Country experiences in the scale-up of male circumcision in the Eastern and Southern Africa Region: Two years and counting

A sub-regional consultation

Windhoek, Namibia

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1. Executive Summary

Data from a range of observational epidemiological studies, conducted since the mid-1980s indicated that circumcised men have a lower prevalence of HIV infection than uncircumcised men. Three randomised controlled trials have been conducted which make it possible to separate a direct protective effect of male circumcision from behavioural or social factors that may be associated with both circumcision status and risk of HIV infection. These trials conducted in Orange Farm, South Africa; Kisumu, Kenya and Rakai District, Uganda showed that following circumcision, the incidence of HIV infection in men was reduced by more than half. In Montreux, March 2007, the WHO/UNAIDS recommended that male circumcision be promoted as part of a comprehensive HIV prevention package, and that countries with generalized heterosexual epidemics and low male circumcision rates be a focus for scaling up this intervention.

Several activities have been organized by the United Nations Inter Agency Team (IATT) on Male Circumcision for HIV Prevention since the March 2007 meeting in Montreux including the development of tools and guidance to support governments and other development partners in the implementation of male circumcision for HIV prevention. A number of regional consultations and training workshops have been held.

Two years since the initial United Nations recommendations a sub-regional consultation was held in Windhoek, Namibia from June 9 to 10 2009 with the overall objective of reporting progress, sharing experiences, exchanging ideas and to forge collaborations in the male circumcision efforts. The specific objectives of the meeting were:

- To share country experiences and lessons learnt in the roll out and scale-up of male circumcision.
- To examine the facilitating and constraining factors to implementation.
- To review the tools and guidelines available to support implementation.
- To identify inter-country, regional and global support actions required to strengthen the scale up of male circumcision services.
- To prepare action plans by country for the following 12 months

Sixty-seven participants attended the meeting including government teams representing the Ministry of Health and National AIDS Council from 9 of the 13 focus countries[1]. Participants also included representatives from, non-governmental organizations(NGOs) with expertise in health service delivery, training and communications as well as headquarters and/or regional representatives of the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF).

The country presentations outlined the progress that has been made in scaling up male circumcision programmes, facilitating factors as well as some of the challenges and, that have been experienced in countries.

Progress in Implementation

All the countries represented have made progress towards establishing the necessary conditions to increase the availability of male circumcision services for HIV prevention. The

[1] Botswana, Kenya, Malawi, Namibia, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe

pace of scale up varies across countries. All faced similar facilitating factors, some critical challenges and constraints.

Political commitment has been strong in some countries, with the active involvement of several high-level political figures, including Botswana's former President Festus Mogae and Kenya's Prime Minister Raila Odinga. The support of traditional leaders and elders in Kenya, Namibia and Lesotho has been pivotal. Women's groups have also been actively involved in Zimbabwe. National and community consultations have taken place in the countries to consult with and to gain the support of key stakeholders. Partnerships involving national and local governments, donors and technical support agencies have been created to sustain and accelerate progress. The Male Circumcision Consortium in Kenya and the Male Circumcision Partnership in Swaziland and Zambia are actively supporting the government programme.

Situation analyses have been completed or are under way in all the countries. Kenya has formally adopted national policy guidelines on male circumcision, while Lesotho, Namibia, South Africa, Swaziland, and Zimbabwe all have draft policies. Scale-up strategies have been developed with defined objectives and targets. Botswana and Kenya have already officially launched national strategies, while Swaziland, Zambia, Zimbabwe are developing implementation plans.

The country teams identified some important facilitating factors and lessons learned. Among these are that high-level political support is critical to accelerating scale-up. The leadership of the World Health Organization, working closely with UNAIDS, UNFPA and UNICEF has been invaluable. The tools and guidance developed by the UN Team has provided clear guidance for country programming. The support from funding agencies/mechanisms, PEPFAR, The Bill and Melinda Gates Foundation, and the Global Fund for AIDS, TB and Malaria has enabled countries to move forward. The need to engage key stakeholders, particularly traditional leaders and women's groups at an early stage is critical to the pace of scale-up.

The pace of scale up has varied in countries and all have faced some critical challenges and constraints. Key constraints include: shortage of human resources for programming and for service delivery, difficulties accessing funds to support programming, creating appropriate and effective communication messages (e.g. that male circumcision is not a 'magic bullet' and should be considered as an additional prevention strategy and delivering services in such a way that HIV positive men are not stigmatized); and, the process of getting buy-in from 'gate-keepers' such as politicians and traditional leaders has been a time consuming process.

Box 1. Male Circumcision Scale-up:
Some important lessons learned

- Leadership at global and country level is critical
- Partnerships and coordination reduce duplication
- Consult and engage key stakeholders from the beginning
- Clear tools and guidance are needed to inform programming
- Clear communication is required at all levels
- Funding is needed
- Advocacy and information sharing is an ongoing process

2. Background

Male circumcision involves the removal of all or part of the foreskin of the penis and is one of the oldest and most common surgical procedures worldwide. It is undertaken for religious, cultural, social or medical reasons. Data from a range of observational epidemiological studies, conducted since the mid-1980s indicated that circumcised men have a lower prevalence of HIV infection than uncircumcised men. Three randomised controlled trials conducted in Orange Farm, South Africa; Kisumu, Kenya and Rakai District, Uganda showed that following circumcision, the incidence of HIV infection in men was reduced by more than half.

In March 2007 WHO and UNAIDS convened an expert consultation to review all the evidence for male circumcision for HIV prevention including the data from the randomised controlled trials conducted in Kenya, South Africa and Uganda. Based on the strength of the evidence recommendations were made that male circumcision (MC) should be considered an important new intervention for HIV prevention and should be promoted as part of a comprehensive HIV prevention package. The WHO/UNAIDS conclusions and recommendations on male circumcision for HIV prevention specify that countries with a high prevalence of HIV, low prevalence of male circumcision and heterosexual epidemics should consider the scaling up of male circumcision as part of the comprehensive HIV prevention package. In the Eastern and Southern Africa (ESA) Region, 13 focus countries[2] have been identified by the UN Interagency Task Team (IATT) for technical support to scale up their male circumcision programmes.

[2] Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe.

3. Purpose of Meeting

The purpose of this meeting was to provide a platform for countries to share their experiences in the development and implementation of scaling up male circumcision for HIV prevention programmes and services. The specific meeting objectives were:

- To share country experiences and lessons learnt in the roll out and scale-up of male circumcision.
- To examine the facilitating and constraining factors to implementation.
- To review the tools and guidelines available to support implementation.
- To identify inter-country, regional and global support actions required to strengthen the scale up of male circumcision services.
- To prepare action plans by country for the following 12 months.

Sixty-seven participants attended the meeting including government representatives for Botswana, Kenya, Malawi, Namibia, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. Participants also included representatives from NGOs with expertise in health service delivery, training and communication as well as headquarters and/or regional representatives of WHO, UNAIDS, UNFPA and UNICEF.

Background documents available at the meeting were UN tools and guidance including: New Data on Male Circumcision and HIV Prevention: *Policy and Programme Implications*; *Information package on male circumcision and HIV prevention*; a UNAIDS paper on *Legal and Regulatory Self-Assessment Tool for Male Circumcision in Sub-Saharan Africa*; *Operational Guidance for Scaling up Male Circumcision Services*; *Male Circumcision Quality Assurance Guide* and *Guidance for decision-makers on human rights, ethical and legal considerations*.

4. Session 1: Background and History of Male Circumcision for Prevention Programming

Opening Remarks

Dr Robalo, the WHO representative in Namibia opened the meeting. In her Opening Remarks she highlighted male circumcision for HIV prevention as an important opportunity to show interest in scientifically proven methods to reduce HIV infection. She emphasized that with the evidence from observational studies that HIV was high in low circumcising regions and the now available robust findings from randomized controlled clinical trials demonstrating the protective effect of male circumcision, it was time to put efforts into developing policies and strategies to scale up this intervention. Dr Robalo said the meeting was a reminder that in the face of continuing high rates of HIV infections the question was whether after 2 years the intervention has been implemented at an adequate scale, and if not what were the impeding factors and what was necessary to facilitate scale-up?. She underscored the need to impart a sense of urgency that it cannot be 'business as usual' in preventing new HIV infections and that scale was important within a short time-frame.

Timeline: Summary of Male Circumcision Events

Dr Hankins' presentation summarized the key events in the timeline of male circumcision for HIV prevention over the past few years (See Box 1).

Box 1: Selected Key Dates In the Timeline for Male Circumcision for HIV Prevention

2005
- **March** South African Trial Stopped
- **July** Aids Conference, Rio- Orange Farm Results Press Release
- **October** Male Circumcision Steering Group Formed

2006
- **February** Questionnaires for 15 UNAIDS Country Coordinators
- **November** Nairobi UNAIDS regional consultation on male circumcision
- **December** Geneva WHO consultation on models and approaches

2007
- **February** Kenya and Uganda trials published in the Lancet
- **March** WHO/UNAIDS stakeholder consultation Montreux
- **March** WHO/UNAIDS recommendations on male circumcision for HIV prevention

2008
- **January** Lusaka first Train the Trainers workshop
- **April** Brazzaville Africa Region Consultation
- **June** Mombasa Implications for Women meeting

2009
- **January** Quality Assurance Toolkit published
- **February** MC Clearinghouse launched
- **April** Geneva MC Move meeting
- **June** Nairobi Operations Research meeting
- **June** Windhoek Two Years and Counting Meeting

Dr Hankins explained that a second UN work plan under the leadership of the WHO was developed with the following key objectives:

1. Set global norms and standards and provide policy and programme guidance for the provision of safe male circumcision services
2. Provide technical support for accelerated action to roll out safe male circumcision services in selected countries
3. Develop guidance for the implementation of effective, culturally sensitive male circumcision communication strategies for regions and countries
4. Coordinate the setting of global research priorities, commission research and develop systems for monitoring and evaluation of male circumcision services

UN Tools and guidelines for male circumcision

Dr Kim Dickson gave an overview of the UN tools and guidance that have been developed to support the scale-up of male circumcision for HIV prevention programmes. She outlined that countries have specific needs and different levels of preparedness for the scale up of male circumcision and therefore programme managers will need to consider a range of factors before implementation. To support scale up a range of guidance and tools were developed that countries can use for implementation. Tools and guidance developed include: information for advocacy; operational and programme guidance; training, quality assurance and communications, legal, regulatory and decision making tools. Dr Dickson encouraged participants to visit the Male Circumcision Clearing House website at www.malecircumcision.org. She mentioned that all the materials presented and much more could be downloaded from this site as well as the WHO website.

Discussions

The discussion that followed focused on policy issues and risk compensation. The country representatives had varying views on the necessity of having a specific policy on male circumcision for HIV prevention. Some countries felt that it was a necessary process to have a stand-alone policy to ensure appropriate mobilization of resources to enable rapid scale up. On the other hand, some countries felt that developing a separate policy for male circumcision was a time consuming process, and could potentially create barriers for rapid implementation, as a result they preferred to encapsulate male circumcision in existing HIV prevention policy.

A concern was raised about risk compensation in men who were already circumcised. Current published data from the Orange Farm male circumcision clinical trial did not show that the men in the circumcision arm were engaging in riskier sexual activities such as having more partners than the control arm. Furthermore, modelling studies looking into the effects of risk compensation/behavioural disinhibition showed that at a population level there would be a negligible increase in HIV infections if riskier behaviours were confined to circumcised men and their partners. However, if risk compensation was adopted by the general population, rates of HIV could rise. This highlighted the importance of good communication and the need to get the messaging right about this intervention.

5. Session II: Country Experiences with Scale up: Progress, Opportunities and Challenges

Two years after the release of the 2007 WHO/UNAIDS recommendations, the pace at which the countries have progressed along the path towards scaling up male circumcision has varied. The presentations by the countries that participated at the meeting summarized their progress in scale-up including; the outcome of the situational analysis, the political support, and policy development and implementation strategies and interventions. Additionally the countries summarized some of the challenges and opportunities they faced with the task of implementing male circumcision. It was noted that a high degree of political will at various levels facilitated the progress towards scale up.

Malawi

Presenter: Adrina Mwansambo, National AIDS Commission

The country presentation described that an estimated 12% of adults are infected with HIV and a high proportion (85%) of the population remain unaware of their HIV status. Malawi is a country with a low male circumcision prevalence with only 21% of males circumcised. Circumcision for males is mainly among those people who inhabit the Lake Malawi shoreline districts and it is done for religious and cultural reasons. A male circumcision subgroup headed up by the Ministry of Health (MoH) has been formed. Participants comprise of representatives from national, multilateral and non governmental agencies including National AIDS Commission, World Health Organization(WHO), United Nations Population Fund(UNFPA), The Joint United Nations Programme on HIV/AIDS(UNAIDS), United Nations Children's Fund(UNICEF), Centre for Disease Control, Population Services International and Banja La Mtsogolo(BLM). Malawi is currently conducting a situational analysis, which they expect to complete by the end of August. One of the challenges has been that the Demographic and Health Survey (DHS) conducted every four years had found that in areas with high traditional MC practice, HIV prevalence was also very high. During the discussion session it was highlighted that self-reported circumcision data from the DHS would not capture information on types of circumcision e.g. incomplete or on associated practices such as sharing unsterilized instruments, which could account for the high HIV prevalence in these areas. It was felt that civil society and health facilities should implement interventions together with the traditional providers to ensure safety by addressing issues such as separate blades and access to facilities. Another challenge is that male circumcision is not widely discussed or promoted by health service providers indicating the need for advocacy to target this group. Additional challenges are the capacity of the current health system to cope with the scale up of services. This includes limited human resource capacity as well as insufficiently equipped facilities.

Zimbabwe

Presenter: Sinokuthemba Xaba, Ministry of Health and Child Welfare

Adult HIV prevalence is 15.6% with approximately one third of the population aware of their HIV status. Current male circumcision rates are low at 10%. The MoH is leading the MC scale up efforts in close relationship with the National Aids Council (NAC) and the Zimbabwe National Family Planning Council, which is serving as training centre. Several agencies are involved in the steering committee including civil society, UN Agencies(UNFPA, WHO) faith based organisations, traditional circumcision providers, student movements, and women's activist groups. Three technical working groups have been established and there is a broad

acceptance of male circumcision for HIV prevention and hygiene reasons amongst non-circumcising communities. Traditionally circumcising communities have also been supportive although their concern is that they should still be able to carry on with their traditional practices, which include various rites of passage without interference. Women have expressed concerns about the procedure including the fear of increased risk behaviour by circumcised partners.

A facility readiness assessment showed that all institutions reported a readiness and willingness to scale up MC through an integrated approach. The necessity for the standardization of procedure and training was identified. PSI is currently providing technical and financial support for the initial learning phase of MC for HIV prevention. Members of the Ministry of Health and Child Welfare have attended regional training workshops in Uganda and South Africa to prepare local teams. A male circumcision Trainer of Trainers workshop was held in April 2009 and the provision of services was launched in the same month.

One concern is that services will be overwhelmed by the demand, for example within 2 weeks of starting the roll out of male circumcision, 700 men had asked for services. To date four pilot sites have been established and 140 men have been circumcised in a pilot. The pilot was in one Zimbabwe National Family Planning Commission site over a period of 4 weeks as part of a training of health providers - approximately eight days were spent doing the surgical procedures. Four training sessions have been conducted. Male circumcision is currently being carried out by surgeons with the possibility of task sharing with lower cadres being explored. Another challenge was the financial resources required in order to ensure sustainability of the program, as there is currently no government funding.

Zambia

Presenter: Dr Mary Nambao, Ministry of Health

Male circumcision prevalence is 13.1% and varies across the country with high male circumcision provinces having lower HIV prevalence. A National Technical Working Group headed by the MoH has been formed with the responsibility of scaling up male circumcision services. Partnerships have been established for: service delivery (Population Services International, Centre for Infectious Disease Research Zambia, Family Health International(FHI), Marie Stopes),training (Jhpeigo), communication(Health Communication Partnership), and logistics (JSI, Clinton Foundation). A decision was made at national level that a stand-alone MC policy is not necessary and in 2008 a cabinet memo incorporating male circumcision into the national HIV prevention strategy was drafted and subsequently approved in 2009. An estimated 600000 male circumcisions per annum are needed to reach the target of 50% coverage by 2019. Training of surgeons, clinical officers, nurses and other associated staff has begun with a target of 1200 trained by 2015. Service delivery has been initiated at 11 sites, and the aim is to increase the number of service delivery sites to 300 by 2014. Service providers trained by University Teaching Hospital or Jhpeigo will be assessed for competency and those facilities that meet specified criteria will be given a seal of quality by the Medical council to maintain high standards.

University Teaching Hospital, Lusaka

Presenter: Kasonde Bowa, University Teaching Hospital

The University Teaching Hospital(UTH) has the leading role of providing training for MC delivery. The UTH MC unit was established in 2007 as a training, medium volume service to provide support for the scale up and to conduct research in neonatal circumcision and devices

for surgery. The pilot adult service provision has carried out 300 procedures since it began last November. Overall 2500 male circumcisions have been carried out since January 2009.

Male Circumcision Partnership in Zambia and Swaziland

Presenter: Luka Sakwimba, Population Services International (PSI)

The Male Circumcision Partnership was formed with the objective of increasing the percentage of adolescent boys and men who are circumcised. The aim is to double male circumcision prevalence in Zambia from 15% currently to 32% in five years and in Swaziland, to increase male circumcision prevalence from the current 8.2% to 68%. The goal is to circumcise approximately 642,000 adolescent boys and men in Zambia and Swaziland over five years. To achieve these targets roll out will have to be done in a cost effective manner with minimal adverse events and to share lessons broadly to inform other scale up programmes in the two countries and elsewhere. The partners bring complementary experience and expertise for example PSI (communication and service delivery), Jhpeigo (training), Marie Stopes (service delivery) and Population Council (monitoring and evaluation). A facilitating factor is the strong working relationship between members of the consortium and the Ministries of Health in both countries. In Zambia PSI's four sites have conducted 4000 male circumcisions to date at both fixed and mobile sites.

To tackle the challenge of scaling up male circumcision in settings where there are scarce human resources different approaches are being explored. A franchise model will be used with collaborations are formed with health providers from government, private and non-governmental organisations. For example the Male Circumcision Partnership is currently exploring a collaboration with the Lions Club in Zambia with the goal of supporting them in adding male circumcision to their existing mobile eye surgery programme. In Swaziland a partnership is being explored with Skill Share who regularly bring in volunteer doctors to Swaziland from abroad for long and short-term missions. Additionally, PSI will support the government in recruiting and placing doctors into public sector hospitals to increase capacity to perform MC without reducing clinician time available for other needs. In both countries, church groups with existing clinics and mission hospitals will be important parts of the franchise. To avert risk compensation in circumcised men and to promote safe sex a post-operative text messaging service to encourage clients to return for follow up visits has been launched in Zambia.

Botswana

Presenter: Chiapo Letesedi, Ministry of Health

The prevalence of male circumcision is low at 11.2%. There is strong political commitment with the former President Festus Mogae, endorsing the initiative. In early 2009 a memorandum was approved by the cabinet to include male circumcision in the national HIV policy. The male circumcision national strategy has been developed and its main objective is to reach 80% of 0-49 year HIV negative males by 2014. A key objective is strengthening of the health service to ensure delivery of services. A training curriculum has been established and the training of surgeons, clinical officers, nurses and counselors has started at the central hospital. The aim is to decentralize the training including the involvement of community leaders training a cluster of core trainers. The results from the situation analysis revealed a very high level of acceptability for the scaling up of male circumcision in neonates with more than 90 percent in favour. With strong political backing, strategy, quality assurance procedures, and monitoring mechanisms established Botswana has made very good progress. Some challenges do remain. For example the 1.8 million population is scattered over a large area makes access to services a challenge. Service provision will be at primary health and district levels and the

number of centres will have to increase to deal with the demand. An in-depth assessment of health facilities is underway to identify the needs more precisely. Additional challenges include human resources for the scale up and tackling HIV stigma.

South Africa

Presenter: Cynthia Nhlapo, Orange Farm Bophele Project

A presentation from the Bophele project outlined the implementation of male circumcision in Orange Farm, South Africa. There was no official country presentation. The goal of the Bophele project is to extend male circumcision services to the Orange Farm Community were the Agence Nationale de Recherches sur le Sida(ANRS) male circumcision randomized controlled trial was conducted. Additionally the impact of the MC scale up on knowledge practices and attitudes to MC and behaviour for example condom use and risk compensation and the rate of HIV in that community will be assessed. A community advisory board comprising of local leaders, NGOs, and scientists has been established. Senior male and female community stakeholders are targeted through workshops. Mobile recruitment teams make door-to-door visits and outreach posts within the communities have been set up for HIV voluntary counseling and testing(VCT). Information sessions for the whole community are held regularly highlighting the partial effectiveness of male circumcision and the need to abstain from sex for 6 weeks after the procedure. The response from the community has been good but the challenge has been to match this demand due to scarcity of surgical staff, financial costs and size of the facilities. The cost for each male circumcision has been reduced to approximately US$ 35 per circumcision through the use of a disposable surgical kit, electrocautery and by optimizing the use of personnel e.g. 4 beds per surgical bay. The nurses prepare the patient, anaesthetize, then the surgeon does the cutting and places anchor sutures, a nurse completes the suturing and does the final dressing and bandaging. Each procedure takes 20 minutes and each surgeon conducts on average 6-10 circumcisions per hour. 8300 circumcisions have been carried out to date with a very low adverse event rate.

Namibia

Presenter: Freida Kutata, Ministry of Health and Social Services

Male circumcision implementation is led by a national task force. Results from the situational analysis showed a male circumcision prevalence of 21%. The majority of male circumcisions are carried out by traditional circumcisers, before 13 years of age. Scale up of circumcision provision is widely acceptable across the general population. A draft policy has been submitted to Parliament, which includes task shifting the surgery to nurses (currently only surgeons can carry out the procedure). One of the challenges has been the concern about raising the demand for male circumcision when the facilities are not ready to supply the procedures at that scale. In order to meet the demand additional recruitment and training of staff will have to be done. Furthermore, the cost of the procedure will have to be reduced by moving from the current practice of male circumcision under general anaesthetic to the use of local anaesthetic. The goal is to have volunteers in use in communities for the second phase of the male circumcision implementation.

Uganda

Presenter: Dr Alex Opio, Ministry of Health

Male circumcision has a prevalence of about 25% in the country where it is conducted mainly for religious and cultural reasons. A national task force has been set up headed by the MoH with local and international partners. The task force has enlisted a high level of technical and political support. The situational analysis has been conducted and reveals that approximately 59% of men would seek medical male circumcision. There is a wide range of charges for male circumcision from US$10-US$200. At present there is no legal framework to support male circumcision implementation at scale and there was the sense that a stand alone policy would be needed in order to ensure the mobilization of resources for male circumcision. Challenges for rapid scale up include a shortage of health care personnel and facilities. The next steps towards scale up include developing a stand-alone policy and the training of health personnel.

Swaziland

Presenter: Muhle Dlamini, Ministry of Health/Swaziland National AIDS Program

The country's population of 1million has an HIV prevalence of 26% and an MC rate of 8%. A task team has been formed and a male circumcision policy is awaiting government approval. At present there are about 20 male circumcisions done per month in government establishments and 30 per month in NGO facilities. The cost of the procedure has been estimated to be US$82. A quality assessment process to improve services in government and NGO facilities is underway. Several service delivery approaches are being taken to increase male circumcision including conducting 'male circumcision Saturdays' - campaigns surgeries and integration into a minimum package for sexual and reproductive health services. Female engagement has been high. The establishment of a centre to serve as a model for excellence in male circumcision services has been proposed and it is planned to be fully operational by November 2010. The political will behind MC is strong however challenges remain to meet scale up including human resources, training and facility capacity and a communication strategy to highlight the partial effectiveness of male circumcision and the need to view it as one part of the HIV prevention package.

Kenya

Presenter: Dr Peter Cherutich, Ministry of Public Health and Sanitation

The HIV epidemic has a heterogeneous distribution with the highest prevalence in Nyanza province where male circumcision rates are lowest (approximately 40%). A national task force has been set up which has also been replicated at provincial level to enable local ownership and mobilization of local partners. A male circumcision policy was developed which was initially met with resistance from leaders in non- traditional circumcising communities (Luo communities) concerned about their traditions being interfered with by the law. The wording has been changed from policy to guidance which was considered more acceptable. In Nyanza province a wide ranging consultative meeting was held in 2008 with the rural council of elders but support from the regional political leadership was initially limited. The Prime Minister made a visit to endorse male circumcision scale up which had a positive effect in the region. 124 facilities in Nyanza region are now offering male circumcision with 300 providers trained. The national strategy is for all provinces in Kenya to have an male circumcision prevalence of 80% by 2013. Under the scale-up programme over 20,000 male circumcisions have been done in the past year. Target groups are males 15-49 years and newborn boys. The challenge are the financial resources to reach 750 000 over 5 years.

Male Circumcision Consortium

Presenter: Isaac Oguma, Male Circumcision Consortium

A male circumcision consortium including FHI, Engender Health and University of Illinois has been established with the aim of supporting the national efforts and providing MC research to improve understanding and address misunderstandings about MC. The focus is on Nyanza province. Operations research is being done including questions on changes in risk behaviour after male circumcision, private sector participation and male circumcision by non-physicians. 20000 circumcisions have been done to date. Challenges remain including that now that the MoH has been divided into 2 ministries, consensus from both ministries is required. Advocacy in non-male circumcision communities still remains a challenge.

Male Circumcision scale up by Faith Based Organisations in Nyanza Province

Presenter: Dr Salvador Garcia De La Torre, Catholic Medical Mission Board

Faith based organizations have been delivering male circumcision since 1960s. Twenty four programmes have been implemented in Kenya and 12000 boys have been circumcised. Adolescent boys are circumcised within a family approach to HIV/AIDS prevention and this approach involves parents, grandparents and siblings participating. This event occurs annually during the winter holiday as a rite of passage for boys during which time the targeted community is mobilized. The boys undergo the procedure in operating rooms during the weekends where there are 15-20 operating tables in operation simultaneously. Medical officers conduct the surgery following the guidelines for voluntary medical circumcision. The boys are kept in the clinic for 3 days after the procedure. After they leave the clinic a community event is held where they receive a certificate and pledge to abstain from sex outside marriage. The circumcisions are carried out at weekends as this is a time when the demand on operating facilities is low.

Tanzania

Presenter: Dr May Bukuku

The male circumcision rate in adolescent and adult men is approximately 70% where it is practiced for traditional and religious reasons. There is a wide variation in male circumcision prevalence with regions of low male circumcision having high levels of HIV prevalence. The MoH has set up a task force to implement male circumcision scale up including local and international stakeholders. There is strong government backing for increasing male circumcision services and male circumcision has been incorporated into the national strategy for HIV prevention. A situational analysis to assess service delivery capacity and community acceptability is currently underway and is due to be completed in June 2009. An implementation strategy will be developed using the results from the situational analysis. Pilot sites will be initiated in August 2009. Human resources and facilities are a challenge as well as how to leverage/engage the expertise of existing traditional male circumcision providers.

6. Session III: The Way Forward

Group work: Opportunities, Facilitating factors and Challenges

Opportunities and Facilitating Factors

A major facilitating factor in determining the progress in scale up efforts was political will. Engagement of stakeholders within the communities and having high-level political champions also facilitated the process.

The Leadership and coordination of the UN was also seen as a key facilitating factor. Countries noted that the availability of tools and guidelines to support programming was very helpful in guiding their programming efforts. In many countries MoH leadership and in collaboration with the National AIDs Councils was seen to help move the process forward. Even though many partners where working hard on the ground little progress was made when MoH was not leading the efforts. Countries that had national multi-stakeholder MC Task Forces and focal persons from the onset seemed to make more rapid progress. This structure had been replicated at provincial level in Nyanza province in Kenya and it was clear that this had helped to accelerate progress.

Engagement of key stakeholders in countries with extensive consultations including traditional providers, women and young people increased buy-in and support for scale-up.

Challenges and Constraints

Participants formed three small groups to discuss the main challenges and facilitating factors experienced in the scale up of male circumcision. Several themes of challenges and constraints to scale up emerged. A critical challenge expressed by all the countries present was the scarcity of human resources. Participants felt that while volunteers from other countries could be brought in to bolster male circumcision roll out, this was a short term solution measure and more sustainable solutions also needed to be developed including increasing training and task shifting. In some countries the MC surgery could only be done by a surgeon. Financial resources and physical infrastructure were also challenges to scale up, as well as ensuring a consistent supply of consumables such a surgical kits and ensuring supplies.

The fear of not wanting to increase the demand when it was not being met by the availability of facilities to carry out safe MC was also a concern that was expressed. It was noted that this caution might be crippling progress of scale up.

How to engage traditional circumcisers was identified as another challenge. It is important to maintain engagement with traditional circumcisers and to avoid alienating them and to use this opportunity for promoting safer traditional practices. Traditional circumcision provides status and source of revenue in some settings. Suggestions on how to engage them included educating traditional MC providers on sterile , hygienic practices including blade sterilization or single use blades and how to deal with complications. The participants expressed that guidance from the WHO about traditional male circumcision providers is needed. Community engagement to influence behavioural change was recognized as a challenge. Additionally

context specific messaging to ensure that male circumcision roll out does not result in risk compensation.

Communication was another challenge with various aspects from service setting to specific populations in communities. Community engagement is one important means to influence behavioural change. Context specific messaging to ensure that MC roll out does not result in risk compensation is a challenge for which guidance from the UN is needed. Another challenge was addressing implications for women on rolling out male circumcision. For example, there may be a reduction in women's ability to negotiate condom use. Furthermore, women need to get the right messages in order to avoid the linking of male circumcision status with HIV seronegativity. The issue of HIV positive men was also a challenge on how to scale up male circumcision efforts for HIV negative men without increasing stigma.

Group Work: Next Steps

During a second session of small group work priority next steps and technical needs for male circumcision scale-up during the next 12 months were identified.. Each country's priority steps for the next 12 months are summarized below:

Botswana

- **Human resources.** Current regulations do not allow nurses to carry out the male circumcision surgery making task shifting currently impossible. Additionally there has been some resistance from the nursing profession towards the idea of enabling nurses to carry out this procedure. Advocacy at various levels will be carried out to resolve this is issue.
- **Funding.** Costing of the strategy for scaling up male circumcision has been done and the next step is to source and acquire funding for the implementation.
- **Communication.** It is necessary to review the current prevention communication strategy with the purpose of identifying ways to integrate male circumcision. Consultant support will be required to facilitate this process.

Kenya

- **Monitoring and Evaluation**. The health management information system(HMIS) needs to be updated and expanded to include monitoring and evaluation indicators for male circumcision.
- **Operational Research**. Research into the safety of male circumcision carried out in the context of traditionally circumcising communities needs to be done.
- **Adolescent male circumcision**. An information package to accompany adolescent medical male circumcision needs to be developed.

Malawi

Current challenges include misinformation, lack of engagement of key decision makers and conflicting DHS data. The following needs were expressed:

- **Situation Analysis**. The DHS data needs to be re-analyzed in order to understand the social and technical issues of scaling up male circumcision in the country.
- **Focal person for male circumcision**. Currently there is no focal person for male circumcision and there is an urgent need to fill the post.
- **Advocacy and Communication**. A "Champion" needs to be identified in the Ministry of Health. Additionally a communication strategy needs to be developed which includes high

level advocacy that will respond to any misinformation surrounding male circumcision for HIV prevention.

Namibia

- **Advocacy**. A stakeholders meeting that involves traditional as well as other political leaders needs to be held. Consultant support will be required for this.
- **Communication**. Engaging traditional circumcisers needs to occur. Support will be required.
- Monitoring and Evaluation. A monitoring and evaluation plan for the programme scale up needs to be developed. Support will be needed to facilitate this.

Swaziland

- **Advocacy**. Although the Prime Minister is highly supportive additional high level advocacy to champion the intervention is still needed.
- **Service Delivery**. The country needs to investigate which service delivery approaches are likely to work in the local setting. Consultant support is required for to facilitate this process.
- **Monitoring and Evaluation**. The monitoring and evaluation strategy is currently in draft form and needs to be finalized. Technical assistance is required to finalize the document.

Tanzania

The situation analysis has been slow especially the component on traditional providers. Support in the following areas is needed:

- **Implementation Strategy**. Demonstration sites have been identified but the process on how to move while the strategy is being developed needs to be outlined
- **Advocacy and communication**. An advocacy strategy to disseminate the results from Situation Analysis needs to be developed.
- **Information exchange**. The country would like to learn from the experiences of other countries which have started to roll out male circumcision services. A field visit to other countries is needed this year.
- **Funding**. Funding sources are required and linkages need to be made with the PEPFAR funding cycle.

Uganda

- **Policy**. The policy for male circumcision needs to be finalized. Technical support is required to facilitate this.
- **Implementation strategy**. The strategy needs to be developed and finalised. Technical support is needed for developing the strategy document and to facilitate the use of the Decision Makers Programme Planning Tool.
- **Human resources**. The task force needs to investigate the use of national and international volunteers to alleviate the human resource constraints to scaling up male circumcision.

Zambia

- **Male circumcision coordination**. A focal person/national male circumcision coordinator needs to be appointed.
- **Implementation Strategy**. The Decision Makers Programme Planning Tool needs to be populated.
- **Quality assurance**. The quality assurance tools need to be implemented into the service delivery.

Zimbabwe

- **Implementation Strategy**. The Decision Makers Programme Planning Tool needs to be populated. Consultant support is needed.
- **The male circumcision Policy needs to be finalised**
- **Human Resources**. Human resources shortage is a challenge and the use of external and internal volunteers to ease the shortage needs to be investigated though the preference is the use of local volunteers as this facilitates the retention of local expertise
- **Traditional healers.** Engagement with traditional healers is needed.

Appendix I: Meeting Agenda

Day 1		
Session 1 Chairperson:	**Background and History of MC for HIV Prevention Programming Dr Alex Opio**	
Time	**Presentation Title**	**Presenter/Facilitator**
0800 – 0830	Registration	
0830 – 0845	Welcome and Opening Speech	WHO Representative, Namibia Dr Magda Robalo
0845 – 0915	Introductions	Tawanda Marufu
0915 - 0925	Background, objectives and agenda	Sibongile Dludlu
0925 - 0935	Summary of main MC events/timeline	Catherine Hankins
0935 - 0945	Overview of UN tools and guidance	Kim Dickson
0945 – 1000	Discussion	
1000 - 1030	**TEA BREAK**	
Session 2:	**Country Experiences with Scale up: Progress, Opportunities and Challenges**	
1030 – 1050	MC Scale up in Malawi: Country Presentation	Andrina Mwansambo
1050 - 1110	MC Scale up in Zimbabwe: Country Presentation	Sinokuthemba Xaba
1110 - 1120	Discussion	
1120 - 1140	MC Scale up in Zambia: Country presentation	Mary Nambao
1140 – 1155	University Teaching Hospital support to scale-up in Zambia	Kasonde Bowa
1155 – 1210	Male Circumcision Partnership in Zambia and Swaziland	Luka Sakwimba
1210 - 1220	Discussion	
1220 – 1240	MC Scale up in Botswana: Country Presentation	Chiapo Lesetedi
1240 – 1300	Discussion	
1300 - 1400	**LUNCH BREAK**	

Session 3: Country Experiences with Scale up: Progress, Opportunities and Challenges Chairperson: Dr Kasonde Bowa		
Time	**Presentation Title**	**Presenter/Facilitator**
1400 – 1420	The Orange Farm project overview and video	Cynthia Nhlapo
1420 – 1440	MC Scale up in Namibia: Country Presentation	Frieda Katuta
1440 – 1500	MC Scale up in Uganda: Country Presentation	Albert Peter Okui
1500 – 1515	MC Scale up in Swaziland: Country Presentation	Muhle Dlamini
1515 – 1545	Discussion	
1545 - 1600	Tea	
1600 - 1800	Group work; Challenges and constraints	
1800	**MEET and GREET**	

DAY 2 10 June, 2009		
Session 2 (cont) : Country Experiences with Scale up: Progress, Opportunities and Challenges **Chairperson: Daisy Nyamukapa**		
0830 – 0840	Reflection on Day 1	Kim Dickson
0840 – 0900	MC Scale up in Kenya Country Presentation	Peter Cherutich
0900 - 0915	The Male Circumcision Consortium model of scale up in Kenya	Isaac Oguma
0915 – 0930	A Kenya FBO experience	Salvador de la Torre
0930 – 0950	MC Scale up in Tanzania: Country Presentation	May Bukuku
0950 - 1000	Discussion and group work guidelines	
1000 – 1030	**BREAK**	
Session 3: The way forward		
1030 - 1130	Group Work: Progress, opportunities and facilitating factors	
1130 - 1200	Feedback from groups: Challenges, constraints, opportunities and facilitating factors.	
1200- 1300	Discussion in country groups - Identification of country support needs, planning	
1300 - 1315	Next steps and Closing	
1315 - 1400	**LUNCH**	
1400 - 1500	UN Inter-agency task team meeting	

Appendix II: List of Participants

Country	Name	Organization	Designation
Botswana	Hilda N. Matumo	Ministry of Health Dept of HIV/AIDS Prevention and Care	Principle Health Officer
	Tumisang Mmolotsi	Ministry of Health Dept of HIV/AIDS Prevention and Care	Technical Officer
	Chiapo Lesetedi	Ministry of Health Dept of Clinical Services	Consultant – General Surgeon
Kenya	Peter Cherutich	Ministry of Public Health and Sanitation	Head – HIV Prevention
	Salvador Garcia De La Torre	Catholic Medical mission Board (CMMB)	Senior Medical Technical Advisor
	John Masasabi Wekesa	Ministry of Medical Services	Deputy Director of Medical Services. Head of Surgery
Malawi	Andrina Mwansambo	National AIDS Commission	HIV/AIDS Policy Officer
	Neema Kandoole	Ministry of Health	Deputy Director Preventive Health
	Charles Munthali	Ministry of Health	Medical Officer Kamuzu Central Hospital
Namibia	Frieda Katuta	Ministry of Health and Social Services	National Prevention Coordinator
	Mbayi Kangudie	Intrahealth International	Technical Director
	Dietrich Remmert	Ministry of Health and Social Services/ Global Fund	Senior Community Liaison Officer
Swaziland	Simon Zwane	Ministry of Health	Senior Medical Officer
	Muhle Dlamini	Ministry of Health/ Swaziland National AIDS Progam	MC Focal Person
	S’bongile Mndzebele	Ministry of Health/ Swaziland National AIDS Progam	Monitoring and Evaluation Coordinator
	Nok’thula Mahlalela	Ministry of Health	Health Promotion Officer

Country	Name	Organization	Designation
Tanzania	Mohamed Ally	Ministry of Health and Social Welfare	Medical Epidemiologist
	Pascience Kibatala	Ministry of Health	Technical Focal Person Male circumcision
	May Bukuku	Ministry of Health and Social Welfare/National AIDS Control Programme	Senior IEC/BCC Officer
Uganda	Sam Enginyu	Ministry of Health	Senior Health Educationalist
	Alex Opio	Ministry of Health	Assistant Commissioner Health Services and Chair MC Task Force
	Albert Peter Okui	Ministry of Health	Senior Medical Officer
Zambia	Kasonde Bowa	University of Zambia – University Teaching Hospital	Assistant Dean Head of MC Unit
	Mary Nambao	Ministry of Health	Reproductive Health Specialist
Zimbabwe	Wenceslas Nyamayaro	Ministry of Health and Child Welfare	Provincial Medical Director
	Sinokuthemba Xaba	Ministry of Health and Child Welfare	MC Focal Person
	Mambewu Shumba	National AIDS Council	Planning and Implementation officer

Name	Organization	Designation
Anthony Kinghorn	Technical Support Facility (TSF)	Director TSF- Southern Africa
Isaac Oguma	Male Circumcision Consortium (MCC)	Programme Officer
Kelly Curran	Jhpiego	Director HIV and Infectious Diseases
Jabbin Mulwanda	Jhpiego	Regional Advisor Male Circumcision
Cynthia Nhlapo	Orange Farm	MC Programme Manager
Emma Llewellyn	Nyanza Reproductive Health Society	Project Coordinator
Emmanuel Njeumeli	PEPFAR	Technical Advisor HIV Prevention – Male circumcision
Luka Sakwimba	PSI	Chief Operations Officer Male circumcision program manager
Glenda Stanislaw	FLAS	Unable to attend
Godfrey Kigozi	RHSP	Unable to attend
Banyana Madi	SADC	Unable to attend
Zacch Akinyemi	Social Marketing Association	Unable to attend
Catherine Barasa	UNAIDS Uganda	HIV Prevention Advisor
Sibongile Dludlu	UNAIDS Regional Office South Africa	Regional Advisor Male circumcision
Cate Hankins	UNAIDS HQ	Chief Scientific Advisor
Nicolai Lohse	UNAIDS HQ	Research Officer
Olufemi Oke	WHO Namibia	HIV/AIDS Officer
Jan Anke Dijkstra	WHO Namibia	HIV/AIDS Officer
Kanyanta Sunkutu	WHO Zambia	HIV/AIDS Advisor
Awene Gavyole	WHO Tanzania	NPO – HIV/AIDS
Beatrice Crahay	WHO Uganda	Medical Officer HIV/AIDS

Name	Organization	Designation
S Banda	WHO Zimbabwe	NPO – HIV Prevention
Benjamin Gama	WHO Swaziland	NPO – HIV/AIDS
Eddie Limbambala	WHO Malawi	HIV/AIDS Officer
Esther Aceng	WHO Lesotho	HIV/AIDS Officer
Kgoreletso Molosiwa	WHO Botswana	HIV/AIDS Officer
Rex Mpazanje	WHO Kenya	HIV/AIDS Officer
Tawanda Marufu	WHO AFRO/Zimbabwe	MC Focal Point
Kim Dickson	WHO HQ	Medical Officer
Julie Samuelson	WHO HQ	Technical Officer
Tim Farley	WHO HQ	Scientist – Reproductive Health and research
Bruce Dick	WHO HQ	Medical Officer
Precious Lunga	WHO	Consultant
Agnes Chidanyika	WHO	Consultant
Daisy Nyamukapa	UNFPA Regional Office, Zimbabwe	
Lotta Sylwander	UNICEF Zambia	Country Representative
David Alnwick	UNICEF Regional Office, Kenya	Senior Adviser
Pierre Robert	UNICEF HQ	