Rakai Operational Research
Challenges in providing safe male circumcision services

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How to scale up?

- Training of health personnel
- What level of personnel?
- Equipment and supplies
- Postoperative care
- Monitoring of services
Minimum requirement to perform circumcision

- Theaters (Operating rooms)
- On the average, one such facility per sub district (approx 300,000 people)
- Medical officers, clinical officers and Nurses.
CHALLENGES

• Who should be circumcised?
  – Children, Adults, Both children and adults

• Consent/assent issues

• Who should do the surgery?
  – Should Nurses/midwives be allowed to do surgery

• Who and how should follow up be done?
  – Issues of over diagnosis, under diagnosis, over treating, inappropriate use of antibiotics
Major Challenges faced post trial

• Political commitment to inclusion of circum in the HIV prevention strategy
  – Clear dissemination of results far and wide

• The potential for possible harm to women if HIV+ men in discordant relationships are circumcised and resumed sex before wound healing.
  – WHO recommended offering circum to HIV positive men if they so request but only after thorough counseling

• Sudden increase in demand for circumcision services with lack of adequate personnel, facilities and infrastructure to meet the demand (both private and Government) and no policy.
  – Establish a center of excellence to provide training and the service (requested and got support from PEPFAR to implement this)
  – Emerging competition between circumcision and other services offered at government.
Type of surgery

- Forceps surgery
- Sleeve procedure
- Dorsal slit
Main operational research issues

• Assess available circumcision services in the country and how they can be improved

• Feasibility of establishing male health centers. (pilot center)

• Evaluation of circumcision techniques (type of surgery, dressing, anesthesia etc.)

• Asses ability of different carders to provide surgery (midwives, nurses, clinical officers, medical officers).
Health System

• Now, HC-IV and hospitals are qualified to offer MC

• Should special centers be established to provide training and QC for new and existing personnel?

• Should special centers be established to provide MC?
  - ? Male reproductive health centers
  – ? Health center III
  - ? Mobile clinics
Policy issues

• Age at circumcision
  – Neonates, children, adults or both children and adults

• Consent/assent issues

• Who should do the surgery?
  – Should it be only doctors?

• Who and how should follow up be done?
  – Issues of over diagnosis, under diagnosis, over treating, inappropriate use of antibiotics
Type of surgery

- Feasibility versus outcomes (e.g., hemostasis/incomplete removal of prepuce/glans injury) in a program setting
- Forceps surgery
- Sleeve procedure
- Dorsal slit
WHAT DO WE KNOW

• There is no significant difference in AE rates by technique.

• There is no significant difference in AE rates by cadre.

• There is a saving of 4 minutes if dorsal slit is used compared to sleeve.

• There is a saving of about 5 minutes to complete surgery if MOs do the surgery.
Theatre modification
WHAT DO WE KNOW

• Pain control is better with mixture of lignocaine and bupivacaine compared to lignocaine alone.

• After training the first 20 surgeries should be supervised to minimize AEs.

• Task shifting and task sharing is possible.

• Cautery is not a requirement to do MC for HIV prevention.

• It is possible to do MC in a modified simple theatre.
WHAT WE DON’T KNOW

• Behavioral dis-inhibition over time
• Long term effects of MC on HIV/STI prevention
• Time to complete healing/keratinisation
• Mobile MC services.
• Cost effectiveness of MC as an HIV prevention strategy
• How to get MC clients to come for surgery in time