



A Report on the Consultative meeting on Medical Male Circumcision as an HIV Prevention Strategy



8th November 2010, Cross Roads Hotel, Lilongwe.

INTRODUCTION

The Centre for Development of People (CEDEP) in conjunction with AVAC a Global Advocacy for HIV Prevention organised a one day consultative meeting on Medical Male Circumcision. The meeting was called upon bearing in mind that nearly two thirds of the people living with HIV reside in sub-Saharan Africa and that new HIV infections are occurring at alarming rates despite a range of prevention efforts.

Prevention of new infections remains the only realistic hope for stemming the HIV epidemic in the African Region. Recent studies in South Africa, Uganda and Kenya have shown that medical male circumcision (MMC) can reduce HIV risk for uninfected men by 50 to 60%. WHO & UNAIDS has recommended that countries with generalized HIV epidemics do include MMC in the existing HIV prevention package. So far, 13 countries in Africa are implementing or are in the process of developing policies and guidelines for MMC.

It is a general understanding that expansion of safe MMC services needs to take into account local socio-cultural, religious and traditional values to ensure acceptability by communities. It is critical that an effective communication strategy is developed alongside to ensure that clear and consistent messages are developed and disseminated to a variety of stakeholders. Careful assessment and dialogue involving key stakeholders is needed in order to scale up safe MMC services in-country. The voices and experiences of civil society groups are fundamental in this process.

The meeting started with a prayer by Mr G Kampango from MANET+ and thereafter self introductions followed. Wiseman Chibwezo, Programme Manager for CEDEP made the welcome remarks and all the necessary logistics.

Meeting objectives:

The consultative meeting explored the following objectives:

- To inform participants on recent research about medical male circumcision as HIV prevention

- To discuss opportunities and challenges around medical male circumcision and messaging.
- To highlight possible barriers and advocacy needs from civil society perspective

PRESENTATIONS

The first presentation was presented by Mr Henry Chimbali from the Ministry of Health. He stated that the Ministry of Health is the lead institution on MMC.

A national Task force was set up to guide the implementation process. The task force is comprised of the following:

National task force (MoH, NAC, PSI, BLM, MIAA, CoM, CHAM, JPHIEGO, USAID, UNICEF, WHO, UNAIDS etc).

The Ministry has now developed MMC standard operating procedures for MMC services in any health facility and it's in draft form. This document looks at eligibility, MMC methodology – Forceps' guided method, client care and follow up, monitoring and evaluation (data collection)

demand creation strategies- communication strategy to guide counseling, creating demand, risk compensation.

He also stated that MMC is a major component in the Round 10 global fund proposal for Malawi.

The presentation highlighted also on gaps that are delaying the MMC program among some are:

- Though MMC has included MMC in the National HIV prevention Strategy, there is no clear policy on MMC.
- Evidence is there that MMC is effective as HIV prevention method (60% risk reduction to HIV) but there is no advocacy by the civil society to force the Government to speed up MMC scale up. Other countries within the region have moved forward e.g. Kenya, Botswana, South Africa, Zambia, Zimbabwe, Tanzania etc
- There is need for more resources (human and finances) to support the scale up
 - Health workers have to be trained to conduct the chosen MC method,

- Health have to be ready to offer the service
- There is need for more awareness for people and organizations to be aware that MMC is part of HIV prevention strategy and not a standalone intervention – supported with safe sex, condom use and abstinence
- One major challenge on MMC is how to with religion and culture as related to MMC. There is a need to delink MMC from culture and religion and emerge as an HIV prevention intervention – this would understood by conducting a formative assessment to guide communication strategy development.

The presentation highlighted what Government is planning to do (next steps).

- Finalize the MMC Standard operating procedures.
- Health systems strengthening – training and procurement
- Formative assessment and then a communication strategy.

The second presentation was done by Dr Eric Umar (College of Medicine).The presentation was on Male Circumcision Studies Conducted in Malawi and the current efforts by the Malawi Government on Medical Male Circumcision The presentation started with quotes by Top Government officials who gave the stand of Malawi on MMC.

This was said in a Sept 7 address to Malawi's 2010 HIV & AIDS Research and Best Practices Conference. The chairman of the Malawi's National Aids Commission, Archbishop Bernard Malango said that a comparison of the rates of infection in Muslim districts, where most men are circumcised, to that of Christian areas of Malawi, where circumcision is not practiced, showed no difference in the rate of infections.

"We have no scientific evidence that circumcision is a sure way of slowing down the spread of AIDS," Dr. Mary Shaba, the government's Principal Secretary responsible for HIV/AIDS in the Office of the President also said similar sentiments.

The following were the highlights of the presentation

- MC is the surgical removal of all or part of the foreskin of the penis
- Removal of foreskin ensures that receptor cells that attract infection are removed.
- Three famous trials show that MC can significantly reduce transmission (60 %)

- Few studies in Malawi have been conducted but centred on exploring behaviour and anthropological issues.
- People believe MMC can reduce HIV infection and enhance hygiene
- Acceptability lower in the north region but higher in the central and south regions of Malawi especially among the youth.
- Barriers due to fear of infection, bleeding, cost and pain.
- Influenced by hygiene, reduced risk of STI, religion, medical condition and sexual satisfaction



Dr Eric Umar from University of Malawi Making presentation on MMC research in Malawi

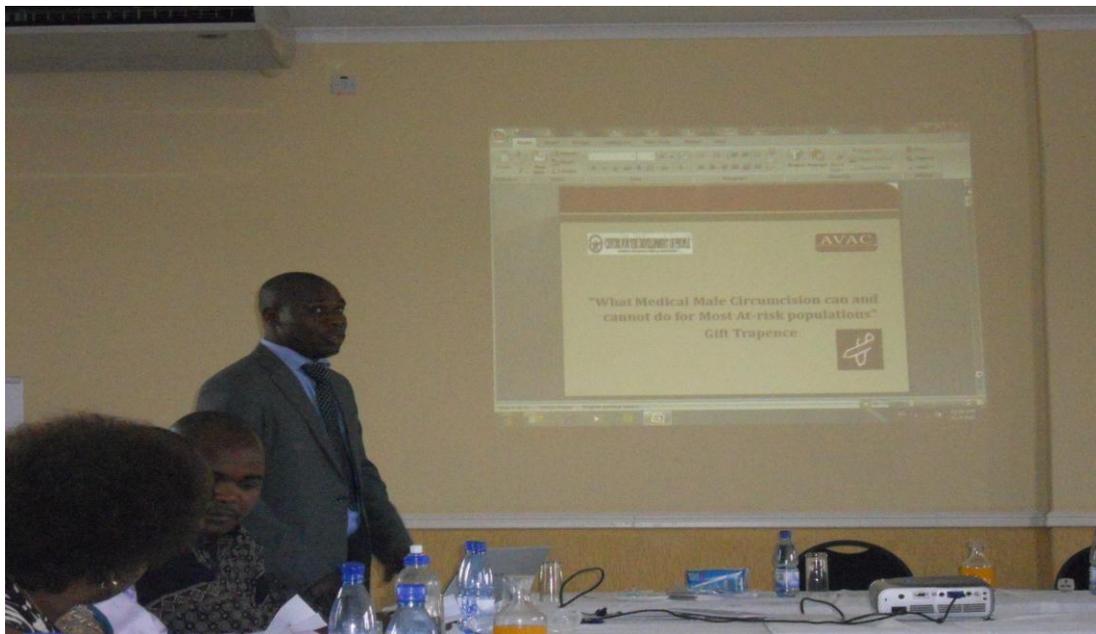
The presentation unearthed the following gaps in as far Medical Male Circumcision is concerned in Malawi;

- No clear policy on MMC though included in the HIV prevention strategy
- Resources both financial and human
- Limited awareness that MC is part of HIV prevention
- Association of MMC and culture and need of delinking MMC from culture and religion

After the presentation members went into plenary where the following were identified as **Emerging Issues:**

- People wished MMC was looked in the lens of public health other than religion or culture
- Malawi is always late in adopting issues e.g. accepting that there is HIV, condom use, MSM and now the issue of MMC
- Condoms not used in semi permanent relationships and in late adulthood
- A policy will be one of the solutions to the current situation
- More research required to unpack some of the underlying causes of higher prevalence rate in some areas despite MMC being practiced.

The second presentation was done by Mr Giff Trapence who informed the gathering that he is one of the Research Fellows shortlisted by AVAC in Africa. He made a presentation which was a summary of the findings of survey being undertaken as a Research Fellow. The presentation was on **“What Medical Male Circumcision can and cannot do for Most At-risk populations”**



Giff Trapence AVAC research fellow making a presentation

The presentation highlighted the following issues ;

- High prevalence rate among MSM in Africa
- There is also MCP concept among the MSMs
- MMC only beneficial for inceptive partners not receptive partners

- 56% of Malawi MSMs are bisexual.
- 75% of have never involved in male circumcision study, the reason cited was that they were not targeted by researchers.
- Only 25% of the respondents had been involved in other MSM HIV studies previously conducted by CEDEP.
- Almost all respondents (99%) who were involved in the study said they are willing to participate in any study on male circumcision because they want to learn more about the benefits of being of circumcised

Emerging issues

- Most at risk population issues are left out in most fora.
- Men do have anal sex with not only men but women as well
- How do we package our interventions to advocate for MMC among the MSMs in the context of our laws and general perception
- MSM are not represented in MMC committees.

Participants went into Group work in order to find out why there is silence on part of the civil society in the rolling out of MMC and find ways to make sure that MSM are also included in MMC committees. The two groups that were set identified the following gaps and strategies:

GAPS/CHALLENGES IDENTIFIED	STRATEGIES
<ul style="list-style-type: none"> • Lack of MMC Strategy despite being mentioned in the HIV Policy 	<ul style="list-style-type: none"> • Lobbying government to come up with a strategy on MMC as part of the HIV prevention strategy and law reform on policy
<ul style="list-style-type: none"> • In adequate Research on Malawi to support the advocacy 	Need for a nationwide research to understand the issues at hand. Replicate the other studies carried out in Kenya, Tanzania and South Africa
Sidelineing of civil society	<ul style="list-style-type: none"> • Lobby for inclusion in the national task

organizations in the National Task forces on MMC	force
<ul style="list-style-type: none"> • Lack of political will in embracing interests of MSM. 	<ul style="list-style-type: none"> • Advocate and lobby for law reform e.g. penal code and MSM
<ul style="list-style-type: none"> • Stigma and discrimination 	<ul style="list-style-type: none"> • Public education on how we can embrace the interests of MSM • On stigma advocacy can be handy
<ul style="list-style-type: none"> • Lack of resources(financial & human) 	<ul style="list-style-type: none"> • Lobby for more resources from government and donors to cater for MMC activities
<ul style="list-style-type: none"> • Information gap on the part of the CSO 	<ul style="list-style-type: none"> • Inclusion of minority groups in HIV programmes • CSOs need to be conversant with the issue of MMC through interaction with researchers and government

RECOMMENDATIONS

The consultative meeting came up with the following recommendations

- There is need for Public Education on the importance of MMC
- More studies on MMC specific to Malawi need to be carried out
- An analysis on the Stigma index survey being carried out need to focus on MSM
- Task force to be formed on part of the CSO(to document evidence, come up with TORs)
- Lobby to be part of the national task force
- Advocacy on Law reform(CEDEP/CHHR Initiative on MSM)
- Explore possibilities of pediatric circumcision.
- Malawi Interfaith Aids Association to represent MSM in the MMC committee.

WAY FORWARD

MMC civil society task force was established comprised of Malawi Network of HIV/AIDS organizations (MANASO), Malawi Network of People Living with HIV

(MANET PLUS), Malawi Religious Leaders Affected by HIV/AIDS (MANALERA), Human rights Rehabilitation Centre, Family Health Association, Youth Net and Counseling, Centre for the Development of People and Malawi Interfaith Aids Association (MIAA).

It was agreed that since MSM are not currently in the MMC task force, MIAA will be serving the interests of MSM in the MMC task force and will be reporting back to the civil society task force.

CONCLUSION

In conclusion, The Executive Director of CEDEP, Mr. Gift Trapence thanked all the participants for availing themselves for the consultative meeting and for their active participation. He called upon all the civil society organizations to be vigilant in defending the interests of the minority and advocating for best practices like MMC in responding to the pandemic.

Annex; list of participants

Annexe 2: Participants List

No.	Participant	Organization	Designation
1.	Dr Eric Umar	University of Malawi- College of Medicine	Researcher
2.	Aberson Mwale	Chiradzulu District	District Aids Coordinator
3.	Robert Chizimba	National AIDS Commission	Head Behavior Change
4.	Gift Trapence	CEDEP	Executive Director
5.	Undule Mwakasungula	Centre for Human rights and Rehabilitation	Executive Director
6.	Henry Chimabali	Ministry of Health	Head of Health communications
7.	Donald Makwakwa	Malawi Network of HIV/AIDS organisations	National Coordinator
8.	Ernest Kadzokoya	Mangochi District Council	District Aids Coordinator
9.	Nery N Notary	Voluntary Service Organization	Capacity Building Coordinator
10.	George Kampango	Malawi Network of People Living with HIV (MANET +)	Programme Manager
11.	Lothiar Ngulube	Blantyre City	Blantyre City Aids Coordinator
12.	Golden Kang'oma	Malawi Interfaith Aids Association	Program Manager
13.	Lucy Stanley Moore	Family Planning Association of Malawi/IPPF	Research Coordinator
14.	Agness Kamanga	Youth Net and Counseling	Programs Officer

No.	Participant	Organization	Designation
15.	Hon Davison Nyada	Parliamentary Committee on HIV/AIDS	Member
16.	John Chipeta	COGHAAM	National Coordinator
17.	Dadley Chifundo Kadyamaliro	CEDEP	Peer educator
18.	Wiseman Chibwezo	CEDEP	Program Manager
19.	Agness Mizere	Blantyre Newspaper	Journalist
20.	Enerst D Kadzokoya	Mangochi District Assembly	District AIDS Coordinator
21.	Raymond Mbembeza	CEDEP	MSM
22.	Ian Phiri	CEDEP	MSM

