



East and Southern Africa Faith Based Organizations Male Circumcision Consultation

Male Adolescent Circumcision for HIV Prevention and as
an Entry Point for Sexual and Reproductive Health:
The Role of FBOs

Brakenhurst Conference Centre
Limuru, Kenya

20-21 September 2007

Meeting Summary Report

*With the technical and financial support of WHO
& in collaboration with UNAIDS, UNFPA & UNICEF*

Table of Contents

List of abbreviations and Acronyms	2
Executive Summary	3
1. Background	Error! Bookmark not defined.
2. Purpose.....	7
3. Participants	8
4. Summary of meeting agenda	8
5. Opening Remarks	9
6. Key Presentations on Male Circumcision, HIV Prevention and Adolescent Sexual and Reproductive Health.....	9
6.1 Male Circumcision, HIV prevention and the UN response. <i>Dr Bruce Dick, WHO, Geneva</i>	9
6.2 New Era for HIV prevention in sub-Saharan Africa. <i>Dr Rebecca Bunnell, Global AIDS Program/CDC-Kenya/PEPFAR</i>	10
6.3 Male Circumcision as entry point to Male ASRH: Feedback from Brainstorming Meeting, Feb 7-8th 2007, Geneva. <i>Ms Helen Jackson, UNFPA CST, Harare</i>	11
7. FBOs experience in providing safe male circumcision services package to adolescents.....	11
7.1 Tanzania: The Christian Social Services Commission (CSSC) Male Circumcision Services. <i>Dr Lumumba Francis Mwita, Catholic Archdiocese of Dar es Salaam</i>	12
7.2 Family Life Association of Swaziland (FLAS) Male Circumcision services. <i>Mr Vusi Norman Dlamini, FLAS</i>	12
7.3 Male Circumcision Services under Christian Health Association of Lesotho (CHAL). <i>Mr Bati Palesa Ramashamole, CHAL</i>	13
7.4 The Status of Male Circumcision in Uganda. <i>Dr Lukwata Hafsa, Ministry of Health, Uganda and Dr Kiswezi Ahmed, Islamic Medical Association of Uganda</i>	13
7.5 Christian Health Association of Malawi (CHAM) Male Circumcision Services. <i>Mrs Desiree Mhango, CHAM</i>	14
7.6 An overview of male circumcision services in Zambia, with reference to Christian Health Association of Zambia (CHAZ). <i>Dr Moses Sinkara, CMMB and Mrs Karen Sichinga, CHAZ</i>	15
7.7 PCEA male circumcision initiative at Kikuyu Hospital <i>Dr. Salvador De La Torre, CMMB, Kenya</i>	16
7.8 The Male Circumcision programme of Methodist Church of Kenya, Kagaa Synod, Meru. <i>Mrs Florence Murugu</i>	17
7.9 The Nazareth Hospital, Banana, Kiambu District Pilot Male Circumcision Programme. <i>Mrs Nkatha Njeri, Nazareth Hospital, Nairobi</i>	17
7.10 The Inter-Christian Fellowship Mission (ICFM), Bugoma District <i>Rev Solomon Nabie, ICFM, Kimili Town</i>	18
7.11. Discussions on Country Experience Presentations	19
7.12. A Synthesis of Country Experiences and Lessons Learnt	20

8. Planning and Implementing Male Adolescent Circumcision Programmes for HIV Prevention and Adolescent Sexual and Reproductive Health	22
8.1. Group 1: Community mobilisation and advocacy in settings where male circumcision is common in order to focus on HIV prevention and ASRH.....	22
8.2. Group 2: Community mobilisation and advocacy in settings where male circumcision is NOT common	23
8.3. Group 3: Curriculum to provide information and develop skills before male circumcision	24
8.4. Group 4: Curriculum to provide information and develop skills before male circumcision	24
9. Priority Actions to Accelerate and Strengthen Action	24
9.1. Key actions in the next six months	25
9.2. Key actions in the next two years	25
10. The Consensus Statement on the Role of FBOs in the Provision of Male Circumcision plus ASRH	26
Appendix 1: Meeting Agenda	28
Appendix 2: List of Participants	31

List of abbreviations and Acronyms

ABC	Abstinence; Be faithful to one uninfected partner; Correct and consistent use of Condoms
ASRH	Adolescent Sexual and Reproductive Health
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Anti-retrovirals
CMMB	Catholic Medical Mission Board
CDC	Centers for Disease Control and Prevention
CHAK	Christian Health Association of Kenya
CHAL	Christian Health Association of Lesotho
CHAM	Christian Health Association of Malawi
CSSC	Christian Social Services Commission (Tanzania)
DFID	Department for International Development
DHS	Demographic and Health Survey
FBO	Faith Based Organization
FHI	Family Health International
HPV	Human Papilloma Virus
HIV	Human Immunodeficiency Virus
JHPIEGO	Johns Hopkins International Program on Obstetrics and Gynaecology
ICFM	Inter-Christian Fellowship Mission
MC	Male Circumcision
MOH	Ministry of Health
M & E	Monitoring and Evaluation
PMTCT	Prevention of Mother to Child Transmission
NACC	National AIDS Control Council
NASCOP	National AIDS and STD Control Program (Kenya)
OVC	Orphans and Vulnerable Children
PITC	Provider Initiated Testing and Counseling
PCEA	Presbyterian Churches of East Africa
PEPFAR	US President's Emergency Plan for AIDS Relief
STIs	Sexually Transmitted Infections
USAID	United States Agency for International Development
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UTH	University Teaching Hospital (Zambia)
VCT	Voluntary, Counseling and Testing
WHO	World Health Organization

Preface and Acknowledgments

Much has been written and presented, recently, endorsing the effectiveness of male circumcision for HIV prevention. Both WHO and UNAIDS have recommended the implementation of male circumcision interventions in places of high HIV prevalence and low male circumcision.

From a faith-based perspective Catholic Medical Mission Board (CMMB) has taken a leadership role in promoting male circumcision for HIV prevention, especially within the context of adolescent sexual and reproductive health. CMMB has also commissioned a study on FBO male circumcision practices in Kenya. This study was authored by Dr. Judith Brown and team. In light of these significant developments, CMMB, with the technical and financial support of WHO, and in collaboration with WHO, UNAIDS, UNICEF and UNFPA, convened the Eastern and Southern Africa Faith-Based Organization Male Circumcision Consultation Meeting, at the Brackenhurst International Conference Center, Limuru, Kenya, on the 20th and 21st of September, 2007. Seventy participants, representing faith-based organizations in Kenya, Lesotho, Malawi, Swaziland, Tanzania, Uganda, Zimbabwe and Zambia attended the gathering. They were joined by international representatives from governments, the United Nations and healthcare NGOs.

Overall, the agenda was aimed at increasing the activities of FBOs in male circumcision as an HIV prevention practice. This was accomplished by highlighting lessons learned, providing specifics of model strategies and producing a joint statement on the role of FBOs in providing safe male circumcision services. The proceedings and outcomes of the consultation are presented in the following pages.

This important collaboration would not have been possible without the efforts of several technical experts, professional colleagues, including the participants, who shared their experiences, lessons learned and best practices. CMMB would like to place on record its special thanks to the WHO team from headquarters and the AFRO region including Drs. Kim Dickson, Bruce Dick, and Brian Pazvakavambwa. Dr. Bruce Dick's constant encouragement, commitment, dedication, and passion for the cause, have been outstanding, and exemplary. Thanks also to Government of Kenya Ministry of Health, the Kenya CDC team, UNAIDS, UNICEF, and UNFPA, for collaboration and cooperation. Thanks are also due to the Crystal Hill Kenya team, and especially to Dr. Chiweni Chimbwete for writing, revising and editing this report. CMMB President and CEO, John F. Galbraith deserves a special mention for his visionary leadership in believing in the efficacy of safe male circumcision for HIV prevention. Sincere appreciation is due to the CMMB Kenya team led by Dr. Salvador de La Torre for their leadership and tremendous support for the successful completion of this Consultation, and for follow-up actions. CMMB would like to thank all those who participated in the logistics, including transportation and accommodation arrangements. CMMB Director of Communications, Barbara Wright, provided support since the planning stages of this Consultation.

The views expressed in the report are a reflection of the discussions held during the meeting, and that they do not necessarily reflect the official position of the collaborating organizations: CMMB, WHO, UNAIDS, UNFPA and UNICEF.

Executive Summary

The Catholic Medical Mission Board (CMMB) with the technical and financial support of WHO and with collaboration of other UN partners (UNAIDS, UNICEF, UNFPA) convened the Eastern and Southern Africa Faith Based Organisation Male Circumcision Consultation Meeting with the theme *Adolescent Male Circumcision for HIV Prevention and as an Entry Point for Adolescent Sexual and Reproductive Health*. The meeting was in response to the evidence on the protective effect of male circumcision for HIV prevention demonstrated by three randomised controlled trials in South Africa (2005), Kenya and Uganda (2007). WHO and UNAIDS recommend the implementation of male circumcision interventions to achieve the greatest public health impact in settings of high HIV prevalence and low male circumcision. These settings are mainly in eastern and southern Africa. The other motivating factor for the meeting is the increased involvement of faith based organisations (FBOs) in male circumcision as an HIV prevention intervention.

The consultation meeting was held on 20 and 21 September 2007 at the Brackenhurst International Conference Centre, Limuru, Kenya. It was attended by about 70 participants representing FBOs from Kenya, Lesotho, Malawi, Swaziland, Tanzania, Uganda, Zimbabwe and Zambia. There were also government, UN and international health NGO representatives with an interest in HIV prevention and adolescent sexual and reproductive health (ASRH). The meeting was officially opened by Dr. Richard Ayisi, Deputy Head of National AIDS and STIs Control Programme (NASCOP) of Kenya, who highlighted the challenge faced by NASCOP to promote safe male circumcision with ASRH in areas where male circumcision is traditionally practiced.

The meeting anticipated the following outcomes:

- 1) *shared experiences and lessons learned* in the development and implementation of adolescent male circumcision initiatives by countries in the region;
- 2) *identified effective strategies of providing safe male circumcision* for HIV prevention and sexual and reproductive health services to traditionally circumcising and non-circumcising communities; and
- 3) *developed a Joint Statement on the role of the Faith Based Organizations* in the provision of safe male circumcision services.

The agenda followed these key outcomes. However, first there were keynote presentations on male circumcision and HIV prevention, ASRH and the international response. The keynote presentations provided an overview of the scientific evidence of male circumcision and HIV prevention expanding over a period of nearly 20 years and the policy and programmatic response of the UN and partners to the evidence; outlined the challenges faced in scaling up current HIV prevention interventions and a discussion on the opportunities, threats, costs and benefits of male circumcision for HIV prevention; and presented the conclusions of a brainstorming meeting on male circumcision and ASRH held in Geneva, February 2007, which was a precedent to this meeting. All three presentations concluded that male circumcision presents opportunities for HIV prevention in sub-Saharan Africa, with resource commitment, effective partnerships involving communities, and leadership by FBOs and others.

A synthesis of the lessons learnt from country experiences identified three key areas that need to be taken into consideration or developed if FBOs want to make a more substantive contribution to providing male

circumcision, both for HIV prevention and as an entry point for adolescent sexual and reproductive health.

- First, it was recognised that *FBOs have a significant role to play in scaling up male circumcision for HIV prevention among adolescents*: they are trusted and respected in the communities; and they already have infrastructure, capacity and networks in the community that could be used to provide male circumcision services.
- Secondly, participants agreed on *priority actions that would need to be undertaken to improve the coverage and effectiveness of male circumcision for adolescents*: a national male circumcision policy framework for guidance; mobilization of communities to improve the acceptability of male circumcision; monitoring and evaluation of existing male circumcision services; and the testing of different models of service delivery, both hospital and community-based, including the use and adaptation of existing programme and technical guidance that are available from WHO and partners, and from countries such as Swaziland and Zambia.
- Thirdly, participants identified *factors to consider when using adolescent male circumcision as an entry point for adolescent sexual and reproductive health*. These included understanding and being respectful of positive cultural norms and practices; being sensitive to religious beliefs; respecting and promoting the rights of adolescents (for example the Convention on the Rights of the Child); clearly defining cost-effective and sustainable male circumcision packages; developing relevant IEC materials; and ensuring that the timing of safe male circumcision is consistent with current practices, for example targeting boys completing primary school during the long school holidays.

Participants outlined the activities to be carried out in planning and implementing male adolescent circumcision programmes for HIV prevention and adolescent sexual and reproductive health.

1. *In settings where male circumcision is common (traditional)*, identify community mobilization and advocacy steps to expand their focus to HIV prevention and ASRH. Actions include: stakeholder meetings and communication that targets traditional circumcisers, church and traditional leaders, and health service providers; the use of written IEC materials, community meetings and entertainment to support male circumcision interventions; and community-wide advocacy activities and resource mobilization to increase the availability and accessibility of youth-friendly safe male circumcision services, in order to increase the uptake of adolescent medical male circumcision.
2. *In communities where male circumcision is not common*, in addition to the above activities special efforts should be made to assess the acceptability of male circumcision, address any myths and misconceptions associated with male circumcision, and present the evidence of the protective effect of male circumcision on HIV infection.
3. Participants outlined the *contents of a curriculum to provide information and develop skills before and after male circumcision*. These include understanding the benefits of male circumcision, personal hygiene, post-surgery wound care, avoidance of high-risk behaviours, gender relations and ASRH.

Participants additionally identified the key actions that need to be undertaken immediately (next six months) and in the longer term (next 2 years) in order to strengthen the capacity of FBOs and partners to provide effective male circumcision services to adolescent boys, and increase the coverage of existing services.

- *Short term key actions:* provide feedback about the consultation to participating organizations; carry out needs assessment, conduct community mobilisation, develop and adapt policy and programming guidelines and tools, mobilize resources and establish a Technical Working Group to operationalize activities.
- *Medium term actions:* develop male circumcision training materials, pilot and scale up male circumcision services integrated within existing programmes, and undertake monitoring and evaluation of the programmes.

It was agreed that CMMB maintain the steering role that it had played in organising the consultation in order to spearhead male circumcision and ASRH implementation in the sub-region.

In their concluding consensus statement on the role of FBOs in the provision of male circumcision and ASRH, participants recommended that FBOs should engage in:

- *Advocating for a National Policy Framework on Safe Male Circumcision*, including the standardization of interventions and procedures;
- *Contributing to the development and implementation of safe male circumcision services for adolescent boys*, within a comprehensive package of interventions for Adolescent Sexual and Reproductive Health, and giving adequate attention to issues related to rites of passage in the target communities;
- *Ensuring that the strategies developed provide adolescent safe male circumcision services that are culturally sensitive.* In addition, ensure that the strategies give adequate attention to the positive values and norms of communities that do and do not traditionally circumcise adolescent boys;
- *Working with other stakeholders to increase adolescents' access to safe male circumcision*, including the Ministry of Health, health care workers, teachers and donors;
- *Providing the adolescent boys who are circumcised with the information, skills and support*, before and after the circumcision, to prevent risk compensation, improve their sexual and reproductive health, and contribute to positive gender attitudes and behaviours;
- *Involving parents and other community members, including girls* as appropriate, to maximize the impact of the intervention and provide effective support for longer term behaviour change;
- *Ensuring that the rights of the adolescents are protected* and their opinions listened to, and that programmes give adequate attention to issues of informed consent and assent;
- *Initiating dialogue with the practitioners of traditional male circumcision* to encourage the adoption of hygienic methods by transforming how the actual procedure is done (by having it done in a modern medical setting), and linking this with the positive aspects of the rites of passage, so that the traditional practitioners may continue to have a role to play;
- *Monitoring and evaluating* the implementation of male circumcision programmes for adolescent boys;
- *Documenting and sharing good practice*, in order to contribute to the development and scaling up of safe male circumcision for adolescent boys for HIV prevention and as an entry point for adolescent sexual and reproductive health.

1. Background

Data from three recently published randomised controlled trials (Orange Farm, South Africa in 2005¹; Kisumu, Kenya in 2007²; and Rakai District, Uganda in 2007³) show that the risk of HIV transmission from women to men during heterosexual sex can be reduced by as much as 60% in circumcised men compared to men who are not circumcised. These findings were reviewed by WHO and UNAIDS and they released recommendations to guide the development and implementation of male circumcision (MC) at country level⁴. WHO and UNAIDS recommend that for maximum public health impact, male circumcision services should be implemented in settings of high HIV prevalence and low male circumcision. Typically, these settings are within eastern and southern Africa.

Faith Based Organizations (FBOs) are present in most countries in sub-Saharan Africa, and on average provide a third to a half of countries' health care services in the subregion, the share being even higher in rural areas. In the high HIV prevalence countries, HIV prevention, care and treatment services currently form a significant part of the services offered through the FBOs health and education networks.

In response to the growing involvement of FBOs in male circumcision programmes, the Catholic Medical Mission Board (CMMB) organized a *Regional Male Circumcision Consultative Meeting*, held at the Brackenhurst International Conference Centre, Limuru, Kenya. The consultation was organized with support from the World Health Organization (WHO) and other UN partners (UNFPA, UNICEF and UNAIDS) and the main theme was *Adolescent Male Circumcision for HIV Prevention and as an Entry Point for Adolescent Sexual and Reproductive Health*

2. Purpose

The goal of the meeting was to define the role of FBOs and agree on the best approaches to providing male circumcision for HIV prevention and as an entry point for sexual and reproductive health services to key target groups in the community.

Three important outcomes anticipated from the meeting were to have:

- i. Shared experiences and lessons learned in the development and implementation of adolescent male circumcision initiatives by FBOs in the region.
- ii. Identified effective strategies for providing safe male circumcision services for HIV prevention and sexual and reproductive health in traditionally circumcising and non-circumcising communities.
- iii. Developed a Joint Statement on the role of the Faith Based Organizations in the provision of safe male circumcision services.

¹ Auvert B, Taljaard D, Lagarde E, et al. (2005) Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. PLoS Med 2(11):e298.

² Bailey C, Moses S, Parker CB, et al. (2007) Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial. Lancet 369: 643-56.

³ Gray H, Kigozi G, Serwadda D, et al. (2007) Male circumcision for HIV prevention in young men in Rakai, Uganda: a randomized trial. Lancet 369:657-66

⁴ WHO/UNAIDS (2007). New Data on Male Circumcision and HIV Prevention: Policy and Programme Implications. WHO/UNAIDS, Geneva.

(See <http://www.who.int/hiv/topics/malecircumcision/en/index.html>).

At the beginning of the meeting participants were asked about their expectations, which tallied well with the original purpose of the meeting. In addition, participants specifically expected to learn how to offer male circumcision services within a faith-based health institution, including associates male circumcision benefits and risks; cost-effective models for scaling up of safe male circumcision services; and updates on the evidence, policy and programming developments for safe male circumcision and HIV prevention.

3. Participants

The Limuru meeting was attended by about 70 participants (refer to list of participants in Appendix 2) representing FBOs from Kenya, Lesotho, Malawi, Swaziland, Tanzania, Uganda, Zimbabwe and Zambia. There were also representatives from government, UN (WHO, UNICEF, UNFPA, UNAIDS); and international NGOs, including Engenderhealth, Family Health International (FHI), the Johns Hopkins International Program on Obstetrics and Gynaecology (JHPIEGO), and PATH. The participants were mainly individuals involved in the management, implementation and coordination of programmes for HIV prevention, with an interest in programmes for young people.

4. Summary of meeting agenda

The programme for the two-day meeting was structured into plenary presentations with time for group work and plenary discussion periods (see Appendix 1 for the agenda). The sessions for the meeting were as follows:

- Overview of the objectives of the meeting, participant expectations and opening remarks.
- Keynote presentations on the scientific evidence of male circumcision and HIV prevention, and Adolescent Sexual and Reproductive Health (ASRH), and the international response.
- Experiences of FBOs in providing male circumcision and ASRH services from countries in the region, with specific examples from Kenya, and a discussion of the lessons learnt.
- Group discussions and plenary feedback on planning and implementing adolescent male circumcision programmes for HIV prevention and adolescent sexual and reproductive health, with a focus on community mobilisation and advocacy, information and skill development, and monitoring and evaluation of programmes.
- Group discussions and plenary feedback on priority actions to accelerate and strengthen action for male circumcision and ASRH within the next two years.
- Development of a Consensus Statement on the role of FBOs in the provision of male circumcision and ASRH.
- Wrap up session to agree on the way forward, and evaluation of the meeting.

5. Opening Remarks

The meeting was officially opened by *Dr. Richard Ayisi, Deputy Head of National AIDS and STIs Control Programme (NASCOP), Government of Kenya*. He highlighted the following:

- The many ways in which FBOs have collaborated with the Ministry of Health to provide health services to the Kenyan population (42% of total health care is provided by FBOs), including: policy formulation, research, health system strengthening, prevention and management of communicable diseases, including TB and AIDS, and work on adolescent sexual and reproductive health.
- The important roles donor and technical partners such as WHO, CMMB, CDC, PEPFAR, UNAIDS, UNICEF and UNFPA have played in providing health services to Kenyans. It was noted that in relation to HIV, support had been provided to get about 162,000 Kenyans on ARVs, and over 800,000 people have been tested for HIV since 2000.
- The importance of the role of FBOs in the provision of safe male circumcision as HIV prevention and as an entry point for young people's SRH, in order to inform the policy development by the Ministry of Health and other key stakeholders.
- Challenge faced by NASCOP: promoting modern male circumcision while ensuring its safety; integrating male circumcision with ASRH in areas that practise traditional male circumcision; and scaling up training of service providers in male circumcision.

6. Key Presentations on Male Circumcision, HIV Prevention and Adolescent Sexual and Reproductive Health

Three presentations were made to provide background information for the meeting. Highlights of the presentations are as follows:

6.1 Male Circumcision, HIV prevention and the UN response.

Dr Bruce Dick, WHO, Geneva

Dr Dick gave an overview of the scientific evidence for male circumcision and HIV prevention expanding over a period of nearly 20 years, and the policy and programmatic responses of the UN and partners to the recent evidence confirming male circumcision as an important HIV prevention intervention.

- Ecological and epidemiological evidence dating back to late 1980s has shown an association between lower HIV prevalence and higher male circumcision. Three randomised controlled trials were recently conducted in South Africa, Kenya and Uganda and completed by December 2006. They all demonstrated a protective effect of male circumcision on the heterosexual transmission of HIV to men by 50- 60%.
- As a result of the evidence from the trials, WHO and UNAIDS convened an international consultation in March 2007 and released policy and programming recommendations on male circumcision and HIV prevention⁵. This consultation had been preceded by a number of preparatory regional and global meetings.
- Country consultations were held in Lesotho, Kenya, Swaziland, Tanzania and Zambia, leading to a regional consultation in November 2006 to share experiences. Global technical consultations were held on strategies and approaches for male circumcision programming (December 2006), social

⁵ WHO/UNAIDS (2007). As above.

science perspectives (January 2007) and adolescent sexual and reproductive health (February 2007).

- At the March 2007 consultation 11 conclusions and recommendations were detailed, covering: partial protection (that it is not 100%), communication, socio-cultural issues, human rights, gender, programming, health systems, resource mobilisation, HIV positive men, and research issues.
- Under the leadership of WHO, UN agencies have developed a work plan whose objectives are: to set global standards and norms; provide technical support to countries, develop communication and advocacy strategies and messages; and coordinate research, monitoring and evaluation of male circumcision services. Other key partners include Bill and Melinda Gates Foundation, Clinton Foundation, JHPIEGO, Population Services International and US government agencies.
- In conclusion, Dr Dick stressed that we have an effective intervention but we will learn by doing as we move from research to practice. There are also many opportunities for male circumcision to make a contribution over and above HIV prevention, such as the ones this meeting is focusing on, namely as an entry point for ASRH.

6.2 New Era for HIV prevention in sub-Saharan Africa.

Dr Rebecca Bunnell, Global AIDS Program/CDC-Kenya/PEPFAR

Dr Bunnell discussed the challenges faced in scaling up existing HIV prevention interventions, and outlined the opportunities, threats, costs and benefits of male circumcision for HIV prevention.

- It is clear that treatment alone cannot stem the AIDS epidemic. Comprehensive prevention delivery has the potential to reduce annual HIV incidence by nearly two-thirds by 2015.
- However, there is low uptake of effective prevention interventions in sub-Saharan Africa: e.g. HIV testing and counselling (knowledge of partner status among couples <5% and PMTCT <11%). Prevention implementation is affected by a number of factors at policy level (e.g. policies, leadership, ideological debates, questions about the evidence-base), implementation level (e.g. no family/couple approaches) and individual level (e.g. 50% of HIV counselors in one study had not tested themselves).
- Despite the skepticism of many people 3-4 years ago, PEPFAR has succeeded in putting 1.1million people on HAART - however, there were 4.1million new infections last year.
- Strengthening HIV prevention will require many things: expand successful ABC programmes, to reduce incidence among youth; universal access to PMTCT, HIV testing and counseling, positive prevention, male circumcision; better understanding of vulnerability and transmission: "know your epidemic" (e.g. in Uganda, in a review of 175 people who became HIV positive in 2005, 65% were married, 26% divorced/widowed and 9% single; while in Kenya, the 2003 DHS shows that 50% of married HIV+ persons had an HIV- spouse).
- Positive prevention is now recommended by WHO and UNAIDS. This supports HIV-infected persons to reduce their risk of HIV transmission, rather than just targeting HIV negative people to avoid acquisition of HIV, which is the primary focus of most prevention programmers (in Kenya, 6% of the population are HIV positive, although this is higher in some regions). Actions include: individual and couple testing, support disclosure, ART provision, PMTCT, STI screening, promotion of leadership by HIV+ individuals.
- Although male circumcision is a proven effective preventive intervention, it is beleaguered by slow policy formulation, lack of resources, socio-cultural factors and individual biases.
- For maximum impact in Kenya, the male circumcision strategy targets high prevalence and low circumcising communities and adolescents, and is developing and evaluating operational models.

In Nyanza, 80% male circumcision uptake would, by itself, reduce adult HIV prevalence from 19% to 10% by 2035. It is cost-effective: it is estimated that 1000 male circumcisions would avert 250 new infections over 20 years at \$200 per infection averted.

- Male circumcision presents opportunities for HIV prevention in sub-Saharan Africa, with effective partnerships providing leadership and resources. FBOs can play a leadership role and work with communities to provide male circumcision.
- In conclusion, Dr Bunnell stressed that we can meet ambitious prevention goals with commitment.

6.3 Male Circumcision as entry point to Male ASRH: Feedback from Brainstorming Meeting, Feb 7-8th 2007, Geneva.

Ms Helen Jackson, UNFPA CST, Harare

Ms Jackson provided feedback from a precursor to this consultation, a brainstorming on male circumcision and ASRH.

- The aim of the meeting was to outline the possible content of a package of ASRH interventions that could realistically be linked with male circumcision, explore approaches and challenges to its implementation, and discuss elements of monitoring and evaluation.
- The benefits and risks of adolescent male circumcision were outlined as: reduce HIV acquisition risk, genital ulcers, penile cancer, and HPV (cervical cancer) in females. Indirect benefits include the opportunity to promote safer sex and positive gender relationships. The risks included too early resumption of sex before healing, and possible risk compensation.
- In addition to a minimum package for male circumcision, an expanded package was also defined, which included information about SRH, and life skills related to relationships, alcohol and substance abuse, and health seeking behaviours. It was agreed that research would be needed to assess the relative benefits of the different packages.
- Issues for consideration in research proposals include: assessing sex behaviour changes and STI prevalence; the impact of different packages; +++safety of traditional male circumcision and the 'socialcision' impact of male circumcision; collaboration with traditional circumcisers to maintain the positive teaching of rites of passage; costing of packages; stigma; involvement of other partners, including the involvement of women and girls.
- In conclusion, it was noted that although there are many issues to be resolved, adolescent male circumcision is an opportunity to reduce HIV incidence and research is needed to identify cost benefits and outcomes of using male circumcision as an entry point for ASRH.

7. FBOs experience in providing safe male circumcision services package to adolescents

One of the objectives of the meeting was to share experiences and lessons learnt in the development and implementation of adolescent male circumcision initiatives carried out by countries in the region. Participants prepared presentations on the adolescent male circumcision services in their countries. The presentations described: who the target population was; the package of male circumcision services offered; who provided the services and the extent of involvement of parents and other community members; and programmatic issues such as the availability of programme support tools, approaches to monitoring the impact of male circumcision on HIV infection, and strategies to increase the numbers of safe male circumcision. There were varied levels of experience and development of safe male circumcision services in the region, with Kenya generally being more advanced than the other countries

participating in the consultation. However, all services had programmatic weaknesses. Below is a summary of the country experiences, with specific FBO experiences from Kenya:

7.1 Tanzania: The Christian Social Services Commission (CSSC) Male Circumcision Services.

Dr Lumumba Francis Mwita, Catholic Archdiocese of Dar es Salaam.

- The Christian Social Services Commission (CSSC) is an Ecumenical umbrella body that coordinates and facilitates the delivery of social services in Tanzania, including health care services. The CSSC brings together 603 health care facilities in Tanzania, which along with other FBO-run facilities provide about 41% of all health care services in the country, 56% of service in the rural areas.
- The HIV/AIDS strategy for CSSC is to contribute to the national goal of overall reduction of HIV by 30% by 2010 through partnerships, lobbying and advocacy in a manner that will ensure transparency, quality, availability and accessibility of services with compassion and love of Christ.
- The overall prevalence of male circumcision in Tanzania is generally high, although it remains low in some regions. The country has a goal to reach 80% male circumcision for HIV prevention coverage by 2010.
- CSSC is a partner in working to reach this goal, and its role includes: training of different cadres of service providers, developing and implementing a male circumcision communication strategy, and developing operational monitoring and evaluation systems.

7.2 Family Life Association of Swaziland (FLAS) Male Circumcision services.

Mr Vusi Norman Dlamini, FLAS

- FLAS, an NGO founded in 1979, provides SRH information and services targeting youth (10-24 years) in collaboration with other partners such as PSI, Church Forum Against HIV and AIDS. FLAS has two static centres and provides outreach services in four communities. Swaziland is a country without a culture of male circumcision.
- The FLAS–MC pilot project was begun in January 2006, funded by USAID/PEPFAR, as part of project to provide ASRH services, with the 12 – 24 year old males being the primary target and those 25 years and older being the secondary target group. The objectives of the project were to improve the knowledge and use of SRH services, and change attitudes and promote safer sexual behaviour, with the aim of having an impact on preventing STIs and HIV. A baseline survey was conducted in March 2006 and a follow up survey is planned for 2008, with WHO support.
- In line with the expected project outcomes, in 2006 more than 300 males were circumcised, 60 doctors were trained on male circumcision, a communication campaign about the services was started, and programme support tools were developed. The tools include data collection forms, consent forms, post-operative care instructions, IEC material and posters promoting male circumcision along with abstinence and faithfulness.
- The FLAS male circumcision service package includes standard surgical procedures, VCT and treatment of STIs.
- FLAS's community outreach programme uses a range of media to give health talks and provide information.
- *Remarks on the FLAS male circumcision programme:*
 - *Strengths:* FLAS has a niche in peer education and youth friendly SRH services, and is involved with the media.

- *Challenges:* lack of resident doctor to provide male circumcision services, high cost of male circumcision (\$45 for those below 24 years and \$75 for older men), clients are unwilling to use VCT services, fear of pain by young men, and low parent-son communication on sexuality.
- *How to best reach adolescents:* school outreach, sensitise parents through church, school and community meetings, make male circumcision services more available during school holidays, train more youth-friendly staff and reduce cost of MC.

7.3 Male Circumcision Services under Christian Health Association of Lesotho (CHAL).

Mr Bati Palesa Ramashamole, CHAL

- Knowledge and practice of medical male circumcision for HIV prevention is still very new in Lesotho, and has hardly spread to the rural areas where the majority of Basotho people live and practise initiation rites.
- There are Adolescent Health Centres/Corners operated nationally by CHAL, offering a wide range of adolescent sexual and reproductive health services: family planning, testing and counseling (in schools and villages), orientation of adolescents on puberty, and antenatal services for young mothers. The target age group is 10-25 years, and mostly students in secondary schools.
- Male circumcision is done at hospitals as a minor procedure in out-patient departments. The Adolescent Health Centres have not been specifically promoting male circumcision. A small number of males who never went to initiation schools have been demanding male circumcision services.
- Within CHAL hospitals male circumcision is provided only by doctors. Counseling, testing and provision of family planning services are done by nurses.
- CHAL works in partnership with Ministry of Health and Social Welfare and other UN partners to provide IEC materials on HIV and AIDS. CHAL reaches out to communities at churches and schools. Parents are not directly involved.
- Remarks on male circumcision services in Lesotho:
 - *Challenges:* There is lack of information on male circumcision as a preventive measure for HIV transmission; no resources have been yet committed to male circumcision; male circumcision is expensive when done by private practitioners; and there are rumours that male circumcision reduces sensitivity of males during sex.
 - *Opportunities to increase number of adolescents reached:* need to strengthen communication on protective effect of male circumcision for HIV; link initiation schools and hospitals to provide medical male circumcision; revive Adolescent Health Corners to become actively involved in male circumcision; and have youth friendly medical officers for the centres.

7.4 The Status of Male Circumcision in Uganda.

Dr Lukwata Hafsa, Uganda Ministry of Health, Dr Kiswezi Ahmed, Islamic Medical Association of Uganda

- In Uganda male circumcision is practised by only about 20% of the population, mainly Moslems, but also the Bamba (1%), and the Sabinu and Bagishu (3%) tribes. Muslims circumcise neonates, while tribal circumcision targets adolescents. There has been increased demand for male circumcision, especially for adolescents, due to the recent trial in Rakai which demonstrated the effectiveness of male circumcision in reducing the risk of female-to-male heterosexual HIV transmission.
- A standard package of male circumcision surgical services is offered by FBOs. Male circumcision is provided by trained clinical officers, medical officers and specialists. For post-circumcision care clients are given antibiotics and pain killers (post-surgery antibiotics are standard practice in

Uganda, but this may not be necessary for scaling up male circumcision). Parents are required to give consent for minors under the age of 18 before male circumcision.

- The peak time for male circumcisions is during the long school holidays (December to February). Up to 20 circumcisions are performed per day in the large centres, and up to 6 in the smaller health centres.
- *Remarks on male circumcision in Uganda:*
 - *Strengths and opportunities:* the government is supportive of male circumcision services for HIV prevention and there are health centres that can perform it; there is confidence among the public that they can access safe male circumcision services.
 - *Challenges:* need to intensify communication strategies, through media and schools, to address negative information regarding male circumcision, such as: fear of pain, infection and loss of sexual pleasure.
 - *How to reach more adolescents:* make available more IEC materials on male circumcision; male circumcision is currently expensive and needs to be provided at low cost if it is to become a public health intervention for HIV prevention; and traditional circumcisers need to be trained on safety of the procedure by having it done in a modern medical setting.

7.5 Christian Health Association of Malawi (CHAM) Male Circumcision Services.

Mrs. Desiree Mhango, CHAM

- Malawi, with a population of 12 million, has a male circumcision prevalence rate of 13%, mostly in four districts dominated by Moslems, and the Yao and Lomwe ethnic groups. Malawi is predominantly Christian, although 20% of the population are Muslim.
- CHAM brings together catholic and protestant health providers, and manages 170 health facilities and 10 health training institutions in Malawi.
- CHAM runs a small-scale (so far 100 young males) male circumcision programme targeting boys aged 10-18 years during their rite of passage to adulthood. The peak for male circumcision is during school holidays between June and July; which helps avoid disruption with schools.
- Selected health centres offer male circumcision, and there are efforts to increase their number. FBOs are also increasing efforts to collaborate with traditional circumcisers to provide safe medical male circumcision for initiates.
- During tradition male circumcision parents take their sons to a camp of temporary shelters under the charge of initiators. Male circumcision is performed without any anaesthesia in the bush, as a proof of masculinity.
- FBOs are now teaching young people on sexuality, promoting AB, accepting condom use in discordant couples, and advocating for the development of a male circumcision policy by government.
- *Remarks on male circumcision in Malawi:*
 - The Government has not yet developed a policy on male circumcision. More consultations are needed with FBOs. The National AIDS Commission is currently coordinating a situational assessment on male circumcision in Malawi.

7.6 An overview of male circumcision services in Zambia, with reference to Christian Health Association of Zambia (CHAZ).

Dr Moses Sinkara, CMMB and Mrs Karen Sichinga, CHAZ

- The population of Zambia is about 10.3 million, and the national HIV prevalence is 16% (urban 25% and rural 13%). Only about 20% of the Zambian male population has been circumcised, mostly for traditional reasons and especially in the North Western Province. HIV prevalence among the circumcising areas is 9%, lower than in other areas.
- The Christian Health Association of Zambia (CHAZ) works with about 400 FBOs and coordinates 135 health institutions in the country, providing about 30% of total national health care service. CHAZ positions male circumcision as a biblical requirement, in order to make it acceptable among Christians.
- Demand for male circumcision is increasing due to its demonstrated protection against female-to-male heterosexual HIV transmission, and largely because of a male circumcision pilot project conducted by Johns Hopkins University Institute of Public Health (2003–2005). Currently JHPIEGO has developed guidelines on male circumcision and reproductive health which are being used at some hospitals in Lusaka (University Teaching Hospital- UTH) and Livingstone.
- The national strategy for scaling up male circumcision services is expected to take a phased approach: a rapid assessment to gauge the expected demand and feasibility of scale-up; development and distribution of male circumcision guidelines and minimum standards, including the certification of service provider institutions; establishment of male circumcision services at health facilities, including training of health care staff; and the development of communication guidelines to help communities make informed decisions about male circumcision.
- Male circumcision services are performed by medical officers, clinical officers and nurses. JHPIEGO and UTH have been training service providers. A manual on male circumcision surgical procedure has been developed in conjunction with WHO⁶. Within the CHAZ programme in NW Province, some service providers performing male circumcision received their training from JHPIEGO/UTH; some traditional circumcisers continue to perform circumcision.
- Almost 90% of male circumcision clients are in the 15 to 35 year old age group, and to date over 300 persons have undergone the procedure. The age of consent for male circumcision is 21 years; however, there are plans to lower this to 16 years, the age of consent for HIV testing.
- CHAZ has targeted the traditional circumcisers for AIDS education and infection control since the late 1980s in the North Western Province. The male circumcision procedure is done in select church health institutions and demand for the service is rising. For example, at Mukinge Mission Hospital the total number of male circumcisions performed in 2006 was 54, and increased to 69 in the first seven months of 2007.
- A number of tools are being developed. JHPIEGO has developed a communication tool on male circumcision (this was shared with participants). The demand for circumcision is coming from males from a wide range of ages, and so far there has not been deliberate effort to target parents in order to generate demand. The strategy is to integrate male circumcision services into reproductive health services with particular focus on adolescents.
- *Remarks on male circumcision in Zambia:*

⁶For more details see WHO, UNAIDS and JHPIEGO (2007) Manual on male circumcision under local anaesthesia (<http://www.who.int/hiv/topics/malecircumcision/en>)

- *Strengths and opportunities:* male circumcision is acceptable across all groups; the health benefit is the main motivating factor for male circumcision; there is donor interest to fund programs (PEPFAR, WHO, DFID).
- *Challenges:* human and physical resource limitations with increasing demand; lack of policy and guidelines; long-term sustainability of male circumcision programmes.
- *How to increase number of adolescents reached:* clear policy; community mobilization backed with services provided as part of HIV and reproductive health services; provide surgical instruments and materials for male circumcision.

7.7 PCEA male circumcision initiative at Kikuyu Hospital

Dr. Salvador De La Torre, CMMB, Kenya

Dr Salvador briefed participants on a male circumcision rite of passage model coordinated by the Presbyterian Churches of East Africa (PCEA) Kikuyu Hospital.

- This is an eight-day resident programme that targets boys aged 12-16 (a local school is used to accommodate the boys). The first day is dedicated to giving of information to the initiates on the circumcision procedure, personal hygiene, risks of substance abuse, and the need for abstinence.
- Male circumcision is performed by trained male clinical staff on the second day and the initiates are advised on post-operative pain and infection management.
- The fourth day, which is usually a Sunday, is a family day, when the initiates and their family have devotion sessions. This includes girls who on this day visit and entertain the audience and role play on life skills, focusing on abstinence.
- For the next three days a number of facilitators educate the boy initiates and girls on a range of topics including HIV prevention, sexual and reproductive health, the dangers of alcohol and substance abuse, family and community values, and responsible adulthood.
- The eighth day is the graduation day, when both boys and girls make a public pledge to abstain from sex until marriage. Certificates are issued and the initiated boys are given an age-group name and are taken home by their family or a member of the local community who the family has selected as a guardian.
- After three months the project team meets with the parents of the boys to obtain feedback on how the boys are doing. This ensures that there is continuous learning and support for long term-term behaviour change.
- *Remarks on the project:*
 - *Strengths:* The project is widely supported by the community since the model is rooted in tradition, culturally-acceptable, respectful of community practices and traditions, and it is replicable in other communities. The project provides a package that includes education and mentoring support with the male circumcision, in order to reinforce behaviour change.
 - *Challenges:* the male circumcision season is once a year and short (late December to early January), just after the primary school final exams. It is a challenge to circumcise large numbers of boys (1400) within this short period. There is no follow-up with the boys following the circumcision. The cost (\$20 surgery plus \$40 education) is too high for some parents, although because male circumcision is part of the culture, the parents generally cover the costs.

7.8 The Male Circumcision programme of Methodist Church of Kenya, Kagaa Synod, Meru.

Mrs Florence Murugu

This presentation was another case study of collaboration of FBOs, health workers and community in providing a safe male circumcision and life skills package to adolescents in a setting where male circumcision is the norm.

- The safe male circumcision programme at Kaaga Synod of the Methodist Church of Kenya is a three-week resident programme. It was started by the Men's Fellowship, targeting boys aged 12 to 18 years old. Parallel to this programme, the Women's Fellowship group started a *'Women of Integrity Programme'* aimed at empowering the girl-child with appropriate life skills to better face life's challenges.
- Prior to the resident male circumcision event, there is community and resource mobilization to ensure that every candidate has the needed \$90 for the procedure and the surrounding activities.
- On the first day the boys are provided with accommodation at a school facility, with a mentor who prepares them for the procedure and teaches the initiates life skills, culture, Christian values, and the importance of continuing with their education.
- The circumcision procedure is done by volunteer health providers. The boys stay in camp for three weeks until the wound is healed, under the supervision of a guardian, and are inspected by health workers. During this period the boys are trained on discipline, morality and the importance of pre-marital abstinence.
- *Remarks on the project:*
 - *Strengths:* there has been commitment and support from the church and community for the programme; there are an increasing number of boys undergoing medical circumcision compared to traditional circumcision.
 - *Challenges:* the \$90 fee is unaffordable for some parents; there is too high demand during the circumcision season (the school holidays after the Standard 8 exams); cultural beliefs that favour traditional male circumcision and underrate medical circumcision; lack of programme support tools and no follow up of initiates due to lack of funds, especially OVCs.

7.9 The Nazareth Hospital, Banana, Kiambu District Pilot Male Circumcision Programme.

Mrs Nkatha Njeri, Nazareth Hospital, Nairobi

The pilot project was conducted in December 2006 and performed 209 procedures in an area where male circumcision is traditionally practised.

- This was a five-day resident project in a hospital ward. The cost was \$50 per client, and this was paid by well-wishers from America. The target beneficiaries were needy 13-15 year old boys who had just sat their Standard 8 exams.
- The programme tried to maintain a balance between safe traditional practices, for example songs and dance, and the provision of safe medical circumcision. The teachings address morality, mentorship and HIV-related issues.
- The boys are prepared for the procedure and given information on positive behaviour change. The circumcision is performed by an all-male medical team, including the support staff, in respect of the culture of the community. The boys spend the second day recuperating.
- From the third day to the fifth day a number of facilitators who are respected personalities from education, business and the community conduct mentorship teaching. The young people are also shown videos entitled *'Shoulder to Shoulder'* and *'Women of Works'* aimed at empowering boys and girls on gender-specific life skills.

- On the fifth day the boys have a graduation ceremony, with celebration through song and dance, presided by a church pastor. A foster father, appointed beforehand, and the boys' parents support the initiate as he makes a vow of good conduct, to be a responsible adult and to abstain from sex until marriage.
- Remarks on the project:
 - *Strengths:* there was commitment from the community and donors who covered most of the costs; they also provided teaching aids and booklets on life skills.
 - *Challenges:* lack of space at the hospital to accommodate the boys while other hospital functions are going on; preference of the community for traditional male circumcision to medical circumcision.

7.10 The Inter-Christian Fellowship Mission (ICFM), Bugoma District

Rev Solomon Nabie, ICFM, Kimili Town

The presentation was a summary description of the ICFM Bugoma District Male Circumcision programme. This is an example of one of the projects of ICFM aimed at integrating community development and spiritual issues in a balanced way.

- The ICFM project was started in response to the community's request to address negative traditional male circumcision practices and messages that contribute to the spread of HIV. The community brainstorming session identified high HIV risk factors in their community as: sharing of blades, practice of risky sexual behaviour associated with substance abuse during lengthy traditional festivities (as reflected by high school drop outs of girls due to pregnancy coinciding with festive periods).
- ICFM started a pilot programme to offer medical circumcision plus counseling package in 2002; 250 boys took part. Although there was resistance from the traditional circumcisers initially, 600 out of about 2000 traditional circumcisers approached have agreed to encourage boys to circumcised medically, while retaining their role in the cultural practices of the rite of passage.
- The male circumcision rite of passage to manhood among the Luhya of Bugoma District happens once every two years. A team of health care providers, supervised by a doctor, are contracted during this period and paid a fixed amount. The cost for the surgery to the initiate is \$4.
- After initial education regarding the procedure, morality, and HIV risk factors, male circumcision is performed in a makeshift theatre in an environment that meets the MOH minimum standards and the operation is performed by an all-male team to respect tradition.
- After circumcision the initiates are retained in a camp at a school to recuperate and to be mentored and taught by church and respected leaders in the community. The boys eventually graduate in a ceremony marked by celebration with song and dance, following which they go home with their foster fathers.
- *Remarks on the project:*
 - *Strengths:* The ICFM programme has benefited 32,000 boys in the greater Luhya community, and has created demand in the neighbouring non-circumcising community of Teso District because people have seen the benefits of the programme. Adult men from non-circumcising communities have also requested male circumcision services from ICFM clinics. There is commitment from local leaders and the community. The programme has been kept simple since it uses existing facilities in the communities.
 - *Challenges:* since the rite of passage only takes place once every two years, the programme has to deal with large numbers of boys at once. ICFM is discussing with government and other stakeholders to take over the provision of male circumcision services so that it can concentrate more on advocacy work.

7.11. Discussions on Country Presentations

- *Affordability and Sustainability:* the Kenyan FBO examples showed that male circumcision performed as part of rites of passage can be costly to the parents of the initiate. The costs cover food, accommodation and the surgery. Parents are known to save for their son's rite of passage. It was noted that during the circumcision season some health providers perform male circumcision as a service at a subsidy, or even at no cost, which keeps the full costs low. It was stressed that it is important that projects charge the full programme cost for male circumcision and not just what it costs the client, if they are to be sustainable. To avoid the classic pitfall of donor funded projects, some countries have found innovative ways of making male circumcision services sustainable, e.g. through private-public partnerships; in Malawi MOH and NAC buy family planning and reproductive services from FBOs, which makes it possible for the FBOs to provide them free to the public: a similar model will be followed for male circumcision. Among the Kikuyu, 'bursaries' are given to boys who cannot afford to pay for the initiation package, especially OVCs. FLAS in Swaziland has a cost recovery mechanism whereby those who are older than 24 years and who are working are charged double the user fees. Swaziland is also raising funds from the private sector (sugar companies) to provide male circumcision.
- *Quality control during mass circumcision:* the importance of infection control was emphasized especially given that circumcisions of initiates take place *en masse* (assembly line).
 - Each of the male circumcision programmes cited from Kenya have a medical officer/consultant surgeon supervising the circumcisers, who are selected using a strict criteria. There is an anesthetist on site. A clean sepsis-free room is used and surgical equipment sterilized, using pressure cookers, for example. As a result there are low rates of complications from medical circumcision performed during the rite of passage.
 - It was also emphasized that quality control should be applied to the information package given to adolescents and not just limited to the surgical procedure.
- *Information materials:* flyers should present the scientific evidence of male circumcision and HIV prevention, and also other benefits of male circumcision e.g. hygiene, reduction of penile cancer and cervical cancer in female partners, and prevention of phimosis. Swaziland is developing a communication strategy for male circumcision.
- *Communication for non-circumcising communities:* male circumcision demand is increasing in non-circumcising settings.
 - This should be an opportunity to focus on other practices that are high risk for HIV infection, e.g. dry sex, population mobility (the NW Province in Zambia is the province where traditional male circumcision is practiced and has had the lowest HIV prevalence; however, the last DHS showed that this is no longer the case).
 - Promote male circumcision for its health benefits. Agents of change, such as those who have been recently circumcised and opinion leaders from the community can be used as advocates for male circumcision.
- *Gender:* male circumcision programming should be gender sensitive.
 - There is need to clearly distinguish between male circumcision and female genital cutting (FGC), in areas where FGC is practiced, as both can be part of a rite of passage to adulthood.
 - The role of women in male circumcision service delivery was emphasized. The consultation meeting was observed to have more male participants than females, yet women are the sex

partners of the men, and male circumcision is only indirectly protective of women (i.e. no decrease in transmission from HIV positive men to HIV negative women)

- It was interesting to note that the involvement of girls in post-male circumcision counseling in the case study from PCEA Kikuyu Hospital was the initiative of the community, and only facilitated by CMMB.

7.12. A Synthesis of Country Experiences and Lessons Learnt

Participants were split into groups to discuss the presentations and identify some of the key issues that need to be taken into consideration or developed if FBOs want to make a more substantive contribution to providing male circumcision for HIV prevention and to use male circumcision as an entry point for adolescent sexual and reproductive health. Three specific questions were discussed: 1) reflections on the role of FBOs in scaling up male circumcision for HIV prevention and ASRH; 2) factors that improve coverage and effectiveness of interventions of adolescent male circumcision, including available support materials; and 3) factors that need to be considered when using adolescent male circumcision as an entry point for adolescent sexual and reproductive health. Below is a summary of the main conclusions from the group discussions:

7.12.1. Role of FBOs in adolescent male circumcision scale up

FBOs have a significant role to play in scaling up male circumcision for HIV prevention among adolescents.

- They are trusted and well respected in the communities where they operate, given their people-centred approach. They are regarded as custodians of the next generation. They are in an advantageous position to mobilize and influence communities to take up male circumcision. This includes giving spiritual support to provide a holistic context for male circumcision (i.e. faith, and sexual and reproductive health package).
- They already have infrastructure and networks in the community (e.g. churches, schools, traditional leadership). FBOs can use these to provide support at grassroots level to mount sustainable campaigns for male circumcision.
- FBOs have the capacity to provide male circumcision services, and some of them are already doing so.

7.12.2. Factors to consider to improve coverage and effectiveness of interventions for Adolescent male circumcision for FBOs, including programme support materials

Participants agreed on the following priority actions to improve the coverage and effectiveness of male circumcision for adolescents:

- Develop, launch and adopt a national male circumcision policy framework that would recognize and facilitate male circumcision as an intervention for HIV prevention, and set standards for the practice.
- Mobilize communities to improve the acceptability and up-take of male circumcision through:
 - advocacy with community leaders, community workers, the media;
 - identify possible synergies in relation to traditional circumcisers working together (adopt the positive aspects of rite of passage) with clinical practitioners (perform safe male circumcision);
 - use of holy scripture where necessary to position male circumcision.
- Undertake monitoring and evaluation of male circumcision services that are being provided, and document and share good practices and lessons learnt.
- Strengthen human resource capacity through pre-service and in-service training on male circumcision.
- Make male circumcision affordable through means such as cost-sharing schemes, donor funding.

- Promote dialogue and support those who have undergone medical circumcision, to show that it is not viewed as less masculine than traditional male circumcision.
- Develop and try different models: hospital-based, mobile facilities, community-based using church and school facilities. As this is a new area of development and it is not possible to prescribe the package or how to implement male circumcision, it is people like the participants at the consultation who can try out models and provide good practice examples.

Participants also agreed on materials that are available/needed to support male circumcision for HIV prevention and ASRH services:

- Currently available: basic facts on HIV and AIDS, STI prevention, AIDS treatment. Countries such as Swaziland (FLAS) and Zambia (SFH) have developed materials for male circumcision.
- WHO and partners have developed (or are developing) materials for programming and technical guidance: rapid assessment tool to assess demand and supply; clinical/surgical procedures manual; human rights, ethical and legal guidelines; male circumcision service management tools, and monitoring and evaluation (refer to www.who.int/hiv/topics/malecircumcision/en/index.html for more details).

7.12.3. Factors to consider when using adolescent male circumcision as an entry point for adolescent sexual and reproductive health

The following were identified as key issues to consider:

- *Recognizing cultural norms and practices:* need to acknowledge the cultural differences and values of different regions/countries. Traditionally circumcising and non-circumcising communities require different approaches and messages. Of particular importance, boys need to be supported by the community to ensure lasting behaviour change.
- *Religious beliefs:* need to be sensitive to religious beliefs of families in relation to ASRH interventions, e.g. condom promotion.
- *Rights of the child:* male circumcision programmes should consider desires, feelings and aspirations of young people. Parents can consent for minors to have male circumcision and the boys need to assent, without coercion. Girls' rights should also be respected.
- *Definition of male circumcision package:* the service package should clearly define what information and what skills we want to develop, in addition to male circumcision.
- *IEC materials and methods of communication:* materials should be relevant and age-appropriate: clear language; appropriate media should be used, and the most effective communication tools; use a standardized curriculum, and use role models and peer educators to promote male circumcision as an entry point for ASRH. Information materials should be replicable/adaptable for different contexts.
- *Timing of circumcision:* in traditional circumcising communities, male circumcisions are done during the school holidays and after the boys have sat exams for the last class of primary school (Standard 8). For example in Kenya (end November and December) and in Malawi (June and July), or every two years (among the Luhya community in Kenya). The timing of male circumcision should, where possible, coincide with traditional timing in communities where it is practiced, in order to improve its uptake through clinical facilities.
- *Costs:* develop cost-effective and sustainable packages that include positive cultural and community norms.

8. Planning and Implementing Male Adolescent Circumcision Programmes for HIV Prevention and Adolescent Sexual and Reproductive Health

During the first part of the consultation, participants shared experiences about existing FBO programmes in the sub region, and identified some of the key issues that need to be taken into consideration or developed if FBOs want to make a more substantive contribution to providing male circumcision for HIV prevention and as an entry point for adolescent sexual and reproductive health. During the second part of the consultation, most of the work was carried out through group discussions, followed by plenary sessions to give feedback and reach consensus on issues raised by different groups. Four working groups discussed different issues related to the provision of male circumcision to adolescent boys: 1) community mobilization and advocacy in currently circumcising settings; and 2) community mobilization and advocacy in non-circumcising settings; 3) information and skills that need to be provided before male circumcision; and 4) monitoring and support after male circumcision, including impact evaluation of the programme.

Pertaining to the first two groups, three questions were discussed: a) key activities to be done to develop and implement male circumcision programmes for adolescents; b) materials available and needed to support the interventions; and c) what would most help FBOs increase adolescents' access to male circumcision for HIV prevention and ASRH.

8.1. Group 1: Community mobilisation and advocacy in settings where male circumcision is common in order to focus on HIV prevention and ASRH

8.1.1. Key activities needed to inform, engage and mobilise communities for male circumcision

- Identify appropriate stakeholders and audience for targeted communication.
- Hold sensitization and mobilization meetings for the target community, using existing community channels and media, including church services, chief's meetings, school and health programmes.
- Meet traditional circumcisers to discuss with them the benefits of medical male circumcision and encourage them to refer their clients to health facilities for the procedure.
- Develop a strategy to guide the implementation of advocacy and communication activities.
- Build the capacity of health care service providers to ensure the demand created is met, in order to avoid disappointments that could impact negatively on the programme. Traditional circumcisers should be involved, where feasible.

8.1.2. Materials available and required to support male circumcision interventions

- Written IEC materials: brochures, posters.
- Electronic media: radio.
- Sermons in church.
- IEC through entertainment: song and dance, drama, film.

8.1.3. Initiatives to be undertaken to increase number of adolescents coming for male circumcision

- Conducting advocacy activities in schools, and involve parents and community members, including traditional circumcisers, to increase demand.
- Improving and increasing the number of health facilities where male circumcision services are provided.

- Making male circumcision services accessible and affordable to everyone who needs them.
- Having youth-friendly facilities and staff at the male circumcision service delivery points.

8.2. Group 2: Community mobilisation and advocacy in settings where male circumcision is NOT common

8.2.1. Key activities needed to inform, engage and mobilise communities for male circumcision in non-circumcising settings

- Undertake an assessment study to understand why the community does not circumcise and to gauge the acceptability of male circumcision.
- Develop a communication strategy and package that explains what male circumcision is and why it is important to undergo the procedure, with a particular focus on HIV prevention and other health benefits.
- Conduct sensitization and mobilization meetings for the target groups using scientific facts and emphasizing the religious basis that can convince people of the need for male circumcision.
- Build the capacity of the health care service providers and community workers, to ensure the demand created is met to avoid disappointments that could impact the programme negatively.
- Identify and address any myths and barriers that may be associated with the practice in communities that do not have a culture of male circumcision.

8.2.2. Materials available and required to support male circumcision interventions in non-circumcising settings

- IEC materials: audio, print.
- Minimum male circumcision standards guidelines and training curriculum.
- Scientific information about male circumcision as an effective HIV prevention intervention.
- Information to correct cultural myths and dispel any negative perceptions with regard to medical male circumcision.

8.2.3. The Initiatives to be undertaken to increase the number of adolescents coming for male circumcision in non-circumcising settings

- Conduct advocacy in schools and seek parents' support for their sons to undergo male circumcision.
- Create partnerships with other informed and respected members of the community (religious and social).
- Develop a policy framework that makes male circumcision a visible HIV prevention strategy.
- Integrate male circumcision, ASRH and HIV/AIDS to ensure the youth who come for one service (VCT) get information on the package of male circumcision services as well.
- Mobilise financial and material resources to support male circumcision campaigns and services.
- Improve and make more accessible physical facilities for male circumcision services.
- Develop youth-friendly facilities and train youth-friendly staff in places where male circumcision is provided.

8.3. Group 3: Curriculum to provide information and develop skills before male circumcision

The following were identified as the contents of a pre-male circumcision curriculum:

- The role of male circumcision in HIV and (some) STI prevention.
- Personal hygiene, especially of the genital area.
- The male circumcision process and procedure.

8.4. Group 4: Curriculum to provide information and develop skills after male circumcision

The following were identified as the contents of a post -male circumcision curriculum:

- Pain management during the first three days
- Wound management to facilitate healing
- Hazards of substance abuse, and avoidance of risky sexual behaviour
- Responsible behaviour in society after male circumcision
- Adolescent Reproductive Health and Sexuality
- Appropriate gender relations.

9. Priority Actions to Accelerate and Strengthen Action

After the participants had shared experiences about existing FBO programmes in the sub-region, and identified some of the key issues that need to be taken into consideration if FBOs are to make a more substantive contribution to providing male circumcision, they brainstormed in their groups about the key actions that need to be undertaken. They focused on immediate actions (next six months) and longer term activities (next 2 years), in order to strengthen the capacity of FBOs (and others) to provide effective male circumcision services to adolescent boys, and increase the coverage of existing services. The following is a summary of the groups' recommendations:

9.1. Key actions in the next six months

- Provide feedback from the Consultative Meeting to FBOs back in participants' home, including presentations and issues discussed
- Explore opportunities to integrate male circumcision into existing programmes offered by FBOs
- Carry out a needs assessment for male circumcision
- Start/continue male circumcision services for different communities
- Mobilize resources, starting with proposal development
- Advocate for male circumcision policy formulation to standardize practice
- Develop monitoring and evaluation tools, including monitoring behaviours post-male circumcision
- Community mobilization for male circumcision services
- Develop and adapt male circumcision guidelines (developed by WHO and partners)
- Establish a Technical Working Group on Male Circumcision to operationalize activities

9.2. Key actions in the next two years

- Fund raising to support male circumcision programmes
- Develop FBOs' male circumcision training materials to provide information and skills before and after male circumcision
- Pilot male circumcision projects in communities that do not circumcise
- Scale up male circumcision in communities that circumcise, and focus on the follow-up after male circumcision
- Hold stakeholders forum to share lessons learnt
- Prepare a strategic plan to guide male circumcision programming
- Strengthen ownership of male circumcision programmes by FBOs and others
- Develop IEC materials to support scale up
- Build capacity for male circumcision programmes
- Integrate male circumcision into existing programmes
- Undertake an evaluation and refine the work plan as appropriate

In conclusion, participants unanimously endorsed that CMMB maintain the steering role it had played at the Consultative Meeting with regard to the FBOs, in order to spearhead the implementation of male circumcision plus ASRH. This would also create a forum where countries would share information on best practices.

10. The Consensus Statement on the Role of FBOs in the Provision of Male Circumcision plus ASRH

One of the expected outputs of this meeting was a consensus statement for and by FBOs on male circumcision as HIV prevention and as an entry point to adolescent sexual and reproductive health

A draft statement was prepared by a task team during the meeting based on the deliberations during the meeting, and was discussed by participants in their working groups. The draft was revised and finalized in plenary.

The following is the Statement:

The HIV pandemic remains one of the greatest challenges many individuals, families, and communities are facing today in Africa. Prevention of new HIV infections, appropriate treatment of those infected, and interventions to decrease the impact of HIV on the lives of those infected and affected are the key strategies to respond to the pandemic.

There is growing evidence of the effectiveness of interventions to prevent HIV infection among young people (WHO 2006). These interventions are provided through a range of settings (e.g. schools, health services, communities and the media) and focus on delaying sexual debut, limiting the number of sexual partners, and increasing the use of condoms correctly and consistently by young people who are sexually active.

Recent studies in South Africa (2005), Uganda and Kenya (2006) have now demonstrated that male circumcision significantly reduces the risk of heterosexual transmission of HIV from women to men. Based on the results of these studies, the WHO and UNAIDS co-sponsors recommend that male circumcision should be promoted in high HIV prevalence countries as part of a comprehensive package of prevention interventions (Montreux, 6 – 8 March 2007).

In countries where male circumcision is carried out as a rite of passage, adolescents are the group who are traditionally being circumcised, and what is needed is to broaden the services being offered to include Adolescent Sexual and Reproductive Health. In those countries with high HIV prevalence and low male circumcision prevalence, adolescents will be an important target group for the development of sustainable male circumcision programmes. For the greatest public health impact of male circumcision on HIV prevalence, it is important that all males are given a comprehensive circumcision package that includes Sexual and Reproductive Health before they become sexually active.

In general, adolescent boys have little contact with health services, especially with regard to sexual and reproductive health. Male circumcision therefore provides an important opportunity to make contact with this group of the population in order to improve their sexual and reproductive health. Faith Based Organizations (FBOs) are in a unique position to increase the coverage and quality of male circumcision programmes because of their strong links with the community, credibility, infrastructure and networks.

In response to the growing involvement of FBOs in male circumcision programmes, CMMB organized a consultative meeting on Adolescent Male Circumcision for HIV Prevention and as an

Entry Point for Adolescent Sexual and Reproductive Health, with the support of WHO and in collaboration with UNFPA, UNICEF and UNAIDS, at the Brackenhurst International Conference Centre, Limuru, Kenya, 20-21 September 2007.

The meeting brought together representatives of FBOs from Kenya, Lesotho, Malawi, Swaziland, Tanzania, Uganda, Zimbabwe and Zambia. The delegates strongly endorsed the important role that FBOs can and should play in the development and implementation of programmes to increase adolescent boys' access to safe and effective male circumcision.

Recognizing that communities are different and that intervention strategies need to be customized to meet local needs, the participants recommended that FBOs should engage in:

- *Advocating for a National Policy Framework on Male Circumcision, including the standardization of interventions and procedures;*
- *Contributing to the development and implementation of male circumcision services for adolescent boys, within a comprehensive package of interventions for Adolescent Sexual and Reproductive Health, and giving adequate attention to issues related to rites of passage in the target communities;*
- *Ensuring that the strategies developed provide adolescent safe male circumcision services that are culturally sensitive, and ensure that the strategies give adequate attention to the values and norms of communities that do and do not traditionally circumcise adolescent boys;*
- *Working with other stakeholders, including the Ministry of Health, health care workers, teachers and donors to increase adolescents' access to safe male circumcision;*
- *Providing the adolescent boys who are circumcised with the information, skills and support, before and after the circumcision, to prevent risk compensation, improve their sexual and reproductive health, and contribute to positive gender attitudes and behaviours;*
- *Involving parents and other community members, including girls as appropriate, to maximize the impact of the intervention and provide effective support for longer term behaviour change;*
- *Ensuring that the rights of the adolescents are protected and their opinions listened to, and that programmes give adequate attention to issues of informed consent and assent;*
- *Initiating dialogue with the practitioners of traditional male circumcision to encourage the adoption of hygienic methods by transforming how the actual procedure is done (by having it done in a modern medical setting), and linking this with the positive aspects of the rites of passage, so that the traditional practitioners may continue to have a role to play;*
- *Monitoring and evaluating the implementation of male circumcision programmes for adolescent boys;*
- *Documenting and sharing good practice, in order to contribute to the development and scaling up of male circumcision for adolescent boys for HIV prevention and as an entry point for adolescent sexual and reproductive health.*

In conclusion, it was agreed that this Consensus FBOs' Statement be shared widely with partner organisations such as Moslem Council and World Council of Churches to obtain their feedback and commitment.

Appendix 1: Meeting Agenda

East and Southern Africa FBO Male Circumcision Consultation

Venue: Brakenhurst Conference Centre

Theme:

Male Adolescent Circumcision for HIV prevention and as an entry point for sexual and reproductive health:

The role of FBOs

Date: Thursday 20th September 2007 & Friday 21st September 2007

Day One Chair: Dr. Edward Kariithi

Time	Topic	Presenter/ Facilitator
8.00am	Arrival/ Registration	Jane Kinyanzui
8.15am	Welcome and Introduction Opening Remarks	Doris Odera
8.30am	Overview of workshop: content and methodology	Dr. Salvador De La Torre
9.00am-9.15am	Officiate Grand Opening	Dr I Mohammed, Ministry of Health, National AIDS and STI Control Program, Kenya
9.15am-9.30am	Key Note Address	Dr Rebecca Bunnell, Director Global AIDS Programs CDC, Kenya
9.30am- 9.45am	Overview of what we know about MC and HIV prevention (feedback from Montreux and Harare meetings)	Dr. Bruce Dick, Department Child and Adolescent Health, WHO Geneva
9.45am-10am	Rationale for using HIV as an entry point for ASRH (feedback from brainstorming meeting)	Dr. Helen Jackson, UNFPA Country Support Team, Harare
10.00am- 10.30am	TEA BREAK	
Plenary Sessions		
10.30am- 10.45am	Tanzania FBO Experience	Lumumba Francis Mwita
10.45am- 11.00am	Swaziland FBO Experience	Mr. Vusie Norman Dlamini

11.00am- 11.15am	Lesotho FBO Experience	Mr. Bati Baptista Paseka R.
11.15am-11.30am	Uganda FBO Experiences	Dr. Hafsa Lukwata/Dr. Magid Kagimu
11.30am- 11.45am	Malawi FBO Experience	Ms. Desiree Mhango
11.45am- 12.00noon	Namibia FBO Experience	Dr. D M Kangudie
12.00pm – 12.15pm	Zambia FBO Experiences	Dr. Moses Sinkala/Karen Edvai Sichinga
12.15pm- 1.00pm	Plenary Discussions	
1.00pm -2.00pm	LUNCH BREAK	
2.00pm-2.15pm	Meru FBO Experiences	Florence Murugu
2.15pm-2.30pm	Nazareth FBO Experiences	Ann. Nkatha
2.30pm-2.45pm	Kikuyu FBO Experiences	Dr. Salvador De La Torre
2.45pm-4.00pm (Tea Break)	Working Groups: <ul style="list-style-type: none"> ▪ Experiences sharing from all the regional countries ▪ Synthesizing lessons learnt and available program support materials 	Doris Odera
4.00pm- 5.00pm	Plenary feedback and discussion/synthesis	Doris Odera
5.30pm Leave for the evening reception (KentMere Restaurant) and Meeting of the drafting group to start preparing the consensus statement		

Day Two: Chair: Dr. E. Kariithi

Time	Topic	Presenter
8.00am-8.30am	Flash Session	Doris Odera
Plenary Sessions		
8.30am- 10.00am	Working Groups: <ul style="list-style-type: none"> ▪ Community mobilization ▪ Talking with Parents ▪ Providing information and life skills before MC ▪ Special considerations during MC ▪ Follow-up after MC 	Dr. Bruce Dick
10.00am-10.30am	TEA BREAK	

10.30am-11.30am	Reports back and synthesis from the working groups (10mins per group)	Dr. Bruce Dick
11.30pm- 1.00pm	Making it happen <ul style="list-style-type: none"> ▪ Actions in the next 6 months ▪ Actions in the next 2 years 	Dr. Salvador De La Torre
1.00pm- 2.00pm	LUNCH BREAK (Meeting of the drafting group to finalize the consensus statement)	
2.00pm-3.00pm	Report back from Groups, discussions and synthesis	Dr. Chiweni Chimbwete
3.00pm – 3.10pm	Presentation of Consensus Statement	Ms. Helen Jackson
3.10pm- 3.40pm (Tea Break)	Working Groups to discuss the consensus statement	Ms Helen Jackson
3.40pm- 4.15pm	Report back and finalization of consensus statement	Ms Helen Jackson Dr. Moses Sinkala
4.15pm-4.450pm	Workshop evaluation & Wrap-up	Doris Odera
4.45pm- 5.00pm	Vote of Thanks	Dr. Salvador de la Torre
5.00pm	Departure	

Appendix 2: List of Participants

	Participant	Institution	Location	Telephone	Email
1	Nkatha Njeru	AIDS Relief Program Coordinator, Nazareth Hospital	Nairobi, Kenya	0733-853456	nanasi@todays.co.ke
2	Muthami Mutie	Outreach Coordinator, Nazareth Hospital	Nairobi, Kenya	0722-690199	nanasi@todays.co.ke
3	Mr. Philemon Keino	Hospital Administrator, AIC Kapsowar Hospital	Kapsowar, Kenya	0721-417245	philemon_kimutai@yahoo.com or aimkapsowarhospital@yahoo.com
4	Reverend Leonard Mbiti	HIV/AIDS & Male Circumcision Cons, ACK Diocese of Mt. Kenya South	Kikuyu, Kenya	0722-377064	leonardmbito@yahoo.com
5	Mr. Wilson Koome	Program Coordinator, Methodist Church of Kenya, Kaaga Synod	Meru, Kenya	0726-276161	koomewilson@yahoo.com
6	Reverend Solomon Nabie	Director, Inter-Christian Fellowship Evangelical Mission Kimilili Town	Kimilili, Kenya	0733-672769	director@icfem.org
7	Clement Kiprop	Clinician, Inter-Christian Fellowship Evangelical Mission	Kimilili, Kenya		
8	Mr. Joseph Wamae	Presbytery's Men's Fellowship Secretary, PCEA Githunguri Presbytery	Githunguri, Kenya	0723-895759	wamgat@yahoo.com
9	Dr. Robert Samora	Clinical Officer, St. Elizabeth Mukumu	Kakamega, Kenya	0725-979482	samora-robert2005@yahoo.com
10	Sr. Alice Ngeny	Hospital Matron, St. Joseph's Migori	Suna, Kenya	0720-562474	info@stjmh.org
11	Franklin Odhiambo Okungu	Nurse, St. Camillus Hospital	Karungu, Kenya	0723-235487	stcamilluskarungu@gmail.com
12	Cleopus Onchari	Nurse, Tabaka Mission Hospital	Tabaka, Kenya	0722-273249 /0736-661329	tabaka@swiftkenya.com
13	John Muchiri	Nurse, North Kinangop	North Konangop, Kenya	0720-384975 / 0721-238016	nkinangop@gmail.com
14	Hastings O Achieng	Social Worker, St. Joseph's Nyabondo	Sondu, Kenya	0721-225378 /0736-251235	nyabondohospital@yahoo.com
15	Japheth Aganda	Nurse (Circumcision), Maseno Hospital	Maseno, Kenya	0733-213120 /0727-561261	nicwere@yahoo.com
16	Jeremiah Kibwaro	Clinician, Kendu Bay Hospital – Dr. Solis	Kiisi, Kenya	0720-842306 /0736-156359	kendu_hospital@yahoo.com
17	Mr. James Kichawa	Clinician, Kendu Bay Hospital	Kiisi, Kenya	0735-435257	kendu_hospital@yahoo.com

18	Mr. Jeremiah Mberia	Clinical Officer, Consolata Hospital Nkubu	Meru, Kenya	064-51016	
19	John Karanja	Nurse, Our Lady of Lourdes Mwea	Karatina, Kenya	060-48055 0722-212304	divinelovecr@yahoo.com
20	Dr. Serem	Project Doctor, Friends Lugulu	Webuye, Kenya	0722-581932	friendshospital@yahoo.com
21	Samuel Irungu	Church Elder, AIC Kijabe/Full Gospel Church	Matathia, Kenya	0722-781956	snirungu@gmail.com
22	Mr. Zakayo Martin	HIV/AIDS Mobilization Officer, AIC Litein Hospital	Letein, Kenya	0722-657453	AIC-Liteinhospital@maf.or.ke
23	Geoffrey Limbere	Clinician, Maua Mission Hospital	Meru, Kenya	0736-413000	commtym@mauamethhosp.or.ke
24	Florence Murugu	HIV/AIDS Program Manager, Methodist Church of Kenya, Kaaga Synod	Meru, Kenya	0733-620953 /0727-986665	fmurugu404@hotmail.com
25	Mr. Jonathan Bii	Health Educator, Tenwek Hospital	Bomet, Kenya	0733-415945 /052-22495	tenwekch@tenwek.com
26	Mr. Nicholas Njeru	Clinical Officer, PCEA Kikuyu Hospital	Kikuyu, Kenya	0725-333095	art@pceakikuyuhospital.org
27	Peter Mwarogo	Family Health International	Nairobi, Kenya	254-20-713913 or 2844000	pmwarogo@fhi.or.ke
28	Dr. Kenneth Chebet	APHIA II, Eastern, JHPIEGO	Nairobi, Kenya	0722-850793	kchebet@jhpiego.net
29	Dr. Job Obwaka	APHIA II, Nyanza, Engenderhealth	Nairobi, Kenya	0722-525500	jobwaka@aphianyanza.org
30	Dr. Ambrose Misore	PATH	Nairobi, Kenya	0722-810411	amisore@path.org
31	Dr. Rebecca Bunnell	Global AIDS Program Director, CDC	Nairobi, Kenya	0724-256809	rbunnell@ke.cdc.gov
32	Mr. Charles Mwai	UN Volunteer, NACC	Nairobi, Kenya	2715127 /0722-306304	cmwai@nacc.or.ke
33	Dr. Rex Mpazanje	WHO	Nairobi, Kenya	0724-416660	mpazanjer@ke.afro.who.int
34	Marcus Rennick	Water Reed			
35	Warren Dalal	Water Reed		0724-255620	Wdalal@wrp-kcn.org
36	Dr. Bruce Dick	Medical Officer HIV/Young People, WHO	Geneva, Switzerland	41 22 791 3799	dickb@who.int
37	Dr. Helen Jackson	HIV and AIDS Adviser, UNFPA/CST Southern Africa	Harare, Zimbabwe	2634338524/5	Jackson@unfapacst.co.zw

38	Dr. Hafsa Lukwata	Senior Medical Officer, Ministry of Health, Uganda	Kampala, Uganda	256 712 445549	hafluk@yahoo.com
39	Dr. Moses Sinkala	Country Director, CMMB, Zambia	Lusaka, Zambia	260 978 47288	mosessinkala81@msn.com
40	Mrs. Karen E. Sichinga	Ag Director of Programmes, Churches Health Association of Zambia (CHAZ)	Lusaka, Zambia	260-1-229702	karen.sichinga@chaz.zm
41	Mr. Bati P. Ramashamole	Planning, Mobilization and Sensitization Officer, Christian Health Association of Lesotho (CHAL)	Maseru, Lesotho	266 223 12500	ecplan@chal.org.ls
42	Mr. Vusie Norman Dlamini	Communications/Media Liaison, Family Life Association of Swaziland (FLAS)	Manzini, Swaziland	268 5053564	flas@africonline.co.sz or vndlamini@flas.org.st
43	Dr. Ahmed Kiswezi	Executive Member, Islamic Medical Association of Uganda	Kampala, Uganda	25671860284 /256 41 570703	imau@utlonline.co.ug
44	Dr. Lumumba F. Mwita	Health Coordinator, Catholic Archdiocese of Dar es-Salaam	Dar-es-Salaam, Tanzania	255 754 095 653	kichera@yahoo.com
45	Ms. Desiree Mhango	Director of Health Programs, Christian Health Association of Malawi (CHAM)	Lilongwe, Malawi	265 1 771 258	dmhango@cham.org.mw
46	Mr.Charakupa S. Ngwerume	Head of Secretariat, NFBCZ, Zimbabwe	Harare, Zimbabwe	263011753653 /2630912990348	sekerupalhbc@yahoo.com
47	Dr. Chiweni Chimbwete	Consultant MC, UN Regional MC Working Group	Johannesburg, South Africa	27 82 909 2642	chimbwete@gmail.com
48	Dr. Salvador De La Torre	Country Director, CMMB	Nairobi, Kenya	254-720-789708	salvador@maf.or.ke or salvador@cmmb.org
49	Doris Odera	AIDS Relief Program Manager, CMMB	Nairobi, Kenya	254-727-534887	dodera@cmmb.org
50	Dr. Edward Kariithi	AIDS Relief Technical Advisor, CMMB	Nairobi, Kenya	254-727-534772	ekariithi@cmmb.org
51	Abel Onyango	AIDS Relief Laboratory Technologist, CMMB	Nairobi, Kenya	254-723-041355	a.onyango@cmmb.org
52	Lucy Njema	PMCT/ART Nurse, CMMB	Nairobi, Kenya	254-720-471560	lnjema@cmmb.org
53	Esther Kibunyi	AIDS Relief Pediatrics Clinical Officer, CMMB	Nairobi, Kenya	254-722-796965	ekibunyi@cmmb.org
54	Jane Kinyanzui	CMMB	Nairobi, Kenya		
55	Natasha Elva	Consultant, UNICEF	Nairobi, Kenya	0733-670386	ntelva@gmail.com
56	Mark Mwathi	Health Ministries Director, SDA Health Ministries	Nairobi, Kenya	254-723-817710 / 7120201/2	mwathi2001@yahoo.com
57	Aphiud Njeru	Program Coordinator, AIC Health Ministries	Nairobi, Kenya	254-722-428198	aphiudnjeru@yahoo.com

58	Peter Ngure	HIV/AIDS Program Manager, CHAK	Nairobi, Kenya	254-722-266054	ngure@chak.or.ke
59	Stanley Tonui	Health Coordinator, Tenwek Hospital		254-721-989736	stonui2003@yahoo.com
60	Michael Mugweru	CHAS Secretariat	Nairobi, Kenya	254-721-656307	mike@chas.or.ke
61	Dr. Samuel Mwenda	General Secretary, CHAK	Nairobi, Kenya		gs@chak.or.ke
62	Hannah Dagnachew	COP, CRS Kenya/AIDS Relief	Nairobi, Kenya		
63	Anthony Ophwette	STO (APHIA II Rift), FHI	Nairobi, Kenya		
64	Dr. Isaac Malonza	Deputy Country Director, JHPIEGO	Nairobi, Kenya		
65	Paul M Matogo	Consultant, Crystal Hill Consulting	Nairobi, Kenya		
66	Jane Tipton	CDC Kenya	Nairobi, Kenya		
67	Dr. Robert Ayisi	Deputy Director ,NASCOP MOH	Nairobi, Kenya		headnascop@iconnect.co.ke
68	Dr. William Murrah	Director; Health Consultant, Crystal Hill Consulting	Nairobi, Kenya		wmuraah@crystalhill.co.ke
69	Andrew Wamari	Consultant, Crystal Hill Consulting	Nairobi, Kenya		awamari@gmail.com
70	Fatuma Ali	Assistant Program Officer (MC), NASCOP Kenya	Nairobi, Kenya		
71	Joyce Lavussa	WHO Kenya	Nairobi, Kenya		