



Feasibility Facility Assessment in Preparation of Introduction of Early Infant Male Circumcision (EIMC) Services at 2 Hospitals in Lesotho: Mafeteng and Scott Hospitals

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Executive Summary

The Lesotho Ministry of Health (MOH), through partnership with MCHIP/Jhpiego and with the financial support from USAID/PEPFAR and UNICEF, has been implementing Voluntary Medical Male Circumcision (VMMC) services in Lesotho since February 2012. These services were initiated following WHO/UNAIDS recommendations for VMMC scale up in areas with low circumcision rate and high HIV prevalence. With the excellent uptake of the adult VMMC program and increasing demand for the VMMC particularly for younger boys, there arose a need to pilot the introduction of Early Infant Male Circumcision (EIMC) services.

Jhpiego, in collaboration the MOH, UNICEF and USAID (through MCHIP), undertook a feasibility assessment to explore the availability of EIMC services, the potential for their integration within MNCH/neonatal care and the potential demand for such services in two districts in Lesotho. More specifically, this assessment sought to: 1) Initiate coordination of EIMC services within the MOH; 2) explore current practices around EIMC in selected district hospitals; and 3) assess site readiness to introduce EIMC services in Lesotho.

Finding from the two sites showed that, in terms of infrastructure, both hospitals presented some location(s) where services could be accommodated. These locations would require improvements to the infrastructure to ensure services would be provided in a safe manner. It was further found that two locations for EIMC need to be established in both hospitals: at the maternity ward and at the PNC clinic. Additionally, staff at the hospitals all expressed an interest in introducing EIMC services in their respective facilities and a willingness to be trained.

Most of interviewees at the hospital showed an interest in seeking EIMC services. Some concerns were raised around pain for the neonate, timing of the MC, and potential future negative consequences. The interviews conducted during the assessment indicated that a communication plan will need to be designed to address community concerns around EIMC.

Recommendations for moving forward include:

- Establishment of an EIMC task team to oversee introduction of EIMC services into hospitals;
- Development of guidelines and tools for service provision and monitoring;
- Continuation of discussions around task shifting of EIMC procedures to nurses;
- Implementation of EIMC services at hospitals on a daily basis where feasible;
- Development of IEC materials for communities on EIMC services

Acronyms and Definitions

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
CHAL	Christian Health Association of Lesotho
DCD	Disease Control Directorate
EMLA	Eutectic mixture of local anaesthetics
FHD	Family Health Division
HIV	Human immunodeficiency virus
M&E	Monitoring and evaluation
MNCH	Maternal, neonatal and child health
PMTCT	Prevention of mother-to-child transmission
PNC	Post Natal Care
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund.
USAID	United States Agency for International Development
WHO	World Health Organization
Early infant	Less than 60 days of age
Low birth weight	Less than 2500g
Preterm	Less than 37 completed weeks of gestational age

Introduction

The Lesotho Ministry of Health (MOH), through partnership with MCHIP/Jhpiego and with the financial support from USAID/PEPFAR and UNICEF, has been implementing Voluntary Medical Male Circumcision (VMMC) services in Lesotho since February 2012. These services were initiated following WHO/UNAIDS recommendations for VMMC scale up in areas with low circumcision rate and high HIV prevalence. In Lesotho, HIV prevalence remains high despite high levels of HIV awareness. Current prevention efforts have not yet succeeded in reducing the number of new infections.

In Lesotho, by March 2013, over 14,000 adolescent and adults had received comprehensive VMMC services through static sites and intensified service delivery campaigns (ISDs). With the excellent take-off of the adult VMMC program and increasing demand for the VMMC particularly for younger boys, there arose a need to pilot the initiation of Early Infant Male Circumcision (EIMC) as a strategy to institutionalize medical circumcision, and reduce the need for adult circumcision in the future.

This pilot would represent the first formal attempt to introduce routine EIMC services into the health system in Lesotho. The proposed program model of EIMC is to integrate the service into existing Maternal, Neonatal and Child Health (MNCH) services in Lesotho. EIMC services would be provided to early infant boys within 1–60 days following delivery. The services for EIMC could be provided as a component of various MNCH services including ante-natal clinic, antenatal ward, immunization clinic, family planning clinic or even in the maternity and labour room, depending on the convenience of the service provision.

USAID and UNICEF Lesotho have therefore expressed interest in assessing modalities for the introduction of EIMC services in existing hospitals in the country. This report summarizes findings of these initial activities.

Background

Three randomized clinical trials have determined that male circumcision (MC) reduces female to male HIV transmission by approximately 60%; post-trial surveillance suggests that risk compensation has not proven to be a problem in the clinical trial sites. Modeling studies demonstrate that VMMC could avert approximately 3.4 million new HIV infections among men and women by 2025. In March 2007, WHO and UNAIDS issued guidance urging countries with high HIV prevalence and low MC rates to incorporate VMMC into their HIV prevention programs as part of a comprehensive package that includes abstinence, partner reduction, condom promotion, HIV counseling and testing, and STI treatment.

EIMC is performed during the first 60 days after birth¹ and has many advantages over circumcision performed later in life, including lower adverse events rates and reduced costs. EIMC can be safely done under local anesthesia using WHO-recommended devices. Many countries in the East and Southern Africa (ESA) region that have begun to scale up VMMC are now incorporating EIMC in their national MC strategies by integrating EIMC services into maternal and child health services in order to sustain the HIV prevention impact of male circumcision over the long term.

EIMC pilot projects have found several challenges in implementing EIMC in the ESA region. In some communities neonates are considered too young for circumcision, either because MC is linked with rites of passage to adulthood or because people believe that neonates are too

¹ EIMC training manual WHO/Jhpiego, 2010

vulnerable for surgery. Low rates of institutional childbirth and limited use of neonatal and early infant care services mean that for many infants the first contact with the health system is at the 6-week immunization visit, beyond the neonatal period. Also, among infants who are born in health facilities, discharge is sometimes as soon as 4 to 6 hours postpartum, limiting opportunities to provide EIMC. While in most settings only one parent is required to provide written consent for EIMC, in reality many new mothers prefer to involve other family members in the decision including fathers and/or grandparents, yet these family members are often not physically present to provide consent. Finally, in some countries only doctors may provide MC, however most facility births are attended by nurse-midwives and non-physician clinicians are the primary care providers for infants and children. Despite these challenges, countries in the region have an opportunity to not only tackle HIV prevention but to address broader neonatal and maternal health issues by scaling up EIMC.

Lesotho has one of the highest HIV prevalence rates in the world, with an estimated 23% of adults infected. With the under-5 mortality rate estimated at 85 and neonatal mortality rate at 35 (UNICEF, 2010), child mortality remains a problem in Lesotho². Moreover, with 13% and 39% of under-fives suffering from moderate and severe underweight and stunting respectively, nutrition remains a concern in Lesotho (UNICEF 2010). These various public health problems justify a comprehensive care approach to addressing children's health.

The Lesotho Ministry of Health (MOH) created an MC Task Force in 2007, but implementation of adult VMMC services began only last year in the public sector. In early 2012, the MOH indicated its intention to expand VMMC service provision to 20 hospitals and facilities, including the development of capable and trained staff (doctors, nurses, counselors and support staff to meet demand). The MOH requested the MCHIP program to scale up VMMC services and pilot the introduction of EIMC services in two sites. Through MCHIP, Jhpiego has also provided technical assistance to the MOH and MC Technical Working Group (TWG) in the review and adaptation of key VMMC documents; organized regular monthly MC TWG meetings, facilitating ownership of the program by the MC TWG; trained over service providers in 10 and supported initiation of VMMC services at these sites.

Even though the rapid impact on the HIV epidemic will be achieved by circumcising adult males, neonatal male circumcision prior to risk of HIV infection has been recommended to ensure sustainability and long term effect in reducing HIV prevalence.³ Neonatal MC can be offered at a lower cost and its implementation is economically feasible in developing countries hit hardest by HIV/AIDS; therefore it should be considered a priority in comprehensive HIV prevention plans for southern Africa.⁴ The MOH has further expressed its willingness to start EIMC implementation in selected facilities.

USAID and UNICEF Lesotho have also expressed special interest in scaling up EIMC services as a routine service in Lesotho district hospital and partnered with Jhpiego/MCHIP Lesotho for implementation of such an activity. This assessment will help Jhpiego/MCHIP, USAID and UNICEF develop a joint program on EIMC (building on the global collaboration between the organizations), which is centered on ensuring that EIMC forms part of, and strengthens, comprehensive mother-baby care in Lesotho.

² http://www.unicef.org/infobycountry/lesotho_statistics.html retrieved on May 29, 2013

³ UNAIDS (2010) Neonatal and child male circumcision: a global review. UNAIDS

⁴ Kalichman S. (2010) Neonatal Circumcision for HIV Prevention: Cost, Culture, and Behavioral Considerations. PloS Medicine, Vol. 7, Issue 1.

Proposal Objectives

The objective of this proposal was to explore the availability of EIMC services, the potential for their integration within MNCH/neonatal care and the potential demand for such services in two districts in Lesotho. More specifically, this assessment sought to:

- Initiate coordination of EIMC services within the MOH;
- Explore current practices around EIMC in selected district hospitals (if any);
- Assess sites readiness to introduce EIMC services in Lesotho.

Within the UNICEF collaboration, a result framework with illustrative activities was developed prior to program implementation as shown in the table below.

Table 1: Result framework for collaborative proposal between UNICEF and Jhpiego Lesotho

RESULTS FRAMEWORK
Goal: Strengthen EIMC services
Intermediate Result: Assessment of the availability and quality of EIMC services, their integration within MNCH/neonatal care and the demand for such services in two districts in Lesotho
Program Component Result: Improved understanding of current EIMC service provision and the potential for scale up within the context of Lesotho
Activities: <ol style="list-style-type: none">1. Develop assessment tool2. Undertake assessment (data collection) at two sites and analyze data3. Conduct a stakeholders meeting to review results and recommend next steps
Illustrative Outputs: <ol style="list-style-type: none">1.1 Assessment complete1.2 Stakeholder meeting conducted
Illustrative Outcome: Recommendations developed to increase EIMC services within the context of MCH/neonatal care

Program Implementation

ADVOCACY AND COORDINATION MEETINGS WITH FAMILY HEALTH DIVISION IN MOH

The Family Health Division (FHD) has the mandate to coordinate MNCH services in Lesotho and represents the appropriate platform for EIMC services coordination. An introductory meeting with the MOH was held on the 5th of February with the FHD (Annex 1). Subsequent meetings were held on a regular basis. Meeting objectives were to discuss introduction of EIMC services in Lesotho, set up a task force, and select sites for the assessment. The FHD was positive in supporting EIMC activities in Lesotho. Two district hospitals were selected for the assessment: Scott and Mafeteng hospitals. This choice was justified by the experience of adult VMMC in these hospitals, the proximity of Maseru for easy supervision, and the opportunity to introduce services in both a CHAL and a public facility during this initial phase.

EIMC READINESS ASSESSMENT TERMS OF REFERENCE (TORS) AND TOOL DEVELOPMENT

Assessment terms of reference including tools (Annex 2) were developed in collaboration with FHD and UNICEF, based on MCHIP/Jhpiego assessments in other countries. The objectives of the assessment were to: identify the status of MNCH programs in selected facilities; identify opportunities and mechanisms for integrating EIMC services into existing MNCH services; sensitize sites managers and health providers for the future introduction of EIMC services in their facilities; and assess EIMC willingness of expecting parents and relevant accompanying relatives attending various services at the hospital. An assessment team was put in place that included staff from the FHD and Disease Control Directorate (DCD) in the MOH, MCHIP/Jhpiego, and DMOs and Matrons in charge of the hospitals visited. The assessment team visited the two hospitals for data collection during April 2013. The visit contributed to:

- Identify potential space for EIMC service provision;
- Identify potential service providers for training on EIMC, especially those who are working in MNCH and maternity department;
- Determine available infrastructure and services that will support EIMC pilot initiation;
- Establish baseline information for male neonates' deliveries and postnatal/early childhood services;
- Get an indication of existing demand for EIMC and potential community mobilization opportunities.

The assessment tools included two components: (i) a site component focusing on physical infrastructure, data collection on MNCH and human resources at the hospital, (ii) as well as a component including interviews with potential parents and accompanying relatives. The interviews were conducted to provide information on acceptability of future EIMC services.

Assessment Findings

As mentioned above, an assessment was conducted in two hospitals to explore the readiness of the selected district hospitals to introduce EIMC services. The assessment team collected information on infrastructure for potential MC services, supplies, and human resources. The status of MNCH was also assessed approximately by collecting hospital data on MNCH services.

The following section provides an overview on the findings. It also addresses key program components for EIMC initiation in these hospitals.

OVERVIEW OF FACILITY ASSESSMENT FINDINGS

Mafeteng and Scott districts hospitals are located in the southern region of Lesotho. Scott hospital is part of Maseru district which include others hospitals. Scott hospital is part of the CHAL hospitals. Mafeteng hospital is a public facility and the only hospital in Mafeteng district.

The average number of total number of deliveries in both facilities was 160 and 103 for Mafeteng and Scott respectively. The tables below summarize statistics collected over a period of 4 months prior to the assessment.

Table 2: Mafeteng hospital statistics over the four months preceding the assessment visit

DESCRIPTION OF THE STATISTICS	LAST FOUR CONSECUTIVE MONTHS' REPORT			
	DECEMBER 2012	JANUARY 2013	FEBRUARY 2013	MARCH 2013*
Total number of deliveries in the facility	190	164	130	-
Number of full term male infants born in the facility	All sexes** 185	All sexes 161	All sexes 130	-
Number of male infant deaths	All 5	All 3	All 0	-
Number of infants below 2 months registered for immunization	N/A	N/A	N/A	-
Number of infants who come for immunization at 6 weeks	All 274	All 42	All 58	-
Number of infants circumcised	0	0	0	-
Number of new ANC clients	53	86	68	-
Number of women attending postnatal care within 7 days of delivery	67	41	54	-
Number of women attending postnatal care within 6 weeks of delivery	47	93	134	-

*Not yet available at the time of the assessment; ** both males and females

Table 3: Scott hospital statistics over the four months preceding the assessment visit

DESCRIPTION OF THE STATISTICS	LAST FOUR CONSECUTIVE MONTHS' REPORT			
	DECEMBER 2012	JANUARY 2013	FEBRUARY 2013	MARCH 2013
Total number of deliveries in the facility	100	102	101	109
Number of full term male infants born in the facility	56	54	52	64
Number of male infant deaths	2	1	2	1
Number of infants below 2 months registered for immunization	N/A	N/A	N/A	N/A
Number of infants who come for immunization at 6 weeks	104	104	109	110
Number of infants circumcised	0	0	0	0
Number of new ANC clients	30	42	43	48
Number of women attending postnatal care within 7 days of delivery*	104	104	109	110
Number of women attending postnatal care within 6 weeks of delivery*	104	104	109	110

*In the above table, statistics for women attending both 7-days and 6-week postnatal care appears the same as they were not separated in the registry book. The total number represents women attending both at 7-day and 6-week PNC visits

In both hospitals, most neonates are full-term as per the statistics collected. Infant deaths were between 1 and 5 per month in both facilities. Five infant deaths were recorded in Mafeteng during the month of December representing 2.6% of total deliveries. Every month more than 40 women attend their first ANC visits in these facilities.

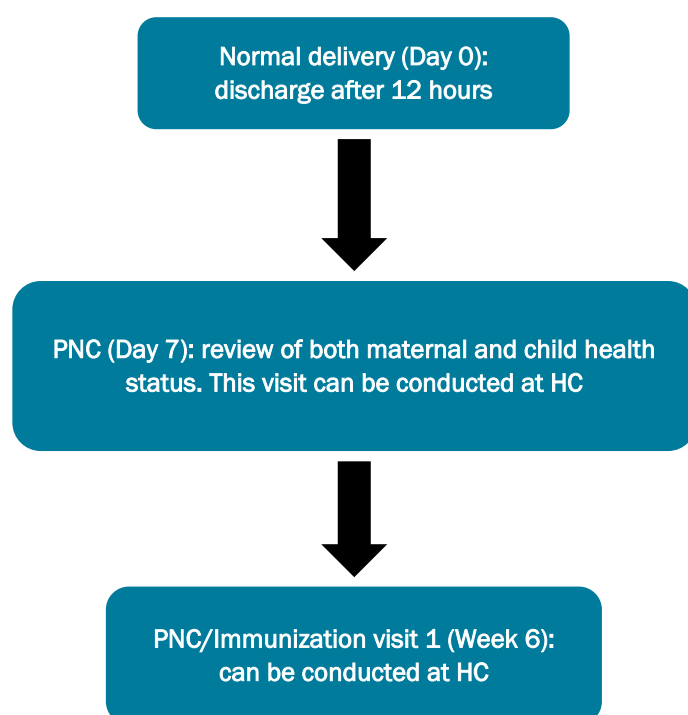
At Mafeteng hospital, the total number of women attending both 7days and 6 weeks PNC visits is lower than the average number of deliveries recorded for the same period (almost half). Thus might suggest that if those women are attending these visits there are conducted

at a lower level of care (health center) as reported by hospital staff. None of the hospital visited is providing EIMC as routine services to date.

POTENTIAL TIMING FOR EIMC AND DAYS OF SERVICE DELIVERY

In Lesotho, women who deliver normally are discharged after 12 hours approximately. Two subsequent post-natal visits are recommended (figure 1) as per the Lesotho Obstetric Record (LOR). These subsequent visits are potential encounters for providing EIMC to newborns as the first is at seven days and the second at 6 weeks. These two visits represent opportunities for male infants to receive circumcision. However, the two visits can be conducted at the health center level when the delivery has occurred at the hospital. To date, health centers are not staffed with medical doctors.

Figure 1: Timing of PNC visits



No ideal time has been identified for performing male circumcision during infancy, however data exist showing that the procedure can be safely performed even immediately after birth⁵. A WHO expert review meeting on neonatal male circumcision concluded that the procedure is easier to perform and associated with less pain and fewer complications when performed within the first two months of life.

The American Academy of Family Physicians recommends that male circumcision should not be performed until at least 12 to 24 hours after birth to ensure the infant is stable. This time allows providers to perform neonatal care and treatment, to completely assess the neonate and to identify abnormalities or contraindications⁶.

In Lesotho, the American Academy of Family physicians recommendation might present challenges as most mothers are discharged 12 hours after delivery and circumcision might not be possible to be performed. However, the program could consider the 12 hours post-delivery as an acceptable time limit and consider each male infant on a case by case before performing the circumcision. The 7-day visit also offers a good opportunity for EIMC. However, the number of mothers attending these visits varies. Some mothers do not come back to the hospital as these visits can be attended at health center. In other instance, the 7-

⁵ WHO, Jhpiego (2010) Manual for early infant male circumcision under local anesthesia

⁶ Cited in WHO, Jhpiego (2010) Manual for early infant male circumcision under local anesthesia

day visit might be the first encounter with the health system especially if the delivery occurred at home. The third possibility would be the circumcised the infant when attending the 6-week immunization visit as the age is still below 2 months. EIMC could represent an extra motivation for mother to attend these PNC visits.

WHO also recommends that male infants of low birth weight undergo delayed outpatient circumcision and that circumcision should be delayed in infants whose penile shaft length is less than 1 cm. Early infant male circumcision is also not recommended in preterm infants or any infant with a medical contraindication.

Introduction of EIMC will need to address carefully the issue of attendance to PNC. EIMC can be seen as an opportunity to strengthen PNC visit attendance at hospital level. Again, these three visits represent the possible routine encounters for EIMC service provision on a routine basis and do not prevent clients to seek EIMC services any other time.

The hospital management was non-committal on how often a week EIMC services would be offered. There was concern of offering services daily due to the staff shortages. However, considering the statistics on number of deliveries during the past 3 months, clients for EIMC might vary between 30 and 50 per month. This does not represent a sizable increase in workload for the providers.

EQUIPMENT AND SUPPLIES FOR EIMC

Specific EIMC supplies are required to perform MC in an infant. The team assessed the availability of the supply and equipment at the two hospitals. The table below shows the standard equipment and supplies needed (as per the WHO guidelines) to conduct an EIMC and their availability at the sites visited.

Table 4: Required supplies for EIMC and availability in both hospitals visited

ITEMS	MAFETENG	SCOTT
Equipment		
Secure work surface (table or infant warmer) – height should be such that the surgeon does not have to stoop or bend	Yes	No
Assistant or mechanism to restrain/position infant	No	No
Hand-washing/cleaning facilities	Yes	Yes
Light source	No	No
Supplies		
Infant padding, blankets and towels	No	No
Clean nappies/diapers and wipes	No	No
Sterile gloves	Yes	Yes
Sterile drape with small opening in the centre (fenestrated)	No	No
Betadyne or other skin-sterilizing preparation	Yes	Yes
Sterile marking pen or gentian violet	No	No
Sterile 2 x 2 or 4 x 4 gauze pads	Yes	Yes
White petrolatum (Vaseline) or white petrolatum gauze	Yes	Yes
Instruments		
Instrument tray wrapped with sterile drape	Yes	Yes
One 7.5-cm to 12.5-cm (3-inch to 5-inch) flexible probe*	No	No
Three small mosquito haemostats, two curved and one straight	No	No
Small straight scissors	No	No
Desired male circumcision device (Mogen, Gomco, Plastibell) and all appropriate parts*	No	No

ITEMS	MAFETENG	SCOTT
Scalpel – no. 10 blade or similar	No	No
Anaesthesia administration		
1% lidocaine (without Epinephrine)**	Yes	Yes
1-ml sterile syringe with small 27-gauge or similar needle	Yes	Yes
Alcohol wipes	Yes	Yes
Post-circumcision bleeding		
Topical epinephrine	No	No
Elfoam or equivalent	No	No
Adson forceps	No	No
5-0 or 6-0 absorbable suture (chromic or catgut) on a needle (6-0 chromic on PC-1 needle or equivalent	Yes	Yes
Petrolatum-coated gauze	Yes	Yes

*See below for more on device; ** there was no anesthetic cream in both facilities

Introducing EIMC in the visited hospitals will require investing in appropriate supplies. Mechanisms for purchase and regular procurement need to be discussed with hospital management. The pharmacy in both hospitals will need to be involved before the start of service delivery so that ordering of these regular supplies can be done on time and regularly. Because EIMC should be introduced as a sustainable and routine service component of the VMMC program, it is necessary that procurement of supplies is included in the list of all hospitals supplies regularly ordered.

The choice of device remains a decision that the nascent program will need to make carefully. From the assessment situation and from experience in other country, it appears that the Mogen clamp will be the appropriate instrument for performing EIMC in the hospital visited. The Mogen clamp comes in one piece and can be reused after sterilization

POTENTIAL SPACE FOR EIMC SERVICES PROVISION

Adequate space for EIMC service provision was observed in the two hospitals. The Management at the two facilities expressed their preference to have EIMC services set up in the maternity ward.

At Mafeteng hospital: two potential spaces for piloting the integration of EIMC with MCH services at Mafeteng Hospital are available. One space is the room that is used once a week for ultrasound scanning in the maternity ward. If the services are to be housed in this space, they would have to be carried out on a day when the ultrasound scans are not being done. Challenges with adopting this space might include:

- The room not being available every day of the week;
- Having babies that have been out in the community return to the Maternity ward as infections might be brought in from outside the hospital into the maternity ward;
- Waiting room space for immediate post-operative care, since some mothers may not be admitted on the ward when their babies receive this service.

The team suggested that post-operative procedure be also integrated within the postnatal clinic while counseling and clients' preparation be integrated in the antenatal clinic.

The second space was a room in the postnatal clinic which at the time of the assessment was not being occupied. The room is partitioned from the bigger health education room in the postnatal clinic.

The post-operative follow up visit can be done in the postnatal care room. Challenges of using this space might include:

- The postnatal room is often crowded with clients seeking other services and with few health providers; however, attempts can be made to use the MCH clinic for the EIMC procedures and observe the feasibility of using this option;
- Mothers seeking circumcision for newborns may find it challenging to move from the Maternity ward to the MCH clinic because of the distance that exists between the two, especially if the mothers have had caesarean sections/episiotomies.

At *Scott hospital*: the assessment team visited a space within the labour ward. This space would have to be partitioned off from the rest of the labour ward to be adequate for EIMC services.



Potential space within the labour ward suitable for EIMC procedure. Photo Jhpiego Lesotho

The follow up visits would be conducted in the postnatal clinic while counseling and client's preparation would be done at antenatal clinic. There was enough space in the antenatal clinic waiting area. In addition the maternity room would be an adequate space for providing EIMC services to newborn before women are discharged. The two facilities will need to be upgraded prior to EIMC service initiation.

HUMAN RESOURCES FOR EIMC

High support was expressed from administrators and staff on the introduction of EIMC in the facility. Relevant staffs are available to be trained for service provision even though shortage of staff, particularly doctors, remains a challenge. In both facilities, management was willing to allow their staff to participate in upcoming EIMC training and follow-on activities.

Despite chronic staff shortages at the MCH, particularly doctors, the hospital was willing to release nurses for EIMC training who will eventually initiate the EIMC service as part of the routine service at MCH. In general, one doctor usually is allocated to the Maternity ward and this doctor would be trained to perform the procedures. However, because doctors at the hospital rotate through the units periodically and the trained doctor would not necessarily be permanent at the maternity department. There would, therefore, be a need to train most, if not all, the doctors in the hospital.

INTERVIEWS ON ACCEPTABILITY OF SERVICES

The EIMC assessment included an interview component with providers and some potential users of EIMC. The objective of the interview was to gather information on potential acceptability of EIMC services by both providers and potential users. Five providers and 33 people receiving services at the facilities were briefly interviewed. Adult clients aged 18 to 60 years attending MCH clinic, adult OPD on the day of the interview were conveniently recruited as potential users of EIMC. Most of the men interviewed were reached through the

OPD. Five providers from MCH clinic and maternity wards were also conveniently recruited, based on their availability on the day of the interview. An English semi-structured questionnaire was used; data was then coded and analyzed to determine the type and frequency of responses.

Of the 33 facility attendees interviewed, 73% were females and 27% were males. The mean age of the participants was 39 years, ranging from 19 years to 76 years, all 33 participants were Christian. About 11 (35%) of the potential users had primary school education, 16 (52%) have either had secondary or higher education and the remaining 4 (13 %) have had no formal education.

Table 5: Characteristics of facility attendees interviewed about EIMC

DEMOGRAPHICS OF POTENTIAL EIMC INTERVIEWED (n)		MALES		FEMALES		TOTAL	
		n	%	n	%	n	%
Religion	Christians	9	100	24	100	33	100
	Muslims	0	0	0	0	0	0
Educational level	Have had no formal education	3	33	1	4	4	12
	With Primary education	3	33	9	37.5	12	36
	With Secondary education	1	12	11	45.8	12	36
	With higher education	2	22	3	12.5	5	15

The mean age for the 5 health providers interviewed was 36 years, ranging from 24 years to 50 years. 4 of the 5 providers had completed diploma training in nursing and 1 had a certificate in nursing.

Summary of views on acceptability of EIMC:

- A majority of facility attendees 26 (78%) reported that they would be willing to have infant sons circumcised if the services was available.
- (15/33)48% of the respondents indicated that they would prefer to circumcise their infant sons at an age of a month or less.
- There is a high expectation among both providers and facility attendees that community will respond positively to EIMC; this was higher among facility attendees than among providers.
- According to interviewees, potential barriers were also seen to exist in regards to community adoption of EIMC, including fear of pain, unfamiliarity with the service, association with circumcision and Muslim religion, and some myths, including circumcision will cause a smaller penis in adulthood.

Of the interviewed facility attendees, 84.8% stated that they would be ready to circumcise their infant if the service were available. There was no difference between female and male respondents.

Five facility attendees indicated that they would not be willing to circumcise their infants. These five interviewees reported concerns related to:

- The penis not being matured enough for circumcision,
- The pain that the infant will feel during and after the procedure,
- Circumcision of neonates not being a common practice in their culture.
- Lack of information on how this would benefit his infant

All the providers interviewed had heard of EIMC before the day of the interview, but reported that it is not common practice. 4 of the 5 providers interviewed indicated that they would be willing to have their male infants circumcised if the service is initiated and established in their facilities. There was also a general feeling of willingness to provide the services if these were established in their facilities. The provider who indicated she would not be willing to circumcise her infant had the same reservation as the facility attendees interviewed: Circumcision of neonates not being a common practice in their culture.

The majority of the views around the importance of EIMC were shared among providers and facility attendees as shown in table 8. The most commonly reported positive view on EIMC related to reducing chances of acquiring infections (mainly UTI) and the fact that circumcision is a hygienic practice. It was also stated that EIMC can prevent the acquisition of STI including HIV during the adulthood. Other reported benefits of EIMC were more general ('good for health') and it was noted that the timing of healing for EIMC coincided with that of the umbilical cord and healing of the mother – this was seen to be positive. One parent mentioned that it was a recommended practice by the bible.

Table 6: Views on the importance of EIMC from facility attendees and health care providers:

THEMES ON BENEFITS OF EIMC	NUMBER OF PROVIDERS REPORTING	NUMBER OF FACILITY ATTENDEES REPORTING	% OF TOTAL RESPONDENTS
Quick healing when an infant	2	1	8
Reduces chances of infections	2	18	53
More control over an infant, easy procedure and care of a child	3	1	11
Less chances of complications compared to adult circumcision	4	4	21
MC is a necessity, earlier is better	2	3	13
Easy to maintain cleanness of infants' penis	2	3	13
Child will not feel much pain	2	6	21
Minimize risks of bleeding because blood vessels are less likely to dilate	2	5	18
Others: Practice is good for health	4	25	76

Preferred age for EIMC

Providers and facility attendees were asked for their preferred age for circumcising infants and were meant to choose either of four options; less than a month old, six weeks old, two months old, and any age thereafter. 47% of all respondents would prefer to circumcise their infants at an age of a month or less, 13 % preferred the procedure to be done at six weeks, 21% preferred it to be done at 2 months while the rest preferred it be done at any later than two months.

Concerns and Fears around EIMC

The levels of concerns or expected problems about EIMC were reported by 54% of the interviewed providers and facility attendees possibly due to low familiarity with the service. The reported concerns and fears around EIMC were shared between providers and facility attendees. The predominant concern (17% of facility attendees, 37% of providers) was possibility for acquiring infection, followed by pain (during the procedure and care post circumcision). Providers also cited possible difficulties with urinating, bleeding and causing damage to the penis. Other concerns cited included; delayed wound healing, failure to

reproduce later in life if the cut is not done well, and the possibility for a small penis when the circumcised baby becomes an adult.

Views on expected community perception around EIMC

Providers and facility attendees were asked what they think the community's response to EIMC will be. A positive response was expected by both providers and facility attendees, with providers feeling more conservative about community support for EIMC. Among providers, 20% felt that community will be resistant to EIMC (reasons cited included common practice of circumcise male children after one year, fear of death and infection). The main barrier cited by facility attendees was that the community would feel that EIMC was simply not commonly practiced (20% facility attendees). Two respondents also mentioned that EIMC is associated with Muslims and this might be a barrier for non-Muslims.

Conclusion

EIMC services are an important component of a VMHC program. This assessment explored the feasibility and readiness for the introduction of EIMC services in two district hospitals in Lesotho. In terms of infrastructure, both hospitals presented some location(s) where services could be accommodated. However, these would require improvements to the infrastructure to ensure services would be provided in a safe manner. Two locations for EIMC need to be established in both hospitals: at the maternity ward and at the PNC clinic. Hospital staff have shown interest in introducing EIMC services in their respective facilities and are willing to be trained.

Most of interviewees at the hospital showed an interest in seeking EIMC services. Nevertheless, some concerns were raised around pain for the neonate, timing of the MC, and potential future negative consequences. The interviews conducted during the assessment indicated that an adequate communication plan will need to be designed to address community concerns around EIMC.

In general, EIMC services can be introduced in the two hospitals that were assessed. Nonetheless, it will require an upgrading of health facilities, prior purchase of supplies and adequate communication with potential parents and services providers. These activities should take place prior to training EIMC providers.

Recommendations and Way Forward

Program implementers:

- Coordination of activities is required to ensure adequate program implementation, *it is therefore recommended to set up an EIMC task team who will have the responsibility to oversee early introduction of services in hospitals.*
- To date EIMC services have not been provided in Lesotho as a routine service in both hospitals visited; *there is a need to develop guidelines and tools for services provision and monitoring of activities.*
- Considering the shortage of doctors in hospitals, *program implementers need to discuss with relevant bodies the possibility of task shifting of the EIMC procedure to nurses.*

Facility level:

- Considering that the three most likely encounters presenting an opportunity to offer EIMC services (delivery, PNC 7days, PNC 6 weeks) might not ensure that all potential clients receive EIMC services, *it is important to explore the possibility to have EIMC services offered on a daily basis at the district hospital.*

Community/demand creation:

- Demand creation activities need to be tailored to the Lesotho context. *It would be of great importance to conduct a rapid formative study to inform the development of communication activities and IEC content*

Table 7: EIMC Follow up activities

PROPOSED ITEM	ACTIVITIES UNDER THE ITEM
Sensitization of the community about the services to start	<ul style="list-style-type: none">• Organize meetings with key stakeholders, responsible officials at the MOH, health workers at the intended service provision sites, local leaders and managers at district level in the districts we intend to start implementing in• Develop a message for integration into the education guide during MCH services• Start developing necessary IEC materials
Training of providers	<ul style="list-style-type: none">• Selection of appropriately trained health providers for training on EIMC• Prepare for the training, by procuring necessary logistics, and creating demand among clients for the training period
Provision of services for EIMC	<ul style="list-style-type: none">• Procurement of supplies at the sites to enable services to be offered• Sites with trained providers to start implementing the program

Annex 1: Meeting Minutes on the Introduction of EIMC Services in Lesotho Hospitals

Date: 05th February 2013

Venue: FHD Director's Office

Present:

Mrs. Florence Mohai

Dr. James Ger

Mrs. Mefaneng

Mrs. Maqhama

Dr Abnwakomba

Dr V. Kikaya

Aim of the meeting

The meeting was to discuss the introduction of EIMC services in Lesotho and to identify initial steps in implementing EIMC program.

ITEM	OBSERVATION	DECISION/TASK
Presentation on EIMC program	<p>A presentation on EIMC program was done. It included:</p> <ul style="list-style-type: none">• Benefits• Types of device• Programmatic implications• Considerations for Lesotho• Proposed key activities for preparatory phase	<ul style="list-style-type: none">• See presentation
Discussion on EIMC service introduction	<ul style="list-style-type: none">• EIMC should be used as an opportunity to reinforce other MCH services as much as possible (i.e. including customer care in training for EIMC services)• There will be need for training Drs and Nurses at the same time• Possibility of motivation and incentive (PBF)	<ul style="list-style-type: none">• Set up a technical task team• Appoint a EIMC focal point in the FHD• Identified facilities for pilot implementation (Mafeteng and Leribe?)• Prepare assessment
Next meeting		<ul style="list-style-type: none">• The next meeting will be called by the Director of Family Health Division.

Annex 2: Readiness Assessment for Introduction of EIMC Services in 2 Selected Hospitals in Lesotho

Terms of Reference

I. Assessment purpose

The purpose of the assessment is to physically visit hospitals that have been selected for EIMC Service provision in order to assess actual status and identify gaps for providing MC services

II. Background

In Lesotho, VMMC modeling has shown a tremendous benefit in supporting HIV prevention effort. Scaling up male circumcision to reach 80% of adult and newborn males in Lesotho by 2015 would:

- Avert more than 121,000 adult HIV infections between 2009 and 2025;
- Yield total net savings of US\$ 618million between 2009 and 2025; and
- Require 177,000 MCs in the peak scale up year

Lesotho has made consistent progress in scaling up adult male circumcision (MC) services. The country has conducted a situation analysis on MC, drafted a policy, strategy and implementation plan and conducted sites assessment for MC provision. Since February 2012, the MOH with support of the MCHIP program led by Jhpiego has introduced MC services in 9 hospitals. These hospitals have since offered high volume MC and more than 10000 clients have been circumcised at these hospital sites.

Even though the rapid impact on the HIV epidemic is achieved by circumcising adult males, neonatal male circumcision prior to risk of HIV infection has been recommended to ensure sustainability and long term effect in reducing HIV prevalence⁷. Moreover, neonatal MC can be offered at lower cost and its implementation is economically feasible in developing countries hit hardest by HIV/AIDS, and therefore it should be considered a priority in comprehensive HIV prevention plans for southern Africa⁸.

As per the national implementation strategy, the senior management in the MOH has decided to introduce EIMC services as a sustainability component for the adult MC program. Two hospitals have been selected as the first step for providing services in the country. One of the first activities in implementing EIMC programs is to assess sites readiness to offer EIMC services.

III. Objectives

The general objective of this exercise is to provide information which will be used as a basis for sites upgrading to offer EIMC services.

More specifically, this rapid assessment will allow to:

- Identify the status of MNCH programs in selected facilities
- Identify opportunities and mechanisms for integrating EIMC services into existing EIMC services

⁷ UNAIDS (2010) Neonatal and child male circumcision: a global review. UNAIDS

⁸ Kalichman S. (2010) Neonatal Circumcision for HIV Prevention: Cost, Culture, and Behavioral Considerations. PloS Medicine, Vol. 7, Issue 1.

- Sensitize sites managers and health providers for the future introduction of EIMC services in their facilities
- Assess EIMC willingness of expecting parents attending other services at hospital

IV. Criteria and questions

Questions have been elaborated to inform on specific program components. These questions are included in the data collection tools (see VIII).

CRITERIA	QUESTIONS
a. EIMC Service delivery	<ul style="list-style-type: none"> • Are EIMC services provided on site? If yes, how?
b. Human resources	<ul style="list-style-type: none"> • What are human resources available in the facility? • How many staff and how much time could staff allocate to future EIMC services? • Has EIMC training been provided to staff?
c. Status of MNCH services	<ul style="list-style-type: none"> • Where and how are MNCH services being offered in the facility? • Who is in charge of providing MNCH services? • What is the status of MNCH services in the hospital?
d. Infrastructure, equipment and material	<ul style="list-style-type: none"> • Is space for providing EIMC available and adequate? • What are the equipment and material for EIMC that are available?
e. M&E	<ul style="list-style-type: none"> • Is data on EIMC currently collected? • How would potential EIMC data be collected?
f. Expecting parents interest	<ul style="list-style-type: none"> • Are expecting parents attending ANC services interested in EIMC • Who will sign informed consent for these services

V. Methods

a. Sites selected for visit

Two sites have been selected for provision of EIMC services and will be visited for identifying needs for services implementation. These sites are Mafeteng and Scott district hospitals.

b. Assessment Team

The team that will conduct the assessment will include staff from Family Health Division (FHD) and Disease Control Directorate (DCD) in MOH, MCHIP/ Jhpiego and UNICEF, as well as DMOs and Matrons in charge in hospitals to be visited.

c. Data collection

Data will be collected by:

- Interviews: with sites managers/health providers; and expecting parents (and accompanying relatives) attending ANC services during the visit.
- Use of data collection checklist and tool (see VIII)
- Observation of service provision

VI. Work schedule and tentative visits agenda

The visits will be conducted from Wednesday 27 March to Friday 29 March at both Scott and Mafeteng hospitals. Sites will be contacted in advance by official correspondence from the MOH with confirmation calls by FHD staff. A tentative agenda to be communicated for each site visit has been elaborated.

ACTIVITIES	TIME
Arrival on site	TBD
Meeting with Medical Officer in charge and Matron	TBD
Data collection and visit of potential space for EIMC services and inventory of equipment and material	TBD
Discussion with MNCH service providers at sites	TBD
Interviews with expecting parents at ANC services	TBD
Debrief with Medical officer in charge and matrons	TBD

VII. Reporting and use of findings

The assessment report will be presented to the DGHS and Director of disease Control and FHD manager in MOH. Results will be disseminated to relevant key stakeholders and partners.

VIII. Sites readiness assessment tool

FACILITY READINESS ASSESSMENT FORM FOR EARLY INFANT MALE CIRCUMCISION SERVICES

Date of Assessment ___/___/___ (Day/Month/Year) Facility _____

Name _____

District _____

Assessors' Names:

1. _____

2. _____

3. _____

Name of the Person in Charge _____

Contact information (Telephone, Email, etc.) _____

Managerial Committees

Catchment Area of the Facility

To be included in the future when EIMC is already established

Size of the catchment area in square km (If available)	
Total Population (Male and Female)	

Some Key Statistics for the Facility

STATISTICS IN THE LAST THREE CONSECUTIVE MONTHS	MONTH 1	MONTH 2	MONTH 3
Total number of deliveries in the facility			
Total number of full term male infants born in the facilities			
Number/proportion of male infant deaths???			
Percentage male infants below 2 months registered for immunization			
Percentage of males who come for immunization at 6 weeks			
Are EIMC services being carried out here?			
If there are EIMC services already in this facility, the total number of infants circumcised in the three months			
Number of Mothers attending ANC in this facility 1 st visit and subsequent visit			
Percentage of mothers who came back for post-natal care at 7 days			
Percentage of mothers who come back for post-natal care at 6 weeks			

Mention the opportunities available in the facility, to reach parents, guardians and expectant mothers with the EIMC messages so that they can seek the services.

Support Services

Please tick whether the following services are available in this facility:

- ☐ PMTCT
- ☐ Care for Exposed Infants
- ☐ ART services
- ☐ PCR
- ☐ Vaccination services
- ☐ Others

Management System:

Please assess whether the following systems are in place and briefly describe how they are organized in this facility:

Supervision and quality improvement _____

Commodity management and supply systems _____

Data management _____

Financial management _____

EIMC Service Planning

EIMC services will have to be offered as part of a comprehensive package that include the following:

- Education to parents/guardians on benefits, risks of EIMC and other issues pertaining to EIMC

- Linkage to other services such as vaccination services, child wellness clinic, care for HIV exposed infants as well as other medical services
- The EIMC procedure itself
- Follow-up care

The facility management has to make a decision which is the most appropriate area to have the EIMC services in the facility (e.g. stand alone, post-natal ward, immunization clinic etc.)

EIMC Services will tentatively take place (tick one)

- ☐ Daily
- ☐ On specific days, if so specify the days in the week _____

Staffing for the EIMC Services

Fill in the details on the total number of staff to be involved in provision of EIMC services

TRAINED STAFF	CADRE	NUMBER NEEDED TO START SERVICES	NUMBER NEEDED TO SUSTAIN SERVICES
	Doctors		
	Nurses		
Non-trained staff	Cleaners		
Mobilizers			
Others			

IPC

- ☐ Written IP Protocols in place
- ☐ Waste segregation practiced
- ☐ Waste disposal area appropriate and secured
- ☐ Final disposal of the waste done according to standards
- ☐ Autoclaving/Sterilization services; size of autoclave ____ litres

Client Flow

Draw a sketch of the proposed space/room/building for EIMC services

Work out the possible client flow considering the key areas of MC Service provision

- Waiting area
- Registration and counseling
- Screening and preparation for surgery
- EIMC procedure room(s) with space for scrubbing
- Post-op area
- Instrument processing area/Sluice
- Store
- Washrooms

Conclusion (Tick only one box, basing on the findings in this assessment)

- ☐ This facility is ready and EIMC services can start in this facility at any time
- ☐ The facility needs to work on the following areas before establishing EIMC services
- ☐ No efforts should be made initiate EIMC services at this facility at this time

INTERVIEWS WITH POTENTIAL PARENTS OF MALE INFANTS FOR SAFE EIMC SERVICES (AT ANC)

Name of Facility _____ Date _____ Code No _____

Socio-Demographic Data of the Interviewee:

Age ____ years

Sex: _____

Religion:

- ☐ Christian
- ☐ Muslim
- ☐ None?

Level of Education:

- ☐ None
- ☐ Primary school
- ☐ Secondary school
- ☐ Higher education

Instructions:

This interview is conducted as part of an assessment for feasibility of establishing EIMC services in this facility. The interview is to be conducted to potential parents whose male infants will be targeted for these services when established. It should be noted that services will be provided to new-borns from the age of 1 day to 2 months only. The interview is on personal opinions and views of the community on the acceptability of the services. It can be conducted anywhere (as deemed appropriate) in the hospital setting such as ante-natal clinic, antenatal ward, immunization clinic, family planning clinic, outpatient department etc. The interview is strictly anonymous and no identity will be linked to the responses given.

1. If EIMC services are available in this facility, will you be willing to bring your new-born child (if a male) for these services?

☐ Yes

☐ No

2. If yes, why do you think it is important to get your new-born infant circumcised at this age?

3. If no, why do you think you want to wait before getting your new-born infant circumcised at this age?

4. At what age would you be more willing to circumcise your new born male child?

☐ A month or less

☐ A month and a half

☐ Two month

☐ Any age

5. What is the general feeling in the community you live about circumcising new-born infants?

6. What do you think could be the problems associated with circumcising very young infants?
