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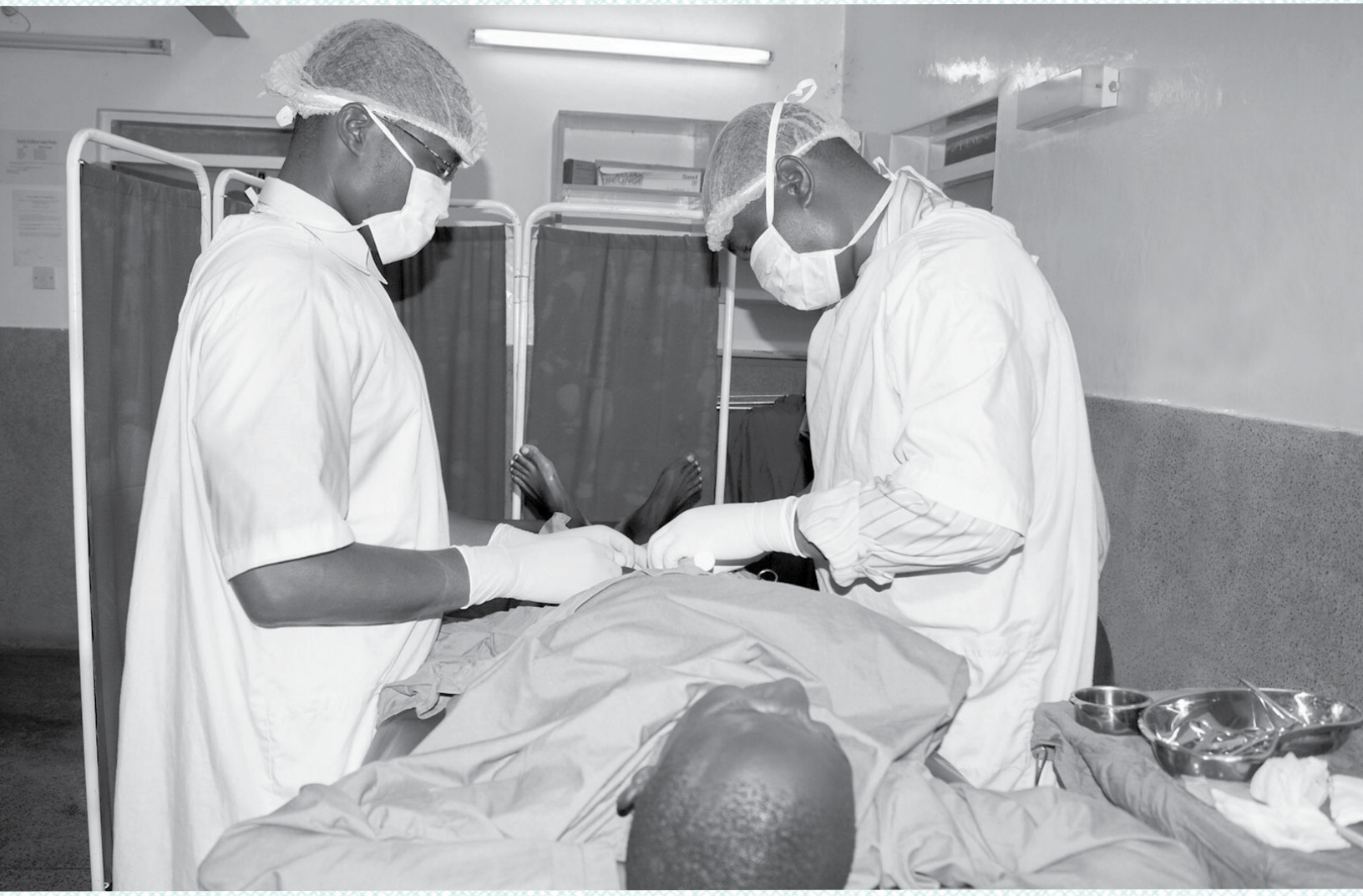

COPE® FOR MALE CIRCUMCISION SERVICES

A Toolbook to Accompany the COPE® Handbook

EngenderHealth's Quality Improvement Series

www.engenderhealth.org/cope

COPE® for Male Circumcision Services

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Preface

By the end of 2008, about 31.3 million adults and 2.1 million children were living with HIV (UNAIDS & WHO, 2009, p. 7). More than 25 years into the AIDS pandemic, HIV infection prevalence rates remain very high, with 2.7 million people newly infected with HIV in 2008 (UNAIDS & WHO, 2009, p. 7). Sub-Saharan Africa continues to bear the greatest burden of infection. With nearly 13% of the world's population (PRB, 2010), Sub-Saharan Africa is home to nearly 67% of all people living with HIV (UNAIDS & WHO, 2009, p. 21). In 2008 alone, an estimated 1.9 million people became newly infected in Sub-Saharan Africa, with more than 1.4 million dying of AIDS (UNAIDS & WHO, 2009, p. 21)—72% of all AIDS deaths globally (UNAIDS & WHO, 2009, p. 21). The continuing increase in HIV infections in many parts of the world, despite years of preventive interventions, has stimulated interest in new approaches that can effectively reduce the risk of HIV transmission. As one such approach, there has been much interest in the potential of male circumcision (MC) to reduce heterosexual transmission of the virus.

The results from three randomized clinical trials carried out in Sub-Saharan Africa have demonstrated that MC provides a protective effect of around 60% against female-to-male transmission of HIV (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007). Although these results demonstrate that MC reduces men's risk of becoming infected with HIV via vaginal sex, it is important to note that it does not provide complete protection against HIV infection. Circumcised men can still become infected with the virus and, if HIV-positive, can infect their sexual partners. What, if any, protection MC provides to female partners of HIV-positive men is not clear, but this question is currently under study. Therefore, MC should never replace other known effective prevention methods and should always be considered as part of a comprehensive prevention package, which includes correct and consistent use of male or female condoms, reduction in the number of sexual partners, delay in the onset of sexual relations, treatment of sexually transmitted infections (STIs), and HIV counseling and testing.

In March 2007, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), following consultation with experts from around the world, recommended that MC be recognized as an additional important preventive intervention to reduce the risk of heterosexually acquired HIV infection in men and should be scaled up in areas with high HIV prevalence rates and low MC rates (WHO and UNAIDS, 2007a). In February 2008, the U.S. Centers for Disease Control and Prevention (CDC) also noted that MC may play a role in the prevention of HIV transmission; however, the CDC is still developing public health recommendations for the United States (CDC, 2008).

Like any surgical procedure, MC requires quality service delivery to promote informed and voluntary decision making and to ensure medical safety and quality assurance. COPE (which stands for "client-oriented, provider-efficient" services) is well suited to improving these elements. COPE is both a process and a set of tools that together assist staff in addressing the issues that are within their reach. Among the first and most critical questions that facilitators ask participants during the first COPE exercise are: "What is quality? If your sister, mother, brother, or uncle came into this facility for services, how would you like them to be treated?" The answers to these questions create a definition of quality that incorporates clients' rights and staff needs: a definition that ensures that a high level of care is always offered and received. Additionally, the answers to these questions produce a collective vision of quality developed from the perceptions of individual staff members at different levels. The

spirit of COPE is based on the notion that changes in quality will be most successful and lasting when they are initiated by staff working together at the facility, using their expertise to identify problems and to develop recommendations for solving them.

To maximize the benefits and minimize the potential negative consequences, MC services should follow a comprehensive, quality, client-oriented approach that:

- Meets clients' needs while empowering them, by providing information and quality client-provider interactions during counseling sessions, to make their own decisions regarding their health and well-being
- Helps to maximize the efficiency and effectiveness of services by doing things correctly the first time someone walks into the facility
- Increases service utilization by reducing stigma and discrimination and offering a comprehensive range of quality services
- Supports comprehensive prevention in which MC is offered alongside HIV counseling and testing, STI diagnosis and management, and ongoing risk reduction counseling on safer sex practices, including condom demonstration and promotion.
- Improves referral networks and links between clinics and communities

Quality of services will be one of the key factors for the success of MC. One critical component of improving or maintaining quality of services is meeting the needs of all health care staff, so that they can provide quality client-centered services. Some impediments to the provision of quality MC services may be beyond the control of site staff, but others may be remedied via simple and creative measures that greatly enhance the services provided. This COPE toolbook is designed to assist MC providers and other health care staff in identifying and solving problems that compromise the quality of adult MC services. While much of what is covered in this toolbook also applies to neonatal circumcision, this resource is not recommended for quality improvement of neonatal MC services.

A number of quality improvement approaches—namely self-assessment, peer assessment, supportive supervision, and accreditation—have proven useful as methodologies for assessing and improving quality of health services. The WHO's quality assurance guide (2008) and its quality assessment toolkit (2009) for male circumcision services encourage staff in a range of health care settings to use peer assessment and self-assessment as well as supportive supervision as part of their quality approach and recommend accreditation for facilities seeking external recognition for their services. *COPE® for Male Circumcision Services*, which is based on a self-assessment approach, complements these WHO quality assurance resources. Both are based on a similar set of standards of care.

One of the advantages of COPE is that it provides a low-cost, practical approach to engaging health staff and managers involved in MC service delivery at the local level, irrespective of the MC service setting (e.g., facility-based services or mobile outreach). It also builds capacity and develops ownership of continuous quality improvement by guiding MC staff and managers to focus on problems that they can address themselves. Finally, it empowers them to proactively and continuously assess and improve the quality of their services over time. The disadvantages of COPE include that it requires initiative and follow-through in the service setting, and participants may lack the technical and clinical skills to assess quality accurately. Based on the advantages and disadvantages of various quality improvement approaches, countries should decide which one best addresses their situation and needs.

Acknowledgments

COPE, which originated as a quality improvement process for family planning services, was developed by EngenderHealth with the aid of a grant from Mrs. Jefferson Patterson and with support from the U.S. Agency for International Development. Since 1988, in collaboration with partners in resource-constrained countries, EngenderHealth has been developing and refining the tools for and the process of COPE. It has now been adopted in an ever-increasing range of countries, organizations, and health care facilities and has over time been adapted for use with other health care services, including HIV and AIDS.

The COPE tools for male circumcision services included in this book are part of that evolutionary process and were made possible by support from the Male Circumcision Consortium. FHI, EngenderHealth, and the University of Illinois at Chicago, working with the Nyanza Reproductive Health Society, are partners in the Consortium, which is funded by a grant to FHI from the Bill & Melinda Gates Foundation.

Many individuals contributed to EngenderHealth's development of this COPE toolbook. Dr. Fred Ndede and Dr. Mark Barone, both from EngenderHealth, wrote the initial version of this toolbook. Dr. Ndede, Feddis Mumba, Regina Mbayaki, and Paul Perchal conducted field tests on the toolbook in Nyanza, Kenya, in 2009. They thank the staff of Rauchonyo District Hospital, Homa Bay District Hospital, Kendu Bay Sub-District Hospital, and Awendo Sub-District Hospital, who participated in the field test activities and provided feedback on this toolbook.

A few EngenderHealth staff members were charged with the final writing and reviewing of this toolbook, with comments and suggestions from their colleagues. They are, Dr. Mark Barone, Paul Perchal, and Dr. Mulamba Diese. Merywen Wigley and Matthews Onyango of FHI also provided feedback on the final version of the toolbook. Christopher Caines copyedited this toolbook, Kathy Strauss formatted it, and Michael Klitsch provided overall publishing management.

Acronyms and Abbreviations

AIDS	acquired immunodeficiency syndrome
CFA	client-flow analysis
COPE	client-oriented, provider-efficient services
CPR	cardiopulmonary resuscitation
ELISA	enzyme-linked immunosorbent assay
HCT	HIV counseling and testing
HIV	human immunodeficiency virus
IDU	injecting drug user
IEC	information, education, and communication
MC	male circumcision
MSM	men who have sex with men
NGO	nongovernmental organization
PEP	postexposure prophylaxis
PLHIV	people living with HIV
QI	quality improvement
STI	sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

About COPE®

COPE is an ongoing quality improvement (QI) process and a set of tools used by health care staff to assess and improve the quality of care that they provide. Two assumptions inform the COPE process:

- Recipients of health care services are not passive individuals waiting to be seen by experts, but rather are autonomous health care consumers, or clients, who are responsible for making decisions about their own health care and who deserve—indeed, have a right to—quality health care.
- Health care staff desire to perform their duties well, but without administrative support and other critical resources, they cannot deliver the high-quality services to which clients are entitled.

COPE was developed around a framework of seven clients' rights and three staff needs that are implicit in these two assumptions (see Figure 1, p. 2). The rationale is that the more these rights are honored and these needs are met, the higher the quality of care.

COPE empowers staff to proactively and continuously assess and improve the quality of their services, ideally in ongoing dialogue with the users of the services—in this case, men seeking male circumcision (MC) and, as appropriate, those men's sexual partner(s). COPE's emphasis on the role of staff in continuous QI makes this possible. It recognizes staff members as the resident experts on quality and fosters teamwork by encouraging staff at all levels to collaborate in identifying obstacles to high-quality care and in using existing resources efficiently to overcome those obstacles. At the same time, rather than finding fault with individual staff members, COPE focuses on identifying problems in service delivery systems and processes. When staff participate in the COPE process, they develop a sense of ownership of the assessment findings, become invested in implementing the recommendations, and feel good about the quality of services they deliver and their contributions to the facility and to the health of their community.

About This Toolbook

This toolbook contains tools that are essential to the COPE process—Self-Assessment Guides, a Client Record-Review Checklist, a Client-Interview Guide, a Client-Flow Analysis, and an Action Plan with Follow-Up Forms. These tools enable supervisors and their staff to discuss the quality of MC services, identify problems that interfere with the delivery of quality services, identify the root causes of those problems, recommend ways to solve the problems,

Figure 1. The Rights of Clients and the Needs of Staff

The Rights of Clients

Information: Clients have a right to accurate, appropriate, understandable, and unambiguous information related to health and health care services. Information and educational materials for clients need to be available in all parts of the health care facility.

Access to services: Clients have a right to services that are affordable, are available at convenient times and places, are fully accessible with no physical barriers, and have no inappropriate eligibility requirements or social barriers, including discrimination based on sex, age, marital status, fertility, nationality or ethnicity, social class, religion, or sexual orientation.

Informed choice: Clients have a right to make voluntary, well-considered decisions that are based on options, information, and understanding. The informed choice process is a continuum that begins in the community, where people get information even before they come to a facility for services. It is the service provider's responsibility either to confirm that a client has made an informed choice or to help the client reach an informed choice.

Safe services: Clients have a right to safe services, which require skilled providers, attention to infection prevention, and appropriate and effective medical practices. Providing safe services also means proper use of service delivery guidelines, quality assurance mechanisms within the facility, counseling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.

Privacy and confidentiality: Clients have a right to privacy and confidentiality during the delivery of services. This includes privacy and confidentiality during counseling, physical examinations, and clinical procedures, as well as in the staff 's handling of clients' medical records and other personal information.

Dignity, comfort, and expression of opinion: All clients have the right to be treated with respect and consideration. Service providers need to ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, even when their views differ from those of service providers.

Continuity of care: All clients have a right to continuity of services, supplies, referrals, and follow-up necessary to maintaining their health.

The Needs of Health Care Staff

Facilitative supervision and management: Health care staff function best in a supportive work environment in which supervisors and managers encourage quality improvement and value staff. Such supervision enables staff to perform their tasks well and thus better meet the needs of their clients.

Information, training, and development: Health care staff need knowledge, skills, and ongoing training and professional development opportunities to remain up to date in their field and to continuously improve the quality of services they deliver.

Supplies, equipment, and infrastructure: Health care staff need reliable, sufficient inventories of supplies, instruments, and working equipment, as well as the infrastructure necessary to ensure the uninterrupted delivery of high-quality services.

Adapted from: Huezo & Diaz, 1993; IPPF, 1993.

Note: This represents a generic description of clients' rights and staff needs. In this toolbook, the description of each client right or staff need at the beginning of each Self-Assessment Guide has been adapted specifically for MC services.

implement the recommendations, and follow up to ensure resolution of the problems. This toolbook is to be used in conjunction with the *COPE Handbook*.[1]

COPE is staff-driven and combines both a process and a set of tools. EngenderHealth's first COPE handbook, published in 1995 (*COPE: Client-Oriented, Provider-Efficient Services*), was focused on family planning. But clients around the world expect quality in all health services, and services for MC are not isolated from other types of health care. Over time, providers have expressed the need for such tools for other health services beyond family planning, so the COPE process and set of tools have since been adapted for use in other health services (see Figure 2, p. 4, for a list of the current range of COPE toolbooks).

In this toolbook, versions of the COPE tools have been adapted to address the relevant range of topics for providing an integrated package of quality MC services, which includes HIV counseling and testing (HCT), promotion of safe sexual practices, condom demonstration and promotion, and screening for and treatment of sexually transmitted infections (STIs), in addition to MC provision. These topics include:

- Client confidentiality and privacy
- Counseling for MC, including informed consent
- HCT
- HIV prevention information and education, including condom promotion and demonstration
- Screening for and treatment of STIs
- Clinical examination and surgical procedure for MC
- Application of universal precautions for infection prevention
- Appropriate follow-up and management of clients, including management of adverse events and complications
- Supply chain management for equipment and commodities
- Functional medical records systems
- Timely and appropriate referral and follow-up to other prevention, care, treatment, and support services
- Mechanisms to involve community leaders, other community members, and community-based organizations in the planning, implementation, and ongoing monitoring of MC services

Principles Underlying COPE

Quality in health care is often defined as providing client-centered services and meeting clients' needs. The QI process is an effort to continuously do things better until they are done right every time. There are several reasons to improve the quality of the health care services provided in any health care setting. Improving quality safeguards the health of both clients and staff, ensures more effective treatment, adds features to attract clients, maintains the organization's strengths, and fosters efficiency and cost savings.

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1 *COPE Handbook: A Process for Improving Quality of Health Services, Revised Ed.,* can be downloaded at www.engenderhealth.org/pubs/quality/cope-handbook.php. To request one or more copies of the *COPE Handbook* or any other QI materials, contact EngenderHealth, Material Resources, 440 Ninth Avenue, New York, NY 10001, U.S.A., or e-mail to materialresources@engenderhealth.org.

Figure 2. COPE Toolbooks: Addressing a Range of Health Services

The following COPE toolbooks are currently available:

COPE® for Male Circumcision Services: A Toolbook to Accompany the COPE® Handbook (2010)

COPE® for Comprehensive Abortion Care Services: A Toolbook to Accompany the COPE® Handbook (2009)

COPE® for HIV Counseling and Testing Services: A Toolbook to Accompany the COPE® Handbook (2008)

COPE® for HIV Care and Treatment Services: A Toolbook to Accompany the COPE® Handbook (2008)

COPE® for Services to Prevent Mother-to-Child Transmission of HIV: A Toolbook to Accompany the COPE® Handbook (2004)

COPE® for Cervical Cancer Prevention Services: A Toolbook to Accompany the COPE® Handbook (2004)

COPE® for Reproductive Health Services: A Toolbook to Accompany the COPE® Handbook (2003)

COPE® for Maternal Health Services: A Process and Tools for Improving the Quality of Maternal Health Services (2001)

COPE® for Child Health: A Process and Tools for Improving the Quality of Child Health Services (draft, 1999)

COPE®: Client-Oriented, Provider-Efficient Services: A Process and Tools for Quality Improvement in Family Planning and Other Reproductive Health Services (1995)

Community COPE®: Building Partnerships with the Community to Improve Health Services (2002) (*Note:* This toolbook presents a variation on the COPE process.)
In addition, COPE tools have been adapted for use in *Quality Improvement for Emergency Obstetric Care: Leadership Manual and Toolbook* (2003).

The COPE process and tools draw on management theories and principles widely used in a range of fields, including health care. The most important QI principles on which COPE is based are the following:

- Meeting the needs and expectations of customers, both external (such as clients, donors, headquarters, and the Ministry of Health) and internal (such as other staff and other departments within the health care setting)
- Having all levels of staff become involved in and feel ownership of quality and of the process for improving quality
- Focusing on processes and systems, and recognizing that poor quality is often a function of weak systems, weak processes, inadequate organization of work, or implementation problems, rather than the fault of individuals
- Promoting efficiency and cost-consciousness by eliminating the costs of poor quality (e.g., repeat work and waste of time, effort, recourses, etc.)
- Enabling continuous staff learning, development, and capacity building, since staff need skills to carry out the QI process and provide quality services, and supervisors and team

leaders need to be able to facilitate the work of staff and the development of those skills (i.e., the COPE process helps to identify learning needs and provides participants with an opportunity to learn about international standards for MC services)

- Making QI work in an ongoing and continuous process

COPE enables staff to apply these principles in a range of service settings through the following four steps of the continuous QI process:

1. Information gathering and analysis
2. Action Plan development and prioritization
3. Implementation of the Action Plan
4. Follow-up and evaluation

Why Use COPE to Improve Quality?

- **COPE promotes teamwork and cooperation among all levels of staff**. By using the tools together, supervisors and all staff, including support staff, become accustomed to working as a team.
- **Self-assessment promotes a sense of ownership among staff**. When all levels of staff assess their own services, rather than having the services evaluated by outsiders, they feel that the problems they identify are theirs and they feel responsible for implementing the solutions they develop. This creates a sense of *ownership* and *commitment* to the solutions developed.
- **COPE relies on the wisdom of the experts**. The experts on the services in a particular setting are the *staff* who provide them and the *clients* who use them. COPE gives both staff and clients a chance to apply their expertise and insights toward improving services.
- **The tools are practical and relatively simple to use**. The COPE tools are directly related to what staff do in their daily work.
- **COPE boosts morale and provides a forum for staff and supervisors to exchange ideas**. Staff members who have used COPE have said, "I knew that we could improve services by doing that, but I never had the opportunity to talk to [the doctor-in-charge] before." By providing an opportunity to become involved in problem solving and decision making, COPE leads to increased staff morale.
- **COPE helps communicate service standards to staff and thereby improves performance**. The COPE Self-Assessment Guides are based on international and national service standards. Using the guides raises awareness of the importance of quality, what quality services are, and what is important to clients and staff.
- **COPE is cost-effective**. COPE is inexpensive to conduct. All that is needed are a few hours of a facilitator's time, time for staff to participate during regular working hours, flipchart paper, markers, and photocopies of the forms and Self-Assessment Guides needed for the exercises.
- **COPE is transferable and adaptable**. COPE has been used in a range of health care settings, from national referral hospitals to small clinics, in both private- and public-sector institutions, and in both very low-resource and very high-resource settings. COPE has also

been applied to many different health services, from family planning to maternal and child health services, to infection prevention practices, and to HIV prevention, care, and treatment services for all staff in a health care setting.

- **COPE helps facility managers work more effectively.** Although service managers may initially find introducing COPE and QI to be time-consuming, once staff become involved in solving day-to-day problems on their own, managers generally find that they have more time to focus on major problems.
- **COPE helps reduce costs associated with poor quality.** If something is not done correctly the first time, it must be fixed, often repeatedly. Moreover, the consequences may be serious, in terms of both cost and the health of individuals and the community. COPE helps reduce the cost of poor quality by assisting staff to identify and solve problems, focusing on processes and systems to prevent problems from occurring in the future.

Implementing COPE

A brief overview of the COPE process, including a description of each of these tools, is presented below. For a detailed explanation of the COPE process and of the use of each tool, please refer to the *COPE Handbook,* the reference and "how-to" manual that accompanies this toolbook.

Getting Started

Before conducting COPE, facilitators should read through the *COPE Handbook* in its entirety and become familiar with the process and the tools. The initial COPE exercise takes place over a period of two to three days. Follow-up exercises should be conducted every three to six months thereafter and take two or three days to complete, depending on whether the facility opts to perform a Client-Flow Analysis. (For an overview of the COPE process, see Figure 3, p. 8.) When conducting COPE for MC services, it is important to remember that, like other areas related to HIV and AIDS (keep in mind that many men will seek circumcision for prevention of HIV infection), MC services need to address potential stigmatization that often occurs in HIV services.

The Facilitator

When health care management decides to introduce COPE at a facility or in some other service setting for the first time, they should seek help from an experienced COPE facilitator. This is usually an external facilitator (from the Ministry of Health, a nongovernmental organization, or a technical assistance agency) who has been trained in COPE and has experience with implementing it. During the initial exercise and the first follow-up exercise, a staff member from the site receives on-the-job training to become a site facilitator. With the assistance of the external facilitator (if needed), the site facilitator will be responsible for organizing all subsequent COPE exercises at the site, together with the QI committee. The committee plays a key role in making QI an ongoing responsibility and the focus of the daily work of staff at all levels. If there is already a QI committee, the ongoing monitoring of COPE activities should be added to its responsibilities.

The Participants

Improving quality is the responsibility of all staff at a facility or in any other service setting; therefore, it is important that a broad range of staff participate in the COPE exercise. This includes manager(s), administrator(s), supervisor(s), service providers, nurses, medical assistants, counselors, health educators, laboratory staff, administration staff, receptionists, guards, cleaning staff, supplies staff, and other support staff, as well as staff from wards or departments that typically refer clients to the service setting. When a staff member is the sole representative from his or her department, it should be made clear that he or she is responsible for sharing information about quality with colleagues and for taking the lead in implementing quality changes together with co-workers.

Preparing for a COPE Exercise

Through site visits or correspondence, the external facilitator should use the time leading up to the initial COPE exercise to do the following:

- Build consensus with key managers, QI committee members, and other key staff about the importance of QI and about their support of and commitment to the QI process
- Discuss with the key staff the site's strengths
- Orient site managers and QI committee members to COPE and to their role in the COPE process
- Gather information about the site
- Instruct management on selecting staff participants and a potential site facilitator for follow-up COPE exercises
- Schedule the COPE exercise and discuss all logistics
- Inform and invite participants
- Prepare materials for the exercise

For follow-up COPE exercises, the external or site facilitator should schedule the exercise, prepare the materials, and help the administration select staff participants.

The Introductory Meeting

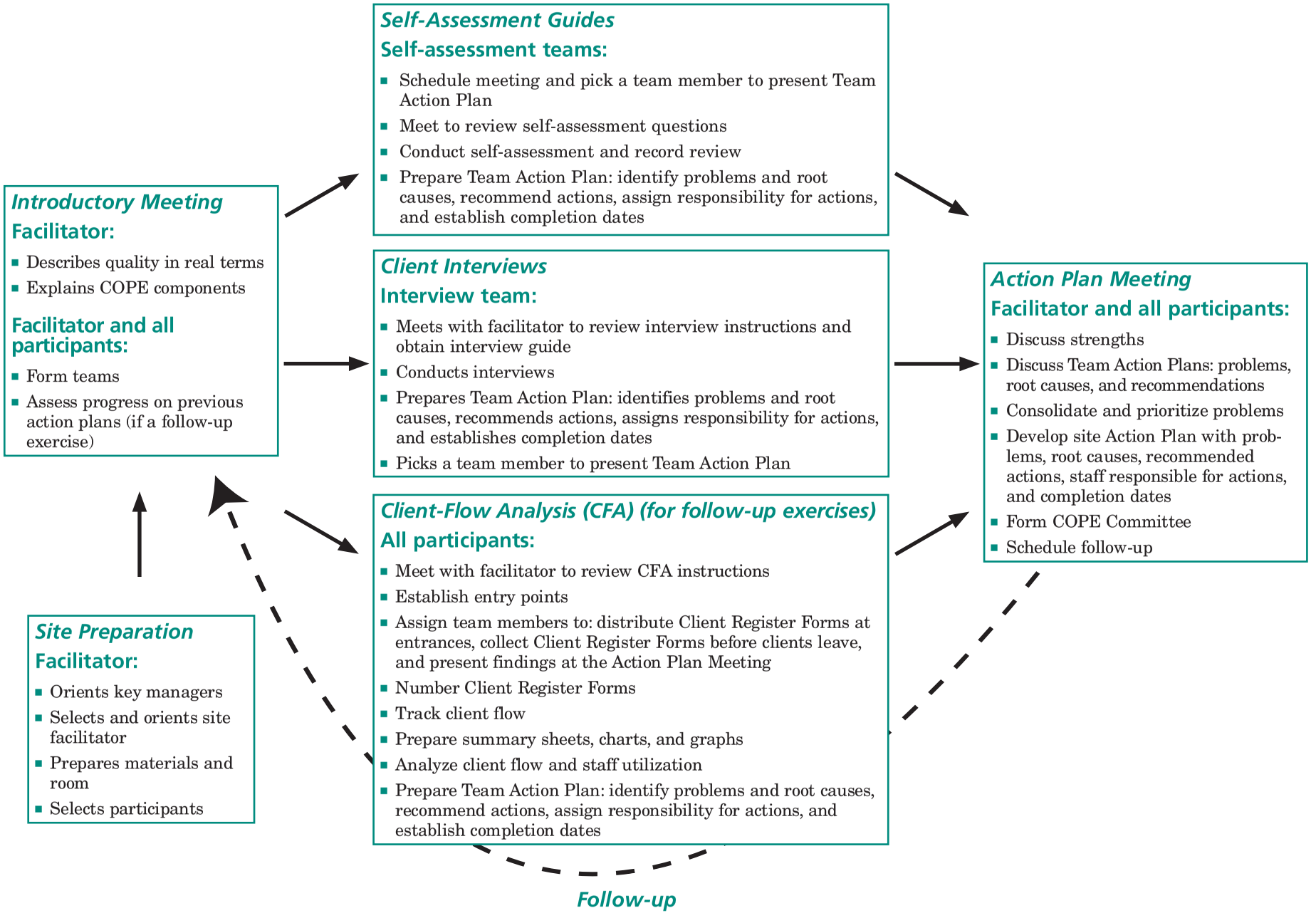
Each COPE exercise begins at an Introductory Meeting, during which the COPE facilitator explains the QI process, defines quality services, and explains the COPE process and tools to all participants. The facilitator and the participants then form teams to work with each of the COPE tools.

The Four COPE Tools

The COPE tools—practical and easy-to-use data collection and analysis forms—are designed to be *flexible*, so that each site can adapt them to meet its particular needs. The tools, described in detail below, include Self-Assessment Guides, a Client Interview Guide, forms needed to conduct a Client-Flow Analysis, and a form for the Action Plan.

- *Self-Assessment Guides.* The 10 COPE Self-Assessment Guides are organized on the framework of clients' rights and staff needs. Each guide consists of a series of yes-no questions related to the quality of MC services in the context of one of the clients' rights or staff needs identified as critical to high-quality care (see Figure 1, p. 8). "No" answers

Figure 3. COPE® at a Glance



point to a problem with quality, no matter how minor or major, that needs to be addressed. If COPE participants are unsure of an answer for any questions in the guides, they will need to do additional research in their health care setting during the COPE exercise so they can answer all of the questions. During the first COPE exercise, the facilitator and participants form teams, and each team is responsible for reviewing one or more of the 10 self-assessment guides. The team members review the questions during their normal workday and decide which questions reveal a problem they have observed or experienced at their site.

As part of an assessment of the client's right to safe services, some team members review client records. Depending on the size of the facility, the type of health care setting, and the number of staff reviewers, one or two team members use the Client Record-Review Checklist to review between 10 and 20 client records, to identify whether the information is complete. Staff reviewing client records must keep confidential all information obtained from these records.

After going through the self-assessment questions individually or as a team, the team members meet to discuss the problems they identified, determine their root causes, and recommend solutions, including who will organize implementation of the recommendations and when. They record their findings in a Team Action Plan, for discussion at the Action Plan Meeting. The Action Plan Meeting provides an opportunity for staff and managers to review all of the problems and actions identified by the various teams based on the guides and create one consolidated action plan. A more detailed description of how to conduct the self-assessments and client record reviews can be found in the *COPE Handbook* (p. 38).

- *Client Interview Guides.* Although the number of interviews may vary, generally three to five COPE participants volunteer to conduct a total of approximately 15 interviews (i.e., three to five interviews per volunteer). The client interview team conducts informal individual interviews with MC clients who have completed their clinic visit, using the client interview form as a guide. The open-ended questions in the guide encourage clients to discuss their opinions about services received, what was good or bad about the visit, and how the quality of the services could be improved. Verbal informed consent is to be obtained from the clients prior to the interviews. Clients are to be informed that all information obtained from the interviews will be kept confidential. The interviewers record the clients' responses, meet with other team members to discuss their findings, and develop a draft Team Action Plan, which they present at the Action Plan Meeting. A more detailed description of how to conduct the client interviews can be found in the *COPE Handbook* (p. 39).
- *Client-Flow Analysis (CFA)*. The purpose of the CFA is to identify the amount of time that each client spends at the facility—waiting for services and in direct contact with a staff member—and thereby identify bottlenecks in services. The CFA also provides information to assess ways in which staff are utilized. CFA team members track the flow of each MC client who enters the facility during a specified time period—for example, from 8 a.m. to noon or from 8 a.m. to 4 p.m. The Client Register Form is used to track clients from the time they enter the clinic until the time they leave, by recording each contact they have with a provider and its duration. One or two team members then complete the Client-Flow Chart and the Client-Flow Chart Summary. They then chart, graph, and analyze the data, discuss the findings, and record them as a Team Action Plan for presentation at the Action Plan Meeting. EngenderHealth recommends that sites not perform CFA at the first COPE exercise. A more detailed description of how to conduct the CFA can be found in the *COPE Handbook* (p. 74).

- *Action Plan.* When COPE participants have completed the self-assessment, the client interviews, and the CFA (if performed), they convene at the Action Plan Meeting to discuss the site strengths, problems identified, and teams' recommendations, and to prioritize the problems and consolidate the findings into a site Action Plan. By following the steps in recording their findings in the Action Plan, staff are able to develop clear problem statements, analyze the root causes of problems, develop solutions, identify staff members who will be responsible for organizing the implementation of the solution, and set a completion date for each recommendation. The staff also select the COPE (or QI) committee members and agree on the dates for the follow-up COPE exercise. A more detailed description of how to develop an Action Plan can be found in the *COPE Handbook* (p. 40).

COPE Committee

If no COPE or QI committee exists at the site, the staff should establish one. This committee ensures that the Action Plan is accessible to all staff, follows up on progress in implementing the COPE Action Plan, provides support to staff members responsible for implementation and to COPE facilitators (as needed or requested), schedules subsequent COPE exercises, informs staff about COPE activities (as needed or requested), and helps to monitor results and inform staff on the status of implementation. The committee members are selected (usually staff members volunteer) before the conclusion of the Action Plan Meeting.

COPE Follow-Up

Once the initial COPE exercise is completed, the facilitator and staff agree on a date for a follow-up exercise. At the follow-up exercise, the participants will reconvene and use the Action Plan Follow-Up Form to assess their progress in solving the problems in the Action Plan from the previous exercise. CFA may be conducted at the follow-up exercise, particularly if client waiting time or staff utilization were identified as a problem at the initial exercise. In addition, staff may wish to repeat one or more of the other tools during the follow-up exercise—for example, to use certain Self-Assessment Guides. It is not necessary to use all 10 Self-Assessment Guides during the follow-up exercise, but staff should *always* conduct client interviews as part of all COPE exercises.

COPE exercises should be conducted every three to six months to follow up on the previous site Action Plan and to identify new issues that need to be addressed. A more detailed description of COPE follow-up can be found in the *COPE Handbook* (p. 55).

COPE for Male Circumcision Services

The COPE tools for MC offer a structured approach for assessing the unique considerations inherent in the delivery of MC services, regardless of the service setting, whether the services are provided through a health facility or through mobile outreach teams. Men can be extremely sensitive to and wary of procedures that involve their genitals. MC can be culturally sensitive; for example, in some communities, MC is a rite of passage, usually from adolescence to young adulthood. MC can also be related to cultural identity (since some cultural groups traditionally circumcise and others do not). To ensure success, those who provide MC services must be extremely sensitive to clients' rights and needs for informed decision making, confidentiality, privacy, and nonjudgmental counseling. Furthermore, health workers must have the proper training, support, and supplies to provide services (including prevention counseling and HIV testing) safely, in ways that make clients feel comfortable.

They must also be able to make appropriate referrals for prevention, treatment, care, and support, as necessary.

MC, defined as the surgical removal of all or part of the foreskin (also known as the prepuce) of the penis, is one of the oldest and most common surgical procedures around the world. It has been carried out for centuries for religious, cultural, social, and medical reasons. MC is associated with a variety of health benefits, including the following:

- Circumcision reduces female-to-male transmission of HIV (Krieger et al., 2005; Weiss et al., 2000; Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007).
- Circumcised men do not suffer health problems associated with the foreskin, such as inflammation of the glans (balanitis) and the foreskin (posthitis), phimosis (an inability to retract the foreskin), or paraphimosis (swelling of the retracted foreskin so that it is unable to return it to its normal position).
- Circumcised men find it easier to keep the penis clean.
- Circumcised men have fewer sexually transmitted infections, in particular ulcerative diseases like chancroid and syphilis (Cook, Koutsky, & Holmes, 1994; Nasio et al., 1996).
- Circumcision is associated with a lower risk of penile cancer (American Academy of Pediatrics, 1989: Dodge & Kaviti, 1965).
- Female sexual partners of circumcised men have a lower risk of cervical cancer (Agarwal et al., 1993).
- Circumcision lowers rates of urinary tract infections in male infants (Wiswell & Hachey, 1993).

As with any surgical procedure, there are risks associated with circumcision. Risks have been found to be as low as one in 50 in circumcision trials and in areas where the surgery is performed by well-trained, adequately equipped, experienced personnel. Adverse events that can occur include:

- Pain
- Bleeding
- Blood clot formation, causing swelling of the penis (hematoma)
- Infection at the site of the circumcision
- Irritation of the glans
- Oversensitivity of the glans penis for the first few months after the operation. (Using a condom helps to alleviate this problem and is important to reduce the risk of acquiring HIV even further.)
- Increased risk of meatitis (inflammation of the opening of the penis)
- Risk of injury to the penis
- Adverse reaction to the anesthetic used during the circumcision procedure
- Difficulty urinating

For nearly two decades, it was suggested that MC was associated with a reduction in HIV infections (Cameron et al., 1989). For example, circumcised men seemed to be at lower risk of HIV infection (Weiss et al., 2000). In addition, HIV prevalence in a given country, geographic

location, or ethnic group appears to be related to the level of MC, with higher HIV rates found in areas or populations with fewer circumcised men (Auvert et al., 2001; WHO, UNAIDS, & JHPIEGO, 2007). This suspected relationship between MC and HIV was conclusively revealed in three large, well-conducted scientific studies, all showing MC to be extremely effective in protecting men from acquiring HIV infection, reducing their risk by 60% (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007).

Women have an important stake in the effort to promote and provide MC for HIV prevention. It is not known whether having a circumcised partner directly reduces women's risk of acquiring HIV (Wawer et al., 2009; Baeten et al., 2010). But the protection that the procedure affords men could dramatically reduce women's chances of becoming infected with HIV, by limiting their exposure to the virus. MC has other important health benefits for women. Studies have found that the female partners of circumcised men contract fewer STIs, including bacterial vaginosis, chlamydia, genital ulcer disease, and human papillomavirus, as well as having a lower risk of cervical cancer (Gray et.al., 2009). However, MC does not provide 100% protection against HIV infection, and HIV-negative circumcised men can still become infected with the virus. Furthermore, circumcision does not reduce the chances of an HIV-positive man's infecting his sexual partners.

MC should never replace other effective prevention methods and should be part of a comprehensive prevention package that includes HCT services, screening and treatment for STIs, the promotion of safer sex practices, and the provision of male and female condoms, along with promotion of their correct and consistent use. Proper and effective counseling and education on HIV and MC is especially critical to prevent men from developing a false sense of security and engaging in high-risk behaviors that could undermine the partial protection that MC provides.

MC provides a unique opportunity to address other heath needs of men and their partners in addition to HIV prevention. MC services should be viewed as an entry point for education on sexual and other health issues. As part of MC services, providers should take the opportunity to promote responsible male sexual behavior, educate men on the critical role they can play in ensuring the health of their families and communities, and encourage them to take greater responsibility for preventing HIV transmission, including promoting positive gender norms and practices. Providers should ensure that men understand that MC provides no protection against pregnancy and offer counseling and information on the available family planning options that they or their partner can use to reduce the risk of unwanted pregnancy, including information on where family planning services are available. Providers also need to give information about circumcision to parents or guardians who are providing adult consent for minors, so they can give informed consent. The information should be given verbally, in addition to the printed information that the parents/guardians take home.

No clinical trials have tested whether circumcision reduces HIV risk among men who have sex with men (MSM), and observational studies have yielded mixed results. A recent prospective observational study of MSM in South Africa suggests that lack of circumcision is associated with an increased risk for HIV acquisition among insertive partners (Lane et al., 2010). However, other studies among MSM either have found no reduced risk associated with circumcision, either overall or among insertive partners (Millet et al., 2007), or have shown no reduced overall risk but a reduction in HIV incidence among insertive partners (Templeton et al., 2007).

Based on the current available evidence, MC is not recommended for HIV-positive men as an intervention to reduce HIV transmission to women, as it is not known whether having a circumcised partner directly reduces women's risk of acquiring HIV. If medically indicated, MC should be provided to all men irrespective of HIV status. If male circumcision is requested by an HIV-positive man, following in-depth counseling on the known risks and benefits, it should not be withheld unless it is medically contraindicated. Providers should be sure to address the care and treatment needs of men who test HIV-positive during HCT offered as part of MC services. MC services should link with other health and social programs and services available in the local community, so that effective referrals can be provided, as appropriate, to those being circumcised.

The global scale-up of the response to the HIV epidemic, in this case in relation to MC for HIV prevention, must be grounded in sound public health practices and in the respect, protection, and fulfillment of human rights norms and standards. The voluntariness of prevention approaches such as MC must remain at the heart of all HIV policies and programs, both to comply with human rights principles and to ensure sustained public health benefits.

In their most recent guidance on HCT, WHO and UNAIDS recommend that in countries with generalized HIV epidemics (i.e., countries in which HIV is firmly established in the general population), HCT should be recommended to all clients attending all health care facilities (WHO and UNAIDS, 2007b). Although men should be encouraged to be tested for HIV in conjunction with getting circumcised, getting tested for HIV should never be made a requirement or prerequisite for MC. The conditions under which men undergo HCT in relation to MC must be anchored in an approach that protects their human rights and pays due respect to ethical principles, including the following:

- Services remain ***confidential***.
- Testing is accompanied by ***counseling*.**
- Services are conducted only with informed ***consent***, meaning that the decision is both informed and voluntary.

In resource-constrained settings, there are clear advantages to using standardized and simplified evidence-based guidelines when attempting to scale up any new health care service while preserving quality. The COPE tools for MC services are intended to support national or WHO guidelines for the proper management and scale-up of MC in a standardized and simplified way to support efficient implementation and to ensure that programs are based on the best scientific evidence.

While not all men seeking MC services will do so with an HIV prevention perspective in mind, in many settings most men will, and as with other areas related to HIV and AIDS, the issues raised by MC for HIV prevention are highly sensitive and include the potential for stigmatization of men who undergo the surgery. Thus, site staff and external facilitators participating in COPE exercises (including service providers who will conduct client interviews) must be oriented to the sensitive nature of the topics to be discussed at different stages of the process and to the need to ensure confidentiality throughout the process. Everyone should sign a pledge of confidentiality at the beginning of the exercise (see copy of the pledge in the appendix to this guide, p. 91). Through the informed consent process, facilitators and staff must ensure that confidentiality is maintained for all individuals involved in the COPE process.

Self-Assessment Guides for Male Circumcision Services

Clients' Right to Information

Clients have a right to accurate, appropriate, understandable, unambiguous, unbiased, and nonjudgmental information related to prevention of HIV transmission, to sexuality, and to health overall. In male circumcision (MC) services, clients have a right to accurate information about HIV transmission and prevention, about MC as a strategy to prevent HIV transmission, about the extent of protection MC provides, and about HIV testing. MC educational activities, information, and materials for clients need to be available in all parts of the health care service setting.

The group working on this guide should include staff who usually provide health education and counseling and HIV testing services, as well as staff who give clients information on the services available in your health care setting. At least one member of the clinical staff should participate in this group.

If any of the following questions reveal a problem in your health care setting, or if you think any of the questions need to be discussed further, write your comments on a flipchart in the following format:

Problem	Cause(s)	Recommendations	By Whom	By When

If you are aware of a problem in your health care setting that is not addressed here, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. Can all staff—including guards, cleaners, and other support staff—inform clients about the following topics?
   - Where and when MC services, including HIV counseling and testing (HCT), are available in your health care setting
   - At what times services are available
   - Which services not available in your health care setting are available by referral to another setting, where this other service setting is located, and how clients can get there
   - How much services cost

2. Are signs in the local languages showing the following information about MC services prominently displayed throughout your service setting (without making clients feel stigmatized)?
   - Place
   - Days
   - Times
   - Costs

3. Does your service setting conduct HIV and MC educational activities for clients seeking other health care services?

4. Do health talks or individual counseling sessions cover the following topics?
   - HIV transmission
   - HIV prevention
   - What MC is and what the procedure involves, including potential risks and benefits (including, ideally, photographs to show men what a circumcised penis looks like)
   - That MC reduces risk of HIV transmission by up to 60%
   - That MC alone does not completely protect a client from contracting HIV, including information about other HIV prevention strategies that can be used
   - The availability of confidential HIV testing for MC clients and the importance of being tested at the time of MC
   - Signs and symptoms of sexually transmitted infections (STIs) in both men and women and STIs' role in promoting the spread of HIV
   - Information about referrals for HIV care, treatment, and support services (if available)
   - Where applicable, how to reduce the risk of HIV transmission among injecting drug users (IDUs)
   - That MC does not prevent HIV transmission resulting from injections or skin punctures
   - How to use male condoms correctly, through age-appropriate demonstrations for men, that use a penis or vagina model and that ask the client to repeat the condom demonstration to confirm his understanding
   - Information about how to reduce condom error and avoid condom failure or breakage

5. Do the staff at your MC setting routinely inform clients on the availability of HCT, MC, and other HIV- and AIDS-related services?

6. Do staff always explain to men the following types of examinations or procedures that will be done in relation to MC, what to expect, and why the examinations or procedures are needed?
   - Reproductive health education
   - HCT
   - Informed consent for surgery
   - Medical history
   - Physical examination to assess for contraindications to MC (e.g., anatomical abnormality, genital ulcer disease, urethral discharge, etc.)
   - Surgical procedure, including preparation for the surgery, anesthesia, and description of method used (e.g., dorsal slit, forceps guided, or sleeve resection method)
   - Postoperative and intraoperative care and management of complications, including wound care and follow-up visits
   - Referral to other specialized services based on the needs of the client (e.g., care and treatment for HIV-positive men, STI treatment, etc.)

7. Are educational aids on MC, HIV, HCT, and related topics, such as pamphlets, posters, anatomical models, and condom samples, available?

8. Are information messages tailored for the special needs of such clients as young men and boys, IDUs, men who have sex with men, and men living with HIV? If staff are working with confined populations (e.g., displaced persons, prisoners, or military personnel), are topics tailored to their special needs?

9. Do the staff in your health care setting organize outreach activities to educate the community, both men and women, about other benefits of MC, including improved hygiene, reduced risk of urinary tract infection in childhood, reduced risk of some STIs, some protection against cancer of the penis and cervix, and prevention of several other medical problems of the penis and the foreskin?

10. Does your facility or service setting provide information to clients on the safety, risks, and benefits of MC (see p. 11) and the advantages of MC services provided at a health care facility as compared with traditional MC?

11. Do staff explain information clearly using appropriate, nontechnical, local language that clients can understand (e.g., terms for sexual practices and anatomical parts such as prepuce, glans penis, etc.)?

12. Does your health care setting have a functioning referral system for MC services if MC procedures cannot be provided there?

13. Do the staff in your health care setting inform clients of the availability of other sexual and reproductive health services?

Other Issues That You Think Are Important:

14. _____

15. _____

16. _____

Clients' Right to Access to Services

Clients have a right to services that are affordable, are available at convenient times and places, are fully accessible without physical barriers, and have no inappropriate eligibility requirements that discriminate based on age, marital status, nationality or ethnicity, social class, religion, or occupation. Clients have a right to access male circumcision (MC) services without fear of discrimination and stigmatization.

> The group working on this guide should include clinicians, support staff providing health education and counseling, a receptionist or guard, and a representative of management.

If any of the following questions reveal a problem in your health care setting, or if you think any of the questions need to be discussed further, write your comments on a flipchart in the following format:

Problem	Cause(s)	Recommendations	By Whom	By When

If you are aware of a problem in your health care setting that is not addressed here, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. Does your facility or other health care setting provide MC services to clients regardless of their age, HIV status, ethnicity, nationality, race, gender, religion, socioeconomic status, level of education, or occupation?

2. Do staff reduce barriers to accessing MC services to the greatest extent possible and within the local culture and laws (e.g., by removing stigma associated with circumcision in a noncircumcising community, addressing issues around men's discomfort when MC services are provided by a female provider, etc.)?

3. Are MC services available during hours convenient for most clients, including working clients?

4. Is the schedule of when MC services are offered posted and accessible to clients?

5. When the services are not available in your health care setting, do staff refer clients to the nearest facility where they can access MC services?

6. Does your health care setting have adequate trained staff for coverage of MC services at its busiest times?

7. Does the staff routinely do HIV counseling and testing for MC clients and provide the necessary HIV treatment and follow-up for those who test positive (or provide appropriate referrals for services not available in your setting)?

8. Do all clients who get tested for HIV as part of MC services receive both pretest and post-test counseling, regardless of whether the results are negative or positive?

9. Does your health care setting have the necessary equipment and adequate supplies of consumables for provision of MC services?

   Note: General equipment required for MC includes:

   - Examination couch
   - Autoclave
   - Counseling table and chairs
   - Recovery beds
   - Emergency trolley with medications for managing anaphylactic reactions
   - Theater lamp
   - Head lamp, in case of power blackout or where there is no electricity
   - Surgical gloves (4)
   - Alcohol hand rub
   - Antiseptic soap for hand washing
   - Surgical gowns
   - Biohazard bags

   In addition, protective equipment required where MC procedures take place includes:

   - Surgical gloves
   - Face masks
   - Eyewear (goggles/face shields)
   - Footwear
   - Aprons

   Surgical instruments required for one adult MC[1] include:

   - Instrument tray wrapped with sterile drape (1)
   - Sponge-holding forceps (2)
   - Bard-Parker (BP) scalpel knife handles and blades (1 small and 1 large)
   - Dissecting forceps (1 toothed and 1 nontoothed)
   - Artery forceps (4 straight, 4 curved)
   - Mayo's straight forceps (1)
   - Curved McIndoe's scissors (1)
   - Stitch scissors (1)
   - Mayo's needle holders (2)
   - Towel clips (5)
   - Drapes (2 large, 2 small, and one "O" drape)
   - Gallipot for antiseptic solution (e.g., povidone iodine)
   - Plain gauze swabs
   - Cotton wool swabs in Gallipot
   - Safety pin

   Finally, disposable consumables required for one adult MC include:

   - Disposable scalpel (1)
   - "O" drape (80×80 cm drape with ~5 cm diameter hole)
   - Povidone iodine (50 ml 10% solution)

1 The instruments required vary, depending on the MC technique used (e.g., dorsal slit, sleeve method, forceps guided, etc.).

- Plain gauze swabs (10 10×10 cm for procedure, 5 10×10 cm for dressing)
- Petroleum jelly–impregnated gauze (5×5 cm or 5×10 cm) ("tulle gras") and sticking plaster
- 15 ml 1% or 2% plain lidocaine (without adrenaline) anesthetic solution in single-use syringe with 21-gauge needle
- 18" chromic gut 4-0 sutures with 13 mm to 19 mm 3/8 circle reverse-cutting needle
- Sterile marker pen
- Condoms (both male and female)

10. Do health care staff do each of the following?
    - Inform the client or parents/guardians of minor children about the procedure and what is involved, including potential risks (e.g., pain, swelling, bleeding, infection, etc.)
    - Explain that the procedure will be done under local anesthesia and that the client will be free to talk with the providers during the procedure
    - Provide services to all clients or parents/guardians of minor children free of stigma and discrimination (i.e., they do not judge clients, deny full quality care, or refuse to provide service)
    - Actively encourage clients or parents/guardians of minor children to talk and ask questions
    - Listen attentively and respectfully to clients or parents/guardians of minor children and respond to their questions
    - Discuss clients' HIV prevention needs and concerns
    - Assist clients or parents/guardians of minor children in making an informed decision about MC
    - Ask clients or parents/guardians of minor children whether the information was explained clearly and what further questions or suggestions they might have

11. Does your health care setting have a mechanism for identifying and contacting clients who do not return for necessary follow-up after provision of MC services?

12. Are health care providers readily available for clients when there is a complication or when they come back with some health concerns about their circumcision? (See p. 11 for examples of possible postoperative or intraoperative complications.)

13. Is your health care setting engaged in efforts to reduce HIV-related stigma and discrimination, both internally and in the surrounding community, to help reduce potential barriers to HIV services, including MC?

14. Before ending any client visit, do staff ask clients if they need any other services?

15. Do the staff in your health care setting routinely book clients for follow-up after the MC procedure?

16. Do all staff, including the guards, know where and when the MC services are available in your health care setting?

Other Issues That You Think Are Important:

17. _____

18. _____

19. _____

Clients' Right to Informed Choice

Clients have a right to make a voluntary, well-considered decision that is based on available options; accurate, unbiased information; and a thorough understanding of the impact of their decision. The process of informed decision making is a continuum that begins in the community, where people obtain information prior to coming to a facility or some other setting for services. It is the service provider's responsibility either to confirm that a client has made an informed choice regarding male circumcision (MC) services by asking specific questions of him**,** or to help a client reach an informed choice by giving him full, current, and objective information. It is the provider's responsibility to explain the details of MC services, including the procedure, the benefits, potential risks, timing of the procedure, and the care after the procedure. In addition, the provider should ensure that prospective MC clients understand that there are other strategies for prevention of HIV and that MC does not provide complete protection against HIV infection

The group working on this guide should include clinicians and other staff who provide information, counseling, or services.

If any of the following questions reveal a problem in your health care setting, or if you think any of the questions need to be discussed further, write your comments on a flipchart in the following format:

Problem	Cause(s)	Recommendations	By Whom	By When

If you are aware of a problem in your health care setting that is not addressed here, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. Are clients or parents/guardians of minors encouraged to make a free and informed choice regarding MC services as a strategy for prevention of HIV infection, without coercion or judgment?

2. Are MC clients or parents/guardians of minor children fully informed of the benefits and risks associated with MC services (see p. 11)?

3. Are clients or parents/guardians of minor children informed that MC alone is not enough to prevent the client from getting HIV and that there are other strategies to prevent HIV infection?

4. Are clients or parents/guardians of minor children given information about all other strategies for prevention of HIV infection (e.g., postponing early sexual debut, abstaining from sex, remaining faithful to one partner, using condoms consistently and correctly, etc.)?

5. Are clients or parents/guardians of minor children told about the availability of counseling and testing for HIV infection, in accordance with your facility's/country's/ Ministry of Health's guidelines for HIV testing in MC services?

6. Are MC clients or parents/guardians of minor children freely allowed to decide if and when they want to have the MC procedure?

7. Are MC clients or parents/guardians of minor children allowed to freely decide whether to have MC procedure performed in your health care setting or to be referred to a service provider of their choice?

8. Are MC clients given information about other sexual and reproductive health services, including use of male or female condoms, how to negotiate the use of condoms during coitus, prevention and treatment of other sexually transmitted infections (STIs), family planning services, etc.?

9. Are clients assisted in assessing their risk for acquiring HIV and other STIs, as well as transmitting HIV and other STIs to their sexual partners, including how to reduce their risk and prevent transmission?

10. Do health care staff do each of the following?
    - Inform the client or parents/guardians of minor children about the procedure and what is involved, including potential risks (e.g., pain, swelling, bleeding, infection, etc.)
    - Explain that the procedure will be done under local anesthesia and that the client will be free to talk with the providers during the procedure
    - Provide services to all clients or parents/guardians of minor children free of stigma and discrimination (i.e., they do not judge clients, deny full quality care, or refuse to provide service)
    - Actively encourage clients or parents/guardians of minor children to talk and ask questions
    - Listen attentively and respectfully to clients or parents/guardians of minor children and respond to their questions
    - Discuss clients' HIV prevention needs and concerns
    - Assist clients or parents/guardians of minor children to make an informed decision about MC
    - Ask clients or parents/guardians of minor children whether the information was explained clearly and what further questions or suggestions they might have

11. Do providers discuss the possibility of involving partners and family members in clients' decision making, when appropriate?

12. Are mechanisms in place to ensure written informed consent for the MC procedure?

13. Are all consent forms signed by clients kept as part of their medical records in cases in which informed consent is required according to national guidelines?

14. Before beginning the MC procedure, do staff reconfirm that clients want to proceed?

Other Issues That You Think Are Important:

15. _____

16. _____

17. _____

Clients' Right to Safe Services

All clients, including individuals receiving male circumcision (MC) services, have a right to safe services, which require skilled and knowledgeable providers, attention to infection prevention (i.e., universal precautions, including safe injection practices), and appropriate and effective medical and surgical practices. Safe services also mean proper use of service delivery guidelines, quality assurance mechanisms within your health care setting, counseling and instructions for clients, complete client records, and recognition and management of complications related to the provision of drugs and performance of medical procedures.

Note: While some of these issues are covered in other Self-Assessment Guides, this guide emphasizes the behavior of staff in ensuring client safety.

Depending on the services available in your health care setting, the group working on this guide should include clinical staff from the following departments: HIV and sexually transmitted infections (STIs), infectious diseases, pharmacy, laboratory, general outpatient services, men's services, and operating theater. This group should also include representatives from the following categories of staff: clinician, nurse, technical or medical assistant, housekeeper or cleaner, and administrator or manager.

If any of the following questions reveal a problem in your health care setting, or if you think any of the questions need to be discussed further, write your comments on a flipchart in the following format:

Problem	Cause(s)	Recommendations	By Whom	By When

If you are aware of a problem in your health care setting that is not addressed here, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. Do clinical staff in your health care setting follow current written national or World Health Organization (WHO) guidelines for MC for prevention of HIV infection?

2. Before MC, do clinical staff explain to the MC client potential risks and possible complications that can develop during and after the MC procedure (see p. 11)?

3. Do clinical staff explain to the client what to do after he has left your facility or other service setting, if he has a problem that requires urgent intervention?

4. Do clinical staff wash their hands before and after examination of the clients, as well as after performing a procedure?

5. Do clinical staff use povidone antiseptic solution or any other appropriate antiseptic solution when preparing the skin before MC?

6. Do clinical staff drape the clients with sterile drapes before the MC procedure is performed?

7. Do the clinical staff ensure that 1% lignocaine (Lidocaine) local anesthetic is used during MC?

8. Do the clinical staff know how to prepare 1% lignocaine from other preparations of lignocaine—for example, from 2% lignocaine?

9. Are trained providers available 24 hours a day throughout the week to handle any emergency condition arising from MC procedures?

   Note: Clients should return to the facility or contact health care staff if:

   - They notice increased bleeding from the surgical wound.
   - The pain or swelling at the surgical wound gets progressively worse.
   - They have difficulty in passing urine.
   - They develop a fever within one week of surgery.
   - They have severe pain in the lower abdomen.
   - The wound is discharging pus.

10. Does your health care setting have any emergency resuscitation equipment, such as Ambu bags, oxygen cylinders, oxygen flow meters, airways, and laryngoscopes?

11. Does your procedure room have an emergency tray with all necessary emergency resuscitation drugs, including intravenous fluids?

12. Can clinical staff at the outpatient department, emergency room, or wards perform cardiopulmonary resuscitation (CPR), including conducting artificial ventilation?

13. If a client who presents with a complication that cannot be treated at your health care setting (e.g., worsening wound infection with signs of gangrene, large hematoma, etc.), is there a referral system to a facility or some other service setting where such clients can be treated?

14. Do staff consistently and accurately document in the clients' records/charts what information has been given to clients, what they have found, and what they have done during the MC procedure, including the amount of anesthetics used?

15. Are all staff in your health care setting trained in infection prevention and control?

16. Are there staff deployed to process surgical instruments? Does the process include the sterilization and packaging of sterile instruments and supplies to make them ready for use during surgical procedures?

17. Are there waste disposal bins with bin linings in all the departments, including the designated area for MC?

18. Are disposable needles and syringes and other sharp objects discarded in a puncture-resistant container (i.e., a "sharps container") after a single use?

19. Are reusable instruments and other items used in clinical procedures decontaminated in a 0.5% chlorine solution for 10 minutes before further processing?

20. After decontamination, are instruments and other items rinsed in clean water, then cleaned with detergent and water using a brush, and finally rinsed in clean water again?

21. Are instruments cleaned in a designated receptacle (e.g., a sink or bucket) separate from where handwashing is done?

22. Are instruments and other items sterilized or high-level disinfected before use?

23. Are all sterilized or high-level disinfected items stored dry and in a way that prevents contamination?

24. Do staff wear heavy-duty utility gloves when required, according to infection prevention guidelines?

25. Do staff wear plastic or any other protective apron or gowns and goggles during a procedure that could involve exposing them to blood or other body fluids (e.g., MC surgery) and when cleaning used instruments?

26. Are surfaces (such as examination and operating tables) wiped with a 0.5% chlorine solution after each procedure?

27. Is medical waste handled safely and disposed of by burning or burying in a safe location, according to the national infection prevention guidelines and standard procedures in your service setting?

Other Issues That You Think Are Important:

28. _____

29. _____

30. _____

Clients' Right to Privacy and Confidentiality

Clients have a right to privacy and confidentiality. This includes visual and auditory privacy and confidentiality during counseling, physical examinations, and clinical procedures, as well as in the staff's handling of clients' medical records and other personal information. Ensuring the confidentiality of services is especially important at sites offering male circumcision (MC) services (including MC counseling and the procedure), because a breach of this confidentiality may lead to stigma, discrimination, and even violence against clients. Guaranteeing confidentiality creates a foundation of trust between providers and clients. Only when clients trust their provider not to disclose sensitive, personal information will they be able to share information that may be critical to providing optimal care.

> The group working on this guide should include staff who provide information or services and those who are responsible for or handle client records, including receptionists, data management personnel, gatekeepers, and guards.

If any of the following questions reveal a problem in your health care setting, or if you think any questions need to be discussed further, write your comments on a flipchart in the following format:

Problem	Cause(s)	Recommendations	By Whom	By When

If you are aware of a problem in your health care setting that is not addressed here, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. Are all services offered in a manner that is respectful, confidential, and private?

2. Does your health care setting have written policies and procedures in place to protect clients' confidentiality?
   - Are all staff aware of these policies?
   - Do they follow them?

3. Do staff sign an oath of confidentiality when they are hired?

4. Where possible, does your health care setting have a process for maintaining the confidentiality of the client's reason for the visit?

5. Are service site managers available to speak with clients should they feel that their confidentiality has been breached?

6. When counseling clients, do service providers remind clients that all services (including counseling sessions and test results) will be kept confidential?

7. Does your health care setting have private space available where clients' physical examinations, MC procedure, and counseling sessions cannot be observed or overheard by others?

8. Do staff take measures to ensure that private counseling sessions and MC procedures are not interrupted by other staff members?

9. When a third party is present during a counseling session, an examination, or MC procedure, do staff explain the person's presence and ask the client's permission for that person to be present?

10. Is the option of anonymous HIV testing available in your health care setting? (Anonymous testing refers to conducting HIV tests when staff have no way of determining clients' names or identities.) If anonymous HIV testing is not available at your service setting, is it available through referral?

11. Is the procedure for giving HIV test results to clients identical whether the test is negative or positive, so as to not indirectly reveal positive test results to other staff and clients?

12. Does your health care setting use a coding system for clients' records to protect client privacy?

13. Are clients' records, including all lab test results, kept in a secure location, with access strictly limited to authorized staff?

14. Does your health care setting use a system to ensure that clients do not have access to other clients' records or test results?

15. Do staff explore with clients the implications of disclosing or not disclosing their HIV status to their partners?

16. Do staff explore with clients the implications of disclosing or not disclosing their HIV status to their family members or friends?

17. If national guidelines mandate partner notification, do providers consult with clients before informing their partners?

18. Do staff respect the decision of clients to not tell family members or partners about their HIV status?

19. Do staff inform clients that their HIV test results may be shared with other staff, to offer the best possible care to the client?

20. Does your health care setting have a mechanism in place for contacting clients who test HIV-positive and who do not return for follow-up services that does not violate their privacy and confidentiality?

21. For clients who test HIV-positive and wish to have a circumcision, does your service setting have a mechanism in place for providing the MC without violating the client's privacy and confidentiality?

22. Do providers discuss client care with other staff only when necessary?

23. When site staff are discussing a client's care (including the client's HIV status) with other staff members, do they respect confidentiality by speaking in a private space so that other staff members and clients cannot overhear the conversation?

Other Issues That You Think Are Important:

24. _____

25. _____

26. _____

Clients' Right to Dignity, Comfort, and Expression of Opinion

All clients have the right to be treated with respect and consideration. Providers of male circumcision (MC) services need to ensure that clients are as comfortable as possible during counseling, tests, treatment, and procedures. Clients should be encouraged to express their views freely, even when their views differ from those of service providers.

The group working on this guide should include a range of staff involved in providing care, including service providers, counselors, receptionists, gatekeepers, and guards.

If any of the following questions reveal a problem in your health care setting, or if you think any questions need to be discussed further, write your comments on a flipchart in the following format:

Problem	Cause(s)	Recommendations	By Whom	By When

If you are aware of a problem in your health care setting that is not addressed here, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. Do staff welcome and respectfully address clients and all persons who accompany them to your health care setting?

2. Do all staff (including guards, receptionists, medical staff, administrative support staff, laboratory staff, and pharmacy staff) treat all clients with kindness, courtesy, attentiveness, and respect for their dignity and without stigma and discrimination, regardless of the clients', ethnicity, race, gender, sexual orientation, HIV status, marital status, drug and alcohol use, occupation, religion, socioeconomic level, or level of education?

3. Do clients have an opportunity to suggest what your service setting can do to provide higher-quality services (e.g., through client suggestion boxes, client satisfaction surveys, or client interviews)?

4. Do staff respect clients' opinions, even when these opinions differ from their own?

5. If staff discuss a client's care in the presence of that client, is he encouraged to participate in the discussions?

6. If clients want to involve their partners or family members in discussions about MC services, do staff facilitate this? Similarly, if clients do *not* want partners or family members involved in these discussions, do staff comply with their wishes?

7. Do staff perform physical examinations, counseling, testing, and MC procedures with the client's dignity, modesty, and comfort in mind (e.g., providing client with adequate drapes or covering, as appropriate; explaining the procedure; and avoiding saying things that negate information provided during counseling)?

8. Do you think that the following areas of your health care setting that clients use are pleasant and comfortable? (For example, do they offer enough space? Is the space well organized, clean, well lit, comfortable, and well ventilated?)
   - Toilets
   - Registration, reception, waiting areas
   - Counseling areas
   - Examination and procedure rooms
   - Postprocedure recovery room/space
   - Pharmacy
   - Other areas

9. Are client waiting times for MC services reasonable in your health care setting?

10. Do staff do their best to reduce unnecessary waiting times for clients (e.g., by having a nurse or other health professional serve clients when it is unnecessary for them to wait for an MC provider, by conducting health talks in the reception area, by having the HIV counseling and testing health worker draw blood and perform rapid tests rather than send clients to the laboratory, etc.)?

11. Does your service setting have an established system in place for receiving clients (e.g., first come, first served; by appointment; with emergency conditions)? Do staff always follow this system?

12. Are records organized so that retrieval is quick and easy?

13. Do staff feel that clients have adequate time with providers to ask all of the questions they might have?

14. Do staff always explain to clients what type of examination, test, or procedure will be done; what to expect and how to avoid postoperative and intraoperative complications (e.g., properly caring for the wound, avoiding sexual intercourse or masturbation for up to 4–6 weeks, and attending follow-up visits); why the examination, test, or procedure is needed; and the reason why clients should come back for review at their appointed time?

15. Do staff ensure that clients experience the least possible pain during procedures (e.g., by administering adequate local anesthetic and observing the client to assess pain during MC procedure)?

16. Do staff engage clients, as appropriate, to make them feel comfortable during MC procedure (e.g., by engaging them in conversation to distract them from an uncomfortable or painful procedure, or by offering comfort when they are in distress)?

17. Does your health care setting offer HIV counseling and testing services in an atmosphere that is inviting for men, including adolescents?

18. Does your service setting have a policy prohibiting discrimination against all men, including people living with HIV and AIDS (PLHIV), young people, sex workers, injecting drug users, men who have sex with men (MSM), or members of other key populations vulnerable to HIV? Do staff follow this policy?

19. Does your health care setting include PLHIV or representatives from other key populations (e.g., sex workers, injecting drug users, MSM) in the planning, design, monitoring, and evaluation of MC services; HIV counseling and testing; care and treatment; and other services related to HIV and sexual and reproductive health?

Other Issues That You Think Are Important:

20. _____

21. _____

22. _____

Clients' Right to Continuity of Care

All clients have the right to continuity of services, supplies, referrals, and follow-up necessary to maintain their health, to prevent HIV transmission, and to prevent the progression of HIV infection. Where possible, continuity of male circumcision (MC) services, specially trained MC surgeons, pretest and posttest counselors, all necessary equipment, and expendable surgical supplies should be available in the facility or other service setting of the client's choice.

> The group working on this guide should include staff who provide care, including MC service providers, counselors, staff responsible for supplies, and field/community workers.

If any of the following questions reveal a problem in your health care setting, or if you think any questions need to be discussed further, write your comments on a flipchart in the following format:

Problem	Cause(s)	Recommendations	By Whom	By When

If you are aware of a problem in your health care setting that is not addressed here, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. For all services provided in your health care setting, are all clients told that they can return at any time if they have questions or concerns?

2. Are follow-up visits in your service setting scheduled with the client's convenience in mind?

3. Do staff communicate with clients not returning for follow-up care (including for test results, treatment, or scheduled procedures) in a way that does not violate clients' right to privacy and confidentiality?

4. Does your health care setting have sufficient equipment and a reliable stock of expendable supplies so that clients receive preprocedure and postprocedure counseling, the MC procedure, laboratory tests, medications (including local anesthetics, painkillers, and antibiotics, etc.), and condoms without delay or other barriers to access?

5. Does your service setting have adequate numbers of trained MC providers who offer services to meet the demand?

6. Do clinical staff know which medications and supplies can be replaced with others in case of stock-outs (e.g., antibiotics for treatment of wound sepsis and sexually transmitted infections)?

7. Are clients' medical and health records completed and clear, with information essential for continuity of care?

8. Does your health care setting have a system in place to ensure that authorized staff receive all of a client's records, so they may provide optimal care?

9. Does your service setting have a mechanism in place to ensure that clients see the same counselor for pretest and posttest counseling?

10. Does your facility or other service setting have follow-up protocols for all clients after they have had MC services?

11. Do HIV counseling and testing services have functional links with other facility-based and community-based services? Functional links can be defined by the following characteristics:
    - Formalized working relationship with the partner agency
    - Up-to-date information about the services offered by the partner agency, including
        - Types of services offered
        - Hours of operation
        - Cost of services
        - Location of services
        - Transportation options, such as
            - Arranging transportation to the partner agency
            - Escorting clients to the partner agency (when possible)
    - System in place to properly refer clients to partner agencies
    - System in place to follow up on clients who were referred to partner agencies (to ensure that they received the services for which they were referred)
    - Ongoing two-way feedback with partner agencies

12. Do HIV counseling and testing services for MC clients provide ongoing referrals for other clinical services, such as the following?
    - Management of severe complications (e.g., excessive pain, bleeding, swelling, or infection)
    - Care and treatment of AIDS, tuberculosis, malaria, and other diseases
    - Family planning and other reproductive health needs
    - Palliative care
    - Other health issues as presented by clients

13. Do HIV counseling and testing services provide referrals for other nonclinical or community-based services, such as the following?
    - Ongoing posttest counseling
    - Psychosocial support for clients who test positive for HIV and counseling on preventing reinfection and infection of their sex partners
    - Nutritional support services (including infant feeding options, when appropriate)
    - Alcohol and substance abuse counseling
    - Gender-based violence counseling

- Counseling for adolescents and youth
- Counseling for sexual assault victims
- Counseling for men who have sex with men

14. Does your health care setting periodically review and update its referral system?

Other Issues That You Think Are Important:

15. _____

16. _____

17 _____

Staff Need for Facilitative Supervision and Management

Health care staff function best in a supportive work environment in which supervisors and managers encourage quality improvement and value staff. Such supervision enables staff to perform their tasks well and thus better meet the needs of their clients.

> The group working on this guide should include administrators or managers, as well as male circumcision (MC) service providers, HIV counseling and testing (HCT) service providers, and support staff.

If any of the following questions reveal a problem in your health care setting, or if you think any of the questions need to be discussed further, write your comments on a flipchart in the following format:

Problem	Cause(s)	Recommendations	By Whom	By When

If you are aware of a problem in your health care setting that is not addressed here, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. Does your service setting's management ensure that a mechanism is in place for planning and conducting a variety of quality improvement activities?

2. Does management ensure that a mechanism is in place for assessing provision of MC services and use of HCT services, as a demonstration of its commitment to quality services?

3. Do supervisors and managers support, encourage, and respect staff, including providing constructive feedback?

4. Do external supervisors (at the district, regional, and headquarters levels) provide staff with constructive feedback (verbal and written) during supervisory visits?

5. Do supervisors conduct medical monitoring activities, including involving staff in the medical monitoring process, to assess the readiness of your health care setting to provide MC and the ongoing quality of MC and related services?

6. Are work shifts well organized and followed by staff?

7. Do supervisors discuss with each staff member his or her roles and responsibilities and job expectations?
   - Are staff roles and responsibilities clearly defined in job descriptions?
   - Are staff given copies of their job descriptions?

8. Does your health care setting have a system in place to assess the site's learning needs and to monitor staff development?

9. Where turnover is high or where demand for services is increasing rapidly, does your service setting have a human resources development plan for expanding the pool of MC providers, counselors, laboratory technicians, and supervisors to MC services?

10. Do supervisors or managers motivate staff to perform well by doing the following?
    - Recognizing work well done
    - Providing timely constructive feedback

11. Do staff feel that they are part of a team?

12. Does your health care setting have a mechanism in place for collecting staff suggestions about improving the quality of services? Are staff encouraged to make suggestions about improving the quality of services?

13. Does your service setting have sufficient trained staff to provide HCT and MC services daily?

14. Do supervisors ensure that HCT and MC service provision guidelines and protocols are available and followed?

15. Is there a mechanism for updating service delivery guidelines to keep pace with the rapidly changing evidence-based recommendations related to MC and HIV prevention, care, and treatment?

16. Do supervisors ensure that trained staff receive regular updates about MC and prevention of adverse events and that they use up-to-date service delivery guidelines?

17. Do supervisors ensure that new staff are appropriately trained and informed about MC services as a strategy for prevention of HIV infection?

18. Do supervisors ensure that staff providing MC services within your service setting share information with the staff from other wards/units through giving health talks related to MC services as strategy for prevention of HIV infection?

19. Do supervisors periodically observe how MC services are provided (including counseling and MC procedure), with client consent, and give constructive feedback to MC providers?

20. Do supervisors ensure that your health care setting has a quality assurance system consisting of the following elements, to ensure that the quality of MC services is maintained?
    - Documentation
    - Standard operating procedures
    - Regular quality improvement activities

21. Do supervisors ensure that the medical records system is properly functioning? Do they periodically review the following records?
    - Clients' cards, files, and notes
    - Medical record forms, including informed consent forms
    - Inpatient and outpatient registers
    - Laboratory records

22. Do supervisors ensure that all staff understand the reasons and procedures for completing records, storing them correctly, and maintaining confidentiality?

23. Are required reports of MC services submitted regularly and on time?

24. Do supervisors share and discuss data, reports, and MC service and HIV statistics with their staff to teach them how to use the data for decision making to improve their work?

25. Do meetings among staff or reviews of complications result in changes and improvements in MC services?

26. Are program and performance indicators identified and used to monitor and evaluate MC services and staff performance in this area?

27. Is there a process in place for reviewing any serious complications (e.g., excessive pain, bleeding, swelling, infection, etc.) that occur after MC, to determine the cause and how they might be prevented in the future?

28. Do supervisors ensure that a mechanism is in place to facilitate effective communication and collaboration between community health workers (home-based caregivers, nongovernmental organizations, associations of people living with HIV) and staff in your health care setting?

29. Do supervisors ensure there are functioning referral mechanisms in place, including feedback mechanism, for both internal and external referrals?

30. Do supervisors work with staff to ensure that your service setting has the following equipment or infrastructure?
    - Reliable supplies for MC services (e.g., local anesthetics and other painkillers, infection prevention supplies, surgical dressing materials, condoms, etc.)
    - Adequate, functioning equipment for MC services
    - Adequate infrastructure for MC services

31. Do staff always give the due respect and attention to:
    - Workers from other departments?
    - Community workers?

32. Is an HIV workplace policy available to protect the rights of HIV-positive staff and supervisors?

33. Are service delivery guidelines available that include identification of exposure-risk procedures (procedures that pose a high risk of injury to the health care worker and may result in exposure of the client's open tissue to blood of the health care worker)?

34. Are guidelines on how to manage accidental exposure to blood, including postexposure wound care and postexposure prophylaxis (PEP), available for staff and supervisors to follow, and are they periodically reviewed and updated according to national and World Health Organization (WHO) guidelines, including protocols for pregnant health workers?
    - Are HIV pretest and posttest counseling available for injured staff? If not, is there a functioning referral mechanism for HIV pretest and posttest counseling?
    - Are PEP drugs available for treatment of exposed staff? If not, is there a functioning referral mechanism for PEP treatment?

35. Does your health care setting have a mechanism in place to protect counselors from overload and work-related exhaustion?

36. Has your service setting developed or adapted guidelines for managing the client-counselor ratio, to avoid compromising the quality of counseling and MC services offered?

37. Do MC providers meet regularly to discuss difficult issues arising during counseling and MC procedure sessions and to provide one another with emotional and professional support?

38. Do supervisors meet regularly with MC providers and counselors and clinicians to debrief and provide support pertaining to challenging cases and other stress-related issues?

Other Issues That You Think Are Important:

39. _____

40. _____

41. _____

Staff Need for Information, Training, and Development

Health care staff need knowledge, skills, and ongoing training and professional development opportunities to remain up to date in the rapidly evolving area of HIV and AIDS health care. Staff also needs professional development opportunities that will help them acquire knowledge and skills on provision of male circumcision (MC) services as one of the strategies of prevention of HIV infection, including current MC techniques and approaches. Every site that seeks to continuously improve the quality of its services should plan for ongoing staff development and provide all staff access to updated information and training opportunities.

> The group working on this guide should include a cross-section of staff representing all departments within your service setting.

If any of the following questions reveal a problem in your health care setting, or if you think any questions need to be discussed further, write your comments on a flipchart in the following format:

Problem	Cause(s)	Recommendations	By Whom	By When

If you are aware of a problem in your health care setting that is not addressed here, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. Do you think your health care setting has sufficient trained staff to provide MC services for prevention of HIV infection?

2. Does your service setting have a system in place to regularly assess staff training and development needs?
   - Does this system involve a staff self-assessment of their development and training needs?
   - Does this system include an assessment of staff's knowledge of issues related to their job duties and MC services in general?
   - Are the technical skills of clinical and other staff assessed regularly (in such areas as the MC procedure, HIV counseling and testing, and sexually transmitted infection screening and management)?

3. Do all staff feel that they have the knowledge and skills they need to follow standards and procedures related to provision of MC services?

4. Have all staff who counsel clients about MC observed the procedures being performed?

5. Has your health care setting developed standards for MC services (or adopted national standards where they exist), with clear roles and job descriptions for various levels of providers?

6. Does your facility or other service setting plan and conduct sensitization training to facilitate positive attitudes among staff and to discourage stigma and discrimination against people living with HIV and other vulnerable groups, such as sex workers, men who have sex with men, and injecting drug users?

7. Is a training system in place to regularly update staff on the following?
   - Knowledge of issues related to job duties
   - Technical skills related to job duties
   - Ability to perform job duties

8. Are periodic orientations, updates, and MC skills training sessions provided to keep staff skilled in and well informed about changing approaches and technologies in MC procedure?

9. Does this training system include tools that measure how effective the training sessions are in improving the knowledge, technical skills, and/or attitudes of the training participants?

10. If any of your site's staff members attend an off-site training session or conference, do they share information with their colleagues about what they learned at the training?

11. Do staff know about and have ready access to current service delivery guidelines (in the form of reference books, guidelines, charts, posters, and other materials) for each type of service provided in your health care setting?

12. Do staff follow the national guidelines and protocols when providing MC services?

13. Do staff have access to resources for continuing education to better meet their clients' information needs?

14. Where turnover is high or where demand for services is increasing rapidly, does your health care setting have a strategic plan for expanding the pool of MC providers, counselors, laboratory technicians, and supervisors to support MC services?

15. To expand services and continue to develop staff skills, have other staff members besides doctors (such as nurses and clinical officers) been trained as MC providers?

16. Have all staff received training on the following?
   - The use of quality improvement tools and approaches
   - Health services provided in your service setting
   - Infection prevention (universal precautions)

17. Have appropriate staff received training on all required MC standards, according to national or World Health Organization (WHO) guidelines/standards, and on procedures for HIV counseling and testing services? These might include the following:
   - Overview of MC and HIV infection
   - Informed consent
   - Pretest counseling

- Posttest counseling
- Confidentiality
- Ethical and legal issues concerning disclosure of HIV status
- Partner notification
- Testing technologies and strategies
- MC surgical skills and postoperative follow-up
- MC techniques and approaches
- Condom demonstration and promotion

18. Do staff get refresher courses or updates on resuscitation of clients, in case of an emergency?

19. Do staff know how to conduct HIV risk assessment through medical history, physical examination, and laboratory screening?

20. Are laboratory staff trained in HIV testing and the other diagnostic tests that they are expected to perform?

21. Have staff received training on how to handle specimens and HIV test kits safely and appropriately?

22. Does your health care setting plan and conduct training sessions for staff to help them become more comfortable talking with clients about sexual anatomy, sexual behaviors, sexual orientation, and alcohol and drug use?

23. Do staff have the knowledge and skills needed to provide accurate, nonjudgmental education and information on MC as a strategy for prevention of HIV?

24. Do all service providers know how to refer clients for health information and services outside their area of expertise or to services that are not available on-site?

25. Are staff trained in record keeping and reporting, including reporting postoperative and intraoperative complications (e.g., pain, swelling, infection, etc.)?

26. Are in-service sessions conducted to train staff to prevent needle-stick and sharps injuries?

27. Have all staff received training in postexposure prophylaxis protocols? Are these protocols posted in a place where staff can read and refer to them easily?

Other Issues That You Think Are Important:

28. _____

29. _____

30. _____

Staff Need for Supplies, Equipment, and Infrastructure

Health care staff need reliable, sufficient inventories of supplies, instruments, and working equipment, as well as the infrastructure necessary to ensure the uninterrupted delivery of safe, quality services. The health care system must have in place a mechanism to ensure quality male circumcision (MC) services that include hygienic and spacious procedure rooms and a constant supply of expendables necessary for provision of MC procedure.

> The group working on this guide should include a service provider (e.g., a staff member who provides surgical MC procedure, counselors, etc.), staff who are involved in purchasing and storing supplies (including local anesthetics, analgesics, infection prevention supplies, and other expendables), and one staff member who has budgeting authority to change the items and quantities ordered.

If any of the following questions reveal a problem in your health care setting, or if you think any questions need to be discussed further, write your comments on a flipchart in the following format:

Problem	Cause(s)	Recommendations	By Whom	By When

If you are aware of a problem in your health care setting that is not addressed here, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. Does your health care setting have adequate waiting area, working space (procedure room, counseling and testing room, recovery room, changing room), and seats, tables, and couches?

2. Does your service setting have a client registration area that ensures the privacy and confidentiality of clients (i.e., a place where other clients or staff cannot overhear conversations between the client and registration staff)?

3. Is the client flow within your service setting such that clients' privacy and confidentiality are protected?

4. Does your MC service setting (e.g., health facility, school, tent, etc.) have a reliable supply of clean water?

5. Does your MC service setting have a reliable source of electricity?

6. Does your MC service setting have adequate ventilation and temperature control (heating or cooling) in the service provision areas?

7. Does your MC service setting have adequate lighting in counseling and testing and procedure rooms?

8. During the last three months, has your service setting had all of the supplies necessary to provide MC services (e.g., local anesthetics and painkillers, infection prevention supplies, wound dressing supplies, stationery, etc.)?

9. During the last three months, has your service setting had all of the HIV counseling and testing commodities needed, and were they in working order?

10. Are all drugs and other expendable supplies, including sutures, condoms, test kits, and reagents within their expiration date?

11. Does your MC service setting keep an inventory to help track supplies and alert staff as to when to reorder supplies?

12. Do staff who work with stocks always observe the first-expired, first-out rule?

13. Does your MC service setting have a functioning mechanism in place for procuring the necessary expendable supplies, including infection prevention solutions and emergency drugs and fluids in a timely manner?

14. Are drugs, test kits, and reagents protected from moisture, light, and extremes in temperature?

15. Is the storage area secure from theft and accessible only to selected personnel who can be held accountable?

16. Does your MC service setting have a protocol for safe disposal of expired HIV testing and MC commodities/supplies?

17. Does your MC service setting have a system for procuring, maintaining, and repairing equipment?

18. Does your MC service setting have separate areas for handwashing and for cleaning instruments (e.g., sinks, buckets, soap)?

19. Do staff have the supplies and facilities needed to properly dispose of sharps and other medical waste (i.e., sharps containers, as well as a functioning incinerator, a covered pit, and/or municipal or commercial means of waste disposal)?

20. Does your MC service setting have supplies for infection prevention, such as soap, gloves, antiseptic solutions, high-level disinfectants, and brushes, available in the necessary quantities?

21. Does your MC service setting have a mechanism in place to ensure reliable autoclaving and laundry of MC equipment? Are autoclaves, electric oven, and boiler in the autoclaving and laundry areas in good working order?

22. Does your MC service setting have the infrastructure and equipment in place for maintaining clients' records (including laboratory results) in a way that does not compromise their privacy and confidentiality?

23. Do providers have job aids for counseling clients on MC, prevention of the transmission of HIV and other sexually transmitted infections (STIs), and on correct use of condoms?

24. Does your MC service setting have a television and a videocassette or DVD player and relevant videos or DVDs for client education, including materials about HIV/STI risk reduction, correct and consistent condom use, HIV counseling and testing, and sexual and reproductive health, including family planning?

25. Are postexposure prophylaxis (PEP) kits readily available for accidents related to occupational exposure, in accordance with national and World Health Organization guidelines?

26. Does your MC service setting have an overall strategic plan that includes commodity procurement (e.g., MC supplies, rapid test kits, infection prevention supplies)?

27. Does your MC service setting have a system to ensure emergency preparedness by routinely doing the following?
    - Displaying emergency protocols on wall charts
    - Preparing a portable emergency tray or trolley with equipment, drugs, and supplies and making it available in client-care areas
    - Checking emergency drugs for availability and expiration dates
    - Ensuring that emergency equipment is working
    - Reviewing emergency guidelines and protocols with staff through discussion and periodic rehearsals

28. Are the following conditions and supplies in place in areas where health talks occur?
    - Adequate space within or adjacent to the client waiting
    - Benches/chairs
    - If available, portable partitions to provide more privacy
    - Where electricity is available and reliable, a television, a videocassette or DVD player, and relevant videos or DVDs, including those on MC, HIV prevention, HIV counseling and testing, and other HIV-related topics
    - Information, education, and communication (IEC) materials, including posters and pamphlets, about HIV and AIDS; HIV prevention; MC; HIV counseling and testing; prevention of mother-to-child transmission of HIV; treatment, care, and support services; and family planning
    - Condoms (male and female)
    - Penis and vagina models

29. Are the following conditions and supplies available where one-on-one or couples counseling takes place?
    - Auditory privacy
    - Visual privacy
    - Job aids for counseling and explaining testing protocols
    - Table and chairs

- IEC materials about HIV and AIDS, MC, HIV prevention, and HIV counseling and testing
- Condoms (male and female)
- Penis and vagina models

30. Are the following equipment and supplies available where standard MC procedures take place?

Note: General equipment required for male circumcision includes:

- Examination couch
- Autoclave
- Counseling table and chairs
- Recovery beds
- Emergency trolley with medications for managing anaphylactic reactions
- Theater lamp
- Head lamp, in case of power blackout or where there is no electricity
- Surgical gloves (4)
- Alcohol hand rub
- Antiseptic soap for handwashing
- Surgical gowns
- Biohazard bags

In addition, protective equipment required where MC procedures take place includes:

- Surgical gloves
- Face masks
- Eyewear (goggles/face shields)
- Footwear
- Aprons

Surgical instruments required for one adult MC[1] include:

- Instrument tray wrapped with sterile drape (1)
- Sponge holding forceps (2)
- Bard-Parker (BP) scalpel knife handles and blades (1 small and 1 large)
- Dissecting forceps (1 toothed and 1 nontoothed)
- Artery forceps (4 straight, 4 curved)
- Mayo's straight forceps (1)
- Curved McIndoe's scissors (1)
- Stitch scissors (1)
- Mayo's needle holders (2)
- Towel clips (5)
- Drapes (2 large, 2 small, and one "O" drape)
- Gallipot for antiseptic solution (e.g., povidone iodine)
- Plain gauze swabs
- Cotton wool swabs in Gallipot
- Safety pin

1 The instruments required vary, depending on the MC technique used (e.g., dorsal slit, sleeve method, forceps guided, etc.).

Finally, disposable consumables for one adult MC include:

- Disposable scalpel (1)
- "O" drape (80 × 80 cm drape with ~5 cm diameter hole)
- Povidone iodine (50 ml 10% solution)
- Plain gauze swabs (10 10×10 cm for procedure, 5 10×10 cm for dressing)
- Petroleum-jelly impregnated gauze (5×5 cm or 5×10 cm) ("tulle gras") and sticking plaster
- 15 ml 1% or 2% plain lidocaine (without adrenaline) anesthetic solution in single-use syringe with 21-gauge needle
- 18" chromic gut 4-0 sutures with 13 mm to 19 mm 3/8 circle reverse-cutting needle
- Sterile marker pen
- Condoms (both male and female)

31. Are the necessary equipment and supplies available for the following basic infection prevention processes for handling contaminated equipment, gloves, and other reusable instruments?
    - Decontamination
    - Cleaning
    - Sterilization or high-level disinfection

32. Is the following equipment for safe disposal of infectious waste available where MC procedures take place?
    - Plastic or galvanized metal containers with tight-fitting covers
    - Puncture-resistant sharps containers for all disposable sharps

33. Are the following equipment and supplies available where blood drawing and testing take place?
    - Disposable gloves
    - Refrigerator (for storing test kits at recommended temperature)
    - Supplies used to collect specimens, such as lancets, disposable needles and syringes, and tourniquet
    - HIV rapid-test kits (test 1, test 2, and test 3 for tiebreaker)
    - Bandages, cotton wool, and gauze
    - Tissues
    - Running water
    - Handwashing items (soap, antiseptics, towels)
    - Disinfectants and cleaning supplies
    - Sharps disposal bins for needles and lancets
    - Waste disposal (biohazard) bags for blood-contaminated materials, such as gauze, swabs, gloves, and testing cards
    - Job aids for HIV testing protocols

Other Issues That You Think Are Important:

34. _____

35. _____

36. _____

Client Record-Review Checklist for Male Circumcision Services

Client Record-Review Checklist for Male Circumcision Services

Site: _____ Reviewer: _____ Date: _____

This checklist is for staff to determine whether key information is being documented in client records. Select the records for 10 male circumcision (MC) clients at random for review. Place a checkmark in the appropriate box if the item in the checklist was recorded on the client's record; put N/A if the item is not applicable to the client. Comments and clarifying remarks should be made in the space provided in the table or at the end of this form.

Before using the checklist, compare the items in the checklist with your health care setting's record form(s). Consider if any important items are missing from your service setting's forms, whether there is a need to update your record form(s), or whether any items are missing from the checklist and need to be added.

For each client record, look for the information specified in the Checklist Item column. If the information has been recorded, write an "x" or a checkmark ( ) in the corresponding space on the checklist. When each item on the checklist has been reviewed against 10 individual records, note the number of boxes left blank and record it in the column labeled Total Answered Negatively.

Review the data collected in the above checklist. Any negative responses to a checklist item suggest there is room for improvement. Consider the answers to the following questions when reporting back to the group and making recommendations for the Action Plan:

Was any key information consistently missing from the client records?

- What could be the root cause?
- What are some possible solutions?

Checklist Item	1	2	3	4	5	6	7	8	9	10	Total Answered Negatively	Remarks
Client Profile												
Client identification information (name, age, sex, residential/postal address, and telephone or other contact information, registration number)												
Emergency contact person (name, relationship, residential/postal address, telephone or other contact information)												

(continued)

Client Record-Review Checklist for Male Circumcision Services *(continued)*

Site: _____ Reviewer: _____ Date: _____

Checklist Item	1	2	3	4	5	6	7	8	9	10	Total Answered Negatively	Remarks
Date of visit												
Purpose of visit												
Client History and Physical Exam												
Counseling on HIV testing provided												
HIV test given												
HIV test results shared												
Partner tested												
Assessment of health and sexual history, including risk for HIV infection and other diseases												
Known history of other diseases (hemophilia, diabetes, etc.)												
Client presenting with urethal discharge, pain in urethra, genital sore, difficulty retracting foreskin, etc.)												
Current medications/ treatments												
Previous surgeries												
Known allergies												
Blood pressure												

(continued)

Client Record-Review Checklist for Male Circumcision Services *(continued)*

Site: _____ Reviewer: _____ Date: _____

Checklist Item	1	2	3	4	5	6	7	8	9	10	Total Answered Negatively	Remarks
Pulse												
Weight												
Eligibility for Circumcision												
Client in general good health												
Client counseled on risks and benefits of MC												
Consent/assent given by client for MC												
Client eligible for MC												
Circumcision Procedure												
Date of circumcision												
Start time												
End time												
Type of anesthesia												
Type of procedure (e.g., dorsal slit method, sleeve method, guided forceps method)												
Name and cadre of clinician												
Name and cadre of assistant												
Pre/postoperative medication given												
Client given postoperative instructions												

(continued)

Client Record-Review Checklist for Male Circumcision Services *(continued)*

Site: _____ Reviewer: _____ Date: _____

Checklist Item	1	2	3	4	5	6	7	8	9	10	Total Answered Negatively	Remarks
Adverse events during operation												
Adverse event rating (e.g., mild, moderate, severe)												
Circumcision Follow-Up Visit												
Date of visit												
Type of visit (e.g., routine, client-initiated)												
Adverse event symptoms (if yes, ensure that Adverse Event Form is completed and see Adverse Event Section below).												
Follow-Up Visit												
Date of visit												
Type of visit (e.g., routine, client-initiated)												
Adverse event symptoms (if yes, ensure that Adverse Event Form is completed and see Adverse Event Section below).												
Adverse Event during Circumcision												
Date of visit												
Date MC completed												
Theater registration no.												

(continued)

Client Record-Review Checklist for Male Circumcision Services *(continued)*

Site: _____ Reviewer: _____ Date: _____

Checklist Item	1	2	3	4	5	6	7	8	9	10	Total Answered Negatively	Remarks
Adverse event (including description and severity)												
Total maximum severity, based on all adverse events recorded												
Treatment provided												
Adverse Event Postcircumcision												
Date of visit												
Date MC completed												
Theater registration no.												
Adverse event (including description and severity)												
Total maximum severity, based on all adverse events recorded												
Treatment provided												

Additional comments on client record review:

Client Interview Guide for Male Circumcision Services

Client Interview Guide for Male Circumcision Services

Greet the client and introduce yourself.

My name is _____, and I work here. We are trying to improve the services we provide to clients, and we would like to hear your honest opinion of how we are doing and what we need to improve. We would like to know both the good things and the bad things.

Your participation in this interview is voluntary. You do not have to take part in the interview at all if you do not want to. If you decide not to participate, you will not be denied any services. Also, you can change your mind during the interview and choose not to participate.

This interview is private and confidential. I am not asking for your name, and your name will not be disclosed or used. Your responses to our questions will not affect any services you will receive at this facility in the future. You can also skip any questions that you do not want to answer. This interview will take about 15 minutes. Your ideas are important to us. May I go ahead and ask you these few questions?

Client Consent Check-Off

IF CLIENT RESPONDS "YES," THE **INTERVIEWER** SHOULD SIGN AND DATE THE STATEMENT BELOW AND CONTINUE WITH THE INTERVIEW.

I certify that I have read the above statement and that the client agreed to the interview. ***I also certify that any information the client discloses will remain confidential.***

Signed: _____ **Date:** _____

IF CLIENT RESPONDS "NO," THE **INTERVIEWER** SHOULD SIGN AND DATE THE STATEMENT BELOW AND WAIT FOR ANOTHER CLIENT.

I certify that I have read the above statement and that the client did not agree to be interviewed.

Signed: _____ **Date:** _____

Client Interview Guide for Male Circumcision Services

Site: _____ Date: _____

Name of interviewer: _____

Note to interviewer: *Ask the questions printed in* ***boldface*** *type. Check (✓) responses the client gives. Write additional notes in the spaces provided.*

1. **Is this your first visit to the facility, or is this a follow-up visit?**
   First visit ..... ❒ Follow-up visit ..... ❒

2. **What type of services did you come for today?** *(Check responses given. Do not read the responses to the client.)*
   a. Counseling/information on male circumcision ..... ❒
   b. To get circumcised ..... ❒
   c. HIV counseling and testing ..... ❒
   d. Unscheduled follow-up after male circumcision ..... ❒
   e. Scheduled follow-up after male circumcision ..... ❒
   f. HIV prevention counseling ..... ❒
   g. Management of sexually transmitted infection ..... ❒
   h. Family planning ..... ❒
   i. Other _____

   _____

3. **Did you get the services that you came for?**
   Yes ..... ❒ No ..... ❒

   If no: **Why not? What happened?**

   _____

   _____

4. **How long did you have to wait today before you saw a:**
   Counselor/nurse? _____ minutes **Doctor?**_____ minutes

5. **What did you do while you were waiting?**

   _____

   _____

6. **Were you given verbal or written information today?**
   Yes ..... ❒ Verbal.....❒
   No ..... ❒ Written .....❒

   If yes: **What type of information were you given?**
   (Check all responses given. Do not read the responses to the client.)
   a. General information about male circumcision (for example, what it is and how it is done)..... ❒
   b. Benefits of male circumcision ..... ❒

(continued)

Client Interview Guide, *continued*

c. Risks of male circumcision ..... ❒
d. Male circumcision for prevention of HIV infection ..... ❒
e. Preoperative instructions (e.g., on the day of surgery, wash genital area and penis well with soap and water; clip pubic hairs, if necessary; wear loose-fitting pants, etc.) ..... ❒
f. Postoperative instructions (e.g., avoid strenuous activity and rest at home; keep area of operation dry for 24 hours; if clean water is available, wash daily; do not remove the bandage until told to do so by clinic staff ; return to clinic if serious complications develop; etc.) ..... ❒
g. Possible side effects and complications of male circumcision (e.g., pain, swelling, bleeding, infection, etc.) ..... ❒
h. What to do and where to go if complications arise after male circumcision ..... ❒
i. General HIV prevention ..... ❒
j. Safer sex practices ..... ❒
k. HIV testing ..... ❒
l. Disclosure of HIV status and partner notification ..... ❒
m. Sexual health ..... ❒
n. Other health ..... ❒
o. How to ensure health of family and community ..... ❒
p. Prevention of gender-based violence ..... ❒
q. HIV prevention, treatment, care and support services available locally ..... ❒
r. Family planning and what methods are available at the site or by referral ..... ❒
s. Other: _____

_____

7. Do you feel that the staff explained information clearly enough?

Yes ..... ❒ No ..... ❒

If no: **Please explain:**

_____

_____

8. Did the provider assure you that the services, including everything you discussed, are confidential?

Yes ..... ❒ No ..... ❒

9. Did the service provider spend adequate time with you to discuss your needs?

Yes ..... ❒ No ..... ❒

If no: **Please explain:**

_____

_____

(continued)

Client Interview Guide, *continued*

What else would you like to have discussed with a provider?

_____

_____

_____

_____

10. Were the staff respectful?

Yes ..... ❒ No ..... ❒

If no: **Please explain:**

_____

_____

11. For how long after your circumcision did the staff say you should abstain from sex?

_____

_____

12. Were you asked to pay for services that you received today?

Yes.....❒ No.....❒

13. Are the services at this facility affordable to you?

Yes.....❒ No.....❒

14. What have you heard from your family, friends, or others in your community about the quality of services at this facility?

_____

_____

_____

_____

15. Are there any areas of the facility that you think need improvement, to make them cleaner, more comfortable, or more private?

Yes.....❒ No.....❒

If yes: **Please tell me which ones and why.**

_____

_____

Note to interviewer: *The following section is only for clients who have previously visited or used services at this setting.*

(continued)

Client Interview Guide, *continued*

16. Since you first started coming here, has the quality of services improved, stayed the same, or worsened?

a. Improved ..... ❒
b. Stayed the same ..... ❒
b. Gotten worse ..... ❒

Note to interviewer: *If the client responded "Stayed the same," skip to Question 18. For other responses, continue with question 17, below.*

17. If the quality of services has improved or worsened, what in your opinion is/are the reason/s for the change?

a. Better? _____
b. Worse? _____

18. What do you like most about services you receive at this facility?

_____

_____

19. What do you <u>not</u> like about services you receive at this facility?

_____

_____

20. I would like to answer any questions that you may have concerning this interview before you leave. Is there anything that concerns you, or anything that I can help you with?

_____

_____

Thank you for your help, your ideas, and your time!

Client-Flow Analysis Forms for Male Circumcision Services

Client Register Form

Client number: _____ Date: _____ Time client arrived at service setting: _____

Primary reason for visit (see Service Type Codes): _____

Secondary reason for visit (see Service Type Codes): _____

	Staff member's initials	Time service started	Time service completed	Contact time (in minutes)
First contact				
Second contact				
Third contact				
Fourth contact				
Fifth contact				
Sixth contact				

Comments: _____

_____

_____

_____

_____

_____

Codes: Service Type

A—Counseling/information on male circumcision
B—Male circumcision
C—HIV testing and counseling
D—Unscheduled follow-up after male circumcision
E—Scheduled follow-up after male circumcision
F—HIV prevention counseling
G—Management of sexually transmitted infection
H—Family planning
I—Other (please describe):

Client-Flow Chart

(Use as many pages as necessary) Page _____

Site: _____ Date: _____ Session: _____

Client number	Time In	Time Out	Total time at site (in minutes)	Contact time (in minutes)	Waiting time (in minutes)	Service type (primary)	Service type (secondary)	Visit timing	Comments
		Total							

Codes: Service Type

A—Counseling/information on male circumcision
B—Male circumcision
C—HIV testing and counseling
D—Unscheduled follow-up after male circumcision
E—Scheduled follow-up after male circumcision
F—HIV prevention counseling
G—Management of sexually transmitted infection
H—Family planning
I—Other (if chosen, please describe):

_____

_____

_____

Codes: Visit Timing

1—First visit
2—Follow-up visit

Client-Flow Chart Summary

Site: _____ Date: _____ Session: _____

Page	Total number of clients	Total time (in minutes)	Total contact time (in minutes)	Percentage of client time spent in contact with staff
1				
2				
3				
Totals				

Average number of minutes (rounded to a whole number): _____
(divide "Total time" by "Total number of clients")

Average contact minutes (rounded to a whole number): _____
(divide "Total contact time" by "Total number of clients")

Action Plan and Follow-Up Forms for Male Circumcision Services

Action Plan

Problem	Cause(s)	Recommendation	By Whom	By When

Action Plan Follow-Up

Problem	Cause(s)	Recommendation	Status	Comments

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Appendix

Pledge of Confidentiality

I certify that any information that I obtain from client records, site registries, log books, client interviews, or any other aspect of the COPE® exercise will remain confidential.

Signed: _____ **Date:** _____

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