



**World Health
Organization**



Scaling-up male circumcision programmes in the Eastern and Southern Africa Region

**Country update meeting to share lessons, explore
opportunities and overcome challenges to scale-up**

A sub-regional consultation

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Executive Summary

In March 2007, the WHO/UNAIDS provided policy and programme recommendations for male circumcision as part of a comprehensive HIV prevention package. A WHO/UNAIDS convened meeting was held in Tanzania in June 2010 with the following objectives:

- to share country experiences and lessons learnt in the scale-up of male circumcision programmes;
- to examine the facilitating and constraining factors to implementation and to propose strategies to accelerate country scale-up;
- to provide opportunities for capacity building on the various tools and guidelines available to support implementation, and
- to identify inter-country, regional and global support actions required to strengthen scale up of male circumcision services and to explore opportunities for South-to - South collaboration.

Participants included one hundred seventeen representatives from: the Ministry of Health and/or the National AIDS Council from 10 of the 13 priority countries¹, non-governmental organizations and associations, researchers, women and youth agencies, the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF).

Ten of the thirteen priority countries have approved policies, strategies and/or operational plans. About 175,000 male circumcisions for HIV prevention have been reported from start up of services until March/April 2010 in eleven of the thirteen priority countries. Strong national leadership, stakeholder contributions and partnerships have been key elements of success. The array of guidance provided by WHO and UNAIDS has facilitated the implementation process.

Several **approaches to scaling up services** were shared including the Rapid Results Initiative in Kenya where 36,077 male circumcisions with the minimum service package were provided in 30 working days. Success required participation of a strong consortium of partners working with government, good coordination and extensive dialogue so that key issues were addressed on a regular basis. Challenges included matching supply and demand, and getting the parental consent for minors. Lessons included that this campaign approach achieved an increase in numbers in short time frames, generated momentum and improved uptake through readily available and acceptable services.

Several **service delivery models** were shared including setting up dedicated sites and using military and uniformed services. The South Africa Bophele Pele and Swaziland Litsemba Letfu were models of high quality, efficient dedicated comprehensive male circumcision services. Implementation at these sites and demonstration clinic sites in Tanzania and Zimbabwe has provided information for country strategies and programming such as the need for outreach and expanded male health services. Military and uniformed services should be drawn upon as they boost national efforts by reaching young men and surrounding communities. Determining the best mix and balance of service delivery for country programmes was an issue for many countries.

The session on **implementing the minimum service package focused on HIV testing and counselling**. Data from countries (Botswana, Kenya, Namibia, Swaziland, Tanzania, Zambia, Zimbabwe) reporting on HIV testing and counselling uptake showed

¹ Botswana, Kenya, Malawi, Namibia, Rwanda, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe

that the HIV testing uptake rate among male circumcision service attendees was high in pilot sites reaching almost 98%. Provider initiated testing and counselling approaches were needed to increase uptake; this required enhanced in-service training on counselling. Kenya and Tanzania indicated that delivering HIV testing and counselling campaigns during a similar time frame as male circumcision service delivery promotion seemed to have a synergistic effect. One challenge raised was the time required for HIV testing and counselling.

In most countries, sexually transmitted infection (STI) management is provided on site or at a nearby clinic to which clients were referred. Kenya estimated that 5% of men presented with an STI. The discussions indicated that condoms are promoted as part of all male circumcision services; in Zambia dual messages are conveyed: use condoms and circumcise. Participants agreed that best practices and efficiency models in delivering the minimum service package should be identified and collated.

Correct communications, particularly interpersonal communications, and messaging are critical to success. All countries represented had a communication strategy, plan and/or are developing education and training materials. Presentations were made on text messaging that is being explored as a means to improve post-operative adherence to key instructions. A key conclusion was that the main challenge facing countries is balancing demand creation and supply.

Gender and youth specific issues were discussed. Panellists indicated that guidance is needed on appropriate sexual and reproductive health counselling with young non-sexually active males. Also that young people need to be more actively engaged and voice their perspectives which may differ from those of the generation in decision making positions. In a number of settings, men are encouraged to bring partners for testing; women have been involved as participants in many stakeholder consultations and should continue to be included as they play a key role as partners and mothers.

The session on **service delivery innovations and managing human resource constraints** highlighted the 'Models for optimizing volume and efficiency' principles which have been tried in a number of settings and have been observed to increase the capacity to handle larger volumes of clients. A challenge identified was how to achieve efficiencies for other aspects of service delivery such as client flow and supply management. Potential approaches for expansion of human resources were discussed such as the use of volunteers and private providers, and task-shifting and task-sharing which must be contextualized to the specific country.

The **research highlights** focused on operational research underway at the research sites where the randomized controlled trials were conducted, infant male circumcision studies, and monitoring and evaluation of devices. The Session concluded that findings from such research need to be shared across countries so that all programmes and policies can benefit.

Costing studies show that on average one HIV infection would be averted per 5-15 circumcisions performed and the cost per infection averted ranges from USD 150 to 900. Rapid scale up is estimated to have the greatest impact with the potential of 23 billion USD cost savings by 2025. During the **procurement, logistics and supplies** session the kit development process for the Supply Chain Management System was described. The logistics cycle and the use of the national system in Zimbabwe were outlined. Needs were identified for strengthening the supply system and working with national programmes as well as logistics training.

Service delivery and health systems issues were discussed in small groups and shared in plenary. Key points about **service delivery** were that variation occurs across countries, and a balanced mix of vertical and integrated approaches is needed especially since male circumcision services were feasible in a number of settings. Supplies have been inconsistently available which interrupts service delivery. Solutions include improved forecasting, strengthening the supply system and building capacity of staff for supply management while using the resources presently available. The application of efficiencies around the surgical procedure can be expanded and there is the need to identify and document non-surgical 'efficiencies'.

Key **health systems** challenges, constraints and solutions faced by the majority of countries for successful scale up of services were highlighted. Human resources quantity and quality remain constraints to success. Potential solutions proposed included first drawing on untapped national resources (such as retired or unemployed health personnel) before seeking external inputs. Creative mechanisms need to be explored, such as task shifting and sharing, motivational factors, inclusion of providers outside the government sector and improving the interface between traditional providers and the formal health sector, south-to-south collaboration and use of volunteers during catch-up campaigns. Participants agreed that innovative and best practices need to be documented and shared.

Additional health systems challenges identified by the small group were matching demand and supply, conveying correct messages and strengthening monitoring and evaluation. Potential solutions included technical support for the development of monitoring and evaluation frameworks, plans, standardized tools and training of appropriate staff. The sustainability of funds is a concern for which it was proposed to advocate for diversified funding sources including national contributions and inclusion of male circumcision in GFATM proposals. Leadership and governance are essential and must be sustained as well as mobilizing others to action. Countries need to identify when advocacy is needed and draw on available resources.

The donor funding session highlighted that the Bill and Melinda Gates Foundation have contributed substantial funding to date with a focus of supporting rapid scale up in target countries and providing short term bridge funding. The PEPFAR programme is transitioning to a dual focus approach: addressing immediate demand and catch up while supporting longer term delivery. A panel on **sustainability** emphasized that programmes need to be conceived and planned with these two components: a catch up for rapid impact and sustainable, long-term services for new cohorts of young men or infants. It is critical to maximize use of current resources while diversifying the sources of funding.

Closing comments

The meeting highlighted that good progress has been made in male circumcision programmes since 2007 and opportunities are currently available with the commitment of multiple partners and donors, support from strategic alliances, political will, and experiences that demonstrate approaches that work and offer some solutions. The primary focus for the coming year needs to emphasize **acceleration of service delivery- increasing the number of male circumcisions performed**. It was highlighted that analysis has demonstrated that impact and cost savings will be greater where scale up occurs over a shorter period of time. **Success** will require ongoing close **coordination and collaboration** of partners for a coherent response that draws effectively on experiences and best practices, and the resources available at the country, regional and global levels. **Sustained political support** and ongoing **advocacy** including key stakeholders are critical.

Background

Male circumcision involves the removal of all or part of the foreskin of the penis and is one of the oldest and most common surgical procedures worldwide. It is undertaken for religious, cultural, social or medical reasons. Data from a range of observational epidemiological studies, conducted since the mid-1980s indicated that circumcised men have a lower prevalence of HIV infection than uncircumcised men. Three randomized controlled trials conducted in Orange Farm, South Africa; Kisumu, Kenya and Rakai District, Uganda showed that following circumcision, the incidence of HIV infection in men was reduced by more than half.

In March 2007 WHO and UNAIDS convened an expert consultation to review all the evidence for male circumcision for HIV prevention including the data from the randomized controlled trials conducted in Kenya, South Africa and Uganda. Based on the strength of the evidence recommendations were made that male circumcision (MC) should be considered an important new intervention for HIV prevention and should be promoted as part of a comprehensive HIV prevention package. The WHO/UNAIDS conclusions and recommendations on male circumcision for HIV prevention specify that countries with a high prevalence of HIV, low prevalence of male circumcision and heterosexual epidemics should consider the scaling up of male circumcision as part of the comprehensive HIV prevention package. In the Eastern and Southern Africa (ESA) Region, 13 focus countries² have been identified by the UN Interagency Task Team (IATT) for technical support to scale up male circumcision programmes.

Objectives of Meeting and Participants

The overall objective of the meeting was to provide a platform for countries to share lessons learned, explore opportunities for collaboration, discuss strategies and innovations to overcome challenges and accelerate programme scale-up.

Specific Objectives

1. To share country experiences and lessons learnt in the scale-up of male circumcision programmes.
2. To examine the facilitating and constraining factors to implementation and identify effective strategies to accelerate country scale-up
3. To share programme support tools and provide opportunities for capacity building on the various tools and guidelines available to support implementation
4. To identify inter-country, regional and global actions required to support scale up of male circumcision services and to explore opportunities for South-South collaboration.

The meeting was attended by 117 participants including government representatives from Botswana, Kenya, Malawi, Namibia, Rwanda, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. Also represented were staff from non-governmental organizations, researchers as well as headquarters and/or regional representatives of WHO, UNAIDS, UNFPA and UNICEF, women and youth representatives.

² Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe.

Opening

Dr Rufaro Chatora, WHO Representative Tanzania welcomed the participants. He emphasized the relation between the goal to halt and reverse the HIV epidemic and the scaling up of male circumcision to contribute to that goal. For this reason WHO and partners are promoting the scale-up of this intervention. He pointed out that 13 priority countries for male circumcision scale-up have been identified and WHO tools and guidelines have been developed, so that countries should be ready to scale-up. He emphasized the importance of leadership and the contribution of WHO towards achieving progress. Partner support in the scale-up of male circumcision services was acknowledged as essential to success.

On behalf of Tanzania's Minister of Health, the Director for Human Resources for Health Development in the Ministry of Health and Social Welfare, Dr Gilbert Mlinga welcomed participants. He stressed that the deliberations will improve regional knowledge on male circumcision progress and allow countries to share experiences. HIV prevalence in Tanzania is 5.7% and work on male circumcision began in 2006. The information obtained from the situation analysis and a second study conducted about traditional male circumcision (a common practice in approximately 50% of the provinces) provided inputs into the development of the national policy on male circumcision. Traditional MC will need to be reconciled with the services provided in medical settings.

He reminded the participants that HIV is not the only national concern but also malaria and maternal mortality. Implementing any interventions to improve these health problems face the major constraint of limited human resources. In addition, male circumcision supplies are also in short supply. These constraints will have an impact on rolling out male circumcision and a call is made to partners to identify sustainable funding for these particular aspects. Despite these constraints, it is important to add male circumcision as an intervention for HIV prevention. Gratitude was expressed to bilateral and multilateral partners and the UN family for the work and support thus far.

Dr Kim Dickson, WHO HIV Prevention Medical Officer, reviewed the objectives and agenda. Introductions were made as country teams.

Catherine Hankins, UNAIDS provided a global overview of the evolving HIV epidemic and the importance of male circumcision within the context of HIV prevention and treatment scale up past, present and future. She gave a historic overview of the HIV epidemic starting in 1900 through to today. Today treatment and goals of universal access have expanded the number of individuals receiving care and treatment. Effective prevention has been demonstrated with randomized trials for male circumcision, mother to child transmission, and one study for syndromic management of STIs. Potential future options for prevention were presented including additional pre-exposure prophylaxis and treatment as prevention. Currently viral types have been mapped and their diversity will affect vaccine design for Africa. Microbicides research is still underway. Biologically it is known that there is one week time period in which to 'prevent' an acquired HIV infection from reaching the lymph nodes and this will guide future intervention research.

She stressed the importance of 'know your epidemic, know your response' - where are the next 1000 infections coming from. Then consider where to target resources and adjust the national response. Currently resources are available to support scale up of the male circumcision intervention; however, as new interventions become available, the focus may shift. Those involved in implementing the male circumcision intervention need to be aware that this scale-up process is being closely watched, and as new prevention options become available, the outcome and success of scaling up male circumcision will be looked at to guide implementation of these new interventions.

Country updates

All countries now have in place approved or draft policies and strategies. Many have an implementation strategy, although several are struggling to develop this document. Many also have a communication strategy and have adapted guidelines for clinical care. The involvement of partners remains strong. Key points in progress and unique activities were described by each country.

Expanding service delivery: Kenya, Swaziland and Zambia

Kenya

Peter Cherutich, Head of the Prevention Unit at the Kenya National AIDS Committee shared experiences to date in Kenya where the national HIV prevalence is 7%. He mapped the journey of voluntary medical male circumcision starting in Sept 2006 with discussions on approaches to the research results. Key events include:

- in January 2008, Kenyan policy and documents were developed, including adaptation of the global clinical manual for male circumcision and the dissemination of implementation and communications strategies.
- nurses were allowed to perform male circumcision. The concept was not new and since nurses already perform other surgical interventions, the MC surgical task was acceptable. The Nursing Council supported it by defining additional competences that are needed.
- the Rapid Results Initiative (details later) was implemented successfully.

Male circumcision scale-up will need to reach about 950,000 men with a 2010 target of 150,000 men. The achievement for this year is 91,300 male circumcisions done or 60.8% of the target. Phased scale-up is planned based on geographic priorities. Nyanza has been the priority to date, but work is now beginning in Nairobi where they have conducted facility assessments as well as engaging stakeholders and establishing provincial directorate and partnerships. In Western Province there are pockets of uncircumcised men; about 5,000 will be provided services with funds from the World Bank to the Government of Kenya. The Rift Valley is the last province of focus. Quality assurance is progressing with quality improvement teams set up.

Key challenges include matching supply and demand; and balancing vertical and integrated approaches. As they move to new provinces different challenges arise such as identifying partners and differences in service financing where out-of-pocket fees are required versus free services in Nyanza province. Also the metropolitan nature of Nairobi with diverse population groups differs from Nyanza, so that circumcised and uncircumcised groups are not easily identifiable. This will require working closely with District Health Teams to identify key target groups. Mobile populations are also difficult to identify.

Opportunities for male circumcision included the Rapid Results Initiative (RRI) for HIV testing and counselling (HTC) which occurred prior to the RRI for MC; and the World Cup to revitalize male reproductive health. A community health strategy is needed to improve access and synergies with other programmes especially between HTC and MC. Political and technical leadership that is sustained beyond the pilot stage will be important for success. Dr Cherutich summarized that they have made progress and he encouraged participants to visit their resources at the marketplace.

Swaziland

Vusi Magagula, Deputy Director of Health Services, Swaziland Ministry of Health described the country situation which has an HIV prevalence of 26% in the reproductive age group and a MC rate of about 8%. The main reasons for HIV transmission in Swaziland are multiple: concurrent sexual partners, inadequate knowledge, low condom use, high mobility, gender inequalities, unacceptable STI rates and substance abuse. Therefore, male circumcision is included as a priority intervention in the National Strategic Framework along with PMTCT, social and behavioural communications and reaching higher risk populations. Currently 10% of the male circumcision target for the 5 year plan is achieved.

Progress for male circumcision as a HIV prevention intervention includes the development of operational and clinical guidance and a behaviour change communications (BCC) strategy aligned to national BCC Strategy. Several Technical Working Groups have been established and a dedicated MC coordinator is in place since August 2009. Extensive communications occur including interpersonal communications at the community level. Services have been strengthened by increasing the facilities providing services from one to six, and training has been provided for doctors and nurses as well as piloting of a volunteer programme. The Accelerated Saturation Initiative (ASI) has been approved by Cabinet in January 2010 (see details under approaches to scale up). Three key experiences include a MC campaign during a three- week school holiday in 2010 when 2,000 male circumcisions were performed; quality targets have been set for all six facilities; and commodities security is assured through partners. Key accomplishments include:

- implementation has been by government and non-governmental organizations with Faith Based Organization, UN, and United States Government involved;
- a men's clinic and satellite clinic from an established NGO were set up;
- strengthened partnerships for service delivery of about 10,000 MCs.

Key lessons learned include that strategic alliances are a great benefit - all is possible if resources are available; and political support plays a key role. Constraining factors include the lack of a clear monitoring and evaluation plan and slow roll-out. Now support is needed to scale up; the mass catch up (ASI) is a plan underway, but human resource issues are the key challenge, so we need to explore further task-sharing.

Zambia

Wezi Kaonga, HIV/AIDS Specialist, Zambia Ministry of Health, explained that the initial drive for male circumcision for HIV prevention came from partners in 2007 but MoH took leadership in 2009. Now coordination mechanisms are established as well as Technical Working Groups; the MoH oversees the programme with a national MC Coordinator in place supported by WHO. Strong partnerships are in place. Male circumcision is an integral part of the HIV/ AIDS policy within comprehensive prevention and the Reproductive Health Policy Act, so a new policy was not needed. A strategy framework and operational plan have been developed. A situation analysis has been conducted and a DMPPT analysis completed.

A 10-year strategic plan was adopted with a focus on high quality. The target is to reach 50% male circumcision prevalence by 2020 from the current 13%. The target population is HIV negative males, 13 to 39 years old. Free services will be provided; providers include enrolled and registered nurses. The minimum package of services will be provided as entry to comprehensive prevention and sexual and reproductive health. 3030 health care workers have been trained with the Surgical Society providing ongoing support. Ninety-nine sites are active with 29,082 male circumcisions performed primarily through outreach services. Key challenges are limited human resources and funds. Next

steps are consolidation of work at province and district, optimizing human resources and incorporating MOVE suggestions.

From pilot to scale-up: Botswana, Tanzania, Zimbabwe

Botswana

Janet Mwambona, National Male Circumcision Focal Point, described the national situation where the population is small at 1.8 million, HIV prevalence of 17% and a male circumcision rate of 11%. The target for safe male circumcision is 500,000 men 0 to 49 years old by 2016. Botswana has focused on integrating male circumcision into current services and systems so that the process seems to move slowly, but by using the same resources as are normally in place, this integrated approach should now move solidly forward. There is also a plan for some mass male circumcision interventions in areas with waiting lists, and to work with traditional providers to further access and safety. It is critical to maximize efforts in next three to five years.

A key achievement of this year emanates from the extensive multi-stakeholder involvement including private practitioners and the Executive Committee and Medical Aid Schemes to discuss the pricing of male circumcision in the private sector. Two medical aid schemes that fund private practitioners now have included the prescribed package, although they normally do not support prophylaxis. This required much discussion but will permit broader access to MC services.

Doctors and nurses still need to be trained on safe male circumcision including private providers. Reporting is mandatory using adapted tools and these are being integrated into the current system. Diverse groups have been consulted and a policy and strategy have been developed with a revised costing for infant and adult MC - it is estimated that 64% of the cost is for human resources. A Quality Assurance focal point is in the HIV Dept and the MC intervention fits within a broader health system strengthening performance improvement intervention. Ten quality assurance standards have been adopted and internal and external quality assurance done at centres of excellence.

Service delivery began in April and now is available in 35 facilities with six centres of excellence. Less than 5% of males seeking male circumcision were HIV positive. One mass event occurred in July 2009 in one district; 88% of men were tested and adverse event rates remained low. Annually as many as 150,000 MCs will be needed for the catch up in a five year plan, while a seven year plan would require a maximum of 100,000 MCs.

Opportunities are similar to other countries, such as political will, partnerships, good infrastructure and health systems, new initiatives such as volunteers, strong community programmes, and high acceptability of MC. Challenges also are similar: inadequate resources particularly health care providers, balancing of demand and supply, implementation approaches which permit high volumes and meeting of targets, ensuring that the population gets the right messages. Key lessons include: the mass MC event allows for strengthened relations between traditional and health sector; scaling up safe MC will require partnerships that are well-coordinated for maximum benefit.

Tanzania

Pascience Kibatala, Surgeon, Ministry of Health and Social Welfare, described the country situation (population of 43 million, HIV prevalence of 5.7% and male circumcision rate of 70% with wide regional variation). The Ministry of Health and Social Welfare is leading with UN agencies and US Government providing support. A Task Force formed in 2007 with a wide range of partners and a Technical Working Group. In 2008-09, situation analyses were done along with a strategic plan which is to be operationalized

by August 2010 and will focus on three geographical regions. Demonstration sites in the three regions are informing further expansion into eight priority regions.

Quality assurance standards are available. A site start-up guide has been developed and facility orientation occurred. Some efficiency ideas from MOVE were included at demonstration sites as are the draft monitoring and evaluation tools. Policy and regulations are included in the national strategy.

Male circumcision is performed throughout the country in the formal health sector; it is acceptable even where not practised traditionally. Traditional male circumcision and medical male circumcision are willing to cooperate and improve safety. Clinical officers and nurses perform MC, some as task shifting and some task sharing. MC clients pay one to three USD in demonstration sites. All clients receive HIV counselling and testing before MC; 4,700 MCs have been done between September 2009 to May 2010 with uptake particularly since March 2010 when started using MOVE options.

Lessons learnt:

- demonstration sites contributed to strategy development;
- no significant opposition exists from traditional or religious sectors;
- there is high demand with minimum mobilization.

Challenges include: shortage of supplies and commodities, shortage of trained health care workers, funds for scale up including kits and materials. Financial support will be needed to address these shortages, as well as technical assistance for costing.

Zimbabwe

Sinokuthemba Xaba, Male Circumcision Focal Point, MoH, presented on the Zimbabwe situation where the population is 12 million with 13.7% HIV prevalence and male circumcision prevalence of 10.3%. Male circumcision as an additional HIV prevention intervention has been adopted through a consultative process and a policy was launched in December 2009. The Male Circumcision programme is coordinated and managed by MOH and Child Welfare. Three Technical Working Groups are in place with the National AIDS Committee providing overall coordination of the national response to HIV/AIDS. There is close collaboration with NGOs and traditional providers. Partnerships exist for funding and implementing purposes. From May 2009 to April 2010, 6,070 males have been circumcised.

Currently only approved sites provide MC; it is available for free, through outreach sites and in collaboration with traditional circumcisers. Pilot services began and a training programme was established for both public and private providers; they are also working with the uniformed services. An evaluation of the pilot is being used in strategy development along with the DMPPT. Key achievements to date include:

- Five pilot MC sites are operational and 104 doctors, nurses and other health care workers trained.
- Sites are using some elements of the MOVE model to improve volume including the forceps guided method, preassembled kits, diathermy and open plan for operating rooms.

Regarding provision of the minimum service package and continuity of care, the uptake of HIV testing and counselling among men seeking male circumcision has been high at over 98%; and recruitment occurs through existing testing and counselling services in pilot phase. Uptake is high also for follow-up services with 94% returning at day 7 and 74% at day 42.

The key challenges are limited funding for rollout and demand creation; and human resource constraints. One solution may be to redistribute providers within the country, but also draw on staff from neighbouring countries for short term services; the motivations of health care providers is also important in order to meet demand.

Key lessons learned to date include:

- stakeholder consultations are critical and needed on an ongoing basis;
- a phased approach is important to identify essential ingredients and processes;
- strong communications are needed for demand creation;
- draw on the comparative advantages of diverse partners.

Suggestions for moving forward are:

- Find solutions to human resources shortage. Consider task shifting, especially the role of nurses. Consider redistribution of providers within the country and discuss with neighbouring countries for short term services. Assess motivations of health care providers to meet demand.
- Link MC services carefully to other programmes such as supply chain management;
- Identify the best mix of service delivery models;
- Obtain additional financial support for roll out.

From strategy to implementation: Namibia, Malawi, Rwanda, Uganda

Namibia

Frieda Katuta, National Prevention Coordinator, MoH, summarized progress on the male circumcision intervention in Namibia (population of 2 million, HIV prevalence of 17 percent and male circumcision prevalence of 21 percent with variation across the regions). A male circumcision task force exists since 2007. In 2009, the results of a situational analysis were disseminated at a stakeholders meeting. The male circumcision policy is in its third revision and was resubmitted for approval in June 2010. A recent visit by the Champions for an HIV-free generation boosted understanding of male circumcision at the highest political levels. A communications strategy has been developed. The male circumcision programme is still in its early stage; 350 male circumcisions have been carried out since September 2009. Approximately 90% of men presenting for MC have been tested for HIV.

Challenges include: male circumcision is only carried out in the public sector and this needs to be extended to private providers is needed; training has been provided for 83 health workers on male circumcision service provision but human resources remain a major barrier for implementation of the intervention; an enabling environment for task-shifting/task-sharing of male circumcision needs to be developed; monitoring and evaluation requires strengthening.

Malawi

Amon Nkhata, Male Circumcision Programme Manager MoH, described the situation in Malawi which has a population of approximately 13.1 million, HIV prevalence of 12 percent (85 000 new infections annually) and male circumcision prevalence of 21% that varies across the regions. Since 2007 a National Male Circumcision Task Force has been in place which is headed by the Ministry of Health and a secretariat at the National AIDS Council. Consultations with key social groups are ongoing. The situational analysis has been completed and disseminated to stakeholders. Male circumcision activities have been included in the National HIV Prevention Strategy and Operational Plan for 2009-2013.

The male circumcision programme in Malawi faces several challenges:

- the cultural and religious links are strong and in the recent past there was opposition from traditional leaders and the Christian community.
- communicating the male circumcision message correctly given the high HIV prevalence in traditionally circumcising communities.
- male circumcision intervention is driven by experts and elders with limited engagement of young people.

Opportunities for male circumcision service expansion include that the Ministry of Health has partnered with several NGO service providers and voluntary medical MC is culturally delinked. Male circumcision is offered in the public sector on a drop-in basis. Donor support, media readiness, and involvement of academic institutions facilitate this area of work. The next steps will be to develop standard operating procedures, a communication strategy and a national operational plan; build capacity including training of service providers and conduct costing of service provision options.

Rwanda

Ange Irakoze, Responsible of Biomedical Tools, Prevention Department TRAC Plus presented the situation in Rwanda where the population is 9.3 million, the HIV prevalence is 3% and male circumcision prevalence is 15%. Male circumcision has been integrated into the national HIV prevention policy since 2007. The National AIDS Council (CNLS) is responsible for the overall coordination of male circumcision activities and MoH is responsible for MC in health facilities; TRAC Plus has responsibility to develop MC tools. A Technical Working Group exists since 2008. The situational analysis has been conducted. There is support for male circumcision across political and community levels including with several civil society groups. A framework for quality assurance, and monitoring and evaluation are under discussion.

Male circumcision has been launched in nine military sites. 542 circumcisions have been conducted between October 2009 - April 2010. Two programme managers, six national trainers, fifty service providers, and 91 counsellors have been trained for MC services. A pilot project is planned in two district hospitals.

Lessons learnt include the importance of political engagement, that community acceptance is likely to be high, but some cultural and sexual practices could undermine MC acceptability and that women are willing to be involved in MC roll-out. Challenges for the scale up of male circumcision services are: development of the operational plan; communication plan, monitoring and evaluation plan, expansion of services are needed; limited number of medical staff and their mobility, and the regional distribution of trained staff; limited number of MC kits. Task shifting still needs to be considered. The next steps will be to finalize the Decision-Makers' Programme Planning Tool and to use the outputs to finalize the operational plan; build capacity and model effective service delivery at district level.

Uganda

Jackson Amone, MC National Task Force Secretariat, described the Uganda situation (population of 32 million and HIV prevalence is 6.4%; male circumcision prevalence is 25%). Support and implementing partners are numerous with the Ministry of Health providing leadership and stewardship. The Male Circumcision Task Force is championing MC activities; they are working with traditional providers to reduce negative reactions from that sector. A situational analysis was conducted in 2008 -9 to determine the acceptability and feasibility of male circumcision promotion in Uganda has been completed and disseminated to stakeholders as well as a mapping survey of male circumcision services. The national launch of the male circumcision policy is scheduled for June 2010. Male circumcision is included in the National HIV Strategic Plan. The strategic, operational and communication plans are in development.

The male circumcision target is 2.4 million with an increase nationally of male circumcision prevalence from 25% to 40%. At present male circumcision is provided in the public sector as part of general surgery. The aim is to use a mixture of vertical and integrated approaches to roll out male circumcision services. The PEPFAR implementing projects reported 5,340 clients circumcised between Oct 2008 and March 2010.

Currently, 232 health workers have been trained at Rakai Health Sciences Research Project (RHSP), the national centre for training excellence. Nationwide training will be initiated soon depending on availability of funding. Quality assurance tools are being initiated by MoH, adapted from WHO guidelines; infection control guidelines are in place. Monitoring indicators are being developed within HIV surveillance and HMIS. A number of research activities continue at the Rakai Health Science Research Project.

Lessons learned include the importance of support from stakeholders, coordination and collaboration to harness resources and mix of vertical and integrated approaches. Several challenges include: inadequate funding; need to remodel some settings to accommodate male circumcision services, decentralization of training, consideration of task shifting and task sharing as it requires in regulation before they and logistics insecurity. Innovations include working with traditional circumcisers, use of existing facilities to deliver services before full scale up and involvement of media houses as advocates.

Posters and Marketplace

Julia Samuelson, Technical Officer, WHO HIV Prevention in Health Services, provided an update on new UN guidance produced since the meeting last year. A document on the inventory of resources is available with brief descriptions of all materials developed by the UN. The *Progress in male circumcision scale up: country implementation and research update, June 2010* provides an overview of progress in countries to date as well as a new section with a compilation of planned and ongoing research on male circumcision for HIV prevention. She reminded participants that all these publications are available on the WHO website and www.malecircumcision.org Clearing House. She invited participants to continue the afternoon by viewing the posters and discussing in more detail with country staff. Resources developed at the global, regional and country levels were on display for viewing and to take.

Approaches to Scaling up Services

This section describes experiences with approaches to scaling up including: two initiatives for rapid catch-up were described from Kenya and Swaziland; and service delivery at dedicated sites, integrated services and Uniformed Services as an additional provider.

Rapid Results Initiative: Kenya

Kawango Agot presented the Rapid Results Initiative (RRI) in Kenya by reminding that rapid scale up is needed as modeling has shown that in high HIV prevalence and low male circumcision settings, MC impact over 10 years depends on rate of scale up and uptake of services. RRI is a strategy used in Kenya by government and ministries for large scale change through small scale result-producing, momentum building initiatives; it has already been used for immunization and HIV testing and counselling.

Implementation was led by MoH with the participation of other ministries like education, civil society and other implementing partners. Coordination systems were set up at

provincial and district levels. MC service providers were trained as well as cadres trained in data collection and management. Teams with team leaders and staff with experience were mixed with inexperienced staff. Weekly review meetings were held to address challenges. Field supervision was done on a daily basis.

The MC minimum service package was offered as included in WHO recommendations. The services were provided by a team consisting of doctor, nurse or clinical officer as surgeon, nurse and clinical officer as assistant to surgeon, MC counsellors, and hygiene/Infection prevention and control officer. The summary RRI results are:

- 36,077 MCs performed in 30 working days.
- 28,672 done by two partners in seven districts
 - Average of 10.2 MCs per team daily
 - 39% of men tested for HIV at MC venues versus 17% during routine services prior to RRI
 - 55% of MCs were done on men older than 15 years; 23% among 12 – 15 year olds
 - Adverse event rate was 1.9%
 - Follow-up rate at MC venue was 23%
 - Among the 6595 who returned, the adverse event rate was 8%. A project is assessing the difference between those who have returned and those who did not, as the adverse event rate may be high because the concerned did return.

Key challenges to the RRI were obtaining parental consent for minors, sustaining demand, obtaining good HIV testing rate and making available MoH staff which was unpredictable at times.

Key lessons from the RRI were that:

- It is effective in programme roll out, service uptake and building momentum for increasing demand.
- The public is ready for MC if the services are readily and safely available.
- MC can be provided in diverse settings.
- MC is cost effective: USD 39 during RRI vs USD 86 in preceding 13 months.

Recommendations for this type of initiative:

- expand MC services within and beyond formal health sector
- RRI is a good strategy for scale up in short time periods
- conduct integrated RRI for HTC and MC
- re-engineer MC messages for older clients

Accelerated Saturation Initiative in Swaziland

Ayanda Ngeketho presented about the proposed Accelerated Saturation Initiative (ASI) in Swaziland. The male circumcision target in Swaziland is to scale up to 80% of 15 - 24 year olds, or 110,000 MCs, over 5 years. At the current rate of uptake, it would take more than 5 years to achieve the target. Thus the ASI seeks to achieve this over one year. The MoH engaged USG and other partners to support ASI. Cabinet approval has been granted and there is strong political will including the support of His Majesty the King, Mswati III and both houses of parliament. Engagement of traditional leaders is necessary for success of ASI. The MC Task Force has formed an ASI subcommittee. ASI will be conducted in three phases: preparation, scale up pilots (August to December 2010), full scale up nationwide to December 2011. The final ASI plan is not ready as it will be informed by the pilots. The target population will be males aged 15 – 49 years. Male circumcision sites will be placed in the public health centres, requiring 25 – 50 clinical teams and support staff.

Further dialogue is required on the following: shortage of trained human resources, limited facilities and acceptance of MC campaign approach. Coordination of scale up will be done through the four Regional Health Management Teams. With a mainly rural population, services have to be taken to the people as well as the people to the services.

Dedicated stand alone services

Dirk Taljaard presented about the dedicated services in Orange Farm, South Africa, where good political will exists with national and provincial government. A National Policy has been completed through SANAC with guidelines and implementation plans awaiting signature. Recently Population Service International established a clinic in Pietermaritzburg, duplicating the Orange Farm model. The objectives of Orange Farm project are as follows:

- to expand services as an ethical obligation as nearing saturation in Orange Farm
- to extend services to other areas around Orange Farm with a plan to transport individuals to the site
- to establish Orange Farm as a centre of excellence.
- to evaluate impact of implementation

The project started by providing information to the general public through advisory boards, community meetings and recruitment through outreach services which were quite extensive including in churches, schools, radio, and local general practitioners, STI clinics, and national communication rollout. Outreach information sessions start with safe sex messaging with a final session on male circumcision. Services include HIV counseling and testing, CD4 count on site, and provision of informed consent. STI management is done at a referral facility about 200m from MC site so as not to duplicate services. The STI site also refers men to the MC services. HIV positive participants are not excluded.

During the research a three-day waiting period was required before surgery, however, this will be removed with surgery available straight away. The surgery site currently has 8 beds, 1 surgeon and 4 auxiliary nurses. With 3 doctors they can conduct 150 plus circumcisions per day. Training needs to be conducted at high volume sites; this will be replicated nationally. Cost of the service (client does not pay) is approximately USD 60 but depends on volume of circumcisions conducted; electrocautery is used. Follow up visits are recommended 2 to 3 days after surgery. The rate of adverse events is approximately 2%. The project has provided input to policy and guideline development, and is looking to develop male health sites and integrated services; also the project is involved in ongoing research.

Integrated Service Delivery

Gladys Magongo described the use of the MOVE principles in Swaziland in the Litsemba Letfu Clinic. The theatre has a similar design as that at Orange Farm in that it allows the MOVE model. There is a uni-directional flow of clients which minimizes infection. Clients move through registration, group counseling, then individual counseling, theatre and recovery area. Task sharing is used with a nurse doing prep and administering the anaesthetic and doctors doing the procedures and completing with two anchor sutures then moving to the next patient. Time spent on surgery is also reduced (about 20 minutes total) by using electrocautery and alcohol rub for hands instead of full surgical scrub between clients. A nurse monitors clients for 20 to 30 minutes for immediate post-op complications; and then provides emergency contact details at discharge. Transportation is available within a certain radius to collect clients who experience adverse events at home. Clients are reviewed at 2 days and 7 days post-op.

From June 2009 to May 2010, 5,052 MCs were performed at the clinic were and 2,065 in outreach. The HIV testing rate at clinic was 81% and adverse events rate of 1.7%. Mobile outreach sites also apply MOVE principles. A Mens Clinic is also attached to these services. Demand creation is mainly by interpersonal communication. The current challenge is transportation to the sites. Next steps will be to expand mobile sites, provide support for the programme in the public sector, and shorten the counseling time.

Military and uniformed services

Anne Thomas, US Dept of Defense, presented about the involvement of the military in MC service provision. Reasons to involve the military include: the population is mostly male, sexually active, 18 years and older but mainly the lower age group target for MC, mostly HIV negative, nationally representative, scheduling is quite easy especially for follow up and the military pace allows opportunities for MC. In addition, a substantial portion of civilians can be reached through military services as they often serve also the surrounding community.

Countries involved with such Uniformed Service provision on a small scale are Botswana, Ethiopia, Mozambique, Namibia, Swaziland. Rwanda started some time ago with a situational analysis to service provision though generally slow pace; Uganda uses fixed sites with very detailed objectives and plans for an integrated programme with task shifting; Zambia has three sites and is scaling up. In general, countries should consider the military as its services can boost national MC efforts further.

Martin Malama from the Zambia Police Services presented about this setting where 66% of the population is male. Most recruits are interested in MC which is provided on a voluntary basis. Two hundred police officers were circumcised with assistance from US DOD; services are provided monthly and include general prevention services. MC service increases testing and knowledge about their HIV status. The officers who are at increased risk of HIV infection are actually those who are off base for longer periods of time. Zambia also links with police services in other countries work with SAPCO, a regional Police Chiefs Organization, currently chaired by South Africa. Issues of mutual interest are HIV prevention and male circumcision specifically.

Innovations and Challenges to Implementing the Minimum

Package of Services

HIV testing issues

Hally Mahler presented about HIV testing and counselling (HTC) in Tanzania. The uptake of HTC was high at 98%. Some sites reported greater than 100% which is believed to be due to partners who test and are counted in the testing statistic, or some men are tested one month but have the circumcision procedure the next month. So the collation of HTC statistics needs to be improved. The team in Tanzania hypothesized five potential reasons for high HTC uptake and then conducted focus group discussions. Findings included:

1. The population is young and not concerned about HTC. In fact less than 1% of men were positive, but most clients are older than 15 years old.
2. Patient testing is opt-out so that it will be provided unless they indicate otherwise.
3. Good counselling is offered as they developed a counselling training stronger than in the WHO manual (a 3 day training among nurses who were already trained).
4. Treatment was available in the same centre. As this is a high HIV prevalence area, stigma may be less and treatment is readily available.

5. A national HTC campaign was just completed in 2007-8 and this campaign prepped clients. About 4.8 million people were tested among 10 million eligible people. President Kikwete strongly promoted it and 'the campaign made it normal to test.'

Challenges in delivering the minimum service package and efficient services:

- the MOVE principles are great, but the preparation of people in advance of surgery is a huge task. They moved much of the counselling out of the clinic to the community.
- further referral mechanisms need to be developed with PITC and VCT.
- test kits need to be assured in an environment of shortages

In summary, as one focus group discussant said: 'Killed two birds with a single shot... got circumcised and tested for HIV.' The synergies between HTC and male circumcision services need to be further expanded.

Karin Hatzold presented several issues about HIV testing and counselling and male circumcision in Zimbabwe, including:

- Low HTC uptake in several of the African country programmes
- Importance of testing because of increased risk of transmission if men HIV positive.
- Concerns that HTC as precondition for MC might prevent uptake
- Concerns over stigma among HIV positive men
- Concerns that HIV positive men might seek MC service outside clinical settings
- Importance of integration and links between HTC and MC
- Consideration on retesting of HIV at MC of previously tested individuals

Reported HTC uptake ranges from 56% in Kenya to 98% in Zimbabwe and Tanzania (Zambia 62%, Swaziland 88%, Botswana 89%, Namibia 94%). Nearly all men were tested at the MC site, except in Kenya and Zimbabwe where only 70% and 28% respectively tested at the MC site. The proportion positive who were circumcised ranged from under 1 to 4% in these countries. In Zimbabwe, over the past year more testing is occurring at male circumcision sites than at HTC sites.

In Zimbabwe, there is a high awareness in the population with at least 40% testing once. A large network of VCT centres exists since 1999 and PITC was implemented since 2007 provisions at over 800 facilities. HTC is one entry point to MC and HTC is routinely offered to MC attendees. About 20,000 men were tested each month and 75% are negative.

MC counselling is integrated at the five pilot sites and uptake of MC services was high when offered as additional prevention intervention during the counselling session. The quality of counselling is good particularly by nurses and counsellors as training is extensive. A number of counselling sessions occur throughout the MC process which reinforces messages. MC and HIV positive men receive in-depth counselling on risks and benefits of MC when positive including discussion on care and treatment and positive living strategies.

Josephine Otchere-Darko shared how the Orange Farm Bopholo Pele MC Service manages HTC. Voluntary counselling and testing changed to provider initiated testing and counselling (PITC) to conform to the National Strategic Plan goal. Society for Family Health offers HTC as a free service and offers to all during group sessions. Among the age group 18 - 45 years old, as of May 1 2010, 76% of men agreed to HTC. Counselling was then done individually usually with the same counsellor and with rapid results. The proportion of men who tested negative was 97%. Those who refuse to test can still be circumcised on the same day if they insist. Men testing positive have CD4 counts done which then informs the next step. The protocol will move to CD4 of 350 given the new

WHO recommendations. If the count is above 350 then counsellors emphasize wellness; and if the patient still wants to be circumcised they are strongly counselled. If the CD4 is less than 200, men are referred to an ARV accredited clinic.

Society for Family Health (SFH) follows up with outreach sites to collect referral forms from the clinics. They encourage men to bring partners but this is uncommon because most have multiple partners; about 4% return with a partner. SFH liaises with social workers who deal with social support needs. About 25% of men return by 2 weeks; the non-return is primarily due to denial, fear, shock. When the CD4 count improves, men can return for MC, but none have returned. Key challenges for service provision to HIV positive men include low clinic follow up rates, poor clinic services at referral sites, discordant partner issues and multiple partners. A main conclusion is that the high HTC rate is encouraging but follow-up of HIV positive clients is challenging.

Implementing the minimum service package: panel discussion

The panelists Kanyanta Sunkuntu, Walter Obeiro, Sinokuthemba Xaba, Hally Mahler, Karin Hatzold, Josephine Otchere-Darko shared experiences on implementation of other elements of the minimum service package.

STI management

At Orange Farm, staff liaise with the STI clinic which is within a few minutes walking distance. They use a referral form with comments from the clinician as well as phone details so that they can follow-up with patients to determine if they sought STI management. In Tanzania all PSI sites include STI management on site and one MC site was already the STI site. Zimbabwe has STI management on site and encourages follow up once STI has cleared; the most complicated cases are referred. In Kenya it was estimated that 5.1% of men had STIs.

Condoms promotion and provision

In Zambia MC service includes the minimum package so condoms are promoted and provided. Condoms are provided prior to MC within public sectors and accompanied by social marketing. Those who enter a health care facility to get condoms will also be referred to MC. There is a launch with a branded condom that includes both messages of HIV prevention: MC and condom use.

Male circumcision and other sexual and reproductive health services:

In Zimbabwe male circumcision is viewed as an entry point to male sexual and reproductive health services. Staff see both men who contact the health care services as well with their partners. In order not to lose gains and confidence, only approved sites can provide the minimum service package. A challenge is that adolescent sexual and reproductive health has been difficult to define for boys and the package of services that needs to be provided is being identified with experience.

Minors

Meeting the male circumcision minimum service package for non-sexually active youth is not as clear as for adults, and the question was raised as to how best this service can be provided. Some minors want the services but they do not have a guardian. It was suggested that WHO should look at this further and have different materials developed for this age group. Women as mothers are bringing their neonates and young sons. As these women accept MC, services must also address them.

Quality and efficiency

Service quality and client movement/flow are also important for efficiency; MOVE considerations are should be complemented by addressing non-surgical aspects. HTC is important and we must recognize that counseling takes time. One suggestion was to

encourage more community information sharing to reduce the amount of counseling time required. Support to strengthen quality assurance and expand decentralized trainings was identified as ongoing need. Other areas to strengthen: referral mechanisms for continuity of care and training health care workers about MC care even if they are not providing direct circumcision services.

The identification of best practices in delivering the various minimum package components was requested as well as documenting the added value that MC brings to reaching men with other services and infection prevention.

Traditional male circumcision:

recommendations from the sub regional consultation

Xola Kanta summarized the April 2010 meeting on traditional male circumcision. The participants at the meeting included a wide diversity of countries and sectors including traditional providers. Two types of circumcision were highlighted: 1) for religious reasons and 2) for cultural reasons such as a rite of passage without anaesthesia among adolescents. A number of people are involved in traditional male circumcision including women in some countries, traditional surgeons, nurses leaders, religious leaders, parents, young males and, lately, health officers. There is a growing interface between traditional male circumcision providers and the formal health sector. Activities to be considered jointly include: training and registering, providing safe equipment, providing the surgical procedure by trained health care workers with the seclusion part of the rite by the traditional providers, monitoring traditional male circumcision, and the inclusion of traditional circumcisers in the MC Task Forces.

Some unsafe practices noted were: occurrence in remote locations with associated risks, unsterilized equipment, inappropriate procedures and teachings including early sexual relations even prior to healing. Safety and complications were identified primarily as a result of pre- and post- rituals and not just the procedure itself.

Recommendations included (report not yet finalized):

1. Develop a policy for the regulation of safe traditional C, including monitoring.
2. Respect different perspectives and practices. Relations between traditional circumcisers and the formal sector need to be improved and a two-way relationship is needed which acknowledges the traditional values and new thinking.
3. Work with all stakeholders including mothers and wives to learn, engage and empower.
4. Adapt approaches to country settings.
5. Improve collaboration, safety, and access options between traditional and formal health sector
6. Research is needed to further understand the practices, attitudes, risk behaviours, impact of counseling and roll-out of MC on traditional MC.

Communications and demand creation

Overview of male circumcision communications

Steve Gesuale presented lessons learnt for communications on male circumcision. Interpersonal communications are key for successful male circumcision programmes in addition to good materials for education and counselling. Male circumcision can be

regarded as a high involvement decision to which people give serious thought. To engage a potential client, he needs an opportunity to talk with someone who is knowledgeable and whom he trusts. This may facilitate the internal decision-making process and encourage the man to seek male circumcision.

Male circumcision programmes need to provide potential clients with the opportunity to speak to someone who will answer their questions which can occur during group education to individual counselling sessions. Various points of contact during service provision are available: initial contact, HTC, pre-operative, post-operative, and follow-up visits, thus permitting numerous opportunities to engage with health workers. Communications with clinical staff are important to improve safety, positive 'bedside' manners and good interpersonal communications. Programmes should ensure that all cadres of staff are trained in interpersonal communication on male circumcision.

There are numerous 'male circumcision' behaviours: undergoing male circumcision, HIV testing, management of healing, abstinence for six weeks and practicing safe sex. Each requires different strategies of communication. It is essential to remember that men may decide to be circumcised for reasons other than HIV prevention including hygiene, social pressure from partners and appearance.

Sustaining demand in the long term and matching that to supply will influence the success of male circumcision programmes, so it is important to move ahead with long term demand creation. However, male circumcision is not an attractive product (pain, abstinence, still need to use condoms) and thus communications must happen from the national to service provider level. Communications must be designed which address different target groups including women as partners and mothers, traditional circumcising communities, parents and providers. Mechanisms will need to be explored to best match supply and demand.

Country case studies on communications: Zimbabwe and Swaziland

Oscar Mundida described the communications work in Zimbabwe. The main objectives of the Zimbabwe communication strategy are to increase the knowledge of male circumcision including health benefits among primary and secondary target groups and to raise the awareness of the availability of male circumcision services. The primary target is males 13 - 29 years old. Secondary target populations are parents, community leaders and the media.

The communication strategy was implemented in a phased manner to align it with the availability of services. The first phase was designed to raise awareness and increase acceptance using limited mass media. The second phase addresses behavioural barriers identified during a research survey. The reach of the communication programme was extended through advocacy with media and community leaders; interactive sessions using drama and music used to reach over 60 000 individuals; and other methods include training men who have undergone male circumcision as 'bring a buddy' agents so that they become peer educators. Communication materials have been designed so that they appeal to men e.g. analogy to football and position men's sense of achievement. There are challenges that communications need to address: addressing myths and concerns such as pain and reduced sexual pleasure, destigmatizing the behaviour and limited use of mass media in current phase.

Glady Magongo described Swaziland communications work. The male circumcision programme targets 15 - 24 year olds and the strategy has been designed to increase the demand for services through communicating the benefits of male circumcision while addressing risk compensation. Demand generation is through trained agents who identify clients at various locations such as schools and colleges, fairs and public events, and

within their residential catchment area. Role models have been used to promote male circumcision.

Amy Herman- Roloff briefly described explorations around the use of mobile phone technology as a useful tool in male circumcision programmes. The Nyanza Reproductive Health Society set up a 24-hour emergency helpline for clients to contact the clinic. A text messaging service study is being implemented to assess whether text messages improve clients' post-operative adherence to follow-up and abstinence until healing. A clinician support helpline is due to be set up in June 2010 with the aim to provide technical support and training for providers.

Male Circumcision Communications Strategy and Toolkit

Sibongile Dlodlu briefly described the revised communications strategy guidance which is being finalized, and also, the development of a toolkit that will provide specifics on the 'how-to' as well as examples of diverse communications materials.

Issues and actions to involve women and youth

Panelists: Cindra Feuer, Marion Natukunda, Edgar Makona, Mawethu Zita

A key point from this discussion was the importance of involving young people and women in male circumcision programme processes. Women were included at the meeting in 2008 Mombasa where concerns were raised as well as advantages that MMC could bring if programmed with sensitivity. Women's HIV prevention Tracking (WHiPT) formed out of that meeting to advocate and monitor new prevention interventions. A report on women's perception of male circumcision in five of the priority countries will be released soon. Recommendations include: provide male circumcision literacy in communities, draft gender sensitive messages, ensure comprehensive rollout that includes the minimum package and other gender related matter, ensure gender indicators exist in monitoring and evaluation, track resources and build linkages with female condom advocacy. Young people need to be more actively engaged and be able to voice their perspectives which may differ from those of the generation in the position of decision making.

Innovations to service delivery and managing human resource constraints

Male circumcision models for optimizing the volume and efficiency of services

Dr Dino Rech summarized the male circumcision models for optimizing the volume and efficiency of services (MOVE) which is a collection of efficiency measures to improve programme output. The MOVE initiative was inspired by the Aravind Eye hospital in India which provides high throughput facilities for cataract correction. The MOVE initiative is designed to apply surgical, patient management and flow improvements to increase the number of procedures that can be provided by a team in a given time period. It also includes management efficiencies such as use of male circumcision kits where considered appropriate. The forceps-guided surgical method has been shown to be less time consuming than the dorsal slit or sleeve methods. After implementing MOVE principles in Tanzania the client throughput was increased from 2-3 patients per hour to 5-8 patients per hour. Several countries have begun to include different elements of the MOVE principles (Botswana, South Africa, Swaziland, Zimbabwe, Tanzania, Zambia and Kenya). Operations research is planned to assess the impact of the different elements of the MOVE programme. Challenges identified with implementing the MOVE model include: balancing demand and supply of services, keeping the flow of patients through

the counselling and testing services to surgery, and managing the participation of part-time doctors and surgeons in the services.

Working with private providers

Abebe Bekele who is a general surgeon with the Surgical Society of Ethiopia (SSE) described the rationale for starting the male circumcision program in Gambella province where there is a 6% HIV prevalence, 46% male circumcision rate compared with national HIV rate of 1.4% and 98% respectively. Gambella province is in the southern part of the country that borders with Sudan. A situation analysis was performed in Gambella and three circumcision service sites are established. The national MC program was launched in January 2008 and three sites were equipped with appropriate supplies and the WHO tools and guidelines were adapted. Also developed were a MC training script, billboards, information flyers, patient information tools, recording and reporting formats, and other materials. SSE identifies surgeons from all over the country and dispatches them to Gambella for a 6-day MC campaign. Six campaigns are currently planned for implementation in July. This project is fully funded and run by SSE. They have trained 5 MDs and 30 non-MDs (involved in task shifting). During the training workshops about 100 men have been circumcised. Three surgeons were also sent from SSE to Swaziland to provide MCs and SSE is willing to support roll out as requested.

Challenges in Ethiopia include that the extreme heat (>40C) means that surgery can only be performed for about 4 hours per day, the region is very inaccessible and often electricity is interrupted, service sites are a long way from the rural population, despite having trained a large number of surgeons, not all are available for deployment to Gambella. They are considering developing more sites in Gambella, establishing mobile services (modelled on the mobile VCT centres) permitting them to move and reach more men.

The Male Circumcision Volunteer Programme

Piloting a volunteer mission in Swaziland

Ayanda Nqeketho summarized the male circumcision volunteer programme to support scale up in Swaziland. The number of men estimated to need circumcision is 161,291 adults, but there are insufficient resources in country to do this. One of the plans to achieve scale is the Accelerated Service Initiative. Currently only physicians are permitted to perform circumcisions. Volunteers would provide additional human resources during the ASI. They would be provided with airfares, visa, accommodation and a mobile phone. A volunteer pilot mission in April 2010 included three urologists from American Urological Association plus one doctor from IVUMed. This visit was planned to coincide with the Back-to-School male circumcision campaign. The volunteers along with local staff performed 253 circumcisions during their visit.

Currently a second volunteer mission is ongoing with three surgeons from Surgical Society of Ethiopia and six nurses from Nyanza Reproductive Health Society. They have been placed at the mission hospitals in Swaziland, within an on-going service delivery programme for motivation and recruitment of patients for surgery.

Preparation for volunteer missions is critical. Prior to deployment to a national MC program it is necessary to check the qualifications and skills of the MC volunteer surgeons. There needs to be an adequate number of counselling and nursing staff with good demand generation in order to use surgeons' time efficiently. So the volunteer programme is linked with in country clinics that provide communications as well as clinic services. One challenge was to manage the transition from the sleeve (common method in Swaziland) to the forceps guided method (commonly used by providers in other

countries). There is a need to maximize the use of local resources including expatriated Swaziland nurses. Whether this is a scaleable solution remains to be seen.

Assessment of feasibility of introducing a volunteer programme in Namibia

Justin Nyando summarized the experience with conducting an assessment to prepare for a volunteer programme in Namibia. The objectives were: to assess selected sites to receive volunteers, to provide technical support to introduce the volunteer program and to identify areas that need strengthening. The team consisted of WHO consultants, MoHSS and development partners who visited 5 health facilities to assess facility space, staffing, equipment and supplies, logistics, client willingness. The findings included that all facilities had space that could be made available full time and doctors performing MC were available in all sites. These sites had a team comprising of at least a doctor and two nurses to perform circumcisions. The main obstacle was the limited time to perform the surgery due to competing demands from other case workload. Generally equipment was available, but more MC kits would facilitate the work. A latent demand for services exists without any demand creation (6 month waiting list) but a maximum of five operations per week were being performed.

The volunteer hosting facilities were fine, and experience with successful volunteers for other purposes such as Operation Smile and Eye Camps had been positive. There will be a need to ensure the availability of the patients in advance of the volunteer team arriving on site. Other preparations could include better layout of counselling and waiting room space. Currently it is hoped that the first mission would be done by October 2010. MoHSS was making relevant preparations by training dedicated staff and nurses and equipping the surgical facilities.

Currently there is not information on the cost-effectiveness of this approach compared with other approaches to expanding service delivery, but it will be assessed at a later date. One of the motivations for developing the volunteer programmes was the absence of sufficient qualified and available people in country to be trained and provide service delivery.

Task shifting and task sharing:

experiences from other services and country examples from male circumcision programmes

Panelists: Peter Cherutich, Vusi Magagula, Kelly Curran

Kelly Curran opened the panel by suggesting that task-shifting was a negative concept and preferred “empowering nurses and other non-physicians to provide life-saving services”. She mentioned examples of nurses successfully giving ART, cryotherapy for treatment of cervical lesions, neonatal resuscitation, and nurse-midwives trained to perform emergency caesarean sections and insert the intrauterine device. She challenged the claim that nurses did not have the resources or time to take on new tasks, and gave the example of nurses in South Africa welcoming the opportunity to dispense life-saving ART. The published research showed that clinical outcomes were just as good, if not better, with specially trained nurses performing procedures. Walter Obiero also raised examples of successful nurse-initiated ART. In Kenya the Director of Medical Services had formally permitted appropriately trained nurses to perform male circumcision surgery. Vusi Magagula (Swaziland) underlined the WHO estimates of critical staff shortages in many countries including his country which has a chronic shortage of health personnel. Nurses are used successfully to provide many health services. There was considerable training of nurses over the years, but most are now working in other countries. The health system had almost collapsed in 2001 when a large number of nurses were recruited to work in the UK

In discussion, it was highlighted that task shifting to other health care providers needed to be done in a sensitive manner, and should be a partnership between different cadres of workers. There were also some national laws that needed to be respected as these may prevent task shifting to lower cadre workers (example from Uganda). It was suggested that the training requirements were over emphasized and much resistance to task shifting was among professionals. Acceptability of female providers was not a problem to perform the surgery. It was more of an issue for the traditional practices and ceremonies around traditional circumcision. There had been no problem in Kenya with female providers performing circumcisions, and suggested that there was no reason that it should be a problem in other countries. One of the reasons for collapsing health services in Africa was the devastating epidemic. Any investment in task shifting to accelerate male circumcision would contribute to reversing the HIV epidemic and was therefore appropriate.

Standardization in the services offered and the remuneration provided by the different organizations or implementing partners was raised. The salary differentials between NGO and private sector and the public health services along with better working conditions attracted trained and qualified staff. The 'brain drain' problem within countries occurs as staff move from one NGO partner to another, or shift from the public to the private sector.

Research highlights

Overview of research at male circumcision clinical trial sites

Bertran Auvert briefly described the current research activities in Orange Farm South Africa. The main aim is to roll out male circumcision for HIV prevention to the community where the trials were conducted and to study effects on community behaviour and HIV incidence. The sample size is 200,000 people. Methods include three cross sectional surveys with questionnaires and genital examinations (to be completed by 2013). The baseline circumcision rate is 15%. Research questions are:

1. compare those who are coming for male circumcision against those who do not
2. assess effect of male circumcision on sexual behaviour
3. assess effect of male circumcision on HIV among women
4. assess the effect of roll of male circumcision on HIV incidence

Mores Loolpapit provided an overview of research activities in Kenya. The original site for the randomized controlled trial by UNIM has been expanded into the UNIM Research and Training Centre. The main objectives of the centre are to:

- Assess behaviour, attitudes, beliefs and acceptability of male circumcision in Nyanza Province
- Evaluate the impact of male circumcision on sexual risk behaviour and rates of HIV
- Assess the safety of male circumcision services to identify ways to improve and expand services
- Assess the potential for private sector providers, clinical officers and nurses to provide safe, high quality MC services
- Determine the viability of using outreach services to enhance access to safe MC

Additional studies being done include:

- evaluation of safe voluntary infant MC (The Mtoto Msafi project)
- assess text messaging to improve follow up
- evaluate the Shang ring
- evaluate HIV and STI in a post randomized controlled trial cohort

- assess post surgical wound healing
- assess communicating partial protection of MC.

Adrian Musige described current male circumcision related research at the Rakai Health Sciences Programme in Uganda. It focuses on three areas. First they are assessing community effects of MC on the HIV epidemic, including:

- a. Post trial community surveillance: acceptance and sexual behaviours, impact at individual and population level
- b. Relevant clinical research: healing by HIV status, surgical stress and HIV viral load and HIV shedding from surgical wound
- d. Foreskin inflammation and mucosal immunology

Second, they are conducting post trial surveillance on HIV and STIs such as in situ analysis of HIV transmission in the foreskin and earliest events and virus-host interactions in HIV transmission and HPV studies. Third, they are assessing genital anaerobes, inflammation and their association to HIV risk in Rakai population such as the correlation between the burden of genital anaerobes and inflammatory markers in HIV negative men and their female partners.

Early infant male circumcision

Rebeca Plank described the research underway on early infant male circumcision in Botswana. One WHO recommendation is for culturally acceptable, neonatal circumcision among HIV negative males because it is easier, safer and less complicated than circumcision for young boys, adolescents and adults; it is cheaper, there is no risk of sex before wound healing, and there is no loss of time from work or school. Most mothers in a small study (92%) accepted the idea of male circumcision for their neonates. Their main concern was for HIV protection and other infections. The current study will assess actual uptake of neonatal MC, barriers to MC uptake and estimate efficacy of various devices (Plastibell or Mogen). The study assesses actual acceptance, safety, and sustainability. Future directions will assess the AccuCirc which is a one-time use device, like a bell, that is not retained on the penis. In general, neonatal MC is acceptable and safe. Sustainability depends on timing of the procedure as these effects outcomes.

David Linyama described research underway in Zambia where neonatal MC is done by a very small proportion of the population (primarily among Muslims, Jews and West Africans). Childhood male circumcision was assessed as acceptable by 80%. The Centres for Infectious Disease Research in Zambia with the MoH and University of Alabama collaborate on studies about infant MC. The main objectives are focused on knowledge, attitudes and practice surveys among parents, determination of uptake of neonatal MC among parents of newborn boys, and evaluation of the knowledge, attitude and practices among providers trained in neonatal MC and assessment of skills and preferences among three methods. Secondary objectives are to evaluate the number and severity of complications, evaluate and document logistical difficulties, and assess satisfaction after the procedure. Key challenges are poor uptake; the confinement period of babies when mothers do not want to bring babies back for NMC; parental refusal to be randomized, for example the Plastibell was refused as a method by the Muslim community; poor uptake at large hospitals as compared to local clinics; and poor understanding of neonatal MC by communities. Plans are to reach the enrolment target, support NMC expansion, develop a sustainable model; and advocate for early infant male circumcision.

June Odoyo described research in Kenya, specifically implemented in three districts in Nyanza province. The research is currently in early stages (began September 2009) as part of the Mtoto Msafi Project. Operational research aims to evaluate demand, parental

decision making around early infant male circumcision and safety of procedure by nurses and clinical officers. The study will also assess demographic characteristics, belief and attitudes of parents accepting the procedure and adverse events. The target population is babies 0 – 60 days. A pilot study was initiated in September 2009. Service providers in public health facilities were trained to provide services using the Mogen Clamp. To date there have been 178 MCs performed with very few adverse effects – 1.3%; follow up was 54.3%. The key challenges are relatively low uptake, turning away infants greater than 60 days, concerns regarding the timing and feasibility of rituals for infant MC when it is done in health facilities, poor compliance with instructions on follow up visits, desire for compensation by MoH staff for additional work.

Experience of monitoring male circumcision services in Nyanza Province

Amy Herman-Roloff described the passive and active surveillance study in Kenya to look at post-discharge adverse events (AE). From the clinical information system, about 3,200 MC clients approached for MC, 3000 enrolled and 2675 were circumcised. The HIV positive rate was 2.8%, 33.2% were negative, 64% unknown status. About 71% of MCs were done by a medical officer or a clinical officer and 30% by nurses. Government staff provided 12% of MCs; the adverse event rate during MC was under 1% and 52% of clients returned for follow up.

For the active surveillance system, 1,050 clients were randomly selected and interviewed at home. Nearly all (99.9%) were satisfied with MC and 90% had an adequate amount of foreskin removed on examination. About 90% healed at 30 to 40 days. One-third had initiated sexual activities prior to healing. Among those interviewed who had resumed sex early, by the 4th week 71% had done so, and yet almost 10% were not healed at the interview exam. Married men engaged in early sex more often (69%) compared to unmarried men.

Client-reported AEs of moderate or severe category was 14.5%, and 8.6% received treatment. Among men with AEs who were actively followed up, factors associated with risk of AE were: MC performed by a clinical officer or medical officer had reduced odds of infection compared to nurses; and if performed by Government staff were more likely to have experienced an AE. Nurses and Government of Kenya staff may not have performed enough procedures to reach a level of expertise for lower rates of AEs. 300 GoK staff has reportedly performed an MC and on average they have done 300 total procedures. There is a need to consider further training approaches, supervisory visits for newly trained staff, additional certification after for example performance of 100 MCs. Preliminary analysis showed a protective effect with frequent bathing.

A two to three fold difference in adverse events was noted between passive and active systems which could be due to correctness of reporting (exam versus self report) and clients' perceptions. As men who have had a circumcision can be good mobilizers, adverse events - or perceptions of - could effect recruitment. Improvements in training are needed regarding the amount of foreskin to remove, frequent bathing, and counseling about the abstinence period. The next step is to complete preliminary analysis and make findings available.

A question was raised about pain, which was assessed using 0 to 10 subjective scale. In active surveillance system, if pain is included in adverse events then there is a 21% rate. Both Government of Kenya and implementing partners' procedures were done at the same facilities. Active follow up is important at this stage as it does allow weaknesses to be identified and actions to be taken such as improving training and supervision. A supervisory system has been formalized with teams that go out regularly to look at forms

and observe quality. There is a need for a mix of surveillance types given 3-fold higher adverse events identified in active surveillance.

Male Circumcision Devices

The Shang Ring acceptability study and future research plans

Mark Barone presented research about the Shang Ring conducted in 2009. He described the Shang Ring including the need for a measuring tape to determine the device size to be used. This device results in minimal bleeding; it remains on the man for 7 to 10 days, and then the man should return for removal which is done by cutting open the rings.

A prospective, non-comparative study was conducted in collaboration with Cornell University and the Kenya MoH in Nyanza Province to assess safety, efficacy and acceptability of the Shang Ring among HIV-negative males from 18 to 54 years old (forty participants). Follow up exams occurred on days 2, 7, 9, 14, 21, 28, 35 and 42. The mean time for the placement (minus anaesthesia) was 4.8 minutes. No adverse events were noted during the procedure. The mean time for device removal was 3.9 minutes. Pain was mainly associated with removal of the inner ring; no serious or moderate adverse events were observed. A total of six adverse events included mild oedema, pain, swelling and minor cutaneous injuries. The main device hazard observed was partial detachment of the ring but no treatment was required. All men indicated that they would recommend the Shang Ring. In summary, the Shang Ring was safe, easy to use and acceptable in this study population.

This research lays the groundwork for other clinical studies in Africa. Planned studies include assessing the needed time to removal, a RCT comparing Shang Ring to WHO recommended surgical methods and demonstration projects in clinical settings with adverse events monitoring. The number of providers needed to apply the ring initially is two, but with increasing skill a single person can apply the device.

Framework for evaluation of male circumcision devices

Tim Farley provided a brief on the framework for evaluation of MC devices that was developed from an expert consultation held in 2009. Devices are potentially faster, simpler, more acceptable, and require a lower level of expertise compared to surgical methods. Several devices have been used and documented among infants and boys, but not among adults in Africa. The progression of studies should be:

- Clinical studies by skilled surgeons in country of manufacture
- Clinical studies by skilled surgeons in country of intended use
- Comparative clinical studies as above, in low resource settings
- Field studies by trained clinical personnel in low resource settings

WHO recommended devices for babies and infants are described as in the WHO/Jhpiego manual and include the Gomco clamp, Plastibell and the Mogen clamp. At present further data on the TaraKlamp need to be collected before the device can be recommended.

Costing: comparison of findings across countries

Male Circumcision Costing and Impact Studies - Overview and methodology

Cate Hankins gave an overview of the development and implementation of the Decision-Makers Programme Planning Tool (DMPPT) which was based on consensus from different cost-effectiveness models. On average, one HIV infection would be averted over a 10-year time frame per 5-15 circumcisions performed; the cost per infection

averted is estimated at about USD150 - 900. The DMPPT models estimate cost and impact of different scale-up time frames and targeting strategies. Teams of consultants, led by The Futures Institute and the UNAIDS Technical Support Facility, have applied the model to all 13 priority countries by inputting data on the country's demographics and HIV epidemic dynamics, including costs from standard sources or country-specific facility-based data. The tool has the capability to vary different parameters of the epidemic and costs, and can assess sensitivity of conclusions to key unknown parameters.

Using the DMPPT: Lessons learned from USAID desk review

Emmanuel Njeumehli reported on the lessons learned from a desk review performed to apply the DMPPT in 14 countries in eastern and southern Africa. The objective was to estimate the cost and impact of implementing male circumcision in the 14 countries. The desk review used readily available data for the impact component of model, using standard unit costs or country-specific data where available; elsewhere average unit cost of adult MC was set at USD 37.

The main scenario was MC coverage to 80% within 5 years for adults and neonates. Implementation scenarios varied over the following time frames: 1, 5, 10, 20 years; coverage varied at 50%, 70%, 80% and 100%. In the main scenario, 28 million men need to be circumcised, reaching a maximum of 12M in peak year. This would avert over 4 million new HIV infections over a 10 year period, or 36%. The model shows that scaling up implementation over a short time period results in greater impact than a slow rate of scale up. Overall costs estimated were USD1 billion over 5 years, resulting in an overall cost saving of \$23 billion by 2025. In high HIV prevalence countries the costs per infection averted were low (<USD 500) while countries with lower HIV prevalence had higher costs per infection averted. The model could be extended to include sexual mixing and other more flexible components of programme scale up.

Results from the DMPPT were used to underpin the change in policy in Swaziland to saturate the country within 1 year. In summary, male circumcision is a highly cost-effective intervention, the impact is greatest if programme scale-up is rapid, and countries should consider targeting groups at higher risk of HIV infection for maximum impact.

Using the DMPPT: Preliminary results of country costing exercises

Urbanus Kioko presented the preliminary results of applying the detailed DMPPT costing exercise in Zambia, Kenya, Uganda and Zimbabwe - countries that had ongoing programme scale up and for which objective costing data could be derived. Sites were selected to be surveyed for determining accurate costs of the different services (range of 4 to 30 sites per country). Costs were obtained for fixed, outreach and mobile sites, included salary elements, overhead, facility costs, indirect costs and consumables. Costs varied from USD 36 - 58 per client; as scale increases, cost is reduced.

The study limitations include that it was not possible to objectively determine the costs of demand generation and community mobilization, training and management costs, exclude the costs (and contribution from) traditional male circumcisers, or address how unit costs might vary with different service delivery models. This preliminary analysis requires validation. While estimates will be useful for planning, the exercise will need to be updated with better cost information as programmes are expanded.

A large difference in costs was noted between urban and rural areas which were primarily due to the overhead, fixed and capital costs. Costs of non-HIV related benefits had not been included and this would be a more complex modelling. No comparison is

possible at present on the difference of costs from a facility review and desk review; but it was noted that the desk review costs had serious limitations and did not include all the elements that needed to be included and modelled in the programme scale up. In Ethiopia, as in Kenya only data from one province had been considered. In countries with a mixture of high and low circumcising communities, not including this element would lead to seriously misleading results.

Procurement, Logistics and Supplies

Sameer Sakallah described the kit development process and stressed that kits were not designed by the US Supply Chain Management System (SCMS) but based on consensus between many organizations. SCMS led in the development of the kit, procurement and supply chain management. The kit composition cannot be substituted. Several kit options are available, and additional supplies may also be purchased, for example for infection prevention and waste management. For the first kit, eight vendors were initially identified, 5 submitted bids and kits, 2 passed the quality checks for sterility, and finally one was selected. Four countries have ordered through this system and a fifth is considering. SCMS provides a 'one stop shop' including forecasting, technical assistance and collaboration on solutions.

Owen Mugurungi, Zimbabwe MoH, outlined the logistics cycle as well as the background in Zimbabwe and the anticipated need for 56,000 procedures over 12 months at 22 sites. The commodities cost is estimated at about 44 USD per procedure in the first year. Forecasting was done with MoH, PSI and SCMS; procurement is underway through SCMS in support of programme scale up (July 2010 to June 2015). Storage and distribution is through the national systems. To ensure continuity of equipment, three categories were created (equipment, replenishable items, sterile kits). Staff will be trained on forecasting and logistics in order to support continual resources.

Tackling challenges and addressing long-term sustainability

Feedback from the round table discussions, Day Two

Group One. The first group reported on their discussions on service delivery and human resource issues.

- Service delivery issues
 - Task-shifting is an opportunity but depends on the local context and resources. Legal barriers may prevent this option, but other countries experiences show that changes are possible
 - Peer-to-peer pressure, learning and sharing are key to unblocking barriers
 - Regional cooperation should be strengthened to support diverse service delivery options
- Identifying human resources is critical as shortages are faced in all countries.
 - Where existing health care workers are fully extended, consider external human resources
 - Garner local health care workers through diverse incentives
 - Better to use unemployed in-country health care workers than bringing in foreign experts.
 - Involve community health workers for selected tasks such as sensitization
 - Involve the private sector: consider how to support them to provide minimum service package, quality of services, cost subsidies.
 - Traditional circumcision providers. Where they exist:
 - build bridges and include as part of country's long term solution
 - address cultural factors including involvement of community leaders and politicians
- Early infant circumcision needs to be built into programmes but it is not urgent.

- Conduct research and demonstration service to understand how to implement: age, procedure, type of personnel, context of mother's health care seeking patterns.

Group Two. The second group reported on their discussions around service delivery approaches to scaling up. They highlighted the five approaches identified thus far:

1. Fixed/static site services: stand alone and integrated
2. Outreach site: primary care level with services on designated days and community sites
3. Mobile sites, on an as needed basis
4. Mass campaigns
5. Private providers

They mapped out challenges/constraints and opportunities to each approach. Key next steps Group Two identified included:

1. Collate best practices to be shared across countries
2. Develop a framework/start up pack for integrating MC into existing services
3. Better incorporate targets into national and provincial targets
4. Improve training: pre- and in-service, including specific training on follow up
5. South-to-south collaboration, such as mass campaigns; databank on human resources
6. Engage more with private sector

Group Three. The third group's discussion focused on three health systems issues.

- Human resources.
 - Key challenges and constraints identified were: insufficient and inadequate HR for MC (quantity, quality and mismanagement / maldistribution); retention of health care workers due to remuneration, low motivation to include MC into normal work day because of competing priorities; inadequate investment in HSS including human resources such as not meeting the 15% budget allocation as recommended.
 - Solutions were mapped around a two prong perspective:
 - A '5 year catch up strategy': maximize in country human resources available, consider shifting of tasks, retirees, split and dual employment, efficient use of donor funds for staffing, improving in service education
 - Medium and long term strategy- improve pre service education, consider mechanisms to motivate HCWs such as career ladders.
 - Opportunities identified include: efficient use of existing funds, south-to-south collaborations, political will for more human resources, use of lay people and traditional circumcisers
 - Next steps:
 - strong advocacy for task shifting and sharing in country specific context.
 - mobilize resources, including GFATM and PEPFAR
 - coordinate and collaborate with partners
 - identify efficient mechanisms for intensive training.
 - review human resource management strategies to be able to draw on local resources
- Procurement, logistics and supplies
 - Key challenges and constraints: limited resources for secure supply and quality products; supply chain management is weak and potentially parallel; rigid procurement regulations
 - Solutions identified: advocate for reduced costs and consider economies of scale, improve management of commodities through training, ensure quality of products
 - Opportunities: bulk purchase of quality assured kits, use existing systems and funds, shorten the supply chain through local procurement.

- Next steps proposed: forecast supply needs, advocate for reduced costs, make available catalogue of supplies, explore local procurement and packaging, provide logistics management training.
- Monitoring and evaluation
 - Key challenges and constraints: limited structure and system including electronic systems and no unique identifier system; poor reporting of MC activities and adverse events including from private and traditional providers; lack of standardized and harmonized reporting tools; no indicators in HMIS on MC.
 - Solutions identified: further training on MC ME, support the use of standardized reporting tools and system, incorporate monitoring indicators into HMIS
 - Opportunities: make use of current HMIS, adopt minimum set of indicators for MC ME
 - Next steps: M&E framework including planning should be developed in each country, training to be conducted in country.

Overview of donor funding for male circumcision programme scale-up

Heather Harrison described that Gates has provided USD 52 million to date including country specific (Botswana, Zambia, Swaziland) and cross cutting activities (device development, evaluation and research, international norms and guides). The total committed through 2013 is USD 98 million. The approach of Gates is to take risks and fill gaps that others won't, maximize leverage, maximize flexibility, and exploit comparative advantages. The future strategy will focus on male circumcision along with five other focal areas. The objective is to support the rapid scale up of early infant and adult male circumcision in target countries as well as short term bridge funding, but not long term service delivery dollars.

Emmanuel Njehumeli described the PEPFAR programme including MC as a component of a comprehensive prevention programme in sub Saharan Africa. PEPFAR is transitioning to a two pronged assistance approach: support immediate demand for MC and allow governments to develop policies and infrastructure for more sustained service delivery. Future directions will focus on efficiency (clinical and programme, technical assistance, operations research) and accelerated saturation of populations (Swaziland example). The activities will include: advocacy, service delivery, communication, monitoring and evaluation, quality assurance, operational research, impact evaluation

Planning for sustainability of male circumcision programmes: Panel Discussion

Panellists: Bennett Fimbo, Heather Harrison, and Emmanuel Njehumeli.

A key point from the national perspective by Bennett Fimbo was that medical male circumcision will only have a long term impact if services are developed in a sustainable manner; and planning must take into consideration the factors that facilitate sustainability. Key facilitating factors for sustainability are advocacy; appropriate leadership from national and UN family members, strategic planning, integrated implementation approach including leveraging all MC service delivery sectors, partnerships and innovative implementing approaches that reflect a mix of vertical and integrated approaches. Advocacy is needed at all levels for consensus building. Supportive leaders advocate and set policy that enables implementation. Strategies for MC must complement or be integrated in HIV prevention strategies. Leveraging all service delivery sectors is vital - including private and public. External resources are available for at least one to three years but it is important to diversify the source of funding, including increased domestic commitment and incorporating male circumcision into the Global Fund proposals. For Round 10 at least four countries are submitting proposals (Botswana, Tanzania, Zimbabwe, and Uganda).

Emmanuel Njehumeli, USAID, reiterated the need for a two approaches that includes a catch-up phase in the short term and incorporates male circumcision services into

routine health systems in the medium and long-term. It will also be important to manage effectively resources for adolescent/adult and early infant male circumcision. Heather Harrison, Bill and Melinda Gate Foundation, stressed that the sooner this intervention is scaled-up, the more cost effective it will be, and that 'prong 2' of incorporating into the routine health system will become the main area of work. She also reiterated the argument for rapid scale-up: that reduced infections will impact on the health systems by minimizing the treatment and care services that will be required.

Closing comments

Cate Hankins, UNAIDS, thanked everyone for the rich conversation in and outside the meeting sessions. She called for increased action to ensure that male circumcision programmes realize their potential impact. She complemented the excellent network and cross-country support – these networks should be exploited and use their potential to help unblock political or logistical barriers. Male circumcision is one programme, but soon there may be competition in the prevention space with PrEP, microbicides, ART as prevention and hopefully vaccines. But male circumcision is a clear intervention to implement and expand. She stressed that the outcomes of the male circumcision intervention are being watched globally for effectiveness and safety.

Kim Dickson, WHO, highlighted that good progress had been made, strong commitment and dedication of partners and donors is evident including those strong partnerships that exist in countries. Innovative strategies are being put forward and much experience has been shared that provides more opportunities. Now there is a need to accelerate progress with male circumcision scale up in order to realize the impact. Kenya and Swaziland have shown commitment and led the way. Substantial sums of money have been put forward to support male circumcision scale up, but countries must put male circumcision into their Global Fund proposals, as not many countries present have yet included MC in their funding applications. The posters were excellent contributions to the meeting. It is critical that countries increase the numbers of safe male circumcisions over the coming year. She offered prizes to the countries that have made the most progress in service delivery by the next meeting. Next immediate steps include: complete and make available the meeting report, upload the presentations and posters on the Clearinghouse for access by all. Further coordination and collaboration will occur over the next year to move forward on key actions identified.

Countries teams expressed gratitude for the organization of the meeting and that this had been a great learning experience. The sharing of lessons is appreciated and they are inspired by the various initiatives in neighbouring countries. The goal by the next meeting is to see increased numbers of male circumcisions so that we start to see decreased numbers of HIV infections. Countries believe that it is possible with the partnerships involved. The need for concerted effort remains to move from policy to action. Tanzania closed the meeting by challenging all countries and participants to commit themselves to averting HIV infections now but also as an investment for the future.

Appendix I: Meeting Agenda



Scaling-up male circumcision programmes in the Eastern and Southern Africa Region

**Country update meeting
to share lessons, explore opportunities
and overcome challenges to scale-up**

Arusha, Tanzania, Tuesday 8 – Thursday 10 June 2010

AGENDA

Tuesday 8 June:

Day 1 Time	Topic	Chair / presenter
08:30 – 10:00	Opening of meeting Welcome address by senior MoH official of host country Welcome remarks WHO Representative Objectives and overview of the agenda Participant introductions and expectations (by country delegations) Global overview of the evolving HIV epidemic and the importance of male circumcision within context of HIV prevention and treatment scale-up: past, present and future	Rufaro Chatora Kim Dickson Catherine Hankins
10:00 – 10:30	Tea Break	
10:30 – 11:20	Country updates: Expanding service delivery: Kenya, Swaziland, Zambia	Chair: Awene Gavyole Peter Cherutich, Vusi Magagula, Wezi Kaonga
11:20 – 12:30	Discussion From pilot to scale up: Botswana, Tanzania, Zimbabwe Discussion	Janet Mwambona, Pascience Kibatata Sinokuthemba Xaba
12:30 – 14:00	Lunch Break	
14:00 – 14:45	Country updates: From strategy to implementation: Namibia, Malawi, Rwanda, Uganda Discussion	Frieda Katuta, Amon Nkhata, Ange Irakoze, Alex Opio
14:45 – 15:00	Overview of global male circumcision tools and guidelines and Male Circumcision Clearing House Introduction to the Market Place	Julia Samuelson
15:00 - 16:00	Market Place Poster discussions: sharing country experiences	Country Teams
16:00 - 17:00	Market place of tools and guidelines	
19:30	Karibu Reception: Dinner/Dance	

Wednesday 9 June

Day 2	Topic	Chair / presenters
08:30 - 09:30	Approaches to scaling up male circumcision services: Overview of different approaches to scale up <ul style="list-style-type: none"> • Rapid Results Initiative: Kenya • Accelerated Services Initiative: Swaziland 	Chair: Faith Dlamini Kawango Agot Ayanda Nqeketho
09:30 - 10:30	Discussion <ul style="list-style-type: none"> • Dedicated stand alone services: Bophelo Pele Clinic (South Africa), Litsembe Letfu Clinic (Swaziland) • Military and uniformed services: Overview of Military Programmes in southern and eastern Africa Zambia Police Services Programme Discussion	Dirk Taljaard Gladys Magongo Anne Thomas Martin Malama
10:30 – 11:00	Tea Break	
	Innovations and Challenges to Implementing the Minimum Package of Services:	Chair: Bennett Fimbo
11:00 – 11:30	HIV testing issues: <ul style="list-style-type: none"> • HIV testing uptake pre- and post-circumcision: Tanzania, Zimbabwe • Management of HIV+ men: circumcision, referral to care: Orange Farm 	Hally Mahler; Karin Hatzold Josephine Otchere-Darko
11:30 - 12:15	Panel Discussion: Zimbabwe, Kenya Male Circumcision Consortium, WHO Country Focal Person	Sinokuthemba Xaba, Walter Obiero, Kanyanta Sunkutu Hally Mahler, Josephine Otchere - Darko
12:15 - 12:30	Traditional male circumcision: Recommendations and key points from the sub-regional consultation	Xola Kanta
12:30 – 14:00	Lunch Break	
	Communications and demand creation	Chair: Catherine Barasa
14:00 – 14:40	Overview of Male Circumcision Communications with Zimbabwe and Swaziland country case studies Discussion	Oscar Mundida, Gladys Magongo
14:40 - 15:00	Technological innovations to engage clients - SMS-based models: Discussion	Amy Herman-Roloff, Steven Gesuale
15:00 -15.15	Male Circumcision Communications Strategy and Toolkit	Sibongile Dlodlu
15:15 - 16:00	Issues and actions to involve women and youth in MC programming Panel discussion	Cindra Feuer, Maria Natukunda, Edgar Makombe Mawethu Zita
16:00 – 16:30	Tea Break	

Day 2	Topic	Chair / presenters
	Innovations to service delivery and managing human resource constraints	Chair: Owen Mugurungi
16:30 – 17:20	MC - MOVE (Models for optimizing the volume and efficiency of services) Working with private providers in Ethiopia The MC Volunteer Programme: <ul style="list-style-type: none"> • Piloting in Swaziland • Assessment of the feasibility of introducing a volunteer programme in Namibia 	Dino Rech Abebe Bekele Ayanda Nqeketho Justin Nyatondo
17:20 - 18:00	Discussion Panel Discussion: Task shifting and task sharing: Experiences from other services and country examples from male circumcision programmes. Panellists: Kenya, Swaziland, Jhpiego Discussion	Peter Cherutich Vusi Magagula Kelly Curran
18:30 – 20:00	Round Table Discussions with Evening Reception <i>Male circumcision service delivery issues</i> <ul style="list-style-type: none"> • Service delivery approaches to scaling-up of MC services • Communications and demand creation • Implementing the minimum package of services <i>Health systems issues</i> <ul style="list-style-type: none"> • Human resources • Procurement , logistics and Supplies • Monitoring and evaluation 	

Thursday 10 June

Day 3 Time	Topic	Chair/ presenter
08:30 - 09:30	Research highlights: <ul style="list-style-type: none"> • Overview of research at MC clinical trial sites: South Africa-Orange Farm, Kenya - Kisumu, Uganda -Rakai 	Chair: Zebedee Mwandi Bertran Auvert Mores Loolpapit Adrian Musiige
09:30 - 10:15	Discussion <ul style="list-style-type: none"> • Early infant male circumcision: Botswana, Zambia, Kenya Discussion	Rebeca Plank, David Linyama June Odoyo
10:15 – 10:45	Tea Break	
10:45 - 11:10	Monitoring and evaluation: Experience of monitoring MC services: Kenya study Discussion	Amy Herman-Roloff
11:10 -11:40	Male Circumcision Devices: <ul style="list-style-type: none"> • The Shang Ring acceptability study and future research plans • Framework for evaluation of male circumcision devices Discussion	Mark Barone Tim Farley
11:40 – 12:30	Costing: comparison of findings across countries <ul style="list-style-type: none"> • Male Circumcision Costing and Impact Studies: Overview and methodology 	Chair: Nick Deluca Catherine Hankins
12:30-13:00	<ul style="list-style-type: none"> • Using the DMPPT: Lessons learned from USAID desk review • Using the DMPPT: Preliminary results of country costing exercises 	Emmanuel Njeuhmeli Urbanus Kioko
	Procurement, Logistics and Supplies <ul style="list-style-type: none"> • Supply Chain Management and Male Circumcision Commodities • Male Circumcision Supply Chain System of Zimbabwe Discussion	Sameer Sakallah Owen Mugurungi
13:00 – 14:30	Lunch Break	
14:30 - 15:00	Tackling challenges and addressing long-term sustainability Feedback from round table discussions	Chair: Rex Mpazanje
15:00 - 16:00	Overview of donor funding for male circumcision programme scale-up 2008 - 2010 Panel Discussion: Planning for sustainability of MC programmes	Emmanuel Njeuhmeli, Heather Harrison Alex Opio, Bennett Fimbo Heather Harrison, Emmanuel Njeuhmeli
16:00 – 16:30	Discussion Tea Break	

Day 3 Time	Topic	Chair/ presenter
16:30 - 17:15	Closing session Summary of key issues from meeting Next steps Closing	Kim Dickson remarks Cate Hankins Bennett Fimbo

Appendix II: List of participants

Scaling-up Male Circumcision Programmes in the Eastern and Southern Africa Region

Arusha, Tanzania

8 – 10 June 2010

COUNTRY PARTICIPANTS

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| <p>6. Samuel Ochola
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| <p>9. Amon Nkhata
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