INVOLVING CIVIL SOCIETY VOICES IN CONSIDERING THE ROLLOUT OF MALE CIRCUMCISION FOR HIV PREVENTION IN RWANDA

Executive Summary - December 2010 – Alliance Nikuze

Introduction

After successful research results from three randomized controlled trials on male circumcision (MC) for HIV prevention (up to 60% protection from HIV infection in circumcised men), the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have recommended adoption of MC as an additional strategy to prevent HIV infection, especially in countries with a high prevalence of HIV with a generalized epidemic and a low MC prevalence rate. With an HIV prevalence of 3% in the general population and a MC prevalence of 12% among men aged 15-59 (RIHDS), Rwanda has added MC as an additional HIV prevention option to its National Strategic Plan (NSP). Rwanda is one of thirteen Southern and Eastern African countries that WHO/UNAIDS identified as priority countries for male circumcision scale up.

Why partner with civil society?

WHO/UNAIDS identified ten critical elements that will play a key role in MC scale up in the above countries. One of them is leadership and partnerships. Rolling out MC requires partnership building and buy-in across sectors and communities including youth, women's organizations, and faith based organizations among many others. Involving civil society organizations and other individuals in discussions as policies and strategies are being developed is critical in raising issues, building partnerships and ensuring that advocacy for MC is seen as an important commitment for groups and individuals committed to reducing the rate of HIV transmission. Over the last five years, there have been multiple platforms for civil society discussion around the rollout of MC for HIV prevention with each other and with the researchers, in countries and regionally. Some of this discussion has happened in structured meetings or consultations, but most of it has been organic - on email lists, as peripheral topics at HIV-related discussions, and between colleagues in the corridors of their work.

Civil society's engagement on MC in Kigali was conducted as part of an HIV Prevention Research Advocacy Fellowship project, where the Institute of Human Virology of the University of Maryland, Rwanda program: IHV, and partnered with Fellowship sponsor, AVAC: Global Advocacy for IHV prevention. The advocacy project mainly concentrated on exploring the opportunities and challenges associated with MC implementation from a community perspective.

Five consultations were held with civil society groups with representatives from organizations working on HIV/AIDS, women's health issues, youth, faith-based health interventions.

Key questions / Issues raised

There are quite a number of questions/issues which were of high interest to the community and civil society's members. Those questions ranged from barriers to acceptability, myths, traditional circumcision, behavioral issues such as risk compensation, knowledge of MC as an HIV

prevention intervention, how MC fits into the broader HIV prevention tool box (understanding partial protection), access (where to get services, who provides the services, who to benefit from services, etc), infant circumcision, to what MC means for women, what it means to HIV-infected males, promotion of MC strictly in terms of HIV prevention, relation of MC to sexual pleasure, abstinence during the healing period, MC terms to be used in Kinyarwanda and many others.

Recommendations

From the different consultative meetings, interviews and key informant discussions, carried out throughout the year, the above issues/questions emerged and participants gave suggestions to address some of them to the best of their ability. Below are some of the key recommendations to the government and other partners:

Accessibility of services, knowledge of MC as an HIV prevention intervention

- Avail affordable MC services of high quality for ALL MEN willing to be circumcised
- Avail less painful techniques to be used during the surgery
- Increase understanding of MC as an additional HIV prevention in the community

MC into the prevention tool box, behavioral concerns (risk compensation)

- Clearly communicate the partial effectiveness of MC and how it fits into the existing prevention package
- Carefully monitor MC programs and timely address possible increase in risky behaviors if any

Barriers to acceptability, myths

- Identify MC champions in the community who will help address some of the identified barriers and myths such as "gukuramo inzembe"
- MC IEC materials have to address barriers and myths raised from the beginning

Recommendations from women

- Clearly communicate that there is no direct MC benefit for women
- Closely monitor if there is misunderstanding of partial protection which could reduce women's ability to negotiate condom use
- Involve men in sexual and reproductive health services
- Make available more women controlled/initiated HIV prevention tools

Way forward

The capacity of CSO and members need to be continuously built so that they can effectively support new HIV prevention interventions. Civil society voices and experiences are critical in scaling-up acceptable and uptake of MC services in communities. As such, there is need to keep them involved in planning, implementation and monitoring of new prevention intervention but also in conducting of research for potential HIV biomedical prevention experimental strategies.

Note: Learn more about the advocacy project and the Advocacy Fellowship by visiting the AVAC website at www.avac.org/fellows. You can also sign up to receive regular updates on this project and other AVAC programs by providing your contact information. Also look out for the full report in January 2011.