Rapid assessment and stocktaking of Early Infant Male Circumcision (EIMC) in 14 sub-Saharan Countries

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Introduction

Early infant male circumcision (EIMC) is recommended as a sustainable approach to HIV prevention and reproductive health but is not widely implemented in Eastern and Southern Africa. Therefore, a rapid assessment looking at acceptability, feasibility, safety, ethical concerns, policy, strategic plans, and current implementation was undertaken to understand the current status of EIMC in sub-Saharan Africa.

EIMC is less expensive than adolescent or adult circumcision and it is a simpler operation in young infants that usually does not require sutures. Healing is usually complete within a week with very low rates of complications. An immediate health benefit of EIMC is the reduction in risk of urinary tract infection, which is higher in infancy than any other year of life.

Objectives

The objectives of the rapid assessment were:

- To understand the acceptability, feasibility, safety, ethical concerns, policy and strategic plans, current implementation and trends, key implementers, and safety studies in the 14 countries
- To assess the perspectives of UNICEF, US Government agencies, ministries of health, and implementing partners regarding EIMC scale up
- To identify barriers to and opportunities for scale up, including best practices, innovative models, funding, and research
- To assess the opportunities for EIMC to be offered as part of MNCH and routine immunization services
- To provide input at the UNICEF EIMC stakeholder meeting (March 2014, Johannesburg)

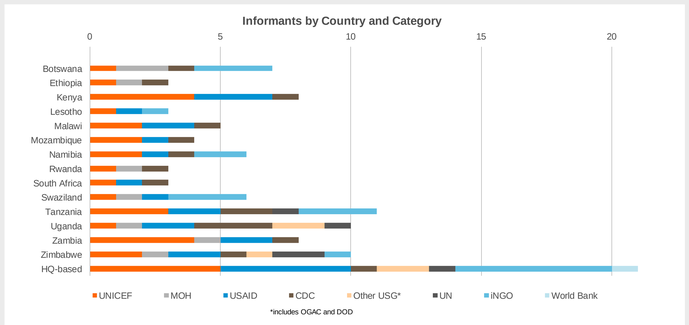
Methods

Qualitative and quantitative country-level data were collected between August-September 2013 via telephone interviews, data collection form and desk review of relevant literature. Using a standard set of questions, representatives from Ministries of Health, UN, US Government agencies, and International NGOs were interviewed on 12 topic areas (see Table 1). Responses were recorded and analyzed by theme and by country.

Table 1. Topics for Stakeholder Interviews

Country landscape and data.
Current EIMC practices and norms.
Cultural, political, legal, and religious barriers and opportunities for EIMC.
Research that has been recently completed or is in progress.
Programs that are underway, conducted by what implementing groups?
Government policies and guidelines on EIMC.
Devices in use, or proposed for use.
PEPFAR and other donor activities – present and future.
Funding and capacity issues that impact EIMC delivery.
Major barriers and facilitators for EIMC.
Current and proposed demand creation efforts and their impact.
Opportunities and challenges for adding EIMC into MNCH and Expanded Program on Immunization (EPI).

In total, 87 respondents were interviewed in 14 countries. These 87 in-country respondents plus the 21 respondents considered global stakeholders, combine for a total of 108 respondents. The table below shows the categorization of interviewees by country and by organization.



Results

Among the 14 priority countries, only Swaziland has a national EIMC program in place. Botswana, Kenya, Lesotho, Tanzania and Zimbabwe are piloting EIMC programs and intend to scale up nationally. Countries in the active planning stage include Namibia, Rwanda (EIMC available at National Referral Hospital), and Zambia (service available in some public facilities). Ethiopia, Malawi, Mozambique, South Africa and Uganda are not actively planning for EIMC implementation.

National Program	Pilot Programs with Intent to Scale Up Nationally	Active Planning and/or Strategy Development	No National Programs or Active Planning
Swaziland	Botswana	Namibia*	Ethiopia
	Kenya	Rwanda**	Malawi
	Lesotho	Zambia***	Mozambique
	Tanzania		South Africa
	Zimbabwe		Uganda

Of the 108 respondents, 59% favored circumcision in infants and largely agreed that EIMC should be provided as part of the routine Maternal Newborn and Child Health system. Table 2 illustrates areas of consensus and areas with a diversity of views among interview respondents.

Table 2. Summary of Options

Areas of Consensus

Value of EIMC: *Stakeholders agreed on the value of EIMC as a public health intervention. We did not seek to sample those who supported or did not support EIMC.*

Providing EIMC as part of MNCH: *Stakeholders felt MNCH services were the best platform for providing EIMC.*

Barriers and challenges: *Capacity, infrastructure, supply chain, and political support were noted by many*

Areas with a Diversity of Views

A. Policy and funding issues: How to develop country-specific guidelines, address informed consent, and consider child's rights? Should funding come through MNCH or HIV programs?

B. Overcoming operational & workforce challenges: What approaches are needed for task shifting, compensation, training, and supply chain?

C. Clinical and safety issues: What is the best timing to perform EIMC; which devices to use?

D. M+E approaches: What tools are needed for monitoring coverage and adverse events?

E. Research and knowledge sharing: Can research from one country be applied to another?

F. Demand creation: What are the best access points in the MNCH system?

Respondents identified human capacity shortages, infrastructure, safety issues, supply chain limitations, political support and child's rights as challenges to implementation. For example, in some countries nurses may not legally be allowed to perform EIMC, yet the procedure is likely to take place at facilities staffed only by nurses. Providing adequate practical training to the correct health care providers is another human resource challenge in many countries. On supply chain management, one respondent said, "If one mother brings her child in for EIMC and supplies are not available, she won't come back and word will get out that it is a wasted trip."

Country Highlights: Swaziland
Expectant women and the parents of newborns are now receiving EIMC messaging at antenatal care clinics, postnatal care, maternity wards, waiting huts, and other entry points. In Swaziland, most babies are delivered in hospitals, facilitating access to EIMC shortly after delivery. In addition, EIMC is currently being integrated into MCH services in both private and public health facilities. In most facilities this procedure is conducted at sites where the postnatal care is delivered. Consent is sought from either parent and the procedure is performed by a trained health care worker, either a doctor or a nurse under a physician's supervision.

Country Highlights: Tanzania
EIMC is traditionally practiced in Zanzibar and other parts of Tanzania through both traditional circumcisers and medical providers. In 2012, Jhpiego conducted a facility and community assessment in preparation for an EIMC pilot program. Now, the MOHSW with support from PEPFAR through Jhpiego is piloting EIMC in Iringa Region. This is the first formal attempt to integrate EIMC into the health system in Tanzania. In the first 11 months of the pilot program, over 1,000 infants were circumcised in 4 pilot sites. The pilot in Iringa and a study on EIMC practices and opinions in Dar es Salaam, Pwani and Kagera will inform a national decision-making process on the future of EIMC services.

Country Highlights: Zambia
The Zambia MOH 2011-2015 National AIDS Strategic Framework (NASF) "…targets neonatal males for circumcision as a strategy to ensure the sustainability of this intervention." To support the effort Zambia will consider and institutionalize task shifting to allow qualified nurses to perform MC, especially for infants at birth. As part of the overall effort the MOH will conduct community mobilization and education to promote adult and neonatal circumcisions. By 2015, it aims to circumcise at least 50% of infants born in a health facility in the first week of life and integrate EIMC services into 80% of PMTCT centers by the same year.

Conclusions

The majority of the 14 surveyed countries are keen to provide infant circumcision and will face unique and complex challenges as they work to scale up EIMC. A list of key issues identified through the assessment will guide the discussions between MNCH, HIV and other stakeholders on how EIMC can be safely initiated and/or expanded into national health systems. Countries can also draw from adult male medical circumcision implementation experience, and share best practices from countries that are currently piloting EIMC programs.

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Acknowledgments

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