

Operation  Abraham



Senegal-Israel Workshop

***TRAINING HEALTH CARE TEAMS IN SCALING-UP MALE
CIRCUMCISION FOR HIV PREVENTION IN AFRICA***

July 6 – 12, 2009

CO-CHAIRS

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Project Report

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¹ Dr. Cyril Fine, a physician and a Mohel was among the most experienced medical circumcisers in Israel. He passed away January 2010. He shall be always remembered by his friends, colleagues and family as the "grandfather" of adult MC in Israel.

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Sharing Experiences on Male Circumcision in Israel and Senegal



EXECUTIVE SUMMARY

Male circumcision (MC) is now an accepted method for HIV prevention. Based on the recommendations of international agencies such as WHO, UNICEF and UNAIDS, and with support of consultants - national policies on MC are being formulated and adopted in various high priority countries throughout Sub-Saharan Africa. It is estimated that MC may reverse the HIV epidemic in Africa if large percentages of the 20 million men in these countries will be voluntarily circumcised.

There is currently a great need for expertise and medical technology in MC in parts of Africa that are highly affected by HIV/AIDS and where access to male circumcision is limited. To respond to this need and by invitation of Swaziland a pilot project was launched in 2007 named "Operation AB". With participation of expert trainers in MC from Israel, the project trained 10% of Swazi doctors in performing safe, swift and effective large scale adult MC, increasing intake at one clinic to 10 clients a day. Requests from other countries required a more comprehensive approach and resulted in the birth of "Operation Abraham Collaborative", a consortium of eight Israeli health institutions, facilitated by Jerusalem AIDS Project.

Further to that initiative, and following discussion in Dakar (Senegal), a new joint effort was agreed, involving West African (Muslim) and Israeli (Jewish) professional teams. This unique project will make best use of the expertise of both professional groups strengthening international cooperation in MC scale up.

A workshop in Israel (July 2009) established recruitment criteria, merged diverse professionals into a cohesive effective team, had exchanges of know how and the development of a plan to engage effectively volunteering surgeons from both respective countries as well as others in future training delegations to Africa. In the second stage of the project surgeons and public health experts from Senegal and Israel will have the opportunity to work together in delegations going to priority countries in Africa as MC trainers and service providers.

This report could inform policy makers, implementers and evaluators in the area of male circumcision for HIV prevention being an important resource on MC technology transfer and schemes for involving international trainers in national efforts to scale up or roll out MC services in Africa and elsewhere.

Several Workshop Participants at the Entrance to MSR in Tel-Hashomer



INTRODUCTION

Background

Adult male circumcision (MC) was proven to reduce the risk of male HIV acquisition heterosexually by 65% in three randomized controlled trials in Africa². The major international health agencies including the WHO and UNAIDS issued direct recommendations to priority countries in Sub-Saharan Africa for the rolling out or scaling up of male circumcision efforts to prevent HIV infection³. Clinical guidelines have been developed (with input from Operation Abraham Collaborative) on the performance of adult MC under local anaesthesia. These guidelines issued by WHO and UNAIDS are the normative recommendations for teams performing surgery in various countries⁴. Based on the recommendations of the international agencies and with support of consultants, national policies on MC are being formulated and adopted in Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. In several of these countries the rolling out of MC is now underway in multiple locations. A major impediment for the scaling up MC in most countries has been the lack of trained doctors (or nurses) to affectively perform large volumes of safe and swift MC as well as educating the clients on HIV prevention and post operation healing.

A pioneer training project involving international teams in Swaziland demonstrated the effectiveness of hands-on training of Swazi doctors by Israeli teams in MC⁵.

Senegal-Israel Collaboration in Training of Medical Providers in MC

Senegal is a country with one of the lowest HIV prevalence rates in Sub-Saharan Africa (0.7%)⁶ with more than 95% of males (mostly Muslim) circumcised. In Senegal, health providers perform most neonatal and children circumcisions under Islam laws. In major towns the procedure is performed in hospitals while in rural areas it is performed in health stations.

² http://www.malecircumcision.org/research/clinical_research.html

³ http://www.kit.nl/net/KIT_Publicaties_output/ShowFile2.aspx?e=1405

⁴ http://www.malecircumcision.org/programs/documents/WHO_MC_Manual_Local_Anaesthesia_v2-5C_Jan08.pdf

⁵ <http://www.operation-ab.org/files/FinalReportFLASJAIP.pdf>

⁶ Senegal DHS4, 2005

Israel is currently the only country in the world with expert surgeons, who have performed massive adult male circumcisions (approximately 100,000) at a rate of 30-34 a day per surgeon in an extraordinary service delivery program. Adult MC were performed at their request on Jewish immigrants to Israel from the Former Soviet Union and Ethiopia, beginning in the late 1980's to the present. A cadre of Israeli surgeons has gained ample experience in developing skills and expertise in conducting large scale MC procedures in adults. In Israel 99% of the male population (Jewish, Muslim and Christian) are circumcised before turning one. Scientific publications indicate that despite the huge volume of MC under local anaesthesia the number of complications was very small and in almost all cases minimal (e.g. access of bleeding)⁷.

In December 2008 the Jerusalem AIDS Project was invited to co-chair a workshop organized with UNICEF and Social Aspects of HIV/AIDS Research Alliance (SAHARA)⁸. The workshop was held in Dakar, Senegal and facilitated in depth exchanges of information and experiences on MC practices in Israel (Judaism) and West Africa (primarily Muslims in Senegal). It was quickly apparent that the shared experiences of Senegal and Israeli surgeons in MC could be further enhanced through joint training and delegations supporting the demands in southern and eastern Africa.

Following the workshop at the ICASA 2008 Conference, meetings in the Ministry of Health in Senegal resulted in an agreement to hold in Israel a joint workshop of Israeli and Senegal experts in the field. Israel is on the crossroads between Africa-Europe-Asia – was characterised as a perfect location for cost effective and innovative training projects in Africa, especially in the field of MC.

The Joint Workshop Partners

- **Operation Abraham Collaborative**

Operation Abraham Collaborative (OAC) is a consortium of eight Israeli hospitals & health institutions committed to internationally advancing the prevention of HIV through MC. The consortium was set up 2008 in order to effectively respond to requests of several African countries interested in Israeli technical support in training of their doctors in safe and swift adult MC. The collaborative is coordinated by Jerusalem AIDS Project (JAIP) which serves as a secretariat and facilitator. Responding to requests from several African countries three Memorandums of Understanding (MOU) were signed with authorized parties. The African countries inviting our

⁷ Schenker I, Gross E (2007). Male circumcision and HIV/AIDS: convincing evidence and their implication for the state of Israel

⁸ <http://www.plusnews.org/Report.aspx?ReportId=81866>

technical assistance included: Lesotho, Uganda and Swaziland. Operation Abraham Collaborative was also contacted by other countries (e.g. Namibia, Botswana, Malawi and South Africa) about cooperation. As a co-signatory of three memorandums of understandings (MOU), JAIP board had agreed to have OAC be the implementing body of the project agreed upon.

JAIP is a 20-year-old NGO, focusing on HIV prevention in young people. It has experience in the area of professional training in HIV/AIDS both in the Middle East and in developing countries in Africa, Asia, Latin America and Eastern Europe. JAIP has implemented HIV capacity building projects in 27 different countries. The organization works closely with UNAIDS, WHO, UNESCO, UNICEF and the international donor community. In Israel, JAIP is a strong advocate for HIV/AIDS prevention-care continuum. Its HIV preventive education curriculum is in place in schools both throughout Israel and internationally. Additionally, JAIP provides a free, confidential, HIV hotline service to individuals throughout Israel from its office in Jerusalem.

- **Operation Abraham Collaborative other members are:**

Hadassah Medical Organization (HMO): HMO is a leading Israeli medical and healthcare institution with international reputation and activities in training and supporting medical training and service delivery in Africa and many other developing countries. HMO, through the Hadassah Ein Kerem Hospital, holds the medical supervision role of the project.

Israel Center for Medical Simulation (MSR): MSR has established itself as a national and global role model in medical simulation, and has gained national and international recognition as a vitally important addition to Israel's medical education network. Based at Sheba Medical Center in Tel Hashomer, MSR is a lead training institution of the Collaborative.

The Edith Wolfson Medical Center (EWMC): During the years 1990-1995 the EWMC participated in the program of mass male circumcision for the new immigrants from the Former Soviet Union. Surgeons of the hospital, including general surgeons, pediatric surgeons and urologists continue to perform adult male circumcisions to date. EWMC is a key contributor of expert trainers in the Collaborative.

Asaf Harofe Medical Center (AHMC): AHMC, one of the largest hospitals in Israel, provides comprehensive medical services to a population of over 372,000 people in Central Israel. The hospital is part of the Tel Aviv University Sackler Faculty of Medicine.

Surgeons of the hospital, including general surgeons, plastic surgeons and urologists continue to perform adult MCs to date.

Israeli Ambulatory Pediatric Association (IAPA): IAPA is a leading organization under the Israeli Medical Association with members from diverse medical background working in the area of pediatric and adolescent care. Several of its members are medical circumcisers with many years of experience. IAPA contributes to the training and monitoring activities.

The Israeli Urological Association (IUA): IUA has a significant professional role, offering surgical expertise, medical and scientific background, and organizational and educational experience. IUA is a lead member of the Collaborative for international physicians' recruitment evaluation and placement.

Israel Association of Pediatric Surgery (IAPS): Several members of IAPS have been involved in adult male circumcision and others are routinely conducting neonatal medical circumcisions. IAPS is a lead member of the Collaborative for international physicians' recruitment and placement.

- **The Senegal Medical Association**

The Senegal Medical association consists of 2,000 physicians in private or public sector practicing in Senegal. Physicians are from different associations existing in Senegal and are determined to work together in all medical aspects. The SMA is a member of the Worlds Medical Association (WMA) since October 2008.

- **HIV/AIDS Department, The Ministry of Health and Prevention – Senegal**

The HIV/AIDS department is the Senegal Ministry of Health and Prevention institution in charge of coordination and implementation of national health policy related to AIDS. This department represents the health sector in a national multi-faceted AIDS control program coordinated by the National AIDS Council. Its interventions include the prevention of STI's and AIDS, PMTCT, VCT, care, support and treatment for persons living with AIDS, OVC, blood safety & post exposure prophylaxis, prevention and care for vulnerable groups.

MC Training Experience - Operation Abraham in Swaziland

A pioneer pilot project in Swaziland demonstrated Operation Abraham Collaborative ability to deliver effective training and MC services hailed by experts, international agencies and media^{9,10}. Three OAC teams travelled to Swaziland on three occasions between October 2007 and February 2008. Each delegation consisted of two surgeons and one public health expert, provided on-the-spot training in Mbabane for local surgeons, nurses and adult MC program managers in scaling up adult MC Service delivery and in rolling out neonatal male circumcision (N-MC). The project was collaboration between OAC of Israel and the Family Life Association of Swaziland (FLAS) co-funded by Hadassah, PACT (PEPFAR), JAIP donors and Tuttnauer. Interestingly, OAC teams to Swaziland included an Israeli Muslim physician.

At the completion of that pilot: 10% of Swaziland doctors were effectively trained in MC; in take at the FLAS clinic was increased from 3 MC a week to 10 a day; and a model for providing MC services at a community level clinics was developed, implemented successfully and sustained¹¹.

Israel-Senegal Cooperation

A joint project was suggested: developing joint Muslim-Jewish professional teams for training in MC in African priority countries where their services are requested. This unique project will make best use of the expertise gained through performing a religious act in Islam and Judaism, now at the service of a major public health challenge. Teaming professional groups from primarily Muslim countries in West Africa and Israel was considered strengthening international cooperation in MC scale up.

The initial discussions about this project were held in Dakar in December 2008 and materialized into a formal agreement in 2009. The following goals and project outline are part of the Memorandum of Understanding (MoU) signed between the Ministry of Health of Senegal, the Senegal Medical Association and the Jerusalem AIDS Project in 2009. The MOU promotes a Senegal-Israel Cooperation in support of male circumcision scale up efforts in southern and eastern Africa.

⁹ <http://www.washingtonpost.com/wp-dyn/content/article/2007/10/20/AR2007102001206.html>

¹⁰ http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=48338

¹¹ [Operation AB –Project report. 2008.](#)

The goals of this collaboration

- To develop a framework for the inclusion of expert surgeons and public health professionals from Senegal and other west African countries in training delegations. of OAC to those African countries that invited OAC assistance in MC scale-up.
- To develop a recruitment plan for expert Senegalese and Israeli professionals in surgery and in public health including selection criteria and process.
- To develop and implement protocols for the inclusion of experts from other Muslim countries in training courses offered by OAC.
- To develop training materials and protocols; and an evaluation program.

This is a two-step project: Step 1 – Joint Workshop in Israel

A joint Steering Committee with members from Senegal (Drs. NDIR and BOUSSO) and Israel (Dr. SCHENKER) established a concrete plan for the workshop. A delegation of 5 physicians and public health professionals arrived from Senegal to Israel for approximately 7 days to participate in a workshop and professional meetings with colleagues from the Jerusalem AIDS Project and Operation Abraham Collaborative, conduct field visits and an extensive joint MC simulation session. The Steering Committee worked effectively in both countries to organize the workshop. Communication occurred via e-mail and multiple conference calls. All decisions concerning the workshop including but not limited to itinerary, sessions and workshop goals were made jointly. Fundraising was the responsibility of both groups as well.

Step 2 – Future Joint Delegations

It was agreed that in the second stage of the project (during 2010) teams from both countries will have the opportunity to work together in delegations going to priority countries in Africa as MC trainers and service providers. The surgeons will be entrusted with training local doctors in MC and/or direct service delivery and training non-surgeons in clients' counselling, education and health system improvement.

THE SENEGAL-ISRAEL WORKSHOP

TRAINING HEALTH CARE TEAMS IN SCALING-UP MALE CIRCUMCISION FOR HIV PREVENTION IN AFRICA

The implementation of the project stipulated in the MOU took effect July 2009 with the arrival of a team from Senegal to Israel for a joint workshop in Jerusalem and Tel Aviv. The major focus of the workshop was the development of a professional response to the need of expertise and medical technology in MC in parts of Africa that are highly affected by HIV/AIDS and where access to Male circumcision is limited. Based on preparatory work of the Steering Committee, the interest of a diverse group of funders and the support and participation of all partner organizations the workshop materialized in a relatively short time. Four major outcomes were expected by the end of the workshop:

- (1) establishment of recruitment criteria for inclusion of surgeons, nurses and public health specialist in future training delegations in MC to Africa
- (2) the merger of Israeli-Senegal and other international medical circumcisers into a cohesive, professional effective team, facilitated by OAC
- (3) professional exchange of know-how and protocols in MC between Senegal (Muslim) and Israel (Jewish) professional
- (4) development of a plan to engage effectively volunteering surgeons from both respective countries as well as others in future training delegations to Africa.

The workshop took place between July 6th-12th 2009 in Jerusalem and Tel Aviv, Israel.

Program highlights

- 1- Site visits to clinics in Jerusalem and Tel Aviv where adult and neonatal MC were performed by using the Clamp (forceps guided) method.
- 2- An intensive workshop, discussions and exchanges on each country's experience in MC including surgery, nursing, health system, anesthesia, and counseling.
- 3- Development of criteria for selection of international surgeons for the project and review of applications from international (including Africa) surgeons that were interested in joining OAC future training delegations.

- 4- Joint training sessions at Israel Medical Simulation Center (MSR) and review of onsite training methods and materials.
- 5- Discussions and agreement on a work plan and protocols for 2010.

Summaries of Lectures and Discussion

TITLE: OVERVIEW OF MALE CIRCUMCISION FOR HIV PREVENTION AND INTERNATIONAL SUPPORT FOR SCALE UP/ROLL OUT OF TRAINING AND SERVICE DELIVERY

PRESENTER: Dr. Inon Schenker

The presentation discussed evidence-based HIV prevention with surgery placed for the first time ever in the frontline of preventing an epidemic. Included were international normative guidelines (e.g. WHO, UNICEF) and networks (e.g. UN Working group on MC) established to lead the way in MC service delivery and integration. MC policy developments in Africa and country specific implementation plans were discussed as well as operational research questions. A historical background on circumcision was given including the clinical trials in Rakai (Uganda) Kisumu (Kenya) and Orange Farm (South Africa) that demonstrated that male circumcision was effective in reducing HIV acquisition to sexually active males by 50% - 65%. It was stated that the scientific evidence of 65% reduced risk of HIV infection through male circumcision is sound. From this science, policies were developed beginning with the Montreux recommendations that recognized the human resource gap and the role that traditional practitioners play in MC. A statement followed this from WHO/UNAIDS in 2007 that echoed the scientific findings and called for scaling up of circumcision in certain African countries and circumcision was included in a comprehensive HIV prevention package. Policy to practice was the next point of discussion. Programs to increase rates of safe male circumcision were reviewed with the different roles of the individual and the community. Some countries have developed and adapted national policies on circumcision while others are setting up national MC task forces. Most countries have adopted the forceps guided (Clamp) method with use of local anaesthesia. There is a dire need for circumcision scale up and this requires funding and sharing of technical expertise.

TITLE: "OPERATION ABRAHAM" INTERNATIONAL TEAMS FOR MC TRAINING & SERVICE DELIVERY: SWAZILAND PILOT

PRESENTER: Dr. Eitan Gross

The goal of this session was to emphasize the practicality of Operation Abraham Collaborative initiative in Africa and its mission to prevent HIV transmission through circumcision in Africa. In Israel circumcision is performed due to various reasons including religion, societal norms and culture. Among Jews, 99.9% of male infants are circumcised on the 8th day after birth – approximately 52,000 procedures are performed annually. The Muslims circumcise at birth or a few

months after birth but rarely beyond the first birthday –approximately 17,000 circumcision procedures take place annually. Christians and Druze follow shortly behind in annual recordings of circumcision and also circumcise before the baby's first birthday. In the last decade approximately 100,000 MC surgeries under local anaesthesia (85%) were performed in Israel. The males who come for circumcision were all Jewish or Jewish converts, aged between 6 months and 96 years. Majority of them are from the Former Soviet Union, Ethiopia and Romania. Complications rates from circumcision are low and new legislation in Israel requires that hospital ER departments notify the Ministry of Health immediately of any neonate or adult seen with post MC complications, whether performed by a Mohel or a medical doctor. In October 2007, collaboration between Swaziland's MC Taskforce, a local NGO -Family Life Association of Swaziland (FLAS), the Jerusalem AIDS Project (JAIP) and Hadassah Medical Organization (HMO), initiated the Operation Abraham (Op AB) Project. OAC developed the pilot project in Swaziland with a goal to train local Swazi doctors in performing safe and effective adult male circumcision. Hadassah provided substantial funding and the equipment. Tuttnauer donated sterilization equipment and JAIP supported with other surgeons, logistics and management. An assessment visit and onsite evaluation of the clinic in Swaziland was conducted. The availability of resources, human (professional personnel) and equipment (operating theatre space, laundry and sterilizing equipment) were assessed and also we looked at registration and quality control, efficiency of patient flow, post operative care and post exposure prophylaxis protocol. The pilot was launched in October 2007 and included three training missions, each for 2 weeks. Two Israeli expert surgeons and one public health expert traveled to Mbabane to train at FLAS. They were able to perform over 200 male circumcisions and 11 neonatal circumcisions resulting in 10 trained local physicians in. Currently six of these trained surgeons are operating at FLAS, five days a week with recorded increase in clinic circumcision rates up to 10 per day. This is a project that can be used as a model for other scale up programs.

TITLE: MOBILIZING NON-CIRCUMCIZING COMMUNITIES: THE CASE OF THE LUO IN KENYA

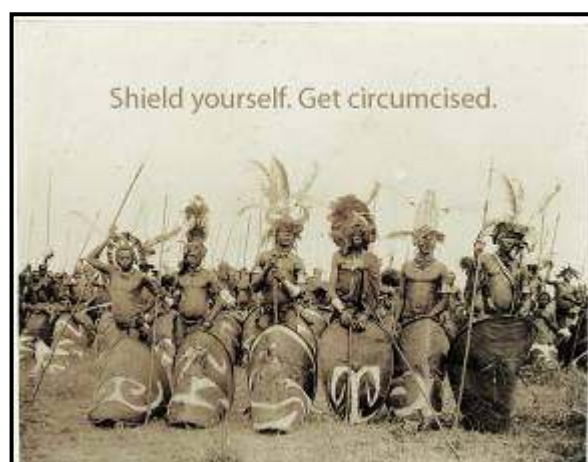
PRESENTER: Dr. Norah A. Obudho

Presentation started with a brief introduction to Kenya and its people. Kenya is a developing country in Eastern Africa and is one of the Sub-Saharan countries reeling with the scourge of HIV/AIDS. National prevalence is 7.4 according to the National AIDS and STDs Control Program of Kenya (NAS COP). Kenya experiences a mixed epidemic with areas of high prevalence established within regions like Nyanza and areas where transmission is as low as 1% as in the North Eastern Provinces. Estimates project that 1.3 million Kenyans are living with HIV/AIDS (PLWHA) and the estimated number of new HIV infections annually stands at 60,000 – 140, 000. Nyanza is a province located on the shores of Lake Victoria in Western Kenya. Nyanza has a population of 4.4 million and is occupied by the Luos tribe. HIV prevalence rate in Nyanza is 15.2% --double the national prevalence rate. Transmission is mainly heterosexually and the Luo tribe from time immemorial do not circumcise. Circumcision is not considered a rite of passage in this community rather other means were employed by removal of the front upper and lower teeth. This practice is no longer

done. This would be an ideal community to run such an intervention. The government of Kenya is supportive in this endeavor and so are the political leaders. However there was resistance to this procedure from the local community voiced through the community leaders who are respected and influential. The community leaders' resistance arose sine they were not consulted bout this venture. They viewed the promotion of circumcision as something forced upon them. In Surveys done in the region, 75% of the Luos viewed circumcision favourably and although 60% of Luos preferred to be circumcised, only 17% actually were. In absolute numbers, approximately 970,000 men are uncircumcised. On the other hand, 60% of women preferred to have a circumcised partner and a majority preferred their children be circumcised. From random interviews it was noted that men viewed circumcision as a painful procedure, were deterred by the 6 week period of abstinence post operation, feared ridicule from community members and were afraid of decrease in sexual pleasure. A few mentioned shortening of the penis and others regarded it simply as not part of their tradition. Being uncircumcised is part of their identity as a Luo. This is a community with a need for circumcision as an intervention however the approach must include introducing and promoting the procedure. Circumcision has been used to ridicule the Luos by the communities that are circumcised and during the 2007/2008 general election it was used as means of chiding the Luos with statements such as 'unfit for presidency". Consequently in the process of scaling up circumcision community acceptance assessment is integral. Promotion of the procedure has now taken an approach that includes community sensitivity resulting in the increase of circumcision demand. The government has now included circumcision in the comprehensive HIV prevention package and has channeled more funding towards the process. So far 20,701 men have been medically circumcised at 124 private and public health facilities across Nyanza, the only province where the circumcision program has been rolled out. In an effort to suggest a strategy how to enhance acceptability of MC among the Luos, a team of MPH students (Norah, Kwame, Liza, Grisha, Lihe and Yahav) developed "Circumcise Me!" – Campaign with several objectives:

1. To develop a mass media campaign promoting the acceptability of male circumcision and safer sex practices among Luo males ages 15-49 in the Nyanza province in conjunction with the current national policy on circumcision.
2. Increase knowledge among local opinion-leaders and health workers on the benefits of circumcision in three districts of the Nyanza province (Kisumu, Siaya and Migori).
3. To develop and implement local sexual health education activities targeting males ages 15-49 in three districts of the Nyanza province (Kisumu, Siaya and Migori).

The project is under consideration for funding.



TITLE: BENEFITS OF THE CLAMP METHOD FOR ADULT MC**PRESENTER:** Dr. Francis Serour

Forceps guided or best known as the Clamp method is one of several techniques for performing male adult circumcision. When circumcising, planning for the procedure is key and the determining factor is the outcome. The chosen method for surgery should have minimal complications as well as a good aesthetic outcome. The WHO manual on MC under local anesthesia qualifies three methods of circumcision namely: forceps guided (Clamp) method; Dorsal slit method and Sleeve resection method. The criteria on which one chose the preferred method are based on: the level of surgical skills of the medical circumciser, the setup required to perform the procedure, requirement of assistance, the cosmetic results, the risks and long term effects. The Clamp method satisfies both the cosmetic and the least complications criteria. It is simple and swift. It can be performed at a community-level clinic setting. If performed in a hospital minimal non-invasive monitoring is needed. As to the actual procedure: paramedian injection of local anesthetic is performed to block the dorsal nerves of the penis on both sides. The effect of analgesia is checked after 10 minutes and when ascertained by gentle pinching of the foreskin with a forceps, the surgery can continue. The foreskin is dilated and retracted with an artery forceps and preputial adhesions released allowing for the glans to be cleaned completely. The prepuce is then brought forward and the foreskin to be excised is marked with a pinch from the forceps at the coronal sulcus level. The foreskin pulled forward by the artery forceps at the 6 and 12 o'clock positions with equal traction to the point where it was marked. A straight forceps is then applied across the marked area with care not to pinch the glans. The forceps is placed in an oblique angle from the 12 to 6 o'clock position with more skin on the dorsal aspect than the ventral. With the thumb and forefinger the glans is pushed back distal to the forceps to ensure no injury occurs on the glans or urethra. A scalpel is then used to cut the skin distal to the straight forceps. The forceps is then released and the apposing skin pushed back to expose the glans. Homeostasis is achieved. Dressing will be removed at post operative day 2. Possible complications include Bleeding, edema, infection, release of suture, injury to the urethra, and injury to the glands, an irregular and extensive/insufficient cut.

TITLE: SENEGAL MC PRACTICES IN NEONATES AND ADULTS: PUBLIC HEALTH ASPECT**PRESENTER:** Dr. Adama Ndir

The Senegal population is 11.4 million; more than 90% are Muslim. The healthcare system is decentralized to 69 health districts. HIV/AIDS in Senegal is described as a concentrated epidemic with low prevalence at 0.7 in the general population and high prevalence in the high risk groups that includes men who have sex with men (MSM) at 21.8 prevalence rate and female sex workers at 19.8. More women than men are HIV positive with a ratio of 2:25. There are also regional disparities. HIV prevention in Senegal has been spearheaded by significant political engagement,

the formation of a multi-sectored response to the epidemic, the implementation of HIV diagnosis, testing services and the implementation of antiretroviral therapy (ART) delivery. In 1986 the first case reported of HIV in Senegal and was followed by a rapid and concerted response which has played part in the current low HIV rates. The government showed immediate commitment to prevention. The national AIDS council and AIDS/STD integration was implemented. Circumcision in Senegal is high (89%) in a background of low HIV prevalence rate. Currently most circumcisions in cities are done in a health facility by paramedical staff consequently less time is spent on initiation period. The hospital setup is preferred due to its ability to anaesthetise, aseptic procedures, good postoperative results and hospitalization if necessary. There is a need for a link between service providers and targeted communities as seen in the Casamance case study of 2006 on 'Building synergies between clinic and traditional settings'. This case study described the need for circumcision to be safe and still maintain its cultural aspects among the Southern tribe in question. It integrated the need for sex education and promotion of behaviour change. Senegal has the expertise and experience in circumcision of boys that can be harnessed to help other countries with low circumcision rates that need scaling up of the procedure to prevent HIV. Senegal has dealt with challenges like: Poor access to health services, less commitment and interest in male circumcision by trained health professionals, as well as a weak medico-legal system. It also has experience in working effectively with traditional MC providers, integration of MC into overall health service delivery, integration of private health providers, poor communication strategies and inadequate counselling leading to confusion and misunderstandings about the degree of protection conferred by male circumcision. Risk compensation among newly circumcised men and the perceptions of non direct benefits for women are within the wide range of lessons that can be drawn from the Senegal experience in its public health approach to circumcision and to maintaining low HIV prevalence.

TITLE: SENEGAL MC PRACTICES IN NEONATES AND ADULTS: THE SURGICAL ASPECTS

PRESENTER: Dr. Issa Labou

Similar to Israel, the Clamp method is used in Senegal for male circumcision. In Senegal it is common to use the "Kocher clamp" however they are not strict to specific equipment and straight forceps have also been used. The use of clamps is also preferred by the non-medical (traditional) circumcisers that perform circumcisions mostly in rural areas. Paramedical providers perform more than 80% of circumcisions in hospital facilities. Circumcision is performed throughout sub-Saharan Africa for multi-ethnic, religious and cultural reasons. The age of the participants varies greatly ranging from young boys to adults. In Senegal, the majority of boys are circumcised during adolescence. Prof. Cheikh Ibrahima Niang studied MC in the Wolof culture in Senegal¹², where the word for the circumcised man (njulli) has the same origin as the word for prayer (julli). In Niang's study attributed to MC are also prophylactic properties. The foreskin is considered dirty, a source of

¹² http://findarticles.com/p/articles/mi_hb264/is_29_15/ai_n29358884/?tag=content;col1

bad smells and disease, or even of evil. In societies with castes the provider is often a blacksmiths or shoemakers who performs the actual circumcisions. He uses a knife invested with sacred qualities. The knife will have been treated beforehand (lugu) so that it does not cause infection (toke). At the end of the removal of the foreskin, a powder is applied to help seal the wound. In the larger cities of Senegal, male circumcision is more and more often practiced only by the family and more frequently performed in medical centers. Huge community circumcision ceremonies tend to disappear. But the traditional system is still strong in the rural areas.

TITLE: ISRAELI MC EXPERIENCE IN NEONATES

PRESENTER: Dr. Melvyn Westreich

Israel birth rate is 120,000 births annually and over 50,000 circumcision procedures are done at an average rate of 142 N-MC a day. The first part of this presentation dealt with Religious\Traditional circumcisers (named Mohel), perform 85 % of circumcisions. Yet complications arising from the procedure are rare and occur equally when done by medical or non-medical provider. The Mohel(s) have wealth of knowledge and expertise on MC, a procedure done by Jews on the 8th day after childbirth. Historically, circumcision has been performed by lay persons for over 3000 years. In Israel there is an insufficient amount of doctors to perform this procedure therefore the lay circumcisers fill in this gap. Every Mohel is trained and supervised by a committee of religious supervisors and medical doctors before being provided with a permit to practice. Families provide payment for services however; there is a limit on how much can be demanded. In addition there is a group of Mohels that perform it for free. Unlike medical circumcision, ritual circumcision does not use anaesthesia and also does not allow the foreskin to be not viable when it is removed. After applying a shield to protect the glands, the cut is made. Clamps are not used as they crush the vessels making the foreskin non viable (which is against the religious norms). The resulting cut edges retract and tend to bleed more and leave an open wound that may take 10 days to heal. The only pain experienced by the baby is at the time of the cut and for only 20 seconds. For effective anaesthesia and pain reduction the baby should receive glucose bolus pre and post procedure. Premedication with mild analgesics and applying local anaesthesia is also helpful. For local anaesthesia, Lidocaine as a gel, spray or solution is commonly used. The Mohel is also responsible for follow up of the patient within 24 hours of the surgery. The Mohel keeps a record of all the procedures done. On preparation of surgery both the family and the Mohel are involved. Any complications must be reported and if the Mohel is at fault, his certificate is suspended.

The second part of the presentation part focused on the complications of neonatal circumcision and the experience in Israel. Complications in neonatal circumcision are rare with an incidence of 1 in 100,000. And when it does occur, bleeding is the most common complication. Others include: infection or aesthetic issue. The worst is injury to glands. Factors that influence complications of neonatal circumcision depend on the condition of the child, his penis, the circumciser and the equipment. Conditions of the child include scores at birth (APGAR), presence of

an infection or other congenital anomalies. Conditions of the penis include infection, hernias, buried penis or thick skin etc. The factors of the circumcisers' are history of chronic/acute illnesses, hidden illnesses or general unhygienic states. Condition of equipment contributes to these complications if we are using the wrong size utensils or unsterile equipment. Other problems may arise from how the procedure is performed including poor preparation for surgery, poor cleaning of surgical area, poor surgical technique and poor dressing. Since bleeding is common gentle pressure was advised and sometimes suturing. The bandaging post-op should not be too tight as the child might not be able to urinate or venous and arterial blockade may occur. Removal of the first bandage can lead to bleeding if not removed properly. Therefore before removal the bandage should be softened using mineral oil.

PANEL DISCUSSION: LARGE SCALE MEDICAL ASSISTANCE IN AFRICA: PREPARATION, PROTECTION AND PREVENTION ISSUES AROUND THE MEDICAL CIRCUMCISER

PARTICIPANTS: Professor Zvi Gimon (moderator), Professor Shlomo Maayan, Dr. Karim Diop, Dr. Jacob Adler.

Dr Jacob Adler presented past experience of deployment of medical teams including surgeons to Africa by Israeli humanitarian medical initiatives. He elaborated on the experience of setting up a field hospital in Rwanda with the purpose of giving first aid, emergency surgical services and deliveries to the population effected by the genocide of 1994. Israel was one of the few counties who provided comprehensive medical services in that emergency and fully equipped a field hospital with a staff of 150 surgeons, physicians, nurses, laboratory personnel and others on the ground for several weeks this initiative was coordinated by the Israeli Defence Forces. Dr Adler explained that a ready made military field hospital was well equipped to serve the needs of medical providers under the emergency circumstances in Rwanda and allowed a lot of flexibility and creative improvisation when solving various technical and logistic matters on the ground. This project brought up ample challenges in several areas relevant to the workshop objectives. Medically it was not a surprise that many of the conditions presented by patients were new to the Israeli team comprised of senior experts in their respective fields but had limited exposure to medical problems that present in developing countries. Examples include infections of clinical manifestation and other dermatological conditions including, malaria, schistosomiasis, many do not even appear in textbooks that Israeli medical students learn. The fact that there were no local medical providers from Rwanda was evident. From an ethical perspective there was a need for the Israeli team members to adopt the norms and culture of medical provision in Rwanda. The protection of the health and well being of the medical team was discussed. Following the setting of stage by Dr. Adler the panel elaborated on the importance of developing protocols that include the providers not only the patients being serviced for humanitarian needs. Issues discussed were:

(1) insuring universal protection against common and specific infectious diseases in the country they are travelling too, including provision of enough disposables, malaria nets (for staff members), detergents against various elements (pesticides).

(2) Medical evacuation procedures for the medical team travelling. (3) Managing working conditions to prevent exhaustion. (4) Medicines for specific conditions that would effectively reduce the chance of acquiring HIV –prophylaxis (PEP) needs to be in stock to ensure immediate intervention in the case of risk exposure during medical treatment. The panel discussed ethical issues involved with PEP, since it would only be available to the medical team. The final part of the discussion focused on preparation of the deployed team for their mission. Such preparation should include: pre-deployment training areas including culture, linguistic, traditions and societal norms of the country they will be visiting. Participants agreed that such training would enhance the medical care of the population served significantly.

TITLE: HEALTH SYSTEMS AND MEDICAL TRAINING IN SENEGAL

PRESENTER: Dr. Abdoulaye Bousso

The structure of the health system in Senegal is managed by the Ministry of Health, Prevention and Public Hygiene. The health system follows a pyramidal structure starting from the medical station, medical district, regional hospital and the highest level being the national hospital. To train a medical doctor it takes eight years and surgical specialization takes four years. Senegal has 2 public universities and 1 private university. Training nurses takes 3 years in the public nursing school and includes nursing speciality courses. Private nursing school give a state diploma for a nurse and a midwife. The Medical Association plays an important role in accreditation and in supporting constant advancement of the medical profession. The latest report (WHO, 2004) on health personnel in Senegal indicated 594 physicians and 3,287 nurses and midwives. Medical education lasts eight years and also includes eight months of internship and four months of work in rural areas. Licenses are of two kinds: “A” for physicians practicing in public sector and “B” for those in the private sector. Surgery speciality requires four more years of targeted medical education.

TITLE: TRAINING OF MEDICAL & NURSING PROFESSIONALS IN ISRAEL

PRESENTER: Dr. Zvi Shkolnik

Training of medical doctors in Israel is conducted currently in four medical schools throughout the country with approximately 300 graduates per year. Medical training towards an MD consists of three parts: (1) basic medical sciences for three years, students receive classes on microbiology, anatomy, immunology and a plethora of other courses relating to the basis of the medical profession, communication skills, pharmacology and initial exposure to the clinical settings. (2) During the next three years medical students will have hands on medical exposure in various hospital departments covering all the major specialities in medicine (internal, paediatrics, obstetrics, community medicine ect.) (3) The last year before graduation students will rotate between clinical departments. At this point they already obtain independence in treating and

examining patients, and developing case management practices. In order to graduate students must submit a research project on a topic of their choice. Medicine is a highly competitive field in Israel and most graduates of medical schools move into residency and specialization that could last between 5-7 additional years. Sub specialization in surgery is common, specialists in surgery could obtain training in plastic, paediatric, or cardiac surgery ect. The nursing profession is academic and most nurses work in hospitals and the community after graduating a four years program offered by academic nursing schools often adjacent to hospitals through out the country. Diploma programs are also offered and ease the high demand for nurses. There are specific courses for surgical theatre nurses. The latest report (WHO, 2006) on health personnel in Senegal indicated 25,138 physicians and 42,609 nurses and midwives.

DISCUSSION ON SELECTION OF TEAM MEMBERS FOR FUTURE JOINT DELEGATIONS

CO-CHAIRS: Dr. Eitan Gross and Dr. Serge Ramou Kuadjovi

To achieve optimal circumcision scale up future joint delegations must constitute a dynamic and task specific team. Team members are selected using various qualifications and this. Selection of doctors for training is by their ability to teach and most importantly that they should be a certified General Surgeon. However, there are religious aspects to circumcision where the Mohel, who is more often than not, not a general surgeon, conducts the circumcision procedure. State law in Israel is that a Mohel can circumcise a male child less than six months and if the child is older then only a licensed medical professional must do it. The nurses' role comes in assisting in the surgery and only when performed on adults in a hospital. In Senegal not only surgeons perform circumcision –other clinical speciality doctors such as paediatricians, urologist, and even General practitioners can do it. Integration of traditional circumcisers into circumcision scale up programs is important. In addition the ability of all medical practitioners to perform circumcision must be increased. In Senegal, state law is that a nurse should not perform surgery yet nurses are performing the procedure. For the fear of developing surgical complications the WHO recommends that, circumcision should only be performed by medical personnel. There is also need to have a baseline assessment before scale up begins. Training of trainers, a system of monitoring and evaluation and costing of surgery must be in placed. Teams must be organised to achieve the circumcision goal within a timed period and with good outcomes. Scaling up protocol can be influenced by input of past experiences for example in regard to training, in Swaziland, the doctors observed while assisting in the procedure and then perform under observation by the trainer and finally on his own. Success of the program is determined by level of service provision and by logistical training. At this point the role of Public Health practitioners is to assess the process indicators regarding the number of doctors trained, number of males circumcised and assessment of risky behaviour among clients. In order to assess risky behaviour there is a need to have a public health specialist in the team.

JOINT SIMULATION TRAINING IN MC

HOSTS: Professor Yoram Mor, Dr. Amitai Ziv and Dr. Yaron Munz

Simulation took place at the Israeli Medical Simulation Centre (MSR) located at Sheba Medical Centre in Tel Hashomer, near Tel Aviv. Preparatory work by the host team for this session included three parallel functions: First, studying, analyzing and fragmentizing the MC surgical procedure and anaesthesia; Second, collecting, assembling and displaying multi-media and other medical education materials in the designated simulation surgical theatre room; Third, arranging the actual simulation setup and inventing a simple model of a prepuce that could be removed again and again during simulation sessions. The MSR main surgical simulation theatre was well prepared for the arrival of the joint Israeli-Senegal teams with three 'working stations' arranged with manikins, the necessary surgical equipment, surgeons' gowns and each manikin fixed with the prepuce simulation model. Teaming up for the simulation session, surgeons from each country first reviewed the equipment prepared, the teaching materials and the simulation models. They then dressed up for the procedure just as if they were at a real surgical clinic. The surgeons took turns practising the Clamp method technique on the manikin. Many of the surgeons found this session essential to the workshop. Surgeons were able to sharpen their skills and it was clear that both groups of surgeons were in agreement on how to perform the surgery. In working through the session repeatedly it was clear that despite the cultural differences and levels of available equipment and space, the respective surgeons found it easy to work together and develop their training skills in MC around the simulation models presented. In a review session, participants highlighted the importance of the simulation part of future training workshops in Africa and suggested that any healthcare provider could be easily trained through the protocol under development in performing MC and will then be ready to practice on a human being with supervision. There were some improvements that need to be made on the material that was being used including for the prepuce model: the thinness, flexibility and the way it was attached to the manikin. Manikins in future can be used as part of a pre-deployment program and on the ground in training missions to follow.

MODELS FOR TRAINING HEALTH TEAMS IN MC

PRESENTERS: Dr. Eitan Gross and Dr. Adama Ndir

The major part of this session discussed in detail the experience of OAC in delivering hands on training by international (Israeli teams) in Swaziland. It was suggested, based on experience, that the best way to produce highly skilled local doctors is hands on experience guided by trainers with ample expertise in large scale MC. Three key elements were mentioned as a prerequisite for hands on training in a surgical theatre in Africa:

- (1) good knowledge of the normative guidelines developed by WHO and UNAIDS.

- (2) exposure and understanding of the OAC service delivery model¹³. This could be done through simulation, visits to OAC clinics in Israel and guided lectures using multi media.
- (3) Non surgeons will acquire the skills of performing anesthesia, suturing, and bandaging.

The hands-on training at the specific (or similar) location where MC will be performed by trainees could involve the following scheme: The training course will be divided into four stages. During the first stage two experienced trainers will demonstrate the procedure when one serves as the surgeon and the second acting as the "scrubbed nurse". This could involve 3-4 clients based on the level of the trainees. In the second stage trainees will take the position of "scrubbed nurse" and assist the experienced trainer during 4-5 operations (number depending on the trainee's experience). During the third stage positions change and the trainee will act as the primary surgeon while the experienced trainer will be the "scrubbed nurse". The number of operations performed at this stage will be 5-10 (number depending on the trainee's experience). In the fourth session the trainee will be the lead surgeon performing with a local nurse supervised by the experienced trainer. The number of operations performed at this stage will be 10-15 (number depending on the trainee's experience). Further on the spot training will involve client education, team work and maintaining records of surgeries performed based on set protocol and forms. Both Senegal and Israeli professionals agreed that the above program complies with international standards.

DEVELOPMENT OF PROTOCOL FOR FUTURE JOINT SENEGAL AND-OAC TRAINING DELEGATIONS TO AFRICA

Group Discussion

On the concluding day of the workshop the joint teams from Senegal and Israel reviewed the workshop and paid attention to the interactions and dialogue between the teams throughout the intensive workshop. It was noted by all that despite the differences in background, culture, religion, international exposure and level of experience in male circumcision all team members found the workshop engendered a strong collaboration between participants who were united by a common vision. Any tension concerning the diversity of participants and their respective countries levels of development was eliminated at the onset of the workshop. It was clear that participants

¹³ We believe that much of the "R & D" needed for the successful roll-out of A-MC in Swaziland has been carried out in the context of the extraordinary service delivery to about 100,000 Jewish immigrants to Israel from Former Soviet Union and Ethiopia, beginning in the late 1980's to the present. The experience gained when the State of Israel began providing free adult male circumcision services under local anaesthesia to tens of thousands of men voluntarily seeking MC is now an asset which could be effectively transferred to priority African nations. Following the formulation in 1989 of appropriate policies and implementation frameworks, several dozens of public and private hospitals across Israel were assigned to provide large scale adult male circumcision services in licensed operating theatres. The procedures were performed under local anaesthesia using a prescribed and internationally recommended method. A selected group of surgeons (and several other specialists) were operating routinely on men voluntarily seeking circumcision for various social, religious and other non medical reasons. During the early 90s' a unique system for large scale, safe and swift A-MC was developed, using a team approach. One medical circumciser, often working in parallel on two operating tables, was able to operate on an average on up to 30-40 and more clients a day. This became a model for performing very large scale, high quality, safe and swift A-MCs prevailing to date. Complication rates and adverse events have been documented and are very rare. Scientific publications present data on extraordinarily low complication rates (<1.5%), with no major adverse event and mostly very minor complications (pain, access of bleeding). The expert surgeons and other team members of the Operation Abraham Collaborative are acclaimed trainers in surgery, teaching at medical faculties in leading universities and are experienced in working in international settings.

where joined by the goals and specific objectives of the workshop and understood it as a conduit to the higher goals of developing joint Israeli-Senegal delegations to Southern and Eastern Africa. Participants also identified enabling factors for the fluid collaboration:

(1) A strong commitment to the goals and objectives. A joint Steering Committee worked on the development and implementation for close to six months. Together with Dr. Schenker on the Israeli part of the steering committee, a team of interns supported the daily logistics, preparation and implementation. They were: Raph Mimoun, Jenn Shuldiner, Dr. Norah A. Obudho and Katja Edelman. The Senegal involvement included Dr. Bousso and Dr Ndir with assistants in their respective institutions. The memorandum of understanding signed by all parties and stipulated that when planning for the workshop significant effort will be made to ensure overcoming potential barriers in reaching the goals of the workshop and 2010 plan. All members of the stirring committee made every effort to adhere to this and in the process of constructing the workshop paid close attention to every challenge and found reasonable solutions. This strong commitment was not limited to the steering committee but was also found in all participants.

(2) Both Senegal and Israeli surgeons agreed that the Clamp method should be employed for foreskin removal. Both groups have used the clamp method for male circumcision extensively and are fully versed with it and found it to be the best of all three methods recommended by WHO and UNAIDS. This factor played a significant role in preparing the simulation and the protocols for the joint delegations to southern and eastern Africa.

(3) The workshop benefitted from a high level professional team. Participants were selected based on criteria established beforehand. They were all authorities in their field (surgery or public health), highly experienced and well informed in the area of MC on a global level.

(4) Operation Abraham Collaborative was able to facilitate the workshop as the host institution in Israel and strived that participants should gain maximum benefit from each institution's significant and unique experience in the MC field. For example the Israeli medical simulation center is world-renowned with excellent facilities and staffed with a team of experts. The collaboration with traditional circumcisers exposed the participants to the practices of Jewish and Muslim neonatal circumcision. The Hadassah Ein Kerem University Hospital setting enabled the exchange of knowledge and information using high tech equipment and lecture halls of the institution. On the final day of the workshop participants also split into two groups – public health experts and surgeons. This way each sub-specialty could discuss specific areas that are relevant their professional sphere and share their knowledge, skill and experience discussed at the workshop, summarize and then feed them into future plans. This process initiated the development of two protocols geared towards a 2010 project. Public health protocol included: The training and pre-deployment preparation of teams. Country level preparation includes the public health segments of the project. The surgery protocol includes the techniques that are to be used and an outline to the development and implantation of the joint delegation project in 2010.



Exposure to Neonatal Jewish Circumcision – a Field Visit

Circumcision is a religious event in Judaism – often referred to as a “Brit Milah” (literally covenant of circumcision) that is used to welcome Jewish boys into a covenant between God and the children of Israel. The ritual is performed by a “mohel” (“circumciser”) on the eight day of the child’s life unless it must be delayed for health reasons. A Mohel is a Jew who has been trained in the safety and physical procedures of circumcision and understands the religious significance of the ritual. He performs the ritual with out a clamp and with out anaesthesia since it is felt the procedure is quick. In Israel almost 100% of men are circumcised. Over 52,000 Jewish, Muslim and Christian infants are circumcised traditionally in Israel every year.

Two field visits were arranged for the Senegal participants so that they could learn first-hand on neonatal MC of neonates in Israel. The first visit was hosted by Dr. Pinchas Gonen, a certified Mohel and a medical doctor with specialization in general surgery. Dr. Gonen is widely known nationally as the “Mohel Doctor”. He initiated and manages the largest medical circumcision clinic for neonates, where he performs daily religious circumcisions accumulating to at least a hundred a month.

Dr. Gonen explained the home-hospitality nature of his clinic and the aim to disassociate it from a “purely medical” setup, so that parents feel comfortable and at ease when bringing their boy for the Brit. The leaving room also serves for the post circumcision families ‘celebration, with wine and food. He took the visitors through the process as he conducts the surgery: First, preparation of the equipment. He has his own technique for sterilization of the non one-time-use equipment. Second, examining the baby and interviewing the parents for any contra indications. Third, the surgical procedure is carried out on a special and convenient baby holder at the doctor’s office. A local anaesthetic EMLA cream is used and in using the shield protecting the glands, Dr. Gonen completes the circumcision of the neonate in less than 30 seconds. He calms the crying baby with sweet wine and suggests to the parents feeding the baby before the religious ceremony begins 15 minutes later. During that ceremony, with blessings and prayers, the boy’s name will be announced. Dr. Gonen responses to many questions of the guests from Senegal. He suggests that there are almost no complications seen at his clinic. Most clients who seek his service are secular Jews who wish that their neonate be circumcised and prefer a physician to do it and not a religious (non medical) circumciser. The procedure is done for a fee, which also covers equipment and consumables.

The second visit of the surgeons from Senegal was to a typical religious MC of a neonate in a synagogue in Jerusalem. The Mohel, Rabbi Yehuda Giat obtained a special permission from the family of the baby to have the unusual guests participate. After the event he was kind to show the one-time-kit used by him for the procedure and answer questions they had. The ceremony itself was scheduled for the morning of a week day, exactly eight days after the boy was born. Mr. Giat came after the whole family already convened at the location. He examined the baby and explained to the parents (this was their first born son) about the procedure. When all were ready, dressed in a whit coat the Mohel entered the synagogue main room holding the baby in his hands and singing a prayer. In the centre of the room, on a pre arranged high chair was seating the grandfather holding a pillow. On a side table there were: a disposable circumcision kit, sweet wine and a cotton diaper.

Mr. Giat placed the boy on the pillow, undressed the lower part of the neonate gown and instructed the grandfather how to hold the spread legs. He then cleaned the area, and with the instruments of the circumcision kit completed the operation in 15 seconds. The boy's name was announced and further to blessings and prayers sweet win sucked in from the Mohel's figure and then privately breastfed by his mother calmed the boy.



Dr. Pinchas Gonen demonstrates a religious MC of a neonate performed at a medical doctor's clinic



Rabbi Yehuda Giat, a non-medical Mohel in Jerusalem demonstrates a religious MC of a neonate performed at a synagogue, using a disposable MC kit



Exposure to Adult Jewish Circumcision – a Field Visit

Adult male circumcision has been performed throughout Israel in large number due to the large groups of immigrants who request the procedure. Many of them did not have access to the procedure in their previous countries or had been estranged from Judaism. In the 1990s about 1000 adult male circumcisions a month were performed on newcomers in hospitals and clinics, in accordance with Jewish law. Israel is one of the few countries with vast experience in adult hospital/clinic-based circumcisions. Since 1989 over 100,000 hospital/clinic-based adult circumcisions were performed in Israel - mostly for newly arriving (Jewish) immigrants from Eastern Europe and Ethiopia (age range 6M-94Y). Operation Abraham Collaborative developed a delivery system which could handle very large volume MC conducting the procedure safe, swift, simple and cosmetic. To see OAC in action, the late Dr. Cyril Fine hosted a visit at MERAV Hospital in Bat Yam, near Tel Aviv. The hospital is one of five facilities authorised currently to perform MC. In the past, when demand was much higher, there were at least 15 such facilities throughout Israel.

The visitors from Senegal could see the procedures performed under local anaesthesia on several young men at a hospital facility, which in Israel is the more common place for operating on men seeking MC. Dr. Fine presented his experience and elaborated on the reason for Israel to be a leader in adult MC. He mentioned that during the last decade and a half, over 1 million new immigrants arrived in Israel from the former USSR and Ethiopia. At least 1/3 of newly arriving males were not circumcised. Their desire “to be like everyone else”, resulted in tenth of thousands of these immigrants, in fact close to 100,000, requesting voluntary MC. OAC members were assigned by the government to provide the service. They were able to quickly establish a protocol for MC under local anesthesia that yield 30-40 clients circumcised safely, swiftly and effectively by one doctor through one working day. The cadre of these surgeons, who circumcised individually between 5,000 – 9,000 clients, is the core team of OAC. Dr. Fine himself conducted close to 25,000 MC to date. Most of OAC specialists are also university professors and heads of departments of surgery across the country.



Exposure to STI/HIV Clinic – a Field Visit

To better understand the services provided in Israel for HIV/AIDS prevention and care, several of the participants from Senegal visited the major STI/AIDS clinic in Tel Aviv, operated by the Ministry of Health. The clinic's director, Ms. Yael Gur shared with them the mission of Lewinsky Clinic, its programs and staffing. The clinic caters mostly for the uninsured migrant workers' populations in South Tel Aviv, and has outstanding programs for reaching out to youth, sex workers and marginalised communities in its vicinity. The clinic offers free HIV testing, medical examination and treatment for STIs and counselling.

Social Events

Part of the workshop involved social and cultural events that were offered for the Senegalese participants for whom this was a first visit to Israel. Events included a group tour of Jerusalem, the old city where religious Muslim and Christian sites were visited, tour of the Tuttnauer Autoclave Factory, Yaffo, Masada, Ein Gedi and the Dead Sea. On Friday night, Israeli doctors opened their homes in order to spend the evening with the Senegalese guests and have a Shabbat Dinner experience together. It was a wonderful opportunity to provide a more personal aspect to workshop.

A dinner in Jerusalem hosted by JAIP Chair, Ms. Hanni Rosenberg and Mr. Ran Tuttnauer, CEO of his family's Autoclaves Factory, was another highlight. It also provided an opportunity to acknowledge the hard work of the local organizing committee in making sure the project was implemented effectively.

Before departure, participants had the pleasure of being hosted at the opening ceremony on the Macabia – Jewish Olympic Games, held every two years in Israel.



Mr. Ran Tuttnauer hosting the Senegal delegation at the Tuttnauer Factory near Beit Shemesh.

WORKSHOP REVIEW AND CONCLUSIONS

A debriefing on the last day of the workshop allowed for each participant to express views and feedback and suggest a way forward. The overall reaction to the workshop program, logistics and field visits was extremely positive. Everyone felt that the goals of the project were achieved and that the merger of two groups of physicians from the two countries and three religions (Islam, Christianity, Judaism) into one cohesive, professionally effective, strong team was evident. The following four outcomes were expected:

1. establishment of recruitment criteria for inclusion of surgeons, nurses and public health specialist in future training delegations in MC to Africa
2. the merger of Israeli-Senegal and other international medical circumcisers into a cohesive, professional effective team, facilitated by OAC
3. professional exchange of know-how and protocols in MC between Senegal (Muslim) and Israel (Jewish) professional
4. development of a plan to engage effectively volunteering surgeons from both respective countries as well as others in future training delegations to Africa.

Assessing the accomplishments under each expected outcome, participants in that session concluded:

Outcome 1: An agreement was reached on selection criteria for future delegations of professionals from two fields: surgery and public health. It was agreed that OAC delegations will ideally be composed of 6 participants: four training surgeons (fully licensed and accredited, with a minimum experience of 100 adult MC), and two public health professionals (minimum MPH, focused area of work: HIV/AIDS with ample coordination and project management experience). Pending funding and specific needs of partners in inviting countries – 50% of delegation members in year 1 will be from Israel, and in year 2 - 50% will be from Senegal and other Muslim countries. The OAC website (www.operation-ab.org) will be opened for receiving applications of interested surgeons globally.

Outcome 2: the Israel-Senegal workshop demonstrated that an important resource of physicians with surgical skills and MC experience exists in West Africa, which is predominantly Muslim. Until now no southern or eastern African government, UN agency or NGO tapped into that valuable resource. This initiative brought to light for the first time the opportunity of developing

collaborations with West African providers in MC and this was highly valued and acknowledged by all participants. The workshop demonstrated the similarities in training, practice and approaches to adult MC under local anaesthesia and the relatively simple pathways for enhancing the collaboration towards cohesive, professional effective teams, facilitated by OAC and widening it to other international groups.

Outcome 3: exchanges as were summarised in a previous section of the report are an important lead to a pressing need for further exchanges on MC practice in various cultures and religions through examination of clinical aspects, training of providers and the traditional vs. medical MC dichotomy. Initial discussions on joint publications or scientific seminars did not result in concrete decisions.

Outcome 4: time devoted to this aspect was insufficient to develop comprehensive protocols. Participants discussed the frameworks, time tables and concrete suggestions of how to best use their training expertise and direct service delivery methods in 2010 missions. These ideas were noted by the Steering Committee members who took upon themselves to work together towards development of two elaborated protocols: the first, on teaming up international surgeons for future delegations and describing their exact role as hands-on trainers in courses implemented in countries inviting OAC and the second, on the participation and exact roles of public health specialists on these missions.

Other reflections of participants during debriefing session:

General comments

- “Very happy to collaboratewas thrilled with the option to actually make a model for teaching adult MC. The workshops were very constructive and people were putting in a lot of efforts”.
- “I could immediately see [that]putting surgeons from different countries, ethnic origins and very different life situations together could really work.... we all speak the same [surgery] language.... there were no gaps”.
- “It was very beneficial for the two groups to meet in Israel. From a cultural point of view it was very interesting. I found the group as a whole very professional, enthusiastic about the project and a willingness to work together”

- “It was good to reach an agreement on the surgical protocol - the use of the Clamp method for MC”.
- “The workshop was a great initiative and was a success in bringing together two groups of doctors from such different cultural backgrounds [to exchange and work together]. There was a very nice atmosphere throughout the workshop and I thoroughly enjoyed meeting doctors [from another far away country]”.
- “Very good feeling for the workshop, we have seen that we use the same technique for male circumcision and can work together]”.

Medical Simulation Session

- “There are some elements that need to be changed with the simulation and improving the model: a few features, the thickness of the material and the way we put on the manikins. Simulation is a very important part of the training. It does not replace hands-on a human being, but closes all the gaps in regards to methods and techniques. After practicing through the simulation model and reaching here the level of proficiency required- moving on to human flash [will be with less complications and greater success]”.
- “It would be beneficial to have the manikins with a similar simulation model developed by OAC as a mobile unit in the African countries where we could train”.
- “Other pre deployment simulations we feel are important relate to communication skills. Surgeons in MC need to communicate with patients, pre-operative on the procedure and consent; during the procedure [on risk compensation] and post-operative on healing, follow up, complications that might occur and [HIV/AIDS] prevention”.
- “Simulation session was good, but not a replacement for training on humans under supervision. To properly train a surgeon [in MC] you would still have to watch an experienced surgeon do 5-10 MCs and then practice [as many] under supervision”.
- “The material that was used to simulate the foreskin was still far from reality. It was very stiff and does not fold like a foreskin. It allows you to perform the technical steps but does not give you the feeling of working with a human. It was fine working with the Senegal doctors”.
- “OAC simulation model would be very useful if we were to teach the Clamp method to non surgeons. It would be a very good base to begin training. It does give one the feeling of performing [MC]”.

- “It permitted us to see that there are no difficulties for Senegal and Israeli surgeon to work together in MC. I don't think that simulation will be necessary to prepare future [surgical] delegations for Africa”.



Appendices

Appendix 1: Final Program of the project

TIME	S U N	MONDAY JULY 6TH	TUESDAY JULY 7TH	WEDNESDAY JULY 8TH	THURSDAY JULY 9TH	FRIDAY JULY 10TH	S S A U D I A R I A N D E M A R T I A N
8:30-9:15		HADASSAH EIN KEREM (REGISTRATION)				TEL HASHOMER	
9:15-9:30		WELCOME BY HOSTS AND STEERING COMMITTEE & SETTING THE STAGE FOR THE WEEK AHEAD				DEVELOPMENT OF PROTOCOL FOR FUTURE JOINT SENEGAL AND OAC TRAINING DELEGATIONS TO AFRICA	
9:30-10:00		OVERVIEW ON MC FOR HIV PREVENTION AND INTERNATIONAL SUPPORT FOR SCALE UP/ROLL OUT OF TRAINING AND SERVICE DELIVERY DR. I. SCHENKER		DEPARTURE FOR TEL AVIV THROUGH BEIT HEMESH	OBSERVING MEDICAL COMMUNITY CIRCUMCISIONS (HOST: DR P. GONEN)	CO-CHAIRS	
10:00-10:30		"OPERATION-ABRAHAM": INTERNATIONAL TEAMS FOR MC TRAINING & SERVICE: SWAZILAND PILOT DR. E. GROSS	VISIT TO MALE CIRCUMCISION OF MUSLIM COMMUNITY IN JERUSALEM. TOUR OF JERUSALEM FOR SENEGAL DELEGATION (SUPPORTED BY THE ISRAELI MEDICAL ASSOCIATION, JERUSALEM)		BREAK		
10:30-10:45		BREAK					
10:45-11:15		MOBILIZING NON-CIRCUMCIZING COMMUNITIES: THE CASE OF THE LOU PEOPLE IN KENYA DR. N. OBUDHO		VISIT TO MC CLINIC IN BAT YAM (HOST: DR C. FINE)	VISIT TO STUIDS CLINIC IN TEL AVIV & WITH JEWISH MOEL S	WORKSHOP REVIEW & DISCUSSION ON 2009-2010 WORKPLAN & FUNDING	
11:15-12:00		WHO/UNAIDS/HPDGO MANUAL ON MC UNDER LOCAL ANAESTHESIA: BENEFITS OF THE CLAMP METHOD FOR ADULT MC DR. C. FINE & DR. F. SEROUR				CO-CHAIRS	
12:00-12:45		SENEGAL MC PRACTICES IN NEONATES & ADULTS: PUBLIC HEALTH AND SURGICAL ASPECTS DR. A. NDIR & DR. I. LABOU					
13:00-14:00		LUNCH			LUNCH	LUNCH AT MSR	
14:00-14:30		ISRAELI MC EXPERIENCE IN NEONATES DR. M. WESTREICH	LUNCH AT HADASSAH EIN KEREM	LUNCH AT TEL HASHOMER	OBSERVING TRADITIONAL COMMUNITY CIRCUMCISION WITH JEWISH MOEL(S)		
14:30-15:00		NEW STUDY: COMPLICATIONS IN NEONATAL MC – GLOBAL REVIEW DRs. H. WEISS, N. LARKE, D. HALPERIN, I. SCHENKER	VISIT TO HADASSAH EIN KEREM AIDS CENTER (HOST: PROF. S. MAAYAN)	INTRODUCTION TO MSR AND TOUR PROF. A. ZIV		PERSONAL VISITS (MOSQUE)	
15:00-16:00		PANEL DISCUSSION: LARGE SCALE MC IN AFRICA: PREPARATION, PROTECTION AND PREVENTION ISSUES AROUND THE MEDICAL CIRCUMCISER PROF. Z. GIMMON (MODERATOR), PROF. S. MAAYAN, DR. K. DIOP, DR. J. ADLER	HEALTH SYSTEMS IN SENEGAL DR. A. BOUSSO	JOINT SIMULATION TRAINING IN MC DR Y. MUNZ PROF. Y. MOR DR. E. GROSS	MEETING WITH HIVAIDS NGO REPRESENTATIVES		
16:00-16:30		DISCUSSION	TRAINING OF MEDICAL & NURSING PROFESSIONALS IN ISRAEL DR Z. SHKOLNIK	MODELS FOR TRAINING HEALTH TEAMS IN MC DR. E. GROSS DR. A. NDIR DISCUSSION: CO-CHAIRS			
16:30-17:30			DISCUSSION ON SELECTION OF TEAM MEMBERS FOR FUTURE JOINT DELEGATIONS CO-CHAIRS		SOCIAL EVENING IN TEL AVIV	HOME HOSPITALITY DEPARTURE TIME FROM TLV: 19:15	
01:40: ARRIVAL AT BEN GURION THEN TRANSFER TO JERUSALEM HOTEL							
TOUR OF ISRAEL'S NORTH							
DEPARTURE							

Appendix 2: Biographies of Workshop Participants and Presenters

Dr. Jacob Adler

Is a medical doctor with specialisations in surgery and trauma. For many years he has been the director of the ER at Sharie Zedek Hospital in Jerusalem. He was a senior military officer with the Israeli Defence Forces where he gained experience in mobilizing military hospitals. Former Deputy Surgeon-General of IDF. Among his senior positions he was the Chief Medical Officer of the UN department of Peace Keeping Operations where he developed the guidelines on HIV/AIDS for UN peace keeping forces.

Dr. Abdoulaye Bousso

Is a medical doctor with specialisations in orthopaedic surgery and trauma. He graduated from Cheikh Anta Diop University of Dakar, Senegal. He served as the Head of the Department of Orthopaedics and Trauma in the regional Hospital of Kaolack. He has published various papers and presented in scientific conferences. He is among the leaders of the Senegal Medical Association. Currently he is a senior surgeon at General Hospital Grand Yoff, Dakar.

Dr. Karim Diop

Is a pharmacist, with expertise in HIV/AIDS. He is working at MOH under the HIV/AIDS program and the General Hospital of Grand Yoff of Dakar.

Dr. Cyril Fine (Z"l)

Dr. Fine studied medicine in Johannesburg, South Africa. Before immigrating to Israel, he worked in various hospitals in Johannesburg and as a General Practitioner. In South Africa he was ordained as a ritual circumciser, and performed over 5000 neonatal circumcisions before 1972. In Israel he worked as a family doctor and has also worked as a medical circumciser. He was on the Ministry of Health Committee for overseeing ritual circumcisers in Israel for 14 years. He was Israel's most experienced male adult circumciser with over 20,000 circumcisions performed from 1990 to the present.

Prof. Zvi Gimon

Obtained his medical degree at The Hebrew University of Jerusalem and has worked as a senior surgeon at the surgical department in Hadassah Ein Kerem Hospital until his retirement. Professor Gimon is the current President of the Israeli Medical Association – Jerusalem Branch. He participated in the OAC training mission to Swaziland during Operation Abrahams second delegation (December 2007).

Dr. Eitan Gross

Is a graduate of the Hebrew University in Medicine. He is a senior paediatric surgeon and the current head of the paediatric surgical oncology unit at Hadassah Ein Kerem Hospital. Dr. Gross is the Medical Director of Operation Abraham. He participated in the assessment visits to Zambia and Swaziland in 2006, was a co-leader of OAC pilot project of training in MC with FLAS in Swaziland (2007-8) and is a co-author of papers and presentation on MC and Israel.

Dr. Serge Ramou Kuadjovi

Is a graduate in medicine and general surgery. He is currently working as a general surgeon in the Hospitalier National Pikine in Dakar, Senegal. Dr. Kuadjovi has hands on experience in MC.

Dr. Issa Labou

Is a medical doctor with specialisation in Urology. He is a senior urologist of the Service d' Urologie-Andrologie at the General Hospital Grand Yoff (HOGGY) in Dakar, Senegal. He has wide experience in MC for medical reasons and religious. He is also a member of regional networks of Urology in Africa.

Prof. Shlomo Maayan

Is the director of the HIV/AIDS centre at the Hadassah Ein Kerem Medical Centre in Jerusalem. He is a specialist in infectious diseases with specific qualifications in HIV/AIDS. He is currently leading several international initiatives in training and capacity building for international health care teams in the provision of care and treatment and support to people leaving with AIDS. He has published extensively in this area and is teaching at the Hebrew University Medical faculty.

Dr. Yaron Munz

Graduated medical studies at the Haifa Faculty of Medicine in the Technion. He is a specialist in general surgery and the director of Surgical Simulation at the Israel Centre for Medical Simulation (MSR) in Tel Hashomer, Israel. He is a senior surgeon at the Dept. of General Surgery and Transplantation at Sheba Medical Centre.

Prof. Yoram Mor

Is a graduate in Medicine of the Tel Aviv University. He is a specialist in Urology and currently the Head of Paediatric Urology at the Sheba Medical Centre in Tel Hashomer, Israel. Prof. Mor has extensive experience in Paediatric MC and is teaching urology to residents and students at the Tel Aviv School of Medicine. He published in the area of MC and serves as a leader of the Israeli Urological Association. He was one of the developers of a simulation MC model for the workshop.

Dr. Adama Ndir

Dr Ndir is a medical doctor and a researcher. He is currently M&E coordinator in the AIDS and STI Division of Senegal's Ministry of Health. He possesses vast experience in HIV/AIDS management and has been published in peer reviewed articles. He is the research coordinator of Senegalese sites in the WADA (West African Data Base on Antiretroviral Therapy) Collaboration, which is a unique collaboration among cohorts in West Africa with a mission to conduct hypothesis-driven epidemiological research on the prognosis and outcome of HIV type 1 and 2 infected people. He was also the national coordinator of HIVDR working group in which he implemented HIVDR assessment tools, data analyses and interpretation of results.

Dr. Norah A. Obudho

Received a Bachelor's degree in Medicine and Surgery (MBChB) from the University of Nairobi, Kenya. She has worked with the Ministry of Health of Kenya, International Rescue Committee in Kakuma Refugee Camp, and briefly with CDC Nairobi prior to proceeding to Israel where she is currently pursuing a Masters in Public Health at the Hebrew University of Jerusalem.

Dr. Inon Schenker

Is a graduate in the Public Health and Community Medicine of Hadassah Medical Faculty in Jerusalem, Israel where he obtained his MPH and PhD degrees. He is a Senior HIV/AIDS prevention specialist and has also served as a staff member of WHO in Geneva and UNESCO. He has researched and been published in areas of school AIDS education, health leadership and in male circumcision for HIV/AIDS prevention. He has been the Director of Operation Abraham since 2006. He lead needs assessment mission on MC to Uganda, Swaziland, Zambia, South Africa and serves as a consultant in this field to UN, NGOs and governments.

Dr. Francis Serour

Is a certified Paediatric and General surgeon. He graduated medicine at University A. Carrel in Lyon, France. He is currently the head of the Department in Paediatric Surgery at The E. Wolfson Medical Centre, Holon, Israel. He has participated in numerous MC projects and initiatives. He was a leading trainer of OAC hands-on training of Swazi doctors in adult and infant MC (Swaziland, 2007). He has participated actively in mass MC programs for new immigrants as the surgeon in charge of adult and paediatric male circumcision. He has performed more than 8,000 circumcisions at the E, Wolfson Medical Centre and where he participates in adult and paediatric MC as a general and paediatric surgeon.

Dr. Zvi Shkolnik

Is a general surgeon and *mohe*l with extensive experience in adult and neonatal MC. He is a full time staff member of Clalit Health Services and operates at Hasharon Hospital in Israel. He obtained his medical degree at the University of Tel Aviv Medical School and also holds a Masters of Health Administration from Ben Gurion University. He was a trainer on OAC mission to Swaziland (2008).

Dr. Melvyn Westreich

Obtained his medical education at the Wayne State University in Detroit, where he specialised in plastic surgery. He is the Head of Department in Plastic Surgery at the Assaf Harofe Hospital in Israel, a lecturer of surgery at the Tel-Aviv University School of Medicine and leads several key professional committees on surgery at the Ministry of Health in Israel. He has vast experience in neonatal and adult MC and is a member of a supervising committee that oversees a joint team of traditional circumcisers at the MOH and the Ministry of Religious affairs. He assisted in MC needs assessment missions to Uganda and Swaziland and was lead trainer at OAC training missions to Swaziland (2007-2008),

Dr. Amitai Ziv

Is the deputy director of Chaim Sheea Medical Centre in Israel. He is a combat pilot by training, obtained his MD from Hebrew University of Jerusalem and specialized in paediatrics. He also has a Masters in Health Administration. He leads Israel's Centre for Medical Simulation (MSR) that serves as a tool for improving medical education, risk management and quality assurance.

Appendix 3: Media Coverage

The Senegal – Israel Workshop on *Training Health Care Teams in Scaling-Up Male Circumcision for HIV Prevention in Africa* attracted quite a lot of media attention. It was emphasized as a pioneer effort of bringing together West African (primarily Muslim) and Israeli (Jewish) expertise in MC. Links to Internet websites of publications in several languages are provided below following two complete stories which we believe present comprehensive and generally accurate accounts of this initiative:

Jews and Muslims find a common cut

By Andrew Jack, Financial Times, in London, July 10 2009

A joint interest in limiting the spread of HIV in Africa has triggered a pioneering partnership between Jews and Muslims to share their expertise of circumcision.

Five specialists from Senegal, which is predominantly Muslim, this week, attended a seminar in Jerusalem organised by Operation Abraham, a group of Israeli-based Jewish experts, signalling the start of joint programmes to train doctors across sub-Saharan Africa in adult circumcision.

The action adds African Muslims to Operation Abraham's own efforts over the past two years to train doctors in Swaziland, with other formal agreements already signed with Lesotho and Uganda, and interest from half a dozen other countries.

It comes amid growing evidence that circumcision sharply reduces the transmission of HIV, the virus that causes Aids, while also being culturally acceptable in many African countries at high risk from the infection.

It signals a fresh engagement between the two religions at a time when international public health specialists have tried to accelerate cooperation between different faiths in efforts to better tackle life-threatening diseases including HIV and malaria.

In his previous trip to Cairo and his current visit to Africa, US President Barack Obama has been urged to tap the influence of faith-based organisations to fight malaria. Proponents argue they could offer a fresh way to reinvigorate both American efforts to engage Muslims and tackle a disease where there are few disagreements between the faiths.

Religious and moral sensitivities have in the past limited united efforts to use religious organisations tackle HIV through programmes such as the distribution of condoms or discussion around safer sexual practices. But the shared practice of circumcision offers common ground for Islam and Judaism.

Inon Schenker, one of the organisers, said: "Abraham brought [Jews and Muslims] together with circumcision 3,000 years ago. Now we have opened an avenue for US funding after President Obama's calls in Cairo to bring Islam together with America."

Israel has probably the world's most extensive experience of 100,000 adult male circumcisions since the arrival of previously uncircumcised Jews from the former Soviet Union and Ethiopia in the 1980s.

A delegation of five surgeons and public health specialists from Senegal concluded a four-day workshop on Friday following a formal agreement between Senegal's ministry of health and its medical association with the Jerusalem Aids Project, a backer of Operation Abraham.

The meeting was the culmination of many months of discreet work to build interfaith links between Jewish and Muslim medical specialists keen to apply their skills collectively while seeking to avoid inflaming any political and religious sensitivity.

An Israeli-based Muslim surgeon last year accompanied Jewish specialists on Operation Abraham's third trip to Swaziland, which has one of the highest rates of HIV in the world.

Source:

http://www.ft.com/cms/s/0/6ec305fe-6d77-11de-8b19-00144feabdc0.html?nclink_check=1

Jewish ritual as AIDS prevention tool

By Karin Kloosterman, July 28, 2009



Doctors from Senegal practice Israeli "clamp" circumcision before attempting the procedure on live subjects.

With its vast experience in male circumcision, Israel is leading the training of African doctors in a procedure that could cut the risk of contracting HIV by as much as 65 percent.

It's a Jewish tradition that started during the time of the Bible, with Abraham. On the eighth day of his life, a newborn Jewish male enters into a covenant or brit with God. A mohel, a man trained for the task, skilfully removes the baby's foreskin. Then the celebrations begin.

The origins of the ritual may be connected to its health benefits. Modern medical practitioners recommend circumcisions for male babies in the US because those who have undergone the procedure have fewer infections. More recently, professionals fighting HIV-AIDS have understood that if penises are circumcised, the infection rates and spread of the deadly virus can be reduced.

Last March, based on "compelling evidence," the World Health Organization (WHO) and UNAIDS accepted expert recommendations that adult male circumcision be recognized as an "additional important intervention" to reduce the risk of HIV transmission.

And according to the United Nations, universal male circumcision in sub-Saharan Africa could help prevent about 5.7 million new infections and three million deaths over a span of 20 years.

In a historic first, three doctors from the Muslim community in Senegal came to Israel to learn from the experts how to perform circumcisions. Two health advisors who accompanied them will assist the surgeons in Senegal. The aim is to spread the important message and recruit adult male patients to be circumcised back in Africa, in an effort to prevent the spread of AIDS.

While the custom exists among Muslims, and 13-year-old Muslim males are sometimes circumcised, the practice is not as widespread as it is among Jews, and it is certainly not undergone by Muslims in all the African countries, Dr. Yaron Minz, who heads a unit at the Israel Centre for Medical Simulation (MSR), tells ISRAEL21c.

World experts in adult male circumcisions

MSR, a centre that provides simulation training for surgical procedures, is a partner in the new training program.

Israel, says Minz, is particularly skilled at performing adult male circumcisions. In recent decades, there was a demand for mass circumcisions from adult male immigrants to the country from Russia and Ethiopia. For whatever reasons, the practice wasn't followed in their home countries, but upon arriving in their homeland, the new immigrants opted for the surgery.

A few years ago, teams of Israeli surgeons travelled to Swaziland where they trained 10 Swazi doctors and backup staff to perform the operation quickly and safely with limited resources.

It was after this trip that the idea to bring the local doctors from Africa to Israel for training was born. In a hoped-for cascade effect, the doctors from Senegal should return home and teach their newly acquired skills to their colleagues.

In Israel, those cooperating on the project include the [Jerusalem AIDS Project](#), the Chaim Sheba Medical Centre at Tel Hashomer Hospital, Hadassah Hospital in Jerusalem, MSR and the Israel Urological Association.

"The idea behind this project is to train the trainers," says Minz, who accompanied the guests from Senegal as they toured Israeli hospitals for a week to learn the procedure. Their training included attendance at Jewish brit mila celebrations where they could observe professional mohels at work, he tells ISRAEL21c.

Training the trainers

Of all the sub-Saharan African countries, Senegal has the lowest HIV rates, since more than 95% of males are circumcised. These circumcisions are performed under Islamic law. It made sense for Israeli doctors to offer their training to a country where the practice is already accepted.

Another reason for choosing Senegal is that it has become a model of AIDS prevention for the surrounding countries, where HIV rates climb as high as 40 percent. The aim is to provide the Senegalese doctors with the tools to share their expertise with other African nations.

Hard at work on agreements and protocols for this world's first pilot project, Minz explains that "the next stage is to take younger doctors to go again through a course using [artificial] models." At the unique medical simulation centre where Minz works, surgeons can practice the "clamp" method of circumcision, before trying it out on real patients with local anaesthesia.

"We don't want a surgeon to do it for the first time on a patient. What we want is to train people outside the operating room and to go into aspects of the clinical procedure," he explains.

Learning the skill of circumcision is only one part of the story, says Minz. The Senegal visitors are also learning the art of communication so they will be able to explain the benefits of circumcision from a health point of view and "sell" the procedure to a community of people – possibly the entire African continent – to help persuade them to agree to it.

AIDS cases can be reduced by 65 percent

The plan is to give doctors in Senegal a "boost," Minz smiles. Eventually he'd like to see doctors from around the world going to Africa to assist in the procedure. "It's not like there will be five cases a week. We are working on the masses trying to produce thousands of circumcisions a month."

"We will start with Senegal and hopefully hook interest from other countries in doing the same thing. I don't think the relation to, or the origin of faith or religion is the main issue here. It's AIDS. It's not only for Muslims or Christians, but a procedure to try and reduce AIDS transmission and dissemination," says Minz.

According to information from the Chaim Sheba Medical Centre, adult male circumcision can reduce the risk of male HIV acquisition heterosexually by 65%. Major international health agencies have issued direct recommendations to at risk countries in Africa for the scaling up of male circumcision efforts to prevent HIV infection.

Minz stresses that the project is not motivated by religious reasons. The Muslim community in Senegal expressed its desire to learn this procedure from Israel, but, he says, its benefits will protect people of all faiths in Africa, be they Muslims, Christians, Zulus or non-believers.

The funding of the Senegal doctors was made possible through private donations and donations from the participating bodies. For information about volunteering in Africa or making financial donations contact the Jerusalem AIDS Project.

Source:

<http://www.israel21c.org/social-action/jewish-ritual-as-aids-prevention-tool>

Other Newspaper and Web articles (in English):

- Ynetnews (Israel): [***African Muslim doctors train in Israel***](#)
- Walta Information Center (Ethiopia): [***Israeli, African MDs Share Circumcision Expertise to Combat AIDs***](#)
- UPI (United States): [***Israeli, African doctors combat HIV***](#)
- Financial times (United Kingdom):
- Israelii (Web): [***Israel Trains African Doctors to Fight AIDS***](#)
- Hadassah International (USA): [***Muslim and Israeli Doctors Train together at Hadassah***](#)
- Ustinet News (Web): [***Israeli, African doctors fight AIDS***](#)
- National News (Israel): [***Israeli, African MDs Circumcise to Combat AIDs***](#)

Other Newspaper and Web articles (in Arabic):

- IBA News (Arabic): [***Circumcision for AIDS Prevention***](#)

Other Newspaper and Web articles (in French):

- France (web): [***Circoncision : coopération judéo-musulmane contre le sida***](#)

- Senegal (Business): [Circumcision: cooperation Israel Senegal](#)
- Guysen News (International): [Interview Dr. Serour](#)
- Jerusalem News: [Coopération judéo-musulmane contre le sida](#)

Other Newspaper and Web articles (in Spanish):

Semanario Hebreo (Uruguay, 23.7.2009)

MÉDICOS MUSULMANES AFRICANOS SE ENTRENAN EN ISRAEL

Por Rose Nahmias - De YNetNews

Una delegación de cinco médicos musulmanes de Senegal llegó a Israel para participar en un taller conjunto con médicos israelíes en el Centro Médico Hadassah-Ein Kerem de Jerusalén.

El propósito de la visita es establecer una misión conjunta de médicos que puedan ayudar en la guerra contra el SIDA en África.

Los médicos llegaron al Hadassah para aprender técnicas especiales utilizadas en la circuncisión y practicadas tanto en el judaísmo como en el Islam, con la intención de ayudar en tales procedimientos en África. Ese es a la luz de estudios médicos que revelaron que la cirugía de la circuncisión reduce en un 65% las probabilidades de infectarse con el virus HIV en las relaciones sexuales.

Israel ya envió tres delegaciones a Swazilandia para llevar a cabo circuncisiones, como un proyecto experimental, cuyo propósito es ayudar al continente africano, donde muy pocos médicos están familiarizados con esa técnica.

El éxito logrado llevó a la creación de contactos entre Israel y Senegal, que resultaron en un acuerdo formal de

cooperación entre organizaciones que incluye ocho hospitales e instituciones médicas de Israel, y del lado se-

El taller conjunto fue parte de esa cooperación.

El taller, de una semana de duración, tuvo el propósito

y formar un equipo que en el futuro será enviado al África Meridional y Oriental para prestar asistencia en cirugía.

Estableciendo tendencias

Una fuente dijo a YNet que, "Este tipo de colaboración no existía hasta ahora. Esa la primera vez que hay colaboración en condiciones de igualdad entre musulmanes y judíos, por lo menos en este tema". A pesar del hecho de que la Operación Abraham aporta el trabajo de hospitales y asociaciones médicas israelíes la actual no es una iniciativa del gobierno sino de la sociedad civil israelí.

Antes de que se llevara a cabo el taller varias organizaciones israelíes se habían puesto en contacto con organizaciones médicas árabes y las invitaron a asistir al taller, pero se les respondió con una negativa.

Aún así, los organizadores dijeron que estaban muy satisfechos con la colaboración que está en marcha con África y expresaron la esperanza de que con este paso hayan establecido una tendencia hacia



Médicos senegaleses e israelíes trabajando juntos en un muñeco de modelo experimental.

cooperación entre organizaciones médicas de ambos países: del lado israelí la Ope-

negalés la Asociación Médica Nacional y el Ministerio de Salud.

de establecer un método de trabajo coordinado entre cirujanos judíos y musulmanes

Appendix 4: Contact information

Operation Abraham Collaborative Secretariat

Phone: +972-2-6797677

Fax: +972-2-6797737

E-mail: contacts@operation-ab.org

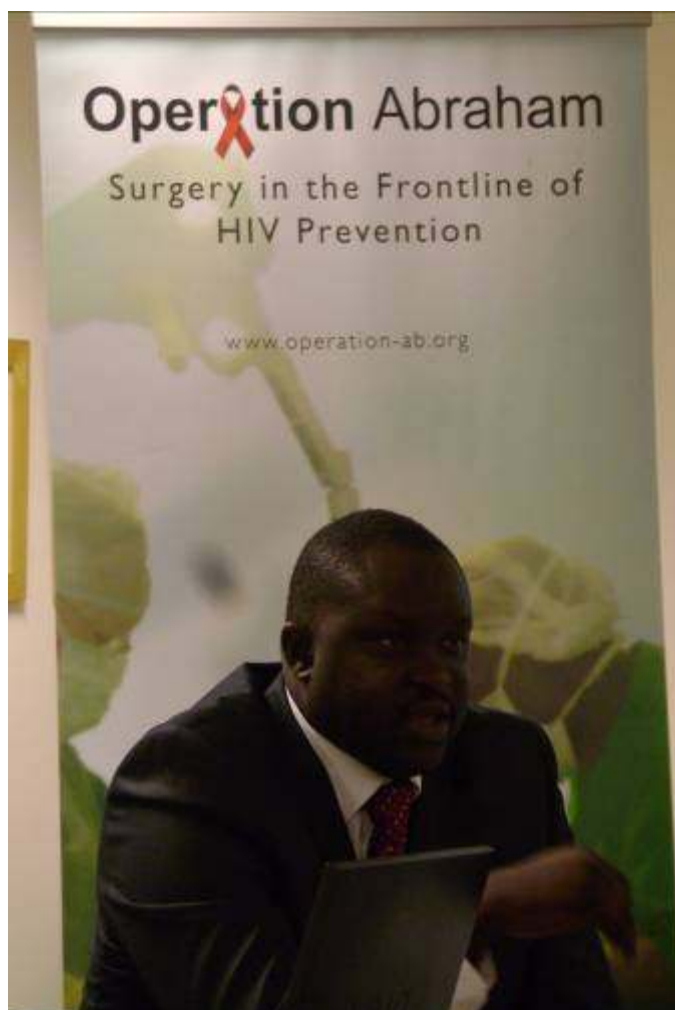
Address:

Jerusalem AIDS Project

4, Eliezer Hagadol Street

POB 7179, Jerusalem 91072, Israel

Appendix 5: Key Web Links for further information (click on title)



[Operation Abraham](#)

[World Health Organization](#)

[Clearinghouse on MC](#)

[CDC \(USA\)](#)

Appendix 6: Photo Gallery

OAC MALE CIRCUMCISION CAPACITY BUILDING IN AFRICA: “OPERATION AB” IN SWAZILAND



OAC MALE CIRCUMCISION SIMULATION MODEL & MANIKINS: SENEGAL-ISRAEL WORKSHOP





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