Rakai Operational Research Challenges in providing safe male circumcision services

Stephen Watya – RHSP/Mulago Hospital

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 (eg., 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