

Progress in Male Circumcision Scale-up Country Implementation Update, July 2009

Country	Leadership, Partnerships & Advocacy	Situation Analysis	Policy & Regulatory Framework	Strategy and Operational Plan	Training	Quality Assurance	Service Delivery	Communication	Monitoring & Evaluation and Research
<p>Botswana Population: 1.8m</p> <p>HIV Prevalence: 17.6%</p> <p>MC Prevalence: 11.2%</p>	<p>1. Leadership: Ministry of Health (MoH) leading programme. Dedicated male circumcision (MC) Coordinator appointed. National Task Force is in place. National and district level working groups have been set up and are functional.</p> <p>2. Partnerships: Africa Comprehensive HIV/AIDS Programme (ACHAP), PEPFAR, BOTUSA, WHO, UNAIDS.</p> <p>3. Advocacy: The former President, Festus Mogae is a Champion and plan is in place with the 'Champions for HIV prevention' end of July 2009.</p>	<p>A health facility rapid assessment and the infant feasibility are complete. A knowledge, attitude and practice study is under way. Further situation analysis planned in August 2009 to review role and training needs of traditional healers and providers.</p>	<p>MC has been incorporated into existing HIV prevention policy and this memorandum has been approved by Cabinet.</p>	<p>Strategy developed and approved by government. Plan is included in the Global Fund proposal. Phased scale-up plan to reach male circumcision prevalence rate of 80% among 0-49 years old HIV-negative males by 2014. Costing and impact derived from Decision-makers' Programme Planning Tool</p>	<p>Safe MC Training curriculum has been developed which includes a video. 2 pilot trainings have been conducted. June 2009 - 17 medical officers and 15 nurses/social workers have been trained. Planning to decentralize training.</p>	<p>Quality assurance framework has been developed. WHO MC Quality Assurance Guide and toolkit are being adapted. Working towards strengthening quality assurance systems.</p>	<p>MC services integrated into existing HIV prevention services so that MC is not a stand alone service. Working towards strengthening tracking systems of number of male circumcisions done.</p>	<p>Communication strategy being developed.</p>	<p>Monitoring and evaluation framework has been developed.</p> <p>Research Ongoing: Safety and acceptability and knowledge, attitudes and practice studies being done by Jhpiego/BOTUSA. Neonatal acceptability study by Harvard.</p> <p>Planned: Safe MC public health evaluation - Protocol in development with support and collaboration from BOTUSA/CDC which will be a 5 year cohort in 2 selected districts.</p>

Note: Thirteen southern and eastern African countries with high HIV prevalence, low levels of male circumcision and heterosexual epidemics have been included in this table. The information about each country was provided by countries, partners, and UN agencies, mostly from discussions at a sub-regional meeting (meeting report at http://www.malecircumcision.org/publications/documents/Country_experiences_in_scale-up_in_Eastern_and_Southern_Africa_06.09.09.pdf). The information in this table will be updated on a regular basis. Please send any updates, revisions or corrections to the Clearinghouse Webmaster: webmaster@malecircumcision.org

Progress in Male Circumcision Scale-up Country Implementation Update, July 2009

Country	Leadership, Partnerships & Advocacy	Situation Analysis	Policy & Regulatory Framework	Strategy and Operational Plan	Training	Quality Assurance	Service Delivery	Communication	Monitoring & Evaluation and Research
<p>Kenya</p> <p>Population: 37.5m</p> <p>HIV Prevalence: 7%</p> <p>Nyanza province: 15.3%</p> <p>MC Prevalence: 40% (Nyanza province)</p>	<ol style="list-style-type: none"> Leadership: MoH leading the programme. A National and Provincial Task Force is in place and operational. Focal MC persons identified at national and district levels. Due to setting up of health ministries under the two political parties a joint male circumcision inter-ministerial task force is planned. Partnerships: The Male Circumcision Consortium (FHI, University of Illinois at Chicago and EngenderHealth. Nyanza Reproductive Health Society, Impact Research and Development, Marie Stopes, International Medical Corps) APHIA (EngenderHealth, PATH, PSI), WHO, UNAIDS, UNICEF Advocacy: The Prime Minister Mr. Odinga has endorsed the scale up of male circumcision and has met with the council of Luo elders to promote MC. 	<p>Situation analysis has been completed for Nyanza, Teso, Turkana and Nairobi provinces.</p>	<p>A male circumcision policy is in place. It is now called 'National Guidance' for MC to enhance acceptance as some groups felt that a formal Policy would mandate MC for all men.</p>	<p>The national Strategy is for all provinces to have a male circumcision prevalence of 80% by 2013. The target groups are 15-49 year olds and newborns.</p>	<p>In Nyanza province - 300 providers have been trained.</p>	<p>WHO MC quality assurance toolkit is being used.</p>	<p>Service delivery has expanded from 41 districts to 230 districts in last few months. 124 facilities in Nyanza province are now offering MC services. Approximately 20,000 MCs done this year.</p>	<p>MC Consortium working with National Govt to improve communication and advocacy.</p>	<p>M&E framework in place. M&E system to monitor MC uptake and adverse events developed.</p> <p>MC incorporated into routine Kenya AIDS Information system. The survey is ongoing</p> <p>Research Ongoing:</p> <ul style="list-style-type: none"> Prospective longitudinal observation study on behavior risk compensation: Sexual Health Attitudes Behavior Study. Cross sectional surveys to determine MC impact in Kisumu municipality: the Male Circumcision Impact Study. Neonatal circumcision, Text messaging for post adherence, Wound healing, Feasibility of private sector Foreskin immunochemistry

Note: Thirteen southern and eastern African countries with high HIV prevalence, low levels of male circumcision and heterosexual epidemics have been included in this table. The information about each country was provided by countries, partners, and UN agencies, mostly from discussions at a sub-regional meeting (meeting report at http://www.malecircumcision.org/publications/documents/Country_experiences_in_scale-up_in_Eastern_and_Southern_Africa_06.09.09.pdf). The information in this table will be updated on a regular basis. Please send any updates, revisions or corrections to the Clearinghouse Webmaster: webmaster@malecircumcision.org

Progress in Male Circumcision Scale-up Country Implementation Update, July 2009

Country	Leadership, Partnerships & Advocacy	Situation Analysis	Policy & Regulatory Framework	Strategy and Operational Plan	Training	Quality Assurance	Service Delivery	Communication	Monitoring & Evaluation and Research
<p>Lesotho Population: 2m</p> <p>HIV Prevalence: 23.2%</p> <p>MC Prevalence: 48%</p>	<ol style="list-style-type: none"> Leadership: MoH leading programme. MC Task Force with two sub-committees has been created –the Clinical Sub-committee and the Advocacy and Communications Sub-committee. MC Focal person has been identified in the MoH. Partnerships: PSI, PEPFAR, WHO, UNFPA. Advocacy: Extensive advocacy has been done with traditional leaders. To get them on board. 	<p>Situation analysis in formal health sector has been completed. Exploring ways of assessing how to work with traditional providers.</p>	<p>Policy development under way. Regulations do not allow certain task shifting to nurses. Planning to review regulations and processes of task shifting in Lesotho and also other countries.</p>	<p>Draft strategy developed and disseminated to stakeholders. Needs resource mobilization.</p>	<p>Training plans with Jhpiego have been developed.</p>	<p>Not yet developed.</p>	<p>Formal scale-up has not started.</p>	<p>Planning to review current prevention communication strategy and see how to integrate male circumcision.</p>	<p>M&E framework has not yet been developed. Plans to be developed for operational research.</p>
<p>Malawi Population: 13.2m</p> <p>HIV Prevalence: 12%</p> <p>MC Prevalence: 21%</p>	<ol style="list-style-type: none"> Leadership: The Ministry of Health is heading the MC subgroup consisting of national, multilateral & NGO representatives. A focal person for male circumcision not yet appointed. Initial leadership provided by the NAC Partnerships: WHO, UNAIDS, UNICEF, UNFPA, Christian Health Association of Malawi (CHAM), CDC, PSI, Banja La Mtsogolo (BLM). Advocacy: Planning to identify a local champion for male circumcision. Advocacy still needed at various political and health provider levels. 	<p>The situation analysis is under way. Results due in the next few months. Planning to review and re-analyze DHS data.</p>	<p>Awaiting results of situation analysis.</p>	<p>Not yet developed.</p>	<p>Not yet developed.</p>	<p>Not yet developed.</p>	<p>Formal scale-up has not yet started.</p>	<p>Plan still to be formulated.</p>	<p>M&E framework not yet developed and operational research plans to be developed.</p>

Note: Thirteen southern and eastern African countries with high HIV prevalence, low levels of male circumcision and heterosexual epidemics have been included in this table. The information about each country was provided by countries, partners, and UN agencies, mostly from discussions at a sub-regional meeting (meeting report at http://www.malecircumcision.org/publications/documents/Country_experiences_in_scale-up_in_Eastern_and_Southern_Africa_06.09.09.pdf). The information in this table will be updated on a regular basis. Please send any updates, revisions or corrections to the Clearinghouse Webmaster: webmaster@malecircumcision.org

Progress in Male Circumcision Scale-up Country Implementation Update, July 2009

Country	Leadership, Partnerships & Advocacy	Situation Analysis	Policy & Regulatory Framework	Strategy and Operational Plan	Training	Quality Assurance	Service Delivery	Communication	Monitoring & Evaluation and Research
Mozambique Population: 21m HIV Prevalence: 12.5% MC Prevalence: 60%	Information to be obtained								
Namibia Population: 2m HIV Prevalence: 18% MC Prevalence: 21%	<ol style="list-style-type: none"> Leadership: MoH leading the programme. A National Task Force is in place. MC focal person identified in Ministry of Health. MC coordinator being hired. Partnerships: PEPFAR, PSI, CDC, WHO, UNAIDS. Advocacy: Former Presidents 'Champions for HIV Prevention' going to Namibia in June 2009. Agenda will include MC within prevention. Advocacy with traditional leaders is required. 	Situation analysis needed in terms of understanding traditional circumcisers' practices. Planning a workshop on how to deal with traditional healers.	Draft policy submitted to Parliament which includes task shifting of surgical tasks to nurses.	Strategy has been developed and being rolled out in parallel with implementation in a limited number of pilot sites. Recruiting a national Male Circumcision coordinator. Costing and impact of national strategy derived from Decision-makers' Programme Planning Tool.	Training planned for July 2009.	Quality assurance training will be included in pilot site training and evaluation.	Formal scale-up not yet started but pilot sites have been identified.	Plan already in place. Main funder for communication and advocacy is PEPFAR.	M&E system being developed and to be included in the national HIV/AIDS M&E framework. No plans in place yet for operational research.
Rwanda Population: 9.7m HIV Prevalence: 2.8% MC Prevalence: 15%	<ol style="list-style-type: none"> Leadership: MoH leading the programme. MC Task Force formed in early 2008. MC focal person appointed and is located in TRAC Plus (Treatment Research AIDS TB and Malaria & other epidemics). Partnerships: WHO, UNAIDS, UNICEF. Advocacy: National advocacy campaign in Sept/Oct 2008. 	Service assessment study carried out and report will be ready in early 2009. Protocol for community component developed and UNICEF has committed funds to this effort.	Policy to be developed after situation analysis.	Plans being developed.	Two surgeons and focal person have attended WHO/Jhpiego training. National training plans to be developed after situation analysis.	Framework and structure not yet developed.	Service delivery has started in the military.	TRAC has targeted all 30 district mayors to include MC in their HIV/AIDS control plans. More field visits, radio & TV debates planned for 2009.	Plans to be developed for M&E and operational research.

Note: Thirteen southern and eastern African countries with high HIV prevalence, low levels of male circumcision and heterosexual epidemics have been included in this table. The information about each country was provided by countries, partners, and UN agencies, mostly from discussions at a sub-regional meeting (meeting report at http://www.malecircumcision.org/publications/documents/Country_experiences_in_scale-up_in_Eastern_and_Southern_Africa_06.09.09.pdf). The information in this table will be updated on a regular basis. Please send any updates, revisions or corrections to the Clearinghouse Webmaster: webmaster@malecircumcision.org

Progress in Male Circumcision Scale-up Country Implementation Update, July 2009

Country	Leadership, Partnerships & Advocacy	Situation Analysis	Policy & Regulatory Framework	Strategy and Operational Plan	Training	Quality Assurance	Service Delivery	Communication	Monitoring & Evaluation and Research
<p>South Africa Population: 48.5m</p> <p>HIV Prevalence: 18.1%</p> <p>MC Prevalence: 35%</p>	<p>1. Leadership: MoH leading with South African National AIDS Council (SANAC) Programme Implementing Committee. MC focal person in MoH.</p> <p>2. Partnerships: Reproductive Health and HIV Research Unit (RHRU), Jhpiego, UNAIDS, UNICEF, WHO</p> <p>3. Advocacy: Advocacy with different SANAC groups (men, women)</p>	Situation analysis in progress.	Initial draft Policy developed and under review by small Committee.	To be developed after completion of policy.	Plans being developed.	Being developed.	Formal national scale up not yet started. Service delivery scaled up in Orange Farm community as a follow up to RCT. Approximately 8,300 MCs done to date.	Strategy being developed.	<p>Research Ongoing: Operational research in progress in Orange Farm community including a series of cross-sectional studies being done at baseline, 3 and 5 years to assess impact of male circumcision scale up on HIV prevalence, knowledge, practices and attitude as well as behaviour on condom use.</p>
<p>Swaziland Population: 1m</p> <p>HIV Prevalence: 26%</p> <p>MC Prevalence: 8%</p>	<p>1. Leadership: MoH leading the programme. National Task Force includes all partners who are working on male circumcision. Deputy Director Clinical Services is the MC focal person and Chair of the MC Task Force. Recruitment of a dedicated MC coordinator in progress. Post has been advertised and funding is available through partners.</p> <p>2. Partnerships: Supporting partners: WHO, UNICEF, UNAIDS, PEPFAR, Family Life Association of Swaziland (FLAS), MC Partnership (PSI, Jhpiego, Marie Stopes, Pop Council)</p> <p>3. Advocacy: Current Prime Minister is strong supporter of male circumcision.</p>	Parts of situation analysis done to inform policy development.	Policy developed and is awaiting Cabinet approval.	Strategy and operational plan developed, awaiting Cabinet approval. Piloted legal and regulatory self assessment tool.	FLAS organized a two week MC training and service delivery initiative with Jerusalem AIDS Project in 2007. Collaborating with Jhpiego /PSI for training. Planning to train all providers - training conducted in June/July 2009.	Quality assurance being actively implemented in 3 sites using the WHO quality assurance toolkit.	Two 'Male Circumcision Saturdays' in 2006 and one in 2007 organized to provide MC services. Five government sites identified to provide integrated MC services. FLAS has been providing MC and male SRH services for several years. New dedicated MC clinic being set up by MC Partnership.	Two 'Male Circumcision Saturdays' in 2006 and one in 2007 Campaigns have proved very popular. Communication and advocacy strategy being developed.	M&E Framework is in draft form. Support needed to finalize this. No operational research plans.

Note: Thirteen southern and eastern African countries with high HIV prevalence, low levels of male circumcision and heterosexual epidemics have been included in this table. The information about each country was provided by countries, partners, and UN agencies, mostly from discussions at a sub-regional meeting (meeting report at http://www.malecircumcision.org/publications/documents/Country_experiences_in_scale-up_in_Eastern_and_Southern_Africa_06.09.09.pdf). The information in this table will be updated on a regular basis. Please send any updates, revisions or corrections to the Clearinghouse Webmaster: webmaster@malecircumcision.org

Progress in Male Circumcision Scale-up Country Implementation Update, July 2009

Country	Leadership, Partnerships & Advocacy	Situation Analysis	Policy & Regulatory Framework	Strategy and Operational Plan	Training	Quality Assurance	Service Delivery	Communication	Monitoring & Evaluation and Research
Tanzania Population: 40m HIV Prevalence: 5.7% MC Prevalence: 70%	<ol style="list-style-type: none"> 1. Leadership: MoH leading the programme. Male Circumcision Task Force was formed in October 2007 with 25 members. MC responsibility added to IEC Head within National AIDS Control Programme in the MoH&SW 2. Partnerships: MIMR, WHO, CDC, UNICEF, USAID, Jhpiego, Association of Private Hospitals. 3. Advocacy: MC has been widely practiced in regions for traditional and religious purposes. There is no evidence of opposition to MC. 	Two studies are currently on going: - Situational analysis to assess health facility and community readiness (Non male circumcising and male circumcising regions). Results due July 2009. - Study to find out challenges and opportunities for working with traditional circumcisers. Results due June 2009.	Being developed.	Will be developed using information from situational analysis.	Not yet developed.	Not yet developed.	Pilot sites to be initiated in August 2009.	Not yet developed.	M&E structures not yet developed. No operational research plans made yet.

Note: Thirteen southern and eastern African countries with high HIV prevalence, low levels of male circumcision and heterosexual epidemics have been included in this table. The information about each country was provided by countries, partners, and UN agencies, mostly from discussions at a sub-regional meeting (meeting report at http://www.malecircumcision.org/publications/documents/Country_experiences_in_scale-up_in_Eastern_and_Southern_Africa_06.09.09.pdf). The information in this table will be updated on a regular basis. Please send any updates, revisions or corrections to the Clearinghouse Webmaster: webmaster@malecircumcision.org

Progress in Male Circumcision Scale-up Country Implementation Update, July 2009

Country	Leadership, Partnerships & Advocacy	Situation Analysis	Policy & Regulatory Framework	Strategy and Operational Plan	Training	Quality Assurance	Service Delivery	Communication	Monitoring & Evaluation and Research
<p>Uganda Population: 30m</p> <p>HIV Prevalence: 6.4%</p> <p>MC Prevalence: 25%</p>	<p>1. Leadership: National Task Force for male circumcision comprised of surgeons, public health specialists, researchers and health communication specialists has been commissioned. Ministry of Health providing overall leadership, guidance and stewardship for Medical Male Circumcision.</p> <p>2. Partnerships: Supporting partners: WHO, UNAIDS, UNICEF, UNFPA, USAID, FHI and Makerere University School of Public Health.</p> <p>3. Advocacy: No local champions identified. Advocacy still required at various levels.</p>	<p>Situational analysis to determine the acceptability and feasibility of Medical Male Circumcision promotion in Uganda has been completed and disseminated. Mapping a survey of Medical Male Circumcision delivery services in Uganda. Statistical modeling to estimate costs of a national Medical Male Circumcision being planned.</p>	<p>Planning to develop a stand-alone male circumcision policy.</p>	<p>Planning for strategy development. Consultations ongoing on which male circumcision surgical technique to adopt and which cadres to do surgery.</p>	<p>Not yet developed.</p>	<p>Not yet developed.</p>	<p>Formal scale-up not yet started.</p>	<p>Strategy not yet developed.</p>	<p>Research Ongoing: In Rakai epidemiological, clinical, operational and basic science research RCT site.</p> <ul style="list-style-type: none"> • Epidemiological research - community-level surveillance of men and women regarding MC acceptance, satisfaction, behavior change and HIV incidence • Clinical research - post MC healing times and the process of keratinization, effect of MC on viral load. Foreskin immunochemistry • Operations research - comparison of sleeve and dorsal slit methods by different categories of staff, number of surgeries required to achieve competency.

Note: Thirteen southern and eastern African countries with high HIV prevalence, low levels of male circumcision and heterosexual epidemics have been included in this table. The information about each country was provided by countries, partners, and UN agencies, mostly from discussions at a sub-regional meeting (meeting report at http://www.malecircumcision.org/publications/documents/Country_experiences_in_scale-up_in_Eastern_and_Southern_Africa_06.09.09.pdf). The information in this table will be updated on a regular basis. Please send any updates, revisions or corrections to the Clearinghouse Webmaster: webmaster@malecircumcision.org

Progress in Male Circumcision Scale-up Country Implementation Update, July 2009

Country	Leadership, Partnerships & Advocacy	Situation Analysis	Policy & Regulatory Framework	Strategy and Operational Plan	Training	Quality Assurance	Service Delivery	Communication	Monitoring & Evaluation and Research
<p>Zambia Population: 12m</p> <p>HIV Prevalence: 14.3%</p> <p>MC Prevalence: 13.1%</p>	<p>1. Leadership: MoH leading the programme. National Task Force in place. National Male Circumcision Coordinator to be appointed.</p> <p>2. Partnerships: Supporting partners: University Teaching Hospital (UTH), MC Partnership (PSI, Jhpiego, Marie Stopes, Population Council) Centre for Infectious Diseases Research Zambia (CIDRZ),</p> <p>3. Advocacy: Local champion still to be identified.</p>	<p>Situational analysis and health facility preparedness has been completed.</p>	<p>Cabinet memo incorporating male circumcision in HIV prevention has been approved. Agreement is not to have a stand alone policy.</p>	<p>Plan is to increase from 11 delivery sites to 300 sites by 2014. Plan to do approximately 10 000 male circumcisions per year, through partners and the national health system.</p>	<p>Partnership with Jhpiego and UTH for training. ~150 providers trained.</p>	<p>WHO QA Guide and toolkit to be implemented.</p>	<p>11 Delivery sites established. About 4 000 male circumcisions have been done to date. In partnership with PSI, FHI, Marie Stopes, CIDRZ for service delivery</p>	<p>In partnership with HCP for communication strategy</p>	<p>M&E framework to be developed. Ongoing operational research through University Teaching Hospital.</p>
<p>Zimbabwe Population 12m:</p> <p>HIV Prevalence: 15.6%</p> <p>MC Prevalence: 10%</p>	<p>1. Leadership: MC Task Force with subcommittees formed. Steering Committee and three Technical Working Groups are in place. Focal person for MC and condom programming identified in the Ministry of Health.</p> <p>2. Partnerships: Supporting partners: Zimbabwe National Family Planning Council (ZNFPC), WHO, UNFPA, PSI, church organizations.</p> <p>3. Advocacy: Working with student movements and women's activist groups for advocacy.</p>	<p>Male circumcision situation analysis conducted and results disseminated during male circumcision stakeholders meeting in Oct 2008. Mathematical modeling workshop was held in Harare August 2007.</p>	<p>Draft policy developed and currently on circulation for comments.</p>	<p>Exploring task sharing with other cadres. Costing to be done and strategy to be developed.</p>	<p>Established central level training site at ZNFPC at Spilhaus, Harare. National Training of Trainers was conducted: 18 national trainers consisting of surgeons, nurses and counselors. Training materials have been adapted from WHO training guidelines.</p>	<p>Being developed.</p>	<p>Phase 1 (Pilot) commenced in April 2009 at 4 service delivery sites- 149 male circumcisions performed in a four week period as of 10th June 2009.</p>	<p>Communication and advocacy strategy has been developed.</p>	<p>M&E system and tools developed and integrated into national HMIS. Operational research plans yet to be developed.</p>

Note: Thirteen southern and eastern African countries with high HIV prevalence, low levels of male circumcision and heterosexual epidemics have been included in this table. The information about each country was provided by countries, partners, and UN agencies, mostly from discussions at a sub-regional meeting (meeting report at http://www.malecircumcision.org/publications/documents/Country_experiences_in_scale-up_in_Eastern_and_Southern_Africa_06.09.09.pdf). The information in this table will be updated on a regular basis. Please send any updates, revisions or corrections to the Clearinghouse Webmaster: webmaster@malecircumcision.org