Consultation on Male Circumcision and HIV Prevention in the African Region

Brazzaville, Congo, 2–4 April 2008

Key Outputs of the Meeting

World Health Organization
REGIONAL OFFICE FOR Africa

AFR/HIV/08.01

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Contents

1. Background

Sub-Saharan Africa remains the region most affected 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 (MC) is common in many African countries and is almost universal in North Africa and most of West Africa. By 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 the rate is 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 determine the apparent protective effect of male circumcision since many factors such as religion and ethnicity are associated with male circumcision and also have a major influence on risk behaviour.

On 13 December 2006, two randomized controlled trials (RCTs) in Kenya and Uganda on 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 MC 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 and their findings and then defined specific policy recommendations for expanding, promoting, and integrating male circumcision into other health services within the context of a comprehensive prevention package.

Using WHO/UNAIDS recommendations as a reference, the WHO Regional Office for Africa shared an information note on MC 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 in 2008 to review the evidence on MC and HIV prevention and discuss the way forward.

The consultation took place in Brazzaville at the WHO Regional Office for Africa from 2 to 4 April 2008. It brought together country representatives, principal investigators involved in the three randomised controlled trials, research experts, HIV/AIDS programme managers, and development partners involved

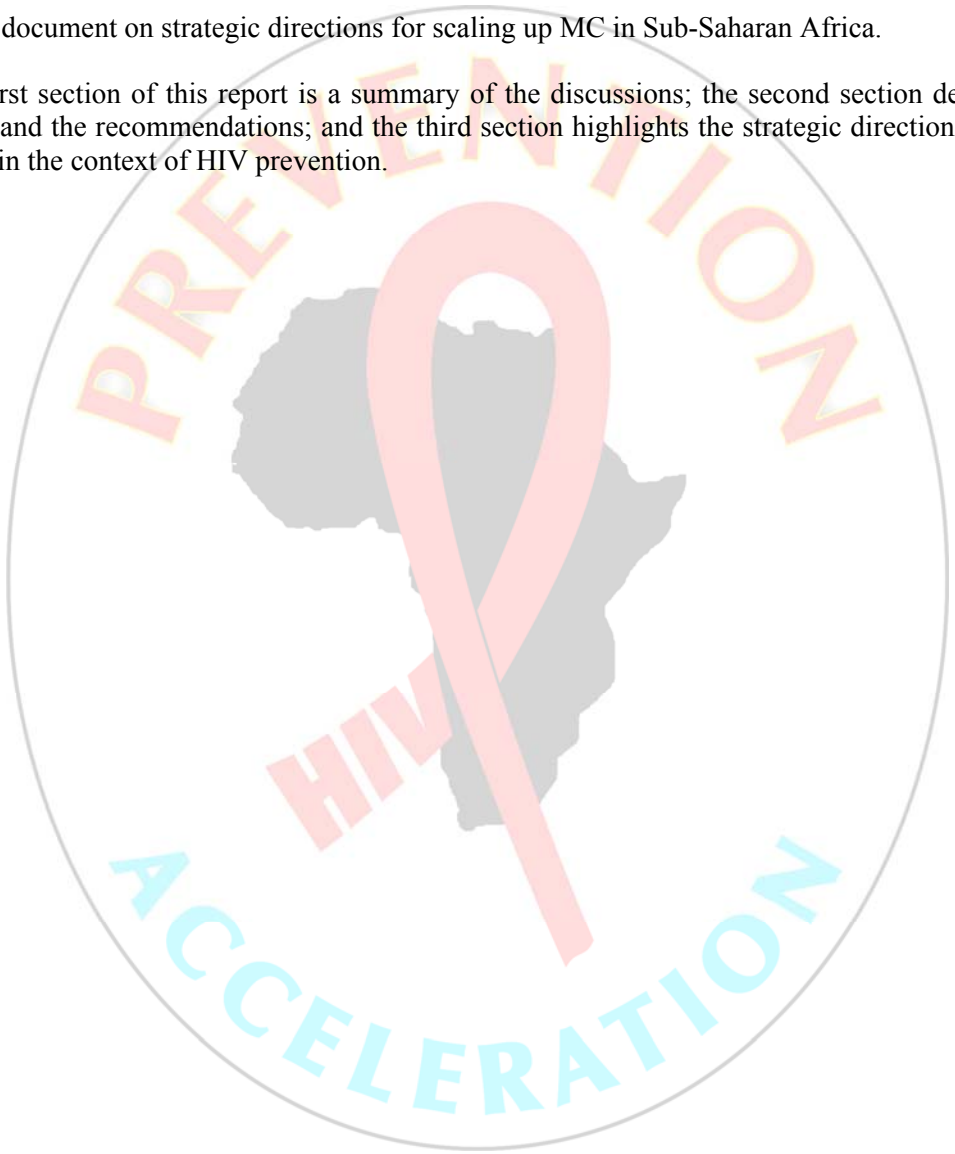
[1] 2007 UNAIDS Epidemiological report.
[2] Male circumcision: Global trends and determinants of prevalence, safety and acceptability, February 2007.
[3] WHO-UNAIDS recommendations on MC and HIV prevention, March 2007.

in supporting scale up of HIV/AIDS interventions in the African Region. Details are repeated in Section I of this report.

The consultative meeting produced three products:

- The meeting report itself which highlights the processes and provides a summary of the discussions that took place;
- The meeting conclusions and recommendations;
- A document on strategic directions for scaling up MC in Sub-Saharan Africa.

The first section of this report is a summary of the discussions; the second section deals with the conclusions and the recommendations; and the third section highlights the strategic directions for scaling up safe MC in the context of HIV prevention.



PART I

SUMMARY OF THE DISCUSSIONS

1. Objectives and Expected Outcomes

1.1. General Objective

The general objective of the meeting was to contribute to the scaling up of effective and evidence based HIV prevention interventions in the African Region.

1.2. Specific Objectives

The specific objectives of the meeting were to:

- Review the evidence on male circumcision (MC) and HIV prevention;
- Review the WHO-UNAIDS recommendations;
- Share country experiences in implementing MC for HIV prevention;
- Based on the reviews, agree on the strategic directions for scaling up MC for HIV prevention in the WHO African Region;
- Formulate recommendations for the way forward.

1.3. Expected Outcomes

The expected outcomes were:

- To review evidence on MC and HIV prevention and WHO-UNAIDS recommendations;
- To share country experiences in implementing MC for HIV prevention;
- To agree on orientation for scaling up MC prevention in the WHO African Region;
- To formulate recommendations from the meeting.

2. Method of work

- Presentations were made in plenary sessions followed by in-depth discussions;
- Groups reviewed the draft document on strategic orientations for scaling up Male Circumcision in the WHO Africa Region;
- A team was put together to draft the meeting's conclusions and recommendations.

3. Participants

Participants were selected based on the magnitude of the HIV burden and the MC rates in their countries. Priority was given to countries with high HIV prevalence and lower MC rates. The countries invited included Botswana, Burundi, Kenya, Malawi, Mozambique, Namibia, Lesotho, Rwanda, Tanzania, South Africa, Swaziland, Uganda, Zambia and Zimbabwe. Participants from Mozambique could not attend the meeting.

Country representatives were senior officials, health policy makers, HIV/AIDS programme managers, epidemiologists, senior researchers, experts working on HIV prevention and MC and development partners involved in HIV/AIDS programming and implementation.

There was also participation from Senegal and Ghana, two countries that culturally practice MC; the principal investigators of the 3 Randomized Controlled Trials (RCTs) in South Africa, Kenya and Uganda; experts or researchers involved in MC work and HIV prevention in the African Region; participants from Health Bureaus of sub-regional organizations (SADC and ECA) and from civil society organizations.

Participants from the World Health Organisation included Regional Office and HIV intercountry support teams staff; staff from the HIV/AIDS Unit, Sexual and Reproductive Health, Health Promotion, Child and Adolescent Health, as well as the WHO/HQ focal person for new technologies. Other UN agencies and partners included UNAIDS and Family Heath International. The list of participants is attached to this report.

4. Opening session

The meeting was opened by the Director, Programme Management (DPM) on behalf of the Regional Director. DPM stated that it was an opportunity to review evidence and recommendations with respect to MC as an additional prevention tool; share early experiences and chart the way forward. He highlighted the need to reverse the trend of HIV through intensified prevention, stating that MC could make a difference in 10 years if implemented on a wide enough scale and if we continued to strengthen health systems. He noted that some countries had endorsed MC as an integral part of their prevention plans and policies but others were still hesitant despite the evidence.

The Director of AIDS, Tuberculosis and Malaria in the Regional Office stated that the results of the randomized controlled trials were promising yet challenging, compared to other new interventions. He added that this was the second time since the advent of Prevention of Mother-To-Child Transmission (PMTCT) that there was evidence of an effective additional prevention tool.

The representative from UNAIDS said MC was a surgical intervention which prevented HIV and some other sexually transmitted infections but we had to be aware of risk compensation.

The objectives and expected outcomes of the meeting were introduced by the Programme Manager for HIV/AIDS in the Regional Office.

5. Presentations and discussions

5.1 Session on Evidence on MC and HIV prevention

5.1.1 Presentations

The first objective was to update participants on the evidence on MC and HIV prevention. A presentation was made by WHO on the 'Overview of the observational and epidemiological evidence on MC and HIV prevention'. The presentation highlighted the prevention research landscape, the historical perspective and prevalence of MC, determinants and health benefits of MC, and findings from observational and epidemiological evidence. Information was also shared on the biological rationale for the MC- HIV link and on modeling of the impact of MC on HIV prevalence and incidence.

The principal investigators made detailed presentations on the findings from the 3 randomized controlled trials (RCTs). Features of all three studies were presented, including details of their objectives, locations, the trials, study design, study population and recruitment, results, discussion, conclusions and recommendations.

A WHO expert made a presentation on WHO/UNAIDS recommendations on MC and HIV prevention. These were drawn from the "WHO/UNAIDS consultation on male circumcision and HIV prevention: research implications for policy and programming". Montreux, 6–8 March 2007". The eleven conclusions and related recommendations were presented.

5.1.2 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 the health sector in non-circumcising communities to scale up MC. Strong points were articulated on the cultural dimension of MC 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 influence changes of culture of non-circumcising communities in the long term.

On the RCTs, issues raised revolved on early resumption of sex before wound healing, client loss to follow up and recruitment of HIV positive men. The main challenge was identified as the rolling out of MC as part of the comprehensive HIV prevention strategy, with emphasis on safe MC and issues related to youth and universal access.

5.1.3 Key conclusions from the discussions

The key conclusions from the discussions were that MC is additional and must be delivered as part of a comprehensive package of prevention interventions in response to HIV and 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. There should also be facilitation of involvement of partners in the decision to undergo MC and to provide support until the wound heals. There should also be consideration for targeting higher risk populations first for better effects.

5.2 Session on sharing country experiences

5.2.1 Presentations

The second objective was to share country experiences in the implementation of MC for HIV prevention. Presentations were made by Botswana and Swaziland. Country experiences were also shared by Ghana and Senegal on MC in the context of traditional or cultural practices.

The presentation from Botswana was entitled "Botswana safe MC add-on strategy for HIV prevention". This was an overview of the past practice of MC in Botswana, where MC rates were estimated to be below 20%, and a report on 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 including shortage of skilled human resources, and the way forward.

The presentation from Swaziland was entitled "Male Circumcision for HIV prevention: the Swazi Experience". A background on Swaziland and the country's HIV and MC situation was given. It also highlighted Swaziland's process of preparing for and scaling up MC which included the constitution of a multidisciplinary task force, development of a policy, formation of clinical and behaviour change communication committees. All this was done to support the integration of MC into existing prevention strategies and programmes.

The second presentation from Swaziland "Circumcision for HIV prevention in Swaziland; achievements and aims", 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, plans, and short- and long-term strategies were also described.

The presentation from Ghana "Male Circumcision and HIV in Ghana" focused on the background of HIV and MC prevalence, regional variations and type of MC practitioners. It highlighted collaboration between clinical and traditional practitioners in making the practice safer through capacity building and how to scale up, monitor and strengthen referrals and linkages.

The experience from Senegal "Questions on the promotion of MC for the prevention of HIV in the context of cultural practice in Africa" focused on the social and cultural context of MC in Senegal. Traditional surgeons cannot 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 a medical procedure but largely as a social practice, with a variety of reasons why it is performed.

5.2.2 Main issues

The main issue was Botswana's progress, which was found to have been remarkable since November 2007, thanks to the political commitment from the President of the country. Swaziland had also progressed as far as developing a detailed and budgeted plan, indicating how many circumcisions could be done within a specific period of time for maximum public heath impact.

5.2.3 Key conclusions from the discussions

Political commitment is key to scaling up 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 considered in order 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 service providers.

5.3 Session on strategic directions for scaling up MC for HIV prevention

5.3.1 Presentations

The third objective of the meeting was to review and agree on the strategic directions for scaling up MC for HIV prevention in the WHO African Region. A presentation was made on proposed strategic directions, and an update given on the Global/Regional level partnerships to support scale up of MC activities.

Three groups were constituted to review the draft AFRO document "Strategic directions for scaling up MC in the WHO African Region", provide inputs and report back to the plenary session.

5.3.2 Main issues

Participants felt that the document was well written but could be strengthened; they gave suggestions. These included adding an executive summary; a preamble introducing MC as a new technology to complement other interventions; document references and in some areas, provide more details. There were also suggestions to harmonize terms, annex all tool kits and reorganize or 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 providers of MC services and how to work effectively with them by making traditional MC more safe (infection prevention and pain management) and effective for HIV prevention through emphasis on complete removal of foreskin. It was also felt that the document needed to specify that available evidence and proposed strategic directions relate to scaling up in the formal health sector (medical circumcision as opposed to traditional circumcision).

Other suggestions were the inclusion of issues of involvement of women and families in an enhanced package; adolescent services; community outreach; acceptability and stigma- associated with HIV and MC. Health system challenges such as infrastructure, referral systems and definition of packages and processes of integration of MC with existing services also needed to be highlighted. The document could also clearly spell out linkages with national HIV strategic plans and MC, 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 also be better clarified. Research needed to be stressed, particularly in social and cultural practices, the perceptions of indirect benefits for women and the best methods of collaboration.

An additional strategic direction was suggested which would deal with human rights, and ethical and legal issues. It was proposed to include key points from the UNAIDS guidelines, e.g.: non-

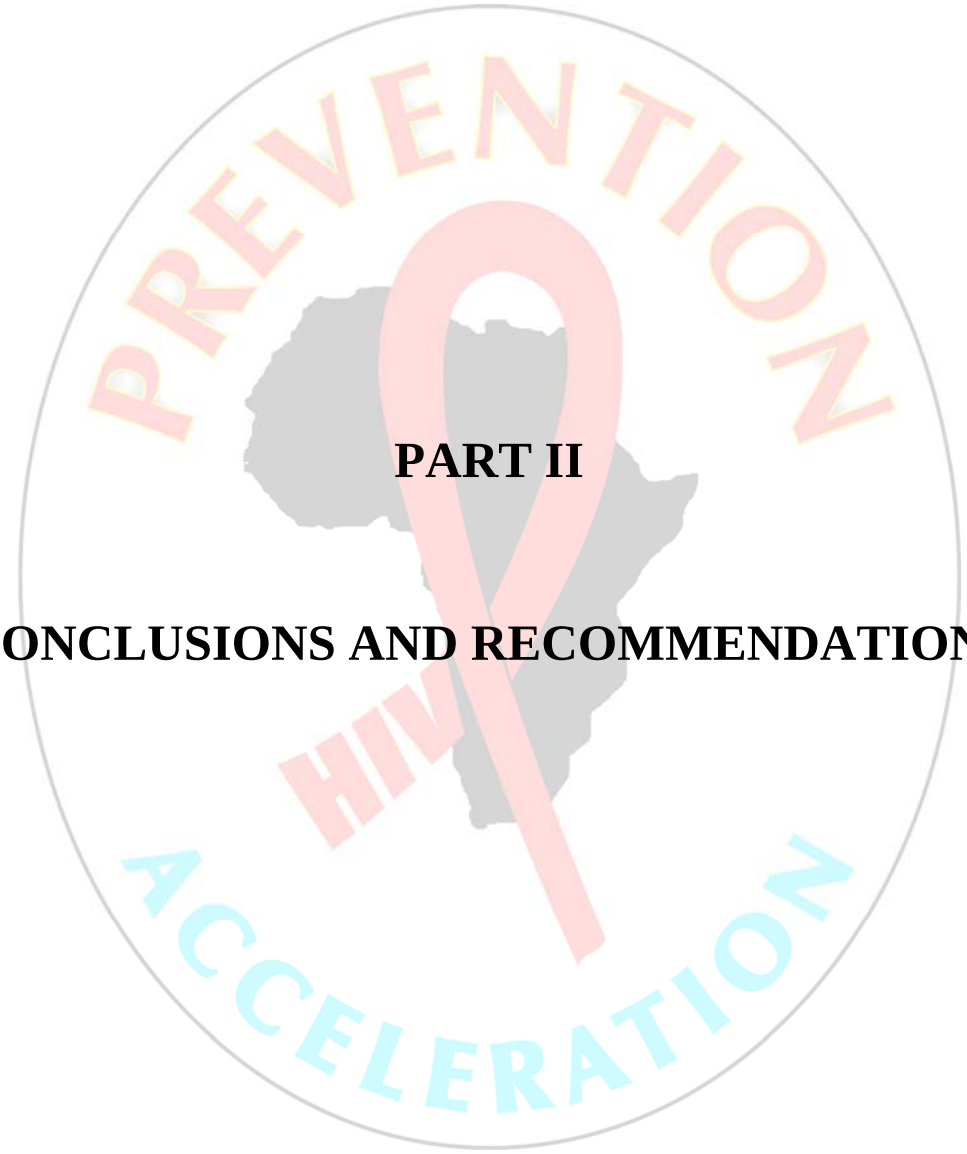
discrimination, informed consent, sensitivity to socio-cultural concerns especially in traditional contexts, confidentiality, age at time of consent, safety and quality assurance.

5.3.3 Key conclusions from the discussions

The revised document which incorporates suggestions made by the groups constitutes Part III of this report.

6. Drafting of the conclusions and recommendations of the consultative meeting

A smaller group of participants, drawn mainly from country delegates, was constituted to draft key conclusions and recommendations of the meeting, taking into account the presentations and the rich discussions which were held during the plenary sessions. The final recommendations adopted by the plenary session are presented as Part II of this report.



PART II

CONCLUSIONS AND RECOMMENDATIONS

Conclusions and Recommendations

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 MC performed by well-trained medical professionals is safe and reduces the risk of 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 MC for HIV prevention, the effectiveness of the protective effect over the long term, models for scaling 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 (2008) to determine the implications of MC for women is critical and needs to be supported.

Conclusion 2

Having reviewed and discussed the WHO/UNAIDS policy and programme recommendations for MC 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 MC 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 MC providers if safe, quality services are to be scaled up to reach a substantive mass over a short period of time.

2.4 It is urgent that the UNAIDS-led *Decision-Makers tool* be made available to countries and that they are 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 in line with the *UN Male Circumcision and HIV Prevention in Southern and Eastern Africa, Communication Guidelines.* Documents should be widely disseminated and countries supported to develop communication strategies.

2.6 MC monitoring and evaluation guidelines need to be urgently finalized, and countries should be supported to implement them.

Conclusion 3

The meeting participants recognized that the country experiences shared at the meeting were encouraging and provided useful guidance to others who are 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 MC. 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-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 scaling up through the WHO-led UN Inter Agency Task Team and the implementing partners of the President's Emergency Plan for AIDS Relief (PEPFAR); all such support should be coordinated.

Conclusion 4

The meeting reviewed the WHO document, *Male Circumcision for HIV Prevention Strategic directions for the African Region,* commended WHO for the efforts, and endorsed the document with suggested amendments.

Recommendations

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

PART III

STRATEGIC DIRECTIONS FOR SCALING UP MC FOR HIV PREVENTION IN THE AFRICAN REGION

Abbreviations

CBO	Community-based organizations
FGM/C	Female genital mutilation/cutting
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
MC	Male circumcision
NGO	Non-governmental organizations
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider-initiated testing and counselling
PMTCT	Prevention of mother-to-child transmission of HIV
STI	Sexually transmitted infection
SADC	Southern Africa Development Community
UNGASS	UN General Assembly Special Session on HIV/AIDS
WHO	World Health Organization

Introduction

This document aims to outline regional strategic orientations to improve the availability, accessibility and safety of MC within the context of broader HIV prevention and improved sexual and reproductive health. It provides strategic orientations on moving from science evidence to programme implementation.

The publication's primary target is programme managers in eastern and southern Africa with the responsibility of advising or taking decisions in relation to MC and HIV prevention.

The background section (Section 1) places MC in the context of broader HIV prevention strategies, and highlights the available evidence on MC and reduction of risk of HIV infection. This section provides information on the preparatory activities that have taken place at the regional level following the release of findings from three randomised controlled trials in Africa which established that MC reduces by 60% the likelihood of men acquiring HIV infection through heterosexual contact. Section 2 analyses the status of MC in the African region; Section 3 discusses the proposed strategic orientations for scaling up MC; and Section 4 is a conclusion.

1. Background

1.1 The HIV prevention challenge

According to current estimates of the global prevalence of human immunodeficiency virus (HIV) infection, sub-Saharan Africa is the hardest hit region, with more than 2.5 million new HIV infections occurring in 2007. More than 8 countries in sub-Saharan Africa have hyper-endemic HIV (i.e. prevalence above 15% among adults in the general population), and most of the remaining countries have generalized epidemics.[4]

Prevention efforts in the African Region have been limited in scale and pace and have had variable impact on the spread of HIV. Risk reduction programmes have included counselling on delayed sexual debut, reducing the number of concurrent partners, and consistent and correct male and female condom use, as well as the treatment of sexually transmitted infections (STIs) and HIV testing and counselling. The existing approaches to preventing heterosexual HIV transmission that have demonstrated impact need to be scaled up, and new, proven approaches added.

One recently proven approach is male circumcision—a one-time intervention that provides males significant, but not complete, protection from HIV infection.

There are other new prevention technologies currently being researched, such as microbicides and vaccines, with disappointing results so far.

[4] UNAIDS-WHO Epidemiological report, 2007.

1.2 Male circumcision and HIV prevention evidence

Three randomized controlled trials that took place in Orange Farm, South Africa; Rakai, Uganda; and Kisumu, Kenya demonstrated that male circumcision confers in males about a 60% reduction in the risk of HIV infection from heterosexual intercourse.[5] The trials provided scientific confirmation of the partially protective effect of MC from HIV infection observed in sub-Saharan African countries since the late 1980s.[6]

A review of 13 studies in 10 East and southern African (ESA) countries showed that MC would be acceptable for reasons of hygiene and prevention of sexually transmitted infection. However, its cost, fear of pain and concerns for safety were some of the main barriers identified.[7]

1.3 Preparations for male circumcision programming

In preparing for the scale up of MC for HIV risk reduction recommended by WHO and UNAIDS, in-country consultations were held in 2006 and 2007 in Botswana, Lesotho, Kenya, Malawi, Swaziland, Tanzania and Zambia. A regional consultation was subsequently held in Nairobi, Kenya in November 2006. The meetings sought to familiarize stakeholders from government, private sector, traditional health care setting, donors, NGOs and the UN with the new evidence on the HIV-protective effect of MC, and to explore the implications of this knowledge for the development of HIV prevention programmes and male sexual and reproductive health services.

In March 2007, a WHO/UNAIDS global consultation was convened in Montreux, Switzerland to discuss the policy and programmatic implications of the new evidence on MC and HIV prevention.

In May 2007, a sub-regional consultation was held in Harare in collaboration with the SADC Secretariat. Participants from 12 East and Southern Africa countries with settings of high HIV prevalence and low MC rates[8] attended the meeting. The meeting was aimed at discussing and agreeing on the policy and programmatic implications of the available evidence for MC in the context of HIV prevention in the sub-region, and developing or updating plans of action at the country and sub-regional levels. The presentations made at this meeting showed that good progress had been made over the past year towards addressing the issue of MC for HIV prevention.

The countries agreed on the following next steps:

- Advise country leaders and other key stakeholders of the national road-maps for scaling up MC;
- Develop policy guidance that defines the demographic groups to be targeted for circumcision and the modalities for achieving this;
- Engage national stakeholders, in particular traditional leaders and practitioners, women, the youth, and faith-based organizations, and develop, where appropriate, national task teams on MC;

[5] Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007.
[6] Weiss et al., 2000.
[7] Westercamp and Bailey, 2006
[8] Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda Zambia and Zimbabwe.

- Integrate MC and its cost into existing national HIV prevention strategies as a means to rapidly increase its uptake in countries; and
- Undertake resource mobilization to fund MC programmes.

In addition to the country and regional consultations, three global expert consultations were also convened: "Strategies and approaches to MC programming" (Geneva, December 2006); "Perspectives from social science on MC for HIV prevention" (Durban, January 2007) and "Male circumcision and HIV prevention operational research implications" (Nairobi, June 2007).

In August 2007, male circumcision for HIV prevention was discussed at the 57th Session of the WHO Regional Committee held in Brazzaville, Republic of Congo. The discussion generated considerable debate, with the Ministers requesting the WHO Regional Office for Africa to organize an African experts' consultation to review available evidence and make recommendations on the way forward. That consultation was held on 2–4 April 2008.

At the global level, WHO and other UN partners are developing a number of tools to guide the scaling up of MC for HIV prevention. These include:

- A guide for standards, certification and accreditation and related facilities assessment tools;
- A guide on quality assurance to enhance the quality and safety of MC services;
- A guide for decision makers on human rights, ethical and legal considerations for safe MC and comprehensive HIV prevention programming;
- A situational analysis toolkit for determining circumcision prevalence, gauging acceptability, identifying key providers, estimating costs, and monitoring numbers of circumcisions performed, their safety, and their potential impact on sexual behaviour.
- A step-by-step operational guide for scaling up MC services.

A number of countries are in the process of preparing for the scaling up of MC as part of comprehensive HIV prevention strategies. Current efforts relate to the development of policy frameworks and implementation plans; carrying out situation analyses, and estimating the cost implications for scaling up MC.

This document proposes key strategic orientations for the scaling up of MC services as part of a comprehensive package for HIV prevention in sub-Saharan Africa.

2. Analysis of the Situation of Male Circumcision in the African Region

Male circumcision is common in many African countries. It is almost universal in North Africa and most of West Africa. In contrast, it is less common in southern Africa, where self-reported MC prevalence is around 15% in several countries (Table 1). In most of West, Central and North Africa, infant and childhood MC is widespread.

Table 1: Male circumcision prevalence in a selection of eastern and southern African countries

Country	MC prevalence (%)
Botswana, Namibia, Swaziland, Zambia, Zimbabwe	15
Burundi, Rwanda	15
Malawi	21
South Africa	35
Lesotho	48
Mozambique	60
Madagascar	>80
Tanzania, Kenya and Ethiopia	70–93

Around 20% of adults in southern Africa are living with HIV and AIDS. Notably, the countries in this region with high HIV prevalence (Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe) have low MC prevalence, whereas in the two southern African countries with low HIV prevalence (Angola, 3.7% and Madagascar, 0.5%), over 80% of the males are circumcised.

The wide variation seen in MC prevalence in Africa is partly due to different ethnic traditions—some ethnic groups stopped the practice centuries ago. In more recent history the two main reasons appear to be the abandonment of MC because of factors such as wars, and in some cases its banning by European missionaries and colonial administrators.[9]

The age at circumcision varies by country and within countries. Neonatal circumcision is common in some countries (e.g. Ghana) but in other countries median age at circumcision varies from boyhood (5–16 years in Burkina Faso, Zambia, and Kenya) to the late teens or twenties (parts of Tanzania and South Africa). In countries like Senegal, MC at age 40 has been reported.

The degree of foreskin removed also varies in traditional circumcision. For example a study among the Babukusu in Kenya found that traditional circumcisions were highly variable, with some resulting in insufficient removal of foreskin, and others with excessive skin removed.

[9] Male circumcision: Global trends and determinants of prevalence, safety and acceptability. WHO-UNAIDS Contributing to Heath Worldwide, February 2007

2.1. Challenges for programming

The main challenge to scaling up MC will be to maximize its impact in reducing HIV infection, while assuring the procedure's safety. Fortunately, this scale up will have the benefit of the many lessons learned from numerous global health initiatives, on how to effectively introduce new technologies in resource-limited settings. For example, the yellow fever and polio eradication campaigns have shown that coordinated efforts can lead to success.

Lessons have also been learned from the poor scale up and uptake of other interventions such as the prevention of mother-to-child transmission (PMTCT) of HIV. To date, PMTCT programme implementation has been dismally low in regions and countries where it is most needed. Currently, only about 10% of women attending antenatal clinics in sub-Saharan Africa receive PMTCT services. The reasons for this include poorly coordinated programme implementation globally and within countries, lack of a well envisioned scale-up strategy, lack of sustained technical assistance to countries, lack of political commitment and poor communication from the global to the grassroots levels.

Various consultations on MC for HIV prevention conducted during 2006-2007 reveal that the main challenges to MC scale up in Africa include:

- Limited access to health services;
- Low integration of MC into overall health service delivery;
- High competition with other priorities and surgical emergencies and limited availability of surgical facilities;
- Cost of the surgery, post-operative care and adverse events management;
- Poor quality services resulting in post-procedure infections or other negative consequences;
- Low involvement of women and families, and perceptions of indirect benefits for women;
- Challenges to working effectively with traditional MC providers;
- Cultural or religious meanings attached to traditional MC, which may compromise safety;
- Poor communication strategies and inadequate counselling, leading to confusion and misunderstandings about the degree of protection conferred by MC, and risk compensation among newly circumcised males.

2.2. Opportunities for male circumcision

If correctly planned, increased provision of accessible, safe MC services could also increase opportunities to educate adolescents and adult men in areas of high HIV prevalence about a variety of reproductive and sexual health topics, including hygiene, sexuality, gender relations and the need for a combination of prevention strategies to further decrease their risk of HIV acquisition and transmission.

The introduction of MC services could also provide opportunities for capacity building in the health sector. This might include upgrading of health facilities, and training of personnel in minor surgical procedures and counseling.

3. Strategic directions

In outlining a generic framework to improve the availability, accessibility and safety of MC and sexual health services as an integral component of comprehensive HIV prevention, this document attempts to answer a number of questions, including the following:

- Which region/sub-region should be prioritized?
- What should be the goal and who should be involved in MC programming?
- What are the possible approaches to service delivery?
- What populations groups and age groups should be prioritised, and why?
- Which cadres should be involved in the scale up of MC?
- What are the entry points and which services should be integrated?
- Which mechanisms should be put in place in order to ensure accessibility (geographical and financial) of male circumcision services?

The WHO-sponsored publication "Strategic Approach to Strengthening Reproductive Health Policies and Programmes" describes a three-stage process for processing policies and programmes. The Strategic Approach starts with the desired end in mind, namely stronger institutions for large-scale, sustainable services and effective policy that will lead to improved access to and quality of care. The implementation of the Strategic Approach involves three stages: (1) strategic assessment to identify needs and priorities; (2) testing of health-service innovations on a limited scale; and (3) scaling up so that the benefits of proven innovations reach more people. This section outlines 17 strategic orientations that countries may consider in scaling up male circumcision services.

Strategic direction No.1:

Countries in East and Southern Africa should prioritize male circumcision as a key HIV prevention strategy

Modelling studies suggest that universal MC in sub-Saharan Africa could prevent 5.7 million new cases of HIV infection and 3 million deaths over 20 years (Williams et al., 2006). The greatest population-level impact of MC will occur in settings where the prevalence of heterosexually transmitted HIV infection is high (HIV prevalence in the general population exceeds 10%), levels of MC are low (below 20%), and populations at risk of HIV are large. The impact would still be considerable in settings with adult HIV prevalence of between 3% and 10%, mainly heterosexual transmission, and low rates of male circumcision.

Many countries in East and southern Africa fall within the categories above and are therefore a priority. These countries need to identify priority geographic settings where the greatest impact of MC on the HIV epidemic can be realized. In African countries with areas where most of the circumcision is carried out by traditional or religious circumcisers, there is need to focus on improving safety and reinforcing behaviour change messages.

Strategic direction No. 2:

Define a clear goal for male circumcision programming

Given that there are many issues to be addressed in order to successfully introduce and scale up MC for HIV prevention, it is critical to have a sound and comprehensive strategy. As part of the strategy development process, it is important to agree on a clear goal for the programme consultations; situation analyses should help in the goal-definition phase, and each country should define a goal, based on its own local context. Examples of goals may be:

- To introduce safe MC as an HIV prevention approach and get as many willing males as possible circumcised. This may be the goal in settings with high HIV prevalence and low rates of MC.
- To provide safe male circumcision services. This could apply to settings with high MC rates, mostly done in the traditional or religious sector.
- To use MC as an entry point to working with adolescent boys and young men—a population that does not often access health services.
- To introduce MC within the context of a broader HIV prevention and sexual and reproductive health programme.
- A combination of objectives.

Strategic direction No. 3:

Conduct a comprehensive situation analysis

A situation analysis should be undertaken to describe existing MC prevalence and practice, cultural and political attitudes, and to map out the anticipated scope of MC scale up in terms of human resources and training needs, infrastructure, commodity and logistical requirements, costs and funding, and systems for monitoring, evaluation and follow-up.

In support of countries' preparations for the scale up of MC as part of a comprehensive HIV prevention package, WHO has developed a *Situation Analysis Toolkit*. The aim of the toolkit is to assist countries that are planning to augment the availability of and demand for safe MC services for HIV risk reduction. The toolkit provides guidance in determining the prevalence of MC in various populations, and assessing cultural and political attitudes towards MC and the capacity of existing medical services to deliver safe MC services.

The toolkit is available and countries are being supported to carry out the situation analysis as a basis for planning the scale up of MC services. Country experiences with situation analyses should be shared.

Strategic direction No 4:

Conduct key stakeholder consultations

The introduction and expansion of safe MC services in Africa must take into account local socio-cultural, religious and traditional values to ensure acceptability by communities and build on existing cultural practices. Consultations are an important step towards reaching consensus among key stakeholders in a country and creating an enabling policy environment for MC programming. Countries and international development partners should make resources available to support community and stakeholder consultations. These should involve traditional practitioners in areas where they perform MC, to ensure the engagement and participation of all relevant partners in the design of safe MC programmes.

Strategic direction No. 5:

Integrate male circumcision services into a comprehensive package for HIV prevention

Because it is only partially effective in protecting an individual against HIV, MC should not be delivered in isolation, but as part of a comprehensive HIV prevention package. The recommended *minimum package* includes:

- Information about the risks and benefits of the procedure;
- Counselling about the need to adopt and maintain safer sex practices, particularly in the post-procedure healing period but also long term;
- Promotion of and access to HIV testing and counselling;
- Promotion of condoms and their provision;
- Management of sexually transmitted infections where required; and
- Surgical MC as described in the WHO/UNAIDS/JHPIEGO *Technical Manual for Male Circumcision under Local Anaesthesia*.

Based on the WHO expert consultation meeting on MC of March 2007, the procedure is not recommended for HIV-positive men as an intervention to reduce HIV transmission. However, if medically indicated, MC should be provided to all willing men irrespective of their HIV status. It is recommended that HIV testing is offered to all seeking MC in line with the provider-initiated testing and counselling (PITC) strategy. Male circumcision would thus be an entry point for PITC.

A key challenge is that of targeting MC to seronegative males, while ensuring that seropositive ones are not denied the service. Programmes would have to be very careful in their targeting strategies; denying HIV-positive males the services could lead to their further stigmatization and discrimination.

If a country has the resources to provide other comprehensive sexual and reproductive services, it may use MC as an opportunity to reach out to men, a group that is otherwise hard to reach. An *enhanced package* would feature community and social aspects, including reaching sexual partners with counselling services.

The enhanced package could include, in addition:

- Counselling on life skills (e.g. negotiation, communication and decision-making, parenting, and prevention of gender-based violence and substance abuse);
- Health education and use of health services;
- Family planning information and skills; and
- Vaccinations for children/integrated management of childhood illness (IMCI).

Strategic direction No. 6:

Target young male population for greatest public health impact

Male circumcision would be most effective if males were targeted before they were sexually active. The personal benefit of MC is immediate. However, the full public health benefit will only be seen after a large proportion of men are circumcised. In order to maximise the public health benefit priority countries should consider first targeting adolescents as a top priority, then young men, and finally older men at particularly high risk of HIV. The priority list would then be:

- Specifically targeting circumcision services at younger males. Experience from reproductive health programmes for young people indicates that boys should be reached before the median age at sexual debut (typically 15–17 years). Consideration should also be given to "easy to reach" boys, e.g. boys with 12–14 years old. This age group can cope better with surgery under local anaethesia than younger age groups.
- Priority could also be given to HIV-negative men of any age who have indications of being at higher risk for HIV, such as men with sexually transmitted infections.
- Since neonatal circumcision is a less complicated and risky procedure than circumcision of young boys, adolescents or adults, countries should consider how to promote neonatal circumcision in a safe, culturally acceptable and sustainable manner. This will have benefits for HIV prevention in the long term.

Strategic direction No. 7:

Foster stronger collaboration between traditional and formal health care systems

Information on MC practices in traditional settings is required, and ways should be found to engage traditional practitioners to improve the safety of their services. Recognizing the importance of traditional health care providers in the African Region, there is need to find ways of collaborating with them.

A regional consultation on traditional MC will be organized to review current practices and discuss collaboration of this sector with the formal health sector, and the implications for scaling up MC in the context of HIV prevention.

Strategic direction No. 8*:*

Ensure safety and standardized services

Ensuring safety in MC service delivery is of paramount importance. The various competencies needed for each element of MC services should be determined: pre-surgical assessment, pre-surgical counselling, circumcision, post-surgical care and referral. Aspects to consider in determining who should provide the services include the knowledge required, the task's complexity, risk of harm and current evidence.

The safety of MC depends on the setting, equipment and expertise of the provider. The three large scale randomized controlled trials show that very low complication rates can be achieved (less than 3 %) when MC is performed by trained workers in adequately equipped medical settings. However, high rates of complications have been found when MC is provided by untrained, poorly equipped providers and in some traditional settings.[10] MC should not be scaled up without the assurance of quality and safety of services, properly trained staff and appropriate follow-up of clients.

Certification guidelines will be made available to help countries with the processes of certification and accreditation of health facilities that will be involved in the scale up of MC. WHO will also support the training of trainers who will be called upon to cascade the training in countries. It is important that the training conducted is linked to supervision and capacity building at the service delivery point.

Appropriate referral systems must also be put in place, with well equipped satellite referral centers able to handle post-surgical complications.

Strategic direction No. 9:

Ensure that standardized male circumcision surgical services are provided

The WHO/UNAIDS/JHPIEGO *Technical Manual for Male Circumcision under Local Anaesthesia* has been developed as part of the work to support countries in providing safe MC services, and ensuring that circumcised men do not perceive themselves as fully protected against HIV and other sexually transmitted infections, and consequently forgo other HIV risk-reduction strategies.

The technical manual is aimed at providers of MC services and programme managers. It describes selected methods for MC chosen on the basis of their safety and practicality for use in resource-limited settings.

For adults and adolescents three methods are described: the forceps-guided, the dorsal slit and sleeve method; for paediatric and neonatal circumcision four methods are described: the dorsal slit; the Plastibell; the Mogen clamp; and the Gomco clamp.

The recommended operative techniques are illustrated in detail for reference in the context of a training course. After the training they can be used to reinforce what has been learnt.

The manual also addresses broader issues of sexual and reproductive health of men, and emphasizes that MC must be set within the context of other strategies for reducing the risk of HIV infection.

[10] Assessment of Clinical and Traditional Male Circumcision Services in Bungoma District, Kenya; Complication rates and Operational Needs, April 2006, Special Report C. Bailey and Omar Egesah, Published by PSI, AIDSMARK and USAID.

A full description of best practices in surgery and anaesthesia in resource-limited settings can be found in the WHO publication *Surgical Care at the District Hospital*. The manual will be part of the training package on MC and will be made available to countries.

The safety of MC should also be an integral part of infection-control measures to be implemented at the health facility level.

Strategic direction No. 10:

Involve different cadres of service providers ("task shifting") to reach high levels of coverage

In order for MC to have the desired impact on the HIV epidemic wide coverage is needed. Modeling has shown that 50% uptake over 10 years would reduce HIV prevalence by more than 50% over 20 years— very significant impact.

In order to meet the goal of universal access to HIV prevention, treatment and care, countries need to identify and implement the most efficient models and strategies for scaling up to attain high numbers of males circumcised in the first few years.

Countries in the African Region are faced with a shortage of skilled health professionals. In order to scale up MC services it will be necessary to consider using available staff and consider "task-shifting" (using nurses, midwives, clinical officers to perform the surgery). There is also need to strengthen partnerships with private health care providers and include male circumcision in the curricula of all the levels of pre- and in-service training.

Since MC services for HIV prevention must be offered as a package, training is required for different cadres of staff, including counsellors, paramedical and medical practitioners, among others. Each country will have to decide which health cadres should be involved in scaling up safe MC services. Experience from family planning and reproductive health shows that non-physicians can be trained to carry out some procedures. Non-physician (mid-level) providers should be trained in MC surgical techniques in order to make the services widely available and accessible to all males.

The acceptability of female health care services providers performing MC needs to be carefully researched because in sub-Saharan Africa the majority of middle-level providers are female.

Strategic direction No. 11:

Identify and use relevant entry points for male circumcision services

There are many health intervention programmes being successfully implemented in countries of the African Region. These avenues can be used to promote MC to individuals who come in for other services.

There is need to review existing sexual and reproductive health services for men and women and identify contact points that could be taken advantage of. Male circumcision could be promoted through, for instance, postnatal care services, adolescent and reproductive health services, testing and counselling,

PMTCT services, and external consultations on sexually transmitted infections. Programmes such as immunization that have a wide reach in the community could be used to promote MC services. Male circumcision could be added to existing communication mobilization systems that involve a network of

community-based health workers, traditional healers, and other public and private health providers. In addition, recreational fora such as sporting events are other possible entry points.

Strategic direction No. 12:

Put in place an effective communication and advocacy strategy

Male circumcision is a new additional intervention for HIV prevention and its scaling up needs to be supported by well planned advocacy and social and behavioural communication strategies appropriate to the local culture. There is need to ensure that clear and consistent, culturally sensitive messages are formulated and disseminated. There is also need to ensure that circumcised men do not develop a false sense of security that could cause them to engage in risky behavior that would undermine the partial protection provided by MC. Male circumcision should always be explicitly linked with the continuing need for risk-reducing behaviour, notably consistent, correct condom use and reduced numbers of sexual partners. A clear distinction must be made between MC and female genital mutilation/cutting (FGM/C) to guard against the inadvertent encouragement of the latter.

Countries are advised to involve community beneficiaries when they develop communication strategies and plans, to ensure that the social environment is conducive to MC scale-up. A communications guidance note for programme managers has been developed and will be made available to countries to guide their development of communication strategies and plans.

Strategic direction No. 13:

Strengthen health systems

Because MC is a surgical intervention and in order to maximize its public health impact, the service should be integrated within the context of existing health care services, involving of a range of government, private sector, community-based and non governmental organization partners.

Countries will need to develop strategies aimed at reaching high levels of coverage of MC in the quickest possible timeframe. Integrated and coordinated approaches to deliver MC services with other essential HIV prevention and sexual health services are most likely to be sustainable in the longer term. However, vertical, stand-alone programmes that provide the recommended minimum package of services may be useful in the short term to rapidly expand access to safe MC services and to train providers in standardized procedures, especially where demand is high and health systems are weak. If such vertical programmes are established there should be a clear strategy to ensure that these are integrated into strengthened health systems as soon as is feasible. The catch up strategy would be a short term one, as the intensity of demand for the services would reduce with time.

Health systems in sub-Saharan African countries are weak and there is a shortage of skilled health professionals. The development and expansion of MC services for HIV prevention should not disrupt health systems or the implementation of other health programmes.

Strategic direction No. 14:

Increase and sustain financial resources

Additional technical skills and resources will be needed to scale up safe MC, hence the need exists to mobilize additional resources, without taking resources away from other essential services. Countries

should mobilize the extra resources as part of their commitment to the Abuja Declaration and UN General Assembly Special Session on HIV/AIDS (UNGASS) on mobilizing resources for health. Countries in the African Region may consider applying for funding from initiatives like the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), President's Emergency Plan for AIDS Relief (PEPFAR), and other bilateral and multilateral channels.

Strategic direction No. 15:

Put in place effective monitoring and evaluation, including operational research

Moving from evidence-based research to public health intervention will happen through a "learning by doing" approach. There should be a clear strategy for monitoring and evaluation, and for conducting operational research as services are scaled up, to determine the most effective ways to provide and sustain MC services. It is also important to have systems in place to monitor post-circumcision behaviour.

The population-level impact of MC will need to be documented by monitoring the incidence and prevalence of HIV through national demographic and health surveillance studies.

Research gaps should be continually identified and prioritized in order to obtain further information for policy development and implementation of safe and sustainable MC programmes. A recent consultation reviewed operational research issues for the scale up of MC services, and developed a set of research priorities that must be implemented during the 2007/8 period. The five highest-priority operational research items were:

1. Evaluation of task-shifting for the delivery of surgical services (that is, can individuals other than doctors, clinical officers and nurses perform MC?);
2. Evaluation of different models of delivering clinical services;
3. Evaluation of counselling strategies to decrease risk compensation following circumcision;
4. Formative research concerning neonatal circumcision;
5. Formative research on the practices of traditional circumcisers, and evaluation of existing services incorporating traditional circumcisers into the formal health care system.

A social science research agenda is equally important and needs to run concurrently with the above, including research into socio-cultural practices that may facilitate the spread of HIV.

Strategic direction No. 16:

Provide sustained, coordinated and integrated technical support

There is need to move rapidly and in a strategic manner with the implementation of MC for HIV risk reduction. Governments should assume leadership of the process of developing plans and mobilizing extra resources, and for the efficient use of available resources in the scale up process.

Countries are encouraged to form national task force teams on MC with clear division of labour within existing structures such as the HIV Prevention Group, wherever possible. Ministries of health, national AIDS coordinating bodies and other strategic ministries need to take the lead in the task force in order to efficiently guide the allocation of technical and financial support from partners. The national task force will coordinate the implementation of MC programmes.

At the regional level there will be a consolidated MC support team to coordinate multi-partner support to countries. The WHO Regional Office for Africa will continue to provide technical leadership and normative guidance for developing plans, implementing programmes and monitoring and evaluation of MC scale up. Other partners include UN agencies, sub-regional economic groups, PEPFAR, and key other technical partners. The various agencies will support countries in implementing activities according to their respective roles and mandates.

A number of tools and guidelines have been developed by WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) and partners for countries to use as they prepare for the scaling up of MC services, and some are already being tested.

Country experiences of MC policy and plan development, situational analyses and the piloting and use of the various tools should be shared so that lessons can be learned, adapted and applied in other countries.

Strategic direction No. 17:

Consider human rights, ethical and legal issues

There is need to review legal, policy and regulatory frameworks to ensure that the scale up of MC is handled in the context of human rights and takes into account ethical and socio-cultural concerns, such as non-discriminatory service delivery, informed consent, confidentiality, age of consent, safety and quality assurance. Relevant tools are under development for these areas.

A clear distinction must be made between MC and female genital mutilation. The latter has demonstrated adverse health effects and no known health benefits. For these reasons, the UN health bodies and a number of medical associations consider FGM/C to be unacceptable, a form of violence against women and girls and an infringement of their physical and psychosexual integrity.

4. Conclusion

This document outlines strategic orientations to improve the availability, accessibility and safety of MC as an integral component of comprehensive HIV prevention programmes. It highlights the need to prioritise countries in eastern and southern Africa with high HIV prevalence and low MC rates for MC programming. The document provides orientations for country action and details the support available from WHO and other partners for scaling up MC

in the next two years. Implementing the strategies will require the integration of MC into HIV prevention strategies and other health services, taking into account legal, ethical and socio-cultural factors. It is important that countries realise that some of the questions that they have on MC programming will be answered by a process of "learning by doing" throughout the course of their implementation of the scale up.

Targeting young males will help attain maximum public health benefit. Improved access to safe MC services will require the mobilisation of extra resources, efficient use of available ones, and improved provision of services within strengthened health systems. Technical support at country and regional levels, and strong country leadership, will be essential components to the implementation of the proposed strategic orientations within countries.

Other useful resources

1. UNAIDS. Guidance for decision makers on human rights, ethical and legal considerations. March 2007.
2. Williams, BG, Lloyd-Smith, JO, Gouws, E, Hankins, C, Getz, WM, Hargrove, J, et al. The potential impact of male circumcision on HIV in sub-Saharan Africa. *PLoS Medicine* 2006: 3 (7):e262.
3. WHO. Strategic Approach to Strengthening Reproductive Health Policies and Programmes. WHO/RHR/07.7 http://www.who.int/reproductive-health/strategic_approach/ index.htm. Accessed on 7 August 2007.
4. WHO. Male Circumcision Situation Analysis Toolkit. WHO, HTM/HIV/SIR. 2007.
5. WHO/UNAIDS/JHPIEGO. Technical Manual for Male Circumcision under Local Anaesthesia. V2.3. 2007.
6. WHO/UNAIDS. Recommendations on male circumcision and HIV prevention. March 2007.
7. WHO/AFRO. Information note on male circumcision and HIV prevention in the African Region. September 2007.
8. Male circumcision and HIV Prevention: Operations research implications. Report of an international consultation 21-22 June 2007.
9. Strategies and approaches for MC programming. WHO meeting report, 5-6 December 2006.
10. WHO/JHPIEGO Male circumcision training package.

Annex 1: Agenda

Time	Topic	Presenter/Facilitator
Day 1, 2 April 2008		
08:00 – 09.00	**REGISTRATION**	
Official Opening		
09:00 – 10:00	Welcome, by Director of AIDS, Tuberculosis and Malaria	
	Meeting objectives and expected outcomes	AFRO
	Introduction of participants	
	Statement from UNAIDS, on behalf of co-sponsors	UNAIDS
	Official Opening by the WHO Regional Director for Africa	
	Administrative announcements including security briefing	AFRO
Objective no 1	**To update participants on the evidence on MC and HIV prevention**	
10:00 – 10:20	***TEA BREAK***	
10.20-10.30	Group photo	
10:30 – 12:30	Overview of the observational, epidemiological evidence on male circumcision and HIV prevention	WHO/HQ
	Selected country presentations on observational data on HIV prevalence in relation with MC prevalence	Malawi, South Africa and Zambia
	Discussion	
	Presentation of the evidence on male circumcision and HIV prevention from the 3 RCTs	Principal investigators
	Discussions	
12:30–14:00	***LUNCH BREAK***	

14:00–14:45	Discussions on evidence (ctd)	WHO/HQ
	Discussion	
14:45–15:30	Presentation and discussion of the WHO-UNAIDS Recommendations on MC and HIV prevention	AFRO
15:30–16:00	***TEA BREAK***	
Objective 2	**To share countries experiences in implementing MC for HIV prevention;**	
16:00–17:00	Country experiences with MC in the context of HIV prevention	Botswana , Swaziland
	Discussions	
17:00–17:30	Secretariat meeting	
18:00–19:30	Cocktail	
Day 2, 3 April 2008		
09:00–09:30	Country experiences with MC in the context of traditional practice (ctd)	Senegal, Ghana
	Discussions	
Objective 3	**To review and agree on the strategic orientations for scaling up MC for HIV prevention in the WHO Africa region**;	
09:30–10:30	Discussion on strategic directions for scaling up MC for HIV prevention	AFRO
	Discussions	
10:30–11.00	TEA BREAK	
11:00–12:00	Update on Global/Regional level partnerships to support scale up of MC activities (UN, PEPFAR, Gates, GFATM)	UNAIDS
12:00–14:00	LUNCH BREAK	

14:00–15:30	Group Work on strategic directions	AFRO
15:30–16:00	TEA BREAK	
16:00–17:00	Group Work on Strategic orientations (ctd)	
17:00–17:30	Secretariat meeting	

Day 3, 4 April 2008

09:00–11:00	Plenary report of group work Followed by discussions	AFRO
11.00–11:30	***TEA BREAK***	
11:30–13:30	Finalization of draft of meeting recommendations	
	LUNCH BREAK	
13:30–14:30	Presentation and adoption of the meeting recommendations	
14:30–15:00	Closing	

Annex 2: List of participants

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