Reviewer's report

Title: A Program Evaluation Report of a Rapid Scale-up of a High-Volume Medical Male Circumcision Site, KwaZulu-Natal, South Africa, 2010-2013

Version: 4
Date: 26 December 2014
Reviewer: Anne Thomas

Reviewer's report:

1. There is no question or hypothesis addressed in the article. This is a program description. It describes a partnership, which supported training of VMMC providers and service delivery in which, over time, the number of clients coming for VMMC declined and funding for the program was eventually cut due to several reasons.

We agree. This article provides a description and simple analyses on the monthly uptake of a VMMC program that was provided in KwaZulu-Natal, South Africa. We have altered the title so that it better reflects the descriptive nature of our analysis. The new title is: A Program Evaluation Report of a Rapid Scale-up of a High-Volume Medical Male Circumcision Site, KwaZulu-Natal, South Africa, 2010-2013

AT - The changes address the issue satisfactorily.

2. A table of client demographics should be presented by year.

We agree that a table of client demographics would improve understanding about the sample of individuals who received circumcision services at Asiphile. However, at this time only aggregate, programmatic data are available to the authors.

AT - This is a severe shortcoming. Without demographic information about the population who were reached, any conclusions about the reasons for service delivery decline are largely speculation.

3. On line 130, the authors state that there was a needs assessment done and that “Based on the results of a needs assessment, the male circumcision program was targeted to HIV sero-negative men aged 15-49 years in a catchment area near the clinic of 200,000 men.” It is unclear to me that the focusing of the program was made on the basis of a needs assessment; rather, this was likely due to the Ministry of Health prevention strategy. If there was more of an assessment done, it would enhance the paper to include the methods of the assessment and more of the findings than were presented here.
We agree with the reviewer that the targeting of program was not based solely on the needs assessment. Rather, the target population was identified through Ministry of Health guidance and surveillance data. The needs assessment identified the physical space, staff, equipment, and supply chain needs that are needed to provide accessible high-volume medical male circumcision services to the target population. We have made changes in the manuscript. Unfortunately, the detailed results of the needs assessment are not available to the authors.

AT – The response addresses this reviewer’s comments.

4. Please provide more details regarding the targeting sero-negative men. Was testing compulsory? Were clients able to get circumcised if they tested HIV positive yet were otherwise healthy? This may have contributed to the decline in clients over time. The South African government policy at the time was to promote medical male circumcision in HIV-uninfected men. While HIV testing was not compulsory for receipt of services at Asiphile, HIV positive men were referred to the nearby St. Mary’s Hospital for further assessment, prior to circumcision. Circumcisions on HIV positive men were reported to be rare, and they were performed in the hospital theatres, rather than at Asiphile. As such, no one was denied circumcision based on status of HIV-infection. HIV infected men were encouraged to discuss with their doctor the risks and benefits of male circumcision. We do not think that HIV status contributed to the decline in clients.

AT - This point should be explored in the discussion. We do feel that HIV testing requirements may reduce acceptability of VMMC in high prevalence communities. This point should not be overlooked in the discussion.

5. The authors present monitoring data that is not questioned. Additional data would improve the strength of the paper. Much of the paper describes the staff training that was conducted but the number of clinicians, and their cadre was not provided. Thus, the conclusion that the program was successful could not be evaluated by this metric. Nor were we able to consider the long term effect of the training. Please include the number of VMMCs per clinician performed. Did they just get trained or did they also provide VMMC clinical services?

We recognize the limitation of monitoring data but as this was not a research study, no confirmatory data are available. There were 10 clinicians trained who were physicians and surgeons employed by the hospital. Yes, the clinicians were trained and performed circumcisions during the reporting period. Trained clinicians rotated on weekly or biweekly basis through the circumcision clinic.

AT - Please add this information to the paper.

6. On Line 51, the authors state, “The uptake numbers increased throughout 2010 and 2011 and began to level off as the demand of early adopters was met”. There isn’t any data presented to support this statement. If assessments were done regarding the fall off in demand it should be presented to support this claim.

We agree that the statement about the leveling off of early adopters is not supported by evidence, and we have altered the statement to read: “The uptake
numbers increased throughout 2010 and 2011 and began to level off as the demand of early adopters may have been met”.

AT - Exploration of additional factors which might reduce demand for services will improve the quality of the paper and should be included.

7. The increases in demand that are said to coincide with the trainings are interesting. Perhaps this was a factor in the demand decline. But this reviewer also wonders if there was a difference in the type of demand outreach that was done for the training periods as compared to non-training period? Perhaps it was a more effective method?

We agree that comparing outreach efforts with the uptake numbers may provide insight into the demand trends and the outreach effectiveness. Unfortunately, the authors also do not have access to any records related to the timing and type of outreach that was conducted.

AT – No further comment.

8. The abstract conclusions should be more fully supported by evidence presented in the paper. There is no information about the role of the international collaborative. Why is that more effective than other implementing partner’ models? The abstract and discussion mention the use of vans to transport clients. This would be better placed in the Program Description section. Further, the timing for when the vans started being used would be of interest. Was this done at the end of the project when there was no further funding, or was this not successful in improving uptake of services?

The international collaborative is the simply cooperation between St. Mary’s Hospital and the Operation Abraham Collaborative to implement the Asiphile clinic. We have updated the manuscript to make this clearer. We did not intend to state that an international collaborative is more effective than other implementing partner models and have made some changes to the discussion in order to temper any unintended conclusions. Additionally, we have added information about the transportation vans to the program description.

AT – No further comment.

9. Please specify if incentives were provided to VMMC clients and what types. There were no incentives provided to clients. We have included this information in the manuscript.

AT – No further comment.

RE Second Reviewer Comments and responses

Please double check the anesthesia used. Guidelines call for a mixture of lignocaine (lidocaine) and bupivicaine; not bupivicaine alone. If this is not correct in the paper it will be a major flaw.

Re calculation of adverse events’ rates:

Since the program did not follow up with all clients with VMMC the denominator
of the AE rate should be those that returned for follow up, not the total VMMCs.

Line 197: The denominator should be the 92% who returned for follow up since there is no knowledge of the other 8%. They could have had an AE and gone to another facility for follow up.