Responses to Questions from Scaling Up Routine Early Infant Male Circumcision (EIMC) Within Maternal, Newborn and Child Health. Webinar, Jan. 28

The following technical questions were submitted to presenters via chat window, but unanswered due to time constraints. Presenter responses have since been collected and are below.

Device-led Early Infant Male Circumcision in Zimbabwe
Drs. Karin Hatzold and Webster Mavhu

Drs. Hatzold and Mavhu summarized a recent pilot study of the safety, acceptability, cost and feasibility of EIMC using AccuCirc in Zimbabwe. This was a two-phase study, first comparing AccuCirc to Mogen clamp (n = 150 participants), followed by a field study of AccuCirc with nurse/midwife providers (n = 500 participants), including qualitative in-depth interviews and focus group discussions with providers and parents.

Can you clarify how the time of the procedure was measured [for both devices]?
We started measuring procedure time from the moment we removed the nappy to wipe out EMLA cream (before cleaning the surgical area). We stopped measuring procedure time when we put back the nappy (i.e., after bandaging and applying petroleum jelly). We used stop watch measurements and videotaped the procedure.

What anesthesia is used in infant circumcision?
We used EMLA cream with both devices.

Can we effectively compare the costs between AccuCirc and Mogen clamp when clearly there was an experience of AEs with the AccuCirc?
There was no statistically significant difference in the comparison study in the incidence of AEs between Mogen and AccuCirc device. The treatment of the AEs did not have any significant impact on the unit cost.

In Zimbabwe, why was there delayed healing in six babies who had AE?
In the comparison study (comparing AccuCirc with Mogen clamp) wound healing was complete in 144/150 boys by day 14 post-circumcision. All 6 infants that had not yet healed by day 14 had received the AccuCirc device. There were only two moderate AEs in the AccuCirc arm (2%; 95% CI 0.4-7.7%). This included one case of excess skin removal (Hydrocortisone cream applied and wound was completely healed 4 months post EIMC); and one case of inadequate skin removal which warranted corrective surgery and was completely healed 20 days post corrective surgery. Both AE cases needed longer time for healing than 14 days, but did resolve. For the other 4 cases, the delay in wound healing (they had not healed by day 14) there is the following explanation: some parents/guardians had challenges with reducing the foreskin (instruction 6) - they hesitated. This sometimes resulted in adhesions which were later taken care of at the clinic but sometimes delayed wound healing.

Wound care information and how people adhered to it? Can you please share the SOPs?

We developed wound care instructions that we pre-tested to check whether parents understood them, revised accordingly, translated into Shona and sent to local IRB for checking and subsequent approval.

Were nurses under supervision by doctors or working independently?
Nurses were working independently, but they were able to call the doctor at any time if she/he faced challenges.

What specifically makes nurse-delivered EIMC cheaper than doctor-delivered EIMC?
The salary of a nurses and midwife in Zimbabwe is much lower than the one of the doctor. This explains the major difference in the unit cost.

Presentation: Providing Early Infant Male Circumcision within Routine Service Delivery
Lauren Bellhouse, UNICEF

Ms. Bellhouse provided an overview of EIMC programmatic and strategic considerations, as well as an update on the recent WHO Technical Advisory Group meeting on AccuCirc.

What are the EIMC procedure numbers of scale up in Lesotho and Swaziland [the two countries reporting EIMC scale up efforts]?

Specific numbers of circumcisions performed were not provided by respondents in the September 2014 UNICEF assessment, but activity updates indicating scale-up were as follows:

- Lesotho: Moving from pilot done in one district to scale up in 18 hospitals nationwide in collaboration with MOH and JHPIEGO. UNICEF is supporting MOH activities with a feasibility study which revealed staff, site and demand readiness. EIMC monitoring and communication tools have been developed. Training of health workers from six hospitals on EIMC carried out, with ongoing dialogue on task shifting. UNICEF is also facilitating the incorporation and strengthening of newborn care through EIMC.
- Swaziland: Development of the National VMMC including EIMC Strategy and its operational plan for 2014 – 2018 has been completed. MOH will be conducting an evaluation for EIMC model that is being implemented by a regional referral hospital. EIMC is being scaled up in Swaziland, more than 15 health facilities are already providing EIMC services. UNICEF supported the MOH with rollout of EIMC services through training of service providers and procurement of EIMC essential equipment and supplies.

Presentation: Introducing Early Infant Male Circumcision (EIMC): DMPPT 2.0 Modeling
Emmanuel Njeuhmeli, MD, MPH, MBA

Dr. Njeuhmeli presented a summary of costing and impact estimates from a recently developed mathematical model.

What is being done to get unit costs for EIMC?
Some costing studies are in the early planning phases.

How would EIMC programs be linked with in-country Adult/Adolescent VMMC exiting programs?
Each country government will decide how this will work based on their own situation and health systems.

Is there any recommendation about the prevalence level at which EIMC will be useful?
Modeling studies indicate that the higher the prevalence of circumcision, the more HIV infections are averted; these benefits accumulate throughout the lifetime of the individual, as well as to the partners of each circumcised individual, and the partners' partners, etc.

Presentation: EIMC Services in Lesotho: Introduction of EIMC Services and Efforts to Scale Up
Virgile Kikaya, MD

Dr. Kikaya's presentation focused on the introduction of EIMC in Lesotho and efforts to scale up the service.

To Lesotho, it seems the uptake of services was quite low in pilot phase, did this relate to any contributing factors?
The low uptake of the pilot phase can be explained as people were still getting accustomed to EIMC because it is still a new practice in the country (in general). We don't believe the low uptake is due to cultural issues because people who were sensitized decided to have their babies circumcised. However two other factors may explain the low uptake: mothers who were reluctant to take a decision in the absence of fathers and the number of available providers.

Was there any link between the mothers that had their babies circumcised to their cultural background where circumcision was the norm?
At this point, we have not seen a link.

Has the nurses' council been involved in task shifting?
The Lesotho Nursing Council (LNC) has not yet approved task shifting for all cadres of nurses. Only nurse clinicians have circumcision in their scope. The LNC has been involved in discussions with the MOH about this issue.

How is the Lesotho program handling issues of staff transfer w/in government systems?
The Lesotho program is putting in place continuous training to replace staff who might be transferred to other hospitals/ facilities.

For AE tracking -- how is the program following mothers who fail to return for follow-up?
Most mothers return for follow up but for the few that do not come, they are contacted by phone.

Why did you have to train many nurses? What is their role?
Other than nurse clinicians, nurses are not providing surgery, but they play a very important role in terms of mobilizing, giving group education, counseling, screening, assisting in surgery and doing post-op care as well as 48-hour and 7-day follow up. Another reason is that they are being rotated monthly between hospital departments so there should be a pool of nurses to use while they are being rotated.

How did EIMC strengthen MNCH- can you unpack this?
Since an infant needs to be screened before EIMC for eligibility, nurses had to refine their skills in doing a routine physical examination, hence an improvement in detecting any malformations/abnormalities or other health issues. Also, in Lesotho, mothers together with babies are supposed to come to the facility 7 days after delivery for a routine post-natal, well-baby check-up. Some, though, wait until 6 weeks after delivery when immunizations are to be given, delaying care for other health issues that might have been detected at the earlier visit. With EIMC, mothers expressed that they did not feel comfortable staying at home because of their baby’s wound so they do attend the 7-day EIMC follow-up, which is then combined with their post-natal follow up.