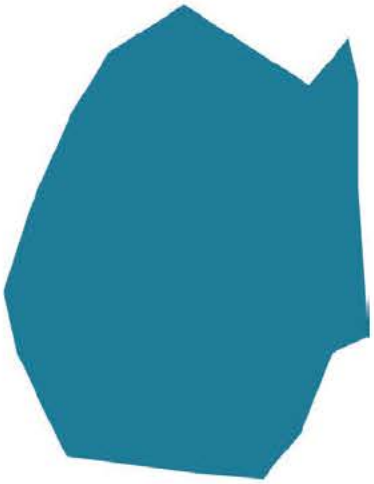
MCHIP Country Brief: Swaziland



Selected Health and Demographic Data for Swaziland	
Maternal mortality ratio (deaths/100,000 live births)	589
Neonatal mortality rate (deaths/1,000 live births)	22
Under-5 mortality rate (deaths/1,000 live births)	120
Infant mortality rate (deaths/1,000 live births)	85
Contraceptive prevalence rate	65
Total fertility rate	3.9
Skilled birth attendant coverage	69%
Antenatal care,4+ visits	79.3%
Sources: World Bank** (2012); DHS 2006-2007*; SHIMS (2010)***; MOH 2012 Annual Report.	

Health Area:

- HIV/AIDS

Program Dates	June 1, 2010–June 30, 2014					
Total Mission Funding to Date by Area	Redacted					
Total Core Funding to Date by Area						
Geographic Coverage	**No. of provinces**	N/A	**No. (%) of districts**	100%	**No. of facilities**	3
Country and HQ Contacts	Laura Fitzgerald, MCHIP Maternal Health Advisor, Pat Taylor, Country Support Manager, Tracey Shissler, Senior Program Officer, Tigistu Adamu, HIV/AIDS Team Leader					

INTRODUCTION

Three randomized clinical trials determined unequivocally that male circumcision (MC) reduces female-to-male HIV transmission by approximately 60%.[1,2,3] Modeling studies demonstrate that MC could prevent up to 5.7 million new HIV infections among men, women, and children over the next 20 years. With an HIV prevalence rate of 31%[4] among adults and 41.1%[5] among pregnant women, the Kingdom of Swaziland faces the highest HIV and AIDS burden in the world.

To address an HIV/AIDS epidemic of this magnitude, the government of the Kingdom of Swaziland (GKOS), Swaziland's Ministry of Health (MOH), and MC Task Force, in collaboration with the World Health Organization and the President's Emergency Plan for AIDS Relief (PEPFAR), finalized a National Strategic Plan for MC in 2010. This set a goal of circumcising 80% of Swaziland's HIV-negative, uncircumcised males aged 15–24 over the next five years.

The MOH's plans for MC expanded into adolescent and early infant male circumcision (EIMC) to ensure a protective benefit of MC in the future. In October 2009, the MOH began laying the foundation for EIMC programming by hosting an international expert consultation on EIMC. Subsequently, EIMC surgical guidelines were incorporated in the National MC Surgical Protocol. In preparation for establishing an EIMC pilot, in 2010PSI conducted a "Knowledge, Attitudes, and Practices (KAP) Survey on Neonatal Male Circumcision among Mothers and Fathers Expecting or Already Having a Male Newborn Baby." This KAP study found that almost a quarter of respondents were aware of EIMC but many were unsure about the appropriate timing for the intervention. The MOH later opened a first pilot site in 2010 at Raleigh Fitkin Memorial (RFM) Hospital in Manzini, the largest city in Swaziland.

With more than 4,000 EIMCs conducted by early 2014, Swaziland now leads the East and Southern African regions in the scale-up of EIMC. Swaziland is also providing regional technical assistance in EIMC, hosting a MOH-supported study tour and clinical training for a delegation from Botswana. Swaziland is the first PEPFAR MC priority country to draft a costed operational plan inclusive of EIMC. Preparation for the 2014–2018 Swaziland Male Circumcision Strategic and Costed Operational Plan for HIV Prevention involved a highly participatory consultative process with both voluntary medical male circumcision (VMMC) and EIMC stakeholders.

The goal of MCHIP's work in support of the MOH in Swaziland was to provide technical assistance in the rollout out of safe EIMC in Swaziland in accordance with Swaziland's National Policy on Male Circumcision for HIV Prevention, and to ensure long-term sustainability of neonatal circumcision services by supporting the MOH in the development of the EIMC operational plan. MCHIP supported the MOH and the MC Task Force in laying the technical groundwork for an additional safe, evidence-based neonatal circumcision pilot in 2010 at Mankayane Government Hospital and its two associated health centers with high delivery rates.

MCHIP's efforts in 2010 and 2011 concentrated primarily on training, quality assurance, and ongoing provider support at the three health facilities, concentrating in the Manzini region. In 2012, via a subgrant from PSI under the USAID-funded Combined Prevention Program,

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[1] Auvert B et al. 2005. Randomized controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 trial. *PLoS Med*.
[2] Bailey R et al. 2007. Male circumcision for HIV prevention in young men in Kisumu, Kenya: A randomized controlled trial. *The Lancet.*
[3] Gray R et al. 2007. Male circumcision for HIV prevention in men in Rakai Uganda: A randomized trial. *The Lancet*.
[4] Government of Swaziland, Ministry of Health. 2012. *Swaziland HIV Incidence Measurement Survey* (SHIMS).
[5] Swaziland Ministry of Health. 2010. 12th Round of National HIV Serosurveillance in Women Attending Antenatal Care Services at Health Facilities in Swaziland. Mbabane, Swaziland.

Jhpiego later provided additional training nationally to all four regions of the country, followed by supportive supervision inclusive of the MCHIP EIMC pilot sites.

In the last year of the MCHIP award, MCHIP was requested by the MOH and PEPFAR to ensure long-term sustainability of EIMC services by supporting the MOH in the development of the EIMC component of the national 2014–2018 Swaziland Male Circumcision Strategic and Costed Operational Plan for HIV Prevention. MCHIP also supported documentation of the MOH's efforts, experience, and successes in EIMC to raise awareness regionally and beyond through success stories with the MOH and development of a manuscript for potential publication on successes and lessons learned.

KEY ACHIEVEMENTS

To achieve these goals, MCHIP concentrated on the following objectives and activities:

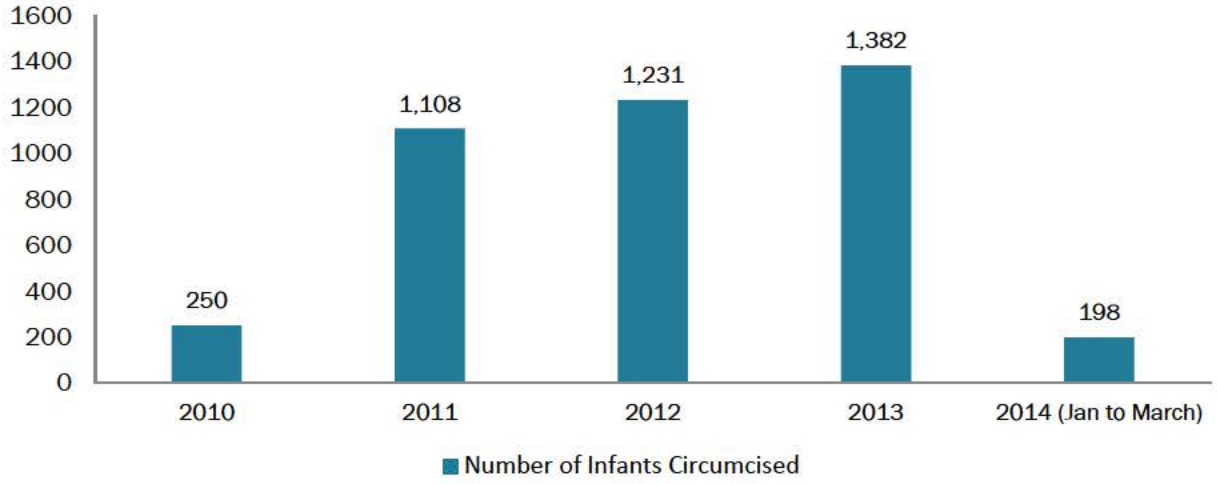
Objective 1: Fostering sustainability of EIMC services to ensure long-term increases in MC prevalence

- MCHIP contributed to increasing access to EIMC by developing and providing the first EIMC training in the country to 14 health care workers (five doctors and nine nurses) from the three public health facilities—Mankayane Government Hospital and two affiliated high-delivery health centers. As a result of MCHIP, providers from that first training were able to begin to advise families about how to access EIMC services.

2011 EIMC clinical training

- As of April 2014, 123 health care providers—45 doctors and 78 nurses—had undergone clinical training on EIMC via 10 additional trainings conducted under other programs. The figure below illustrates the trends in EIMC in Swaziland over the project period, January 2010 to March 2014. Although 4,169 EIMCs have been conducted, there has not yet been a single reported adverse event for the EIMC program in Swaziland.

EIMC Trends in Swaziland, January 2010–March 2014 [Data source: PSI]



Objective 2: Improving the quality of EIMC services

- Ensuring that EIMC is introduced safely, comprehensively, and uniformly requires close follow-up. To that end, with support from MCHIP, a package of quality assurance tools, "Performance Standards for Early Infant Male Circumcision," was developed. Providers and facility staff from the three EIMC pilot sites were oriented to the quality assurance approach as well as the standards in order to assume local ownership of the process and ensure program sustainability. These tools were taken up by the MOH and implementing partners for use nationally in EIMC implementation rollout.

Objective 3: Provide support to the MOH's development of an EIMC component to the operational plan

- Since the first rollout of EIMC training, Swaziland has made significant progress in EIMC, with 15 sites now providing services; all health facilities with doctors are now providing EIMC services. Leading this effort, and to guide this process, in late 2013 the MOH requested technical assistance from PEPFAR and MCHIP in the development of an EIMC operational component to the 2014–2018 Swaziland Male Circumcision Strategic and Costed Operational Plan for HIV Prevention. MCHIP has supported the MOH, Management Sciences for Health (MSH), and other involved partners to assemble the most up-to-date and comprehensive information in order to provide background and the current status of EIMC services.

Objective 4: Support the MOH's documentation of the efforts, experiences, and successes in EIMC to raise awareness regionally and beyond

- MCHIP developed external documents including success stories and a manuscript on behalf of and with leadership from the MOH that summarize the status and successes found in Swaziland, with the intent to share best practices regional and globally.
- These external documents will be important to record the government of Swaziland's collective efforts to date in EIMC development and service delivery. They will serve as useful references for other MOHs and HIV prevention donors and partners that are moving through the establishment of EIMC services.

WAY FORWARD

The facility-level assistance under MCHIP and throughout the country under partner projects, in addition to MCHIP's support to the MOH to develop the national EIMC operational plan and document the MOH's efforts to date in EIMC, has provided MCHIP with a perspective to make the recommendations below. These recommendations are in line with recommendations made by MCHIP in the development of the strategic plan.

- The provision of EIMC services should not be an isolated and vertical intervention.

  An EIMC program must be integrated into the maternal, newborn, and child health (MNCH) platform that the MOH recognizes. This integration starts during the pre-pregnancy period and continues through to the postnatal period. EIMC messages accompany messages about birth preparedness, proper prenatal and antenatal care, and comprehensive "Day of Birth" care for the mother and the newborn. Contrary to some beliefs, adding HIV prevention, care, and treatment services within the maternal and child health (MCH) setting does not necessarily compromise the quality of MCH services but has the potential to increase the use of reproductive health services and improve infant outcomes.[6] The focus of health care providers should continue to be: to provide

[6] Van den Akker T et al. 2012. HIV care need not hamper maternity care: A descriptive analysis of integration of services in rural Malawi. (January)

comprehensive information and education for parents and guardians to make informed choice about EIMC; to provide high-quality and safe EIMC services; and to provide families the opportunity to access other health care services when they are in contact with the health system. Implementation of EIMC in Swaziland follows the reproductive cycle and therefore should enhance the use of services during pre-pregnancy, pregnancy, birth, and the postnatal period.

- Expand EIMC services into the private sector.

  According to the 2006/2007 Swaziland Demographic and Health Survey, 31% of deliveries take place in the private sector. Building demand among privately insured and self-paying clients, as well as introducing EIMC services to all private facilities with antenatal care, delivery, and postpartum services, will have a significant impact on reaching EIMC targets.

- Strengthen linkages between community and facility and referrals.

  A well-structured MOH system for community referrals to public sector facilities, as well as facility-to-facility referrals, is newly in place. EIMC will be one of the services to which clients can be linked and referred through this mechanism. Further, PSI's HIV testing and counseling referral and linkages program, which traces clients with mobile phones and confirms referrals with facilities, has a 65% linkage success rate. Such linkage and referral innovations should be tested for EIMC.

- Address policy and structural concerns related to human resources for EIMC.

  EIMC is currently offered in all MOH facilities where doctors are available for EIMC backup and supervision, that is, it is available in all public sector hospitals and health centers. While EIMC is intended as a midwife-led intervention, regulations are not yet in place to provide full, legal protection to the nursing cadre in independently performing the procedure. This leads to a concern that, should a severe adverse event take place, the midwife who performed the procedure will be at legal risk, even if nurses and midwives are viewed as the backbone of service delivery.

- Facilities will need to actively prepare to include EIMC surgical instruments and consumables in their routine logistics and procurement processes.

  As EIMC is integrated within the MNCH platform, procurement for EIMC equipment and consumables will be routinized through the existing systems, with the national budget accommodating the needs of the EIMC services. Transitioning the procurement for EIMC services to government mechanisms means that these services will be vulnerable to existing supply chain challenges in the public sector. Meeting these challenges will require advocacy and careful supply chain forecasting from facilities.