avoid in this period; explaining how to access further help and support to deal with any queries or complications.

#### **Presentation**

Simple, and accessible presentation, with a warm, friendly and reassuring tone. Strong use of graphics and visuals, including images of circumcised and uncircumcised penises. This document will need to be translated into appropriate languages to ensure accessibility in all regions.

#### **Medium**

A simple colour brochure with similar lay-out and style to other health IEC materials, ensuring that the document corresponds to other similar, trusted health information.

#### **Key considerations**

For a lay-audience, this document should be presented in format that is accessible for those with weak literacy. Care should be taken in the translation of biological terms which may not have exact equivalents in the local idiom. For this reason, and to ensure appropriate cultural adaptation, this document should be tested with representative samples of people from different groups and regions.

#### **4. A leaflet for NGOs and CBOs working in prevention.**

As noted in the communication strategy, there are many CBOs and NGOs working on HIV prevention within communities across Namibia. Many people working for these groups know something of circumcision for HIV prevention, but few have all the necessary facts. Ensuring that those working with communities are equipped with up to date, basic but comprehensive information on MC is probably one of the most efficient ways of communicating widely through community and interpersonal channels.

##### **Purpose**

This leaflet would act as a key resource for those groups who are already working with the community. This audience, incorporating NGOs, CBOs and FBOs (faith based organisations) will be able to disseminate information, record community feedback, and to combat misconceptions and any risk compensation relating to MC and HIV prevention.

Because this document is intended in phase one, before scale-up, the document would not seek to raise demand for MC services, but would aim to instill a basic understanding of the issues, and target any attitudes, knowledge or behaviours relating to risk-perception.

##### **Content**

This leaflet would carry all the key messages listed in the MC communication strategy. It would explain, with the use of graphics, what MC is. It should explain what the benefits of MC are and some very basic information about MC prevalence in Namibia, both now and in the past. It would specifically address any misconceptions, for example explaining that MC only gives partial protection; MC is a procedure carried out by diverse cultures around the world (not any specific cultural or language group); circumcised men can still be infected with HIV, and can still infect others; the sexual partners of all men should still insist on condoms and other healthy behaviours to protect themselves from HIV.

##### **Presentation**

This leaflet, perhaps more than any of the other outputs for immediate production that are mentioned in this document, will need to be translated into local language. It will need to be carefully pre and post-tested with different groups, though this should not be a lengthy process. The leaflet should assume basic literacy, but should use simple, succinct language with plenty of graphics where appropriate

##### **Medium**

The recommendation is that this should be a folded leaflet, the equivalent of 2 sides of A4 text and graphics, printed economically but in colour.

##### **Key considerations**

This document will have to travel widely through many diverse organisations. Getting early buy-in, ownership and input from key representatives of these organisations as the output is being developed should help facilitate its dissemination. Key messages around MC, risk compensation, and the need to maintain health behaviours should be checked with samples of target audiences in different regions.

## 5. Generic content for MC materials

Because a large number of partners exist who work on HIV prevention related issues, one of the most efficient and effective ways of using their communication capacity, channels and influence is by working with them to incorporate MC into a number of their efforts and materials. The MC Communication Strategy outlines the need for content for other partners use to adapt and insert into their outputs.

### **Purpose**

The purpose of this work would be to ensure that NGOs and CBOs were equipped with information and materials that could help them communicate effectively on MC, and to target any related misconceptions.

### **Content:**

This work would contain segments of text echoing the content of the leaflet for CBOs above, but complimented with more context, background and detail of MC issues by drawing upon some of the text included in the other outputs (for example the fact-sheets for policymakers, healthcare workers and the media).

Strong visuals and graphics, showing maps of MC prevalence, photographic imagery of circumcised/uncircumcised penises, and other pieces of visual content already included in the above mentioned outputs.

This content should include a guide outlining on how to adapt and use the materials. In developing this guide, specific attention should be paid to ensuring none of the communication elements can be taken out of context.

### **Medium:**

A print-out of clearly signposted segments of text, and visual elements could be circulated alongside a digital CD of the elements in electronic format (graphics in high resolution) for people to copy and adapt. This digital CD copy of materials would probably have an HTML interface to enable ease of use and navigation.

### **Key considerations:**

This CD should be designed in close consultation with those Namibian organisations, both governmental and non-governmental, who are working with communication programming. This would ensure relevance and appropriateness.

Further, care should be taken to ensure that none of the materials are used out of context, and a clear covering letter should aim to address this, along with a carefully developed distribution list and clear guidance included with the actual product.