Traditional Male Circumcision in the Context of HIV Prevention

A WHO/UNAIDS
East and Southern Africa Regional Consultation

13-15\textsuperscript{th} April, 2010

Glenburn Lodge,
Muldersdrift, Johannesburg, South Africa

Meeting Report
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Abbreviations/Acronyms

ABC Abstain, be faithful, use a condom
AE Adverse events
ASRH Adolescent sexual and reproductive health
DMO District medical officer
DO Designated medical officer
DOH District officer
ESA East and southern Africa
FGD Focus group discussion
Jhpeigo NGO affiliated with Johns Hopkins University
HIMS Health information management systems
IcFEM Interchristian Fellowship Evangelical Mission
M and E Monitoring and evaluation
MC Male circumcision
M-CHIP USAID’s maternal and child health integrated programme
MMC Medical male circumcision
MMCs Medical male circumcisers
MOH Ministry of health
NGO Non-governmental organization
RCT Randomized controlled trial
STI Sexually transmitted infection
TMC Traditional male circumcision
TMCs Traditional male circumcisers
UNAIDS Joint United Nations Programme on HIV
USAID United States Agency for international Development
WHO World Health Organization
1. Executive Summary

Background and Rationale
Since the publication of the randomized controlled trials that confirmed the observational data indicating that male circumcision (MC) is protective for the acquisition of HIV by men through heterosexual sex, there has been significant mobilization to increase men’s access to safe, affordable and effective MC. This mobilization has mostly focused on those countries, or regions of countries, where HIV prevalence is high and MC rates are low – predominantly countries in East and Southern Africa.

In nearly all of the countries with high HV prevalence and low MC rates, some MC is taking place among certain groups of the population, much of it during adolescence as one component of rituals that provide a rite of passage into manhood. As national MC programmes are being rolled out it has become increasingly clear that traditionally circumcising communities cannot be ignored if countries are to ensure that everyone has access to safe, affordable and effective male circumcision.

Overview of the meeting
In order to share, learn from and synthesize the experiences of countries where traditional male circumcision is taking place, WHO and UNAIDS organized an East and Southern Africa Consultation on Traditional Male Circumcision in the Context of HIV Prevention, from the 13th to the 15th April, 2010, at the Glenburn Lodge, Muldersdrift, South Africa.

The meeting brought together traditional male circumcisers, people providing medical male circumcision, representatives from governments, UN and non-governmental organizations responsible for male circumcision policies and programmes, and researchers. The participants were predominantly from East and Southern Africa (ESA) but also included a small number from countries in West Africa where traditional male circumcision is carried out, although this is predominantly done during the neonatal period rather than during adolescence.

The objectives of the meeting were to:
1. Improve understanding among key stakeholders about traditional male circumcision (TMC), and identify similarities and differences within the region;
2. Share and synthesize experiences with TMC from the Africa region, and identify lessons learnt/good practices for improving communication and collaboration between the health sector, TMCs and others involved in TMC rituals;
3. Identify effective approaches that countries have adopted to develop a systematic way forward for ensuring that TMC contributes to increasing access to safe, effective and affordable male circumcision for HIV prevention.

The overall process of the consultation included plenary presentations, and discussions in working groups and in plenary. The first presentations helped develop a common understanding among the participants of the current situation of MC in the sub-region, including TMC; the second session focused on countries’ experiences
of strengthening dialogue between TMCs and the formal health system, the third set of presentations and discussions dealt with efforts to improve the safety of TMC; and the fourth session added to this by focusing on the lessons learnt from experiences in the sub-region of linking MMC and TMC. The final session was devoted to developing consensus around a set of core recommendations, based on country experiences, and identifying next steps, including research priorities and the development of country plans.

**Key outcomes/recommendations**
In traditionally circumcising communities in ESA, TMC is an important cultural practice, although changes in attitudes are taking place in some communities and it will be important for Ministries of Health and others to be able to respond to these changes and ensure that people are able to realize their choices. While there are a number of similarities in relation to TMC in the sub-region, there are also many differences, which range from the age at which the circumcision is carried out to the willingness of communities to have the circumcision carried out by trained medical personnel. This has important implications for developing responses to TMC, in particular the need for decisions to be country and even community specific.

There was good consensus among the range of participants at the Glenburn consultation that there are some broad areas for action that need to be considered in order to ensure that all adolescents have access to a safe, effective, voluntary and pain-free male circumcision that will contribute to preventing them from acquiring HIV. There were also a number of examples from countries in the sub-region where significant progress has been made in relation to each of these priority areas for action:

1. **Improve the collaboration** between TMCs and the formal health sector, by increasing knowledge and understanding of traditional male circumcision, strengthening respectful dialogue and communication, and involving TMCs in a meaningful way in decisions that are taken about male circumcision and HIV prevention.

2. **Improve the safety** of TMC and its effectiveness for HIV prevention, through training, the provision of equipment, referral systems to ensure that complications are rapidly and effectively dealt with, and the development and implementation of regulations and certification.

3. **Improve the options** that adolescent boys have for accessing a safe, effective and pain-free circumcision by linking MMC and TMC, and providing opportunities for the circumcision to be done in medical facilities while retaining those aspects of the rite-of-passage ritual that are important for the cultural heritage.

In general, communities who practice TMC have not been seen as being a priority for improving access to MMC, since they are already being circumcised. However, the discussions during the consultation indicated that such communities should not be neglected, both in terms of increasing their access to MMC services, and also of improving the safety of TMC, through training, the provision of equipment and regulation.
TMC is a cultural ritual, and it is most unlikely that traditionally non-circumcising communities will want to adopt such a practice as a way of preventing HIV transmission, provided that there is access to MMC. The challenge for countries will be to ensure that in those communities where TMC is practiced the procedure and associated activities are safe and regulated; that in both non-circumcising communities and traditionally circumcising communities access to safe, affordable and effective MMC is available; and that overall there is adequate understanding and collaboration between TMCs, community leaders and the formal health sector, to facilitate collaboration and avoid conflict.

There were a number of over-arching themes that were highlighted in many of the presentations and discussions:

1. Give adequate consideration to different perspectives, priorities and practices, and be clear about the differences between MC for HIV prevention (and other health improvements) and MC as part of a cultural practice that includes many other associated rituals.

2. Work with communities, to listen to them, inform them, engage and empower them (including women, both as mothers and as wives/girlfriends). Information is required by many different groups in order to improve understanding and facilitate decision-making, including traditional leaders, TMCs, parents and adolescents, health workers.

3. Appreciate that it is often not a question of either/or, but more a question of balance: between cooperation and control, between formal and informal approaches to improving safety and strengthen linkages between the formal health sector and the traditional sector, and between self-regulation and national legislation. This has important implications for the development and implementation of policies and standards.

4. Develop relations between TMCs and the formal health sector that are two-way and reciprocal. MMC rollout has much to learn from TMC in terms of community support and demand, and TMCs may be in a good position to contribute in other ways to HIV prevention and to contribute more generally to the sexual and reproductive health of adolescent boys. At the same time, adolescent boys in traditionally circumcising communities should also have access to safe, effective and affordable MMC.

5. While much is known about TMC, much remains unknown about a practice that has been around for many years. If decisions are to be rational and based on evidence, rather than anecdote, there is an on-going need for research, and a number of research priorities were identified during the consultation, with short, medium and long-term implications.

During the final day of the consultation the participants worked in country teams to identify key activities that they would carry out in order to make further progress in relation to improving understanding, safety and cooperation, based on the challenges highlighted during the meeting and the experiences of other countries.
2. Introduction

2.1. Background and Rationale for a meeting on TMC

Following the publication of the results from the three randomized controlled trials (RCTs) that demonstrated 50-60% efficacy of male circumcision in preventing heterosexual HIV transmission from women to men\(^1\), male circumcision (MC) is now recommended as a core component of the comprehensive package for HIV prevention, with the main focus being on countries with high HIV prevalence and low MC rates\(^2\).

As a practice, MC is not new. Traditional male circumcision (TMC) has been carried out for many years for religious and cultural reasons, with the prevalence of the practice changing over time. TMC usually takes place either during the neonatal period and early childhood, often for religious reasons, and is common in West and North Africa, or during adolescence as a rite of passage, more common in East and Southern Africa (ESA).

Countries in ESA with high HIV prevalence and low MC rates are now rolling out medical male circumcision (MMC) programmes through clinical settings. However, in most of these countries varying portions of the population are already undergoing traditional male circumcision, the practice showing marked variations between and even within countries\(^3\). It is therefore important for Ministries of Health\(^4\) and others to have a clear understanding of the benefits and challenges associated with TMC, and to know how other countries have responded to the challenges in order to maximize the contribution that TMC can make to HIV prevention. Such understanding is important for the development of policies and programmes that ensure that adolescent boys have access to MC that is safe and pain-free, and contributes to the prevention of HIV acquisition.

2.2. Objectives and Participant Expectations

To this end, and within the context of the joint UN Work-plan on Male Circumcision for HIV Prevention, WHO and UNAIDS organized a regional consultation for Eastern and Southern Africa, with support from USAID M-CHIP, to stimulate and support country level discussion and action related to TMCs, with the following objectives:
1. To improve understanding among key stakeholders about TMC and identify similarities and differences within the region;
2. To share and synthesize experiences with TMC from the Africa region, and identify lessons learnt/good practices for improving communication and

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\(^1\) Add ref
\(^2\) Add ref
\(^3\) Data on TMC in many countries in the subregion are either weak or not available. Despite the fact that there is a question on MC in the DHS, this does not clearly differentiate why it was done or by whom.
\(^4\) The need to develop a better understanding of, and collaboration with traditional male circumcision was highlighted during the AFRO meeting on MC held in April 2008.
collaboration between the health sector, traditional male circumcisers (TMCs) and others involved in traditional male circumcision rituals;

3. To identify effective approaches that countries have adopted to develop a systematic way forward for ensuring that TMC contributes to increasing access to safe male circumcision for HIV prevention.

During the initial session of the consultation participants shared their expectations for the three days, which were summarized as follows:

1. To identify ways to maximize the contribution of TMCs to HIV prevention, to support what is being done well (retain traditions and good practices, and recognize the important roles and contributions of TMCs) and improve what is not being done well;

2. To strengthen the capacity of TMCs so that they can improve the safety of TMC practices;

3. To explore approaches to transitioning to MMC while retaining traditions and engaging the wide range of people involved with TMC;

4. To strengthen links between the formal health sector and TMCs, including "formal rules of engagement", in order to strengthen collaboration, dialogue, integration and linkages between the biomedical and traditional approaches, in order to make TMC safe and minimize the problems;

5. To improve available data, policies, standards, training, funding and linkages with sexual and reproductive health;

6. To share experiences and lessons learnt;

7. To support WHO/UNAIDS to make recommendations about TMCs;

2.3. Overview of the agenda: content and process

The meeting consisted of presentations\(^5\), plenary discussion, plenary brainstorming, and group work with plenary feedback and synthesis.

The meeting started with several presentations to set the scene, including an overview of the evidence for MC as a key intervention for HIV prevention; a presentation by a cultural leader to ensure that from the outset adequate recognition would be given to the need to understand the different perspectives that would be represented in the consultation; and an overview of some of the broad similarities and differences of TMC in the ESA region.

Following this, there were a number of presentations from countries that focused on their experiences of improving understanding about TMC through situation analyses, and approaches that had been made in countries to improve communication and dialogue between TMCs and the formal health sector. In addition to plenary discussion, there was then time in working groups to further share experiences and identify some "do's" and "don'ts" for improving collaboration with traditional male circumcisers, which were then shared and synthesized in plenary.

\(^5\) All of the presentations made during the meeting are available at www.malecircumcision.com
After a presentation that highlighted some of the challenges of assessing adverse events following TMC, there were then a series of presentations from countries that outlined their approaches to improving the safety of TMC and then a number of presentations that described how countries had strengthened the linkages between MMC and TMC, including strengthening MMC roll-out using some of the concepts of TMC, for example having contact with the adolescents before and after the circumcision. These presentations were followed by plenary discussion and group work, to provide an opportunity for further sharing of country experiences and discussion. The outcome of the working groups was then shared in plenary.

During the final day there was a brainstorming session on key research issues that require further attention, followed by some time for countries to work in groups to reflect on what they had learnt during the workshop and how they would use this when they returned.
3. Setting the Scene

3.1. Overview of TMC in the ESA Region
The meeting started with an overview of the evidence for male circumcision as a key contribution to HIV prevention [Kim Dickson, WHO], an outline of the WHO/UNAIDS recommendations on Male Circumcision that were developed from the research findings, and some of the activities that have taken place since the recommendations were drafted.

A traditional leader's perspective [Marx Mbunji, Traditional Leader Luvale Tribe Zambia]: a major challenge when strengthening collaboration between the formal health sector and the traditional sector is to ensure that there is understanding and respect for different perspectives. To this end the consultation started with a presentation on TMC from a cultural leader from the Luvale tribe in Zambia.

TMC is an important part of the cultural heritage of many communities in the ESA sub-region, with different groups having different stories that support the practice. In Zambia the story goes that long ago a man was attacked by a leopard. He survived the attack, but had injuries to his genital region. The wounds did not heal, despite the use of herbal remedies, so it was decided to remove the injured foreskin. Following this, not only did the wound heal but when he returned to the community everyone was impressed by the circumcised penis, and his wife enjoyed having sex with this circumcised man and boasted around the community so much that in the end the whole community adopted male circumcision as a general practice.

There are a number of tribes in Zambia that carry out TMC, and the circumcision along with the surrounding rituals, which last one month, are the passport to manhood. The circumcision is usually carried out on boys aged between 7-12 years old, and the associated activities contribute to character development and include a range of teachings, including the principles of sanitation. Circumcision at this early age helps to ensure good healing, and additionally it is prior to sexual activity. The benefits for the initiate are many, including defining his social role. HIV prevalence is generally lower among traditionally circumcising communities in Zambia, and HIV awareness is increasingly integrated into the teaching provided during TMC.

There are a number of people involved with the TMC, including the traditional surgeon (Chikeji), who is a respected personality held in high social esteem by the society, is very experienced, has equipment that is only used for circumcision, and develops a special relationship with the initiates. There is a significant support structure for the TMC: Chijika Mukanda (the host of Mukanda), Ngungu Mukanda (who oversees the ritual), Chikeji (the surgeon), Kafungu (the surgeon's helper), Chilombola (the nurse and tutor), Kalombwachika (the peer, social support system of already circumcised), and the Kandaji (the initiate). These traditional structures provide an elaborate aftercare service following the circumcision, and lifelong support for the initiate.
TMC is ‘a precious ritual that has been brought into the public domain’ and there is some ‘fear of cultural dilution’. The Luvale TMC has received a UNESCO proclamation for being a Masterpiece of Oral and Intangible Cultural Heritage of Humanity, which has implications for the preservation of this cultural practice, including the associated behavioural norms and values. However, there is a growing interface between traditional male circumcisers and formal health sector, including the provision of equipment that has been introduced into the traditional setting, and even in some instances anaesthesia that is given before the TMC by medical providers, who must be circumcised Luvale males (uncircumcised males and women are not allowed to participate in the procedure). Everyone is concerned to minimize adverse events and the presenter said that there had been ‘no deaths from circumcision in my community’ and that ‘concerns about safety were only from people who have not undergone the ritual’.

A public health perspective [Tawanda Marufu, WHO]: TMC occurs everywhere in ESA except for Swaziland and Botswana (discontinued in 1930). TMC differs in terms of rates, reasons, types, rituals, age, providers and cost. TMC is predominantly carried out as a rite of passage in ESA, and in addition to the characteristics of the circumcision differing, the time and content of the associated activities that take place before and after the circumcision differ.

TMC has clearly contributed to the results noted in a number of observational studies that have been carried out over the past 20 years that have demonstrated an association between male circumcision and lower rates of HIV. However, not all TMC is likely to be protective against HIV, because insufficient foreskin is removed among some groups. There is also some indication that activities surrounding the TMC, such as festivities, may increase the chances of HIV transmission.

Severe complications have been reported in relation to TMC, either as a result of the procedure itself or the related activities that take place during the period of seclusion following the circumcision. While some communities see advantages to the circumcision being carried out in a medical setting (while retaining the associated cultural practices) other communities are resistant to such changes. Overall, however, TMC is an important cultural practice that needs to be understood and responded to, as countries roll out MMC for HIV prevention. Dialogue between TMC and MMC needs to be a two-way process that capitalizes on the strengths of the two systems.

Improving understanding - situation analysis: several countries have carried out detailed situation analyses in the region in order to better understand TMC and identify approaches to strengthened collaboration.

In Tanzania [Wamburu Mwita, National Institute for Medical Research, Tanzania], HIV prevalence is generally lower in traditionally circumcising communities (the rate is 5.7% overall, ranging from 1.5% in Manyara, a traditionally circumcising community, to 15.7% in Iringa, a predominantly non-circumcising community). The
situation analysis was conducted in six regions, and included surveys, focus group discussions (FGDs), and a Service Utility Survey.

As with many countries in the sub-region, there are two types of TMC taking place: religious (Muslims, to confirm relationship with god, carried out by an Islamic circumciser) and cultural (a rite of passage, without anaesthesia to demonstrate bravery, and accompanied by extensive rituals). TMC takes place predominantly in the East of the country, although regions are not homogeneous, and the age at circumcision differs across different groups, depending on the reason (religious or cultural).

When carried out for cultural reasons there is significant social pressure to be circumcised, and it is carried out in clan-designated areas. Traditional circumcisers charge less than medical practitioners, with payment often being in kind, although in addition to financial benefits their motivation is also the respect that they receive from the community. This is also true for traditional leaders who also profit from TMC.

In terms of safety, rates of complications following circumcision are more than ten times higher when circumcision takes place outside clinical settings than in clinical settings. This is likely to be at the heart of the fact that in traditionally circumcising communities there are strongly positive attitudes towards MMC: 38% of traditionally circumcised males would like to be circumcised at health facilities, and 60% of those traditionally circumcised would like their sons to be circumcised at a health facility. Tribal identity has been much less important in Tanzania since independence, and as marriages between different tribes are possible this is likely to have had an impact on whether or not parents want their children traditionally circumcised.

There are no formal relationships between TMCs and medical providers, but complicated cases are referred, and health workers are sometimes approached for equipment. There is no legal framework for traditional circumcisers: the 2002 Traditional and Alternative Medicine Act excluded TMCs.

The situation analysis raised a number of issues that need to be taken into consideration when developing strategies for working with TMCs, in particular the importance of the social and economic interests of TMCs and the lack of models demonstrating that improvements in the safety of TMC are possible. The situation analysis also raised the question as to whether integration of TMC with the formal health sector is possible at all in Tanzania, and that co-existence is a more likely solution in the short-term, with the most probable scenario being the two systems working in parallel.

In Lesotho [Paul Phahlane, Traditional Circumciser], TMC takes place primarily as a rite of passage. It is carried out on 16-18 year old boys from June to December, with significant activities occurring before and after the circumcision: 3 months at home for preparation and 3 months afterwards in the mountains. There are significant
support structures: the chief of the area, the owner of the initiation school, the traditional doctor to protect initiates from evil spirits and witches, and other traditionally circumcised men and their families.

Training for traditional healers on TB and HIV has been carried out in Lesotho, but in 2002, as a result of growing awareness about the high rates of complications following TMC, TMCs agreed to collaborate with hospital (predominantly in terms of the provision of equipment). There are currently discussions taking place about the possibility of TMCs using the Tara clamp\(^6\).

In **Uganda [Leonard Bufumbo, FHI]**, there preliminary results have recently become available from a formative assessment of TMC in traditionally circumcising groups in the Eastern and Western regions of Uganda. District Health Officers directed researchers to clan leaders, who helped them identify the traditional male circumcisers.

In terms of the characteristics of TMCs in Uganda, two thirds had completed primary education and those in Eastern Uganda had already received training in infection and bleeding control, although there had been no training of those in Western districts, apart from the traditional systems of training: after ‘initiation’ (spirit possession, hereditary, graduation) and learning by observation.

There were perceived negative consequences by the TMCs of MMC rollout, fearing cultural demise, loss of livelihood, reduced access to circumcision for the communities due to distance to health centres and increased costs of MMC.

In terms of attitudes to safety, TMCs and clan leaders perceived TMC to be a safe practice in most cases. Unsafe aspects that were identified included unsterilized knives, sharing knives, transmission of diseases through blood contact, sprinkling fine baked dust on the penis or washing the penis in a river after circumcision, lack of post-operative care and overcutting. However, TMCs and clan leaders also perceived MMC as an unsafe practice, with anaesthesia being seen as a cause of impotence, and MMC potentially leading to amputation of the penis or excessive cutting.

Concerning interactions between TMCs and the formal health sector, TMCs sometimes provide circumcision in health facilities and medical personnel provide post-op care and treatment; medical providers treat adverse events; hospitals/health centers provide medical supplies to TMCs; health workers are available during the circumcision period to provide guidance on health related issues and oversee TMCs; and TMCs refer initiates to medical providers for treatment of diseases such as STIs and urethral disorders. There have also been recommendations for TMCs on the use of oral antibiotics for post-operative wound care.

Collaboration is clearly taking place, but could be strengthened (e.g. medical providers assisting with adverse events, TMCs providing MC in health facilities). It

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\(^6\) Note: the Tara Clamp is not currently recommended by WHO in view of the lack of evidence for its safety
was felt that it is important for their social role for the TMCs to be left intact during MMC roll-out, and that they could even be involved in certain aspects of the roll-out (e.g. the majority of TMCs and MMCs said that TMCs could help with counselling on HIV and condom provision). There is a need for gradually phased approaches, especially building on existing interactions.

In the **Western Cape, South Africa [Mthobeli Guma Anthropologist and Indigenous Healer]**, Sotho and Hlubi male initiation practices have changed over time to incorporate various aspects of biomedical science, especially recently with regards to HIV. TMC is practiced by a number of ethnic groups in the Western Cape (overall rates in the Western Cape: 67.5%, including circumcision for religious purposes).

TMC is now mainly performed between October and January (school holidays), the boy must be over 15 years of age; there must be approval and financial support from the parents or next of kin, and a cleared health record. Each boy has a sponsor - the criteria for being a sponsor is a person of significance in the community with a clean criminal record. In addition to the traditional male circumciser it is preferable for a traditional healer to also be available during the circumcision, as well as a team of elders and mentors, and a trained health educator. There is a reciprocal relationship between circumcision school sponsors and biomedical practitioners.

In the **Eastern Cape, South Africa [Xola Kanta, MC Trainer/Researcher]**, there has been Provincial legislation relating to TMCs for nearly a decade (Application of Health Standards in Traditional Male Circumcision Act 2001). This covers a range of issues, including designated medical officers (nurses, health promoters, environmental health practitioners have access to initiation schools); a parent/guardian consent form; a permitted age of TMC (18 years of age and above, although above 16 years of age it may be permitted if there is strong motivation from parents or guardian); a pre-circumcision medical exam; permission to hold a circumcision school (signed by the traditional nurse and a designated medical officer); and permission to perform a circumcision (signed by the traditional surgeon and a designated medical officer). TMC without fulfilling these requirements is now rare. Despite the regulations, however, there is significant morbidity and even mortality associated with TMC in the Eastern Cape - there were 91 deaths reported in 2009.

In addition to the TMC there is traditional nurse, who is a lay person (male), whose job is to look after the overall wellbeing of the recently circumcised initiate. Training of some TMCs has taken place, including contraindications to TMC. However there are challenges of having suitable places to set up the initiation schools, with crowding and sanitation being on-going problems. The complications associated with TMC are mainly due to after-care, for example over-tight bandages, or to the rituals associated with TMC rather than the circumcision itself. There have been cases reported of suicides at initiation schools after botched circumcisions. The fact that TMCs are often remunerated with brandy may negatively affect the quality of the circumcisions carried out by some TMCs.
3.2. Similarities and differences
There are a number of similarities between countries in terms of traditional male circumcisers and TMC:

- TMC is practiced to some extent in nearly all countries in the sub-region (except Swaziland and Botswana)
- A range of activities generally take place before, during and after the circumcision (with the exception of Namibia) and a range of different people are involved in the ritual (TMCs, elders, family, etc.)
- In TMC practising communities there is significant demand for circumcision and there are support and legitimization structures for TMCs
- TMCs are motivated by both community demand and their own social and economic interests (which has important implications for collaboration)
- Where it occurs, TMC is an important cultural practice, although cultures are not static and there is evidence of change
- Significant work has already taken place in most countries to better understand TMC and strengthen communication and collaboration between TMCs and the formal health sector.

At the same time there are a number of differences between countries, including:

- Rates of TMC within and between countries (tend to be lower in southern Africa, except for SA)
- Historical factors influencing TMC (cultural heritage, missionary influences)
- The rationale for TMC (religious, cultural)
- Selection of TMCs (hereditary, community, self-selected)
- Remuneration received by the TMCs (financial, in kind)
- Geographical location of TMCs (based in one community or moving from community to community)
- Training and supervision of TMCs by the existing support structures
- Setting for the TMC (under the tree, in secluded areas "in the bush", in medical facilities)
- Age when boys are circumcised
- Amount of foreskin that is removed
- Provision of equipment to TMCs (blades, gloves, antiseptics, bandages, antibiotics, anaesthetics)
- Training/orientation/"supervision" of TMCs by the formal health sector (safety, hygiene, health education including HIV prevention)
- Extent of complications following TMC and how they are monitored
- Systems for referral between TMCs and health services – the extent of the "reciprocal links" between traditional and biomedical practitioners
- Amount of formal/external "regulation" of TMCs (consent, pre-circumcision examination, accreditation, etc.)
- Whether or not there is an association of TMCs
- Willingness/resistance by TMCs to collaborate and change - attitudes of TMCs to MMC (and visa versa)
- Degree to which TMC communities do/do not want the circumcision done as MMC (while retaining the rituals)
• Degree to which TMCs are explicitly involved in HIV prevention

Some of the key differences between TMC and MMC that were highlighted in the presentations and discussions are summarized in the Table 1

Table 1: Key differences between TMC and MMC

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>TMC</th>
<th>MMC</th>
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<tbody>
<tr>
<td>Purpose</td>
<td>Rite of passage Religious reasons</td>
<td>HIV prevention</td>
</tr>
<tr>
<td>Contact with the circumciser</td>
<td>Long-term</td>
<td>Short-term</td>
</tr>
<tr>
<td>Activities surrounding the circumcision</td>
<td>Extensive, including after-care and on-going social support</td>
<td>Minimal: follow up for complications as required</td>
</tr>
<tr>
<td>Age</td>
<td>Adolescents and children Neonates</td>
<td>Any age depending on indication</td>
</tr>
<tr>
<td></td>
<td>Clearly culturally defined</td>
<td>For HIV prevention target group depends on the HIV prevalence</td>
</tr>
<tr>
<td>Standardization of training and equipment</td>
<td>Minimal/moderate</td>
<td>Extensive: use of sterile instruments, anaesthesia, complete removal of the foreskin</td>
</tr>
<tr>
<td>Consent/Assent</td>
<td>Family/community/cultural pressure/expectation(^7)</td>
<td>Individual informed consent, with parental consent if the initiate is a minor (plus assent of adolescent)</td>
</tr>
<tr>
<td>Involvement of women in the MC procedure</td>
<td>Only men provide the circumcision (although women may sometimes be involved in the ritual)</td>
<td>Men and women may provide the circumcision</td>
</tr>
</tbody>
</table>

\(^7\) Comment from one of the participants about consent for TMC: ‘I was not consulted when taken for formal education either’
While there were a number of examples in the presentations of ways in which the formal health sector could support TMCs, there are also a number of lessons to be learnt from TMCs that could be important for MMC rollout:

- The importance of strong community and family support
- Contact with the adolescent boys before and after the circumcision
- Seeing the circumcision as an "entry point" to help boys become men
- Ways to identify the boys in order to ensure that they are supported and do not start/resume sexual activity until they are completely healed following the circumcision (e.g. a unique hairstyle in Namibia).
4. Strengthening Communication between TMCs and the Health Sector

4.1. Challenges
A number of issues, challenges and questions relating to communication and dialogue between people involved with TMC and the formal health sector were highlighted during the first day. These included:

- The need to be clear about the difference between the circumcision and the rite of passage - they cannot necessarily be responded to in the same way, even by the same sector
- The need to understand the range of "providers" providing the circumcision in TMC, which has implications for training and regulation
- The need to ensure that there is adequate recognition and "space" given to the range of different perspectives involved in discussions about TMC.
- The need to consider both formal and informal mechanisms for collaboration
- The need to find effective ways to identify and involve TMCs in the development of MC strategies in countries

4.2. Country examples
In Zimbabwe [Sinokuthemba Xaba, Ministry of Health], significant work has already been carried out in relation to rolling-out MMC in the country. The national programme was initiated in June 2007 with work in the first 5 sites starting in January 2009. Over 5000 people have been circumcised to date. An MC policy has been launched, the MC costing exercise is nearing completion and strategy development is progressing.

Following initial meetings with TMCs in 2007, a situation analysis was carried out in 2008. This indicated that traditional circumcisers are concerned that MMC may "take away their culture". However, there is a desire by TMCs to be involved and a ‘If you don’t work with us, we will circumcise people anyway’ attitude.

In terms of strengthening dialogue with TMCs, they have been involved in all stages of the policy and programme formulation, with TMCs identified as core members of the MC Steering Committee from its inception, and being given the opportunity to make presentations at the first stakeholders meeting.

There have been positive responses from the health sector to requests from traditional circumcisers, and a significant amount of non-formal collaboration, in some instances with medical providers doing pre-circumcision HIV testing and counselling and the TMCs carrying out the circumcision. There have been some efforts to train and certify TMCs (the request for this certification coming from the TMCs themselves), media involvement to sensitize people about the positive aspects of TMC, and requests to traditional chiefs to make positive statements about MMC (in addition to a weekly radio programme on MC in general).
In Namibia [Mbayi Kangudie, USAID], TMC varies widely by region and is mostly restricted to several regions in the North of the country. TMCs went through a period of persecution in the late 90's based on their perceived role in HIV transmission, and as a result of this many went underground.

Although TMC is a cultural practice, it is not accompanied by rituals and is carried out on a younger age group than many other countries in the sub-region (1-7 years), predominantly for reasons of hygiene. TMCs inherit their skills from parents or relatives, and there are a relatively few of them so they are easy to regulate. They move from region to region, on request from communities and with announcements of their planned visits, in collaboration with the Ministry of Health (MOH). They have standard equipment (blade, blanket, gloves, methylated spirit, mercurochrome, powder, herbal) and stay with their clients for 6 hours post circumcision. Few cases of adverse events (AE) have been reported to date, and these are recorded by some TMCs.

TMCs were involved in the initial MC stakeholder consultation in 2008 and indicated that they were open and willing to collaborate.

In Uganda [Belyejjusa Jaffer, Surgeon], TMCs have no formal training at all but it is claimed that the skills are acquired hereditarily through clan lineage. The Cultural Board oversees the ritual, which is performed biannually. This board includes stakeholders such as the District Health Visitors, District Health Inspectors and the Council member for health from the district. The Board is responsible for reviewing the licenses of the local TMCs.

Their first official contact with the DMO was in 1994 when the TMCs were sensitized on hygienic practices during circumcision. Since this time there have been a number of successes. A series of meetings were convened through the cultural board to sensitize TMCs to the potential dangers of the practice. Yearly meetings were then conducted to continue updating the TMCs on issues relating to HIV. More recently a National Task Force on MMC was launched which has brought together political leaders, religious leaders and TMCs to initiate dialogue on traditional circumcision. More people from traditionally circumcising communities are now reporting to hospitals for MMC, and TMCs are referring people who develop complications as a result of TMC to health facilities.

A number of challenges persist, however. Sexual activity, that could potentially expose community members to HIV, may be associated with the dancing and festivities that are part of the TMC ceremonies. The early resumption of sexual activity before healing (6 weeks) is also of concern. At the same time, integration is perceived as a loss of income to the TMCs and there is still a problem with identifying and referring those initiates who have developed complications following TMC. TMCs believe that their work is spiritually guided, and some of the advice for decreasing AEs is not acted on: "Boiling a knife makes it blunt" and "the use of gloves is difficult because they are slippery". Furthermore there is often a poor understanding of the difference between sterilization, disinfection and cleaning.
4.3. Summary of Working Group Discussions
The report back from the Working Groups that focused on improving understanding, dialogue and collaboration included the following recommendations:

**Do**

*To Improved Understanding*
- Define the community entry points for initiating dialogue (traditional leaders, individuals, groups)
- Identify the different stakeholders and their roles (TMC/MMC)
- Make sure that the rules of engagement with TMCs for undertaking the Situation Analysis are clear before the situation analysis is carried out
- Identify similarities and differences between TMC and MMC in order to build on commonalities and avoid conflict/barriers
- Understand the TMC package (different components, actors, roles) and ensure a holistic approach to TMC that includes the circumcision and the associated rituals and practices - but separate the procedures: the circumcision and the culture
- Understand what the present practice is so as to be able to identify specific issues that need to be improved
- Document the process of TMC (how many, when, where) and the AEs

*To Improved dialogue*
- Use local structures when communicating with TMCs and ensure that the chiefs/traditional leaders are part of the process
- Sensitivity to cultural norms (no female circumcisers) - respect cultural values and practices
- Establish systems of regular communication (coordinators)
- In MMC roll-out, address traditionally circumcising communities differently from non-circumcising communities

*To Improved collaboration*
- Develop a national policy on MMC and TMC so as to provide leadership
- Ensure the early involvement of TMCs and traditional leaders
- Include TMCs in technical working groups and stakeholder meetings
- Invite TMCs to be part of the integrated MC task force
- Identify doctors and nurses from circumcising groups to build linkages between medical and traditional providers
- Ensure regulation/certification is ethical and impartial
- Develop communication strategies that are sensitive and respect culture (e.g. political and traditional leaders can make announcements in the media in support of MMC and TMC)
- The government (MOH) should be ready to play its part in meeting the demands of the TMCs when these are expressed in negotiations
- Identify ways to support those TMCs who are certified, including training on hygiene and safety to conduct TMC
- Encourage TMCs to initiate referral to health facilities
- Respect the age when male circumcision traditionally occurs
- TMCs need recognition, affirmation and empowerment

**Do not**
- Condemn, criminalize TMC or make it illegal
- Demonize the practice of TMC, but identify ways to improve it with new developments of modern medical practice
- Go on the offensive, do not be confrontational, do not undermine the authority of TMCs or disrespect their culture, do not be patronizing
- Be judgmental and apply medical practice standards to TMC
- Be seen to be opposing traditional practices in general
- Disregard channels and procedures for communication and engagement with TMCs: don't go directly to them
- Do anything in traditionally circumcising communities without involving them
- Invite TMCs to discuss issues after decisions have already been taken about them
- Try to turn traditional circumcision into a profession - maintain its cultural characteristics
- Impose MMC on traditionally circumcising communities
- Give the impression that there is an attempt being made to move people from their culture
- Ignore cultural requirements
- Be seen to be sending out messages that imply the end of TMC
- Cause TMCs to "go underground" and carry out their work in hiding, which may have many negative effects

**General recommendations** raised in the discussion included:
- Resources must be available to improve TMC in national plans for MC roll-out
- Develop a Framework of Understanding between the traditional and formal sectors for co-existence, describing the relationships (e.g. referral)
- Traditional health practitioners and bio-medical practitioners must establish symbiotic relationship in promoting circumcision as part of HIV prevention
- Engage TMCs continuously to allay anxiety that cultural practices will be undermined or replaced, and ensure the participation of community structures such as clan leaders, village health teams, rural health motivators
- Develop feedback mechanisms for TMCs: number of circumcisions performed, AEs, etc.
- Enrol/certify TMCs and traditional nurses only after they have received some training on HIV/AIDS, wound management and the management of dehydration - develop guidelines for this training including HIV testing and HIV prevention
- Help to develop associations of TMCs at local, district level and provincial levels with a code of conduct that is developed with the involvement of TMCs themselves
- Support TMC associations, with training curricula, best practices, supply them with minimum starter kit
- Facilitate TMCs to work hand-in-hand with medical providers from the same tribe
- There needs to be a land set aside for TMC lodges or initiation schools
- Develop guidelines for traditional circumcisers, checklist for post-operative care, etc.
- Consider incentives for traditional circumcisers referring males for circumcision in hospitals/clinics
- Consider pre-circumcision workshop for boys, including information about what they can expect during the camp
- Protect the initiation practice by having appropriate legislation and policy in place
- Prepare a manual on male circumcision for chiefs, religious leaders and politicians that addresses both the positive aspects of MC and also concerns and fears about TMC
- Promote the benefit of TMC for women
- Avoid mixed messages e.g. HIV status for the TMC and the initiate, TMC procedures
- Understand that there are different perspectives on safety (e.g. how much bleeding is ‘normal’?)
5. Improving the Safety of TMC

5.1. Challenges
A number of challenges relating to improving the safety of TMC were highlighted during the first day of the consultation. These included:

- How can MOHs better monitor and respond to complications resulting from TMC?
- What is the role of training and equipment to increase safety and hygiene and decrease complications (including the use of antibiotics by TMCs)?
- What are the advantages/disadvantages of formal vs informal approaches to regulation and collaboration?

An introductory presentation [Robert Bailey, Researcher] highlighted that while there is much discussion about AEs related to TMC, this is frequently more anecdotal than scientific or analytical. Rigorous monitoring and evaluation of TMC practices and outcomes is difficult and rare, and there are many issues to consider, not the least being how an AE is defined. Even what constitutes a traditional male circumcision is sometimes not clear: one carried out by a TMC or simply circumcision provided in an informal setting by an untrained, unsupervised and under-equipped health worker.

All approaches to assessing AEs have limitations. When reviewing individual cases the denominator is usually unknown; retrospective studies from health facilities not only have unknown denominators but in addition it is unlikely, for a number of reasons, that all complications have reached the health facilities; and prospective studies are more expensive and may have high rates of loss to follow-up.

There have been a number of studies that have attempted to quantify AEs following MMC. For neonates and infants (16 studies) the median frequency of AEs was estimated to be 1.5%, with very few serious complications. There have been 10 studies assessing AEs following MMC in older children and adolescents (often carried out for medical problems) that have a median frequency of AEs of 6%. For traditional male circumcision the AEs for children and adolescents are usually higher and more serious, although the quality of the studies is often poor.

5.2. Country examples
Several examples from countries that had tried to assess or respond to the problem of AEs following TMC were presented during the consultation.
A prospective study in Kenya was presented [Robert Bailey, Researcher] from a community where families have begun to shift away from traditional circumcision rites and rituals towards medical circumcision. The study showed AE rates of 10% in public health facilities, 22.5% in private health facilities, and 34.3% following traditional male circumcision. All of these rates of AE are significantly higher than those found in the MC clinical trials or in MMC rollout programmes. In addition, incomplete circumcision is common, as is the need for re-circumcision.

Both health workers providing MMC in this setting and traditional circumcisers were inadequately trained, and many health facilities lacked proper supplies and instruments. Most people in this traditionally circumcising community would have preferred to have had medical circumcision over traditional circumcision, but feared stigma and disapproval within the community.

Key recommendations from the study were that:
- Traditional circumcisers should receive training in reproductive health and HIV/STI counselling, and that it is important to seize the opportunity to educate boys about safe sex and responsible gender relations
- Parents and young boys should be educated to enable them to make an informed choice about who to go to for circumcision
- Clinician training is required even in circumcising communities
- Consider provision of a low cost kit containing consumables.

The training of TMCs (wanzams) in Ghana [Beatrice Okoh, Public Health Nurse] to carry out male circumcision on neonates has been taking place for a number of years. The Wanzam role is handed down from generation to generation within families, and the vast majority of boys are circumcised during the neonatal period. Wanzams are known to the family of the boy who is circumcised, and there is strong patronage. However, a number of challenges had been identified: there was no hand washing, there was insufficient sterilization of instruments, post-operative dressings used tobacco leaves and ginger, and complications were not reported to hospitals for fear of creating problems for the family wanzams.

The Ghana Health Service assumes a leadership role for male circumcision in Ghana, and the Public Health Nurses Group (PHNG) in the Greater Accra Region took up the challenge of assisting the wanzams to provide better services to their clients. Most wanzams are Muslims and it is difficult to move in these communities as a woman, so the training efforts were channelled through young men. Communities were initially sceptical because of cultural respect for elders and the fact that all nurses were females. However, training was started on infection control techniques, taking place once a week for six weeks, using health centres rather than in the community in order not to confront potential cultural barriers.

The objectives of the training programme was to identify traditional wanzams, teach them infection control techniques, educate them on the incidence, causes and prevention of HIV infections, teach them about the importance of early referrals to health facilities and build an association of trained wanzams for effective monitoring, supervision and evaluation. Following the training the wanzams are given a kit with the necessary supplies (which was demonstrated during the meeting).

The communities were divided into five zones, each represented by a leader. The leaders make sure that untrained wanzams do not practice in the community. The trained wanzams are introduced to the various health institutions by identifying them with ID cards, and nurses and medical officers are the contact persons for prompt attention to all wanzams who report to their clinics with bleeding and other related post-circumcision complications. An association of trained wanzams was formed which meets with the public health nurses once every month.

Since the inception of the programme, 548 participants have been trained with 325 members in active practice. Public health nurses have noticed that the healing time has decreased as a result of the training.

In the Eastern Cape, South Africa [Xola Kanta, Researcher, Sehlangu Kekana, National Department of Health, Chabula-Nxiweni Eastern Cape Public Health Directorate, Lunga Mlungi Traditional Male Circumciser], for many years there has been concern about AEs following TMC among adolescent boys. In 2009, in the Eastern Cape, there were 60,485 traditional male circumcisions, resulting in 91 reported deaths, 47 penile amputations and 744 hospitalizations.

As one approach to decreasing these AEs a training programme has been developed for the TMCs ("traditional surgeons") and the people responsible for the after-care of the initiates "traditional nurses", with a view to standardization and preparing the TMCs for formal regulation. Communities are involved in the selection of TMCs for training.

The five-day training involves a lead trainer, local DMO’s, provincial officers and traditional leaders, although for a number of reasons the traditional leaders have not been much involved: they were not interested in attending these trainings and there was some friction because they felt that they were not adequately involved in the development of legislation relating to TMC that was to be implemented by the Department of Health (DOH). The Department of Health, the municipality and research institutions have provided funding.

The content of the training includes: sharing of statistics down to municipality level, anatomy, contra-indications to TMC, the legal environment in the Eastern Cape, cultural norms, STIs, HIV (handling of blood and body fluids, safe sex, harmful myths such as having sex soon after TMC enhances wound healing), infection control measures (liquid soap vs. hard soap), and the procedure (what to cut, what not to
cut), post-op wound care, fluid management, construction of initiation schools and sanitation).

The overall approach to the course is practical and commonsense (e.g. tying bandages around fingers to demonstrate the effect of too-tight post-operative bandaging). TMCs are encouraged not to circumcise boys with complications (e.g. phimosis) and are recommended to undergo a general HIV training course separate from this course on circumcision.

Following the training the TMCs are provided with a certificate and, when funds permit, they are given a kit that includes: surgical blades, scalpel handles, surgical gloves, liquid soap, paper towels, gauze and bandages, savlon/dettol and glutaraldehyde.

There are many challenges and it is not clear that the training has led to behaviour change (a follow-up study with a research institution was terminated after a serious AE occurred). In one follow-up it was noted that a trained TMC had still used the same blade to circumcise 400 boys (TMCs are praised for speed, and if safer approaches decrease speed the TMC may lose business). As a traditional/cultural practice the belief systems are quite different from the bio-medical model\(^9\): instruction is provided by the ancestors, there are alternative theories about causation of illness and post-TMC symptoms, there is significant secrecy about the procedure and the camps, and pressure from elders to maintain the status quo. There are also barriers to accessing safer materials, including cost, and there is little systematic monitoring of TMC because there are not sufficient DMOs to visit all the initiation schools.

In addition to training, another approach to improving safety is to strengthen regulation, and this has also been implemented in other parts of the Eastern Cape. An example from one municipality was presented during the meeting as a response to the fact that it was sometimes difficult for communities to identify the ‘real’ TMCs who had expertise and experience, too many boys were being circumcised too rapidly and they were therefore not being provided with adequate attention and care, and a range of AEs including sepsis and gangrene.

The TMCs are enrolled and the municipality provides them with a pack that includes a surgical blade, scalpel, haemostatic dressings and bandages (the pack was demonstrated by a TMC during the meeting). Traditional nurses are also provided with a kit that includes bandages and haemostatic dressings (so as to avoid too tight bandaging).

\(^9\) In the past, initiates had to abstain from sex for 3 months before going to the initiation school, although more recently this has been decreased to three weeks, the purpose being to decrease the chances that boys will have STIs during the time at initiation school. A family member was identified by the traditional nurse to look at the circumcision wound when the dressings are changed.
A checklist was developed for the attendants, and when any of the signs on the checklist were observed, a DMO (who is either a nurse, a health promoter or an environmental health practitioner) should be called to assess the condition of the initiate and must then refer to a health facility. Since 1988, no deaths from circumcision had been recorded in the municipality.

TMCs have also been trained in HIV/AIDS, and "ABC" messages are given to the initiates by attendants. In line with regulations, medical examinations are to be carried out on all boys prior to initiation. A code of conduct was developed among the TMC including ‘no liquor during the camp’ and ‘one boy, one blade/circumcision instrument’ (some TMCs are still using traditional instruments for circumcising the initiates).

On-going challenges are the registration of trained and experienced TMCs onto an accredited Circumcision Rites Association at local, sub-regional, regional, provincial and national levels, and the development of workshops to take place at national, provincial, regional and local levels within in the health structures of public, private and social sectors to address the question of developing and supplementing the traditional methods associated with circumcision rites, taking into account the diversity of cultures in South Africa.

At the Provincial level there are a number of processes in place to regulate the activities of TMCs and the initiation camps. There are 2 assistant Directors responsible for the program who report to the Deputy Director Traditional Health Services, who in turn reports to Director Primary Health Care. There are 7 district coordinators who report to Provincial Managers who are either nurses, Environmental Health Officers or Health Promoters. Twenty-four sub-district coordinators report to the district coordinators on all sub-district activities in the different localities. These Provincial officials oversee and coordinate all traditional male circumcision activities.

There are a number of tools to support the application of Health Standard in Traditional Circumcision Act: parental consent; a pre-medical certificate; a certificate for permission to perform a TCM; and a certificate for permission to treat an initiate. There is a Circumcision Register and an Authorization Book for Traditional Leaders. Monthly statistics are collected and end of season statistics compiled.

In Namibia [Epafras Anyolo, Ministry of Health and Johaness Kambausuka, Traditional Male Circumciser], where 52% of circumcisions done traditionally, plans are currently under-way for registration and legislation relating to TMCs, including coordination, training to make practice safer, quality assurance, systems for monitoring and evaluation and active surveillance of AEs. The Traditional Healer Act is currently before parliament, and this includes the registration of TMC using references from local leaders, the setting up of a TMC association and a certification process (already in one region only “TMC card holders” are able to obtain supplies)
Is it really possible to train TMCs when they believe that they have inherited their skills from parents/relatives? Standardized kits have been considered but there is currently no funding (blade, gloves, blanket, antiseptic solution, antiseptic powder). Should forceps be included in the kit so as to replace the current rope-guided technique? How should the issue of waste management be dealt with (some TMCs are still reluctant to use the health sector waste disposal system)?

In terms of the way forward, it will be important to allow the TMCs to continue their work: for the moment “they are here to stay”. A priority will be given to training them in areas such as infection safety, basic HIV competency and behavioural counselling. It will be important to establish waste management systems, strengthen referral systems and maintain continuous dialogue, and establish monitoring and reporting systems.

In addition to the examples from countries outlined above, a number of other countries have developed training programmes (even in one instance to help TMCs tie bleeders), provide TMCs with equipment and have strengthened referral between TMCs and MMCs.

5.3. Summary of Working Group Discussions

**Brainstorming on improving safety:**

- Need mechanisms to identify TMCs and to be clear about who is doing the circumcision in TMC (TMCs or people carrying out MMC who are untrained/unsupervised/underequipped MCs)
- Need training of TMCs by the formal health sector
- Need to have a policy on traditional practices (where this does not exist) that includes TMCs (where these are not included)
- Need to put regulatory mechanisms in place (including numbers that can be done per unit time) and disseminate information in communities about recognized/accredited TMCs
- Need to develop a "minimum package" to standardize what takes place, that includes training, equipment, medicines, facilities, and post circumcision care
- Need systems for monitoring (including inclusion in HIMS) the activities of TMCs, adverse events and the implementation of the regulations that are developed

**Synthesis of the feedback from the Working Group discussions on safety:**

- Develop a policy regulating the safety of TMC and the responsibilities of TMCs.
- Need to put in place regulatory framework for the practice of safe TMC and establish minimum standards for practice (e.g. infection control, the procedure and the use of disposable kits) and standardized training guidelines. There also needs to be community buy-in into safety proposals for TMC. Standardization needs to include the correct sequencing of events during TMC, correct staffing, matching skill sets to duties, and ensuring adequate preparation for TMC events.
- Health sector should pro-actively approach TMCs for workshops and develop training curricula, together with the TMCs (a needs assessment should be carried out
to determine training requirements). It is important to provide feedback to the TMCs on complications admitted to hospitals. Need to differentiate between TMCs and MMCs carrying out circumcisions in traditionally circumcising communities.

- Form associations of TMCs (local, regional and national) and develop a database with enrolled TMCs per district. TMC communities to identify practising TMCs who can be registered by the government. Ministry of Health should carry out periodic certification of TMCs and continuous TMC assessment, and there should be government recognition for competent TMCs. Consider using TMCs to reach out to fellow TMCs regarding safety and hygiene.

- Develop code of conduct for TMCs and also for medical providers to receive clients with complications from TMCs. Establish a referral system between TMCs and hospitals and provide continuous support for TMCs by the health sector (supportive supervision). There is a need for Framework of Understanding that covers the interaction between TMCs and MMCs, their roles and responsibilities, who does what, when, how. Health workers should preferably serve in their birth areas due to cultural sensitivity and continuity.

- Establish monitoring and evaluation systems and incorporate TMC into Health information management systems (HIMS): numbers and AEs.
6. Linking Medical MC and TMC

6.1. Challenges
A number of challenges relating to linking MMC and TMC were highlighted during the first day. These included:

• How can TMCs be better integrated into MC rollout and HIV prevention?
• How has MMC been integrated/inserted into TMC?
• What is the role, if any, of TMCs in traditionally non-circumcising communities?

6.2. Country examples
A number of countries have had experience of strengthening the linkages between TMC and MMC.

In Zambia [Evans Chinkoyo, Jhpiego], male circumcision is widely accepted and there is a long history of collaboration between TMCs and missionaries. With the rollout of MMC for HIV prevention an agreement was reached with the TMCs about the provision of MMC. Key elements of the agreement included: MMC would be provided free of charge in a health facility within the circumcising territory; only circumcised males would take part, with no females permitted near the premises; counselling services would be provided as per the MC minimum package and local anaesthesia would be permitted during the MMC; initiation ceremonies would take place according to traditional practices and there would be follow-up of circumcised clients in both the health facility and camps, where necessary.

The steps that were taken to strengthen the linkages between the traditional and formal sectors started with consensus building workshops held in 2006 and 2007, to which traditional and other civic leaders were invited. A sensitization meeting was carried out in 2009, to which traditional leaders from circumcising and non-circumcising tribes were invited. Planning meetings were then held to respond to specific requests by traditional leaders, and the local health facilities where the MMC was to be carried out were visited and a site assessment conducted.

Based on the site assessment, supplies were provided to bridge the gaps identified (mainly surgical consumables and instruments). An advance team was sent two days before the start of the MMC campaign to prepare site, which included meeting with Chief and local health officials, orientation of staff, cleaning of clinical area, and establishing client flow pattern.

One of the lessons learnt is that working with traditional leaders requires meticulous planning. In line with TMC practices, this is a seasonal outreach activity and includes group education followed by individual counselling; HIV counselling & testing on an opt-out basis; and well defined support to ensure care for the initiates (cooking, wound care, education and life skills coaching).
In Kenya [Solomon Nabie, Interchristian Fellowship Evangelical Mission (IcFEM), Robert Sichang, Traditional Male Circumcision Provider] a number of hospitals are providing MMC within the context of TMC rite-of-passage rituals. In one example from Western Kenya, certain traditions had been identified as roadblocks to progress, and one of the priority traditions that required attention was traditional male circumcision. In response to this, in 2002 IcFEM organized various workshops were organized that brought together custodians of culture (opinion leaders, mostly older people of 75 years and above), TMCs, women, youth representatives (age sets are an important social grouping), women (especially mothers of the soon-to-be-circumcised boys), members of the provincial administration including District Officers (DOs), chiefs, church leaders and some medical practitioners.

During these meetings, apart from concerns about safety, it was estimated that the total cost for circumcising the boys in Bungoma district was almost equal to what the government was paying for primary school education in the whole district for one year (the average total cost for TMC was estimated to be 30,000 Kenya shillings per circumcision, while the cost for MMC at the time worked out to 990 Kenya shillings – about 25,000 boys are circumcised every other year in the larger Bungoma district). There were therefore concerns about both the procedure and the costs.

It was agreed that TMC as a right of passage needed to be maintained but that it needed to be adapted to the current needs and challenges, and that a more medicalized approach was needed in order for the communities to benefit from medical science. The community felt that adaptations were needed because a good culture should serve the people and therefore the people’s interest should come first, not vice versa ("a good car should serve your interest, if not, however good looking, whatever brand and however much it costs, it is useless").

Following the meetings, parents were encouraged to take their boys to hospital for circumcision; TMCs who met minimum required qualifications for training as MMC would undergo training, with the training being be provided by the MOH or other qualified personnel; and there was agreement to start a pilot action plan.

In 2002 the intention was to provide MMC to 250 boys, but 1700 signed up. In 2004, 4800 parents registered their children for MMC, and the services were overwhelmed. In 2006, 25 clinics were prepared for MMC and 16000 boys were circumcised. The project demonstrated rapid change of a traditional practice, with the majority of boys now circumcised medically in a previously traditionally circumcising community. These changes were not brought about by changing TMC practices, but by mobilizing communities and responding to their needs.

Clearly some of the TMCs were not happy with these changes since it affected their source of income, although some were happy because they "learned medical techniques". However, in general it was felt that while important aspects of the surrounding rituals would and should continue, consideration should be given to "payments of recognition for TMCs for their work in the past, so that they can retire and give room to medical practice".

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In Zimbabwe [Christopher Samkange, Surgeon], the Ministry of Health convened a Stakeholders meeting in 2007 on MMC that endorsed the WHO/UNAIDS recommendations on MC rollout. Mathematical modelling demonstrated the importance of accelerating the provision of MMC. 10% of Zimbabwean men are circumcised, the majority by TMCs.

In the feasibility study, all communities, both traditionally circumcising and non-circumcising, were approached through the normal channels. Traditionally circumcising communities stated a desire to work with the Ministry of Health. The situation analysis had already indicated that 60% of men were willing to be circumcised and 70% were willing to let their sons be circumcised.

First national MMC programme was carried out in April, 2009. The one week training for those involved included theory and practice on: HIV and AIDS, counselling, the surgery of male circumcision, infection control, adverse events and post exposure prophylaxis, and managing the programme. In addition two teams of Moslem practitioners were trained.

In addition to MMC being provided within the ritual of TMC, there are some examples from countries of MMC strategies benefitting from some of the concepts associated with the TMC activities that take place around the circumcision.

In Kenya [Salvador de la Torre, Catholic Medical Mission Board], hospital based MMC was started in the 1920s as a response by missionary doctors to concerns about AEs seen following TMC. However, although the circumcision was provided in the hospital there was respect for the traditional rite of passage (seclusion), with elders providing mentorship to adolescents on community values, responsible adulthood, life skills, and medical doctors providing health education during the seclusion period.

This type of approach has been continuing, with PCEA Kikuyu Hospital providing group MMC linked to rites of passage. The 6-Day Program is a once a year event (as with TMC) and has developed a family approach to HIV/AIDS prevention: parents are encouraged to know their status and are educated on HIV/AIDS prevention, care and treatment; sibling girls also participate in mentorship sessions together with boys.

Set up in 2000, with refresher training provided for clinical officers and residential facilities for the boys being circumcised, it started with 50 boys. In 2008, 1400 were provided with MMC in a two-day session, with 1% adverse events reported. The boys were supported by peers who had already undergone the ritual. In addition to the circumcision there is teaching on cultural values, HIV/AIDS, ASRH education, all of which is available on a DVD that parents can use at home. Graduation completes the programme that is sustainable because the Kikuyu are ready to cover the costs for circumcision.
As MMC is rolled out in Kenya into non-circumcising communities, the challenge was to see if some of the lessons learnt in traditionally circumcising communities would benefit the acceptability and impact of MMC rollout. To date, 6,100 MMCs have been performed in Nyanza province that have included a strong educational component for the boys, their parents (10,100) and sisters (1,500), and almost 1,300 parents have been tested for HIV.

The experience in this non-circumcising community demonstrates that MMC can provide an important entry point for ASRH, and that significant family and community involvement can be generated, which supports MMC (community mobilizers) are key to promote buy-in and create demand for MC services. However, sustainability is likely to be more of a problem in non-circumcising communities as they are not used to paying for MC.

In Kwa-Zulu, Natal, South Africa [Nceba Gqaleni, MC Provincial Task Force Member], a traditionally non-circumcising part of the country since Shaka Zulu banned the practice, MMC is about to be rolled-out in response to the high HIV prevalence in this part of South Africa. The king of the Zulus chose a culturally important day to start the MMC rollout, and proclaimed that it was a ‘return to culture’ with the formation of age regiments for the cohorts of adolescents and young men circumcised each year, which can generate solidarity among them and potentially peer pressure for safe sex and HIV prevention in the future.

While the MMC programme will target all of the 2.5 million males between 15-49 years in Kwa-Zulu, it will specifically include ‘camps’ (boarding schools or colleges), targeting 15-19-year-olds during school holidays. In these camps there will be educational and cultural activities for one day before and after the circumcision, including ASRH education.

6.3. Summary of Working Group Discussions

MC/TMC linkages

- Linking TMC and MMC may not be a concept that is applicable in all communities (e.g. parts of the Eastern Cape). In settings with strong cultural resistance to MMC it may be more effective to concentrate on improving the safety of TMC.

- It is important to clarify roles when “linking” TMC and MMC (who is supposed to do what, are the roles acceptable to both groups?)

- Legislation and standardization of practice is crucial. There is a need to established clear and acceptable 2 way training and a reciprocal referral system between TMC and MMC, and to identify areas of common activities that can be jointly carried out e.g. counselling, testing.

- Need to establish a joint Task Force on male circumcision where both TMCs and MMCs are represented - there needs to be oversight of all MC activities by a single entity.
Develop models for linking TMC and MMC (for example medical teams perform the MC and the TMCs continue with associated rituals and traditional practices in the community (e.g. Zimbabwe, Zambia, Western Kenya). In consultation with the community discuss which model works best for them - if it is community driven it is more likely to be sustainable.

Legislative requirements for regulation need to include:
- registration of traditional circumcisers
- validation of status as a traditional circumciser (versus a informal practitioner)
- determinations of how to oversee/"police"
- clarity of reporting chain.

Where this would be housed (Ministry of Health, Ministry of Culture) should be made on country-by-country basis.

Suggestions for a generic list for issues that need to be included in TMC policies/regulations:
- Preamble (including the characteristics of MC necessary for HIV prevention, for example the amount of foreskin that needs to be removed)
- Definition, methods of selection and remuneration of TMCs
- Minimum requirements for safety, including equipment and post-circumcision care
- Specification of places/settings where TMC can be carried out
- Records and approaches to monitoring TMCs
- General guidance on formal collaboration and working relations between TMCs and the health sector
- Other matters
7. Conclusions and Recommendations

Traditional male circumcision in East and Southern Africa provides an important cultural milestone in many communities that marks the time when boys become men, both symbolically and also in terms of knowledge, behaviour, and social roles/expectations. Although not explicitly carried out for the purpose, TMC is also likely to have provided some protection from HIV to a number of traditionally circumcising communities in ESA.

However, as countries in ESA roll out medical male circumcision as a key component of comprehensive strategies for HIV prevention, there is increasing attention being paid to TMC, with renewed concerns about safety; issues of consent, assent and human rights; the pain and deprivations experienced during both the circumcision and the period of seclusion following the circumcision; the fact that if the circumcision is incomplete it will be ineffective at preventing HIV transmission; and furthermore that some of the activities traditionally associated with TMC may actually encourage early sex among recently circumcised boys or unsafe sex in the community at large.

As with many situations in which there is a meeting of different belief systems, finding ways to create cooperation rather than conflict is not always easy - although it is to the credit of TMCs and people working in the formal health sector in countries in ESA that so much collaboration has been achieved. This sense of a desire for understanding and collaboration was evident among the participants during the consultation, although there was inevitably sometimes points of tension and quite different perspectives. For example concerns about AEs that were expressed from the biomedical perspective were countered with comments such as "but of course we love and care for our children", and discussions about the need for training of TMCs received a response along the lines of "we have been doing this for thousands of years - do you think that we need your help now?"

In traditionally circumcising communities in ESA TMC is clearly an important cultural practice, although changes in attitudes and practices are taking place in some communities and it will be important for Ministries of Health and others to be able to respond to these changes and ensure that people are able to realize their choices. In addition, while there are a number of similarities in relation to TMC in the sub-region, there are also many differences, which range from the age at which the circumcision is carried out to the willingness of communities to have the circumcision carried out by trained medical personnel. This means that when developing responses to TMC it will not be possible to have a one-size-fits-all approach: many decisions will need to be country specific, and even within countries may need to vary between different TMC practicing tribes and communities.

However, that being said, there was good consensus among the range of participants at the Glenburn consultation that there are some broad areas for action that need to be considered in all countries in order to ensure that all adolescents have access to a safe, effective, voluntary and pain-free male circumcision that will contribute to
preventing them from acquiring HIV. There were also a number of examples from countries in the sub-region where significant progress has been made in relation to each of these priority areas for action:

1. **Improve the collaboration** between TMCs and the formal health sector, by increasing knowledge and understanding of TMC, strengthening respectful dialogue and communication, and involving TMCs in a meaningful way in decisions that are taken about MC and HIV prevention.

2. **Improve the safety** of TMC and its effectiveness for HIV prevention, through training, the provision of equipment, referral systems to ensure that complications are rapidly and effectively dealt with, and the development and implementation of regulations and certification.

3. **Improve the options** that adolescent boys have for accessing a safe, effective and pain-free circumcision by linking MMC and TMC and providing opportunities for the circumcision to be done in medical facilities while retaining those aspects of the rite-of-passage ritual that are important for the cultural heritage.

This has important implications for the rollout of MMC in countries where there are communities who practice TMC. In general, these communities have not been seen as being a priority for improving access to MMC, since they are already being circumcised. However, the discussions during the consultation indicate that such communities should not be neglected, and that adolescent boys living in these communities also have the right to access safe and pain free male circumcision. At the same time, while increasing access to MMC services is being developed in these communities, it is important to improve the safety of TMC, and a number of examples were outlined during the consultation for achieving this, from the provision of training and equipment for TMCs to ensuring that the regulation of TMCs is incorporated into those existing laws and policies that focus on MC and on traditional healers more generally. If this is not done, not only will adolescent boys continue to be exposed to unacceptable risks in some settings, but these AEs may also undermine MMC rollout.

TMC is a cultural practice, and it is most unlikely that traditionally non-circumcising communities will want to adopt such a practice in order to prevent HIV transmission, provided that they have access to MMC. The challenge for countries will be to ensure that in those communities where TMC is practiced that the procedure and associated activities are safe and regulated; that in both non-circumcising communities and traditionally circumcising communities access to safe, affordable and effective MMC is available and regulated, in order to prevent the provision of services by people who do not have sufficient training, equipment, facilities or supervision; and that overall there is adequate understanding and collaboration between TMCs, community leaders and the formal health sector, in order to facilitate collaboration and avoid conflict.

There were a number of over-arching themes that ran through the presentations and discussions:
1. First, the need to have respect for different perspectives, priorities and practices, and to be clear about the differences between MC for HIV prevention (and other health improvements) and MC as part of a cultural practice, and at the same time to differentiate the circumcision and the associated rituals of TMC. This has important implications for the role of the MOH, because while it does not generally have a mandate for cultural matters (this is usually the responsibility of other ministries, such as the Ministry of Culture), it does have a mandate for ensuring the people’s health is promoted and protected, in this context to ensure that the MCs that are done are effective in terms of HIV prevention and that adolescent boys do not suffer, and even die unnecessarily.

2. Secondly, the need to work with communities, to listen to them, inform them, engage and empower them (including women, both as mothers and as wives/girlfriends). It is important to help communities look at the pros and cons of a cultural practice that may have negative consequences on both the health of their adolescent boys and on their own financial circumstances. Communities need information to make choices, and there a number of groups who both require information about MC, HIV and traditional male circumcision and who also need to participate in the discussions that are held and the decisions that are taken. This includes traditional leaders, so that they are supportive; TMCs, so that they can improve the safety of their practices; parents and adolescents so that they can make informed decisions about which services to access; and health workers so that they can be supportive in terms of helping to decrease AEs from TMC and increase people’s options for MC.

3. Thirdly, many of the issues raised during the consultation are not a question of either/or, but more a question of balance: between cooperation and control, between formal and informal approaches to improving safety and strengthen linkages between the formal health sector and the traditional sector, and between self regulation and national legislation. The consultation highlighted the need for policies and laws to regulate TMC, , and the policies that are developed are not an end in itself but are only as helpful if they are implemented and monitored. Similarly the need for standardization was stressed in many of the discussions, in terms of training, equipment, supervision, monitoring and the organization of TMC. At the same time, while it is possible to standardize the procedure, it is not possible to standardize the culture.

4. Fourth, there was an emphasis throughout the consultation on the need for relations between TMCs and the formal health sector to be a two-way and reciprocal. This was highlighted in a number of ways, not least the fact that MMC roll-out has much to learn from TMC in terms of community support and demand, and that TMCs may be in a good position to contribute in other ways to HIV prevention, provided that they are provided with information and support, and to contributing more generally to the sexual and reproductive health of adolescent boys.
While much is known about TMC, much remains unknown about a practice that has been around for many years. One of the reasons for this is that it is surrounded in secrecy. However, if decisions are to be rational and based on evidence, rather than anecdote, there is an on-going need for research. A number of research priorities were identified during the consultation, with short, medium and long-term implications, including:

- Quantifying adverse events associated with TMC, including approaches to monitoring adverse events for both TMC and MMC
- Assessments of the prevalence of TMC in different communities and the variations/different types of TMC that are carried out in the sub-region
- Carrying out investigations of TMC: the herbal medicines used for dressings, the knives and other equipment used, post-operative care and referral, and potential occupational health safety considerations
- Assessing community attitudes to TMC, to the circumcision being carried out by medical practitioners (e.g. potential stigmatization) and to pre-pubertal and neonatal circumcision in traditionally circumcising communities; and to the role of women in supporting/discouraging adolescents being traditionally circumcised (as partners and mothers)
- Assessing sexual risk behaviours following TMC (and those associated with cultural practices surrounding TMC, such as "dances")
- Evaluating the training programmes to improve the safety of TMC
- Evaluating the impact of the information/counselling messages provided by TMCs (compared with MMCs)
- Assessing the impact of MMC roll-out on TMC
- Carrying out operations research on models for integrating TMC and MMC, of using TMC as an entry point for ASRH (e.g. education in the camps), and of maximizing the contribution of TMCs to HIV prevention

During the final day of the consultation the participants worked in country teams to identify key activities that they would carry out in order to make further progress in relation to improving understanding, safety and cooperation, based on the challenges highlighted during the meeting and the experiences of other countries. These are outlined in Annex 3 of this report. It is clear that despite some broad commonalities, the specifics of how to move forward with strengthening collaboration with TMCs, improving the safety of TMC, and developing the linkages between TMC and MMC will require country-level focus and action. Many of the country teams envisaged that the organization of a country consultation to feedback the outcomes of this meeting would be a key follow-up activity to the consultation.

The presentations from the consultation are available on the Male Circumcision Clearinghouse www.malecircumcision.com and this report will be made widely available in order to provide a larger audience with an overview of the issues and solutions to ensuring that adolescent boys have access to safe and effective male circumcision as a contribution to the prevention of HIV

The outcomes from the meeting will be included into future country update meetings, in order to monitor progress and share programme support tools, and the
research agenda will be incorporated into future discussions about research priorities for male circumcision rollout.
## Annex 1: Meeting Agenda

### Day 1:
**Tuesday, 13 April 2010**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter</th>
<th>Method</th>
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<tbody>
<tr>
<td>08:00-08:30</td>
<td>Registration</td>
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<tr>
<td>08:30-09:30</td>
<td>Session 1: Setting the Scene</td>
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<tr>
<td></td>
<td>Welcome</td>
<td>UNAIDS/DOH/AFRO</td>
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<td>Participant introductions</td>
<td>Geoff Setswe</td>
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<td>Participant expectations</td>
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<td>Overview of the agenda</td>
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<tr>
<td>09:30-10:00</td>
<td>Medical male circumcision and HIV prevention</td>
<td>Kim Dickson, WHO Geneva</td>
<td>Presentation and discussion</td>
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<tr>
<td>10:00-10:30</td>
<td>Traditional male circumcision and HIV prevention</td>
<td>Marx Mbuunjii (TMC) Zambia</td>
<td>Presentation and discussion</td>
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<tr>
<td>10:03-11:00</td>
<td>Coffee break</td>
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<tr>
<td>11:00-11:20</td>
<td>Traditional male circumcision in East and Southern Africa: opportunities and challenges</td>
<td>Innocent Ntaganira (WHO AFRO) Tawanda Marufu (WHO/IST Harare)</td>
<td>Presentation and discussion</td>
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<tr>
<td>11:20-11:40</td>
<td>Understanding the situation: Tanzania</td>
<td>Wambura Mwita (NIMR) John Wandwi (TMC)</td>
<td>Presentation and discussion</td>
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<tr>
<td>11:40-12:00</td>
<td>Understanding the situation: Lesotho</td>
<td>Molotsi Monyamane (NAC Lesotho) Paul Mabitle Phahlane (TMC)</td>
<td>Presentation and discussion</td>
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<tr>
<td>12:00-12:20</td>
<td>Understanding the situation: Uganda</td>
<td>Leonard Bafumbo (FHI)</td>
<td>Presentation and discussion</td>
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<tr>
<td>12:20-12:40</td>
<td>Understanding the situation: Western and Eastern Cape, South Africa</td>
<td>Mthobeli Guma (MC Task Team) Xola Kanta</td>
<td>Presentation and discussion</td>
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<tr>
<td>12:40-13:00</td>
<td>Understanding the situation: Senegal and Guinea Bissau</td>
<td>Hamadou Boiro</td>
<td>Presentation and discussion</td>
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<tr>
<td>13:00-14:00</td>
<td>Lunch</td>
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### Session 2: Strengthening communication and dialogue between traditional male circumcisers and the formal health sector

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<tr>
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<tr>
<td>12:40-13:00</td>
<td>Understanding the situation: Senegal and Guinea Bissau</td>
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<td>Presentation and discussion</td>
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</table>
14:00-14:30  Strengthening dialogue between traditional male circumcisers and the health sector: **Zimbabwe**

Sinokuthemba Xaba (MOH)
R Vhurinosara/ Ali Matora (TMCs)
Presentation and discussion

14:30-15:00  Strengthening dialogue between traditional male circumcisers and the health sector: **Namibia**

Mbayi Didier Kangudie
Johaness Tjivita Kambausuka (TMC)
Presentation and discussion

15:00-15:30  Working with associations of traditional circumcisers: **Uganda**

Belyejjusa Jaffer (MOH)
Haji Yusuf Wamboga (TMC)
Presentation and discussion

**15:30-16:00**  Coffee break

16:00-17:00  Working Groups: lessons learnt and good practice for understanding the situation and improving communication and dialogue

Geoff Setswe
Working Group discussion

17:00-17:30  Plenary report back and synthesis

**19h00**  Reception

**Day 2: Wednesday, 14 April 2010**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter</th>
<th>Method</th>
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<tbody>
<tr>
<td>08:30-09:00</td>
<td>Summary of Day 1 and Admin matters</td>
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**Session 3: Approaches to improving the safety of traditional male circumcision**

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<th>Time</th>
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<tbody>
<tr>
<td>09:00-09:30</td>
<td>What do we really know about adverse events following traditional male circumcision?</td>
<td>Bob Bailey</td>
<td>Presentation and plenary discussion</td>
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</tbody>
</table>
| 09:30-10:00 | Training traditional circumcisers: **South Africa**                   | Xola Kanta
Eastern Cape SA
Ntloko
Senzangakhona
Solomon (TMC) | Presentation and discussion |
| 10:00-10:30 | Training traditional circumcisers: **Ghana**                         | Beatrice Okoh
Yussif Mohammed
(Wanzam)
Ghana | Presentation and discussion |

**10:30-11:00**  Coffee break
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<tr>
<th>Time</th>
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<th>Presenters</th>
<th>Description</th>
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<tbody>
<tr>
<td>11:00-11:30</td>
<td>Regulating the activities of traditional circumcisers: <strong>Eastern Cape, South Africa</strong></td>
<td>Sehlangu Kekana (DOH) EM Chabula-Nxiweni Lunga Mlumbi (TMC)</td>
<td>Presentation and discussion</td>
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<tr>
<td>11:30-12:00</td>
<td>Regulating the activities of traditional circumcisers: <strong>Namibia</strong></td>
<td>Epafras Anyolo (MOH) Johaness Tjivita Kambausuka (TMC)</td>
<td>Presentation and discussion</td>
</tr>
<tr>
<td>12:00-12:30</td>
<td>Plenary Discussion: improving the safety of traditional male circumcision through training and regulation</td>
<td>Geoff Setswe</td>
<td>Plenary brainstorming</td>
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<tr>
<td>12:30-14:00</td>
<td><strong>Lunch</strong></td>
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<tr>
<td>12:30-14:30</td>
<td><strong>Session 4:</strong> Linking medical male circumcision with traditional male circumcision and benefitting from activities/concepts related to traditional male circumcision</td>
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<td>14:00-14:30</td>
<td>Collaborating with traditional circumcisers: carrying out the circumcision in clinical facilities: <strong>Kenya</strong></td>
<td>Solomon Nabie (ICFEM) Robert Sichangi (TMC) Peter Cherutich (MOH)</td>
<td>Presentation and Discussion</td>
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<tr>
<td>14:30-15:00</td>
<td>Collaborating with traditional circumcisers: carrying out the circumcision in clinical facilities: <strong>Zambia</strong></td>
<td>Evans Chinkoyo (Jhpeigo) Marx Mbunji (TMC)</td>
<td>Presentation and Discussion</td>
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<tr>
<td>15:00-15:30</td>
<td>Collaborating with traditional circumcisers: carrying out the circumcision in clinical facilities: <strong>Zimbabwe</strong></td>
<td>Christopher Samkange Emmanuel Vhurinosara and Ali Matora (TMC)</td>
<td>Presentation and Discussion</td>
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<tr>
<td>15:30-16:00</td>
<td><strong>Coffee break and Market Place</strong></td>
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<td>16:00-16:30</td>
<td>Experiences from <strong>Nyanza Province, Kenya</strong></td>
<td>Salvador de la Torre (CMMB)</td>
<td>Presentation and Discussion</td>
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<tr>
<td>16:30-17:00</td>
<td>Experiences from <strong>Kwazulu Natal, South Africa</strong></td>
<td>Roger Phili (MOH)</td>
<td>Presentation and Discussion</td>
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<tr>
<td>17:00-18:00</td>
<td>Group Work: linking medical MC and TMC activities/concepts</td>
<td>Geoff Setswe</td>
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**Day 3:**
**Thursday, 15 April 2010**
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<th>Time</th>
<th>Session</th>
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| **Session 5:** Finalizing the recommendations | **08:30-10:00**  
Plenary report back from Day 2  
Working Groups, discussion and synthesis | Geoff Setswe | Plenary |
| **10:00-10:30**  
Additional issues to be incorporated into the final recommendations and Parking Lot review | | | |
| **10:30-11:00**  
Coffee break and Group Photo | | | |
| **Session 6:** Next Steps | **11:00-12:00**  
**Country Groups:** country plans for  
- improving collaboration between the health sector and TMCs;  
- improving the safety of TMC;  
- linking TMC with MMC  
"what will you take away from the meeting and how will you use it?" | All | Group Work |
| **12:00 - 13:00**  
Plenary feedback from country groups and discussion | Geoff Setswe | Plenary |
| **13:00-14:00**  
Lunch | | | |
| **14:00-14:30**  
Research priorities | Geoff Setswe | Plenary brain-storming |
| **14:30-15:30**  
Next steps and closure | Kim Dickson | Plenary discussion |
| **15:30-16:00**  
Coffee break | | | |
| **16:00** | Participants leave | | |
Annex 2: List of Participants

Traditional Male Circumcision in the Context of HIV Prevention
A Sub Regional Consultation

13 - 15 April 2010
South Africa

List of Participants

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>PARTICIPANTS</th>
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</table>
| GHANA           | 1. Beatrice Okoh  
Public Health Nurse  
Ministry of Health  
Accra, Ghana       |
|                 | 2. Yussif Mohammed  
Traditional Neonatal Circumcision Provider  
(Wanzam)  
Accra, Ghana       |
| KENYA           | 3. Salvador de la Torre  
Country Director  
Catholic Medical Mission Board  
Nairobi, Kenya     |
|                 | 4. Solomon Nabie  
Director  
Inter-Christian Fellowship Evangelical Mission  
Kimilili, Kenya   |
|                 | 5. Peter Cherutich  
Head of HIV Prevention  
MC Focal Person in MOH  
National AIDS/STD Control Programme  
Ministry of Health and Sanitation  
Nairobi, Kenya     |
|                 | 6. Robert Muniafu Sichangi  
Traditional Male Circumcision Provider  
Kimilili, Kenya    |
| LESOTHO         | 7. Maud Boikanyo  
HIV Directorate  
Ministry of Health and SW  
Maseru, Lesotho    |
|                 | 8. Molotsi Monyamane  
Chairperson, The National AIDS Council  
Maseru, Lesotho    |
|                 | 9. Palesa Mohaleroe  
Surgeon  
Maseru, Lesotho    |
|                 | 10. Mr Paul Mabitle  
Administrator &  
Traditional Male Circumcision Provider  
St Josephs Hospital  
Roma, Lesotho      |
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<td>Amon Nkhata</td>
<td>Ministry of Health responsible for MC/TMC</td>
<td>Ministry of Health, Lilongwe, Malawi</td>
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<tr>
<td>12</td>
<td>Epafras Anyolo</td>
<td>MC Coordinator</td>
<td>Directorate of Special Programs, Ministry of Health and Social Services, Windhoek, Namibia</td>
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<td>13</td>
<td>Johaness Tjivita Kambausuka</td>
<td>Traditional Male Circumcision Provider</td>
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<td>14</td>
<td>Mbayi Didier Kangudie</td>
<td>HIV/AIDS Treatment Technical Adviser</td>
<td>USAID Namibia, Windhoek, Namibia</td>
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<td>15</td>
<td>Friedrich J. Kutsaa</td>
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<td>16</td>
<td>Mthobeli Guma</td>
<td>Academic Anthropologist and Practicing Indigenous Healer</td>
<td>Member of Male Circumcision Task Team, Cape Town, South Africa</td>
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<td>17</td>
<td>Mzukisi Mawonga</td>
<td>Manager Male Circumcision</td>
<td>Department of Health Eastern Cape, Thornton, South Africa</td>
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<td>18</td>
<td>Nceba Gqaleni</td>
<td>KZN MC Provincial MC Task Force Member</td>
<td>Roger Phili, Director of HIV/AIDS, STIs and TB, KZN, Ministry of Health, Durban, South Africa</td>
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<td>19</td>
<td>Xola Kanta</td>
<td>Medical Doctor, Author, Trainer, Researcher on Male Circumcision</td>
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<td>20</td>
<td>Karl Peltzer</td>
<td>Research Director, Health Promotion Social Aspects of HIV/AIDS and Health</td>
<td>Human Sciences Research Council, Pretoria, South Africa</td>
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<td>21</td>
<td>Dr Elizabeth M Chabula-Nxiweni</td>
<td>Executive Director: Public Health Directorate</td>
<td>The Nelson Mandela Bay Municipality, Port Elizabeth, South Africa</td>
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<td>Mr. Lunga C. Mlumbi</td>
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<td>Sehlangu Kekana</td>
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<td>National Department of Health, Pretoria</td>
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<td>Ntloko Senzangakhona Solomon</td>
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<td>Pascience Kibatala</td>
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<td>John M. Wandwi *</td>
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<td>Julius Massaga</td>
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<td>Leonard Bufumbo</td>
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<td>Jaffer Saddiq Balyejusa</td>
<td>Surgeon and member of the National MC Task Force</td>
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<td>31</td>
<td>Haji Yusuf Wamboga</td>
<td>Spokesman for the Association of Traditional Circumcisers in Uganda</td>
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<td>Jonas Mwale</td>
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<td>Marx Mbunji</td>
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<th>40. Hamadou Boiro</th>
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<td>Professor Epidemiology &amp; Biostatistics</td>
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<td>School of Public Health</td>
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<td>Research Director: Social Aspects of HIV/AIDS and Health (SAHA) and Regional Director: SAHARA Southern Africa Human Sciences Research Council</td>
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<th>51. Kelly Curran</th>
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|   | **52. Molly O'Bryan**  
Senior Programme Coordinator  
Jhpiego - an affiliate of Johns Hopkins University  
Baltimore, USA | **53. Emmanuel Njeuhmeli**  
Senior Biomedical Prevention Advisor  
Global Health Bureau/Office of HIV/AIDS Technical Leadership & Research Division  
USAID  
Washington DC, USA |
|---|---|
| **54. Jason Reed**  
*Medical Epidemiologist  
Division of Global AIDS  
Center for Global Health  
US Centres for Disease Control and Prevention  
Atlanta, USA* |   |

*Unable to attend*
Annex 3: Country Plans

**Kenya**

**Recognize TMC**
TMC has a role to play in TMC practicing communities. However there are concerns for safety.
- Encourage collaboration between TMC and MMC practitioners.
- Establish and strengthen dialogue with MOH to support and improve TMC practice.
- National MC Task Force/Regional MC Task Forces should create an enabling environment for dialogue.
- TMC practitioners should establish an association, and together with MOH and other stakeholders define the norms and collaborative mechanisms to improve TMC practice.

**TMC monitoring and evaluation, quality improvement/assurance**
- Together with MOH and other stakeholders establish an M&E system to track TMC performance with emphasis on improving the quality and safety.

**TMC research**
MOH MC National/Regional Task Forces should consider carrying our research on the following areas of TMC to inform decisions on norms affecting TMC practice:
- Instruments currently in use.
- Cutting technique.
- Wound management
- Adverse events
- Enrolment and preparation for TMC

**Lesotho**

**Improving understanding and communication**
- Ministry of Health to have consultations with the National Traditional Council, using formal structures.
- Discussion will be around issues of male circumcision in the context of partial HIV reduction.
- Ministry of Health to establish Guidelines and Policies around TMC.
- Representative of TMCs to be part of the Nation Task Team.
- There needs to be ongoing information sharing between the MOH and TMCs.

**Improving Safety**
- Have methods for communities to identify Approved TMCs.
- Provide training.
- Supply the TMCs with appropriate equipment.
- Develop reporting and M&E systems.
Linking Medical MMC with TMC
- Since TMC will be part of the National Task Force they should actively participate in issues that involve them
- Develop system of referrals

Namibia

Improving collaboration
- The National MC policy recommends engagement with TMC and leaders
- Guidance from this meeting will help outline rules of engagement and guidelines
- Establish a TMC Association with regional representation
- Involve TMCs in the MC task force and at regional management level
- Ensure inclusion of a section on TMC in the Traditional Healer Act that is currently before parliament

Improving safety of TMC
- Identification/mapping/registration of all TMCs
- Standardized training (infection control, HIV competency, waste disposal, use of basic kits, post-operative care, medication, behavioural counseling, monitoring, evaluation and reporting)
- Supply of kits and replenishment
- Certification process
- Quality assurance

Linking TMC with MMC
- Develop framework of understanding/guidelines (level of interactions, roles and responsibilities, who does what, when and how)
- Establish a reliable bi-directional referral system between TMC and MMC
- Health sector to provide regular support visits to TMCs and camps
- Include TMC statistics in the national reporting system

South Africa

Collaboration
- Communicate recommendations from TMC meeting to National Department of Health (including human rights)
- Intersectoral task team (health, faith based, traditional health practitioners including TMC, traditional leaders, Traditional Nurses, SANAC task team) [bottom up approach]
- Reaching out: national/provincial/local/district
- Consultative workshops

Safety
• National THP act (gaps in the national legislation; rework, include traditional nurses; implementation code of conduct, minimum standards of training)
• Location, demarked space, access for monitoring
• Review and recommend TMC instrument and wound management
• Establishing of research and training academy in traditional MC and care (documentation of TCM, case studies)
• Provinces establishing a division in department for monitoring and evaluation, dedicated personal

Link TMC & MMC
• Integrated service (physical exam, HCT, involving TMC provider in exam, SRH, curriculum)
• Best practice (MMC & ritual; MMC in ritual location; etc)
• Task shifting (e.g. nurses carrying out MMC)

**Tanzania, Malawi, Uganda**

**Improvement of Understanding**
- Identification of TMCs through clan leaders: who are TMCs and where are they?
- Encourage formation of Associations of TMCs. Tanzania already has a Traditional and Alternative Medicine Act (2002)
- Invite TMCs and clan leaders to be part of the membership of oversight bodies
- All messages to go through grass root community structures
- M and E of the TMC process and eventual outcomes, including AEs. Feedback loop to be available inform TMCs

**Improvement of Safety**
- Regulatory framework in place
- Training of TMCs, e.g. anatomy, HIV, etc.
- Provision of supplies targeting infection control, haemorrhage, etc.
- Local surgical associations to be involved in the TMC e.g. training, monitoring
- M and E

**Building linkages between TMC and MMC**
- Formation of Task Force on male circumcision whose membership includes TMCs and MMCs
- Develop and encourage referrals between TMCs and MMCs
- Identify acceptable medical personnel to deliver health education messages to TMCs

**Zambia**

**What We Will Do**
- Consultative/Consensus Meeting
  - Defining a body
Consensus on components of a policy framework

- Engagement of TMCs in the development of standards
- Carry out a needs assessment
- Finalize training package, up-grade sites and establish referral systems, and develop an M&E framework
- Leveraging resources for on-going programming

Components of a Policy Framework

- Selection/Identification of TMCs
- Registration while regulatory framework is being developed
- Guidance on collaboration
- Client screening (including age/selection/referral)
- HIV counseling and testing, and MC counseling
- Consent and assent
- Safety issues (IP and surgical procedure, environment and after care)
- Use of drugs and anesthesia
- Issue of standardization of circumcision to suit both HIV risk reduction objectives and traditional standards
- Policy enforcement mechanism including M&E
- Protection of respect of cultural values and practices
- Description of minimum standards of TMC premises
- Guidance on how to manage AEs

Zimbabwe

Zimbabwe has already held a meeting with the TMCs and most of the issues discussed in this meeting have to some extent been addressed.

Improving collaboration between TMC and MMC

- Feedback to the MC steering committee and MOH
- Feedback to the TMC leadership
- Feedback to the chief's council chapters
- Stakeholder meeting to discuss how the linkages should be managed with representation of the MC Programme, TMC groups, traditional leadership, and representatives of the population.
- Meeting chaired and convened by MOH.

Actions to improve safety

- Identification of TMCs in the different parts of the country.
- Develop a minimum training package for TMCs to include the type of procedure and referral
- Putting in place a system for monitoring TMC
- Training of TMCs

Improving linkages

- Consultative meetings with chiefs
Clarity on what each sector is contributing/bringing to the discussion.
- Non-confrontational approach
- Identification of the good things each sector is doing in MC
- Representation of the TMC in the local level health sector

**West Africa (Ghana, Guinea Bissau, Senegal)**

**What to do:**
- Disseminate information from the consultation to Ghana and Guinea Bissau health services
- Strengthen existing communication between MMC and TMC to improve MC in general
- In Guinea-Bissau promote the reduction of the age of circumcision from 30 years to 7 years
- Involved women in MC

**Safety**
- National policy on TMC
- Who should do TMC
- What age for the most effective prevention of HIV
- Where should the TMC be done
- Standardize instruments to be used
- Develop a training package
- Structured training for TMCs
- Develop monitoring tools and involve nurses and some TMCs in the monitoring

**Linkages**
- Improve understanding between MMCs and TMCs
- Meeting with leaders of TMC groups e.g. imams, kanma, balobeiro, dunu di chon
- Identify good practices of TMC and build on it
- MMCs to take part in the operations of TMCs where possible
- Sensitize the TMCs in prevention of HIV