Integrating Male Circumcision (MC) into HIV Prevention Efforts: Our Learning in Ethiopia, Kenya and Rwanda

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April 6, 2009
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EXECUTIVE SUMMARY (Abstract Form)

Background: Three trials have shown that male circumcision (MC) can reduce female to male HIV transmission by >50%. Rwanda has declining HIV prevalence, is not a traditionally circumcising nation and is considering policy options for MC.

Methods: Two surgeons, an Infectious Disease (ID) epidemiologist, an AIDS specialist and a health communications specialist recently met with Rwandese colleagues and also conducted a preliminary assessment in Gambella, Ethiopia.

First, a visit was conducted to Kisumu, Kenya, to learn about established efforts.

Activities in Rwanda included surgical exchange and demonstration on MC methods, and meetings with staff and leadership at the Ministry of Health (MoH), Medical Faculty at the National University of Rwanda, military medical leadership, representatives of foreign funders, UNAIDS staff and Family Health International personnel. The group toured a local health centre, district and referral hospitals, and truck-stop outreach sites and held conversations with clients at these facilities and discussions with several groups representing persons living with HIV.

Results:

Rwandese surgeons were already acquainted with forceps controlled technique. Mogen, Gomco and Plastibell methods were demonstrated. Rwandese surgeons are consulting with the Ministry of Health on generalizable approaches for the country. Themes emerging from conversations:

- There is some awareness and uptake of MC for HIV prevention thanks to media and community coverage;
- Networks where people have circumcised friends may predispose; cost in excess of 3000 francs ($6 CDN) was seen as an obstacle;
- “Risk compensation” is a concern so that education is required to reinforce condom use, limitation of partner exchange and safe post-op behaviour;
- Pre-operative counseling of attached young men undergoing the procedure should involve the partner;
- Logistics dictate that non-medical personnel must be trained to provide most procedures; and
- The Rwandese MoH has costed neonatal circumcision for the country.

Gambella is a pocket of Ethiopia with high HIV prevalence and low uptake of male circumcision. Local authorities are interested in developing a Ministry of Health sanctioned plan to increase training and availability of MC.
Conclusions:

Dr. Agnes Binagwaho announced Rwanda’s support for a neonatal approach to be offered by the same personnel who attend births (January 2009). This would be more sustainable and less of a drain on health human resources and on employment time for adolescent and adult patients or those attending them. An announcement to this effect was made on January 5, 2009.

Possible future supportive roles in this area include:

- Providing assistance with planning undergraduate medical or nursing training or continuing health education for those in practice;
- Providing assistance with training models for other health care workers (existing centres of expertise in East Africa should be considered); and
- Providing assistance in procuring any key re-usable surgical supplies with a high upfront cost.

The Rwandese Ministry of Health will be encouraging of procedures in adolescents and young men. Further discussion may be required to determine if extramural funding of outreach to higher risk groups of adolescents and young men would be welcome. Any such activity would have to be integrated with ongoing HIV prevention and general health care and in an area where there was sound education against risk compensation.

Although out of scope for the MC consultation, other issues were discussed in Rwanda:

- Consideration of future collaboration on skills transfer around non-scalpel vasectomy or other surgical approaches to family planning.

- Linkage of the National University of Rwanda with other academic Continuing Professional Education programs to support its expanding role in this activity.

- It would be logical to consider both of the above in the context of established links with the Canadian Network for International Surgery in Rwanda.
BACKGROUND

Male circumcision (MC) has been shown to reduce female to male transmission of HIV by over 50%. (1-3) Aside from antiviral drugs to prevent maternal-child transmission, there has been no other short-term intervention with lasting effect available in the fight against HIV. Epidemic models conclude that millions of lives could be saved in Africa if widespread implementation of MC becomes both feasible and safe in high prevalence countries. (4-6) The benefit extends to women and their offspring as uninfected males do not transmit. As a result, UNAIDS has placed a high priority on implementation. This must be done carefully and with adoption of impeccable technique and ethical treatment so that complications do not lead to poor acceptance and uptake. (7)

Rwanda has made progress in HIV prevention in recent years. Prevalence has been declining, age at sexual debut is relatively advanced and antiretroviral therapy programs are rolling out. (8,9)

Recently, the government of Rwanda has announced an interest in incorporating MC into its program of HIV prevention. The purpose of the visit was to assess the need for and feasibility of surgical training to aid the ramp-up of MC as part of a comprehensive HIV and health strategy in Rwanda.

TRIP OBJECTIVES

• To review with decision makers their interpretation of the impact of MC on HIV transmission and establish an understanding with regard to Rwandese philosophy on the role of this procedure in the established health care milieu.

• To review the preceding UNAIDS experience, including cautions around the need to integrate with overall health care planning and HIV prevention and to avoid unintended harms.

• To gain greater understanding of where HIV/AIDS is placed as a perceived threat in Rwanda compared to other threats such as security, nutrition, water supply and other endemic diseases.

• To gain an understanding of ethical, cultural, political and logistical considerations of integrating MC into HIV prevention programs.

• To review available information on HIV prevalence and current MC practice.
• To identify areas of greatest need/opportunity within the country.

• To gain insight into current public communications around MC.

• To work with a candidate group for training on methods.

• To assess the current skills of those health care providers who are looking for training.

• To review the adequacy of facilities and supplies.

• To outline the major elements of a training plan based on local resources.

• To produce a summary of the trip that will allow for dissemination of lessons learned.

• To conduct a preliminary visit to Gambella, Ethiopia to determine if a full assessment could be conducted.
OVERVIEW OF LOGISTICS AND METHODS

Funding and Facilitation

Funding was obtained from the following sources:

- The Canadian Institutes for Health Research – Core Meeting Grant.
- The Centre for Leadership Initiatives (Charles & Lynn Schusterman Family Foundation) – as part of a leadership grant to Julie Schneiderman.
- The Jewish Federation of Greater Vancouver – for travel of Dr. Ma’ayan.
- Private donations from family and friends of Dr. Pollock for surgical instruments through the BCCDC foundation.

Pre-trip logistics were managed and coordinated by Julie Schneiderman and David Patrick with staff support from the BCCDC.

In country logistics for Ethiopia were arranged through the collaboration and leadership of Dr. Dawit Wolday of Medical Biotech Laboratories (and country director for Hadassah Hospital, Jerusalem) and Dr. Shlomo Ma’ayan.

Drs. Stephen Moses and Bob Bailey made possible the visit to, and knowledge transfer from, clinics and sites in Kisumu, Kenya, with particular logistical support from Emma Llewelyn and the staff at the Nyanza Reproductive Health Society (NRHS).

In country logistics for Rwanda were arranged through the kind collaboration of Family Health International, particularly the Rwanda team. In this, they had active collaboration from Dr. Agnes Binagwaho, Permanent Secretary for HIV/AIDS to the Ministry of Health of Rwanda and Dr. Innocent Nyaruhirira, Chief Executive Officer of King Faisal Hospital, Kigali.

The team is grateful for the assistance and advice of Ms. Louise Binder (Canadian Treatment Action Council) and Mme. Floride Nyiraneza (We-Actx, Rwanda) in developing key community connections and for facilitating a number of the community sessions in Kigali.
OVERVIEW OF MEETING ACTIVITIES AND OBSERVATIONS

The meeting was composed of several related activities. These will be described in more detail along with cogent findings in the following sections:

*Preliminary Assessment in Gambella, Ethiopia*

*Review of Existing Efforts at Kisumu, Kenya*

*Plenary Introductory Session at King Faisal Hospital, Kigali*

*Surgical Demonstration at King Faisal Hospital, Kigali*

*Meeting, Consultations and Conversations in Rwanda*
Preliminary Visit to Gambella, Ethiopia

Team members Julie Schneiderman and Shlomo Ma’ayan were joined by Dr. Dawit Wolday of Medical Biotech Laboratories (Hadassah Hospital country representative Ethiopia) for the first part of the trip in Ethiopia. The goal was to build upon longstanding HIV training partnerships between Israel and Ethiopia and to understand the HIV testing, treatment and prevention landscape in the Gambella region, with a specific focus on adult male circumcision. Gambella is located in the southwest of Ethiopia, bordering Sudan. The visit centred on its capital, Gambella Town.

The Gambella region has historically been insecure due to internal ethnic tension and cross-border incursion from South Sudan. It has been somewhat inaccessible to foreign universities and NGOs, other than for emergency humanitarian missions. Endemic malaria, uncontrolled TB, high prevalence of HIV/AIDS and very low immunization coverage coupled with the internal displacement of people and ongoing conflicts have left the population in need of support and interventions. (Report from Swedish International Development Cooperation Agency, SIDA, November 2007.)

The rest of Ethiopia has a national HIV prevalence of approximately 3.5% coupled with a relatively high rate of adult male circumcision due to a cultural acceptance from the large Coptic Christian and Muslim populations. With the exception of Gambella and one other southern region, male circumcision is nearly universal.

By contrast, 53% of men in Gambella are not circumcised. (11) According to the same report, the Gambella region unexpectedly exhibited the highest prevalence of HIV of any area in the country, including Addis Ababa.

HIV prevention is a very high priority in Ethiopia. While prevalence is not as high as in some of the regions to the south of the Sahara desert, there is significant risk that it could mount in some areas of the country and some evidence that prevalence may already be higher where MC is not well taken up.

The purpose of this initiative is to bring Canadian urologists, surgeons and epidemiologists into contact with Ethiopian colleagues and their Israeli counterparts to facilitate the birth of a sustainable training program and to evaluate this implementation process. We have identified Canadian and Israeli leaders in adult and neonatal surgical technique who are willing to translate their knowledge to local health care providers. We have begun to identify willing regional partners in Gambella Town and to sow the seeds for the development of a comprehensive training model.

The team connected with:

- Francesca Stuer, FHI Country Director Ethiopia (Addis Abab)
- Dr. Zarihun Desta, HAPCO Gambella
- Mr. James Bol, JHPIEGO and Johns Hopkins University focal person Gambella
- Deputy Director, Gambella Health District
• Gambella Hospital, VCT Centre and Adelahu Gebre, Operating Room Nurse

The region, which has nine health centres and one district hospital, is very open to new training models and systems for their staff. They would prefer training to take place at the Gambella Hospital. Some small training of staff has taken place in Addis Ababa through JHPIEGO, however any formal projects would need support from the Ministry of Health. The district estimates there are approximately 100,000 adult males to circumcise in the region.

The Gambella Hospital reportedly performs 5-6 circumcisions per week, mostly on children. They use a scalpel method. The demand is more than 10 per week. However, due to staff shortages they are unable to accommodate more circumcisions. Regional staff seem very interested in pursuing the development of a new project and feel the recent World Bank data on HIV infection in Gambella needs to be addressed.

Conclusions & Next Steps

• Connections with existing initiatives such as those through JHPIEGO and JHU are encouraged.
• A comprehensive training program in adult MC that included other surgical training such as gynecological training would be welcomed.
• The region appears very open to further discussions about training programs and is prepared to work in partnership with various NGOs.
• Follow-up with the Ministry of Health is needed, as well as further exploration on the development of a comprehensive surgical training program that is well linked to the HIV treatment and prevention continuum.
• Facilitated discussions with community stakeholders and the broader engagement of local expert stakeholders should follow.
Review of Existing Efforts at Kisumu, Kenya

Before, arriving in Rwanda, the full visiting group travelled to Kisumu, Kenya to see the work of the Nyanza Reproductive Health Society (NRHS). This collaboration of the Universities of Nairobi, Illinois and Manitoba (UNIM) performed one of the three randomized controlled trials of MC. We were hosted by Project Coordinator, Emma Llewellyn and UNIM Clinic Manager, Dr. T. Onyango. The team visited the main UNIM clinic, where an average of 10-15 circumcisions are performed each day (to a maximum of 20) and watched a circumcision there. A second visit took place at an outreach clinic at a local prison, where circumcisions are performed daily by skillful UNIM staff in a clinic without electricity and running water.

Nyanza has some of the highest rates of HIV in Kenya. This has been attributed to a high rate of sexual concurrency among men and women and is associated with traditionally low rates of MC. NRHS now operates a central teaching clinic at the UNIM site in Kisumu. They also provide MC services through seven outreach and eight mobile sites. One hundred or more procedures are performed per working day. These activities are currently funded by PEPFAR and related operational research by a Gates Foundation grant (through FHI).

The NRHS has codified an approach to MC that includes:

- Collection of patient demographic information
- Counseling and informed consent
- Screening to rule out contraindications
- Surgery
- Post-op instructions
- Day 7 review

Follow-up is supported by a hotline number, free pick-up for return visits and the innovative use of a 40-day SMS reminder service to clients' mobile phones.

Surgical services are offered by Clinical Officers who have had extensive training in the forceps guided method as described in the WHO surgical manual (10). The advantages of the approach for adults and adolescents would include an excellent potential for sterile technique and hemostasis even in the mobile setting, the latter because ligatures rather than cautery are used for hemostasis. Drs. Kinahan and Pollock (visiting surgeons) commented on the high caliber of technique.

The UNIM team has offered training to 180 personnel including 40 surgeons. Training takes approximately 1-2 weeks. While the focus has been Kenya, Ms. Llewellyn indicated some openness to the possibility of training practitioners from nearby countries.

The NRHS group identified some ongoing challenges. It has proved difficult to integrate support for MC into the work descriptions of existing public health or clinical personnel.
This may relate to a lack of incentive within the system to add further work but also a current organizational dichotomy in Kenya between health services (which would traditionally provide surgery) and public health. Current work is ongoing to see if it is possible to ramp up delivery to a point where a huge backlog of demand among adolescents and young men can be met. Extramural funding (outside of the traditional health funding envelope) may be critical to ensure that other critical health services do not suffer from staff drain.

A national communications strategy is being developed, which will include education for women about male circumcision.

**Conclusions**

Clinical officers can perform MC to a high technical standard. Kisumu represents a strong centre for regional training.
Plenary Introductory Session at King Faisal Hospital, Kigali

The full visiting group had an introductory meeting with staff at King Faisal with some members of the National AIDS Control Commission (CNLS).

- Dr. Innocent Nyaruhirira provided introductions.
- Dr. Anita Asiimwe described the current status of planning at the Ministry of Health.
- Dr. Patrick provided a brief review of the evidence on MC and HIV Prevention.
- Dr. Ma’ayan described the north south collaborative training model operating between Israel and Ethiopia.
- Drs. Pollock and Kinahan were introduced by Dr. Emmanuel Kayibanda and provided an overview of several techniques for infant and adolescent circumcision.
- There was robust input from the audience.

The meeting helped to set an atmosphere of mutual respect for accomplishments made and establish the goal of learning from each other during the visit. There was some attendance by print and television media with considerable national coverage that evening. (See appendix 3).

Surgical Demonstration in Rwanda

Our hosts had been interested in the demonstration of various techniques. Demonstrations on infant circumcision occurred with about 85 children. Twenty or so were performed using Gomco or Plastibell and the rest using the Mogen Clamp. There was a receptive group of doctors eager and able to learn new and improved techniques to fulfill the increased demands.

Two surgeons focused on learning the Mogen clamp approach. Dr. Pollock felt that they had acquired reasonably sound grasp of technique and were committed to teaching it to interested colleagues. A detailed approach to preparation for neonatal circumcision was used including the use of topical anaesthetic, use of sugar balls, the dorsal penile block and careful attention to restraint and a tranquil environment. The prospect of improved analgesia and more efficient procedure taking less surgeon time had appeal for them. There was some transfer also of a model based teaching system and considerations for clinic or service layout and organization.

Dr. Kinahan brought Gomco clamps and Plastibell devices for demonstration with babies as well as adult Gomco clamps. He emphasized the need for complete, symmetrical foreskin removal, avoidance of glans injury, managing hemostasis with vessel/skin crushing, cautery and ligature, post-op dressings, and the proper process of hand suturing in both adults and babies.
Kinahan observed that the Mogen method seemed suitable for most early neonatal procedures. Rwandese surgeons also had some interest in Plastibell as a quick procedure but cost for consumable rings could pose an obstacle to its adoption in smaller centres.

There were a number of observations and recommendations with regard to how to improve similar efforts in the future:

- It may be wise to position a support team in place first to assure that all issues around preparation, counseling and consent are in full order.
- Rolling out adult MC may prove to be dependent on finding and certifying alternative service providers through teaching by existing practitioners; this could be supported by further Canadian or regional support.
- On a short visit, it was not possible to fully address the spectrum of educational assessment and peri-operative care.
- More time could be budgeted to consider consultation, needs assessment, evaluation of current surgical training, knowledge backgrounds, experience, willingness to be taught, progressive hands on surgical teaching, knowledge around complications and how to deal with them, and need for early and late patient follow up.
- It might be possible to use digital images and electronic transmission to allow “outsourcing” of the follow up.

While our hosts had been interested a priori in learning of a number of surgical options, our team concluded that it would be wise prior to further initiatives to make sure that there is common ground on a pedagogic and surgical approach on one or a limited range of procedures.

**Consultations and Conversations in Rwanda**

A wide array of meetings and informal conversations and consultations were held with individuals and groups from the Government of Rwanda, local and international NGOs, community associations, clients from local health centres, as well as medical and expert colleagues. These discussions were led by Dr. Patrick and Julie Schneiderman, mostly in parallel to the surgical training program at King Faisal Hospital, so as to maximize the role of all team members as well as to broaden the reach and learning of the team. Efforts were made to consult broadly with adult males, women, as well as vulnerable populations including people living with HIV/AIDS. The team is grateful to all who gave up time to meet and share their expertise and opinions:

- Dr. Agnes Binagwaho, Permanent Secretary for HIV/AIDS to the Ministry of Health
- Dr. Vivens Kalinganire Human Resources for Health at the Ministry of Health
• Elivanie Nyankesha (Prevention Department), Dr. Antoine Rwego (Biomedical prevention), Mme. Lilioise Niyetegeka et al. HIV/AIDS Treatment and Research Centre of the Ministry of Health (TRAC+)
• Dr. Anita Asiimwe, Executive Secretary et al. National AIDS Control Commission (CNLS)
• Mme Mutagoma Madina Juma M & E Coordinator, Réseau Rwandais des Personnes Vivant avec le VIH-sida (RRP+). Rwandan Network of People Living with HIV/AIDS
• Philomene, Vivianne Furaha, Jacqueline and other members of Femmes Intellectuelle Rwandaise Seropositives
• Visit to Local Health Clinic in Kisumu and conversations with mothers of children in the immunization clinic and a group of PLWHIV from the community
• Visit to District Hospital
• Visit to Safe-T Stop – an outreach centre for truck drivers, sex workers and local community with M. Melchiade Ruberintwari (FHI)
• Conversations with mothers of young children, a group of young men, older men (heads of household) associated with Safe-T Stop
• Conversation at We-ActX (Women’s Equity in Access to Care and Treatment) with HIV positive men
• Dean Herbert Nsanze, Dr. Patrick Kyamanywa and faculty at National University of Rwanda Medical School
• Dr. Felix Ndagije – Prevention Specialist CDC; Noni Gachui, Prevention Specialist PEPFAR, Dr. Mary Kabanyana, USAID
• Visit to Kanombe Military Hospital
• Dr. Kekoura Kourama and Mme. Elisabetta, UNAIDS Discussion
• Dr. Jessica Price, Country Director, FHI Rwanda
• Follow-up discussion with Dr. Innocent Nyaruhirira, CEO of King Faisal Hospital
• Meeting with Jérémie Zoungrana, Country Director of JHPIEGO Rwanda and Therese Bishagara (ACCESS Program Manager)
FINDINGS FROM CONSULTATIONS AND CONVERSATIONS IN RWANDA

Rwanda

Rwanda remains a developing nation and works to address its very high population density. Government is democratically elected, stable and according to all reports, functioning with a high level of competence and accountability.

Challenges in Health

Major challenges in health for Rwanda include rapid population growth and the need for continued vigilance on nutrition and new initiatives in family planning.

Local health centres are the focus of health care in rural regions. A typical health centre may be managed by one or more nurses and will have ancillary health personnel. The centre will take care of most basic health care, ranging from maternal-child health, through immunization, nutritional assessment, management of some infectious diseases (e.g. diarrhea, uncomplicated malaria) and in recent years, even antiretroviral therapy is available through these centres with weekly supervision by a visiting physician. Remarkably, the health centre at Kisumu raises its own protein in the form of eggs and milk to treat protein malnutrition.

Sicker cases and more complicated surgery will be referred to district hospitals. Such hospitals also serve as a base of operations for physicians who will rotate visits to local health facilities.

Even a few years ago, the ratio of physicians to population was as low as 1 in 50,000. The medical school at Butare has been graduating more doctors so that the ratio has recently improved to 1 in 17,000 but many doctors are busy with administrative duties. This means that nurses and medical technicians deliver much of the front line care.

Shortages of medical professionals, particularly doctors and nurses remain a pressing issue in Rwanda, as in much of Africa.

Status of HIV Prevention

Gains have been made in the last decade and a half in HIV prevention. Prevalence is declining and presently estimated to sit at 3%.

Prevention programming focuses on the usual areas of abstinence, fidelity, condom use. As in most countries, there is room for improvement in condom utilization.
Compared with many countries in the area, Rwanda is advantaged by a slightly advanced average age at sexual debut.

Messages are reinforced through a pattern of public communication that includes radio as well as regular discussion at church.

There is also an active program of mitigation of existing infection. In recent years, the government has managed to coordinate a number of foreign donors to provide a wide scale expansion of antiretroviral therapy to people living with HIV. PLWHIV in Kisumu said that this had given them new hope, helped them feel healthier so that they can work to feed their families and given them a chance to survive to raise their children. There is some concern, however, that one day, ARVs will stop coming or that there will be a shortage of meds and people will be forced to buy them. The country has programs to address the needs of orphans and children with AIDS. Some AIDS Service Organizations focus on providing microcredit to assist with economic needs of PLHIV. There is also a focus on helping people achieve an adequate nutritional status.

Several informants living with HIV felt that the stigma associated with the diagnosis was still real, but diminishing. Some expressed concern around men and testing, commenting that even when their pregnant wives test positive, many men still refuse to get tested.

**Current Scenario for Male Circumcision**

The government of Rwanda announced an interest in integrating MC into HIV prevention efforts in 2007. Some urban males in Kigali have begun to access MC services. This appears to be most likely where there are people in the social network who have already been circumcised, for example, if there are peers in the network who are Muslim or who were circumcised during the Diaspora in the Congo and other places. About 10% of men overall are thought to be circumcised.

There was no overwhelming cultural opposition to circumcision reported and many informants felt that provision of information and positive peer pressure could increase uptake. However, a number of informants identified some important barriers to the practice that must be considered:

- In some segments of the population, presence of the foreskin is informally thought to enhance sexual pleasure for one or both partners. This was especially an issue among younger men.
- The word in Kinyarwanda for circumcision also can be interpreted to mean, “To convert to Islam”. This creates a cultural association that may be a barrier for some. Some health planners are considering whether a less “loaded” term should be introduced.
- Some young men avoid the procedure for fear of pain or of the operation itself.
• Which type of health professional is performing the procedure (some informants insisted they would only see a doctor, while others seemed fine with a well-trained nurse or health officer).
• Cost of the operation. Many saw cost as a prohibitive aspect and felt that even 3000 RWF would be too expensive for the very poor and for orphans.
• Time required off work to heal and the costs associated.
• Mandatory HIV testing.
• Lack of education about the procedure in the countryside and outside of urban centres.

The Ministry of Health has been actively engaged in costing efforts for the country. While these were not available for review before the Ministry’s own announcement of final approach, it was clear that there was active comparison of costing between a neonatally delivered program and one following the examples of Kenya, South Africa and Tanzania with a focus on younger men.

The Ministry has arranged a formal Community Advisory Board for direction on MC and has also established a Technical Advisory Group comprised in part of some of the surgeons who participated in the methodological exchange at King Faisal Hospital. A meeting with the TAG group was planned to occur shortly following our consultation.

Representatives of UNAIDS in Rwanda understand the logic of the government looking at neonatal programming. They note that if resources are directed at neonates, it may make it harder to achieve short-term prevalence targets for 15-24 year old men. However, this may be mitigated if there are other focused efforts involving that age group.

**Counseling around the procedure**

UNAIDS strongly recommends a structured counseling service which includes risk reduction counseling, provision of information on the procedure, a process for informed consent and an offer of HIV testing.

• Dr. Anita Asiimwe reports that a standard counseling package is being prepared by the MoH.
• Our consultations with various groups of people suggested that the counseling might best be accomplished with couples. Their reasoning for this recommendation is that presence of the partner could help to reinforce post-operative risk reduction advice. In fact, even the men-only groups insisted that women should be included in counseling sessions, as well as more broadly targeted information campaigns and sessions.
• It was felt that in both cases of adult male circumcision and infant circumcision, women could play a key part in education, dissemination of community information and partner support.
Mass public education around HIV prevention and the use of circumcision in conjunction with other prevention tools was also raised as a critical issue. A number of informants felt that more was known about adult male circumcision in city centres, but less so in the countryside. The need for further education and particularly education that includes women, was a theme reinforced through many of the conversations.

Another issue raised, was that of multiple partners. The case of PMTCT was used to highlight what happened when women only brought their husbands for HIV counseling and not their other male partners. The lesson, it was suggested, could be applied to men and multiple female partners.

A number of HIV positive informants felt that peer counseling and education from HIV positive individuals to the general public would be a very effective way to highlight the prevention message around MC.

HIV testing as part of the work-up for circumcision in older boys and men is recommended. All groups with whom we discussed this suggested that it should be routinely offered but that mandatory testing might lead to lower uptake of circumcision.

**Human Resources**

It would be wasteful of scarce surgical resources to launch any MC program in Rwanda with surgeons alone. There was interest among the medical faculty at Butare in seeing if basic technique in neonatal circumcision could be integrated into the essential surgical skills component of the medical undergraduate curriculum. Of interest, the ESS module has been provided for nine countries in the region by the Canadian Network for International Surgery. Medical faculty and MoH staff also thought that there should be some consideration both to including similar training for nurses and midwives and making it available in a Continuing Professional Development format.

At present, a few physicians at King Faisal hospital have been trained to a reasonably high degree of competence and could train others. There may be a need to provide some form of incentive for such activity.

Finally, given our experience in Kisumu as above, we feel that intensive training of medical technicians for adolescent or adult surgery could take place regionally with the Nyanza Reproductive Health Society should this work for both parties. Skills are high in the area and the costs of moving personnel around regionally would be much lower than those associated with bringing in surgeons from North America.
RECOMMENDATIONS & AVENUES FOR FUTURE ACTION IN RWANDA

1. Await consultation between King Faisal surgeons and Ministry of Health about preferred strategy and methods.

2. Define a role in supporting the training of medical students, nurses, and health care workers in practice in neonatal circumcision. (This in collaboration with NUR in Butare and with Nursing Colleges).

3. Explore through FHI contacts the idea of extramural funding for one or more projects to help catch-up the highest risk males (e.g. truck stop) by applying a model similar to that used in neighbouring countries.

4. Discuss the role of surgical approaches in Rwandese family planning efforts and the future of skills transfer from urologists, gynecologists and other surgeons in that area.

5. Assure some discourse around the current training interaction with the Canadian Network for International Surgery, Rwanda.

6. Encourage any future programs in adult male and infant circumcision to involve broad community consultation and encourage the inclusion of woman and people living with HIV/AIDS in the broader public outreach and education process.
REFERENCE LIST


**APPENDIX A : COPIES OF ITINERARIES**

**Schedule agenda for Patrick David, Julie Scheiderman, Shlomo Ma’ayan**

Note: The agendas represent the initial schedules set prior to arrival in Rwanda. A number of modifications were made during the visit to accommodate scheduling changes and additional meetings. These changes are not reflected below.

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<tr>
<th>Date</th>
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<tr>
<td>Dec 8, 2008</td>
<td>22:40</td>
<td>Arrival, airport transfers</td>
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<tr>
<td>Dec 9, 2008</td>
<td>8:40</td>
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<td>9:00-9:20</td>
<td>Introductions and orientation of King Faisal</td>
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<td>9:20-9:30</td>
<td>Introduction and background of visiting team (Dr. David Patrick)</td>
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<td>9:30-9:45</td>
<td>Male circumcision and HIV prevention: a brief update on the research and its implications (Dr. David Patrick)</td>
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<td>9:45-10:15</td>
<td>Dr. Neil Pollock’s infant circumcision techniques + Q/A</td>
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<td>10:15-10:45</td>
<td>Dr. Tom Kinahan’s infant and adult circumcision techniques + Q/A</td>
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<td>10:45-11:30</td>
<td>Q/A, discussions, and AOB re plans for organization and plans for surgical training</td>
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<td>11:45-12:15</td>
<td>Jean de Dieu Gasanagera, RRP+ Acting Manager at RRP+ offices</td>
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<td></td>
<td>12:30-13:30</td>
<td>Lunch with Mme Lilliose Niyitegeka, TRAC employee completing masters-level research on perceptions of MC among men at high risk of HIV infection</td>
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<tr>
<td>Date</td>
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<td>TBD</td>
<td>TBD</td>
<td>Vivianne Furaha, Vice President of Femmes Intellectuelle Rwandaise Seropositives dans la lutte contre le VHI-Sida (filling in for Philomene)</td>
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<tr>
<td>15:00-15:30</td>
<td>Dr. Anita Asiimwe, Executive Secretary of the National AIDS Control Commission (at CNLS offices)</td>
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<td>16:00-16:30</td>
<td>Elivanie Nyankesha, VCT and PMTCT Coordinator, HIV/AIDS Treatment and Research Center of the MOH (at TRAC+ offices)</td>
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<tr>
<td>Wednesday</td>
<td>7:30</td>
<td>Hotel pick up</td>
</tr>
<tr>
<td>Dec 10, 2008</td>
<td>8:15-11:00</td>
<td>Visit Kivumu Health Center (accompanied by FHI/Muhanga Office staff member and Alexie Mukamugenzi)</td>
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<tr>
<td></td>
<td>8:15-8:30</td>
<td>Introductions</td>
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<td></td>
<td>8:30-9:30</td>
<td>Tour/visit of the health center services</td>
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<td></td>
<td>9:30-10:15</td>
<td>“FGD” with women in vaccination services</td>
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<td></td>
<td>10:15-11:00</td>
<td>“FGD” with members of PLHA association</td>
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<tr>
<td></td>
<td>11:00-11:15</td>
<td>Travel to Gitarama</td>
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<tr>
<td></td>
<td>11:15-12:30</td>
<td>Brief tour of Kabgayi District Hospital to: (a) understand the role in supporting health centers and the capacity of district hospitals; (b) visit the HIV/AIDS patient care and treatment services; (c) visit maternity (at near by health center), lab, and surgery facilities</td>
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<td></td>
<td>12:30-13:30</td>
<td>Lunch in Gitarama</td>
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<td>13:30-15:00</td>
<td>Travel to Butare</td>
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<td>15:00-16:30</td>
<td>Visit with dean (or delegate) and faculty of the School of Medicine to: (a) understand the content of the current curricula as relates to MC (from epidemiological aspects of prevention to actual surgical practice), (b) re surgical practice and scale up, understand how (if at all) pre-service and in-</td>
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<td>service training are linked, and (c) explore possible future links between the UBC and NUR School of Medicine for curricular updates and future collaboration.</td>
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<td></td>
<td>16:30-19:00</td>
<td>Return to Kigali</td>
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<tr>
<td>Thursday Dec 11, 2008</td>
<td>8:00</td>
<td>Hotel pick up</td>
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<td></td>
<td>8:30-9:00</td>
<td>Visit Safe-T-Stop center, a social support/recreational and VCT center set up for truck drivers but that is linked to a variety of community organizations and associations for holistic risk reduction. This center will provide access to three groups for FGDs: (1) “parents” – mom’s and dad’s; (2) healthy young men between 18 and 25 years old; and (3) long distance truck drivers – accompanied by Melchiade Ruberintwari</td>
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<td></td>
<td>9:00-9:45</td>
<td>FGD with Group 1</td>
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<td></td>
<td>10:00-10:45</td>
<td>FGD with Group 2</td>
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<td></td>
<td>11:00-11:45</td>
<td>FGD with Group 3</td>
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<td></td>
<td>12:15-13:00</td>
<td>Meeting with Dr. Felix Ndagije, Prevention Specialist, CDC; Dr. Eugene Zimulinda, DOD; and Noni Gachui, Prevention Specialist at USAID (at FHI offices)</td>
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<td></td>
<td>13:00-13:30</td>
<td>Quick lunch</td>
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<td></td>
<td>14:00-16:00</td>
<td>Visit Kanombe Military Hospital (Around 15hr for two hours, exact times still to be confirmed. Hopefully Dr. Murego will be back; also, would be nice if DOD were present at this time. Will try.)</td>
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Integrating Male Circumcision into HIV Prevention Efforts: Our learning in Ethiopia, Kenya and Rwanda

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<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td><strong>Friday Dec 12, 2008</strong></td>
<td>TBD</td>
<td>Dr. Agnes will be getting back on Wednesday night – so, we hope to give her a minute to breathe and ask if she will have any time on Friday morning to meet with you. (ICASA conf)</td>
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<td>Depending on PS’s and / or (??) minister’s availability, we can plan in the following: (a) exchange with FHI MDs who treat HIV and AIDS patients (≈1 hour), (b) time permitting, a visit to Kigali PHC, and (c) any other meetings</td>
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<td>Also, UNAIDS or WHO and the Rwanda Women’s Network</td>
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<td>16:00 (latest)</td>
<td>Travel to Ruhengeri</td>
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<tr>
<td><strong>Saturday Dec 13, 2008</strong></td>
<td>Gorilla trekking</td>
<td><strong>Sunday Dec 14, 2008</strong> Departures</td>
</tr>
</tbody>
</table>

Meetings to be scheduled with:

**Government of Rwanda leaders:**
1. Dr Agnes Binagwaho, Permanent Secretary, MOH
2. Dr Anita Asiimwe, Executive Secretary, National AIDS Control Commission
3. Dr Michael Kramer, Director, TRAC Plus-Center for Infectious Diseases
4. Dr Charles Murego, Director, Kanombe Military Hospital

**Civil Society Associations:**
1. Beatrice Kagoyire, RRP+
2. Philomene Cyulinyana, PHA Association
3. Winnie Muhumuza, Rwanda Women’s Network

**Donor and multilateral agencies**
1. UNAIDS
2. CIDA
3. USG (USAID or CDC or DOD)
**Schedule agenda for Drs Neil Pollock and Tom Kinahan**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>Monday Dec 8, 2008</td>
<td>22:40</td>
<td>Arrival, airport transfers</td>
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<tr>
<td>Tuesday Dec 9, 2008</td>
<td>8:40</td>
<td>Hotel pick up</td>
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<td></td>
<td>9:00-9:20</td>
<td>Introductions and orientation of King Faisal</td>
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<td></td>
<td>9:20-9:30</td>
<td>Introduction and background of visiting team (Dr. David Patrick)</td>
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<td></td>
<td>9:30-9:45</td>
<td>Male circumcision and HIV prevention: a brief update on the research and its implications (Dr. David Patrick)</td>
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<td>9:45-10:15</td>
<td>Dr. Neil Pollock’s infant circumcision techniques + Q/A</td>
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<td>10:15-10:45</td>
<td>Dr. Tom Kinahan’s infant and adult circumcision techniques + Q/A</td>
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<td>10:45-11:30</td>
<td>Q/A, discussions, and AOB re plans for organization and plans for surgical training</td>
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<td>11:30-14:00</td>
<td>Demonstration of techniques using clamps in preparation for follow on training sessions</td>
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<td><strong>Pollock (Mogen Clamp)</strong></td>
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<td>5 babies</td>
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<td></td>
<td>14:30-17:00</td>
<td>Rwandan surgeons practices on Pollock’s models in preparation for training on babies</td>
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<td>14:00-17:30</td>
<td>Kinahan join team in meetings (?time permitting?)</td>
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<td>Wednesday Dec 10, 2008</td>
<td>7:30</td>
<td>Hotel pick up</td>
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<tr>
<td>8:00-14:00</td>
<td>Surgical training at King Faisal</td>
<td>**Pollock (Mogen Clamp)</td>
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<td>20 babies</td>
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<td>8-10 babies</td>
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<td></td>
<td></td>
<td>4-5 adults</td>
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<td>15:00-???</td>
<td>Visit Muhima and Kanombe Hospitals</td>
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<tr>
<td>Thursday</td>
<td>7:30</td>
<td>Hotel pick up</td>
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<td>15 babies</td>
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<td>6-8 babies</td>
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<td>3-4 adults</td>
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<td></td>
<td>14:00-16:00</td>
<td>Visit Kanombe Military Hospital (Around 15hr for two hours, exact times still to be confirmed. Hopefully Dr. Murego will be back; also, would be nice if DOD were present at this time. Will try.)</td>
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<td>8-10 babies</td>
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<td>4-5 adults</td>
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<td></td>
<td>14:00-15:00</td>
<td>Mutual / joint assessment of training – mutual suggestions for future training for safe roll out</td>
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<td>16:00</td>
<td>Depart for Ruhengeri</td>
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<tr>
<td>Saturday</td>
<td>Gorilla trekking</td>
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<td>Dec 13, 2008</td>
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<td>Sunday</td>
<td>Departures</td>
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<td>Dec 14, 2008</td>
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Rwanda: Local, Canadian Surgeons Brainstorm on Circumcision

Kigali — Local doctors and their Canadian counterparts have started a five-day brainstorming session aimed at exchanging skills and experiences on how to carry out safe male circumcision.

This comes after a recent government decision to embark on a countrywide campaign of encouraging circumcision for both male adults and children as a way of curbing the prevalence of HIV/AIDS.

In the workshop that started yesterday at King Faisal Hospital in Kigali, surgeons from the two countries will exchange techniques and practices on how they can go about circumcising their patients.

"How do we deal with cultural differences while doing circumcision? Some patients come back complaining about the result of the operation," asked Dr Emmanuel Kayibanda of King Faisal Hospital.

He made the intervention following a power-point presentation by his Canadian counterpart, Dr. Neil Pollock.

The two doctors agreed that some patients ask doctors not to remove a large portion of their foreskin from their organs during circumcision while others need it depending on their social background.

"We need to learn about the realities in a given environment in order to introduce a model to do circumcision operations," said Dr. David Patrick, an epidemiologist from Canada's University of British Columbia.

Research conducted in Uganda and Kenya suggests that male circumcision could reduce a man's risk of contracting HIV through heterosexual sex by 65%.

In response to the findings, the World Health Organization (WHO) and the UNAIDS recommended the procedure in 2007 as a way to help reduce transmission of the epidemic through heterosexual sex.

Rwanda has since embarked on a plan to address myths about male circumcision, which encourages men to be circumcised.

"We are looking at how circumcision can be added on other means we use to prevent HIV/AIDS," said Dr. Anita Asiimwe, the Executive Secretary of the National AIDS Control Commission (CNLS), shortly after attending the surgeons' workshop.

She said that Rwanda's Treatment and Research AIDS Center (TRAC-PLUS) is still devising ways on how to implement a national plan to scale up male circumcision after considering all the perceptions that Rwandans have on the procedure.

Fourteen Rwandan doctors from five hospitals in Kigali City, and 3 Canadian doctors are attending.

Dr. Kayibanda, said that they have been able to learn how to use new equipment to carry out circumcision much quicker than they were doing it.
Rwanda: MINISANTE embarks on newborns’ circumcision
The New Times, Jan 2009

Kigali - The Ministry of Health is to adopt a new policy of circumcision newly born babies as it is more sustainable in the long run and ten times cheaper than adult circumcision, Permanent Secretary in the ministry Dr Agnes Binagwahoh has said.

Binagwahoh said this yesterday during an exclusive interview at her office.

“As much as circumcision is important in the fight against HIV, the process in terms of technical know-how and equipment is very expensive especially for adults. But in infants, it is ten times less costly and more sustainable,” Binagwahoh said.

She said that government intends to integrate circumcision into the ordinary package given to newly born children because there are far less complications during the operation.

“We are working on modalities to ensure that all Rwandans who need the operation get it. However, it is still a long process because there is need to get skilled doctors and the necessary equipment ready before fully embarking on it,” she said.

Binagwaho added that the government is mainly targeting two groups mainly students and the military. She however cautioned that as much as it helps in reducing the risk of acquiring HIV/AIDS, circumcision is not one hundred percent safe.

“It is only 60 percent safe and if you misbehave, you are likely to get the deadly virus so people should take into account the fact that chances of contracting the disease are 40 percent which is still high and risky,” Binagwahoh added.

She concluded that many other stakeholders are working with the government and have already carried out studies on how to go forward on this.