Male Circumcision and HIV Prevention

Tanzania Country Stakeholder Consultation Meeting Report

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ABBREVIATIONS

ANRS	Agence National de Recherché sur la Sida
ARV	Anti Retroviral Drugs
DSMB	Data Safety and Management Board
GUD	Genital Ulcer Disease
HIV	Human Immunodeficiency Virus
HQ	Head Quarters
MC	Male Circumcision
NIH	National Institute of Health
NIMR	National Institute for Medical Research
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother to Child Transmission
RCT	Randomised Controlled Trial
SAM	Service Availability Mapping
STI	Sexually Transmitted Infection
TACAIDS	Tanzania Commission for AIDS
TBAs	Traditional Birth Attendants
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Fund Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1.0 INTRODUCTION

The Tanzania Country Consultation meeting on Male Circumcision (MC) and HIV Prevention was organized in collaboration with the Tanzania Commission for AIDS, UNAIDS, and WHO office in Tanzania. The forum was called to order at 9.00am by Mr. Richard Ngirwa of the Tanzania Commission for AIDS in the Prime Ministers' Office. The Meeting was chaired by Dr. B. Fimbo from the National AIDS Control Programme in the Ministry of Health and Social Welfare.

This two day consultation meeting had three main objectives - (a) to review and discuss latest evidence on Male Circumcision and HIV Prevention (particularly reduced partners and condom use) at the Global, Africa and Country levels (b) discuss implications of MC within the country context (acceptability, risks and barriers, health service delivery, traditional practices, counselling and consent, human rights, ethical and regulatory issues and (c) discuss strategies for follow up for programming. The meeting aimed to achieve three main outputs namely (1) a description of consensus generated among stakeholders on male circumcision as a potential public health intervention for prevention of the spread of HIV infection (2) a summary description of implications for scaling up safe male circumcision in Tanzania and (3) a list of important steps to be taken in promoting access to safe male circumcision services in Tanzania.

This meeting brought together more than 30 individuals from different disciplines: researchers and general academia, medical practitioners in Tanzania's district, regional and referral hospitals, policy makers from different sectors in Government, representatives of civil society organizations including religious institutions, local and international non government organizations and representatives of UN agencies (WHO, UNAIDS, UNICEF). The list of participants and their respective institutions is presented in Annex 1. The meeting was organized around three sessions focusing on the three main objectives of the meetings. The meeting programme is presented in Annex 2. The process was mainly structured into presentations and plenary discussions. Group discussions were also held to generate more discussion on evidence, implications and strategies for programming.

2.0 KEY MESSAGES

The key messages from the Tanzania Country Consultation Meeting are as follows:

2.1 Consensus on Potential of Male Circumcision in Prevention of the Spread of HIV Infection

- Evidence from studies both in Tanzania and elsewhere though inconclusive, demonstrate that male circumcision men who are not circumcised are more at risk of getting STDs including HIV as well as transmitting the virus to others. In addition, MC also has potential of lessening the chances of women getting HIV from infected partners. The evidence also suggests that MC may be a cost-effective measure for HIV prevention.

- The meeting is cautious that even though MC has the potential to be taken on to be effective in reducing HIV acquisition risk, it would not offer total protection but will be complementary to other prevention measures (condom use, partner reduction, voluntary counselling and testing and proper management of STI and PMTCT).

- Evidence from review of the effectiveness of HIV prevention approaches in eastern and southern Africa (Kenya, Uganda, Zimbabwe, Namibia, Swaziland and Tanzania) shows that the existing approaches are working but very slowly and that not adequate investments are directed to prevention.

- Few countries have reliable and timely information on trends in HIV incidence in young people on which to make decisions on what to do more or less of.
- The results of the two trials going on in Kenya and Uganda are expected to be out by July or September 2007. However, the Data Safety and Management Board (DSMB) will be reviewing the interim results again in December 2006. In case they find good reasons they can stop the trials especially if they are consistent with the Orange Farm results. While waiting for this confirmation of evidence from the RCTs Tanzania needs to prepare for institutionalization of MC within the formal health delivery system now.
- For Tanzania, securing acceptance on MC is not likely to be a major challenge as already MC is common among the majority of tribes and it is estimated that almost 70% of adult males are circumcised. However, critical issues for Tanzania are (a) Safety of current MC services, given that is mainly delivered through traditional systems. The issue for Tanzania therefore, is how to make safe the traditional practice and part of the formal public health delivery system and (b) how to scale up and deliver the service to the remaining 30% of males who are mainly from non-circumcising belt as well as meeting future demand.

- While much of MC in Tanzania is done through traditional care system not much is known about the adverse events given cultural sensitivity surrounding this type of care delivery system.

- MC as a surgical procedure within the public health care system is mainly done by junior health workers informally without any standard guidelines. Some felt that it should be offered by qualified surgeons. However, it was felt that insistence on such a policy may not be practical given acute shortage of qualified medical personnel in Tanzania specifically in remote rural areas of the country where the majority of poor people reside. Outlawing *Ngaribas* (traditional circumcisers) by professionalization of the MC services was perceived to be an unrealistic option by most participants.

- There are many opportunities for institutionalising MC in Tanzania including:
  i. MC being culturally practiced in most parts of the country with the exception of some tribes in seven administrative regions (Mbeya, Ruvuma, Mwanza, Shinyanga, Kigoma, Kagera and part of Mara).
  ii. A trend towards increasing MC acceptance among some of the traditionally non-circumcisizing tribes.
  iii. Experience to perform MC from all sectors of health provision.
  iv. Institutional and strategic frameworks for, and experience in coordination of HIV prevention measures. Overall coordination by the Tanzania Commission for AIDS in the Prime Ministers' Office and its guiding National Multi-sectoral Strategic Framework for combating HIV and AIDS within which the Health Sector HIV and AIDS Strategic Plan coordinates response in the health sector. Review and development of a second strategic framework is being finalized giving the timely opportunity to include MC as a potential intervention. .

2.2 Summary Implications for Scaling up Safe Male Circumcision in Tanzania

- Policy framework: Need for strengthening/putting in place a policy framework (legal and institutional) to enable MC services to be delivered as part of the public health care system in Tanzania. Currently MC services are provided in public health facilities for therapeutic reasons and/or through interpersonal arrangements. There are no guidelines for MC to be done as routine for non therapeutic reasons.

- Workload: currently 30% of the 18 million men (different age groups) in Tanzania are estimated not to be circumcised. As such there is a huge backlog. At the same time plans will have to be made to meet future demand once MC is adopted as an additional HIV prevention measure.
- Costs and equity issues: Currently MC is not provided free of charge. At the moment the average cost for MC in a public health facility is estimated to be between US$ 10 and 20, which is unaffordable to the poor (with 36% below poverty line according to the Household Budget Survey of 2001). Thus, the introduction of MC as an additional HIV prevention measure is likely

to overwhelm the already overburdened health care system. Despite these concerns hard choices have to be made given current evidence on the potential of MC in prevention of the spread of HIV.

- General capacity issues: While there is some experience in MC among traditional and conventional practitioners, there are issues of limited experience on MC in non-circumcising belt. Other capacity issues relate to absolute shortage of staff and health facilities specifically remote rural areas of Tanzania. This calls for more practical approaches into the delivery of MC services.
- Integrating MC into Reproductive Health Services: where services are provided free-of-charge integration should be strongly advocated.
- Currently there is no policy on the optimum age for MC in Tanzania; this will be guided by WHO guidelines which recommend ages from seven years through adolescence mainly because of better cooperation from the older boys since it is recommended to be done under local anaesthesia.

2.3 Important Steps to be taken in Promoting Access to Safer Male Circumcision Services in Tanzania

- The Tanzania Commission for AIDS (TACAIDS), Government agency for coordination of HIV interventions, and UNAIDS-Tanzania should champion and ensure the confirmed need and planning for integration and scaling up safe MC filters through into the policy agenda of the Government of Tanzania.
- Formation of a task force and preparation of a plan of action to prepare Tanzania for the scaling up MC as part of a comprehensive HIV prevention package in the event of further evidence on potential of MC in HIV prevention from the ongoing studies in Uganda and Kenya. However, the recently created task force for HIV prevention under TACAIDS could be considered as yet another opportunity for coordination of MC interventions. Some members to the meeting felt this could have more potential for enhancing integration of MC as an integral part of a comprehensive HIV prevention package in Tanzania.
- Decision need to be made on representation of Tanzania to the forthcoming Regional Consultative meeting to discuss country recommendations and progress from the consultation meetings of five countries targeted for support to scale up MC.
- A well-articulated communication strategy to ensure the right messages regarding MC and HIV prevention are communicated to the policy makers, and the general public at large. This is important and urgent to avoid giving the impression that MC is the solution to stopping the spread of HIV.
- Carryout additional studies on localities targeted for operationalization of MC interventions as well as the working of conventional and traditional MC practices to inform planned interventions for scaling up MC in Tanzania.
- Promote wider discussion on, and adaptation of Tool kits to make them relevant to Tanzania's needs.

- Promote availability of safe MC as a medical procedure in public and private modern health facilities, and not wait for the Plan of Action (PoA) to be developed.

3.0 MEETING PROCEEDINGS

3.1 Background to the Country Consultation Meetings

Dr Chiweni Chimbwete a consultant for the UNAIDS- Regional Support Team for East and Southern Africa, in Johannesburg

He presented the objectives and expected outputs of the Tanzania Country Stakeholder Consultation meeting. In his presentation he informed participants on the background of the country consultation meetings. The consultations are held against the background emerging evidence and ongoing research on potential of male circumcision in prevention of spread of HIV, developing countries. The UN family developed a work plan to support countries to consider/prepare for possible scaling up male circumcision as part of their comprehensive HIV prevention. The aim of these country consultation meetings is to discuss the evidence and its implications HIV prevention and understand country context for readiness for scaling up safer MC.

Chiweni shared with the meeting experience from Lesotho, Kenya and Zambia where similar consultations have been held. In Lesotho the key issues are having a common understanding on MC between conventional medical practitioners and those from traditional practice. In Kenya 85% of males circumcise and the key issue is about safer MC. In Zambia, MC was not widely practised stigmatized until recently, when acceptability has increased. There is a team of health providers performing MC in the country.

3.2 Session 1: Presentations on Evidence

3.2.1 Opening Remarks and UN-Tanzania Position on MC and HIV Prevention

Speech by Dr. Louise Setshwaelo - Chair, United Nations Theme Group on HIV/AIDS and FAO Representative in Tanzania

Dr Louise welcomed the participants to the meeting and extended her appreciation for their taking time to attend the meeting. She reminded participants of the African Union (AU) declaration of 2006 as a year of accelerating HIV prevention across the continent given the high record of number of infections. While underscoring the importance of and UN support to innovations for complementary approaches for HIV prevention, including making better use of those cultural practices, that may be found, to have potential in reducing HIV infections, she reiterated the UN position with the regard to approaches to HIV prevention. She noted that 'the ABC (Abstinence, Being faithful, and Consistent use of both male and female Condoms) approach to HIV prevention is still, the most effective approach that we have had'. She further observed that even though MC as a cultural practice has shown to have potential in reducing HIV risks, men and women must understand that male circumcision lessens the risk but does not offer total protection against the virus.

She cautioned participants that even though studies in Africa indicate that MC, may have some impact in reducing the risk of HIV infections, the precise mechanism of how actually this works, is however not

yet clear. As such it is important that, further research continues to be done to validate the recent findings. The UN awaits keenly, the results from current studies going on in Africa while at the same time taking steps to develop tools and protocols to scale up MC at country level if need arises. While the UN is preparing itself for meeting the challenge of scaling up MC globally, developing countries also need to prepare early enough to respond to the challenges should further studies confirm effectiveness of MC on reducing HIV infection. Evidently, as the demand for MC increases, countries will have to develop capacities to respond to the challenge. There will be financial implications as we may know some families may not be able to access safer MC. Governments and other stakeholders will have to support MC for these other groups.

Lastly, Dr. Louise assured Government and partners of UN commitment on the fight against HIV and AIDS.

3.2.2 General/Global Scientific Evidence

Dr. George Schmid of WHO-Geneva: Background to male Circumcision.

Dr. Schmid presented participants with scientific information on the potential of male circumcision in prevention of sexually transmitted infections including HIV. He also presented information on the quality of evidence on the relationship between MC and HIV prevention by highlighting on two commonly used types of evidence: ecological and observational studies. He highlighted on the weaknesses of ecological data in explaining the relationship between two variables. Ecological data showing the relationship between HIV and MC began to be conducted in mid 1980s. He argued that observational studies are better in explaining the relationship between MC and HIV prevention. However, he cautioned that the influence of MC on HIV prevention is not necessary attribution. He presented results from an observational study on incidence of HIV-1 infection in male STD patients after sexual contact with infected prostitutes done in Nairobi 1988. The study shows that the risk to HIV infection is high among heterosexual uncircumcised men with genital ulcers. The presenter explained the need for randomized controlled trials as gold standard for establishing more evidence of the protective effect of MC on HIV prevention which prompted such studies in South Africa and East Africa to be conducted.

3.2.3 Evidence from Africa

Presentation by Mr Dirk Taljaard, from Progressus, South Africa: Investigator, Orange Farm MC Effectiveness Study.

The objective of the study was "to study the effect of MC on HIV incidence among young males in semi-urban areas of Orange Farm in South Africa". The study targeted general population from age 18-24years old uncircumcised men. A Total of 3,035 participants (including HIV positive people) were recruited to be followed for 21 months, with visits at month 3, 12, 21 for counseling, collection of information on sexual behavior, blood tests and clinical examination and treatment of genital ulcer disease (GUD). The study showed strong evidence of the protective effect of Male Circumcision on male HIV infection with a mean of 18 months observation. There were 20 people who became HIV-

positive in the intervention group and 49 in the control group (0.85 per 100 person years). In other words, the MC intervention prevented 6 out of 10 potential HIV infections.

In his conclusion Dirk raised a number of questions to guide participants in their deliberations on the potential of MC in reducing HIV risk in Tanzania. Can MC as an HIV prevention measure be implemented in Tanzania? What about standard of care, different types of circumcision practices in each community? What are the safety concerns, what age should we focus and what are the consequences. What are costs implications? He quoted Prof. Veller who showed that in South Africa at least 1,000 circumcisions per day will be needed making a total of 2,500,000 every year to meet the demand of all illegible men. Despite costs can Tanzania afford not to have MC as a preventive measure against HV?

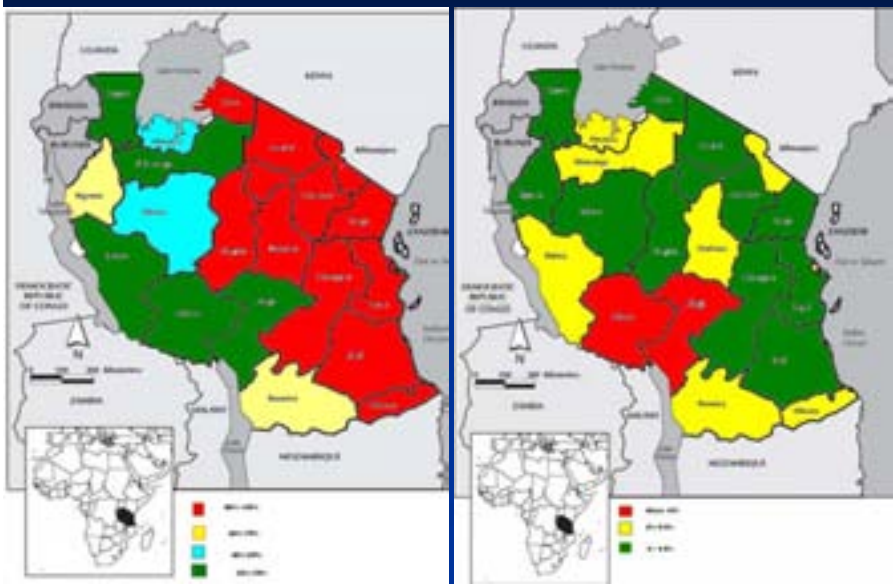
Presentation by Mr Robert Davis: HIV Prevention in Eastern and Southern Africa – are we succeeding? Would we know if we were?

Robert shared with the participants information on renewed interest for intensification of prevention in Africa by the UN. He provided information on the Draft UN Policy Position Paper for Intensifying HIV Prevention. The paper provides UN position on essential programmatic actions for HIV prevention; and the principles of effective prevention. He presented an assessment of effectiveness of prevention measures in Eastern and Southern Africa and contended that while some notable progress has been achieved through existing prevention approaches, more efforts in terms of additional measures in prevention are needed. He highlighted potential costs of failed prevention using a cohort of 1000 people aged 15 years at HIV prevalence rate of 1% in 20 years prevalence rate will be 11% prevalence.

3.2.4 Evidence from Tanzania

Presentation by Mr. Wambura Mwita of the National Institute for Medical Research-Mwanza.
Mr. Wambura presented results of existing studies on MC and HIV prevention in Tanzania. He observed that most of the studies reviewed were not intended to study the relationship between MC and HIV prevention as such conclusions from his presentation should be taken with caution. He observed that ecological data show strong relationship between MC and HIV prevention. HIV prevalence is high in some areas with lower rates in the non-circumcising belt. Mbeya and Ruvuma are in non-circumcising belt and have highest HIV prevalence rates. However, results from other observational studies are mixed. Some studies show strong relationship between MC and safe sex behavior. Ecological data on status of male circumcision in Tanzania is presented on the map in Figure 1:

Figure 1: Male circumcision and HIV prevalence among males aged 15-49 years in Tanzania



In conclusion, he noted that in a homogeneous non-circumcising society, it is likely that MC will be accepted by a large part of the population in Tanzania especially where there is: Islamic influence, mixing of tribes (which include sexual partnerships), urban centres, fishing and trading centres. On the hypothesis that MC has potential on improving penile hygiene including reduction in HIV infection, there are mixed results. Some of the factors contributing to a significant number of people in non-circumcising belt to accept MC include, mobility (mixing of ethnic groups in schools, urban areas etc) and awareness-raising from health programmes.

Issues for consideration include safety of MC practice especially those performed in traditional system which caters for the majority of MC cases in Tanzania. There are issues of costs and affordability of MC to boys and unemployed men. There are also Issues of cultural barriers in non-circumcising areas. Capacity issues nationwide specifically human and financial resources to cater for demand for safer MC. More information on adverse effects of MC especially services offered through traditional system need to be studied. So far not much is known about possible adverse events associated with MC in Tanzania.

3.2.5 Plenary Discussion: Question and Answers

Most of the questions were directed to the presentation on evidence from Tanzania

Question: On biasness of information on circumcision status: why would men want to lie about their circumcision status?

Mr. Wambura: Most studies that look for self reported behavior are subject to bias where participants tend to say what they think researchers want to hear and/or what is acceptable in the society.

Question: The data presented is for mainland Tanzania only and none for Zanzibar. What is the status of MC in Zanzibar where 90% of the population is Moslem?

Mr. Wambura: I did not get hold of relevant studies conducted in Zanzibar on the subject. However, there is an assumption that 91% of Zanzibar population is Moslem and because of the Islamic culture majority will be circumcised.

Question: Is the sample for Tanzania studies big enough to make any kind of conclusion?

Mr. Wambura: Yes the study sample size is small but participants should understand that the studies were not designed to answer questions on causation between MC and HIV prevention.

Question: How can the researcher (Tanzania-studies on MC and HIV prevention) say circumcision reduces HIV infection without taking care of confounding factors such as use of condoms/or sexual intercourse? Has NIMRI done qualitative work on MC specifically on confounding factors?

Mr. Wambura: The studies were not designed to answer the question on impact of MC on HIV protection. Some studies controlled for confounding factors but not all of them.

Question: Whether the proposal to give incentives to young people who are HIV negative to remain negative has considered its impact on increasing stigma?

Mr. Davis: The idea of providing incentives is good for Peer Pressure but one would not want to do it on a large scale. All the proposals we are advocating here have not been applied before so it is important to avoid replicating on a large scale. The proposals need to be tried on a small scale before they are rolled out

Question/
Comment: Some of the issues that came out in other consultancies are on data to validate the information that could be useful for influencing policy. What could you say on how should we move? What data should we collect? What should be the take home message?

Mr. Wambura: The take home message is we need more randomized studies for Tanzania. The key message is that there is evidence that MC has influence on reducing HIV prevalence but results are inconclusive. We should be prepared and not wait for the results of the two studies. Data to validate MC protection against HIV infection need more studies to fill in gaps and investigate some of the unanswered issues.

Question: What about political leadership - what made the difference in Uganda is strong leadership. How do we equip heads of state to stand out? Is it about providing them with more evidence?

Mr. Davis: Political leadership is necessary; this is why we think a well thought out communication strategy is necessary for rallying and mobilizing support for scaling up MC among policy makers

Dr. Fimbo: On less use of condom by uncircumcised men - Whether the methods and penile models used to demonstrate use of condom is a valid explanation for less use of condom among uncircumcised men. The penile model used for demonstration is similar to a circumcised penis.

This could contribute but others also thought it may be more cumbersome to put on a condom on uncircumcised penis.

Question:

Can we get clarification on the assertion that people who are circumcised tend to use condom more than those who are not? Is it condom that reduces HIV infection or MC?

Dr. Schmid: This had been addressed in the designs of studies especially the RCT

Question: The presenter for evidence from Tanzania said, HIV is higher in urban areas and that MC prevalence is higher in urban areas, does this not contradict the assertion that MC has protective effect on HIV?

Mr. Wambura: This is an area that needs further investigation

Question: Where do women fit in the whole discussion on MC and HIV prevention? Can you validate the assertion that men who are circumcised are more likely to be accepted by women?

Mr. Wambura: Weaknesses in observational studies calls for more studies on randomized trials. Study by Kapiga shows that women whose husbands are not circumcised were more at risk than those whose husbands are circumcised. The issue of protection of women against HIV by MC is being investigated in at least one of the ongoing trials of Rakai Uganda and Kisumu Kenya.

3.3 Session 2: Country Context of Male Circumcision

Presentation by Dr. Sifuni Koshuma, Iringa Regional Hospital and Dr. Jasper Nduasinde, Rukwa Regional Hospital

The two presented on the status and practice of male circumcision in Tanzania. They noted that in Tanzania, MC is not institutionalized. The service is provided through a private arrangement between a service provider and client, with minimal supervision and documentation. They noted that, most MC circumcision services are delivered through traditional care system with *Ngaribas* being the main service providers. It is also provided in government health facilities with junior staff being the main service providers.

Tanzania does not have a specific policy on MC but the practice is guided by a policy on surgical procedures, which among others requires informed consent of the client. The presenters also spoke about common MC methods in Tanzania, preferred age for MC, risks associated with the practice and likely implications for scaling up. With regard to risks, they noted that while there is no documented evidence on complications associated with circumcision in both modern and traditional practice in Tanzania, like other surgical procedures circumcision may have complications.

The likely implications for scaling up male circumcision in Tanzania include increased demand for the service especially in modern health facilities where the service has been offered but not on a wider scale.

3.3.1 Plenary Discussion: Questions and Answers

Question: What is the current situation in public health services provision of MC in Tanzania? Is MC freely available?

Dr. Koshuma: MC is provided in public health services for therapeutic reasons and is not offered free-of-charge except for old men (who are provided with free health care services).

Question: If MC is already carried out for religious, hygienic, and cultural reasons why can't we promote these reasons? Can these reasons help in scaling up?

Dr. Koshuma: Yes, the other benefits can be used for promoting MC acceptance especially now that we are not yet confident to use MC as a valid medical measure to explain its effectiveness in reducing the spread of HIV.

Question: In view of potential misuse of MC in prevention of HIV, can't we run into risk of complacence and people taking this as a solution and forget other behavioral interventions which Tanzania has been advocating in the past?

Dr. Schmid: Within UN, MC is and has never been considered as a replacement of other HIV prevention measures. MC is considered as a complementary measure advocated together with Abstinence, being faithful and condom use.

Question: What is the average cost for the procedure (circumcision) in Tanzania? The US $ 20 quoted by presenters (Drs Sifuni and Nduasinde) happens to be less than what is quoted elsewhere?

Dr. Nduasinde: It varies but data available estimate the cost to be between US$ 10 and 20 in most places of the country.

Question: Are there any known risks with MC care delivered by junior staff in public health care delivery?

Dr. Koshuma: Currently the risks are not documented

Question: Who is currently providing MC services in public health facilities in Tanzania and where did they get their training from.

Dr. Koshuma: Nurses usually working in theatres currently do MC in public health facilities. The experience is mainly gained through practice. If MC is promoted as HIV prevention measure demand for experienced practitioners is likely to increase with potential of surpassing the existing capacity. This will raise need for training existing and or additional practitioners.

Question: Why do we need to promote MC when trends in MC acceptance show increase in non-circumcising belt even without any major effort?

Dr. Koshuma: We need to promote MC in non-circumcising belt because only 1/3 circumcise for religious reasons as such the remaining 2/3 may not have any good reasons and hence they need to be convinced.

Question: Why are we worried about increasing demand for MC when you have already said it is being practiced widely?

Dr. Koshuma: When demand rises, costs to an already over burdened heath care system will rise. We saw in South African experience the costs are high (consumables, training to service providers etc.) But also even though it is increasing the pace is still slow given the HIV prevalence rates especially in non-circumcising belts of Mbeya and Ruvuma.

Question: The decision of policy makers to support or not to support MC in Tanzania will depend on evidence provided in favour of MC. What can the meeting advice policy makers?

Dr. Koshuma: The need to prepare early for possible scaling up MC once results from controlled trials from Rakai and Kisumu are out

Question: What are the medical personnel views on the belief that circumcising an infant retards growth of the penis?

Dr. Fimbo: So far no medical evidence on the belief. This is just hearsay.

Question/ Comment: Is it possible that uneven distribution of capacities between rural and urban areas may not result in a two-tier system in which the urban areas would be more able to respond?

Dr. Koshuma: This is an area that needs to be looked at carefully

3.4 Group Work and Presentations

Participants worked in three groups to discuss at length issues related to:

1- adverse events of traditional practices,
2- desirable interaction between the modern medical sector and traditional practitioners; and
3- how to minimize 'risk compensation and other HIV prevention activities to be linked to the provision of MC?

1- Adverse events of traditional practices:

- the group was of the view that such events do occur and that detailed information on the magnitude and severity is not known because of the secretive nature of such services.
- The group noted that cultural initiation practice provides a good opportunity for introducing safer MC in Tanzania.
- That the various roles involved can be shared between modern and traditional practice, with the former specializing on surgical procedure and the later initiation rites/ceremonies and health sex information.
- promotion of both modern and traditional practices where the former is dominant and modern MC and eventual phasing of traditional practice where it is not strong.

2. Desirable interaction between the modern medical sector and traditional practitioners

- the group identified the circumcising belt to comprise 11 regions and the non-circumcising belt 9 regions
- The group identified some of the reasons for non-circumcision as abnormal sexual practices, e.g. homosexuality, stigma.
- the group identified the following factors as important for safe circumcision, involvement of Ngaribas in scaling up MC, promoting public private partnership in the delivery of MC services. Ngaribas in MC belt should collaborate with public health providers like Traditional Birth Attendants (TBAs).
- The group recommended for raising profile of MC in public health facilities
- The group recommended for promoting MC in non-circumcising belt could involve policy documents and regulations for MC practice.

3. How to minimize 'risk compensation and other HIV prevention activities to be linked to the provision of MC?
    - The group made the following recommended for a national policy framework for safer MC. This new policy framework could come from the Ministry of Health, but consider multi-sectoral nature of MC.
    - The group also recommended for raising awareness among the public on the need for safer MC, its availability, delivery channels including whether to use existing 1000 VCT centres and other issues relevant to the service sector as well as a need to harmonize the MC service as a public health care delivery issue with the National Health Insurance Fund (NHIF).
    - The group recommended that the proposed policy should also consider the following issues
        - ethical issues specifically those related to informed consent for those below 18,
        - how the traditional practice should be brought into line with modern standard practice,

- whether MC for non circumcising belt be made available or promoted, determining the specific roles private sector and public sectors and other in MC,
- whether a specific policy should be formulated to integrate Ngaribas into modern health care system,
- who should finance safer MC and how and lastly who should drive the MC agenda in Tanzania is it TACAIDS, the Ministry of Health etc.

3.4.1 Plenary Discussion: Questions and Answers

Question: Have women been involved in the promotion of circumcision and what benefits do they get out of circumcised men.

Mr. Wambura We do not know whether women will promote MC. We need studies to understand situation on the ground,

Comment: Issue of Public Private Partnership (PPP) is good and is not new to our medical practice with existing good examples. Bombo Hospital in Tanga is a case in point where traditional healers and conventional medicine are working very closely in the area of HIV and AIDS. Collaboration of traditional circumcisers and the formal health system need to be considered.

Question/
Comment: There are adverse events associated with Ngaribas practice of MC in addition to those highlighted by the group these included blood loss leading to anaemia, infections from use of unsterile knives etc.

Question: On the issue of capacity building specifically training for both conventional and non–conventional providers, what do we want to train them on?

Dr. Schmid: The needs assessment/and or Situational Analysis studies will provide detailed information on the training needs. But it is true different roles will need different training to meet the challenge of their new roles in the context of MC.

Dr. Nguma: There is no need for policies and guidelines because all issues related to HIV prevention are coordinated through the Tanzania Commission for AIDS (TACAIDS) which. TACAIDS is in the process to review the National Multi-sectoral Strategic Framework 2004-2007. Efforts should thus be made to get MC as an HIV prevention measure included into TACAIDS agenda. The issue is whether localised information will be readily available to get into NMSF on time.

Question/
Comment: Since the Ministry of Health treats MC as a surgical procedure; it has to be performed by medical professionals. As such ways have to be sought out to ensure medical professionals and not junior staff carry out MC. If we leave the procedure to non-professional staff (*Ngaribas*) we will not be adhering to national guidelines advocating for surgical procedures to be provided by professional staff.

Dr. Swai: The proposal to outlaw *Ngaribas* or non-medical professionals in the delivery of MC service is not practical given severe shortage of staff, mid wives, nurses and medical professionals in the country. By advocating for professionals to provide such services we are looking for many years away to make safe MC accessible to most Tanzanians. We need *Ngaribas* as they are involved in the practice regardless of their level of education. We also need to think how, on a larger scale, what kind of advice UN Geneva can give people at country level. There will be a meeting in Geneva in November 2006 on what works and what is not working, hopefully this information will help country level programming.

Comment: We agree that accessing data from traditional practice is a major challenge for comprehensive mapping of adverse events of MC in Tanzania. However, the issue is not one on accessibility but rather it is that of appropriate methods to access the information. For some tribes the right of passage is a secretive undertaking and may not allow documentation or witnessing by outsiders.

Dr. Antipas D. Swai/Comment: On interaction between modern and conventional MC practices, proposals were made for allowing the two systems to work together specifically for surgical procedure to be left to conventional practice and rites ceremonies to traditional practice. The meeting should note that circumcision in some cultural settings is not only about the surgical procedure but also on how one was circumcised. Maasais' and Kuryas' may not respect a person circumcised in conventional facilities.

Question: What institutions at the community level have replaced the chieftainships structure; who are the gatekeepers on MC at community/village level?

Dr. Fimbo: The issue of chiefs was brought up where MC is not practiced, where discussions on cultural issues are organized through chiefs who are responsible for cultural meetings. In areas where circumcision is practiced there are ways by which cultural issues are dealt with.

3.5 Strategies for MC Programming

3.5.1 Global Level

Presentation by Robert Davis: Introduction to Programme Possibilities

Robert Davis presented to the meeting practical thoughts on a framework for Programming of MC interventions. There are basic questions that a programme should respond to, including:

- Who to include both circumcising and non circumcising belts and their special needs;
- What? focusing on the services including safe and affordable MC to those who can give formal consent;
- When? the services need to be ready before and not after the increase demand; where which involves defining position of traditional MC most likely will go on in either existing venues, or move to the clinic;

- How? includes defining institutional arrangements (finance, technical support and training) for scaling up MC; and
- Why? Involves providing justification for MC to different stakeholders: to donors it saves money and for public health, it saves lives.

3.5.2 State of Preparedness at UN Level

Presentation by George Schmid WHO Geneva

George started his presentation by responding to question raised during the meeting on the benefit of MC to women. He stated that since HIV prevalence in men will fall, fewer infected men will be available to infect women. Men with HIV will likely have lessened transmission efficiency.

He informed the meeting that the UN is preparing for action in eventuality of positive results from the studies. The preparations have included preparation of UN position on male circumcision, developing work plan, tools and protocols, as well as preparing countries for possible scaling up of MC. On UN position on Male Circumcision the UN is not "promoting" male circumcision (MC) for HIV prevention and advocates that it should be done with the assent/consent of those having it and that wherever it is done, it should be done safely. Other preparations include reviewing evidence at UN level, countries and expert consultations and issuance of guidance. With regard to guidance, the UN has prepared the following assessment tools, (i) Manual for MC under Local Anaesthesia, (ii) Situation Analysis Toolkit (iii) Service Availability Mapping (iv) Programmatic Evaluation Toolkit and (v) DHS and other surveys. UN preparations are guided by a UN Male Circumcision Work Plan which begun in September 2005. Its purpose is to prepare UN health agencies, and countries, for the possibility of male circumcision being adopted as a strategy to prevent HIV.

The support for the UN Work Plan on Male Circumcision and HIV include: Funding amounting to (US$ 1,040,000), currently from USA National Institutes of Health (NIH), Agence national de recherche sur le sida (ANRS), UNAIDS and Bill & Melinda Gates Foundation but many other agencies/donors are expected to come in. Programme support is offered by HQ and regional offices of UNAIDS, WHO, UNICEF, and UNFPA. Other Collaborators include World Bank (regional), USAID, and PEPFAR

3.5.3 Country Level: Preparing for Possible Scaling Up of MC

Discussion on state of preparedness on Tanzania focused on practical steps that are needed to prepare Tanzania to meet the challenges for scaling up safer MC in the country. Through plenary discussion participants indicated the following practical steps.

- Preparation of a Plan of Action.
- Formation of a task force to coordinate the preparation of Plan of Actions.
- The UN and government should convene a meeting to decide on a national body to coordinate MC issues in Tanzania.
- The meeting report to be forwarded to TACAIDS through UNAIDS for official consideration by the Government. The Ministry of Health and Social Welfare will also be part of this process.

- Toolkits need to be available in time for Tanzania to comment on and adapt.
- Tanzania has to appoint representatives to the Regional Consultative Meeting

3.5.4 Plenary Discussion: Question and Answer

Question: When will the toolkits specifically the Situational Analysis Tool be made available to countries?

Dr. Schmid: The Situational Analysis Toolkit will not be finalized until after six (6) weeks from now; then Geneva will share with countries.

Dr. Nguma/comment: There is need for a quick needs assessment to map out the status of MC in Tanzania. This information will help the development of a communication strategy that will guide this process and then see how this strategy fits in with what is going on in the country.

Dr. Kigadye/comment: Though we are told trends towards circumcision are improving we should not wait but let us be transparent and inform the public through our health facilities on the availability of this service.

Dr. Dr. Lamine Thiam/Comment: While it is important for Tanzania to carry out a Situational Analysis, we need protocol for Comprehensive Situational Analysis. The country is too huge covering about more than 130 districts. Decisions will have to be made whether to cover the whole country in conducting needs assessment? The assessment should be comprehensive to look at different dimensions of MC not just whether MC is traditional or conventional.

Mr. Davis: There is a need for a coordination body to drive the process for scaling up MC in the country. For instance, where the responsibility for coordination of MC should be placed.

Response from

The Chair, Dr. Fimbo: The decision for coordination and further follow up will be made by responsible authorities in Government. Let us have the report of this meeting and submit it to the competent authority for decision. Tool kits have to be made available.

Dr. Nguma: The meeting should take note that three weeks ago the Government through TACAIDS formed a Prevention Task Force to spearhead scaling up MC could be integral to this Prevention Task Force.

Dr. Lamine Thiam Recommendations/

Comment on M&E Toolkit: Regarding the UN Toolkits on the Components of the Monitoring and Evaluation. The existing toolkit has adequately addressed the link between supportive supervision as problem solving approach with quality improvement efforts and monitoring evaluation. However, the monitoring and evaluation toolkit needs to be less conceptual and be more practical. It should provide tools to the program managers to assess the root causes of low quality MC services and implement quality improvement plans at the regional and district health facilities in Tanzania. SUGGESTION: The

toolkit developed by John Hopkins University in close collaboration with USAID through the Quality Assurance Project (Q&A) can be used to improve the contents of the M&E toolkit

Dr. Lamine Thiam, Recommendations/

Comment on Service Availability Mapping toolkit: Tanzania through the WHO Country Office has already promoted and implemented the Service Availability Mapping (SAM) in some regions. Data are in the process of being analyzed by the Ministry of Health and Social Welfare. We have to make sure that MC issues are integrated in the next of SAM in Tanzania

Annex 1: List of Participants and their Organizations

S/N	Name	Institution/Ministry
1	Mr. Boniface Joseph	Tanzania Human Rights Foundation (THEF)
2	Dr. Z. Sekirasa	Regional Administrative Secretariat-Mara
3	Dr. A.Makala	Ministry of Health and Social Welfare-Headquarters
4	Anthony John	TANASSO-CARE NGO
5	Dr. Yusuf. Bwire	Maswa District Medical Officer
6	Dr. S. S. Ulomi	Regional Medical Officer-Shinyanga
7	Dr. Antipas D. Swai	District Medical Officer Manyoni
8	Robert Davis	UNICEF- Regional Office Nairobi
9	Jacqueline Daldin	UNAIDS- Dar Office
10	Catriona Byrne	UNDP- Tanzania
11	Dr. Lamine Thiam	WHO Country Office-Tanzania
12	Jan Baaroy	UNICEF-Tanzania
13	George Schmid	WHO, Department of HIV – Geneva
14	Chiweni Chmbwete	UNAIDS, RST-ESA- Johannesburg
15	Jennifer Kotta	UNESCO-Country office Dar es Salaam
16	Jane S. Tembo	UNAIDS-Dar es Salaam
17	Dr. Justin Nguma	Healthscope Tanzania
18	Dr. B. Fimbo	National AIDS Control Programme (NACP)
19	Dr. Sifuni. R. Koshuma	Regional Hospital-Iringa
20	Dr. Jasper.S. Nduasinde	Regional Hospital Rukwa
21	Richard Ngirwa	TACAIDS
22	Mr. Dirk Taljaard	Progressus (Investigators Orange Farm Male Circumcision Trial)
23	Dr. F. L. Kigadye	Tanzania Episcopal Council (TEC)
24	Ms. Clotilda T, Ndezi	Christian Council of Tanzania (CCT)
25	Dr. John R. Tupa	Ministry of Health and Social Welfare
26	Dolorosa Candelaria	Tanzania Commission for AIDS (TACAIDS)
27	Samuel Komba	Tanzania Commission for AIDS(TACAIDS)
28	Isabela Mdatu	Tanzania Commission for AIDS 9TACAIDS)
29	Dr. Awene Gavyole	WHO Country Office Tanzania
30	Jacobo Kingazi	Tanzania Commission for AIDS (TACAIDS)
31	Samuel Kiowi	Tanzania Commission for AIDS (TACAIDS)
32	Daniel Mbidu	Tanzania Commission for AIDS (TACAIDS)
33	Dr. Cosmas W. Swai	Family Planning Coordinator, Reproductive and Child Health Services (RCHS), Ministry of Health and Social Welfare
34	Dr. R. O. Swai	Ministry of Heal and Social Welfare-National AIDS Control Programme (NACP)
35	Mr. Wambura Mwita	National Institute for Medical Research (NIMRI)-Mwanza
36	Herry Adili	Impact Development Management Consultancy (IDMC)
37	Suma Kaare	Impact Development Management Consultancy (IDMC)

Annex 2: Meeting Agenda

Male Circumcision and HIV Prevention
Country Stakeholder Consultation Meeting
Dar-es-salaam Protea Hotels – Courtyard 14-15 September 2006

Agenda

Time	Discussion Topic	Presenter
Day 1: 14/9/06 **Morning**		
Session One: Introduction & Current Situation re MC & HIV **Chair: Director Preventive Services MOHSW**		
9.00-9.15	Opening and welcome remarks	Dr. Donan Mmbando - TACAIDS
9.15-9.20	Meeting Objectives	Chiweni Chimbwete
9.20-9.30	Statement by UN in the context of the country	UNTG Chairperson
9.30 – 10.00	Evidence on male circumcision and HIV prevention: ▪ findings from Orange Farm study and other studies	An investigator from the team Orange Farm study team
10.00 – 10.30	Discussion	
10.30-11.00	**TEA BREAK**	
11.00 – 11.30	Male circumcision in the context of a comprehensive HIV prevention programme	Robert Davis (UNICEF)
11.30 – 12.00	Discussion	
12.00 – 12.30	In-country studies on male circumcision	Wambura Mwita – NIMR Mwanza
12.30 – 13.00	Discussion	
13.00 – 14.00	**LUNCH BREAK**	
Day 1: Afternoon		
Session Two: Country context of male circumcision		
14.00 - 14.45	Cultural MC practices	Dr. Sifuni Koshuma Dr. Japhet Nduasinde
	Acceptability of MC	
	Risks and barriers to MC	
	Surgical/Clinical MC services	
14.45 – 15.00	Plenary discussions	
15.00 – 15.45	Group Discussions	UN Facilitators
15.45 – 16.30	Plenary discussions	
16.30	End of day	
Day 2: 15/9/06 **Chair:** **Chairperson: Dr. Fimbo - MOHSW-NACP** **Morning**		
9.00 – 9.15	Recap of Day 1	

Session Three: Strategies for MC programming		
9.15 – 9. 30	Introduction to programme possibilities	Robert Davis (UNICEF)
9.30 – 10.00	Discussion	
10.00 -10.30	Assessment tools	George Schmid (WHO)
10.30 – 11.00	**TEA BREAK**	
11.00 – 11.30	Discussion on assessment tools	
11.30 – 12.00	Plenary discussions	
12.00.- 12.45	What needs to be done/Key needs for follow up	Dr. Fimbo - MOHSW
12.45 – 13.00	Concluding Remarks & Closure	Dr. Fimbo –
13.00	**LUNCH**	