Ministry of Health

Male Circumcision Situation Analysis

December 2009

Ministry of Health

Male Circumcision Situation Analysis

A Report on the National Male Circumcision Situation Analysis Conducted by the Ministry of Health and Co-operating Partners.

Compiled by:

Dr. Jonas C Mwale , MD, MMed

Finalised by :

Dr Mulambya Jairos , MD, MPH

December 2009

Table of Contents

Foreword

The government of Zambia through the Ministry of Health has embraced male circumcision as one of the preventive strategies to reduce HIV transmission in the population according to National Male circumcision strategy implementation plan, 2010-20 .

Male circumcision (MC) has been shown to reduce the transmission of HIV if used with other prevention strategies .

The situation analysis on Male Circumcision was designed to assess the current practice and inform on the effective interventions to be used in the scale up .

MC has been taking place in hospitals , partner supported facilities and in traditional settings but with little or no monitoring and supervision .

MC facilities standards have been solely adhered to in second level and partner supported facilities .

In order to create demand there will need for sensitization at community and political levels. There is also need for health facilities to adhere to standards of care so as to provide an enabling environment .MC reporting will need to be integrated into the existing HMIS .Logistics management will need to standardized nationally .

The Ministry of Health would like to thank all partners who supported the MC situation analysis and its hoped that the findings will be useful in the MC scale up .

Dr Peter Mwaba ,

Permanent Seacretary

Ministry of Health

Acknowlegements

The Ministry of Health would like to acknowledge the profound contributions of individuals and organizations towards the finalization of the Male Circumcision situation analysis report.

The Ministry of Health wishes to acknowledge the World Health Organisation for the financial and technical support towards the report .

The following were so key to the production of the report ;

Dr Wezi Kaonga	MoH
Mrs Grace Mumba Tembo	MoH
Ms Muntanga Veronica	MoH
Dr Mzaza Nthele	MoH
Dr Mwale Jonas	CDC
Dr Mulambya Jairos	Consultant
Dr Susan Zimba Tembo	WHO
Mr Luka Sakwimba	SFH
Dr Chanda Chama	NAC
Dr David Liyama	UTH
Ms Mangani Ethel	UTH
Dr Mary M Zulu	HPCZ
Mr Griffen Banda	HPCZ

The Ministry of Health will always remain indebted to you for your valuable inputs during the finalization of the Male Circumcision Situation Analysis Report .

List of Acronyms

CDC	Centres for Diseases Control and Prevention
CoH	Corridors of Hope
HIV	Human Immune Deficiency Virus
HPCZ	Health Professions Council of Zambia
MC	Male Circumcision
MoH	Ministry of Health
NAC	National AIDS Council
SFH	Society for Family Health
TWG	Technical Working Group
UNZA	University of Zambia
UTH	University Teaching Hospital
WHO	World Health Organisation
ZDHS	Zambia Demographic Health Survey

Executive Summary

According to the 2007 ZDHS, Zambia's population stands at 9.9 million (2000 population census) and current population projection estimates it to be at 13 million in 2010 .Fourteen point three percent of the Zambian adult population is HIV positive with the prevalence ranging as high as 21% percent in some urban areas.

Because of the high HIV prevalence , more HIV prevention needs to been done and hence the Zambian government has endorsed male circumcision (MC) as one of the key preventive strategies to be scaled up according to the National MC Strategy and implementation plan, 2010-20 .

In order to have an insight in the issues of supply and demand on MC, in 2009 the Ministry of Health undertook the MC situation analysis study using the WHO situation analysis tool kit..

According to WHO situation analysis tool kit, a situation analysis is primarily intended to inform a better choice of intervention.

The primary goal of this situation analysis therefore was to generate an understanding of the determinants and scale of current MC practices in Zambia, to determine the willingness of populations to support and come forward for male circumcision and to assess the capacity to perform safe male circumcision in various clinical settings, with cognizance of the existing capacity gaps.

In order to undertake the study the following methodology was used ;

The monitoring and evaluation committee of the MC National Technical working group (TWG) facilitated the study, dates for the data collection were agreed upon, WHO generic tools were revised, objectives were formulated, and consensus on data collection procedures was reached..

There were no ethical implication in this study as no human subjects were used.

The limitations of the study was that the tools were not piloted and so there were challenges to responses.

The main objective of the study was to describe the current situation ;that is determine

-key sociopolitical and tradition influences on MC

-key behaviors and attitudes that influence MC amongst individuals and communities

-health service capabilities for safe MC

The second task was to inform the scale of intervention to increase the rates of MC

-ability to meet current and future demands

-capacity and possible mechanisms to increase demand

-insight into what interventions might be effective and possible responses to them

-assessment of capacity gaps

In order to have wider understanding of the MC programme in Zambia, literature review was done and revealed the following;

On the key determinants of MC in the country, according to the behavioural surveillance study conducted by corridors of hope amongst out of school, unemployed and unmarried the male and female aged 15-24 years, tradition/culture (63.8%) was the strongest in areas with high MC prevalence such as N/Western province, HIV prevention (27.4%) took prominence as MC prevalence dropped such as in central province, and hygiene (8.4%) was the weakest determinant in all areas surveyed .

There has been media coverage (print and electronic) on MC linking it to HIV prevention and hygiene .Dr Kasonde Bowa , a urologist at UTH and HIV activitist Charley Mubanga and his son have been featured in the Post News Paper .The Minister of Health has also been featured on ZNBC radio and TV.

According to the 2007 ZDHS, the national MC rate is 13.1% .The MC rates for the provinces are known ;Northwestern (71% is the highest),Western (40.2%), Copperbelt (14.4%), Lusaka (10.2%), Luapula (9.9%), Central (5%), Southern(4.4%), Northern (3.3%), and Eastern (3.2% is the least)

-On the modalities of service delivery, there is insufficient information on the quality of MCs being provided in second ,first level ,and health centre facilities. Forty three MC sites are being supported by partners ,29 by SFH ,and 14 by MSI .

Following the assessment of key informants, focus groups, and health services capabilities, the findings were as follows:,

On the Key behaviours and attitudes that influence MC amongst individuals and communities ,perceptions, views of women on MC, fear ,age group based suited for MC, changing attitude and views on outcomes of MC were prominent .

On perceptions MC was thought to be cultural ,religious and shunned due to stigma .It was culturally accepted in North western province and not in Luapula province .

The women's view on MC was that it was a welcome practice in terms of hygiene and better sex .The traditional women were likely to opposed it unlike modern women.

On age best suited for MC ,there was a tendency of number of children coming for MC as compared to the adults . A traditional healer in central province indicated that, for old people it is not beneficial, because the skin does not harden.

On changing attitude , on a more positive note there was a view that MC may initially be opposed but would be accepted after sensitization .

On views on outcomes of MC, the positive results were appreciated firstly in the sense that one became more hygienic than a non circumcised person, and had reduced chances of contracting HIV. Secondly, such a person had better sex.On a negative note ,there was fear of injury to the private parts, MC was thought to offer full immunity against HIV, the fear of satanist issues surrounding the skin and blood taken from the MC procedure.

On the key socio-political and traditional influences on MC, awareness among influential leaders and main factors believed to be affecting rates of male circumcision in Zambia were highlighted .

On the awareness among traditional leaders, the association between male circumcision and reduced risk of HIV infection was not totally unheard of in Zambia. Central, Copperbelt,Lusaka ,and Western provinces scored the higher number of key informants indicating that they were aware.Eastern province scored the least .

On the main factors believed to be affecting rates of male circumcision in Zambia ,the following factors would promote MC: cultural (e.g in North-Western province), traditional and or religious beliefs,HIV/STI prevention and hygiene.The following factors would affect MC negatively: Lack of or inadequate information and knowledge, stigma and cultural beliefs (e.g in Eastern province).

On Health Facility Capabilities for Safe MC,the most important factors needed to be changed in order to increase the provision of health-facility-based male circumcision were mainly in the areas of sensitization, training, increasing numbers of skilled personnel, transport, infrastructure and provision of incentives (to the circumcised ,staff and free MC service)

All the provincial hospitals (level 2) visited during the data collection as well as the district hospitals (Level 1) offered medical male circumcision services at least for medical indications with gaps in the MC package and only 50% of level one hospitals implemented the full MC package..All health centres supported by partners met the MC minimum package .

On infrastructure situation ,60% of level two hospitals had adequate space compared to 22% for level one hospitals.The challenges were primarily with counseling areas, including waiting area, operating space, and recovery areas .There will be need for minor infrastructural improvements and provision of furniture to the facilities.

On logistic management ,supply of consumables for MC has not been standardized across the country, and health facilities other than those receiving partner-support are not ordering supplies specifically for MC, but rather they order general surgical supplies.Major challenges being experienced in the facilities were stock outs of sutures (cut-gut),disinfectants for infection prevention and plastic aprons.

On the human resource situation, in all facilities visited, there were no staff dedicated to MC service delivery, but staff that were trained provided the service at certain times only.

On data management,it was found that the HMIS officers have not been involved in MC work.

On quality assurance, there was no MC Quality Assurance standards being enforced in the facilities visited so as to assure quality of MCs being performed..

Generally the MC programme is gaining ground in Zambia but more capacity needs to built in key areas.

Recommendations

- Sensitisation on MC is needed, particularly in low prevalence provinces (Eastern, Luapula, Northern)
- Perception by public that skills to perform are not adequate in health facilities need to be addressed. Focus on quality within the scale-up will be vital if we are to build confidence with the public and not risk breaching this as a result of quality problems
- Increasing Access to Services is obviously needed. There is need to increase access in order to initially equalize the current demand with capacity before further demand stimulation can be done.
- Increase availability of trained personnel. However, there is also need to explore service delivery approaches that will provide feasibility in meeting targets in the context of the current human resource situation in the country
- Resolve issue of infrastructure to cater for privacy
- Resistance of women being involved in service delivery may need to be addressed in a culturally accepted manner, particularly were this is a problem

Issues to high-light in stimulating demand

- Messages on Benefits must be developed based on the findings of the situation analysis. These messages must include;
  - Hygiene Benefits
  - HIV/STI prevention
  - Better sex -Reduced chances of cervical cancer in women
- Engagement of Key figures will be key, particularly in dealing with the 3 provinces with lowest prevalence and highest resistance to MC. Key figures must include
  - Traditional leaders
  - Politicians, teachers, religious, and traditional leaders

- Privacy assurance - what do we do about the MOVE concept as we attempt to attain the numbers? This will need to be piloted to determine acceptance
- Messages advocating for HIV testing need to be carefully designed to avoid negating MC programme.
- Strengthening of MC leadership at all levels to accelerate MC scale up in Zambia

Introduction

The Back-Ground

According to the WHO situation analysis tool kit, a situation analysis is primarily intended to inform a better choice of intervention. In line with the principles of the WHO tool kit therefore, this situation analysis endeavored to provide information on what is happening around the country as regards male circumcision (MC), and as much as possible provide an understanding of why things happen to be that way[1]. This would form the basis for making decisions on how the Ministry of Health should best proceed with leading the scale-up of MC services around the country as guided by the goal and objectives of the National Male Circumcision Strategy and Implementation Plan; 2010 – 2020.

The primary goal of this situation analysis therefore was to generate an understanding of the determinants and scale of current male circumcision practices in Zambia, to determine the willingness of populations to support and come forward for
male circumcision, and to assess the capacity to perform safe male circumcision in various clinical settings, with cognizance of the existing capacity
gaps.

The Literature Review

Key Determinants of Male Circumcision in the Country

According to the results of a behavioural surveillance[2] study conducted by the Corridors of Hope Project amongst out of school, unemployed and unmarried male and female youth aged 15-24 years, there was a varying picture on strength of determinants across sampled areas of the country, with higher MC prevalence areas having culture as the strongest determinant, whilst the lowest MC prevalence areas having HIV prevention as the strongest determinant. Four districts were sampled representing the North-Western province (Solwezi), Central Province (Kapiri-Mposhi), and Southern Province (Livingstone and Chirundu). However, Chirundu which was one of the Southern Province sites being a border town in close proximity to Lusaka is more of a mixed population as regards culture and may also be a proxy to the picture in Lusaka.
In this study, in the North-Western province with the highest MC prevalence (55.7%), by far, the strongest determinant was culture (72.8%) followed by HIV prevention (21.5%) and hygiene (5.7%), in that order.
In the Southern province which was the next province with the highest MC prevalence in this study (18%), the strongest determinant for MC was HIV prevention (44.4%), followed by culture (39.7%), and hygiene (15.9%) in that order.
In the Central Province which was the province with the lowest MC prevalence (5.3%), the strongest determinant for MC was HIV prevention followed by culture.

The pattern from this study therefore was that;

i. In areas that practice traditional MC, the strongest determinant for MC was culture.
ii. The traditionally circumcising area also had the highest proportion of uncircumcised males who were interested in being circumcised, though it was not clear if these were indigenous men to the area or not, and why they were more interested in circumcision.
iii. As MC prevalence dropped, HIV prevention assumed a stronger determinant power for MC, with culture dropping to second position
iv. In all areas surveyed, hygiene was the weakest determinant for MC

It is not clear from this study if these uncircumcised males were indigenous to the province or were of a different cultural group. This question would be important to answer as it may provide a picture as to whether pressure to conform within an area that practices cultural circumcision is an important determinant for decisions for MC in such areas amongst men from other cultural groups.
If so, a further question then would be what aspect or aspects of the cultural MC practice are most attractive to men from other cultural groups but living in an area that practices traditional MC?

Table 1.1: Determinants for Male Circumcision

Main reason men get circumcised	Chirundu n (%)	Kapiri Mposhi N (%)	Livingstone n (%)	Solwezi n (%)	Total N (%)
Hygiene	0 (0.0%)	5 (21.7%)	10 (15.9%)	15 (5.7%)	30 (8.4)
Prevent HIV	5 (55.6%)	10 (43.5%)	28 (44.4%)	56 (21.5%)	99 (27.4)
Traditional/culture	4 (44.4%)	8 (34.8%)	25 (39.7%)	190 (72.8%)	227 (63.8)
Total	**9 (100)**	**23 (100)**	**63 (100)**	**261 (100)**	**356 (100)**

COH II - Behavioural Surveillance Survey. 2009[2]

Table 1.2 : Table for key determinants of MC

Determinant description (age, religion, location, culture, etc.)	% of population influenced[1]	Reference
Tradition/Culture	63.8%	COH II Project. Behavioral Surveillance Survey
HIV Prevention Benefits	27.4%	COH II Project. Behavioral Surveillance Survey
Hygiene	8.4%	COH II Project. Behavioral Surveillance Survey

Media Coverage

Zambia has, over the past two to three years had media coverage on MC, linking it to both hygiene and partial HIV prevention benefits. Media coverage has both been via the electronic media and the print media, and have ranged from radio and news paper interviews with persons identified to be specialists and to television discussions by Ministry of Health officials. News paper articles carrying advocacy messages by community advocates and role models for the purpose of promoting MC have equally featured.

1. In the Post News Papers edition of Tuesday the 3rd April 2007[3], Dr Oliver Kasonde Bowa a Consultant Urologist (UTH), Senior Lecturer of Urology (UNZA), and Assistant Dean of the School of Medicine was cited as welcoming the UN's announcement that MC must be adopted by countries as part of the comprehensive package of HIV prevention interventions
2. Author and HIV/AIDS activist Charley Mubanga and his son Mukuka featured in a full page article in the Life Style section of the Post News paper of the 28th December 2008 [4], after both had just under-gone circumcision at the New Start Centre. The article promoted MC in terms of hygiene and health benefits in terms of HIV protection. The article was meant to capture the attention of older men like Mr Mubanga as well as younger men like his son.
3. Ministry of Health officials including the Hon Minister of Health have featured either on ZNBC radio or ZNBC television programs to discuss the Governments stand of adopting MC as a component of the National HIV prevention package of services.

The central theme in all the media coverages that have been cited here has been around MC providing partial protection from HIV amongst men as well as on MC enhancing hygiene and therefore indirect benefits to female partners in terms of lowered cervical cancer risk.

Though the media coverage has not been consistent and structured, there is evidence that interest amongst men has been stimulated based on the demand for the procedure in regions that have not been practicing traditional circumcision, but in which the majority of men that have expressed interest in being circumcised have been driven by the health benefits of MC [2].

Studies on Male Circumcision Rates in Zambia

According to the 2007 Zambia Demographic and Health Survey (ZDHS) [5], male circumcision rates in Zambia averages 13.1%, but with wide variations demonstrated between regions ranging from the lowest at 3.2% in the Eastern Province to 71% in the North-Western Province. Below figure 1.1 shows the MC rates by province.

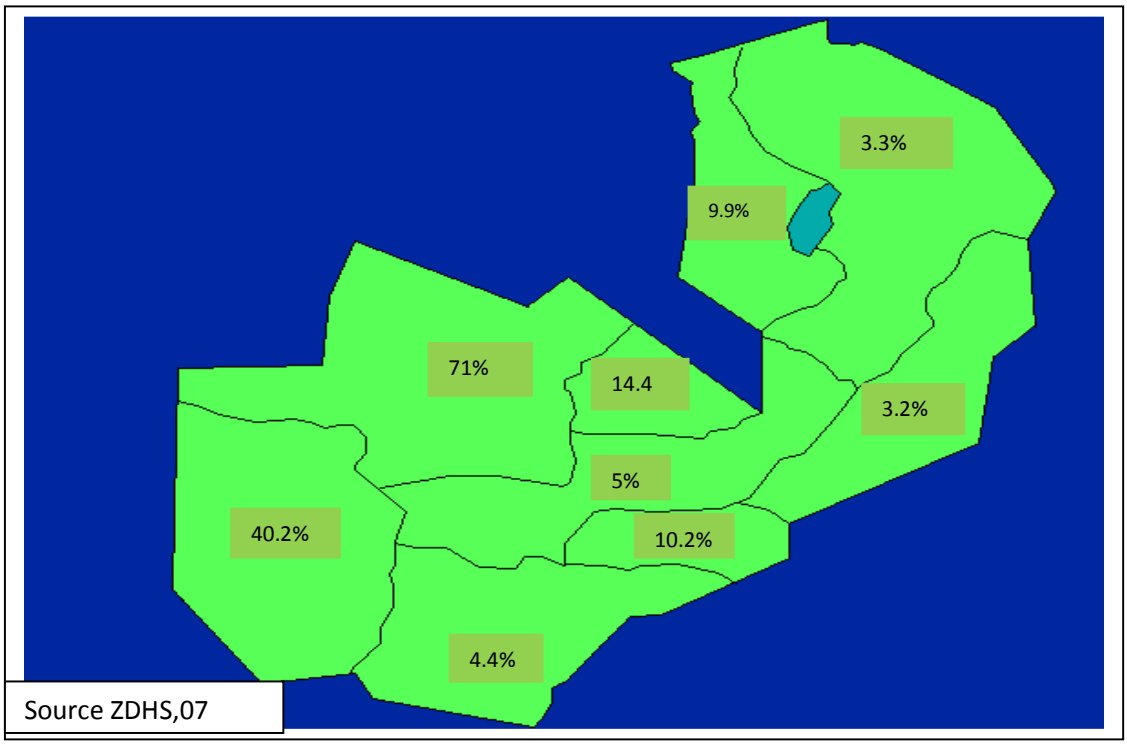


Figure 1.1 : Male Circumcision rates by province

More recent but smaller regional surveys have similarly announced prevalence rates within the range that the ZDHS suggests [2] . For more information on the percentage of men aged 15-49 who reported having been circumcised, by background characteristics you can turn to annex 1.
Table 1.3 below shows details of the male circumcision rates studies that have done in Zambia

Table 1.3 Male Circumcision Rates Studies in Zambia

Title of study	Date (dd/mm/yyyy)	Description1	Conclusions
ZDHS	2007	GRZ periodic survey on health and demographic indicators	Av. Prevalence is 13.1% (3.2% – 71%)
COH II Behavioral Surveillance Survey	2009	Behavioral survey in selected districts	Av. Prevalence is 26.2% (5.3% – 55.7%)

Modalities of Service Delivery

There is no literature that provides definite information as to whether MC services are provided on demand from the patient or by recommendation for medical purposes. There are however two scenarios obtaining in the government health facilities based on general knowledge of the public health services. It is anecdotally known that the determinant for which of the two scenarios a facility falls into is whether or not the
facility has received, or still receives support in setting up comprehensive MC services for HIV prevention. Those that do not receive any support usually will be performing
MC's for medical indications, whilst on-demand MC's are usually based on bookings which can involve long waits. On the other hand, facilities with some form of support are the ones that offer MC on demand to larger numbers of clients.

As regards cost of the procedure, again, there is no citable literature in response to the question as to whether MC services are free or not, and if so, what the cost is. However, it is known that facilities receiving some support for MC programming which is intended for HIV prevention is for free. It is not clear what obtains in facilities that do not receive any support, though it is anticipated that the abolishment of user fees in rural districts for users applies to elective circumcisions as it does to other services offered in the health facilities within the district.

As with the question of cost of MC services, there is no citable literature that would provide an answer as to which staff and facilities are providing MC services. However general knowledge is that MC's are by and large done in hospitals only, and by medical officers and surgeons. However, in sites that are being supported to set-up comprehensive MC programming for the purpose of HIV prevention, clinical officers and nursing staff have also been trained to provide MC services. Definite information including under what circumstance such MC's are done, and at what age, will only be made available through the situation analysis.

Only anecdotal evidence exists at this time as to what, or who, determines whether a client receives MC services

• Similarly, there is no citable literature as to what the list of indications is for MC in general.

• Nationally representative data is not available on rates of adverse events for MC's that are done in public facilities, and particularly in those facilities that are not supported for delivery of comprehensive MC for HIV prevention.

• As numbers and other details of MC's done in hospitals are not reported through the main-line HMIS, information on age specific groups that under-go circumcision is not readily available and a picture of national trends will need to be developed out of the data collected through the situation analysis.

Regional Variations in Male Circumcision Rates

Common knowledge on regional trends are known in Zambia, with the North Western province of Zambia being widely identified as the region in Zambia with the highest prevalence. Male circumcision amongst the people of the North Western Province is part of initiation rituals conducted on boys that have attained puberty as a traditional practice. However, there are pockets of migrants from the North Western province, Moslem communities, and Jewish settlers who practice circumcision. The ZDHS – 2007 provides the main official data on the distribution of MC prevalence by province

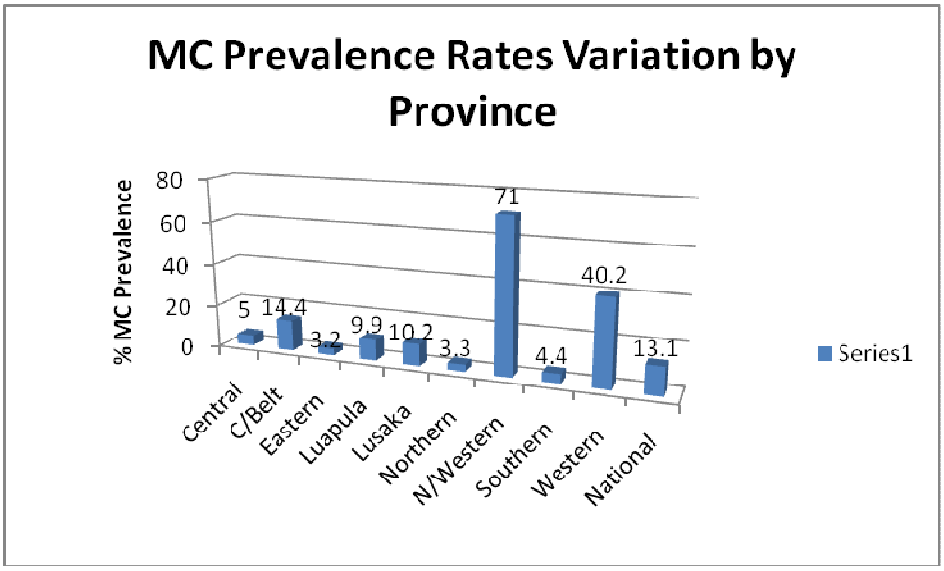


Figure 1.2 :Source – ZDHS 2007

The Male Circumcision Package

A minimum package of services that constitute comprehensive MC services is well defined in by the Zambian Ministry of Health National Male Circumcision Strategy and Implementation Plan 2010 – 2020. According to the plan which is a direct result of the high level advocacy meeting convened by the Ministry and involving all stake-holders in the MC arena, a minimum MC package must include the following services.

1. Informed voluntary consent
    a. From birth to 6years – written/documented parental/guardian consent
    b. From 7 – 17yeas – as above, plus documented oral assent from the client. In the event there is no parent/.guardian, Min of Community Dev will take up the case.
    c. 18years and above – written/documented consent
2. Pre-procedure counseling on HIV and STI transmission and risk that is on-going even if MC is not done
3. Pre-procedure counseling on the MC, including risks and benefits
4. Routine counseling and testing for HIV on an opt-out basis

5. Routine treatment of sexually transmitted infections (sti's)
6. Routine distribution of condoms
7. Point of entry for other men's health services
8. Safe medical services incorporating pain management, infection prevention, and surgical technique that conform to the national standards and protocols for male circumcision.
9. Post operative counseling on medical aspects of post-operative care and follow-up, including reinforcing risk reduction messages and practices such as the need to abstain from sex until the surgical wound is completely healed.

There does however exist, an information gap on two fronts. On one part, there is no citable literature as to whether this minimum package of MC services is currently being delivered in facilities that have thus far not received support for scale-up of MC services for HIV prevention, and to what degree. On the other part, we do not know to what extent this minimum package is being adhered to by the facilities that have established MC services for HIV prevention under donor support.

Table 1.4 : Male Circumcision Sites in the Provinces

S/n	Province	3rd/2nd Level Hospitals	1st Level Hospitals	Health Centres	Total
1.	Lusaka	1	3	22	26
2.	Copperbelt	2	3	10	15
3.	Central	1	1	5	6
4.	Southern	1		1	2

Source :MoH 2010

Table 1.4 shows the number of male circumcision sites from four provinces namely Lusaka,Copperbelt ,Central and Southern provinces .Lusaka province is leading with the number of MC sites at 26 compared with Southern province having the least number of MC sites of 2 .Of the 43 partner supported sites ,26 are supported by Society for Family Health (SFH) and 14 by Marie Stopes International (MSI) .There is need to collect some information again on the number of MC sites from all provinces.

Table 1.5 Number of MCs Performed in Selected Hospitals

MC performed Jan 2009 to March 2010							
	Site	**Ranking** **Tot 2009**	**Jan-10**	**Feb-10**	**Mar-10**	**Apr-10**	**Totals**
	Kitwe Central	5 241	45	25	22	0	333
	Solwezi General	2 198	74	46	29	85	432
	Ndola Central	1 309	31	66	85	107	598
	Livingstone	4 278	26	30	32	0	366
	Mansa	11 11	27	7	7	0	52
	Kabwe	6 126	3	3	13	19	164
	Chipata	3 228	30	24	31	110	423
	Matero Ref	7 114	15	15	8	0	152
	Kasama	9 90	3	4	0	0	97
	Mwami	8 114	11	4	3	0	132
	George Clinic	12 30	5	0	0	0	35
	Lewanika General	10			83	0	83
	Maina Soko	13				8	8
	Total	**1739**	**270**	**224**	**313**	**329**	**2875**

Source :MoH 2010

The above table shows the number of MCs done in the selected health institutions. .Ndola central hospital performed the highest number of MCs (598) and Maina Soko hospital the least (8) .A total of 2875 MCs were done.

Methodology

The situation analysis process was undertaken against the foundational principle of fostering partnerships amongst all stake-holders in order to maximize on mutual ownership of the situation analysis process as well as the programming that would follow. The build-up to the situation analysis therefore focused on strengthening the new National Technical Working Group (TWG) by constituting all four of its functional organs, i.e. the sub-committees. The work involved placement of stake-holder organizations into relevant sub-committees, drawing up of terms-of-reference for each sub-committee, and officially appointing individuals into membership of the sub-committees. Full TWG meetings were held at each stage of the process in order to;

1. reach agreement on dates for the situation analysis data collection field work dates.
2. To constitute the data collection teams using only members of the TWG
3. Revision of the WHO generic data collection tools
4. Sharing of objectives of the situation analysis. Initially, there was some disagreement about the need for a situation analysis, but with further consultation and discussion, an agreement was reached
5. To develop consensus on data collection field work procedures

The situation analysis involved collection of both qualitative data focusing on the demand and influencing factors for the service, (individuals and communities views, perceptions, attitudes, and behaviors regarding MC), and quantitative data which was focused mainly on the supply capacity of health services (situation and readiness to cushion a scale-up of MC services delivery).

Ethical Implications

The situation analysis did not involve and experimental procedures involving human subjects, and so did not require ethical approval.

During the focus group discussions involving either non-circumcised individuals, circumcised individuals, and female groups, no names of participants were collected and the results are not attributed to anyone individual, but rather are reported as views of the particular population group.

Further, only verbal consent was obtained so as not to have any documentation that would carry any informant's particulars.

Key informants were interviewed based on their official responsibilities.

Care was taken to ensure that no informant went away with any ideas that men who are circumcised are safe from HIV, or that unprotected sex with them is safe.

Specific Objectives

Describe the Current Situation

- Key sociopolitical and traditional influences on MC
- Key behaviors and attitudes that influence MC amongst individuals and communities
- Health Service capabilities for safe MC

Inform the Scale of Intervention Required to increase rates of MC

- Ability to meet current and future demands
- Capacity and possible mechanisms to increase demand
- Insight into what interventions might be effective and possible responses to them
- Assessment of capacity gaps

Limitations of the Assessment

Due to various factors, it is acknowledged that this evaluation had some limitations which have affected the completeness and accuracy of the results. Limitations included;

1. The data collection tools were never piloted after adaptation. Consequently, a number of challenges as regards interpretation of questions by data collectors and respondents arose during the actual data collection period. This resulted in;
    1. some inappropriate responses to some sections.
    2. Gaps in data collected by the various data collection groups

Findings and Discussion

The findings of the key informant interviews ,focus group discussions, health facility capabilities will be discussed under three headings;

i)key behaviours and attitudes that influence MC amongst individuals and communities
ii)key socio political, cultural influences on MC
iii)health facility capabilities for safe MC

i) Key behaviours and attitudes that influence MC amongst individuals and communities

Perceptions

Male Circumcision was mostly perceived as a practice based on some cultural or religious groups rather than as a medical procedure. This was more widely viewed to be so in Luapula province. North Western province, culturally known for MC practice in Zambia had the second highest number of respondents alluding to this view. In areas where MC is not practices culturally, MC was perceived as being associated with stigma. The attitude towards MC in these areas were stigma was apportioned to the practice was that it was looked down on and shunned. Circumcised men were viewed as ignorant and uneducated and that the normal thing was to be uncircumcised .For more details of the assessment on what the non-circumcised thought about MC you can refer to annex 2 .

To change the perception of the uncircumcised ,there is need to continuously sensitise the influential leaders and communities on the benefits of MC.

Views of Women about MC

The women's perspective of Male circumcision indicated higher frequencies in the area of it being a good and welcome practice.

The views on what women think of male circumcision given by key informer respondents indicated significantly more positive than negative views in comparison to those given by the non circumcised men. Sixteen (16), of the responses affirmed the practice as a good thing as opposed to only eight (8) of the uncircumcised male respondents welcoming it.
None of the female respondents thought that pain associated the MC procedure was anything significant to affect the attitude on people towards MC.
There was a view that modern women would be more receptive to the idea of male circumcision as opposed to the traditional ones.

Sensitisation of the women and communities on the benefits of MC (such as lowering the cases of cervical cancer in women for example) would be helpful .

Fear

Male circumcision was also perceived as a practice that instilled fear amongst uncircumcised men, with the most highly indicated source of fear being that of the pain experienced with the procedure and the healing process of MC. One respondent described it as unnecessary pain. Fears were also expressed on the healing process where it was believed that it did not go very well for those old in age.

Some people's fear was that one could die from the procedure. Amongst the key informants interviewed, an official from Ndola thought MC was not safe, because he had heard of someone who died from it. Some thought that circumcised men die from the cold. A chief in Eastern province revealed that people's fear of circumcision was especially that of losing fertility and would require a full explanation to avert this fear.
Another fear expressed by uncircumcised men in the focus group discussion was that they felt most health staff did not know how to conduct the procedure, though other respondents disagreed with this view and felt confident that staff in the medical centres, know how to operate.
It would be important to inform the public that safe MCs are offered in the facilities where health staff have been trained and that pain-killers (such as brufen) are given to the circumcised to lessen the pain.

Age group best suited for MC

A respondent from Matero health centre, in Lusaka observed that there is a transition to general acceptance of the practice. More people were bringing children for male circumcision and the program was concentrated on this age group. A traditional healer in central province indicated that, for old people it is not beneficial, because the skin does not harden.

It will be important to educate the public that circumcising male neonates and babies is technically easier than circumcising older boys or men and there are fewer complications.

Changing Attitude

On a more positive note there was a view that MC may initially be opposed but would be accepted after sensitization. Similarly in Ndola, a Clinical Care Manager at Ndola Central Hospital indicated that Information was filtering through and there is a lot of positive interest. This indicated a more positive attitude in the urban part of Zambia.

Views on out-comes of MC

Peoples ideas on MC results were explored by looking at people's ideas in general, identifying the main factors and then stating whether MC would lead to riskier sex behaviour or not.

*People's Positive ideas on the results of Male circumcision that were noted were that**;***

a) One was more hygienic and cleaner.

b) There was reduction of HIV and human papilloma virus
c) They were confident of health
d) Better sexual performance
e) Someone who is circumcised is a cultured person and it enhances the value system
f) It was better to use hospital; the cultural way was a form of torture. Hospitals offered a more friendly environment
g) Other men may want to also undergo it
h) Should be encouraged that they will still perform as men after MC
i) It is a good and welcome idea according to Muslims
j) Women prefer circumcised men and
k) It is a simple operation

The results of MC in general were appreciated firstly in the sense that one became more hygienic than a non circumcised person, and had reduced chances of contracting HIV. Secondly, such a person had better sex.

Ideas of what people think of the results of MC on a non positive note were that

a) They led a riskier Sex life
b) There faced the risk of death;
c) They had no children,
d) They suffer injury to the glans and private parts and suffer complications
e) No difference in sexuality
f) Poorer sex enjoyment
g) The sick think MC will treat them
h) Loss of shape,
i) Circumcised people thought they were immune from HIV/STI and that they were free from all diseases
j) Prolonged time for healing of wounds
k) Loss of fertility/impotence
l) They underwent the process because of their religion
m) The circumcised becomes an outcast
n) Satanist issues that would arise on the skin and blood that is taken through the procedure.
o) Think it is strange, funny and unnatural.
p) Curiosity in girls who would want to know and may be want to have sex with them.
q) Pain
r) It is traditional. It is something that is hardly talked about. It is a private matter
s) Circumcised men are not very enlightened or welcome
t) It takes less time to heal,
u) They think that you cannot get infected with HIV /AIDS

The results that were firstly most negative were the risk of death and injury to the glans and private parts and the suffering of complications that could arise. Secondly was the misconception that once circumcised one had full immunity against HIV. There was also the thought that one lost the shape of their private parts, had poorer sex, and lost their fertility or impotence. Added to this was the fear of Satanist issues surrounding the skin and blood taken from the MC procedure. The other results listed above were less thought of as results of MC.

Main factors that were found to be obtaining in terms of what people think come about as a result of MC included;

a) Hygiene
b) HIV/STI prevention
c) Enjoyment of sex
d) Medical benefits
e) Privacy, to reduce on stigma
f) Once others have undergone MC the other members may feel encouraged
g) Ideally a Muslim doctor to do MC on Muslim neonates, they understand their culture
h) Use hospitals, clinics, health centres
i) Perform it at tender age
j) Difficult because it is not talked about, until people are educated about it
k) The participants highlighted that whenever they hear the word, "circumcision", they think of "Mukanda" the traditional cutting of the male penile foreskin in male children associated to the Luvale and Lundas of Northwestern province.

To the mothers, circumcision is an opportunity for cleanliness and a sigh that the child has entered the adult world. Before the decision for the child to be circumcised were made by parents according to the child's age. No money was paid apart from parents contributing food.

The women indicated that circumcision do not only prevent infections but also make it easy for the lady to clean the male penis after sex as dictated by tradition. "It is easier to clean a circumcised and given a chance would go for the circumcised," they said in unison.

HIV/STI prevention as a result of MC rated highest with respondents alluding to that thought. Medical benefits rated second followed by medical benefits and sexual enjoyment as thoughts people would have of what would result from taking MC. Privacy to reduce stigma, resulting from MC, was also significantly noted as an important factor in MC

Male Circumcision scale up

Of the issues that might prevent someone from accessing MC services, participant's highlighted the following;

a) "No sex for six weeks can bring in marital problems especially if not discussed as a couple. One participant narrated the story of one man who recently under went circumcision but hid it from the wife. A week without sex made the wife to table the issue among the elders. Only then did she learn that the husband had been circumcised and will have no sex for the next five weeks.
b) "Circumcision is for children and not for adults. A circumcised man especially the married will only see thighs/breasts and develop an erection and will end up having sex despite the wound" lamented one participant.

c) Knowledge and clarity of information especially pain can hinder some from taking their children for male circumcision.

Of the issues that might prevent someone from accessing male circumcision services, participant's highlighted the following;

a) "The length of time before starting to have sex is just too much for me, I can't stay that long without sex" indicated participant 2.
b) "Have been married for sixteen years, and if I decide to do Male circumcision today, what will my wife think of me…a play boy?" "I do not want conflicts at home" said one married man.
c) Want to be natural and with complete sensitivity during sex.
d) Fear of pain
e) In the old age may be difficult to reach orgasm
f) "We hear people sign before the Male circumcision procedure and that means that the whole issue is complicated and one can die" lamented one participant.

However the participants also indicated that benefits of male circumcision according to the newspaper and radio;

a) Reduce the acquisition of sexually infected infections
b) Reduces cancer in male and female
c) Reduces HIV transmission
d) Increased sexual satisfaction in women
e) Its clean and hygienic

Bad effects were highlighted below:

a) The foreskin removed during male circumcision protects the urethra therefore you become prone to infection
b) Fear of pain and the wound cannot heal in time especially for the old.
c) Conflicts at home before the wound heals
d) You can become a bull sexually, "kuti waleka umwana wabene afenta during sex"
e) Can encourage prostitution

f)12-15 years because you can teach them on the benefits/risks and are not sexually active therefore abstinence from sex is not applicable", indicated one participant

ii)Key socio-political and traditional influences on MC

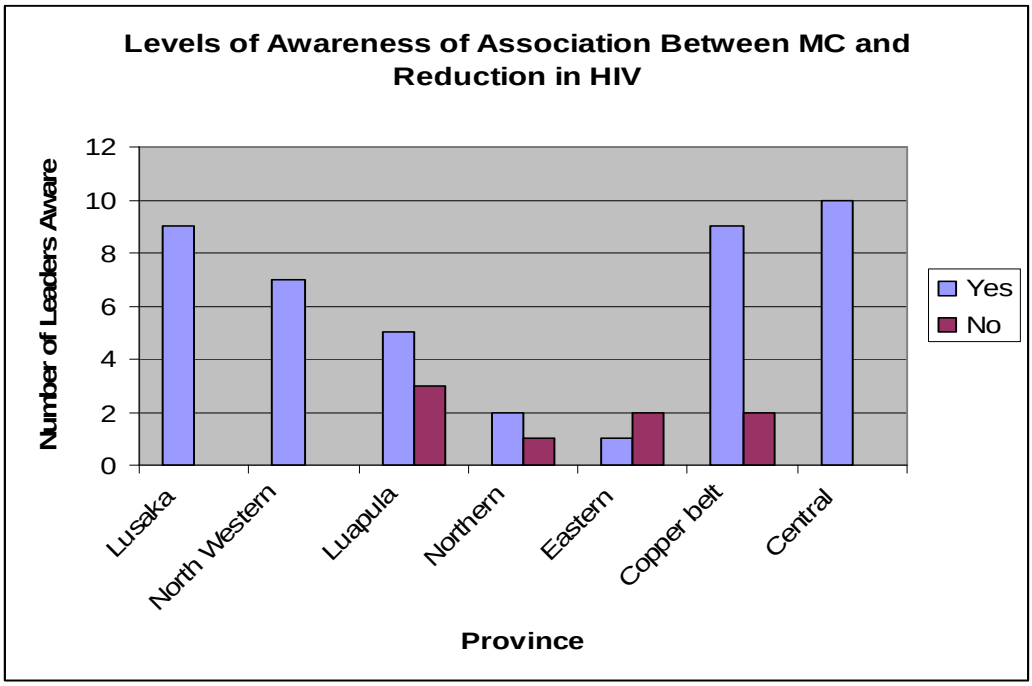
Awareness among influential leaders

The association between male circumcision and reduced risk of HIV infection is not totally unheard of in Zambia. Information from key informer interviews indicates that more leaders were aware of the association than those that were unaware. The awareness is much more in the urban than the rural areas. Central, Copperbelt and Lusaka provinces scored the higher number of key informants indicating

that they were aware. Western province was the highest rural province indicating any awareness. Eastern province had the lowest score. Responses given by other leaders were that they learnt of the association through reading literature and health articles.

It will be important to raise the levels of awareness on MC and its association with HIV prevention among all influential people in the society such as chiefs,church leaders ,role models and politicians in order to promote MC .

Figure 1.3 Levels of awareness of association between MC and Reduction in HIV



Main factors believed to be affecting rates of male circumcision in Zambia

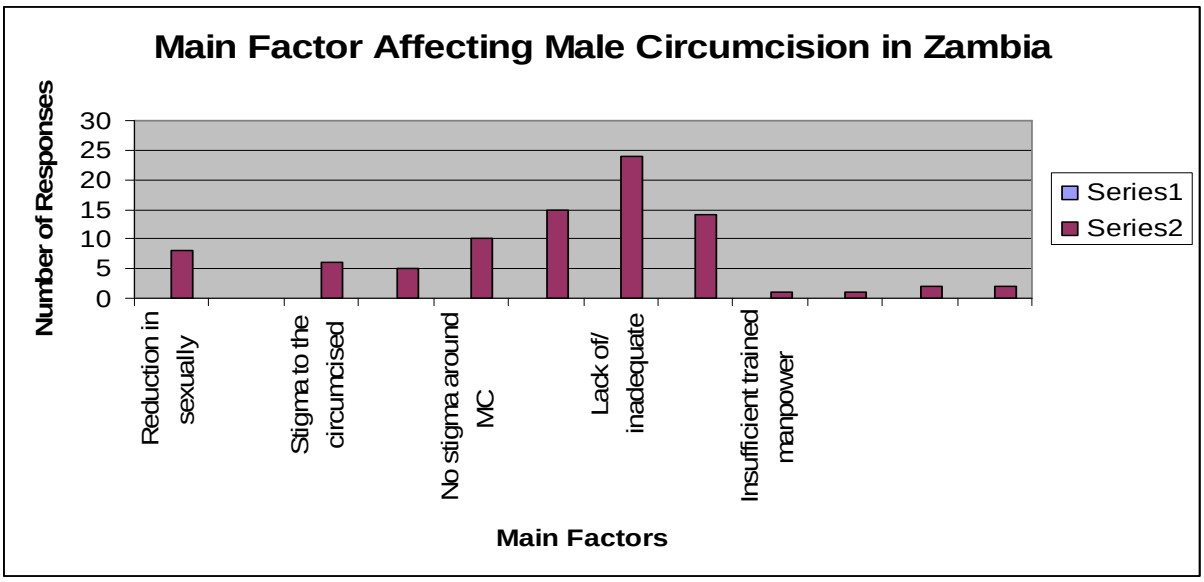
Main factors believed to be affecting rates of male circumcision in Zambia, yielded consistent responses in the area of cultural, traditional and or religious beliefs, Lack of or inadequate information and knowledge, stigma and health related reasons. Prominent in this category was the element of culture and tradition. Inadequate information was also widely alluded to as affecting the MC rates. The

tendency also was that MC was done with minimal explanations apart from the fact that a male child was of age. It was passed on to children with no explanation.

Prevention and reduction of sexually transmitted infections and HIV, hygiene, cleanliness and medical benefits were also significantly alluded to by a mix of health personnel and the clergy as factors affecting rates of MC.. A good number of respondents thought that cultural beliefs had a significant effect on rates of male circumcision, with eleven respondents alluding to this fact While cultural beliefs appeared as a factor in every province it appeared with a stronger emphasis in eastern province of Zambia. In another perspective MC had traditional restrictions to cultures in North western province.

Related to this was the factor of stigma and then also religious beliefs. In Addition inadequate or lack of complete information had a profound effect.

Figure 1.4 Main Factors Affecting Male Circumcision in Zambia



Factors for MC were cultural ,tradition or religious beliefs,HIV/STI prevention and hygience .

Factors against MC were lack of/inadequate knowledge ,stigma,cultural beliefs ,no education and government support.

iii) Health Facility Capabilities for Safe MC

Service Delivery

All the provincial hospitals (level 2) visited during the data collection as well as the district hospitals (Level 1) offered medical male circumcision services. The MC services that were being offered included informed consent, pre-operative medical assessment for anesthesia, the surgical procedure, and post operative review. the components that were missing from the minimum package of MC services included HIV counseling and testing, counseling on MC, promotion of condom use, and STI counseling, screening, and treatment. All the 10 Level 2 hospitals that were visited, offered the minimum package of MC services. However, only half of the level one hospitals were found to be providing the full package of MC services.

As compared to the level 2 hospitals that primarily will require strengthening in order to provide comprehensive programming, the level 1 hospitals will require actual setting up of MC service delivery.
All Health Centers providing MC were those supported for setting up MC programming for HIV prevention by NGOs. Consequently, these all were found to be providing the minimum package of MC services.

Table 1.6 Facilities Offering MC Services

Province	Level 2 Hospital	Level 1 Hospital
Central (Kabwe/Kapiri)	Yes	No
Copperbelt (Ndola/Twapia)	Yes	No (HC)
Eastern (Chipata/Lundazi)	Yes	No
Luapula (Mansa/Kawambwa)	Yes	Yes
Lusaka (Lusaka/Matero)	Yes	Yes
Northern (Kasama/Mbala)	Yes	Yes (L2)
Northwestern (Solwezi/Kazembe	Yes	No (HC)
Western	Yes	No
Southern (Livingstone/Zimba)	Yes	No

Infrastructure

Lack of or insufficient infrastructure for MC centres and long waiting time before the procedure, were among factors identified to affect MC during interview of key informants.
Focus Group Discussions with health workers revealed that space was limited and they had challenges with equipment .The discussion further revealed that space in theatre would only be chanced for MC and only three procedures could comfortably be done on a clinic day.

Overall space for scale-up of MC services was adequate in 6 of the 10 level 2 hospitals visited, whilst 2 Of the 9 Level 1 hospitals had adequate space for scale-up.

The challenges identified were primarily with counseling areas, waiting area, operating area and recovery areas. It was noted that minor infrastructural improvements and provision of furniture will be required to assure quality of the MC service .

Table 1.7 :Service Delivery

Hospital		**Availability of Space For Male Circumcision Programme/Services**					
	Overall Space Available For MC	Counseling Space	Operating Space	Recovery Space	Training Space	Waiting Space	Functional Status of the Institution
Chipata General	YES	NO		YES	YES	YES	Level 2
Twapia Clinic	NO	YES		NO	N0	NO	Health centre
Lundazi	NO	NO		YES	NO	NO	Level 1
Kabwe General	N0	NO		YES	NO	NO	Level 2
Kapiri	NO	YES		NO	YES	NO	Level 1
Solwezi General Hospital	N0	NO	NO	NO	NO	NO	Level 2
Mbala General Hospital	YES	YES		YES	YES	NO	Level 1
Matero Referral centre	NO	YES		NO	YES	NO	Health cenre
Kazembe RHC	YES	YES		YES	YES	YES	Health centre
Mansa General	YES	YES		YES	YES	YES	Level 2

Kawamba	NO	NO		NO	N0	YES	Level 1
Mosi-otunya RHC	NO	NO		NO	NO	NO	Health centre
Livingstone General	YES	YES		YES	YES	YES	Level 2
Kasama							No feed back
Copperbelt							No feed back

Logistics Management

- Most of the facilities interviewed indicated that Supply of consumables for MC has not been standardized across the country and that health facilities use general medical surgical supplies meant for other services to undertake MC. However few sites supported by partners had medical surgical supplies specifically for MC though according to the key informants interviewed the challenge in these partner supported sites has been that health workers are not allowed to use MC specific kit for other cases especially where there are stock outs of particular items on the other services. These under-scores the need to integrate MC into existing services so that the whole logistics system for surgical supplies is strengthened.

  These findings were supported by focus group discussions with the health workers that reported a shortage of MC kits at the MC sites and having experienced the challenges noted above.

The human resource situation

- In all facilities visited, there were no health workers (HW's) dedicated to MC Service delivery, but staff that are trained provide the service at certain times only.

  The table below shows-:

  i. The average numbers of various health workers that facilities across the country feel can be allocated to MC services.

  ii. The table also shows the average numbers of health workers that are currently trained in MC.

Table 1.8 :Proposed human resource distribution for MC services

Facility Level	Health Worker Category	No. Can Be Assigned	No. Trained Currently	Comment
Level 2 Hosp	Medical Officer	2	2	CO's and Nurses, are likely to be key in service delivery. More need to be trained
	Clinical Officer	4	3	
	Nurse	7	3	
	Counselor	5	-	
Level 1 Hosp	Medical Officer	1	1	This level of facilities constitutes the larger % of new sites for 2010. Training still required, particularly for CO, Nurses, and counselors
	Clinical Officer	2	1	
	Nurse	2	1	
	Counselor	2	-	
Health Centre	Medical Officer	0	1	Training saturation will be reached quickly at this level, and focus may need to be placed more on out-reach services, except for the urban sites that have more health workers
	Clinical Officer	1	2	
	Nurse	2	1	
	Counselor	1	-	

- Key providers will differ at different levels of service delivery. As was found, in the sites not oriented/trained in the MC programme, the procedure was done primarily by medical officers.

- Dedicated data personnel for MC were not available. Information tasks are primarily carried out by the health workers involved in MC Service delivery.
- In the focus group discussions suggestions were that they should be specific people to run MC Services and also suggested the need to have an MC Counselor.

Data Management

It was found that the District Health Information Officers have not been involved in MC work. There are no standardized data collection tools on MC though there are data collection tools in centres that are partner supported . As a result, it was very difficult to collect reliable disaggregated data on number of clients by ages that were circumcised over the period under review.It will therefore be important to integrate MC into the HMIS .

Quality Assurance

There were no standardized MC quality assurance (QA) guidelines for health workers in all the facilities though partner supported facilities had general MC guidelines. However, most hospitals had QA committees, even though these committees did not address MC QA issues in their activities.

Most level 1 hospitals had required surgical equipment (all level 2 hospitals, and six 6 of 9 level 1 hospitals)

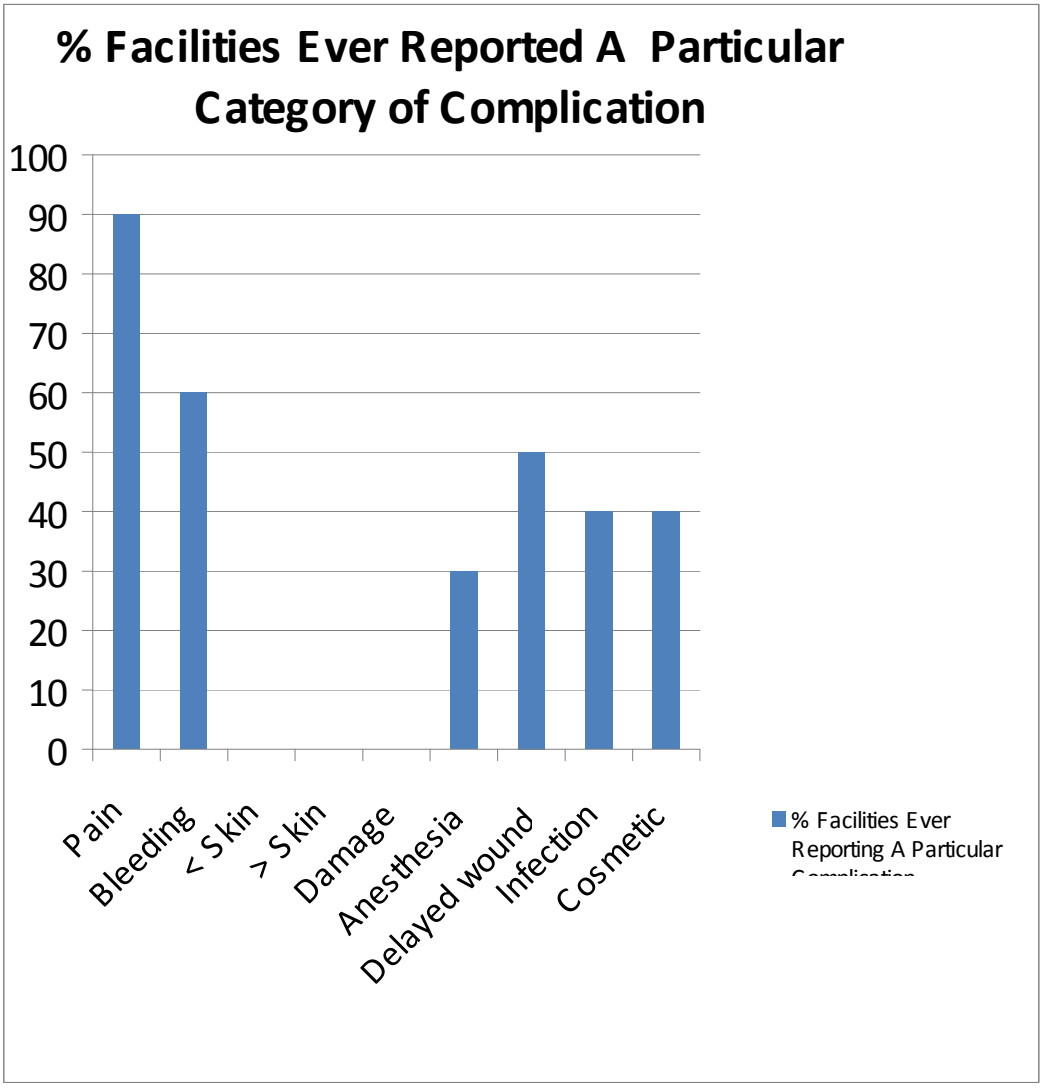
All the 19 facilities visited used the commonly used method (dorsal slit approach) and local anesthesia, for clients above 12 years.

All facilities were using paracetamol for analgesia except for a few who reported use of opioids.

From the data that was collected, it appeared that lower levels facilities did not have any higher risk of recording any particular category of complication that higher level facilities did. This is based on the results from the level two, one, and health center information collected during this assessment.

Table 1.5 shows the percentage of facilities ever reported a particular category of complication

Figure 1.5 : Percentage of facilities ever reported a particular category of complication



Input From Focus Group Discussions On Improving Service Delivery

The most important factors needed to be changed in order to increase the provision of health-facility-based male circumcision

Important factors that would need to be changed in order to increase the provision of Health facility based male circumcision were indicated mainly in the areas of sensitization, training, increasing numbers of skilled personnel, transport, infrastructure and provision of Incentives.

a) Important Factors Needing Change

Sensitization was highly recommended as an important factor in bringing about the change that would increase the provision of health facility based male circumcision. It was suggested that Sensitization could be done through church and communities leaders, such as pastors, chiefs and counselors. It was important the availability of information to Area development Committee's (ADC's) was done as they were not well informed.
It was also necessary to create demand for the service by showing the benefits of MC. There was a need to take this programme to village level through sensitization.

It was suggested that MC Service should be given priority and made available every day.
It was felt that clients for male circumcision should not be made to queue with other patients. In building capacity in traditional settings an illustration was given in this vein to integrate or marry traditional circumcisors during facility MC procedures and by setting up camps and co-opting surgical system to traditional and vice versa.

Training was an important factor in the MC scale up. It was suggested that training in the procedure of MC should be incorporated in the curriculum of health personnel. It was also suggested that the number of skilled personnel should be increased at the centers. Others felt that the MC providers needed to be supervised by medical doctors to minimize complications.

Infrastructure was also indicated as an important factor in bringing about change in relation to increasing health facility based circumcision. Prominent among the suggestions was to renovate the existing structures rather than building new ones. The renovated clinics should be equipped with instruments, consumables and transport for the service.

Provision of incentives was raised as an important factor and suggestions on ways in which it could be done were given in a number ways. These included Making Circumcision free so as to increase uptake. A contrary view to this one suggested making circumcision self sustaining by charging a fee.

Other factors noted included, outreach, the moving away from traditional practice to medical centres, combining medical and traditional methods and improving aftercare services,

b) The use of Financial Resources in increasing the Provision of Health Facility Based Male Circumcision

The use of funds or resources was allotted to the use of the following items;

- Training of providers
- Outreach

- Sensitization on benefits of Male circumcision through community structures such as traditional, religious authorities using:
  1. IEC materials
  2. Mass media communications
  3. Interview role models
- Incentives for Community volunteers
- Supplies, drugs, cleaning materials, provide basic minimum supplies in 9 provincial hospitals
- Building operating rooms.
- Resources for providing quality and safe MC

- Taking the MC service closer to the community
- Equipment and transport
- The cost of actual MC procedure
- Incentives for providers

c) Roles of Key Stake holders in Increasing MC Services

Respondents cited several roles that organizations could play in increasing male circumcision services. These included;

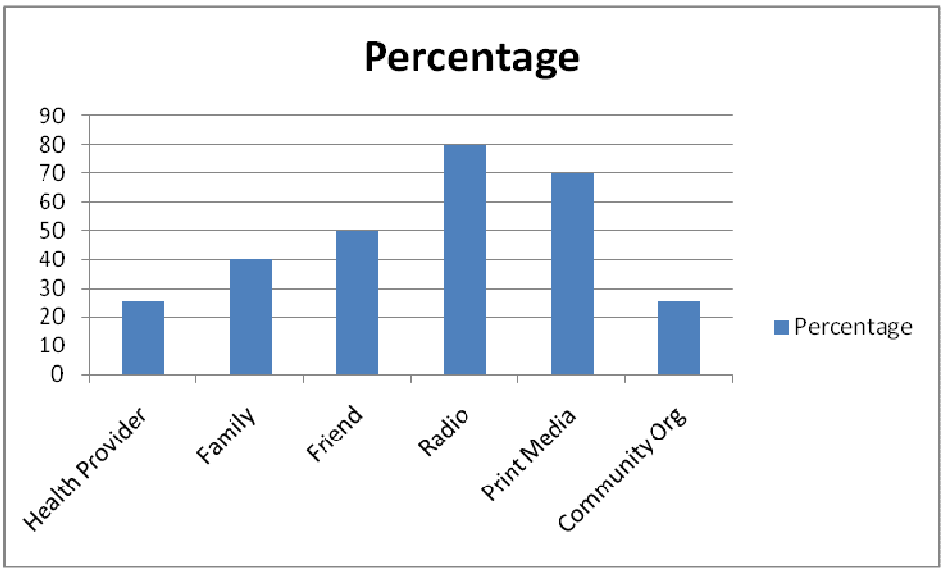
- Community mobilization
- Train providers, set up many centers with minimum standards
- Doing the actual procedure (medical centre), for others only if they are trained and supported.
- Working with DHMT, to provide the service
- Lobbying from government and donors, advocacy
- Provide political leadership.
- Organizations can disseminate information
- Provide materials, equipment, drugs
- Working with traditional male circumcisers

d) Things to Do to Increase the Demand for Male Circumcision

Regarding changes that would need to be done to increase the provision of health facility based circumcision, sensitization was the most indicated thing that would need to be done in order to increase the demand for MC. Fifty seven of respondents alluded to this factor. A respondent from eastern province suggested to target pregnant mothers and would be fathers through antenatal clinics and maternity wards. Information could be given to mothers during ant-natal visits and additional posters displayed on the walls of MCH including caption on ant-natal cards. Parents would be reminded of MC during gestation hence it would easy for them to decide on MC upon the birth of their child. Mobile hospitals were suggested in one province, Luapula. .For more information on the assessment refer to annex 8.

From the data collected from the field for example amongst males that had procured a circumcision, it appeared that radio and print media contributed the most towards the number that had sought the service. This underscores the to intensify sensitization to create demand These results correlate well with the findings from the focus groups discussions. However, the coverage of this means of information dissemination is apparently still limited and other methods which can influence a larger group of the community should be brought on board.

Figure 1.6 :Proportion of Clients Influenced by Source of Information



e) The Likely Age at Which Parents Would Have Their Male Children Circumcised

The age at which parents would decide to have their male children undergo circumcision, given *that Circumcising male neonates and babies was technically easier than circumcising older boys or men and there were fewer complications* was subscribed to . To the contrary a few thought it not the best, to have them circumcised at that age.

f) Combining the MC Program with the Offer of an HIV Test with referral service to the HIV Positive

The view was given that programs for male circumcision will probably include the offering of an HIV test, with referral to counseling and medical services if the person is HIV-positive. Taking an HIV test will not, however, be mandatory, and men who are HIV-positive may receive a circumcision. A question was raised on whether this policy of offering HIV testing would affect the program, to increase male circumcision. Further, queries were raised on how a country could go about prioritizing male circumcision services, for men who are HIV negative and what the possible reactions would be, to such a policy, by men seeking MC.

g) Effect of Combining HIV Testing with MC Program on the Policy of increasing MC

A significant number of respondents thought that offering a HIV test with referral to counseling and medical services for the HIV positive would negatively affect the MC program. Fewer respondents, but quite a significant number held an opposite view that an offer of an HIV test would not reduce the numbers of people seeking MC ..

Further expressions on the subject were that the HIV test would generate stigma and would be a form of discrimination. Other thoughts were to;

Use opt-out approach
Make HIV testing mandatory, but that is not desirable
MC should be offered to HIV positives and negative's if they want it so long as they are aware of the risks and benefits
Focus on those who come voluntarily.
Country puts up mandatory policy for those that are HIV negative
Introduce a policy that all men should be circumcised, disseminate benefits, and give incentives
Continue to educate and counsel or sensitize on circumcision
Emphasis should be on MC not VCT

Under this analysis it was strongly felt that men would be reluctant to seek MC and that there would be elements of discrimination to such a policy than the fact that it would be taken favourably.

For more information on the assessment refer to annex 10.

Conclusion

The Ministry of Health has embraced male circumcision as one of the key preventive strategies to reduce the transmission of HIV in the sexually active population. In order to realize the benefits of male circumcision

- Sensitization will need to be intensified to the influential leaders and communities to address the behaviours ,attitudes and the socio- political cultural issues
- There will be need to create an enabling environment in terms of building health care capacity and adherence to MC standards so as tow win public confidence
- There is need to improve the infrastructure, human resource, logistics management, quality assurance as well as integrate MC data management in the existing HMIS
- There will also be need for strong leadership and political commitment at all levels in order to accelerate the MC scale up programme in Zambia.

Recommendations

Critical areas needing change

- Sensitisation on MC is needed, particularly in low prevalence provinces (Eastern, Luapula, Northern)
- Perception by public that skills to perform are not adequate in health facilities need to be addressed. Focus on quality within the scale-up will be vital if we are to build confidence with the public and not risk breaching this as a result of quality problems
- Increasing Access to Services is obviously needed. There is need to increase access in order to initially equalize the current demand with capacity before further demand stimulation can be done.
- Increase availability of trained personnel. However, there is also need to explore service delivery approaches that will provide feasibility in meeting targets in the context of the current human resource situation in the country
- Resolve issue of infrastructure to cater for privacy
- Resistance of women being involved in service delivery may need to be addressed culturally sensitive manner, particularly were this is a problem

Issues to high-light in stimulating demand

- Messages on Benefits must be developed based on the findings of the situation analysis. These messages must include;
  - Hygiene Benefits
  - HIV/STI prevention (and lowering chances of cervical cancer in women)
  - Better sex
- Engagement of Key figures will be key, particularly in dealing with the 3 provinces with lowest prevalence and highest resistance to MC. Key figures must include
  - Traditional leaders are going to be key to engage
  - Politicians, teachers, religious, and traditional leaders
- Privacy assurance - what do we do about the MOVE concept as we attempt to attain the numbers? This will need to be piloted to determine acceptance
- Messages advocating for HIV testing need to be carefully designed to avoid negating MC program
- Strengthening of MC leadership at all levels to accelerate MC scale up in Zambia

References

1. WHO (2009). Male Circumcision Situation Analysis Tool Kit. Male Circumcision Clearing House; www.malecircumcision.org/

2. Corridors of Hope Project/FHI. Round 4; Behavioural Surveillance Survey – Preliminary Data. October 2009

3. Post News Paper edition of Tuesday the 3rd April 2007

4. Post news Paper edition of the 28th December 2008

5. Zambia Demographic and Health Survey. 2007

6. Ministry of Health National. Male Circumcision Strategy and Implementation Plan 2010-2020

7. Zambia Country report ,Monitoring the Declaration of Commitment on HIV and AIDS and the Universal Access,2010

Annexes

Annex 1 :Male Circumcision

Percentage of men aged 15-49 who report having been circumcised, by background characteristics

Background Characteristic	Percentage circumcised	Number of men		Background characteristic	Percentage circumcised	Number of men		Background characteristic	Percentage Circumcised	Number of men
Age				**Residence**				**Province**		
15-24	11.4	2,482		Urban	13.1	2,601		Central	5.7	559
15-19	10.1	1,416		Rural	12.4	3,395		Copperbelt	14.4	1,140
20-24	13.2	1,066						Eastern	3.2	795
25-29	12.2	977						Luapula	9.9	387
30-39	14.1	1,671						Lusaka	10.2	1,072
40-49	14.3	865						Northern	3.3	805
								N/Western	71.0	303
								Southern	4.4	621
								Western	40.2	315

Education	Percentage circumcised	Number of Men		Wealth	Percentage circumcised	Number of men		Total	Percentage Circumcised	Number of men
No Education	12.6	267		**Quintile**				15-49	12.7	5,995
				Lowest	11.1	1,114				
Primary	11.9	2,775		Second	15.8	869		Men		
Secondary	13.1	2,512		Middle	13.9	1,097		50-59	14	505
Post Secondary	14.8	441		Fourth	12.4	1,381		Total men		
				Highest	11.7	1,534		15-59	12.8	6,500

ZDHS 2007

Annex 2 - What Non Circumcised Men Think About Male Circumcision

Province	Lusaka	N/ Western	Luapula	Northern	Eastern	C/Belt	Central	**Total**
Response								
It is a painful procedure/afraid of healing process	2	0	2	0	0	2	0	6
It is a traditional/Cultural Practice	1	2	0	1	1	4	3	12
It is only for Muslims	0	0	0	0	1	0	0	1
Only provided by traditional people	0	0	0	0	0	1	0	1
Reduces Men's Sexual enjoyment	2	1	1	0	0	0	1	5
Reduces risk of contracting HIV	0	0	1	0	1	0	2	4
Think it is 100% protection from HIV	3	0	0	0	0	0	0	3
Risky process/may lead to death	0	1	0	0	0	2	1	4
Can cause Impotence	1	0	0	0	2	0	1	4
It is welcome/ More recently/ with information	4	0	0	0	1	2	1	8
Looked down on/shunned	1	3	4	1	1	0	3	13
Poor healing due to old age	0	0	0	0	0	0	1	1
No comment/don't know	1	2	1	1	0	2	0	7
Uninformed/insufficient information/ no Knowledge of it	0	0	0	0	0	4	0	4
Non Christian males (un)Married should go for it	0	0	0	0	0	0	1	1

Leads to careless sexual behavior	0	0	0	0	0	1	0	1
Women enjoy it better than men	0	0	0	0	0	0	1	1
Apprehension/Ambivalence/suspicion	0	0	2	0	1	1	0	4
The circumcised Look down on the uncircumcised	0	1	0	0	0	0	0	1
Not mandatory	0	1	0	0	0	0	0	1
No response	0	0	0	0	0	0	0	0
Total respondents	10	7	8	3	3	11	10	52

Annex 3-What women think about MC

Province	Lusaka	N/ Western	Luapula	Northern	Eastern	C/belt	Central	Total
Response								
That it is generally a good thing/ is welcome (No particular reason given)	5	3	2	0	0	3	3	16
Reduces risk of sexually transmitted infections (HIV/ STI's, UTI's)	2	1	1	0	1	0	3	8
Increases sexual enjoyment	2	2	3	0	0	1	2	10
Cleanliness	1	2	2	0	0	0	2	7
Makes no difference/not necessary	1	1	2	1	1	2	1	9
Insufficient/no information/knowledge/ Do not know	3	2	1	1	1	4	1	13
Tribal /not	2	1	0	0	0	2	0	5

common practice								
Traditional women will oppose it. Modern women will embrace it	1	0	0	0	0	0	0	1
No Comment	0	0	0	1	0	0	0	1
Circumcision associated with rituals	0	1	0		0	0	0	1
Will appreciate non circumcised men (Zambian Men)	0	0	0	0	0	0	0	0
Respondent Total	10	7	8	3	3	11	10	52

Annex 4 – Important factors to change to increase provision of health facility based MC

Province	Lusaka	N/ western	Luapula	Northern	Eastern	C/belt	Central	Total
Sensitization	4	4	4	0	2	6	6	26
Staff Training	4	0	0	1	1	2	2	10
Include training in curriculum	3	1	0	0	0	1	0	5
Increased skilled personnel	1	2	1	0	1	0	3	8
Transport	1	1	0	1	2	2	1	8
Infrastructure	2	3	1	0	1	2	1	10
Outreach	1	0	2	0	0	2	0	5
Provide Incentives	1	2	0	1	0	2	2	8
Move away from traditional practice to medical centre	0	0	0	0	1	0	0	1
Combining medical and Traditional methods	0	2	0	0	0	1	0	3
Incorporate Privacy	1	1	1	0	1	1	0	5
Misconceptions, myths, beliefs (dealt with)	0	0	1	0	0	1	3	5
Staff are unskilled to	3	1	5	0	1	0	8	18

perform procedure								
Existing staff are skilled to perform procedure	1	2	2	0	2	0	0	7
Community mobilization	1	0	1	0		0	0	2
After care of the circumcised	0	0	0	1	1	0	0	2
Make service more easily accessible/bring closer to people	4	1	0	0	2	2	2	11
Provide Materials/ Supplies	3	1	1	1	0	1	0	7
Make MC self sustaining (charge fee)	0	1	0	0	0	0	0	1
Involve Government	0	0	0	0	1	0	1	2
Organisation Roles:								
Actual procedure (If trained)and/ supported	1	0	1	0	0	2	0	4
Community mobilization	1	0	0	0	0	0	1	2
Sensitization	4	4	0	1	2	4	1	16
Literature distribution	0	1	1		0	0	0	2
Physical Presence	0	0	0	0	1	1	1	3
Provide materials, equipment, drugs	0	0	0	0	0	1	1	2
Train Health Practitioners	1	0	0	0	0	0	4	5
No response/don’t know	10	0	8	2	0	0	0	20
Total respondents	10	7	8	3	3	11	10	52

Annex 5 Frequencies – Ideas people may have about the results of male circumcision

Province	Lusaka	N/ western	Lua-pula	North-ern	East-Ern	C/belt	Cen-Tral	Res-ponse Total
Response								
Peoples Ideas on MC results:								
More hygienic; cleaner	4	1	0	0	0	1	0	6
Think they are immune from HIV/STI	1	0	0	0	0	1	1	3
HIV reduction; reduced human papillona virus	1	0	0	1	0	1	3	6
Think they are free from all diseases	1	0	0	0	0	0	0	1
Confident of health	0	0	2	0	0	0	1	3
Riskier Sex life	0	1	0	0	0	0	0	1
Risk of death;	1	0	0	0	0	2	1	4
No children,	1	0	0	0	0	0	0	1
Injury to glans, private parts/complications	1	1	0	0	0	1	1	4
Better sexual performance	2	0	2	0	0	1	0	5
No difference in sexuality	1	0	0	0	0	0	0	1
Poorer sex enjoyment	1	1	0	0	0		1	3
The sick think MC will treat them	0	0	0	0	0	0	0	0
Loss of shape,	2	1	0	0	0	0	0	3
Prolonged time for healing of wounds	1	1	0	0	0	0	0	2
Loss of fertility/impotence	0	0	1	0	1	0	1	3
Because of their religion	1	0	0	0	0	0	0	1
Cultured person, enhances the value system,	1	1	0	0	0	0	0	2

Become outcast	1	0	0	0	0	0	0	1
Use hospitals, culture is form of torture, Hospitals offer more friendly environment	0	1	0	0	0	0	0	1
Satanist issues on skin/blood	0	0	1	1	0	0	1	3
Think it is strange, funny and unnatural.	0	0	0	1	0	0	0	1
Curiosity in those girls would want to know and may be want to have sex with them.	0	0	0	0	1	0	0	1
Other men may want to also undergo it	0	0	0	0	1	0	0	1
Should be encouraged that they will still perform as men	1	0	0	0	1	0	0	2
It's a good welcome idea according to Muslims	0	0	0	0	1	0	1	2
Pain	0	0	0	0	0	1	0	1
It is traditional. It is something that is hardly talked about. It is a private matter	0	0	0	0	0 0	1	1	2
Women prefer circumcised men	0	0	0	0	0	1	0	1
Circumcised men are not very enlightened or welcome	0	0	0	0	0	1	0	1
It takes less time to heal	0	0	0	0	0	0	1	1
It is a simple operation	0	0	0	0	0	0	1	1
They think that you can not get infected with HIV /AIDS		0	0	0	0	0	1	1

Main Factor:								
Hygiene	3	0	0	0	0	0	0	3
HIV/STI prevention	4	4	0	0	0	1	6	15
Enjoyment of sex	1	0	0	0	0	1	1	3
Medical benefits	4	1	2	1	0	1	0	9
Privacy, to reduce on stigma	0	0	0	1	0	0	0	1
Once others have undergone MC the other members may feel encouraged	0	0	0	0	1	0	0	1
Ideally a muslim doctor to do MC on muslim neonates,they understand their culture	0	0	0	0	1	0	0	1
Use hospitals, clinics, health centres	0		0	0	0	1	0	1
At tender age	0	0	0	0	0	1	1	2
Difficult because it is not talked about, until people are educated about it	0	0	0	0	0	1	0	1
Riskier sex after MC?-								
Yes	5	2	7	2	0	3	3	22
No	3	1	1	1	0	1	1	8
Inform them of protective measures as circumcision is not 100%	0	4	1	1	3	0	3	12
Riskier sex if sensitization is not good enough	3	1	3	1	0	3	1	12
No response	3	1	1	1	1	6	2	15
Total respondents	10	7	8	3	3	11	10	52

Annex 6 - Frequencies –Awareness on the Association between MC and the reduced risk of HIV

Province	Yes	No	No Response	**Totals (Respondents)**
Lusaka	9	0	1	10
North Western	7	0		7
Luapula	5	3		8
Northern	2	1		3
Eastern	1	2		3
Copper belt	9	2		11
Central	10	0		10
TOTALS	44	8	1	52

Annex 7 : Frequencies- Main factors affecting male circumcision in Zambia

Province	Lusaka	N/ western	Lua-pula	North-ern	East-ern	C/belt	Cen-tral	Total
Response								
Reduction in sexually transmitted infections HIV, STI's	4	3	1	0	0	0	0	8
Hygiene/cleanliness /medical benefits	2	2	1	0	0	0	1	6
Stigma to the circumcised	0	1	2	0	0	1	1	5
Stigma to the uncircumcised	5	4	0	0	0	0	1	10
No stigma around MC	0	1	2	3	2	5	2	15
Culture/Tradition/Religion (beliefs)	4	2	2	1	2	7	6	24
Lack of/ inadequate	1	1	5	0	1	1	6	14

information/knowledge/Sensitization								
Poor healing of wounds	0	0	0	0	0	0	1	1
Insufficient trained manpower	0	0	0	0	0	0	1	1
Lack of/insufficient MC centres/-Long wait time before the procedure	0	0	0	0	0	0	2	2
Fear of complication of deformities	0	0	0	0	0	1	1	2
Least important- - infrastructure	0	0	0	0	0	0	1	1
- Tradition	1	0	0	1	0	0	0	2
- Pain	0	0	0	0	0	0	1	1
- The safety of the procedure	0	0	0	0	0	0	1	1
sexual pleasure	1	1	1	0	0	0	0	3
Respondent Total	10	7	8	4	3	11	10	52

Note: response totals will not tally with no. of respondents as some respondents gave more than one response per question.

Annex 8 : Frequencies – Important factors to change to increase provision of health facility based MC

Province	Lusaka	N/ western	Lua-pula	Norh -ern	East-ern	C/belt	Cen-Tral	Total
Sensitization	4	4	4	0	2	6	6	26
Staff Training	4	0	0	1	1	2	2	10
Include training in curriculum	3	1	0	0	0	1	0	5
Increased skilled personnel	1	2	1	0	1	0	3	8
Transport	1	1	0	1	2	2	1	8
Infrastructure	2	3	1	0	1	2	1	10
Outreach	1	0	2	0	0	2	0	5
Provide Incentives	1	2	0	1	0	2	2	8
Move away from traditional practice to medical centre	0	0	0	0	1	0	0	1
Combining medical	0	2	0	0	0	1	0	3

and Traditional methods								
Incorporate Privacy	1	1	1	0	1	1	0	5
Misconceptions, myths, beliefs (dealt with)	0	0	1	0	0	1	3	5
Staff are unskilled to perform procedure	3	1	5	0	1	0	8	18
Existing staff are skilled to perform procedure	1	2	2	0	2	0	0	7
Community mobilization	1	0	1	0		0	0	2
After care of the circumcised	0	0	0	1	1	0	0	2
Make service more easily accessible/bring closer to people	4	1	0	0	2	2	2	11
Provide Materials/Supplies	3	1	1	1	0	1	0	7
Make MC self sustaining (charge fee)	0	1	0	0	0	0	0	1
Involve Government	0	0	0	0	1	0	1	2
Organisation Roles:								
Actual procedure (If trained) and/ supported	1	0	1	0	0	2	0	4
Community mobilization	1	0	0	0	0	0	1	2
Sensitization	4	4	0	1	2	4	1	16
Literature distribution	0	1	1		0	0	0	2
Physical Presence	0	0	0	0	1	1	1	3
Provide materials, equipment, drugs	0	0	0	0	0	1	1	2
Train Health Practitioners	1	0	0	0	0	0	4	5
No response/don’t know	10	0	8	2	0	0	0	20
Total respondents	10	7	8	3	3	11	10	52

Annex 9 : Frequencies- Things That Need to be done to Increase the Demand for MC.

Province	Lusaka	N/ Western	Lua-pula	North-ern	East-Ern	C/belt	Cen-Tral	Res-ponse Total
Response								
Sensitization, education,	10	4	4	2	1	7	2	30
Information dissemination	2	1	1	0	3	2	3	12
Mobile hospitals,	0	0	1	0	0	0	0	1
Health centres	0	0	1	0	0	0	1	2
Equipment	0	0	0	0	0	2	0	2
Personal testimonies from those who have had MC	1	0	0	0	0	0	0	1
Introduce MC in schools	0	1	0	0	1	0	0	2
Encouraging Through								
Message on benefits	5	3	1	2	2	1	1	15
Increase manpower	1	1	0	0	0	1	0	3
Information on importance of MC for children	1	1	1	0	0	2	0	5
Counselling	0	0	0	0	0	0	0	
Incentives	0	2	0	0	1	0	1	4
Traditional circumcisors to be oriented to modern methods	0	1	0	0	0	0	0	1
Addressing issues of stigma	0	0	0	0	1	0	0	1
Influential People								
Musicians	3	0	0	0	0	0	1	4
Artists	2	0	0	0	0	0	1	3

Churches	2	3	0	0	1	1	1	8
Teachers	2	2	0	0	0	0	0	4
Police	1	0	0	0	0	0	0	1
Medical Staff	3	2	0	0	0	1	0	6
Politicians	2	1	1	0	0	2	2	8
Church Leaders	4	2	2	0	0	2	1	11
Neighbourhood health committee (NHC)/CBO,s	2	0	1	0	0	0	3	6
Journalist	1	0	0	0	0	0	0	1
Not traditional people	1	0	0	0	0	0	1	2
traditional leaders	0	3	2	2	2	2	0	11
Community Leaders	0	0	0	0	0	3	0	3
Traditional Healers	0	0	0	0	1	0	1	2
Government	0	2	0	0	0	0	0	2
NGO's/Civic leaders	0	2	2	0	0	1	0	5
The already circumcised	0	1	0	1	0	1	0	3
Family heads/Parents	0	1	0	0	2	1	0	4
High Profile people, celebrities	0	0	0	0	1	0	0	1
Declaration by head of state	0	0	0	0	0	0	0	0
Influential Messages								
MC as an HIV prevention tool	5	3	0	2	0	5		15
MC is hygienic/ Health benefits/cleanliness	5	2	1	0	0	1	0	9
Better early- easier to heal for Children	1	0	0	0	0	1	0	2
Have policy on male born	0	1	0	1	0	0	0	2

children to be circumcised.								
Attach conditions, no circumcision no school admission.	0	1	0	0	0	0	0	1
Avoid promiscuity	0	0	0	0	1	0	0	1
Longer life	0	0	0	0	0	0	0	
Messages - in local Languages	0	0	0	0	0	1	0	1
Safety of MC Procedure	0	0	0	0	0	1	0	1
Preferred MC age		0			1		0	1
At birth		4	2	3	1	3	1	14
Immediately after birth (after 8 days)	1	0	0	0	0	1	0	2
Most prefer immediately within 1 month at about2 weeks when umbilicus heals	2	1	0	0	1	0	0	
6 months and above	1	0	0	0	0	0	0	4
Less than 1 year	0		2	0	0	0	0	5
1 yr after birth	1	0	0	0	0	0	0	1
Parents would want MC before 5yrs for children	1	0	0	0	0	1	1	3
Between 6-18yrs	2	2	0	0	1	4	3	15
Not at birth	1	0	0	0	0	0	0	1
At any age	1	0	2	0	0	1	0	4
Ease of male neonates MC on parents age decision for their male infants	10	7	7	3	2	6	6	41
Ease of male neonates MC on parents age Not decision for their male infants	0	0	0	0	0	1	2	3
No response	1	0	1	1	1	9	9	22
Total respondents	10	7	8	3	3	11	10	52

Annex 10 : Frequencies - Effect of Combining HIV Testing with MC Program on the Policy of increasing MC

Province	Lusaka	N/ Western	Lua-pula	North-ern	East-Ern	C/belt	Cen-tral	Total
Response								
Effect on Policy:								
Yes	2	5	5	2	1	5	6	26
No	7	1	3	0	1	3	2	17
No when its optional	0	0	0	0	0	2	2	4
Receive it with mixed feelings	1	0	0	0	1	0	0	2
MC for the HIV Negative:						0		
Policy on MC for HIV –ve not the best, may produce stigma, discrimination	5	3	0	1	0	0	2	11
Use opt-out approach	1	0	0	0	0	2		3
Make HIV testing mandatory, but that is not desirable	1	1	0	0	0	0	2	4
Offer MC to HIV +ve's and –ve's if they want it so long as they are aware of the risks and benefits	2	2	0	1	0	0	1	6
Focus on those who come voluntarily.	0	0	0	0	0	0	0	0
Country puts up mandatory policy for those that are negative/Test the HIV –ve	0	1	1	1	0	0	0	3
Introduce a policy that all men should be circumcised, disseminate benefits, give incentives	0	1	0	0	0	1	0	2
Continue to educate and counsel/sensitizatio	0	1	0	1	0	3	5	10

n on circumcision								
Emphasis MC not VCT/separate them	0	0	1	1	1	1	0	4
Reaction to policy by men seeking MC		0	0	0		0		0
Men would be reluctant to come for MC/ will be difficult	2	1	1	1	0	3	4	12
Will be okay. Men will take it favorably	1	0	1	1	0		2	5
Men will come for services provided they are adequately sensitized	1	1	4	0	0	0	0	6
This will be seen as discriminatory (what about re-infection risk?	5	1	0	0	0	1	3	10
Depends on level of enlightenment, could be positive/negative	0	1	1	0	0	0	1	3
Do not involve women in issues of circumcision.	0	1	0	0	0	0	0	1
Councilors, traditional leaders, church need to be involved.	0	1	0	0	0	0	0	1
No response	3	3	0	1	7		3	17
Total Respondents	10	3	8	3	3	11	10	52