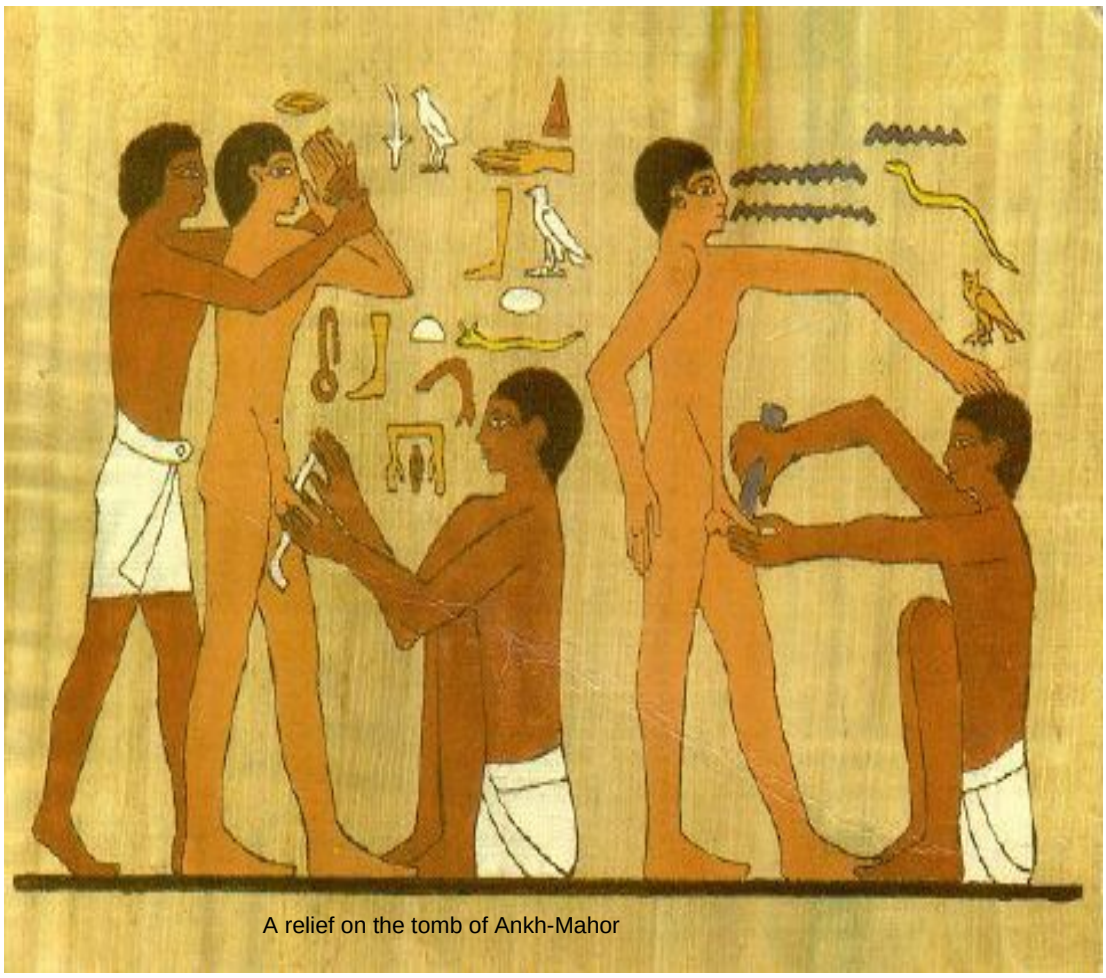

A relief on the tomb of Ankh-Mahor

MALE CIRCUMCISION CONSULTATIVE MEETING REPORT

FOR THE MEETING HELD ON 11-12 SEPTEMBER 2006 AT CHISAMBA PROTEA IN LUSAKA, ZAMBIA

Report by Evah Mwariri-Mugo

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I ACKNOWLEDGEMENTS

This workshop would not have been a success without the help of the National AIDS Council, Ministry of Health, the United Nations and all the presenters who made their presentations during the sessions and Dr. Mannasseh Phiri the workshop facilitator. There would have been no workshop if there were no participants they definitely made all the difference in making the workshop a success. Others who were present but may not be in the picture are Dr. Ben Chirwa, NAC Director General and Dr. Stella Anyangwe, UN Theme Group Chair on HIV and AIDS and WHO Country Representative among others.

Front Line from left to right: **Ms.Florence Mulenga, Mrs.Evah Mwariri-Mugo, Dr. Jabbin Mulwanda, Mrs Arlene Phiri, Dr. Kanyanta Sunkutu, Dr. Mannasseh Phiri, Mr. John Mapulanga, Mrs Beatrice Chokotola, Mr. David Alnwick, Professor J. Karashani, Mr. Dirk Taljaard, Mr.Crispin Silungwe.**

Back line from right to left: **Mr. Chimbwete Chiweni, Dr. Kasonde Bowa, Dr. Kwasi Torpey, Dr. Catherine Sozi, Dr. George Schmid, Dr. Peter Mwaba, Mr. Steve Gesuale, Dr. Alex Simwanza, Dr. Tesfaye Shiferaw, Dr. Dorothy Kasonde, Mr. Rick Hughes –** photo by Chisamba Staff

II SUMMARY

The male circumcision consultative meeting held on the 11 and 12 September 2006, is part of the UN work plan to support countries in providing safe male circumcision whilst waiting for the confirmation in Kenya and Uganda of the South Africa randomized control trial result that found male circumcision has a 60 per cent protective effect on HIV. The Chisamba meeting drew over 30 participants from the civil, private, UN and public sectors. The meeting aimed to discuss the implications of the evidence for safe MC and comprehensive HIV prevention programming.

Dr. Ben Chirwa, the National AIDS Council Director General, chaired the morning session. In his opening remarks, he encouraged participants to come up with a comprehensive HIV and AIDS prevention package. He also mentioned that the former Central Board of Health had produced some draft manuals for health workers and trainers on male circumcision as early as 2004.

Dr. Stella Anyangwe the UN Theme Group Chair on HIV and AIDS and also the WHO Representative officially commenced the meeting. In her opening remarks, she emphasized that the UN promotes safe circumcision in places where it is currently practised. However, a decision to promote male circumcision should wait until the Uganda and Kenya trials confirm the protective capability of male circumcision against HIV.

The Orange Farm study findings presented by Mr. Dirk Taljaard confirmed participant's curiosity on the interlink ages of male circumcision and HIV prevention. He explained the randomized trials observed the inter-linkages between male circumcision and HIV prevention and ran for two years. The recruits ranged from 18-24 years. At the beginning of the trial all the recruits were uncircumcised and most were healthy. They randomly divided the groups and circumcised the control group. The studies revealed that circumcised males had a lower HIV incidence rate as compared to the uncircumcised males. Only 40% of the circumcised males had sero-converted. Thus the studies concluded that male circumcision could offer 60% protection.

In Zambia male circumcision is only practiced in the North Western and some pockets of Eastern Province. Coincidentally the North Western Province also has the lowest HIV prevalence rate of 8% in comparison to the national prevalence rate of 16% among 15-45 year olds. It is also offered in a few clinical sites namely: University Teaching Hospital, Chinama, George Clinic, and Livingstone Hospital.

In his presentation on Male Circumcision in Zambia, Dr. Jabbin Mulwanda from JIPHIEGO mentioned that the USAID JIPHIEGO funded a pilot programme aimed at strengthening existing services in areas where circumcision was required. JIPHIEGO also aimed to develop test tools and approaches to strengthen male circumcision should scale up be necessary. A stakeholder meeting was held followed by an acceptability study of male circumcision. The programme was conducted in George Clinic, Chinama Health Centre and the University Teaching Hospital. After assessments, the sites were enhanced in terms of space, equipment, provision of lunch allowances and additional training for support staff. They also adopted a standardized male circumcision procedure. The programme found that when the sites were enhanced the clinics were able to accommodate more clients hence an increase in the number of men being circumcised. On the other hand when support was withdrawn the numbers of clients attended to went down therefore fewer men being circumcised.

Dr. Kasonde Bowa mentioned that the University Teaching Hospital has been offering male circumcision since 2004 and have conducted 900 male circumcision procedures. UTH normally uses the dorsal slit surgical method. Over the years, the demand for male circumcision services mostly by men aged 14-35 years has steadily increased forcing UTH to offer the service every

afternoon from thrice in a week. Over the years UTH has learnt that financing should be scaled up to ensure sufficient equipment. The need for other medics other than doctors is necessary to fill in the gap. However he mentioned that UTH was still struggling on how to anaesthesate children as at the moment the sedation method is used.

Rick Hughes presented on the risks and obstacles to male circumcision scale up. Mr Hughes warned that there could be misconceptions of male circumcision as the ultimate proof and in return a rise in risky sexual behaviour. Hence he mentioned that the messaging needed to include the other preventive practices. He highlighted the need for quality in the surgical service, counselling and the linkages with the sexually transmitted and HIV counselling and testing. He warned that male circumcision services would be competing for the already strained human resources and facilities. Hence he advised the options of involving non medics such as traditional circumcisers. Finally he recommended a national roll out plan factoring in the logistical, human resource and other associated costs.

Mr. John Mapulanga Men Make a Difference (MEN DIFF) Executive Director mentioned that MEN DIFF is an NGO lobbying for positive and active participation of men in the fight against HIV and AIDS in Mazabuka district, Southern Province. Since the inception of the male circumcision programme MEN DIFF has trained over 50 peer educators. The main message MENDIFF is disseminating on male circumcision is that it is hygienic, reduces your chances of developing cancer, gives sexual fulfilment and you have lesser chances of contracting sexually transmitted diseases including HIV if used together with the ABC's. They recommend a budget to train clinical officers, nurses and traditional circumcisers to ease the burden on doctors.

Professor Joseph Karashani discussed on Ethical issues pertaining to male circumcision. He defined Ethics as what is morally right or wrong, a behaviour or conduct. He went on to mention that any procedures should be based on the three ethical principals mainly respect for persons, benefiance (doing no harm), and Justice. Hence he emphasized the need for informed consent. Critical issues such as how much information is enough, do we wait for the children to grow up, the poor and mentally challenged among other issues were raised as the guardians make decisions. Finally he bemused participants by asking what happens to the foreskins after they are removed. He warned them that informed consent should be given prior to the procedure. If the foreskins are needed for research out of the country he pointed out the service provider would need the ethical clearance forms and an export licence.

Mrs Kondwa Chibiya the Chairperson of HIV and AIDS committee in the Law Association of Zambia presented on Human Rights. She mentioned that male circumcision was not directly addressed in the areas of human rights in Zambia. However she mentioned that certain instruments such as the UN Convention on the rights of children, and the UN convention on Human or Civil and Political rights convention would be implied.

Mr. Philemon Ndubani from the Costella Futures Consultancy presented on the cost and impact assessments of male circumcision in southern Africa. He mentioned that the USAID funded assessments hope to get a comprehensive view of the associated costs to male circumcision including the outreach methods. Additionally it would also review the pre and post counselling and surgical procedures. The will mainly use literature reviews and consultations with key stakeholders. Upon completion, they will draw up the resource requirements based on protocols and expected demand.

Mr. David Alnwick from UNICEF presented on male circumcision in the context of a comprehensive HIV prevention programme. He highlighted the need for a national roll out plan with clear goals and leads. Thus he suggested the need for a taskforce to implement the scale up. He

also emphasized on the need for policy if the service will be provided for free. He stressed on the need for a comprehensive plan incorporating the technical and financial resources on the interlink ages of the male circumcision service with the reproductive health and sexually transmitted diseases including HIV. Finally he mentioned that the media was key in scaling up hence there would be a need for a spokes person to ensure accurate messages get to the public.

Mr. George Shmid in his Assessment tools presentation revealed that there is already a working group in the UN which had developed some assessment tools should the studies prove successful. He highlighted the need for guidelines for safe circumcision which would mean reviewing existing manuals on the surgical technique, counselling and sexual behaviour advice. In addition he pointed out the need for a situational analysis toolkit. These would categorize the need based on age, region among others. The tool kit would also incorporate the reasons for males seeking circumcision services, the locations and the capacity of health care services and providers to meet the demand and what needs to be done to meet this gap.

The consultative meeting ended with a panel discussion. The panellists comprised of Dr. Alex Simwanza from NAC, Dr. Kasonde Bowa from UTH, Dr Dorothy Kasonde from Multi Medical Centre (representing the Private Sector) and Dr. Peter Mwaba from the Zambia Medical Association, Mr. Rick Hughes from JIPHIEGO and Mr. David Alnwick from UNICEF Regional Office. The discussants expressed the need for male circumcision to be promoted as part of the ABC's. Additionally, the need for mapping out the inter-linkages between male circumcision with services such as reproductive health and sexually transmitted counselling and testing inclusive of HIV are important in scaling up of male circumcision service and increasing male involvement in the fight against HIV. All the discussants agreed on the need for a national roll out plan.

RECOMMENDATIONS AND WAY FORWARD

Most participants stressed on the need to promote male circumcision as part of the ABC's to avoid eroding gains made on previous prevention efforts. In addition, participants felt that Human Rights can be overridden for the public good. A case in point was circumcising children for their medical welfare against their wish. Participants also mentioned on the inclusion of traditional circumcisers and non doctors to be trained on the comprehensive male circumcision package to ease the gap. The participants' discussion and recommendation after the panel discussion are summarized as follows:

- Devise means to meet high male circumcision demand
- Offer male circumcision as part of a comprehensive prevention package
- Address the Human Resource Crisis and Health Infrastructure to enable the roll out of male circumcision
- Involve Traditional Leaders and Traditional Circumcisers in the planning of male circumcision scaling up
- Ministry of Health should take the lead
- Promote couple counselling before male circumcision
- Use available funds to conduct male circumcision assessment studies e.g. PEPFAR

Dr. Alex Simwanza the Director of Programmes at the National AIDS council called the meeting to a halt by summarizing the consultative meeting recommendations and way forward as follows:

- Form a male circumcision working group which would be part of the NAC prevention Technical working group to provide policy guidance, planning and steering of merging issues on male circumcision
- Preparation of an information package for communities, health care providers as well as traditional circumcisers and others

- Inclusion of male circumcision in the pre-service training at the medical school, Chainama College of Health Sciences for clinical officers and registered nursing training schools
- Ensure that male circumcision services are a complete package including appropriate counselling and education are available to meet existing demand for services. This would entail strengthening existing male circumcision services including the integration of HIV prevention and care activities.
- Engaging the Royal Foundation of Zambia to advocate for male circumcision in the respective areas of the traditional rulers, especially in the non-circumcising areas
- Engaging the Traditional Health Practioners of Zambia and traditional circumcisers and similar bodies to equip them with appropriate information on male circumcision
- Engage and educate religious leaders on the evidence about male circumcision to ensure that there is no backlash
- Formulate a costed male circumcision roll-out plan

The participants summed up the main message from the workshop as "Male circumcision is a promising HIV prevention method. However, it has to be used together by abstaining, mutual faithfulness, and condomizing. Once the randomized controlled trials in Kisumu and Rakai are out, Zambia shall decide on whether or not to scale up male circumcision"

III INTRODUCTION

The quest for the inter-linkages of Male circumcision and HIV date back to the late *1980's by Bongaarts*. However it was not until the Orange Farm randomized trials in South Africa that got the world curious on the preventive capabilities of male circumcision against HIV. The Orange Farm trials showed that circumcised men had a 60% chance of not contracting HIV unlike their uncircumcised colleagues. Currently, there are two eagerly awaited randomized trials on the inter-linkages on HIV and Male Circumcision being conducted in Kisumu-Kenya and Rakai-Uganda. If the trials confirm that male circumcision can partially protect men from acquiring HIV then there will be great need for a national roll-out plan. However, the decision to roll out male circumcision will entirely depend on governments.

In April 2006, Zambia joined the rest of Africa in launching 2006 as the year for accelerating prevention. The launch was meant to speed up the realization of the targets set during the United Nations General Assembly Special Session (UNGASS 2001) dedicated to HIV and AIDS in 2001 by the Heads of States. Zambia was also part of the recent Think Tank Meeting in Maseru on HIV Prevention in High Prevalence countries in Southern Africa. During this meeting the key drivers of the epidemic in southern Africa were defined as **"multiple and concurrent partnership by men and women with low consistent condom use and in the context of low levels of male circumcision."** Bearing this in mind one of the key recommendations was for countries to come up with a possible male circumcision roll out plan should the trials prove successful.

Zambia like most of her neighbouring countries has a high HIV prevalence rate of 16.5% among 15-45 year olds. Additionally, male circumcision is only practiced in North Western Province and a bit in the Eastern Province. Coincidentally in the North West Province the HIV prevalence levels are at 8% which is considerably lower than the rest of the country. Hence if the trials prove successful Zambia would have the chance to involve men in HIV prevention and reproductive health. Thus the two day male circumcision consultative meeting on male circumcision aimed at reviewing the current evidence and discussing the implications of a possible roll out in Zambia and possible programming strategies.

The report depicts the presentations and discussions during the Male circumcision meeting in Chisamba Protea on the 11 and 12 September 2006. The meeting is part of the UN work plan to support countries in providing safe MC whilst waiting for the confirmation in Kenya and Uganda of the South Africa randomized control trial result, which found 60 per cent protective effect of MC on HIV. The report includes remarks by the NAC Director General Dr. Ben Chirwa and the UN Theme Group Chair on HIV and AIDS and also WHO Representative, Dr. Stella Anyangwe. It also captures the science of male circumcision, the Orange farm case study, Ethical considerations and the human rights perspectives. Lastly it summarizes the mapping out of services and a roll out plan and the panel discussions and participant's recommendations.

DAY I

1 Session One: Introduction and country situation on male circumcision and HIV

1.1 Opening Remarks

1.1.1 Dr. Ben Chirwa

Dr. Ben Chirwa the National AIDS Council Director General welcomed the participants to the meeting. During his first remarks as Chair of the morning session, he stressed that Zambia had been bold. He explained that the country had taken some big risks such as passing a free anti-retroviral therapy policy. "Most people said it was impossible in the public sector but a few believed on the benefits treatment would have in the long term as opposed to the short term challenges" "This shows that if we are a group like we are here and embark on something we believe in it can be done" Dr. Chirwa also mentioned that the former Central Board of Health had developed some draft manuals on male circumcision for health workers and trainers in 2004.

He also mentioned NACs involvement in the recent mission with His Excellency Stephen Lewis the UN Envoy on HIV and AIDS in Africa. Dr. Chirwa revealed "In the same breath that the UN Envoy publicly declared that he is circumcised I am one of the few Zambians who are circumcised…….. He posed and then confirmed "So I am circumcised" His personal testimony created a lot of interest from participants as the workshop mood was livened up.

1.1.2 Facilitator: Dr. Manasseh Phiri

A retired doctor is following his passion as a journalist and part-time DJ. He has also been producing a radio programme known as 'Your Health Matters on Radio Phoenix' and has consulted for the National AIDS Council.

He was the main facilitator for the workshop. In his opening remarks he mentioned "I am Manasseh Phiri, uncircumcised" Dr. Manasseh Phiri' after a round of introductions and participants expectations summarized the meeting objectives as follows:

- ✓ Review and discuss latest evidence on male circumcision and HIV prevention
- ✓ Discuss implications of male circumcision within the country context; acceptability, health service deliver, traditional practices, counselling and consent, ethical and regulatory issues
- ✓ Discuss strategies for follow-up programming

He then welcomed all and hoped for open and fruitful discussions.

1.1.3 Dr. Stella Anyangwe Opening Remarks

The workshop was officially opened by Dr. Stella Anyangwe in her capacity as the UN Theme Group Chair on HIV and AIDS and also the WHO Country Representative. In her opening remarks, she mentioned that the UN promotes safe circumcision in places currently circumcising. However she cautioned that a decision to promote male circumcision as a HIV prevention tool should wait until the Uganda and Kenya trials confirm the protective capability of male circumcision.

About 20% of men globally and 35% of men in developing countries have been circumcised. Dr. Anyangwe elaborated that in West Africa where male circumcision is common HIV prevalence rates are below those of East and Southern Africa. Though the practice is not new in Southern Africa, it was not until recently that stigma towards male circumcision in Zambia begun wading off. In Zambia male circumcision is practiced in the North Western province which apparently has the

second lowest HIV prevalence rate. She pointed out that anecdotal evidence confirms that demand for male circumcision in Zambia exists.

Dr. Anyangwe hoped that the meeting would consider safe male circumcision within a comprehensive HIV prevention package which should include correct and consistent condom use, behaviour change, counselling and testing for HIV infection. She emphasized that a new prevention strategy should not undermine existing prevention strategies that have proved useful.

Public health recommends the need to conduct acceptability, feasibility and costing studies for making male circumcision widely available. Dr. Anyangwe mentioned that acceptability studies conducted in Kenya, Uganda, South Africa, Swaziland and Botswana have revealed that around 60% of the men would like to be circumcised as long as it is safe.

Finally, she warned participants of the danger of the public acquiring false perception that circumcision is the magic bullet of prevention. "With a false sense of security, the public could easily abandon good common sense regarding tested and tried safer sexual behaviours". Hence she hoped that the meeting would assess the current status of male circumcision in relation to safety, prevalence and acceptability. Additionally she hoped that the meeting would evaluate the clinical capacity of facilities and service providers.

1.2 EVIDENCE OF MALE CIRCUMCISION AND PREVENTION

1.2.1 A little background : Dr George Schmid, WHO, Geneva.

Male circumcision is irreversible and maybe the oldest and most common surgery performed on humans. Abut 20-25% of men have been circumcised. As a surgical procedure it carries risk, which is the reason UNAIDS/WHO are taking care.

Dr George Schmid gave a little background on Male circumcision he begun his session by asking what about women? Where do they fit in the whole of male circumcision?

He described two major benefits of male circumcision in the era of HIV to women as:

- If the studies in Rakai, Uganda and Kisumu, Kenya show that Male Circumcision contributes to HIV prevention it means that the number of men with HIV infection will be lower hence fewer women will be infected
- Men with HIV will also have lessened transmission efficiency

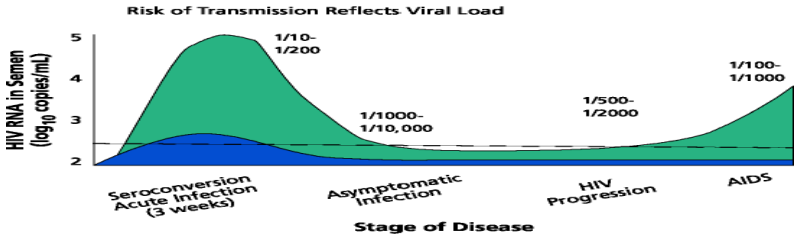


Diagram by Cohen M. Topics in HIV Medicine, 2004; 12:104.

The peak time for HIV transmission is when the viral loads are high. This is before someone turns positive upon being infected (window period 0-3 months) and whilst at the AIDS stage. Referring to the Rakai study in Uganda, he explained that more circumcised males are less likely to get infected from a HIV positive woman. The Rakai studies also showed that women are less likely to

get HIV infection from circumcised males who are HIV positive. However, he cautioned that male circumcision may not have much effect in reducing HIV infection if the male or female viral loads are high.

Dr. Schmid highlighted the UN position on Male circumcision as follows:

SUMMARY OF UN's Position on Male Circumcision

- ✓ The UN is not promoting male circumcision for HIV prevention
- ✓ Male circumcision should be done with assent/consent of those having it
- ✓ Wherever male circumcision is done it should be safe

Why circumcise from a biological perspective:

- Easier to maintain penile hygiene
- Reduced risk of urinary tract infections in children
- Prevention of inflammation of the glands and the foreskin
- Prevention of scar tissue causing inability to retract the foreskin and ir foreskin to go back to its normal position
- Reduced risk for sexually transmitted infection such as ulcerative chancroid and syphilis
- Reduced risk of penile cancer

George reviewed various types of epidemiological studies that help in making decisions about an intervention, as follows:

Ecological Study

Ecological study is the association of two variables. He divided the room into two and said if my left hand side of the room was HIV positive and the right hand side was HIV negative in an ecological study one would deduce being on the left hand side of the room is associated with HIV. Ecological studies help us to develop ideas however they do not give a cause and effect relationship. For example, a study by Bongaarts in 1989 showed HIV infection rates were higher in areas where men do not circumcised men than in circumcising areas.

Observational Study

Since as per the above examples there could be various reasons for the cause of HIV then researchers engage in observational data. In observational studies the researchers observe but do not intervene. There are various types of observational studies such as:

- Cross sectional studies – Measurements are made on a population at one point in time. For example a survey done in village to identify the number of individuals with hypertension. The villagers are screened with blood pressure measurement at one point in time. The number of times there hypertension is detected is examined in relation to age, sex, social economic status and other risk factors for hypertension. They mainly measure prevalence and cannot measure incidence.
- Case-control studies – It measures and compares diseased and non-diseased individuals using historical data. Hence the exposure status is determined by looking backward in time. However, they are more difficult to comprehend. The measure in these studies is called an Odds Ratio (OR)
- Cohort studies – measure and compare the incidence of disease in two or more study cohorts (group) who are similar in almost every aspect except for the exposure you are looking for, in this case

circumcision. For example one group would be circumcised and the other will not be circumcised. It is rated the strongest of all observational designs.

Relative Risk

He explained the concept of relative risk since it is important in understanding the evidence of MC protection against HIV infection. It is the Risk or protection one has from acquiring a disease or not. For example. 20 men visited a prostitute, 10 use a condom. Out of these four out of the ten who used condoms contract HIV. The other 10 who did not use a condom all of them contract HIV. Hence the chance of someone contracting HIV whilst using a condom is 40% chance hence the Relative Risk is 0.4.

1.2.2 FINDINGS FROM THE ORANGE FARM STUDY AND OTHER STUDIES: DIRK TALJAARD INVESTIGATOR FROM THE ORANGE FIRM STUDY TEAM

In his presentation Mr. Taljaard mentioned that the first search for the linkage between HIV and Male circumcision is shown in the studies conducted by Fink in 1986. The linkages between HIV and male circumcision have been followed by a lot of observational studies done in sub Saharan Africa.

In South Africa, the HIV prevalence at the time the Orange Farm Study was commencing was 31.6%. Approximately 20% of South Africans practice male circumcision. The cultures target a median age of 17years. Hence, the Orange Farm study aimed to asses the effect of MC on HIV incidence among young males in South Africa.

How the Orange Farm Study was done

The study (randomized controlled intervention trial) recruited males from the general population aged 18-24years who were uncircumcised but were willing to be circumcised. The participants then signed informed consent to be used for the randomized trials.

The first step included screening which involved blood tests including HIV, circumcision tests to certify that they were uncircumcised and they were eighteen years and above. This was followed by dividing people into groups. One group was circumcised at the beginning of the trials by physicians in their surgeries. The physicians used the forceps guided method and local anaesthesia as recommended by Wits University in South Africa.

Mr. Dirk pointed out circumcision was the only difference in the two groups. The groups were monitored after three, twelve and twenty one months respectively. During each of the monitoring visits, participants were counselled, tested for HIV, clinically examined and treated for genital ulcers and they filled in sexual behaviour questionnaires. In the cases where participants seroconverted they were given anti retroviral therapy. Conversely, he pointed out that all the staff was blinded through out the trial. On the other hand, the recruits were not informed that male circumcision can be protective. Hence there was no significant difference observed on the number of sexual encounters with a risky partner or spouse. But, he mentioned that the trials did not finish to its full time span as the government of South Africa felt it was not ethical not to offer male circumcision to the other groups in the study.

What were the Findings?

At the end of the trials, the results revealed differently. Circumcised males had a lower HIV incidence rate as compared to the uncircumcised males. The number of circumcised males who sero-converted during this period were 40%. Hence the study concluded that Male Circumcision could offer 60% protection. However, Mr. Dirk observed like any other HIV prevention intervention it has to include the use of condoms, being faithful, reduction in multiple and concurrent partners and abstinence.

During the discussion following Dirk's presentation, participants felt that it was important to integrate Male circumcision as part of the prevention package. They felt if promoted in isolation the general public might not see the need to use condoms or reduce the number of sexual partners they have which could result in a bigger health crisis. A number of participants were also interested in finding out the benefits which the Orange farm trials enticed the recruits with in order to agree to enrol for the studies and to be circumcised.

1.3 MALE CIRCUMCISION IN THE CONTEXT OF A COMPREHENSIVE HIV PREVENTION PROGRAM: David Alnwick (UNICEF)

Mr. David Alnwick acknowledged the main drivers of the epidemic in Southern Africa as multiple and concurrent partners. He mentioned that this was happening together with low condom usage within a context of low levels of male circumcision. Bearing this in mind, male circumcision would be part of the prevention approaches currently being used. He mentioned that this year being the year to accelerate access to HIV prevention the UN together with SADC convened a three day Expert Think Tank Meeting in HIV prevention in High Prevalence countries in Southern Africa.

He highlighted that in Zambia's context where there are low levels of male circumcision, it would mean mass male circumcision for any considerable effect on the rate of new HIV infections.

However, Mr. Alnwick mentioned that there is no convincing evidence that HIV incidence rates are reducing. This is because the current data from the Demographic Health Surveys in Uganda, Kenya, Rwanda and Zimbabwe are focussed on prevalence. He mentioned in most countries what had worked was the reduction of multiple and concurrent partners and increased condom use.

SADC Expert Think Tank Meeting Recommendations

- ✓ **Reduce the number of multiple and concurrent partnerships**
- ✓ **Prepare for the possible roll out of male circumcision**
- ✓ **Address male involvement and responsibility for sexual and reprodu including HIV prevention and support**
- ✓ **Increase consistent and correct condom use**
- ✓ **Continue programming around delayed sexual debut in the context programming and reduced partnerships**

Mr. Alnwick concluded by mentioning that if the observation trials in Kisumu and Rakai prove that male circumcision can contribute in lowering HIV infection rates it would be worth venturing in scaling up male circumcision services. He mentioned that unlike the microbicides which might only come in effect in 2012 or the vaccine trials which are on going, male circumcision is a once- off intervention and is already being practiced by some communities.

Following Mr. Alnwick presentation, participants agreed it was important to focus on the lessons learnt in Southern Africa by sharing the best practices in order to curb the main drivers of the epidemic highlighted in his presentation.. Additionally, they emphasised that the major drivers of the epidemic should be prioritized and tackled using comprehensive strategies. Participants highlighted that a lot of emphasis should mention that male circumcision alone is not a magic bullet to HIV prevention but a combination of the ABC's just like the ART is a combination therapy. Hence, even if one is circumcised they still need to stick to one partner and for those who cannot abstain they would still need to use condoms correctly and consistently every time they had sex.
The major concern by participants was how to communicate to the public on the effectiveness of male circumcision without having an effect on the already low condom usage in most countries. Moreover, participants pointed out that it was important to realize that people are real and will not continuously use condoms at every sexual act hence the need for proper messaging. Despite the concerns, most participants agreed that should the randomized control trials prove successful male circumcision should be promoted on a large scale.

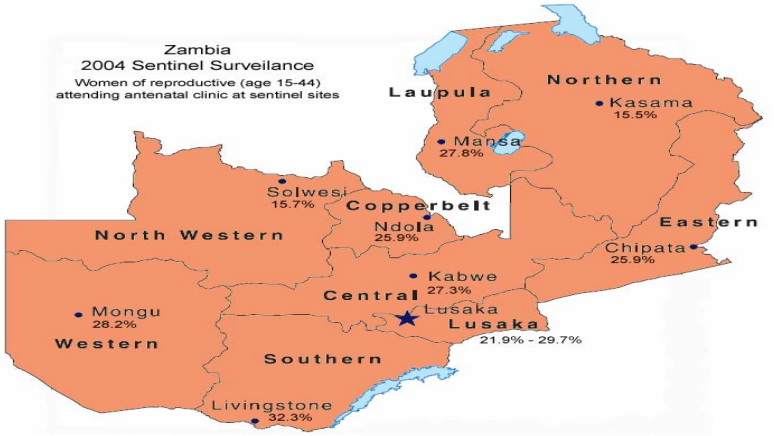
In response to the participants concerns, Mr. Alnwick suggested that perhaps male circumcision could borrow from the polio eradication and also the traditional setups where they target various age groups. Nonetheless, he mentioned whilst it was important to focus on children who were nine months the results would only be seen in about 20 years time when they are grown. For this reason he suggested it would be better to focus on the average age of men just before they become sexually active. Most doctors present in the room also argued that it was easier to perform male circumcision on the child than on an adult.

In spite of these arguments, some participants cautioned it's important to ensure the communities cultural and traditional aspects of circumcision are considered in order to modify procedures that could expose young men from HIV such as practices after circumcision e.g. sleeping with a woman or use of one knife for all. The participants also added that it was important to include the Traditional Male Circumcisers just like it has been done with the Traditional Birth Attendants due to the Human resource crisis already in the health sector.

2 SESSION 2: COUNTRY CONTEXT

2.1 MALE CIRCUMCISION IN ZAMBIA by Dr. Jabbin Mulwanda-JHIPIEGO

Situation in Zambia



Zambia is one of the countries depicting low levels of circumcision rates (20% of circumcised men) with a high HIV prevalence rate of 16%. Dr. Mulwanda mentioned that the demand for male circumcision exists and both traditional and clinical male circumcision are offered.

In Zambia male circumcision is offered in North Western and Eastern provinces. Traditional circumcision is done on 7-10 year boys as part of a rite of passage and camp setting with other education of male responsibility in the family. During traditional circumcision, herbs and water are used in place of local anaesthesia. There have been fairly low complications of people who have gone through the traditional male circumcision. However, Dr. Jabbin mentioned that in communities that do not practice male circumcision, most people preferred to get services from qualified personnel from clinics.

On the contrary, in the current clinical sites conducting male circumcision in Zambia, no additional reproductive health services are given. In most clinics where male circumcision is conducted, he mentioned there are long waiting lists of up to four months. Male circumcision for non medical reasons is also given low priority due to the few numbers of staff offering the service. However, in high demand areas like North Western Province Clinical Officers and Nurses have been trained to conduct the procedure.

Dr. Mulwanda mentioned the fees for the clinical circumcision in public clinics like the University Teaching Hospital range from K10,000 ($2.6 appx) while in the private clinics the fees range from K250,000 ($66) – K300,000 ($78).

JHIPHEGO Pilot Programme

USAID funded the JHIPEGO Pilot Program and worked closely with Ministry of Health. Dr. Jabbin outlined the programme objectives as follows:

- Strengthen existing services in areas where circumcision was required.
- Develop and test tools and approaches to strengthen male circumcision services should scale up be necessary

How was the Pilot Programme implemented?

A stakeholder meeting comprising of traditional circumcisers, private and public clinics was held followed by a study on the acceptability of male circumcision. Thereafter, a technical working group was formed to guide the programmes activities. Three sites with unmet male circumcision demand were selected namely the University Teaching Hospital, George Clinic and Chinama Health Centre. Site assessments were conducted followed by site strengthening in terms of space, equipment such as surgical sets, stitches, lunch allowances and trained support staff, among others. A standardized male circumcision procedure was adopted for the selected sites. Male reproductive health training and also development of patient education on circumcision, HIV and other STIs, family planning and alcohol and drug abuse was also incorporated in addition to a study tour to the Male circumcision project in Kisumu, Kenya.

Findings

Upon data collection JHIPEGHO found that:

- ✓ When clinic site strengthening was increased the clinics were able to accommodate more clients hence more men were being circumcised.
- ✓ When support was withdrawn the numbers of clients attended to went down.

- ✓ They also found out that most men seeking the services were aged between 15-35 years, were Christian and single.
- ✓ They had sought the services on their own accord (self-referral) or had been referred by a parent.
- ✓ Mostly men underwent the procedure for either religious or social purposes.. The surgical procedure lasted for about 15-30 minutes and there were no severe complications.

Dr. Jabbin mentioned that finally the programme concluded that there was an unmet need for male circumcision in Zambia. Additionally male circumcision services can be provided safely with minimal costs. He also pointed when support services were withdrawn other clinical priorities superseded male circumcision and the numbers of clients attended to went down. To date, there are few dedicated sites such as UTH, Chinama, George Clinic and Livingstone Hospital. Thus, Dr. Mulwanda mentioned should the clinical trials confirm the protective effect of MC on HIV Zambia might want to map out the support services needed in the selected clinic sites for male circumcision and enhance them for better results.

In Livingstone, male circumcision started as a workplace programme and later others joined and would go to Livingstone General Hospital to be circumcised. He said "In Livingstone we found not a doctor, nurse but a traditional circumciser himself conducting the services" This is how they have tried to ensure safe traditional practice and also deal with the human resource crisis in the hospital.

2.3 Dr Kasonde Bowa, University Teaching Hospital - Male circumcision operational perspectives

In Zambia there are three main sites offering male circumcision namely; the University Teaching Hospital, Chainama/George Clinic and the Livingstone General Hospital.

The University Teaching Hospital (UTH) is part of the Urology section and has conducted male circumcision since 2004. To date, the hospital has conducted 900 male circumcision procedures. However, Dr. Bowa mentioned that UTH is a service site therefore no research on male circumcision and HIV interlink ages has been done.

Dr. Bowa mentioned that initially the site offered male circumcision service three times a week but due to high demand, they currently offer the service every afternoon. He also added that the site is not externally/separately funded. Due to this UTH male circumcision section frequently runs out of the operational equipments such as sutures (stitches), surgical sets. The site has mixed service providers comprising of two clinical officers, two postgraduate registrars and him. He mentioned that the site has trained about 17 service providers. At the moment the Zambia Medical Association and Surgical society are advocating for training. The Association has also proposed to the Ministry to scale male circumcision services.

UTH male circumcision site provides: reproductive health counselling e.g. vasectomy safe sex counselling among others. Although UTH has a broader clientele 14-35 years is the mode age group that uses the service. Owing to the increasing demand in relation to the few service providers there are long waiting lists of 2-3 weeks. On the other hand, Dr. Bowa mentioned that the long waiting list presents an opportunity for slower counselling. During the waiting period patients are counselled and given an opportunity to reflect and counselling before the surgery.

Most of their clientele are circumcised for hygienic reasons to prevent themselves for infections. Other reasons are mainly medical referrals and to a small extent religious.
Normally local anaesthesia is used except for children where sedation is used. UTH uses the dorsal slit surgical method. The complication rates so far have been approximately less than 3%.

Costs:

He summarized the operational costs as per the table below.

Parameters	RAKAI	KISUMU	ORANGE	UTH
Funding	?	1,000,000US	?	27,000
Type	Research Vertical	Research Vertical	Research Integrated Private	Integrated Public
Cost	69USD	25USD	50USD	15USD
Operator	CO	CO/MO	GP	CO/UR/UC

Table by Dr. Kasonde Bowa - UTH

Lessons UTH has learned

Two years since UTH begun offering the male circumcision services these are some of the lessons they have learnt.

- Financing needs to be scaled up. At the moment Dr. Bowa mentioned that UTH only charges for the sutures (stitches) and *Lignokane* (anaesthetic) which adds up to approximately K57, 000 ($15)
- The UTH site would welcome suggestions on how to anaesthetise children as at the moment sedation method is used
- The site should be set up separately (vertical integration) – however participants felt that it should be part of an integrated service offering voluntary counselling and testing, and reproductive health counselling
- There should also be increased use of Clinical officers in order to fill in the human resource gap

Following Dr. Bowa's presentation, participants felt that a more comprehensive budget should be done to increase the number of service providers such as clinical officers or male nurses to perform the operation. Additionally other operational equipment should be included in the budget to meet the demand.

2.3 RISKS AND OBSTACLES TO MALE CIRCUMCISION SCALE UP: Rick Hughes, Director JHPIEGO

Rick Hughes begun by saying that the Male circumcision reproductive health linkages JHPIEGO project borrowed from post-abortion care services in the US. Just like the post abortion care the male circumcision offers an entry point in engaging men on reproductive health services and also on STI testing and counselling.

Male circumcision risks being perceived as a religious or tribal promotion in a nation where male circumcision is not the norm and is only practiced by few tribes. Furthermore, he added that changing of taboos and perceptions may be interpreted as some sort of imposition/colonialism on certain communities. Whilst promotion of male circumcision in clinical setups is ideal, it risked eroding the traditional educational components. Hence, it is important to consider what will fill in the educational component gap once the kids reach adolescent.

Mr. Hughes cautioned that misconceptions such as Male circumcision being a HIV prevention tool might see a rise in risky sexual behaviour which might erode previous gains made on prevention, counselling and testing. Mr. Hughes highlighted uncircumcised males might be stigmatized should the studies in Kisumu and Rakai prove successful.

Mr. Hughes highlighted the extra strain male circumcision would bring to the health sector which at the moment is overwhelmed with patients. He added that male circumcision would also be competing for space, commodities and human resources. Additionally, counselling and service delivery might need to be enhanced to meet the new demands which may arise with the linkages of circumcision, reproductive health and STI counselling and testing.

Mr. Hughes also emphasized on the quality of care especially on delivering male circumcision as a package. He pointed out care should be taken on ensuring quality surgical service, counselling on male circumcision procedure, informed consent linking up with STI including HIV counselling and testing and post procedure follow-up up. He also highlighted it was important to consider how the information will be managed and monitored in order to improve the services

While we might want to scale up male circumcision, Mr. Hughes suggested it might be worthwhile to consider costs attached to the male circumcision service and other hidden costs such as transportation to the health centre and the limited availability of surgical services in low resource settings.

In the short term

In his recommendation Mr. Hughes mentioned that:

- ✓ It was prudent to strengthen services to meet the existing demand.
- ✓ Use education based evidence and discuss with traditional practioners in traditionally circumcising areas. These discussions should address how a clinical service fits in (what is termed as a rite of passage), what the gaps in both the traditional and clinical services are and how the two can be integrated.

In the long term

In view of scaling up male circumcision nationally,

- ✓ Develop a strategy on how the roll out will be done.
- ✓ Conduct site assessments- these would come in handy in site strengthening and also in running competency based training of provider teams such as counsellors, assistants and clinical officers.
- ✓ Ensure the services are male friendly such as ensuring the service are offered in the weekend or afternoon considering most men are in gainful employment.
- ✓ Devise strategies to ensure service providers are motivated to compensate for the time and income lost by providing late and weekend services.
- ✓ Mobile male services could be an option especially during school holidays in high demand areas. It was also important to engage other stakeholders such as the private sector to ensure that male circumcision is affordable.

He concluded by emphasizing that male circumcision was a good entry point to engage men in the following areas as shown in the diagram below:.

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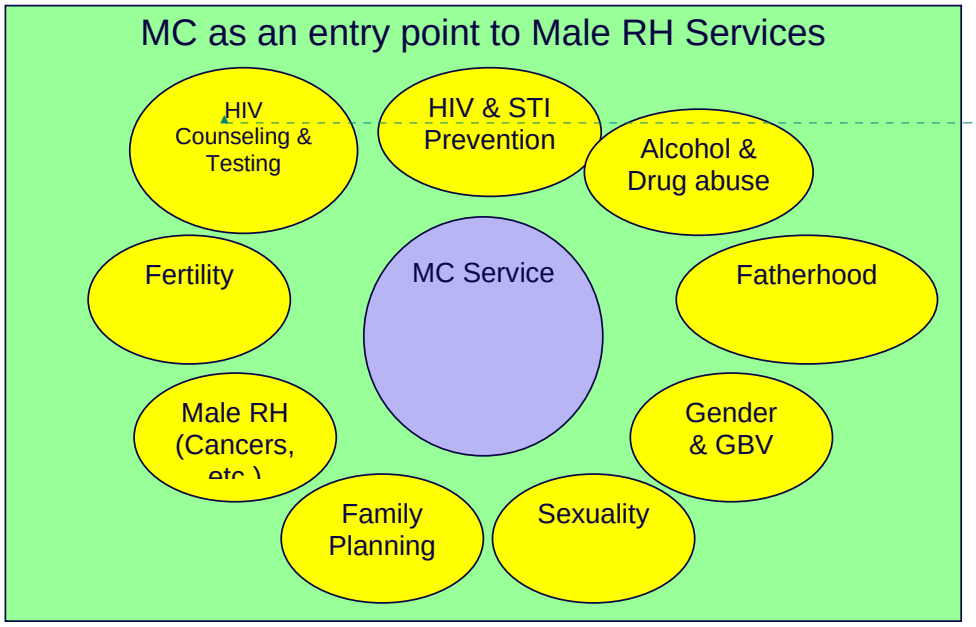

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Diagram from Rick Hughes presentation

Following Mr. Hughes presentation, participants agreed that Male circumcision could target a particular age group and could use similar approaches to Eye Camp and the Child Health Week in order to ensure that as many young men are reached especially during the school holidays. They also pointed out while mobile services might be easier there might be a challenge in generating demand.

Participants also mentioned the current challenges in offering the service is the varied circumcising techniques. Additionally the anaesthesia used also varies from area to area.

2.4 MEN MAKING A DIFFERENCE (MENDIFF):John Mapulannga, Executive Director

MEN DIFF was formed in 2004 to implement critical issues that men would address to halt the spread of HIV and AIDS. The non governmental organization is based in Mazabuka in the Southern Province of Zambia.

Mr. Mapulanga mentioned that MEN DIFF started an ongoing anti brothels campaign triggered by the number of mushrooming guest houses. Before commencing the anti brothels campaign MEN DIFF conducted a baseline survey to find out the gaps and needs to be addressed in Mazabuka in regards to HIV. The baseline survey revealed that there was a huge need to sensitize the commercial sex workers. During the stakeholders meeting the need to promote male circumcision was emphasized.

PACT Zambia funded a baseline study to examine the attitudes in communities to the possible introduction of male circumcision as a public health option in the prevention of HIV. This study was important as Southern Province is a non male circumcising community.

Turning Point

During the stakeholder meetings with the traditional, health, district, District AIDS Task Force and non governmental organization leaders, it turned out that the most influential counsellor was circumcised and all his sons. Automatically the counsellor became the role model and he testified on the benefits of male circumcision. Hence the stakeholders agreed in principle they would promote male circumcision. They also incorporated people from North Western province currently based in Mazabuka who have been instrumental in guiding how male circumcision is conducted. The North Westerners have also been good advocates of male circumcision.

Currently MEN DIFF is working with six rural areas. They normally wait for July – August school holidays and enrol recruits who are put in camps. Mr. Mapulanga reported that the school holidays proved to be an opportune time to get young men before their first sexual debut.

At the moment the male circumcision message MENDIFF is giving is that:

- It is clean
- Those circumcised their partners have less chances of having cancer
- Sexual fulfilment
- Less prevalence of HIV

Lessons learnt

- ✓ After almost two years, they face financial challenges
- ✓ Currently there is no literature on male circumcision to give people
- ✓ Legal implications of promoting male circumcision need to be addressed as well
- ✓ School holidays are an opportune time to get young men before their first sexual debut
- ✓ Government involvement in the stakeholders meetings makes it easier to implement procedure at the health clinics and hospitals
- ✓ Medical or lay people assisting in male circumcision need monetary and technical motivation to enable them to meet the demands.
- ✓ There are high medical personnel turn over rate, shortage of personnel leading to long waiting periods for men to be circumcised
- ✓ Finally, he said for a successful programme the chiefs would need to be involved from the beginning

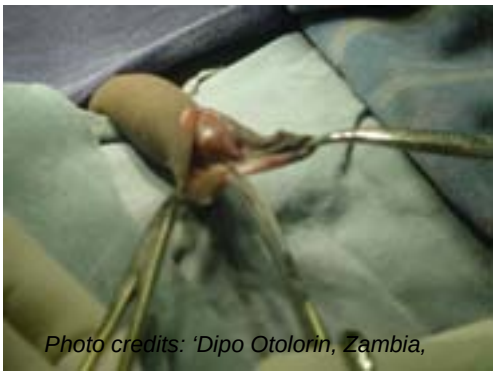
2.5 MALE CIRCUMCISION PROCEDURE - Dr. Kasonde Bowa

Dr. Kasonde Bowa listed the three surgical methods currently taught as:

- Dorsal Slit
- Clamp
- Shield

Dr. Bowa explained that UTH uses the dorsal slit method. He elaborated the dorsal slit method involves removing the skin that covers the gland. The foreskin is pulled and a slit is made on the dorsal part of the penis followed by making a circular incision. He emphasized that the ditch in the penis should be exposed because it's where most of the secretions accumulate. Afterwards less than 9 stitches are done.

He noted that the clamp method is faster, quicker and easier for a non medic to understand. The surgical method is being used in the clinical trial in Kisumu, Kenya. On the other hand, Dr. Bowa explained the Dorsal Slit is more precise and it gives a beautiful outcome. "It actually peels off like a banana" he said.



Pictures from Dr. Boas's presentation on the Dorsal Slit method

Dr. Bowa mentioned the current challenge is that there are no devices to hasten the process. For once the devices available are for children. He also mentioned it was easy to perform the procedure on children such as new born's because the blood vessels are small.

2.6 MALE CIRCUMCISION AND HIV PREVENTION ETHICAL ISSUES :Professor Karashani,Chair of the University of Zambia (UNZA) Ethics Committee

In his introduction Professor Karashani the Chair of the UNZA Ethics Committee
said he does not believe that there is any part of the human body that is useless. He added that people have lived in their old age with their prepuces and nothing much has happened.

He mentioned that he was not sure whether there was an ethical code of conduct regarding male circumcision. However he stated the Declaration of Helsinki would act as a guide. It states:

'In current medical practice and research, most prophylactic, diagnostic and therapeutic procedures involve risks and burdens'

Principle Ethics
He defined Ethics as behaviour, conduct or what is morally right or wrong.
He mentioned that the basic principles of ethics that should always be taken into account are:

- ✓ Respect for Persons: Ethics means respect for persons: mean every individual has some autonomy and right for self determination what should be done to their bodies or given to them
- ✓ Beneficence: Do no harm to anyone. You must ensure their physical, mental, social well being
- ✓ Justice: Vulnerable subjects e.g. children who will decide for them. These are kids later on they may grow up and decide the parents made the wrong decision. In regards to the illiterate would it be justifiable to take them through male circumcision without taking the time to explain to them in detail of the pros and cons?

Professor Karashani mentioned that before performing any procedure on an individual the person needs to give informed consent. Informed consent is permission given by a competent individual who has received, understood without being enticed or coerced. Nowadays, he explained clients visiting hospitals want to know what the doctor is up to. Now more than ever informed consent is needed. Hence one needs to take more time to educate the public.

Informed consent in the case of male circumcision one would mean giving the full description of the procedure. The individual should also be made aware of the risks, benefits and also informed if there any alternatives. In this regard the individual view should be taken into consideration. Additionally

confidentiality is at a personal level. One cannot say they are circumcising a whole village if that is the case how will confidentiality be maintained, more so in a non-circumcising society?

Professor Karashani also warned that it was important for people not to exaggerate the benefits. He questioned how ethical it would be to subject someone to pain for the benefit a partner or a spouse? "There are people ready to sacrifice for their wives but not all are willing to take such extremes".

Once the foreskins are out who stores them; who owns the foreskins?
The question seemed to baffle participants. However, Professor Karashani explained that the client still had ownership. Should the service providers want to use foreskins for research, the clients need to make an informed consent before being circumcised and sign the necessary paperwork. In case one would like to take them for a research out of Zambia one would need ethical clearance and an export licence.

2.7 HUMAN RIGHTS: Mrs Kondwa Chibiya, HIV and AIDS Convenor Law Association of Zambia-

Mrs Kondwa Chibiya is the Chairperson on the HIV and AIDS Committee of the Law Association of Zambia. She pointed out that male circumcision is not directly addressed in the areas of human rights. However she mentioned that there are some declarations which make some mention which could be implied in the area of male circumcision.

Some of the instruments which would assist are the UN convention on Human Rights or Civil and Political rights convention and the UN Convention on the rights of children.

UN convention on the rights of the child
Article 8

"States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name an recognized by law without unlawful interference.

Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide a and protection, with a view to re establishing speedily his or her identity.

Referring to the latter, article eight states that "parties should preserve his/her identity:
E.g. UN Convention on rights of Children: Reference to article state parties to preserve his/her identity: One should not be altered to look like ones father. The convention further states that the child shall have the right to freedom of expression. While professor Karashani was discussing on informed consent on the individual Mrs Chibya was reinforcing by saying the child actually has a right to decide what part of the body he/she should keep.

In the Southern Africa region she mentioned that only South Africa has made a provision on children and directly made some linkage to male circumcision. In the South African constitution it states that the parents are allowed to make a decision for their children as long as there is no clear wrong: e.g. medical and religious reasons. This was due to the rising kidnapping cases owing to the cultural set up of circumcision that no one is supposed to know where and when it is happening. A lot of other people started abusing this cultural aspect and the state had to protect the parent and child.

Following her presentation, participants argued that sometimes the individual rights could be compromised by the greater rights of all. The medics argued that their mandate was to save life and cannot wait in the case of a child to make up his mind. A case in point is the polio immunization

where participants argued no child would agree to get an injection but parents and medics still go ahead and immunize the child for his/her good.

Participants added that a law should also hold traditional healers and traditional circumcisers accountable. While medical personnel were held by the medical ethical guidelines there were none in the case of the traditional practices which could compromise the quality of services. On the other hand, some participants argued that the traditional circumcisers are held accountable by the society they serve despite the fact that they are held so highly that no one could dispute them.

2.8 COST AND IMPACT OF MALE CIRCUMCISION IN SOUTHERN AFRICA :Dr Philemon Ndubani, Consultant, Costella Futures

The cost and impact of male circumcision in Southern Africa assessments are being carried out by Costella Futures who are funded by USAID. Dr. Philemon explained that the cost and impact assessments of male circumcision aims to calculate the costs associated in providing male circumcision services. The exercise also aims at gaining a comprehensive view of the costs including the recruiting and outreach methods. The first thing will be to define the target population. This will be followed by reviewing the costing of the type of services to be offered such as pre and post counselling, surgical procedures and follow-up costs. This exercise would benefit implementers and Partners.

The exercise will review existing literature and protocols. Additionally they will interview key informants and current potential providers. This will be followed by country consultations with key stakeholders. Thereafter, there will be an estimation of the resource requirements based on protocols and expected demand. Finally, a simulation model will be done to determine the impact of male circumcision on new infections.

DAY II

3 Session Three: Strategies for male circumcision programming

3.1 PROGRAMMATIC APPROACH: David Alnwick, UNICEF Regional Office, Nairobi

Mr. David Alnwick mentioned that some elements of a programme have got to do with establishing goals. It would be useful to prepare for the possibility of a programme rollout should the clinical trials prove successful. Firstly he mentioned it might be useful to articulate what the goals and targets might be. He mentioned though PMTCT was far less controversial and the need and urgency was evident in the past years, only 25% of HIV+ mothers have been enrolled in Zambia. In reference to the PMTCT programme he mentioned that initially governments were worried about creating a demand which could not be fulfilled. Now it seems availability of test kits and low levels of motivation among health workers are resulting in fewer people being enrolled.

He mentioned some key questions that need to be pondered on are the nature of male circumcision services. Would male circumcision be free, subsidized or clients will meet the costs? If the male circumcision service would be free would government need a policy decision?

In regards to programming, Mr. Alnwick mentioned there would be a need to plan on the number of surgeons available. In cases where other cadres would be involved, the cost implication would need to be factored. In addition, the type of logistical support should be factored. He advised that it would be useful to target a certain population for example adolescent boys. In order to link male

circumcision with reproductive health and sexually transmitted diseases counselling services, it is key to map out a referral system and its associated costs.

A campaign approach might be an option as it has proved successful in polio eradication and Child Health Week all over Africa. The campaign approach would need for this plans to include short term support staff for a few weeks in a year.

Mr. Alnwick mentioned it would be useful to establish the lead organization and have it on paper. In regards to implementation formalizing a taskforce and circulate members' contacts to stakeholders. Hence a policy and strategy would need to be developed and also clear guidelines on male circumcision.

Lastly he mentioned it is important that the media put out the correct information. Hence there is a need for a central spokesperson and central coordination of messages. He added a communication and advocacy plan on how to roll it out to the media would be useful.

3.2 ASSESSMENT TOOLS: George Schmid, WHO, Geneva

Dr. George Schmid revealed that there is already a working group in the UN mainly comprising of WHO and UNAIDS developing some assessment tools should the male circumcision randomized control trials prove successful. The UN work plan was developed in 2005 and involves developing briefing packs, technical guidance and stakeholder consultations. He explained that the toolkit collects information through desk reviews, key informant interviews, focus groups, workshops and survey instruments at the individual level.

Dr. Schmid suggested that if the studies are positive the UN will bring all UN agencies and the countries most affected by male circumcision for a consultative meeting. Then it would issue guidance, so that countries can determine how to use the information.

He highlighted some key things to be considered while scaling up male circumcision as:

1. Guidelines for safe circumcision. Hence there is a need to review the manuals outlining the surgical technique, pre and post surgical counselling on sexual behaviour and technical advice and finally information on HIV counselling and testing.

2. Development of an in-country situational analysis toolkit would come in handy in the male circumcision roll out. This would include

    - ✓ The need of male circumcision divided by geographical region, ethnic group among others and the determinants of male circumcision.
    - ✓ Why and where male circumcision would be conducted
    - ✓ The attitudes towards male circumcision both at an individual and societal level, and the effects of these attitudes in people accessing male circumcision services.
    - ✓ The ability of the health care services to meet the demand bearing in mind the age group
    - ✓ undergoing circumcision
    - ✓ The capabilities of health workers to perform male circumcision would also need to be included in the plan.

In conclusion, he mentioned that WHO had developed a service mapping tool which would help in developing an in country tool kit. It can be accessed on www.who.int/healthinfo/systems/serviceavailabilitymapping/en

4 SESSION FOUR: KEY NEEDS FOR FOLLOW-UP

4.1 PANEL DISCUSSION- Dr. Mannasseh Phiri (moderator)

To end the consultative meeting there was a panel discussion comprising of Dr. Dorothy Kasonde from Multi Medical Health Centre representing the Private Sector, Dr. Alex Simwanza from the National AIDS Council (NAC), Dr. Kasonde Bowa from UTH, Dr. Peter Mwaba from the Zambia Medical Association, Mr. Rick Hughes from JHIPIEGO and Mr. David Alnwick from UNICEF. The panellists gave their insights, what they felt needs to be done and what they thought would be the way forward for Zambia. There after, there was a discussion and input from the participants on the same.

Dr. ALEX SIMWANZA - NAC-

In his opening remarks Dr. Simwanza mentioned that "we have an issue in the country which we cannot ignore. When it's on the ground there are questions of activism and being sober on how to address the issue. It is a welcome consultative meeting it helps me to look at male circumcision in a more sober mind especially with the information that has been shared by presenters on where we stand on the effectiveness of male circumcision in preventing HIV. The message I have got is that we have not yet got to a stage we would promote male circumcision as a HIV prevention technique. The way forward would have to be incorporated in the national strategic framework. NAC currently has six themes one of them being Prevention with sub theme such as PMTCT among others. NAC has been thinking to broaden the prevention realm by having a bigger Technical Working Group to address emerging prevention efforts. Hence, male circumcision will be included as one emerging issue in preparation for the evidence roll out. The immediate thing I feel we need to address is what we will say to everyone else. This I shall give while closing the meeting."

Kasonde Bowa-University Teaching Hospital (UTH)

Dr. Kasonde Bowa highlighted points of importance as follows:

- "Status of male circumcision in Zambia. Acceptability is high; feasibility to start male circumcision is good. Infact, the evidence is that sites have been running for two years with reasonable experience. The safety is good from the running sites. It is extremely cost effective considering other estimations; the UTH estimate is $3 which is below what others had estimated."
- "Let me make a few comments on awaited trials. The next decision is critical on what we perceive as we await the trial outcome. My simple look at the current evidence in terms of sero-conversion rates indicates to me male circumcision will contribute towards HIV prevention. I suspect that even the awaiting randomized trials will confirm the Orange Farm study. Hence Zambia is placed in a position where we have experience in leading the way to pilot male circumcision as a means to prevent HIV."

Rick Hughes – Director, JHIPEGO

Mr. Hughes begun by saying "I would recommend a three-prong approach." I would highlight that there are more benefits to support male circumcision for those seeking the service. There is already evidence that demand of male circumcision exists and is increasing even without promotion. Hence I would recommend that, we aggressively improve quality including counselling, HIV testing as well as prevention. I believe to do that we can't rely on existing health delivery systems because they are stretched. Thus it would take a fair subsidization by a donor to achieve reasonable penetration to achieve high numbers in order to have an impact on HIV incidence rates.

Suddenly, the people seeking male circumcision services are not from traditionally circumcising communities. I also suspect the trials in Kisumu and Rakai will confirm Orange Farms trials. Hence, there is a need to develop champions in different groups who will be agents of change. It

will not be easy to change people's attitudes overnight even if people are convinced. In summary, I would make sure that the circumcision is quality. I think a lot of demand will come from parents interested in protecting kids for a healthy productive life. Therefore, we should be prepared to meet infant circumcision even if we are talking adolescent. Zambia should consider ethics in providing proper information. Our obligation is to provide quality services based on evidence."

Dr. Dorothy Kasonde- Multi Medical Centre (Private Sector)

"I think we have evidence showing MC reduces HIV infection some of the evidence pointed out from the clinical point of view makes sense.

Who should we target I want to think it's a long term preventive strategy and should we adopt it I would like to see we target the infants and adolescents who are not yet sexually active. Those already sexually active see a danger in losing out on all preventive messages we have built on but make sure message giving to them should be those additional to ABC control sexual desire, condom use and circumcision. If we can package this we will not lose the gains.

Where does the private sector fit in this? People giving more requests will be from the private sector. I want Dr. Kasonde and his team in UTH to try to think about this. Try and standardize the procedure which is being nicely done at UTH. We do not want it to be a money spending venture, there should be locks to reduce tariffs, strengthen existing programmes e.g. youth friendly services, Planned Parenthood Association of Zambia, male reproductive health services as well as have church-based programmes. Additionally, we should include male circumcision as part of the ART programme.

I will take home that Zambia is agreeing to the evidence and at an appropriate time we will make a decision as to what position Zambia will take."

Dr. Peter Mwaba-Zambia Medical Association

Dr. Mwaba begun by asking "Is Zambia able to meet the existing demand for male circumcision services?" He continued by saying "Already there is evidence that without promotion male circumcision services in the clinic are not meeting the demand. Thus I would recommend that we forget the results of the trial and meet the current demand both traditional and non traditional.

I also see an opportunity to sell to the training institutions to include MC in the curriculum which is a good entry point.

The current demand seen from 10–100 circumcised males' means there is already a message out there. It is also important to note that the Traditional Circumciser handles 10 times what UTH does. Targeting the traditional circumcisers and harmonizing the messages is important. It would also be important to look at the religious and cultural aspects as well. It would also be important to know the impact the message would have in case the trials prove successful, find out the type of people seeking the service, their reasons for undergoing male circumcision and whether they are HIV positive. Additionally, conduct an operational research in light of possible monies from PEPFAR as mentioned earlier.
My take home message is that the NAC recognises male circumcision as one of the preventive services it does not commit but actions activity.

David Alnwick- UNICEF Regional Adviser

"In Africa, people know a good thing when they see it particularly parents if they see what will benefit their kids." "I have a feeling people in Zambia will not necessarily wait for the government." He mentioned that the public was already getting information from media and also from people who have been circumcised. "It is also evident that people would talk about male circumcision." He warned that unless government puts barriers male circumcision would spread without clear guidelines. He pointed out some innovations which did not wait for the government's decisions. "A case in point is the mobile phone technology. People saw the need in having and using mobile phones and they used it before government had put any policies. He warned male circumcision could have a similar reception."

He mentioned the benefits of male circumcision are that no special drugs or special equipment is needed. Experiences drawn from Kisumu-Kenya are men are being turned away due to the high demand and limited service providers in the clinics. Hence there will be the demand and it will roll out. However, government needs to support, regulate and monitor this. In addition, there should be a plan to set up additional sites. He mentioned that assessment tools can be developed now while awaiting the trials. In spite of this, he was sad that the Ministry of Health were not present at the meeting.

He concluded by talking about the need for financing. "Clear guidelines on how male circumcision would be implemented are pertinent. Will there be tokens, will private sector subsidize the costs will the services be franchised?" He concluded by pointing out that Zambia could be a leader. Hence, he said "if I was the National AIDS Council (NAC) or Ministry of Health (MOH) I would develop a comprehensive proposal as we await the clinical trials results."

4.1.1 General Discussions and participants recommendations

In the discussions following the panel discussions participants recommended the following:

Meeting of high male circumcision demand: FHI- mentioned that they have found that demand for male circumcision is increasing in the provinces they are working at. On the other hand, they mentioned they had discovered that service providers are few and cannot meet the demand. They recommended that UTH could work with JIPHIEGO and come up with a Centre of Excellence. This can be decentralized to other provinces and districts using satellite.

Offer male circumcision as part of a comprehensive prevention package: Most participants recommended that male circumcision should be offered as part of a comprehensive prevention package. If isolated, there would be a risk of the public thinking it's the ultimate solution for HIV prevention eroding previous gains from HIV prevention campaigns. They highlighted it was important to note the scale at which multiple and concurrent partnerships is contributing in driving the epidemic and encourage fidelity and abstinence alongside consistent and correct condom usage.

Address the Human Resource Crisis and Health Infrastructure: Participants also highlighted the importance of ensuring the Human Resource Crisis is dealt with to enable the health centres to adequately deal with clients. Additionally the health facilities should be well stocked with the equipment needed for the procedure in addition to proper counselling and testing services of STI's including HIV and reproductive health. In this regard participants felt that male circumcision provided an opportunity to engage men in HIV prevention and reproductive health information.

Involve Traditional Leaders and Traditional Circumcisers: Participants emphasized on the importance of traditional leader's involvement at the inception of the roll out to ensure that they had

proper HIV prevention messages. Furthermore traditional circumciser's involvement would bridge the gaps between the clinical and traditional circumcision information loss in cases where it is a rite of passage.

Ministry of Health should take the lead: Participants highlighted the need for the Ministry of Health to lead. Additionally participants proposed that the sub committee for the consultative meeting would continue to advocate for follow-up meetings with the relevant stakeholders.

Promote couple counselling before male circumcision: Participants highlighted it was important to promote couple counselling before male circumcision due to the sexual pros and cons attached with male circumcision. Some of the key things to be addressed are sensation during intercourse. Couple counselling would also present an opportunity for HIV and other STI counselling and reproductive services. Hence proper linkages would need to be mapped out.

Use available funds to conduct male circumcision assessment studies: The meeting was also informed that the Presidents Emergency Plan for AIDS Relief (PEPFAR) had called for proposals in the area of male circumcision assessment studies. The funding was approximately $100,000 and is expected to increase in 2007. Participants agreed that a proposal should be developed to conduct male circumcision assessment studies with clear objectives and targets.

4.2 CLOSING REMARKS by Dr. Alex Simwanza from the National AIDS Council (NAC)

The meeting was called to a close by Dr. Alex Simwanza from the National AIDS Council on 12 September 2006. In his closing remarks he said, **"**Looking at the passion and the discussions on the ongoing trials in Kisumu and Rakai, and the concluded Orange Farm trials we have heard in this room that it is evident that male circumcision is a promising HIV prevention method."

Dr. Simwanza noted that it was clear that male circumcision protects against certain sexually transmitted infections and the transmission of the Human Papilloma Virus (HPV) which is the cause of cervical cancer. Additionally, the Orange Farm trials have shown that circumcision provides and element of risk reduction which is not complete. As such, it is a promising HIV intervention strategy but it has to be taken as a combination therapy .i.e. combined HIV prevention strategy promoting fidelity and correct and consistent condom usage and the other ABC strategies.

Dr. Simwanza finalized the workshop recommendations as follows:

The first activity would be to form a Male Circumcision Working Group which would be part of the NAC prevention Technical Working Group to provide policy guidance, planning and steering of emerging issues on male circumcision. This working group would be tasked to perform the following:

- Preparation of an information package for communities, health care providers as well as traditional circumcisers and others
- Include male circumcision in the pre-service training at the Medical School, Chainama College of Health Sciences for clinical officers and registered nursing training school
- Ensure that male circumcision services are a complete package including appropriate counsellin available to meet existing demand for services. This would entail strengthening existing male circumcision services including the integration of HIV prevention and care activiti
- Engage the Royal Foundation of Zambia to advocate for male circumcision in the respective ar rulers, especially in the non-circumcising areas
- Engage the Traditional Health Practioners of Zambia and Traditional Circumcisers a and similar bodies to equip them with appropriate information on male circumcision
- Engage and educate religious leaders on the evidence about male circumcision to ensure that there is not a backlash
- Formulate a costed male circumcision roll out plan

As the meeting drew to a close, most participants were excited with the meeting outcome. However, participants kept wishing that the Ministry of Health was around during the workshop. They hoped that the Ministry of Health would champion this process and make the necessary preparations should the government decide to scale up male circumcision services depending on the much awaited randomized controlled trials in Kisumu and Rakai.

Dr. Simwanza finally blew the whistle and adjourned the meeting by thanking all who had participated in the consultative meeting and made it possible to have fruitful discussions.

Annex 1:

MALE CIRCUMCISION AND HIVE PREVENTION COUNTRY STAKEHOLDER CONSULTATION MEETING 11-12 SEPTEMBER 2006, CHISAMBA, LUSAKA

PROGRAMME

TIME	DISCUSSION TOPIC	PRESENTER
DAY 1: Morning		
0830 - 0900	Introductions and opening remarks	Dr. Mannasseh Phiri
Session One: Introduction & Current situation : Male circumcision and HIV **Chair: Dr. Ben Chirwa, Director General, NAC**		
0900 - 0930	Statement by UN in the context country	Dr. Stella Anyangwe, UN Theme Group Chair on HIV and WHO Country Representative
0930 - 1000	Evidence on male circumcision and HIV prevention: ▪ Findings from Orange Farm stud and other studies	Dirk Taljaard Investigator from the Orange Farm study tea
1000 – 1030	**TEA BREAK**	
1030 – 1100	Male circumcision in the context of a comprehensive HIV prevention programme	David Alnwick (UNICEF) or the MC regional working group
1100 – 1200	PLENARY DISCUSSIONS	
Session Two: Country context of male circumcision **Chair: Dr. J Simpungwe, Director Clinical Care and Diagnostic Services, MOH**		
1200 - 1230	Male circumcision in Zambia	Dr. Jabbin Mulwanda/ Rick Hughes JHPIEGO
1230 – 1300	Risks and barriers to MC	Dr. Jabbin Mulwanda /Rick Hughes JHPIEGO
1300 - 1400	**LUNCH**	
1400 – 1430	Surgical/Clinical MC services	Dr. Kasonde Bowa - UTH
1430 – 1500	Ethical and regulatory issues	Prof. Karashani – School of Medicine

1500 - 1530	**TEA BREAK**	
TIME	**DISCUSSION TOPIC**	**PRESENTER**
1530 – 1600	Human Rights	Kondowa Chibiya, Chairperson HIV/AIDS Committee of the Law Association of Zambia (LAZ)
1600 – 1630	Plenary discussions	
Day 2: Morning		
0830 – 0900	Recap of Day 1	Dr. Mannasseh Phiri
Session Three: Strategies for MC programming **Chair: Dr. Stella Anyangwe, WHO Country Representative**		
0900 – 0930	Introduction to programme possibilities	David Alnwick (UNICEF)
0930 – 1000	Assessment tools	George Shmid (WHO)
1000 – 1030	**TEA BREAK**	
1030 – 1100	Cost and impact of male (proposal of a project being Lesotho, Swaziland and Zambia)	Gayle Martin (or partners f Group)
1100 – 1300	Plenary discussion	
Day 2: Afternoon		
1400 – 1500	Panel discussion: What needs to needs for follow up	Dr. Mannasseh Phiri
1500 – 1530	Concluding Remarks	Dr. Ben Chirwa, DG NAC Dr. Simpungwe, MOH

Annex 2
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