Meeting Report

Consultation on Male Circumcision and HIV prevention in the African Region

Brazzaville, Congo, 2-4 April 2008
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1. Introduction

Sub-Saharan Africa remains the most affected region by HIV/AIDS. Some 1.7 million people were newly infected with HIV in 2007, bringing to 22.5 million the total number of people living with the virus.\(^1\)

Male circumcision is common in many African countries and is almost universal in North Africa and most of West Africa. In contrast it is less common in Southern Africa, where self reported prevalence is around 15% in several countries (Botswana, Namibia, Swaziland, Zambia, and Zimbabwe) although higher in others. Prevalence in Central and Eastern Africa varies from approximately 15% in Burundi and Rwanda to 70% in the United Republic of Tanzania, and 93% in Ethiopia.\(^2\)

There is a strong geographical correlation between male circumcision practices and lower HIV prevalence, and numerous observational studies have also identified lack of circumcision in men as a risk factor for acquisition of HIV, particularly among men at higher risk of acquiring HIV. It has been difficult, however, to unravel to what degree the apparent protective effect of male circumcision is due to confounding, as many factors such as religion and ethnicity are associated with male circumcision and also have a major influence on risk behaviours.

On 13 December 2006, two trials in Kenya and Uganda assessing the impact of male circumcision on HIV incidence in men confirmed results of a similar trial in South Africa which demonstrated at least a 60% reduction in risk.\(^3\) The challenge now is how to translate this research evidence into policies in countries most affected by the HIV epidemic and with low MC prevalence rates. Another critical issue is to support the implementation and rapid scale up of comprehensive and sustainable country programmes.

In March 2007, following the release of the findings from the Kenya and Uganda trials on Male circumcision and HIV prevention, WHO convened an International consultation in Montreux, Switzerland, on “Male circumcision and HIV Research; Implications for Policy and Programming” to examine the results of the trials and their implications for countries, particularly those in sub-Saharan Africa and elsewhere with high HIV prevalence and low male circumcision rates. The Consultation reviewed the detailed trials findings and then defined specific policy recommendations for expanding, promoting, and integrating male circumcision into other health services in a context of a comprehensive prevention package.

Using WHO/UNAIDS recommendations as a reference, the WHO Regional Office shared an information note on Male circumcision and HIV prevention at the 57th Session of the Regional Committee. The debate generated interest and inputs from the Ministers were incorporated into the final draft that was released in September 2007. During the discussions, the Ministers recommended that a consultative meeting be organised early 2008 to review the evidence on MC and HIV prevention and discuss the way forward.

This consultative meeting brought together country representatives, experts involved in HIV prevention and MC and development partners involved in supporting scale up of HIV/AIDS interventions in the African region. The meeting came up with consensus on strategic orientations for MC within the context of the broader HIV prevention agenda in the African region.

\(^1\) 2007 UNAIDS Epidemiological report
\(^2\) Male circumcision: Global trends and determinants of prevalence, safety and acceptability, February 2007
\(^3\) WHO-UNAIDS recommendations on MC and HIV prevention, March 2007
2. Objectives and Expected Outcomes

2.1. General Objective
The general objective was to contribute to the scaling up of effective and evidence based HIV prevention interventions in the African region.

2.2. Specific Objectives
The Specific objectives of the meeting were to
• review the evidence on MC and HIV prevention and WHO-UNAIDS recommendations;
• share country experiences in implementing MC for HIV prevention;
• review and agree on the strategic orientations for scaling up MC for HIV prevention in the WHO Africa region;
• formulate recommendations for the way forward

2.3. Expected Outcomes
The Expected Outcomes were as follows
• Evidence on MC and HIV prevention and WHO-UNAIDS recommendations reviewed;
• Country experiences in implementing MC for HIV prevention shared;
• Orientations for scaling up MC for HIV prevention in the WHO Africa region agreed upon;
• Recommendations from the meeting formulated;

3. Methods of work
The methods of work were
• Plenary presentations followed by discussions;
• Group work to review the draft document on strategic orientations for scaling up MC in the WHO Africa region;
• A team was put together to draft meeting’s recommendations.

4. Participants
Country participants were selected based on the magnitude of HIV burden and the level of MC rates, particularly countries with high HIV prevalence and lower MC rates. Participating countries included Botswana, Burundi, Kenya, Malawi, Mozambique, Namibia, Lesotho, Rwanda, Tanzania, South Africa, Swaziland, Uganda, Zambia and Zimbabwe. Country representatives were senior technical programme managers including health policy makers, HIV/AIDS programme managers, epidemiologists, senior researchers, experts working on HIV prevention/MC and development partners involved in HIV/AIDS.

There was also participation from two countries that culturally practice MC; Senegal and Ghana; the Principal Investigators of the 3 RCTs in South Africa, Kenya and Uganda; experts/researchers involved in MC work and HIV prevention in the African region; participants from Health Bureaus of Sub-regional Organizations SADC and ECA and an NGO network (African Youth and Adolescents Network on Population and Development).

Participants from the World Health Organisation included AFRO Regional and IST Prevention focal persons, staff from HIV/AIDS Unit; Sexual and Reproductive Health Unit; Health Promotion; Child and Adolescent Health; DSD as well as HQ Prevention in the Health Sector focal point. UN and other partner Representation was from UNAIDS/HQ; UNAIDS RST for East
and Southern Africa; UNFPA RST for East and Southern Africa; UNICEF ESARO; PEPFAR and the Bill and Melinda Gates Foundation;

5. Opening session (Highlights of the opening remarks)
The meeting was opened by DPM on behalf of the Regional Director who stated that it was an opportunity to review the evidence and recommendations with respect to Male Circumcision (MC) as an additional prevention tool; share early experiences and formulate the way forward flowing from the debate from a similar meeting held last year. He highlighted the need to reverse the trend of HIV through intensified prevention, stating that MC could make a difference over 10 years if implemented on a wide enough scale whilst also contributing to strengthening the Health System. He noted that many countries had endorsed MC as an integral part of prevention plans and policies but others were still hesitant despite the evidence.

ATM stated that the results of the Randomized Control Trials were promising and yet challenging compared to other new interventions and indeed this was the second time since the advent of PMTCT that we have an additional prevention tool. The representative from UNAIDS spoke about MC as being a surgical intervention which prevented sexually transmitted infections but also reiterated the need to be wary of risk compensation.

The objectives and expected outcomes of the meeting were introduced by RPA

6. Presentations and discussions

6.1. Objective 1
The first objective was to update participants on the evidence on MC and HIV prevention. Presentations were made by WHO on the ‘Overview of the observational, epidemiological evidence on Male Circumcision and HIV prevention’; by Investigators from the 3 RCTs on the actual evidence and by WHO on the ‘WHO/UNAIDS recommendations on MC and HIV Prevention’.

6.1.1. Summary of the main contents of the presentations
1. Overview of the evidence
The presentation highlighted on the prevention research landscape; the historical perspective and prevalence of Male Circumcision; determinants and health benefits and Male Circumcision for HIV prevention. Information was shared on the biological rationale for the HIV/MC link; modeling of the impact of MC on HIV prevalence and incidence as well as the different studies and evidence.

2. Evidence on MC and HIV prevention from the three RCTs
Features of all three studies where presented including details of their objectives, locations, trial/study design, study population and recruitment, results, discussion, conclusions and recommendations. All three studies were stopped midway by their respective data safety and monitoring boards before their completion dates.

3. WHO/UNAIDS Recommendations on MC and HIV prevention
The background of the expert consultation on safe male circumcision held after the 3 RCTs proved that MC provided partial protection was given. The eleven conclusions and related recommendations were also presented.
6.1.2. Main issues
The main issues for discussion included MC as part of a comprehensive package; its implementation within each country’s context and the challenges of rolling it out. Specifically discussed were communication, cost, age at which circumcision is best performed, access concerns (especially for youth and rural areas), and the capacity of health workers and facilities for hospital based circumcision for non-circumcising communities. Strong points were articulated on concerns of cultural context and the need to look more closely at traditional circumcision. In circumcising communities, issues included assessing and building capacity to provide safe circumcision, engaging traditional circumcisers and making facility based and neonatal circumcision more popular. There was some deliberation on whether it is possible to change culture of non-circumcising communities in the long term.

On the RCTs, issues raised were around early resumption of sex before would healing, client loss to follow up and the recruiting HIV positive men. The main challenge was identified as the rolling out of MC as part of the comprehensive HIV prevention strategy, with the emphasis being on SAFE MC, addressing issues related to youth and universal access.

6.1.3. Key conclusions of the discussions
The key conclusions of the discussion were that MC is additional and must be delivered as part of a comprehensive package of prevention interventions in response to HIV and also that it must be seen as an opportunity to reach men. It should be scaled up within the broader local context and correct packaging of communication is critical. Health systems issues must be addressed to ensure that services are provided safely. Consideration must also be given to the fact that MC is easier to perform in infants and children. Maximizing the public health benefit is crucial and traditional circumcisers and communities should be engaged in the scale up. Also there should be facilitation of involvement of partners in the decision to undergo MC to support until wound heals and targeting of higher risk populations first for better effects.

6.2. Objective 2
The second objective was to share countries experiences in implementing MC for HIV prevention and presentations were made by Botswana and Swaziland. Country experiences were shared by Ghana and Senegal on MC in the context of traditional / cultural practice.

6.2.1. Summary of the main contents of the presentations
1. Botswana safe MC add-on strategy for HIV prevention
The presentation gave an overview of past practice of MC in Botswana, where MC rates were estimated to be below 20%, and also progress since October 2007. High level political commitment has resulted in the development of structures, consultations and the development of a strategy. The presentation also discussed challenges of which human resource was most major, and the way forward

2. Male Circumcision for HIV prevention; the Swazi Experience
A background on Swaziland and the country’s HIV and MC situation was given. Swaziland’s process of preparing for and scaling up MC which included the constitution of a multi disciplinary task force, development of policy, formation of clinical and BCC committees all to support the integration of MC into existing prevention strategies/programmes

3. Circumcision for HIV prevention in Swaziland; achievements and aims
The presentation described the Swaziland Task Force and its operations which included having 'circumcision Saturdays', standardized protocols and specifically trained doctors and facilities
and methods of patient recruitment and follow up. Government policy, plan, short and long strategies were also described.

4. Male Circumcision and HIV in Ghana
The presentation focused on the background of HIV and MC prevalence, Regional variations and practitioners. It highlighted collaboration between clinical and traditional practitioners towards making the practice safer through capacity building and the way forward of scaling up, monitoring and strengthening referrals and linkages.

5. Questions on the promotion of MC for the prevention of HIV in the context of cultural practice in Africa
The presentation focused on social construction of change within the context of MC in Senegal. The traditional surgeons can not be found in all ethnic groups but other groups take their children to them. It also elicited the fact that MC is not seen as medical but largely social as well and with a variety of reasons why it is performed. These socio-cultural issues should all be taken into consideration when considering the expansion of MC and its sustainability.

6.2.2. Main issues
The main issue was Botswana’s progress, which was found to have been remarkable since November 2007 because of the political commitment from the President of the country. Swaziland had also progressed as far as developing a detailed and costed plan, indicating how many circumcisions could be done within specific period for coverage which will maximize the public health benefit.

6.2.3. Key conclusions of the discussions
Political commitment is a major influence on the scale up of MC. It is also critical to have policies and realistic plans developed taking into consideration the realities on the ground. Integration, training, standardization of the procedure and equipment also facilitates roll out and task shifting must be a consideration to ease the human resource challenges. There is a need to target most at risk men in the context of HIV status, particularly sero-discordant couples.

Sharing of information, documentation and experiences provides encouragement and ideas and there is a need to ensure that there is balance between culture and medicine as well as dialogue between communities and the clinical group.

6.3. Objective 3
The third objective was to review and agree on the strategic orientations for scaling up MC for HIV prevention in the WHO Africa region. A presentation was made on the strategic orientations, an update given on the Global/Regional level partnerships to support scale up of MC activities and then participants undertook group work.

6.3.1. Summary of the main contents of the presentations
The key principles of the strategic orientations for scaling up were the avoidance of isolation of MC programming and the customization to local contexts. The fourteen strategies were presented for discussion.

6.3.2. Main issues
The three groups individually reviewed the Strategic Orientations document and made presentations on their versions of the updated document. The TORs for group work were

o Review the draft strategic orientation document and provide inputs
The draft document on ‘HIV Prevention: Strategic Orientations for Scaling up Male Circumcision for HIV Prevention in Sub-Saharan Africa’ which was developed to improve the availability, accessibility and safety of MC within the broader context of HIV prevention and sexual reproductive health formed the basis of group work.

Methodology

Participants were divided into 3 groups with the defined terms of reference. Based on the evidence, recommendations and discussions of the previous days in the meeting, the experiences and expertise of the individuals, groups were asked to

1. review the draft document and provide inputs
2. summarize the group inputs in a 10 minute PowerPoint presentation
3. present the outcome of the group work in the plenary session

6.3.3. Key conclusions of the discussions

Key inputs into the strategic orientations document

Participants felt that the document was well written but could be strengthened and gave suggestions. These included adding on an executive summary; a preamble introducing MC as a new technology to complement other interventions; document references and in some areas, more detail. There were also suggestions to harmonize terms, annex all tool kits and reorganize/restructure the document for better flow. It was thought that some points needed more emphasis including the compelling nature of evidence; the role of traditional MC providers and how to work effectively with them by making traditional MC safe (infection prevention and pain management) and more effective for HIV prevention through highlighting complete removal of foreskin.

Other suggestions were the inclusion of issues of involvement of women and families in an enhanced package; adolescent services; community outreach; acceptability and stigma-associate to HIV and Male Circumcision. Health systems challenges such as infrastructure, referral systems and definition of packages and processes of integration of MC with existing services also need to be highlighted. The document could also clearly spell out linkages of national HIV strategic Plan and MC; and deal with issues of integration of private health providers and inclusion into in and pre service curricula of health workers. The roles of other development partners and UN agencies as sponsors could be also be better clarified. Research needs to be stressed on, particularly in social-cultural practices, the perceptions of non direct benefits for women and for establishing best methods of collaboration

An additional Strategic Orientation was suggested which would deal with Human Rights, Ethical and Legal Issues Include key pts from the UN guideline: e.g.: non-discrimination, informed consent, sensitivity to socio-cultural concerns especially in traditional contexts), confidentiality, age of consent, safety/quality assurance
7. Group work
A smaller group of participants was constituted to come up with the key conclusions and recommendations of the meeting, taking into account the presentations and the rich discussions which were held during the plenary sessions.

8. Key conclusions and recommendations of the meeting
The small group worked together during breaks on two of the days to consider the issues discussed and developed the document with the conclusions and recommendations of the meeting. These centered on research gaps and priorities, advocacy, partnerships, effective communication, improved collaboration, policies and strategies for scale up, human resource issues, monitoring and evaluation as well as tools, guidelines and technical assistance

Draft Document

1. Background

Nearly two thirds of the people living with HIV reside in sub-Saharan Africa. New HIV infections are occurring at alarming rates despite a range of prevention efforts. Preventing new infections is key to stemming the HIV epidemic in the African Region.

The WHO and UNAIDS international expert consultation on male circumcision and HIV prevention held in Montreux, Switzerland from 6 to 8 March 2007, concluded that the evidence from randomized controlled trials, undertaken in Kenya, South Africa and Uganda demonstrates that safe male circumcision reduces the risk of heterosexual transmission of HIV infection from women to men by approximately 60%. The trials also showed that male circumcision performed by well-trained medical professionals in properly equipped facilities is safe.

The Montreux meeting concluded that the research evidence is compelling and recommended that safe male circumcision should be recognized as an efficacious intervention for HIV prevention. Eleven conclusions and recommendations for policy and programmes were outlined in the document New Data on Male Circumcision and HIV Prevention: Policy and Programme Implications. The recommendations emphasized that male circumcision provides only partial protection against HIV and therefore it should be considered as part of a comprehensive package of HIV prevention interventions.

In August 2007, the WHO Regional Office submitted an information note on Male circumcision and HIV prevention at the 57th Session of the Regional Committee for review by the Ministers of Health. Inputs from the Ministers were incorporated and the information note was released in September 2007. During the discussions, the Ministers recommended that a consultative meeting be organized early 2008 to review the evidence on MC and HIV prevention and discuss the way forward. A consultative meeting on male circumcision and HIV prevention in the African region convened in Congo, Brazzaville from April 2-4, 2008 as a follow up to the request. The meeting participants consisted of representatives from 17 countries in sub-Saharan Africa, researchers and technical experts.

2. Conclusion 1
Having discussed the available research evidence from the observational, epidemiological and randomized controlled trials, the meeting participants concurred with the conclusions and recommendations of the Montreux 2007 international consultation.
The meeting participants agreed that the evidence that male circumcision provides partial protection against HIV acquisition in men is indeed compelling.

Participants noted that there remain research gaps and unanswered questions that still need to be addressed. Critical issues that emerged from the consultation include: the implications for women of male circumcision for HIV prevention, the effectiveness of the protective effect over the long term, models for scale up, traditional providers.

**Recommendations**

1.1 Urgent steps need to be taken to determine the research gaps and identify research priorities. This agenda needs to be determined and led within the region with the full involvement and engagement of the relevant regional bodies.

1.2 The proposed WHO/UNAIDS/UNFPA/UNICEF meeting at the end of June to determine the implications of male circumcision for women is critical and needs to be supported.

**Conclusion 2**

Having reviewed and discussed the WHO/UNAIDS policy and programme recommendations for male circumcision and HIV prevention the meeting participants agreed that the recommendations address many of the critical issues and questions facing countries. The participants endorsed the recommendations, encouraged countries to consider them and customize them to suit particular local contexts.

**Recommendations**

2.1 WHO should lead advocacy within the region to disseminate the recommendations.

2.2 Traditional male circumcision plays an important role in the African region and meeting participants strongly recommended that regional and country consultations be held to review and assess the role of traditional practitioners, determine the synergies, investigate possible models of collaboration and make specific recommendations on their role to maximize the contribution to HIV prevention.

2.3 Considering the critical human resource constraints within the region task shifting strategies should be considered to increase the number of male circumcision providers if safe, quality services are to be scaled up to reach a substantive mass over a short period of time.

2.4 The UNAIDS led Decision-Makers tool needs to urgently made available countries supported to use it to determine resource requirements for alternative programming choices and impact on the epidemic.

2.5 Scale up plans should have strong communication components. Appropriate communication strategies need to be developed to The UN Male Circumcision and HIV Prevention in Southern and Eastern Africa, Communication Guidance documents should be widely disseminated and countries supported to develop communication strategies.

2.6 Male Circumcision Monitoring and Evaluation Guidance needs to be urgently finalized and countries support to implement it.

**Conclusion 3**

The meeting participants recognized that the country experiences shared at the meeting were encouraging and provided useful guidance to others planning on scaling up.
Recommendations
3.1 Where relevant, countries need to develop national policy and strategy through a consultative process to guide roll out. This process should cover a thorough discussion of the evidence and the limitations of male circumcision. Operational guidance needs to be developed to support country programme planning and implementation.

3.2 Mechanisms should be put in place for ongoing exchange of experiences and south-to-south collaboration.

3.3 Tools and guidelines being developed by the WHO-led UN Inter Agency Task Team and partners need to be disseminated and countries supported to use them.

3.4 Systems and mechanisms need to be developed to provide technical support to countries for scale up through the WHO-led UN Inter Agency Task Team and PEPFAR implementing partners and there should be coordination of such support.

5. Conclusion 4
The meeting reviewed the WHO Male Circumcision for HIV Prevention Strategic Orientations for the African Region document, commended WHO for the efforts and endorsed the document.

Recommendations
4.1 The document needs to be revised based on the suggestions provided by the meeting participants and finalized as soon as possible and disseminated.

9. Closing

On behalf of the participants, the participant from Burundi thanked the organizers for the meeting, institutions and countries who shared the evidence and experiences and all other partners who participated. He described as a good sign of South-South cooperation which will be supported especially by WHO and

Closing remarks were delivered by UNAIDS who thanked participants on behalf of the UN agencies

The meeting was closed by ATM on behalf of the Regional Director, who reminded participants of the emergency HIV; current efforts and resources for HIV response activities; progress made in countries and the need to do a lot more. Evidence is available but there are also questions and further issues which need to be addressed and also ensure that countries and the agenda move forward. Further consultation needs to be held on MC and women as well as MC and traditional practices. He announced that there was a need to share results with the Ministers before the end of June and thanked participants for their contribution.
### Annexes

Consultation meeting on Male Circumcision and HIV prevention in the African region  
Brazzaville, Congo, 2-4 April 2008  
Provisional Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Facilitator</th>
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<tbody>
<tr>
<td><strong>Day 1: 2 April 2008</strong></td>
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<tr>
<td>08:00 – 09.00</td>
<td>Registration</td>
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<tr>
<td><strong>Official Opening</strong></td>
<td>Welcome, by Director of AIDS, Tuberculosis and Malaria</td>
<td>AFRO</td>
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<tr>
<td>09:00 – 10:00</td>
<td>Meeting objectives and expected outcomes</td>
<td>AFRO</td>
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<tr>
<td></td>
<td>Introduction of participants</td>
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<td>Statement from UNAIDS, on behalf of co-sponsors</td>
<td>UNAIDS</td>
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<td></td>
<td>Official Opening by the WHO Regional Director for Africa</td>
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<td></td>
<td>Administrative announcements including security briefing</td>
<td>AFRO</td>
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<tr>
<td><strong>Objective no 1</strong></td>
<td>To update participants on the evidence on MC and HIV prevention</td>
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<tr>
<td>10:00 – 10:20</td>
<td><strong>TEA BREAK</strong></td>
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<tr>
<td>10:20-10.30</td>
<td>Group photo</td>
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<tr>
<td>10:30 – 12:30</td>
<td>Overview of the observational, epidemiological evidence on male circumcision and HIV prevention</td>
<td>WHO/HQ</td>
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<td>Selected country presentations on observational data on HIV prevalence in relation with MC prevalence</td>
<td>Malawi, South Africa and Zambia</td>
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<td>Discussion</td>
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<td></td>
<td>Presentation of the evidence on male circumcision and HIV prevention from the 3 RCTs</td>
<td>Principal investigators</td>
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<td>Discussions</td>
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<tr>
<td>12:30 – 14:00</td>
<td><strong>LUNCH BREAK</strong></td>
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<tr>
<td>14:00 – 14:45</td>
<td>Discussions on evidence (ctd)</td>
<td>WHO/HQ</td>
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<td>Discussion</td>
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<tr>
<td>14:45-15:30</td>
<td>Presentation and discussion of the WHO-UNAIDS recommendations on MC and HIV prevention</td>
<td>AFRO</td>
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<tr>
<td>15:30-16:00</td>
<td><strong>TEA BREAK</strong></td>
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<tr>
<td><strong>Objective 2</strong></td>
<td>To share countries experiences in implementing MC for HIV prevention;</td>
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<tr>
<td>16:00 – 17:00</td>
<td>Country experiences with MC in the context of HIV prevention</td>
<td>Botswana, Swaziland</td>
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<td></td>
<td>Discussions</td>
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<td>17:00-17:30</td>
<td>Secretariat meeting</td>
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<td>18:00-19:30</td>
<td>Cocktail</td>
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<td>Time</td>
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<tr>
<td>**Day 2</td>
<td>3 April 2008</td>
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<tr>
<td>09:00 – 09:30</td>
<td>Country experiences with MC in the context of traditional practice (ctd)</td>
<td>Senegal or Ghana</td>
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<td>Discussions</td>
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<tr>
<td><strong>Objective 3</strong></td>
<td><strong>To review and agree on the strategic orientations for scaling up MC for HIV prevention in the WHO Africa region</strong>;</td>
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<tr>
<td>09:30-10:30</td>
<td>Discussion on strategic orientations for scaling up MC for HIV prevention in the African region</td>
<td>AFRO</td>
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<td>Discussions</td>
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<td>10:30-11:00</td>
<td><strong>TEA BREAK</strong></td>
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<tr>
<td>11:00-12:00</td>
<td>Update on Global/Regional level partnerships to support scale up of MC activities (UN, PEPFAR, Gates, GFATM)</td>
<td>UNAIDS</td>
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<td>12:00-13:30</td>
<td><strong>LUNCH BREAK</strong></td>
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<tr>
<td>14:00-15:30</td>
<td>Group Work on strategic orientations</td>
<td>AFRO</td>
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<td>15:30-16:00</td>
<td><strong>TEA BREAK</strong></td>
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<tr>
<td>16:00-17:00</td>
<td>Group Work on Strategic orientations (ctd)</td>
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<td>17:00-17:30</td>
<td>Secretariat meeting</td>
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<td><strong>Day 3: 4 April 2008</strong></td>
<td><strong>Plenary report of group work Followed by discussions</strong></td>
<td>AFRO</td>
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<tr>
<td>09:00-11:00</td>
<td>Plenary report of group work Followed by discussions</td>
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<tr>
<td>11:00-11:30</td>
<td><strong>TEA BREAK</strong></td>
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<tr>
<td>11:30-13:30</td>
<td>Finalization of draft of meeting recommendations</td>
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<td><strong>LUNCH BREAK</strong></td>
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<tr>
<td>13:30-14:30</td>
<td>Presentation and adoption of the meeting recommendations</td>
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<tr>
<td>14:30-15:00</td>
<td>Closing</td>
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**Reference documents:**

- HIV prevention in the African region “Strategy for renewal and acceleration”