Medical male circumcision coverage from 2007 to 2014 in Rakai, Uganda

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Rationale

• Medical male circumcision (MMC), an important HIV prevention strategy.
• WHO/UNAIDS set the goal: “MMC prevalence of at least 80% among 15-49 year old males” in the priority countries.
• Monitoring of MMC scale-up helps assess program performance and identify subgroups with low coverage.

Context

• Rakai District in rural South-central Uganda (Fig 1), ~85% males are non-Muslims and do not practice circumcision by tradition.
• Prior to 2003, MMC prevalence in non-Muslim men ~4%.
• 2003-2006, a Rakai MMC trial showed efficacy of MMC reducing HIV risk in men.
• Since 2007, MMC benefits disseminated, and scaled up under PEPFAR funding. Free MMC services provided at a central facility, four satellite clinics since 2007, and also mobile camps from 2011 by the Rakai Health Sciences Program. MMC also available at local government health facilities.

Purpose

• To estimate MMC coverage in men and in non-Muslim men aged 15-49 years, by their demographic and risk behavioral profiles, and HIV serostatus from 2007 to 2014.

Methods

• Data source: the Rakai Community Cohort Study that conducts surveys every 12-18 months on 15-49 years old consenting residents.
• Participant were consented and interviewed by trained same-sex interviewers to collect sociodemographic, risk behaviors and health and care seeking information. Men reported their circumcision status. Blood samples were collected for HIV testing.
• This analysis used data from 30 communities consistently surveyed in the five most recent completed survey rounds.
• MMC coverage in all men and in non-Muslim men was estimated for each survey.
• Coverage was also estimated by demographic and risk behavior characteristics, community residence type (urban main road trading centers, secondary road trading centers, and rural agricultural villages), self-perceived risk of HIV exposure and by HIV status.

Results

• Fig 2 shows MMC coverage in all men and in non-Muslim men.
• Fig 3 shows MMC coverage in non-Muslim men by subgroups.

Figure 2

• MMC coverage in all men and in non-Muslim men.

Figure 3

• MMC coverage in non-Muslim men by age group.

Conclusions

• With increasing MMC coverage in all subgroups, MMC became more normative in Rakai.
• The recent increase of coverage in adolescents aged 15-19 years probably reflects higher MMC uptake among young boys in the MMC programs. They became age eligible in the latest survey.
• MMC coverage was consistently highest in main road training centers, possibly due to easier access to MMC services and more information flow in urban communities.
• Coverage was higher among sexually active men-> MMC reached men at risk to HIV.
• No evidence of reduced condom use with MMC.
• MMC coverage still fell short of the 80% WHO target. There is continuing need for demand generation.

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