The Kingdom of Swaziland

Report of the Male Circumcision & HIV Prevention Country Consultation Meeting

September 26-27 2006,
Esibayeni Lodge, Matsapha, Swaziland

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Armstrong Dlamini

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List of Acronyms

ABC	-	Abstinence, Be Faithful, Condomise
AMICAALL	-	Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
BCC	-	Behaviour Change Communication
FBO	-	Faith Based Organisation
FLAS	-	Family Life Association of Swaziland
HAART	-	Highly Active Antiretroviral Therapy
IEC	-	Information, Education and Communication
MC	-	Male Circumcision
MOHSW	-	Ministry of Health & Social Welfare
NERCHA	-	National Emergence Response Council on HIV & AIDS
NGO	-	Non-Governmental Organisation
SNAP	-	Swaziland National Aids Programme
SRH	-	Sexual and Reproductive Health
STI	-	Sexually Transmitted Infection
UNAIDS	-	Joint United Nations Programme on HIV/AIDS
UNICEF	-	United Nations Children Fund
WHO	-	World Health Organisation

Executive Summary

Evidence from two decades of observational studies suggests that MC can partially protect men from acquiring HIV. Results form the Orange Farm Intervention Trial in South Africa indicated a 60% reduction in HIV acquisition among uncircumcised men aged 18-24 years thus prompting UNAIDS to issue a position statement and to develop a UN Work Plan on MC & HIV. In line with this plan, UNAIDS is working with countries to determine the potential role of MC within their comprehensive HIV prevention programmes and Swaziland is one of the countries receiving support through the UN Work Plan. Despite increased investments in HIV&AIDS interventions, Swaziland has been losing the war against the pandemic with the HIV prevalence multiplying ten times from 3.9% in 1992 to 42.6% in 2004.

The Maputo Declaration by African Health Ministers which pronounced 2006 as the Year for Accelerating HIV Prevention in Africa placed Male Circumcision among the key prioritized interventions. Therefore through support from the UN Work Plan on MC & HIV and as part of the broader strategy for Accelerated HIV Prevention in Africa, a Male Circumcision country stakeholder consultation meeting for Swaziland was held on 26-27TH September 2006 at Esibayeni Lodge, Matsapha. The objective of the meeting was to:

- Discuss implications of MC within the country context: considering issues of acceptability, risks and barriers, health service delivery, traditional practices, counselling and

consent, human rights, ethical and regulatory issues;

- Discuss strategies for follow-up programming.

The meeting provided stakeholders with a situation analysis of MC in Swaziland and it also provided a platform for consensus building on future MC Programming. Situational evidence was provided on the MC programme which reflected that on a monthly basis an average of 41 circumcisions are being performed country wide reflecting the general acceptability of MC by Swazi society. In terms of clinical capacity it was reported that public health facilities were facing challenges in service delivery resulting in a backlog in MC cases.

The key outcome of the meeting was the establishment of a national Multi-sectoral Task Force on MC tasked with implementing a country MC Preparedness Action Plan. The main terms of reference of the Task Force are:

1. Conducting a situation analysis to determine needs, capacity and acceptability of MC;
2. Standardisation. A single set of guidelines for surgical procedures was recommended and Swaziland was encouraged to apply the same set of standards in all facilities including FBO, NGO and private clinics.
3. Development of an MC Monitoring & Evaluation (M&E) plan;
4. Coordination of national MC activities;
5. Resource Mobilisation for MC programmes;
6. Identification and engagement of other relevant stakeholders
7. Supervising behaviour change interventions for MC.
8. Capacity Building for MC Service delivery.

Background

Evidence from two decades of observational studies suggests that MC can partially protect men from acquiring HIV. Results from the Orange Farm Study in South Africa indicated a 60% reduction in HIV acquisition among circumcised men aged 18-24 years thus prompting UNAIDS to issue a position statement and to develop a UN Work Plan on MC & HIV prevention. The Work Plan focuses on increasing the safety of MC pending results of other randomised controlled trials in Kenya and Uganda as well as laying the policy and programming framework for future decision making at country level (UNAIDS, 2006).

UNAIDS took the position that although it was premature to recommend male circumcision service as part of a comprehensive HIV prevention package, governments should take steps to ensure that current MC is conducted by trained practitioners in safe, adequately equipped settings to reduce post-operative complication rates.

Objectives of the Meeting

In working with countries to determine the potential role of MC within their comprehensive HIV prevention programmes, UNAIDS is supporting countries in gathering data necessary for informed decision-making. As part of this support, a country stakeholder consultation meeting for Swaziland was held on 26-27TH September at Esibayeni Lodge, Matsapha. The objective of the meeting was to:

1. Review and discuss latest evidence on MC and HIV Prevention at the global, Africa and country levels;
2. Discuss implications of MC within the country context: considering issues of acceptability, risks and barriers, health service delivery, traditional practices, counselling and consent, human rights, ethical and regulatory issues;

3. Discuss strategies for follow-up programming.

Above: David Alnwick (UNICEF), Prince Magudulela (Traditional Authority), Ms Mulunesh Tennagashaw (UNAIDS) & Faith Dlamini, (NERCHA).

Stakeholder Representation & Profile of Participants

The meeting drew representation from most of the key stakeholders in the country. There was high profile representation from the health sector, including the Ministry of Health (MOHSW). Most participants were either in leadership or significant and relevant technical positions in their organizations. There was also a panel of experts linked to the UN Working Group on MC at the global and regional level (see List of Participants). Relevant traditional and cultural authorities were represented through Chiefs and the Traditional Healers

Association (THA). The participation by stakeholders across the spectrum helped to broaden the discussions to cover the whole range of clinical, economic and socio-cultural issues relating to MC in Swaziland.

Programme Overview

The programme was structured into three plenary sessions comprising of expert presentations on the different thematic areas. Each session had a discussion component which was used to interrogate issues, draw conclusions and develop consensus on country implications. The sessions were sequenced as follows:

- Session One : The Link between MC & HIV Infection
- Session Two : MC in the Country Context
- Session Three : Strategies for MC Programming

A cross section of participants follows the proceedings

Session One: The Link Between MC and HIV

Overview of Evidence on MC and the Link with HIV Infection
According to experts, ecological data on MC began to be acquired in the mid 1980s and since that time, five ecological studies have been conducted and by 2002, there was a substantial interest in numerous studies mostly observational and epidemiological which suggested that MC had a considerable protective effect on HIV infection.

Three controlled trials were carried out and the one, in Orange Farm, near Johannesburg was stopped early because of clear results. The results showed a considerable protective effective of safe MC on HIV acquisition by males. However the study only showed the short term effect because the average follow-up period was 18 months.

The 2004 Kenya DHS Study also produced some interesting results. It was found that 13% of Kenyan men who are uncircumcised are HIV infected compared to 3% of those circumcised. In Nyanza Province, men who are uncircumcised were found to be 10 X more likely to be HIV + than men who are circumcised.

There were three aspects of the foreskin which were identified to have an influence on HIV infection.

1. Cellular content of the foreskin:
   a. The inner mucosa of foreskin is rich in HIV target cells (9-fold uptake of HIV in one study);
   b. After circumcision the only vulnerable mucosa is meatus.

2. Vulnerability of the foreskin:
   a. The external foreskin / shaft is keratinized and not "vulnerable to HIV,"while the inner foreskin is not keratinized.
   b. During sex there are, micro-tears, especially of frenulum

3. The intact foreskin is associated with infections:
   a. Genital ulcers (especially chancroid)
   b. Balanitis

MC's Efficacy

In view of the evidence presented (particularly from Orange Farm) there was general consensus that as a prevention measure, MC does pose some useful possibilities for Swaziland and Africa. However it was stressed that MC is not a magic pot and it still had to work complementarily with other prevention interventions.

Integration & Dis-inhibition

There was consensus that MC is most effective if it is integrated with other HIV prevention programmes and that health facilities would have to harmonise the provision of MC with other health services. Such integration will safeguard against the diversion of resources to MC at the expense of other equally important services.

It was recommended that MC needs to be done in such a way as to avoid disinhibition. The key messages should highlight the fact that MC reduces the risk of STIs but that it was no replacement for the 'ABC' approach.

MC Techniques & Complications

The are two main techniques that have been recommended for the MC programme, namely the sleeve and dorsal slit technique with the former being the safest and most preferred. The sleeve technique is the one being used in MC procedures in Swaziland.

The following Possible MC Complications were identified:

1. Cosmetic imperfections
2. Haematoma
3. Meatal stenosis
4. Removal of too little skin
5. Removal of too much skin
6. Urethral fistula
7. Injury to the glans
8. Partial or total amputation of the penis
9. Anaesthesia

Cost of MC

The key justification for expenditures on MC is that it is a prevention measure that helps to avert significantly higher expenses for future HAART. The estimated cost of MC is a once off expenditure of US $ 50 p/p whereas the cost of HAART is US $ 500 p/p per annum.

Ethical Issues

Despite the positive results of the MC studies, participants raised concerns regarding the ethical measures surrounding these studies.

MC Impact on Sexual Pleasure

The meeting noted that available information did not adequately address the impact of MC on sexual pleasure and that greater clarity was required regarding the impact of MC with regards to the level of sexual pleasure. It was recommended that FLAS should make a follow up survey to investigate this subject through its MC pilot study cohort.

Identified Knowledge Gaps

Concerns were raised with respect to the lack of adequate explanations for the high number of sexual contacts attributable to circumcised men in the Orange Farm Study.

Expert Panelists (L-R), Daniel Halperin: USAID, Dr George Schmid: WHO & MC Working Group Chiweni Chimbwete: Consultant, MC Regional Working Group, Dr Dirk Taljaard: Progressus South Africa.

Session Two: MC in the Country Context

MC in Swazi Society

Historical experts submitted that MC is not an alien practice in Swaziland, but that rather it is an old customary practice, which has faded out over the years after it was stopped by King Mswati II in the eighteenth century. It was therefore recommended that the behaviour change strategies that will be applied to re-introduce and revive MC should clearly articulate it as a norm rather than a new innovation in society.

There was consensus in favour of a normative approach that will

ensure easier assimilation by the community. Participants argued that it was important to have a proper modelling of MC through participatory planning approaches in order to take cognisance of cultural and religious sensitivities and the MC strategy should enable the community to articulate their own voices with regard to the subject. The historical context of MC would be used to aid efforts aimed at reviving the practice, provided that MC advocacy is articulated through culturally sensitive messages.

It was established that traditional leaders have no veto power over MC but that their influence could be harnessed to facilitate cooperation from households. The persuasive role of traditional leaders in health interventions had been similarly put to positive effective in the past particularly during the campaign on breastfeeding.

It was further noted that the challenges confronting the fight against HIV& AIDS are compounded by a sense of fatalism in society and that therefore the campaign for MC should attempt to identify and be sensitive to cultural concerns. A key cultural-religious concern was the protocol to be used in the disposal of the foreskin once it has been removed from the patient. Clarity in this matter was critical for addressing the myths and superstitions associated with the removal of human tissue. Patients would have to be assured that these would not be used for rituals associated with witchcraft.

It was recommended that patients should be given the option to dispose the foreskin if they feel strongly about it. Traditional healers were viewed as an important constituency and potential partner and that they could play a critical role in addressing some of the taboos

Popular Radio Personality Bongani 'Sigcokosiyancinca' Dlamini.

Situation Analysis

It was reported that most Swazi men are not circumcised and that therefore health facilities have limited experience with MC procedures and in view of the increasing demand, this capacity limitation posed a serious challenge to service delivery. A positive outcome is that in January 2006, 50 clinicians were trained on MC through a NERCHA/UNICEF funded refresher training programme.

Until recently, there has not been systematic record keeping of MC data and therefore it was not possible to determine the number of MC's conducted across the country over a specified period. However at the Mbabane Government Hospital, which is also the national referral hospital, existing MC figures are as follows:

Mcs Conducted per month	:	21 (Period, July-October)
Fees / cost per procedure	:	E 25
Number of outstanding MC's	:	85
Operating Times	:	Friday Mornings

The FLAS MC pilot project (based in Mbabane urban area) had a target of 300 MC in twelve months and it has already exceeded its target by 9% with 325 MCs performed between January and September. The prescribed fee for the FLAS conducted MCs is E300 per person.

The high turnout illustrates that cost is not a big disincentive to MC. At the FLAS clinic, up to 5 procedures can be carried out each day.

MCs Conducted per month	:	33 (January October)
Fees / cost per procedure	:	E 300
Number of outstanding MC's	:	Nil
Operating Times	:	Afternoons

Total Recorded MCs in Swaziland: January - October = 411

Perceptions towards MC

In January 2006 a Rapid Assessment was conducted from a survey of 400 men in the Manzini region with the following results.

Table 1: 2006 Rapid Assessment Survey Results

Survey Question	Respondent Results (Affirmative)
Do you want MC for your son?	71%
Does MC reduce risk of STIs?	81%
Does MC reduce risk of HIV?	18%
Would you want MC if it reduces HIV?	87%
Will MC be acceptable in Swaziland if it reduces HIV?	93%
Would you want MC now?	54%

Source: D Halperin & S Tsela Rapid Assessment Survey

It was noted that there were some studies that are being carried out relating to MC in Swaziland and it was recommended that the outcomes of these studies need to be carefully reviewed for the benefit of scaling up processes. These include the pilot study on MC in Swaziland and the Knowledge, Attitudes and Perceptions Study on MC both conducted by FLAS.

The meeting was also given an overview of the USAID/Futures Group project which comprises of a study that will seek to determine the cost and impact of MC. The study will be carried out in three countries, namely Zambia, Lesotho and Swaziland. It shall commence in October 2006. Study outputs will comprise the under listed that will be in turn be used to inform MC programming in the country.

1. Defining the MC Intervention;
2. Costing the MC Intervention;
3. Modeling the Impact;

Management of MC Provision

It was noted that as a critical first step, Swaziland had already set up Multi-sectoral Task Team on MC. The purpose of the Task Team was to ensure the safe, competent and cost effective provision of MC in Swaziland. However it was reported that the Task Team was not fully operational and therefore it was essential to address the challenges affecting its operations. The existing backlog in circumcisions (extending to February 2006) was found to be an embarrassing challenge that needed urgent redress in order for the health sector to cope with increasing demand for MC.

MC Benefits for Women

The meeting acknowledged the benefits of MC that accrue to women and that these benefits should be featured highly in MC advocacy campaigns. Specific benefits were that:

1. Since HIV prevalence in men will fall, fewer infected men will be available to infect women;
2. Men with HIV will likely have lessened transmission efficiency.

Other Health Benefits of MC

Participants noted that apart from reduced HIV infection, MC posed several health benefits and it was recommended that these should be magnified to assist in the campaign. MC eliminates:

- Phimosis
- Paraphimosis

- Balanitis.

MC reduces the likelihood of:

- Urinary tract infections
- Cancer of the penis
- Cancer of the cervix.

Dr Adams Groeneveld, Chief Urologist, Mbabane Government Hospital

Session Three: Recommendations for MC Programming

Participation and Ownership

It was recommended that the MC process should be driven by Swazi nationals and that a high profile should be ascribed to national programme partners. Consultations with communities through

leadership structures (i.e Chiefs, Emabandla) were considered vital for dispelling misconceptions about MC as well as developing a sense of ownership. It was argued that by harnessing the consensus of community leaders, MC can be packaged with other positive cultural practices that help with HIV prevention.

A sensitive dissemination method including the identity of the messenger was viewed as a critical issue. It was argued that the message should be appropriate for the audience i.e a young female health worker would not be viewed as a suitable messenger to an adult male audience.

The meeting identified male involvement in advocacy campaigns as a critical factor for programme success as well as in dispelling MC taboos and establishing consent within the household.

(L-R) Sikelela Dlamini: Under Secretary, Ministry of Health & Social Welfare and Richard Phungwayo, SNAP.

The MC-Initiation Nexus

Experts were of the opinion that MC can best be assimilated if it is also linked to initiation, particularly for adolescents. It was argued that a circumcision strategy that excludes initiation and psychosocial counselling would send the wrong signal; whereas initiation was a complementary process for HIV prevention. Adolescent health weeks or camps involving NGOs and FBOs were suggested as one of the associated strategies that could be employed.

Counselling & Testing Services

The meeting noted that the provision of counselling services for MC was inadequate and called for the provision of effective pre and post MC counselling. It was also recommended that MC services should also facilitate access to HIV testing and Counselling in order to convey the message that MC effectively works in consonance with other prevention messages. Such integration was viewed as necessary in order to dispel the prevailing confusion regarding MC.

Behaviour Change Communication

It was recommended to the meeting that MC programmes should be based on the right communication concepts i.e those that clearly articulate that MC aids risk reduction and not the elimination of HIV. It was further emphasised that an effort should be made to solicit the voices of women and the youth. Another key issue that required further attention was how to deal with post MC behavioural scenarios including the provision of protected environments for both men and women. Attitudes towards MC, as well as trust among couples were also identified as priorities for effective behaviour change.

Neo-natal vs Adult MC

Whilst noting the benefits and ease of administering infant circumcision, the meeting was of the view that adult (and adolescent) MC was a priority as it was geared for immediate impact.

Social Mobilisation

It was recommended that in terms of its orientation, the design of the MC programme should seek to integrate and not to verticalise. A two track strategy that engages the communities in dialogue on the one hand, whilst addressing the unmet demand on the other was recommended.

Facilitating conversations, through focus group research, that take place between the MC partners on the one hand and traditional chiefs on the other were considered to be critical. The objective would be not merely to find out about traditional authority attitudes towards reviving MC, but also to learn from them how best to proceed.

(L-R) Ms Futhi Dennis: NERCHA & Dr Benjamini Gama: World Health Organisation

National MC Task Force

The meeting resolved to strengthen and consolidate the MC Task Force into a Multisectoral Task Force with enhanced membership to facilitate MC preparedness. MOHSW, UNAIDS and NERCHA were mandated to rationalise the membership and come up with a final list of stakeholders which should not exceed fifteen.

MC Task Force:

1. Dr Cesphinah Mabuza	Director of Health Services (Chair)
2. Dr Vusi Magagula	Deputy Director of Health Services (Alternate Chair)
3. Mr Richard Phungwayo	SNAP
4. Dr Adam Groenwald	Medical Association
5. Mr Nhlanhla Khoza	SRH Programme

6. Ms Faith Dlamini	NERCHA
7. Mr Africa Magongo	Health Education
8. Ms Dudu Simelane	FLAS
9. Dr A. Ntilivamunda	WHO
10. Ms.M. Tennagashaw	UNAIDS
11. Dr R. Bitchong	RFM Hospital
12. Chief Magudulela	Traditional Authority
13. Dr Fabian Mwanyumba	UNICEF Representative
14. Mr Bongani Dlamini	Media Representative
15. Mr Sibusiso Mngadi	NERCHA
16. M & E Coordinator	Health Sector M & E Unit
17. Representative from	SWANNEPHA

Task Force Terms of Reference

Whilst awaiting the outcome of international studies, the meeting agreed that Swaziland would continue to strengthen its preparedness through the following activities:

1. Development of a tool for guiding safe circumcision practices and to consider all critical aspects of the procedure, including the following:
    a. Aspects of Circumcision Procedure
    b. Preoperative information and counseling
    c. Anaesthetic technique
    d. Surgical technique
    e. Instrumentation
    f. Postoperative management
    g. Follow up schedule
    h. Recording and treatment of complications
    i. Record keeping and monitoring

2. Standardisation. A single set of guidelines for surgical procedures was recommended and the Swaziland was encouraged to apply the same set of standards in all facilities including FBO, NGO and private clinics.
3. Conducting a situation analysis to determine needs, capacity and acceptability of MC;
4. Development of an MC Monitoring & Evaluation (M&E) plan;
5. Coordination of national MC activities;
6. Resource Mobilisation for MC programmes;
7. Identification and engagement of other relevant stakeholders i.e Swaziland National Youth Council, Traditional Healers;
8. Supervising behaviour change interventions for MC.
9. Capacity Building for MC Provision.

In considering the most effective and efficient implementation of the MC programme, the following Human Resource Options were to be considered:

1. Training as many doctors as possible;
2. Importing foreign doctors to do MC only;
3. Training nurses and technicians to do MC;
4. Allocating circumcision weekends and deploying optimum staff for the purpose.

National MC Preparedness Action Plan

It was recommended that efforts should be made to scale up immediate provision of services to those on the MC waiting list in

public hospitals which runs into February 2007. In spite of this backlog, Swaziland was encouraged to intensify campaigns aimed at demand creation. However, the meeting noted that the cost of scaling up MC services was not known and that cost and impact studies were urgently needed to prepare the country for a possible roll out.

In line with the terms of reference of the Task Force, the meeting drew up a country action plan on MC preparedness for which the Task Force is responsible.

Table 2: National MC Preparedness Action Plan

Recommendation	Key Output	Timeframe	Responsibility
Finalise Task Team Composition	Multi-sectoral MC Task Team	30 October 2006	MOHSW, NERCHA
Resource Mobilisation Strategy	Resources for meeting backlog, future needs	Ongoing	Multisectoral Task Team
Carry out National Assessment Study and review findings of current studies	National MC preparedness Report	December 2006	Multisectoral Task Team
Situation Analysis	Information on MC acceptability	January 2007	Multisectoral Task Team
IEC & BCC Strategy	BCC Programme for MC	To be finalised	Multisectoral Task Team
Training of MC Practitioners	Decentralisation of MC services	To be finalised	Multisectoral Task Team
Establish M&E Framework	M&E Strategy	To be finalised	Multisectoral Task Team

Annex 1

List of Participants

Name	Organisation	Position
1. Betty Moyane	Traditional Healers Organisation	Public Relations Officer
2. Dr Adams Groeneveld	Mbabane Government Hospital	Chief Urologist
3. Anne Motsa	Matsapha Central Prison	Staff Nurse
4. Futhi Dennis	NERCHA	Asst Coordinator Behaviour Change Communication (BCC)
5. Elizabeth Skorochod	NERCHA	P R Officer
6. Paul Skorochod	Church Forum	Finance Manager
7. Dr Davis McCollum	Baylor Clinic	Physician
8. Gainet Nkambule	Swaziland Federation of Trade Unions	Field Officer
9. Nhlanhla Mnisi	SNAP	Programme Logistic Officer
10. Khanya Mabuza	NERCHA	Assistant Director
11. Faith Dlamini	NERCHA	Health Sector Coordinator
12. Modison Magagula	Sphila Nje Drama Society	Director
13. Dr Mauro Almaviva	Italian Cooperation	Director
14. Gugu Khumalo	CANGO	Programme Manager
15. Bheki Dlamini	SWAGAA	HIV Prevention Specialist
16. Daniel Halperin	USAID	HIV Prevention Adviser
17. Dirk Taljaard	Progressus South Africa	Orange Farm Study Director
18. David Alnwick	UNICEF	MC Regional Working Group
19. Dr Fabian Mwanyumba	UNI CEF	Physician
20. Nana Mdluli	NERCHA	Public Relations Officer
21. Ms Mulunesh Tennagashaw	UNAIDS	Country Coordinator
22. Helen Odido	UNAIDS	M&E Advisor
23. Patty Wheatley	UNAIDS	JPC
24. Makhosini Mamba	UNICEF	Assistant Programme Officer
25. Rudolph Maziya	AMICAALL	Director
26. Thembisile Dlamini	UNAIDS	National Programme Officer
27. Andrew Agabu	UNICEF	Programme Specialist
28. C Stevens	US Embassy	HIV & AIDS Project Coordinator
29. S Vilakati	Mankayane Hospital	HIV & AIDS and MC Programme Manager
30. Muhle Dlamini	Health Education Unit	Health Education Officer
31. Dr R Bitchong	RFM Hospital	Senior Medical Officer
32. Dr W. Fakudze	Emkhuzweni Health Centre	Senior Medical Officer

33. Dr R. Davis	UNICEF	Regional Advisor
34. Dr S. Nirupam	UNICEF	Programme Officer
35. Khosie Hlatswayo	BCHA	Coordinator
36. B. Mazibuko	Swazi TV	Journalist
37. Dr M Mbelu	SAPPI	Medical Officer
38. Nozipho Mkhatshwa	NERCHA	Coordinator - Impact mitigation
39. Dr Chiweni Chimbwete	MC Regional Working Group	Consultant
40. Sibongile Maseko	MOHSW	Epidemiologist
41. Beatrice Dlamini	SNAP	Programme Manager
42. Promise Dlamini	MOHSW	Psychologist
43. Anson Zwane	WHO	BCC Specialist
44. Sibusiso Mngadi	NERCHA	BCC Coordinator
45. Prince Magudulela	Traditional Authority	Chief
46. Chief Ndlondlo Tsabedze	Traditional Authority	Chief
47. Bongani Dlamini	Swaziland Broadcasting Services	Radio Personality
48. Rejoice Nkambule	Futures Group	MC Project Consultant
49. Dr C Mabuza	MOHSW	A/Director of Health Service
50. Sanelsiwe Tsela	NERCHA	Monitoring & Evaluation Coordinator
51. Dr Benjamin Gama	WHO	WHO HIV&AIDS - NPO
52. Jabu Mthethwa	Swaziland Red Cross	Site Coordinator
53. Maria Katulu	Swaziland Red Cross	Swiss Delegate
54. Dudu Simelane	FLAS	Deputy Director
55. Dudu Mkhatjwa	FLAS	MC Project Nurse
56. Dr Augustine Ntilivamunda	WHO	HIV&AIDS Medical Officer
57. Zanele Nxumalo	Royal Swaziland Police	HIV& AIDS Coordinator
58. Dr C Humphreys	Good Shepard Hospital	Medical Officer
59. Dr George Schmid	WHO	MC Working Group
60. Thamsanqa Dlamini	WHO	IT Specialist
61. Armstrong Dlamini	Policy Research Group	Social Scientist

Annex 2

Panel of Experts

Dr Adams Groeneveld
Chief Urologist, Mbabane Government Hospital

Daniel Halperin
HIV Prevention Adviser, USAID

Dirk Taljaard
Orange Farm Study Director, Progressus South Africa

Dr Chiweni Chimbwete
Consultant, MC Regional Working Group

Dr C Mabuza
Director of Health Services, MOHSW

Dr George Schmid
MC Working Group, WHO

Bongani Dlamini
Radio Personality, Swaziland Broadcasting Services

Rejoice Nkambule
MC Project Consultant, Futures Group

David Alnwick
MC Regional Working Group, UNICEF

Annex 3

Meeting Programme

Time		Discussion Topic	Presenter
Day 1: Morning			
8:00 – 8:30		Registration	
Session One, Part 1: Introduction and Current Situation in regards to MC and HIV Chair: Mr. Sikelela Dlamini, Under Secretary MOHSW			
8:30 - 10:40	8:30 – 8:40	Opening and Welcome Remarks	Ms. Nomathemba Dlamini, PS MOHSW
	8:40 – 8:50	Background on the Male Circumcision Country Consultations	Dr. Chiweni Chimbwete, Consultant, MC Regional Working Group
	8:50 – 9:00	Statement by UN Theme Group on HIV/AIDS Chairperson	Dr. David Okello, UNTG Chair, Swaziland
	9:00 – 9:10	General overview of evidence on male circumcision and HIV prevention	Dr. George Schmid, WHO, Geneva
	9:10- 9:40	Evidence on male circumcision and HIV prevention: Findings from the Orange Farm study.	Mr. Dirk Taljaard, Progressus, South Africa
	9:40 – 10:40	Plenary Discussion	Mr. Sikelela Dlamini, Under Secretary MOHSW
10:40 – 11:20		Tea/Coffee Break	
Session One, Part 2: Introduction and Current Situation in regards to MC and HIV Chair: Dr. C. Mabuza, Director of Health Services			
11:20 – 1:00	11:20 – 11:45	Male circumcision in the context of a comprehensive HIV prevention programme	Mr. David Alnwick (UNICEF) Member of the MC Regional Working Group
	11:45 – 12:00	Situational Analysis	Dr. Adam Groeneveld
	12:00 – 1:00	Plenary Discussion	Dr. C. Mabuza, Director of Health Services
1:00 – 2:00		Lunch	

UNAIDS

JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNHCR
UNCEF
WFP
UNDP
UNFPA

UNODC
ILO
UNESCO
WHO
WORLD BANK

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