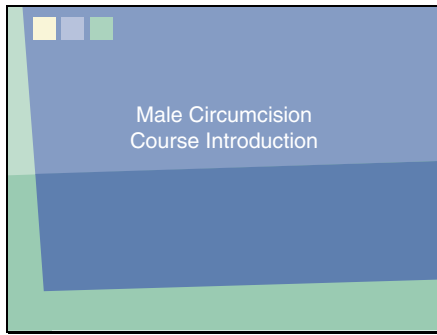


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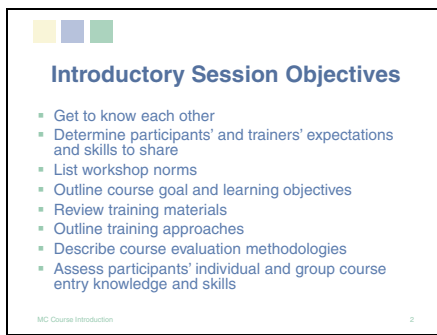
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Slide 3




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Slide 4



### Participants' Expectations

Kindly indicate your **expectations** **skills to share**  
(e.g., coaching, use of audiovisuals) on flipcharts provided.

<p>▪ <b>Expectations:</b></p>	<p>▪ <b>Skills to share:</b></p>
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MC Course Introduction 4

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Slide 5



### What Should Be Our *Group Norms*?

<p>▪</p> <p>▪</p> <p>▪</p> <p>▪</p> <p>▪</p>	<p>▪</p> <p>▪</p> <p>▪</p> <p>▪</p> <p>▪</p>
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MC Course Introduction 5

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Slide 6



### Course Goals and Objectives



MC Course Introduction 6

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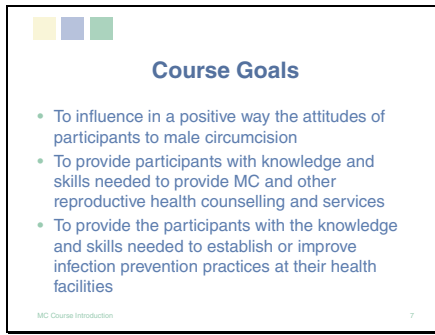
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Slide 7



MC Course Introduction 7

### Course Goals

- To influence in a positive way the attitudes of participants to male circumcision
- To provide participants with knowledge and skills needed to provide MC and other reproductive health counselling and services
- To provide the participants with the knowledge and skills needed to establish or improve infection prevention practices at their health facilities

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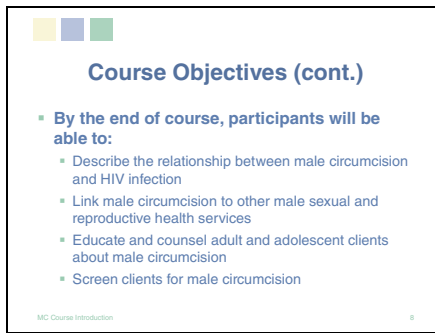
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Slide 8



MC Course Introduction 8

### Course Objectives (cont.)

- **By the end of course, participants will be able to:**
  - Describe the relationship between male circumcision and HIV infection
  - Link male circumcision to other male sexual and reproductive health services
  - Educate and counsel adult and adolescent clients about male circumcision
  - Screen clients for male circumcision

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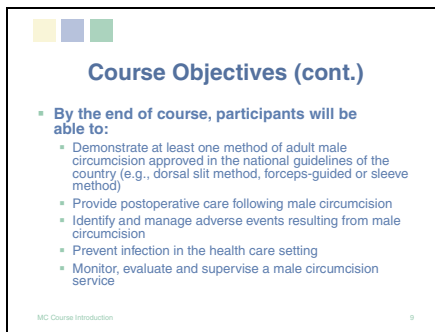
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Slide 9



MC Course Introduction 9

### Course Objectives (cont.)

- **By the end of course, participants will be able to:**
  - Demonstrate at least one method of adult male circumcision approved in the national guidelines of the country (e.g., dorsal slit method, forceps-guided or sleeve method)
  - Provide postoperative care following male circumcision
  - Identify and manage adverse events resulting from male circumcision
  - Prevent infection in the health care setting
  - Monitor, evaluate and supervise a male circumcision service

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Slide 10



### Training Materials

- WHO/UNAIDS/Jhpiego Generic **reference manual**: *Male Circumcision under Local Anaesthesia*
- WHO/UNAIDS/Jhpiego Generic Male Circumcision under Local Anaesthesia **Participant's Handbook**
- MC handouts of **presentation graphics**
- Relevant UNAIDS, WHO and UNFPA and guidelines on male circumcision

MC Course Introduction 10

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Slide 11



### Course Logistics

- Meals/tea break arrangements
- Whom to see if there are problems:
  - Logistical
  - Technical

MC Course Introduction 11

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Slide 12



### Training/Learning Methods

- Illustrated lectures
- Small group exercises
- Large group discussions
- Games
- Case studies
- Counselling role play
- Clinical practice sessions



MC Course Introduction 12

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Slide 13

**Methods of Evaluation**

- Precourse knowledge questionnaire (Day 1)
- Midcourse knowledge questionnaire (Day 5)
- Use of checklists
- Individual and group assignments
- End of course evaluation form

MC Course Introduction 13

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Slide 14

**Expected Competencies**

```
graph TD; A[1. Group Education and Counselling for MC] --> B[2. Client Assessment]; B --> C[3. Suturing and Knot Tying]; C --> D[4. Adult Male Circumcision]; D --> E[5. Postoperative Care and Counselling]; E --> F[6. 48-Hour Postoperative Review];
```

MC Course Introduction 14

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Slide 15

**Enjoy the Course.....**

MC Course Introduction 15

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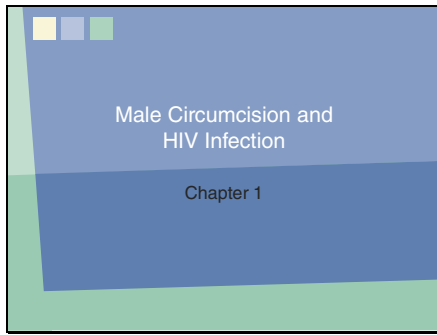
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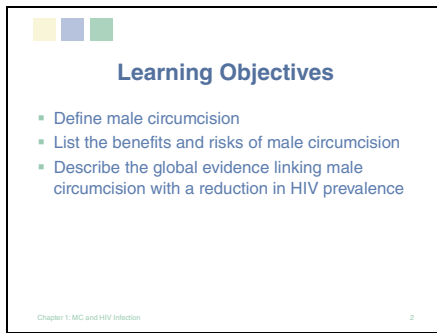
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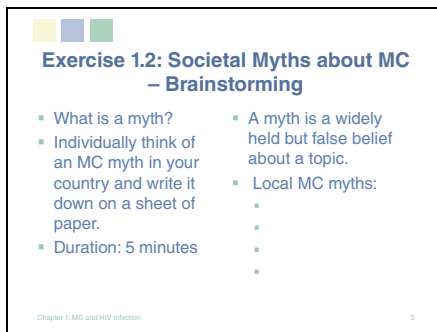
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Slide 3



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Slide 4

**What is male circumcision?**

- Male circumcision is the **surgical removal of the foreskin**, the fold of the skin that covers the head of the penis.
- It is an **ancient practice** that has its origin in religious rites.
- In many communities, it is **often performed** within the first two weeks after birth, or at the beginning of adolescence as a rite of passage into adulthood.

Chapter 1: MC and HIV Infection 4

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Slide 5

**How is MC performed?**

- Briefly:
  - The foreskin is freed from the head of the penis (glans).
  - Excess foreskin is clipped off.
- If done in the newborn period, the procedure is simpler and quicker than in adolescents and adults.
- The period of superficial healing after MC is 5–7 days (although it takes 4–6 weeks for the wound to be fully healed).

Chapter 1: MC and HIV Infection 5

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Slide 6

**What are the benefits and risks of male circumcision?**

Chapter 1: MC and HIV Infection 6

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Slide 7



### Benefits of Male Circumcision

- Easier to keep the **penis and surrounding areas** clean
- **A reduced risk of urinary tract infections** in childhood
- **Prevention of inflammation of the glans** (balanitis) and the foreskin (posthitis)
- **Prevention of phimosis** (the inability to retract the foreskin) and **paraphimosis** (swelling of the retracted foreskin and the inability to return the foreskin to its original location)

Chapter 1: MC and HIV Infection 7

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Slide 8



### Benefits of Male Circumcision (cont.)

- **A reduced risk of some sexually transmitted diseases in men**, especially ulcerative diseases like chancroid and syphilis
- **A reduced risk of men becoming infected with HIV**
- **A reduced risk of penile cancer**

Chapter 1: MC and HIV Infection 8

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Slide 9



### Risks of Male Circumcision

- **Pain**
- Risk of **bleeding**
- **Haematoma** (formation of a blood clot under the skin)
- **Infection** at the site of the circumcision
- **Increased sensitivity** of the glans (first few months)
- **Irritation** of the glans
- **Meatitis** (inflammation of the opening of the penis)
- **Injury** to the penis
- **Adverse reactions to the anaesthetic**

Chapter 1: MC and HIV Infection 9

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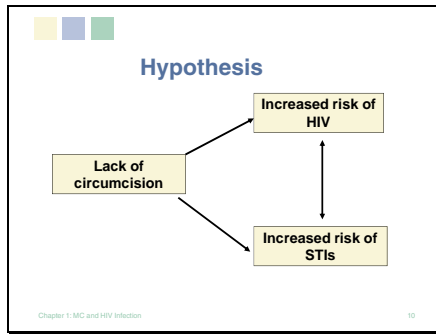
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Slide 10




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Slide 11

**Table 1.1: HIV prevalence according to frequency of male circumcision**

Low circumcision rate (<20% circumcised)			High circumcision rate (>80% circumcised)		
Country	HIV prevalence		Country	HIV prevalence	
<b>Sub-Saharan Africa</b>					
Botswana	24.1		Benin	1.8	
Malawi	14.1		Cameroun	5.4	
Mozambique	16.1		Democratic Republic of Congo	3.2	
Namibia	19.6		Gabon	7.9	
Rwanda	3.1		Gambia	2.4	
Swaziland	33.4		Ghana	2.3	
Zambia	17.0		Guinea	1.5	
Zimbabwe	20.1		Kenya	6.1	
			Liberia	5.9	
			Nigeria	3.9	
			Sierra Leone	1.6	
<b>South and Southeast Asia</b>					
Camodia	1.6		Bangladesh	<0.1	
India	0.9		Indonesia	0.1	
Myanmar	1.3		Pakistan	0.1	
Nepal	0.5		Philippines	<0.1	
Thailand	1.4				

Source: Updated from Halperin and Bailey, using most recent UNAIDS data where available.

Chapter 1: MC and HIV Infection 11

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Slide 12

**Remember...**

Countries with low prevalence of male circumcision have a higher prevalence of HIV

Chapter 1: MC and HIV Infection 12

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Slide 13



### Male Circumcision and HIV: Data from India

- Reynolds SJ et al. 2004. MC and risk of HIV-1 and other STIs in India. *Lancet* 363: 1239–1240.
- **Prospective study** of 2,298 HIV-uninfected men attending STI clinics in India
- **Findings:**
  - Circumcision strongly protective against HIV-1 infection (adjusted relative risk 0.15; 95% CI 0.04–0.62; p=0.0089)
  - No protective effect against herpes simplex virus type 2, syphilis and gonorrhoea

Chapter 1: MC and HIV Infection 13

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Slide 14



### RCT Findings from South Africa

- French/South African researchers led by Dr. Auvert, of the French National Institute of Health and Medical Research\*
- Study population: **3,274 HIV-negative men ages 18 to 24** in a South African township called Orange Farm were enlisted into the RCT of MC.
- **Results:** Male circumcision **reduced by about 61% the risk that men will contract HIV** through intercourse with infected women

\* Source: Mark Schoofs, Sarah Lueck and Michael M. Phillips, *The Wall Street Journal*, 1294 words Jul 5, 2005.

Chapter 1: MC and HIV Infection 14

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Slide 15



### RCT Findings from Kenya

- Bailey, RC et al. 2007. *Lancet*, 369: 643–656:
  - Randomised controlled trial of **2,784 men aged 18–24 years in Kisumu, Kenya**
  - Intervention group (circumcision n=1,391) or a control group (delayed circumcision, 1,393)
  - Assessed by HIV testing, medical exams and behavioural interviews
  - After adjustment, the **protective effect of circumcision was 60%** (32–77)

Chapter 1: MC and HIV Infection 15

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Slide 16



### RCT Findings from Rakai, Uganda

- Gray, R et al. 2007. *Lancet* 369: 457–466:
  - Randomized trial of 4,996 uncircumcised, HIV-negative men aged 15–49 years in rural Rakai district, Uganda
  - Assigned for immediate circumcision (n=2,474) or circumcision delayed for 24 months (2,522)
  - After 24 months, the estimated efficacy of intervention was 51% (95% CI 16–72; p=0.006)

Chapter 1: MC and HIV Infection 16

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Slide 17



### WHO Comments and Recommendations on MC

- The 3 RCTs showed that **male circumcision** was safe and reduced the risk of acquiring HIV infection by **approximately 60%** and therefore:
  - **Male circumcision** should now be recognized as an **efficacious intervention for HIV prevention**.
  - Male circumcision **should be recognized as an additional, important strategy** for the prevention of HIV infection in men.

Chapter 1: MC and HIV Infection 17

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Slide 18



### Biological Reasons for MC's Protective Effect against HIV

- The **inner foreskin** is much less keratinized than other genital mucosa, so its **numerous Langerhans cells** and other immune cell targets are **unusually susceptible to HIV infection**.
- In an *in vitro* study, viral uptake in this tissue was 7 times more efficient than in cervical tissue.

Chapter 1: MC and HIV Infection 18

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Slide 19

**HIV Entry Points on the Penis**

Source: McCoombe and Short, 2008; AIDS 2006 20: 1491-1495.

Chapter 1: MC and HIV Infection 19

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Slide 20

**Biological Reasons for MC's Protective Effect against HIV (cont.)**

- The highly vascularized foreskin mucosa, which is prone to tearing or bleeding during intercourse (especially with the "dry sex" practices common in Southern Africa), facilitates HIV infection in uncircumcised men.
- Also, ulcerative STIs like HSV-2, chancroid and syphilis, which are more prevalent in uncircumcised men, facilitate HIV infection.

Chapter 1: MC and HIV Infection 20

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Slide 21

**MC Protection for Women**

- A multi-country study\* found HPV infection was lower in circumcised men and, as long suspected, cervical cancer rates were higher in the female partners of uncircumcised men.

\* New Engl J Med 2002, 346: 1105-1112.

Chapter 1: MC and HIV Infection 21

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Slide 22



### Other Health Benefits of MC

- MC eliminates or greatly reduces the risk of:
  - Human papillomavirus (HPV) infection
  - Invasive penile cancer

Chapter 1: MC and HIV Infection 22

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Slide 23



### Exercise 1.3: Cultural Issues— Group Discussion

Divide into country or district teams of 4 or 5 individuals.

- Discuss the following issues:
  - Cultural view on male circumcision and changes to that view as a result of evidence linking it to HIV prevention
  - Cultural factors that **MUST** be considered in order to link male circumcision to other male reproductive health services
  - A list of stakeholders to be involved in the formulation of a policy on male circumcision
  - One member of your group to present a summary
  - Duration: 20 minutes

Chapter 1: MC and HIV Infection 23

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Slide 24



### Summary Questions

- What is male circumcision?
- List five benefits of male circumcision.
- List three risks of male circumcision.
- What is the relationship between MC and HIV infection?

Chapter 1: MC and HIV Infection 24

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Slide 25



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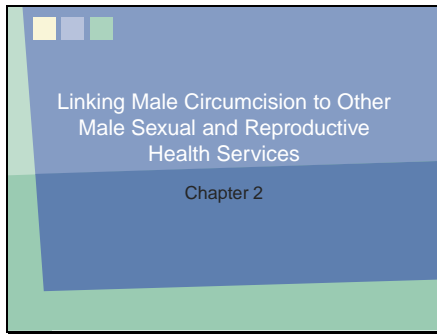
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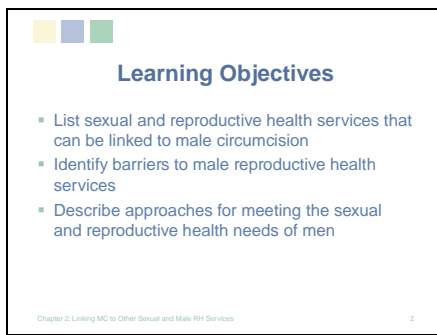
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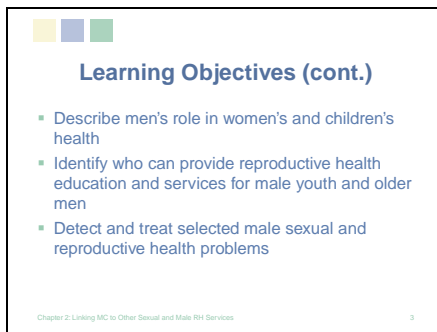
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Slide 4

**What does MC not do?**

- Male circumcision **does not** provide:
  - 100% protection against HIV infection and STIs;
  - Protection against unwanted pregnancy in one's sexual partner;
- Therefore, there is a need to link MC with other sexual and reproductive health services

Chapter 2: Linking MC to Other Sexual and Male RH Services 4

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Slide 5

**MC vs. HIV**

Chapter 2: Linking MC to Other Sexual and Male RH Services 5

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Slide 6

**Male Circumcision Is an Entry Point to Male Reproductive Health Services**

Chapter 2: Linking MC to Other Sexual and Male RH Services 6

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Slide 7

**No Missed Opportunities!**

- There should be no missed opportunities for advancing male involvement in sexual and reproductive health.
- Educate boys and men about SRH.

Chapter 2: Linking MC to Other Sexual and Male RH Services 7

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Slide 8

**Barriers to Male RH Services**

- **Lack of information** about men's needs and concerns that could be used to design appropriate programs and services
- Men's embarrassment and alienation due to a **lack of clinics that address men's reproductive health needs**
- Men's **hesitance to seek medical care**
- **Inadequate training** of health workers to address men's sexual and reproductive health issues
- **Limited availability of contraceptive methods** for men

Chapter 2: Linking MC to Other Sexual and Male RH Services 8

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Slide 9

**Barriers to Male RH Services (cont.)**

- **Negative attitudes of policymakers and service providers towards men;** for example (1):
  - Viewing men as irresponsible, or
  - Viewing men as not interested in playing a positive role in support of women's reproductive needs, or
  - Viewing men as not an appropriate clientele for reproductive health services

Chapter 2: Linking MC to Other Sexual and Male RH Services 9

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Slide 10



### Barriers to Male RH Services (cont.)

- **Negative attitudes of policymakers and service providers towards men;** for example (2):
  - **Unfavorable legal and policy constraints**, such as bans on promotion of condoms
  - **Logistical constraints**, such as lack of separate waiting and service areas for men
  - Lack of trained male staff
  - Lack of male-friendly clinics and inconvenient clinic hours for working men

Chapter 2: Linking MC to Other Sexual and Male RH Services 10

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Slide 11



### What can you do?



Chapter 2: Linking MC to Other Sexual and Male RH Services 11

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Slide 12



### Meeting the Sexual and Reproductive Health Needs of Men

- **Add sexual and reproductive health services for men**
- **Establish separate services for information, education and counselling on:**
  - Sexuality education and physiological development
  - Family planning education and counselling
  - STI and HIV education and counselling
  - Genital health and hygiene
  - Interpersonal communication skills, sexual and reproductive behaviour

Chapter 2: Linking MC to Other Sexual and Male RH Services 12

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Slide 13



### Meeting the Sexual and Reproductive Health Needs of Men (cont.)

- **Screen clients for:**
  - STIs and HIV
  - Infertility
  - Sexual dysfunction
  - Male genital tract cancers
- **Diagnose, treat or refer clients with:**
  - Sexual dysfunction
  - STIs and HIV
  - Cancer of the prostate, testis and penis
  - Medical indications for male circumcision
  - Valuation of infertility

Chapter 2: Linking MC to Other Sexual and Male RH Services 13

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Slide 14



### Other Approaches

- **Community-based distribution of male contraceptives** using male field workers
- **Condom social marketing**—community distribution of condoms using male field workers
- Reaching men with **information and services through the workplace**, the military and men's groups

Chapter 2: Linking MC to Other Sexual and Male RH Services 14

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Slide 15



### Other Approaches (cont.)

- **Special outreach campaigns** to young men
- **Educational campaigns** through the media
- **Special initiatives**, such as outreach through popular **sporting events** such as football matches
- **Promotion of vasectomy** as appropriate

Chapter 2: Linking MC to Other Sexual and Male RH Services 15

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Slide 16



### Gender Issues

- Identify the needs and perceptions of both men and women, and young people
- Use gender analysis as a tool to examine the gender implications of proposed activities
- Evaluate the impact of activities using gender-related indicators

Chapter 2: Linking MC to Other Sexual and Male RH Services 16

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Slide 17



### Men's Role in Women's and Children's Health

- Preventing the spread of STIs to their partners by using condoms consistently and correctly and supporting and **encouraging regular condom use by others**
- Using or **supporting the use by partners of contraception** so that women are better able to control the number and timing of pregnancies

Chapter 2: Linking MC to Other Sexual and Male RH Services 17

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Slide 18



### Men's Role in Women's and Children's Health (cont.)

- **Supporting women** during pregnancy, childbirth and the postpartum period
- **Supporting women to make decisions** about their health in the absence of their partners
- **Responding to** the physical and emotional needs of women following abortion

Chapter 2: Linking MC to Other Sexual and Male RH Services 18

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Slide 19



### Men's Role in Women and Children's Health (cont.)

- Refraining from, and encouraging others to avoid, all forms of violence against women and girls
- Working to end harmful sexual practices, such as female genital mutilation and "dry sex"
- Sharing financial resources with women, and supporting the notion of shared property rights

Chapter 2: Linking MC to Other Sexual and Male RH Services 19

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Slide 20



### Men's Role in Women and Children's Health (cont.)

- Supporting women's full participation in civil society, including their access to:
  - Social, political and educational opportunities, many of which have a direct or indirect impact on women's health
- Supporting the rights of daughters to the same health care, education and respect as sons

Chapter 2: Linking MC to Other Sexual and Male RH Services 20

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Slide 21



### Exercise 2.1: Male Sexual and Reproductive Health Services: Debate

- Divide into two teams – A and B
  - Team A:
    - Develop an argument in support of family, peers, school and religious community as primarily responsible for supporting male sexual and reproductive health care services
  - Team B:
    - Develop an argument in support of the health care system (family planning, STI, HIV clinics) as primarily responsible for supporting male sexual and reproductive health care services
- A representative of each team should present the argument prepared by the team to the other side
- The other team should try to rebut the argument
- Duration: 30 minutes

Chapter 2: Linking MC to Other Sexual and Male RH Services 21

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Slide 22

Who should provide SRH services and information boys and men?

- Parents
- Teachers
- Peers
- Media (including Internet sources)
- Community-based organizations, e.g., churches and youth groups
- Family planning clinics
- STI clinics
- HIV services
- Youth-friendly services
- Health professionals

Chapter 2: Linking MC to Other Sexual and Male RH Services 22

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Slide 23

Detection and Treatment of Selected Male SRH Problems



Chapter 2: Linking MC to Other Sexual and Male RH Services 23

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Slide 24

Sexually Transmitted Infections

- Causes of STIs in men may include:
  - Gonorrhoea urethritis
  - Chlamydial infection (commonest cause of non-gonococcal urethritis)
  - Balanitis caused by candida albicans
  - Trichomoniasis

Chapter 2: Linking MC to Other Sexual and Male RH Services 24

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Slide 25

**Sexually Transmitted Infections (cont.)**

- **Causes** of STIs in men may include:
  - **Genital ulcers, vesicles and buboes** due to:
    - Chancroid (soft chancre)
    - Syphilis
    - Lymphogranuloma venereum (LGV)
    - Granuloma inguinale (Donovanosis)
    - Genital herpes
    - Genital warts (condylomata acuminata)

Chapter 2: Linking MC to Other Sexual and Male RH Services 25

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Slide 26

**Sexually Transmitted Infections: Signs & Symptoms**

- **Painful urination** or burning sensation in the penis
- **Genital ulcer**

Chapter 2: Linking MC to Other Sexual and Male RH Services 26

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Slide 27

**Sexually Transmitted Infections: Signs & Symptoms (cont.)**

- **Urethral discharge** (with or without milking of urethra)



Chapter 2: Linking MC to Other Sexual and Male RH Services 27

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**Sexually Transmitted Infections:  
Laboratory Tests**

- Urethral smear:
  - Wet mount (may show increased number of polymorphonuclear leukocytes; >5/high power field suggests urethritis)
  - Gram stain (may show gonococci organisms)

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**Sexually Transmitted Infections (cont.)**

- Treatment:
  - Treat STIs including genital ulcerative disease (GUD) according to national treatment guidelines
  - For STI patients seeking non-medically indicated male circumcision, **delay surgery until the condition has been satisfactorily resolved**

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**Balanitis**

- Definition:
  - Inflammation of the skin covering the head of the penis
  - Most often occurs in men and boys who have **not been circumcised** and who have **poor personal hygiene**



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### Symptoms of Balanitis

- Redness or swelling,
- Itching,
- Rash,
- Pain, and
- Foul-smelling discharge.

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### Causes of Balanitis

- **Phimosis:** the foreskin is too tight to be retracted, allows dead skin cells, smegma and bacteria to accumulate under the foreskin
- **Dermatitis/allergy:** An inflammation of the skin often caused by an irritating substance or an allergic reaction to chemicals in certain products
- **Thrush infection** with the yeast *Candida albicans*
- Certain STIs can produce symptoms of balanitis

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### Treatment of Balanitis

- Treatment for balanitis *depends on the underlying cause:*
  - If there is an infection, treatment will include an appropriate **antibiotic** or **antifungal** medication according to national guidelines
  - In cases of severe or persistent inflammation, a **circumcision** may be recommended
  - In cases of severe or persistent inflammation, **or if there is difficulty in retracting the foreskin (phimosis), circumcision is usually the best treatment**

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**Phimosis**

- **Definition:**
  - A condition in which the foreskin of the penis is so tight that it cannot be pulled back (retracted) from the head of the penis



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**Causes of Phimosis**

- Can occur at any age and may be present at birth
- Can be caused by:
  - **Infection** (e.g., recurrent balanitis)
  - **Scar tissue** formed as a result of **injury** or **chronic inflammation**
- Very tight phimosis can interfere with urination, causing a thin urinary stream

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**Treatment of Phimosis**

- In **extreme cases**, urine collecting between the foreskin and glans can cause ballooning of the foreskin and an **urgent circumcision is necessary**, usually using the dorsal slit method.
- If **seen at the district health facility**, the **patient should be referred** to a higher level of care for proper assessment and treatment, which will usually involve circumcision.

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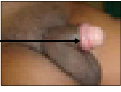
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**Paraphimosis**

- Paraphimosis occurs when the **retracted foreskin cannot be put back in place because of swelling**
- Occurs when the penis is erect** and during sexual intercourse
- The retracted foreskin swells and tightens around the penis causing more swelling

Swollen retracted foreskin 

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**Treatment of Paraphimosis**

- Wrap the swollen area in gauze and apply increasing pressure on the gauze to **squeeze the tissue fluid out** for 10–15 minutes of pressure.
- It is then usually possible to **replace the foreskin back** over the glans.
- Circumcision can then be done **as a planned procedure a few days later**.
- If this procedure fails, or in cases of chronic paraphimosis, send the man to the nearest surgical referral centre.

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**Treatment of Paraphimosis (cont.)**

- If the patient is seen at a district level facility, refer to higher level of care for emergency treatment.**



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### Urinary Tract Infections (UTIs)

- Urinary infections are infrequent in adult men but **more frequent in children and older men.**
- Usually there is an underlying cause, for example, kidney or bladder stones.
- All men and boys with symptoms of urinary tract infection **should be referred** to the appropriate hospital for investigation.

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### Symptoms of UTIs

- A frequent **urge to urinate**
- **Pain and burning feeling** in the area of the bladder or urethra during urination (dysuria)
- Feeling tired, shaky and weak (**malaise**)
- Feeling pain in the bladder or urethra even when not urinating
- Despite an intense urge to urinate, only a **small amount of urine is passed**

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### Symptoms of UTIs (cont.)

- **Urine** may look **milky or cloudy, or reddish** if blood is present
- **Fever** (suggesting that the infection has reached the kidneys)
- **Pain in the back or side**, below the ribs
- **Nausea and vomiting**

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### Diagnosis and Treatment of UTIs

- **Distinguish from urethral discharge** caused by sexually transmitted infections
- Encourage patient to **drink plenty of water**
- **Give appropriate antibiotic** to treat the underlying cause of the infection

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### Infertility

- **Failure to conceive after at least 12 months of unprotected vaginal intercourse**
- **Involves 60–80 million couples worldwide** and majority in developing countries
- **Most** cases of infertility in developing countries are **attributable to STIs**, resulting in **tubal damage** and **obstructed sperm ducts**
- Reproductive tract infections in men can affect the prostate, the epididymis, or the testis

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### Infertility (cont.)

- In many societies, childlessness is **highly stigmatized**:
  - The female partner is considered responsible for the failure, resulting in marital tension, divorce, polygamy and ostracism
- A WHO investigation of 5,800 infertile couples concluded that:
  - **Infertility is driven by high rates of STIs**, particularly in developing countries
  - **Reduced male reproductive capacity is contributing at least 50% of these couples**

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### Infertility (cont.)

- In order to provide more efficient, systematic and economic care for infertile couples, **health care providers must ensure that all essential information is collected.**
- The **WHO manual** on infertility **provides clear guidelines and a logical sequence of steps** for clinicians to follow in evaluating both partners of the infertile couple.

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### Summary Questions

- Does male circumcision provide full protection against HIV acquisition?
- List some other sexual and reproductive health needs of men and boys.
- Who should provide sexual and reproductive health education for boys and young men?
- What is the difference between phimosis and paraphimosis?

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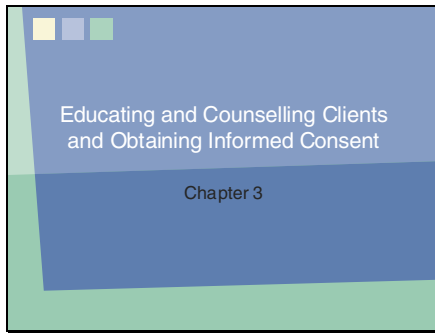
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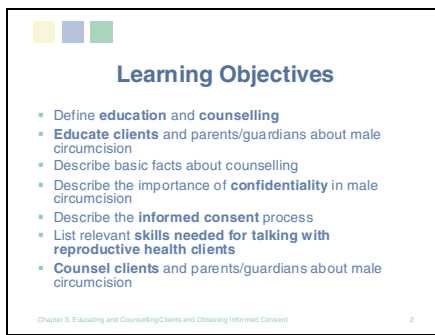
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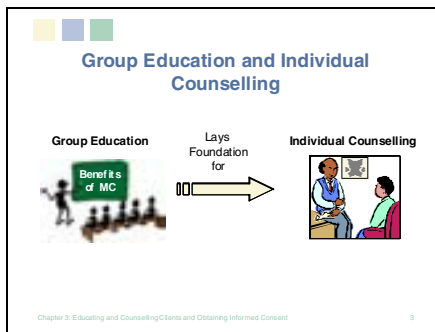
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### Group Education

- Used to **support counselling services**
- Allows clients to be **given information**, before an individual counselling session
- Allows counsellors to work more with clients on specific issues regarding MC, SRH
- Makes the first counselling session shorter, an advantage for busy MC and RH sites



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Slide 5



### Key Messages on Male Circumcision and Male Reproductive Health

- Men and boys also have sexual health and reproductive health needs, just like women and girls
- Description of male circumcision including:
  - Definition of MC
  - Benefits and risks of MC
  - How the surgical procedure is performed
  - What happens after MC

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### Key Messages on Male Circumcision and Male Reproductive Health (cont.)

- Importance of knowing one's HIV status, including:
  - How HIV is transmitted
  - How to protect oneself from HIV
  - Where support can be found if client tests positive
  - Importance of partner testing
- Patients with STIs have a greater chance of becoming infected with and transmitting HIV

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**Key Messages on Male Circumcision and Male Reproductive Health (cont.)**

- Importance of avoiding HIV infection and strategies for reducing the risk of acquiring HIV infection:
  - Abstinence
  - Being faithful/Partner reduction
  - Condoms

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**Key Messages on Male Circumcision and Male Reproductive Health (cont.)**

- Patients with STIs have a greater chance of becoming infertile in the future.
- **Only condoms**, when consistently and properly used, **protect against STIs and HIV infection**.
- **Vasectomy** is the most effective and permanent male contraceptive method, but **does not protect against STIs/HIV**.
- Men should **support emergency contraception**, e.g., when the condom breaks or slips off.

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**Key Messages on Male Circumcision and Male Reproductive Health (cont.)**

- **Men should treat women as equal partners** in sexual and reproductive health decision-making.
- **Men should support women's sexual and reproductive health and children's well-being**, with equal regard for female and male children.
- **The importance of not perpetuating gender-based violence** against women and young girls, and not forcing women to have sex against their wishes (rape), should be stressed.

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**Group Education: What is male circumcision?**

- Male circumcision is the **surgical removal of the foreskin** of the penis (also called the prepuce).
- MC is one of the **oldest surgical procedures** in history.



*Children in Uganda*

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**Group Education: Benefits of MC**

- The health benefits of MC include:
  - Reduced risk of urinary tract infections in childhood
  - Reduced risk of some STIs in men, e.g., herpes, syphilis
  - Some protection against cancer of the penis
  - Reduced risk of HPV infection and cervical cancer in female sex partners
  - Prevention of several medical problems of the penis and foreskin such as balanitis, phimosis and paraphimosis

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**Group Education: Level of Protection Provided by MC against HIV**



Because **MC does NOT provide 100% protection against HIV** acquisition and transmission, **safer sex** (i.e., ABC—abstinence, being faithful and using condoms) **remains the best line of defense against HIV infection.**

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### Group Education: Risks of MC

- There are risks associated with circumcision, but they are low in well-equipped and organized facilities.
- Problems associated with circumcision may include:
  - Pain
  - Bleeding
  - Swelling of the penis (**haematoma** formation)
  - Infection of the surgical wound
  - Increased sensitivity of the exposed penis (glans)

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### Group Education: When to Resume Sexual Intercourse after MC

- Because it takes:
  - 4–6 weeks for the MC wound to become strong enough to withstand gentle sexual intercourse
  - 3–4 months for MC to completely heal
- Clients **must**:
  - Avoid sexual intercourse or masturbation for first 4–6 weeks after MC
  - Use condoms for at least 6 months until the wound is completely healed

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### Exercise: Group Education Practice

- Divide into groups of three. Participants will act the following roles:
  - Counsellor
  - Client
  - Observer
- Each participant will practice giving group education on MC. Rotate roles after 10 minutes.
- Duration: 60 minutes

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## Counselling about Male Circumcision

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## Counselling and Group Education

- How does **counselling** differ from group education?



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## Counselling

- Definition:**
  - Counselling is a process in which individual communication is used to **help people examine personal issues, make decisions and make plans for taking action.**
- In counselling for MC, **the provider ensures that the client (or if the client is a minor, his parents) has all of the necessary information** he needs to make a decision about undergoing the procedure.

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### Counselling (cont.)

- Counselling is **NOT**:
  - Telling clients what to do
  - Criticizing clients
  - Forcing ideas or values on clients
  - Taking responsibility for clients' actions or decisions



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### Counselling Involves...

- **Listening** to clients or parents of young boys
- **Respecting** clients' needs, values, culture, religion and lifestyle
- **Talking with clients about the risks and benefits** of circumcision
- **Answering clients' and/or parents' questions** about the male circumcision procedure and myths
- Asking clients and/or parents questions that help them identify risky behaviours of acquiring STIs or HIV

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### Counselling Involves...

- **Allowing clients and/or their parents to make their own informed decisions** on whether or not to choose male circumcision
- Helping clients understand the benefits of knowing their HIV status
- Helping clients understand their HIV or STI test results

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### Counselling Involves...

- **Helping HIV-negative clients** understand that male circumcision does not provide full protection against HIV infection and suggesting how they can **stay negative**
- Helping HIV-positive clients to find support and treatment services and ways to **avoid spreading HIV to others**
- **Helping clients obtain other services**, such as family planning, screening and treatment for STIs, and counseling and treatment for alcohol and drug abuse

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### Confidentiality

- Confidentiality is an important characteristic of all SRH services.
- **Counsellors should keep all client information private** and allow clients to decide when and with whom to discuss their sexual and reproductive health problems.
- Clients will feel more comfortable about sharing personal information with counsellors and getting tested for STIs or HIV if they know this information will remain secret.

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### Confidentiality (cont.)

- Confidentiality is important because stigma is associated with conditions and behaviours perceived as unusual.
- An atmosphere of trust will encourage clients to discuss other sexual and RH needs.
- Sometimes, health care workers at a clinic need to know a client's HIV status. The counsellor should give this information to the client before the client makes a decision about the service.

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**Informed Consent for Surgery**

- The **goal** of this consent process **is to ensure the clients and/or the parents understand** the surgical procedure. At the same time, they should be given the opportunity to make use of other sexual and reproductive health services.
- **Only clients or parents** who have appropriate decision-making capacity and legal status **can give their informed consent to medical care.**

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**Elements of Informed Consent**

- Provision of **full information** in plain language (including benefits and risks of MC)
- **Assessment of patient's understanding** of the information provided
- Assessment of the **capacity of the patient to make the necessary decision(s)**
- **Assurance that the patient has the freedom to choose** whether or not to be circumcised without coercion or manipulation

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**Informed Consent (cont.)**



- For MC in **underage children, parents or guardians must give a written, informed consent** based on full information about the procedure.

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**Adolescent Boys: Consent and Confidentiality for MC**

- It is important that health care workers know how to respond to an adolescent boy's request for circumcision in a way that respects confidentiality.
- Health care workers need to know what the law says about consent for minors (at what age and in what circumstances can minors **legally** make an independent decision to seek clinical or medical services without agreement of their parents or guardian?).

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**Adolescent Boys: Consent and Confidentiality for MC (cont.)**

- **No adolescent boy should be subjected to a medical procedure**, such as circumcision or HIV testing, **without his informed consent**.
- All health services provided to adolescents should be confidential.
- Health care workers should be guided in their response to adolescents by human rights principles: all adolescents have a right to use health services.

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**Adolescent Boys: Consent and Confidentiality for MC (cont.)**

- **Circumcision is an opportunity to make contact with adolescent boys and provide them with information and counselling about their own sexual and reproductive health** and that of their current or future partners.
- Adequate time must be allowed for counselling.
- Adolescents must be advised to return after the procedure for a check-up and further counselling and information on condom use.

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### Basic Counselling Skills

- Empathizing
- Active listening
- Questioning
- Focusing
- Affirming
- Clarifying and correcting misperceptions
- Summarizing

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### Exercises for Module 3

- Work in pairs
- Read Module 3 exercises and answer the questions that follow
- Duration: 20 minutes

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### Question #1

What type of questions are these (open-ended or closed questions)?

**Question #1.1:** How old are you?  
**Answer #1.1:** Closed

**Question #1.2:** What has brought you here today?  
**Answer #1.2:** Open

**Question #1.3:** Did you come to the clinic with anyone?  
**Answer #1.3:** Closed

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**Question #1 (cont.)**

**Question #1.4:** Can you tell me more about the pain you are experiencing in your penis?  
**Answer #1.4:** Open

**Question #1.5:** Why do you want to undergo a male circumcision?  
**Answer #1.5:** Open

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**Question #2**

**Question 2.1:** Which counselling skill is demonstrated in this dialogue:

- Patient: I have been working on my tobacco addiction. I now smoke fewer than five cigarettes a day.
- Counsellor: It's really good to know that you are taking some positive steps to change those behaviours that put you at risk.

**Answer 2.1:** Affirming

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**Question #2 (cont.)**

**Question 2.2:** Which counselling skill is demonstrated in this dialogue:

- Patient: My dad is insisting that I should have this male circumcision done because he heard that it would protect me against HIV infection. But most of my friends in school have not had it done and my teacher thinks it is unnecessary. I don't know how to tell my father. In any case, he may be right.
- Counsellor: Help me understand this. You are afraid to tell your father that some of your friends and your teacher think that male circumcision is unnecessary, even though he has a different view and wants you to be circumcised in order to protect you from HIV infection.

**Answer 2.2:** Clarifying

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### Question #2 (cont.)

**Question 2.3:** Which counselling skill is demonstrated in this dialogue:

- Patient: Doctor, I do not want to have any more children but I am afraid of undergoing vasectomy, which I heard can lead to failure of erection.
- Physician: You mentioned that you heard that vasectomy could lead to erectile dysfunction. Actually, many people believe this, especially in Africa, but it is untrue. Vasectomy on its own does not cause erectile dysfunction. There are many other causes of erectile dysfunction in men, whether circumcised or uncircumcised.

**Answer 2.3:** Correcting false information

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### Question #3

A couple has brought a 12-year-old boy to the male circumcision clinic to undergo the procedure. During client assessment, the boy tells you he does not want to have the procedure done.

**Question 3.1:** What will you do?

**Answer 3.1:**

- Ask the parents why they want the boy to be circumcised
- Also, ask if they have discussed the matter with the boy
- If so, ask them about the boy's reaction
- Educate the parents about the importance of verbal and/or written consent before the procedure can be done

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### Integrating Clinical MC with Traditional Practices

- The increasing interest in clinical circumcision in countries that have a culture of traditional circumcision provides an opportunity to integrate the traditional event with safer clinical procedures.
- The "rites of passage from adolescence to adulthood" are usually both festive and educational for participants and the community.

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### Exercise 3.1: Integration with Traditional Circumcision Events

- Work in groups of four or five individuals.
- Discuss the coordination of a group circumcision event with traditional circumcisers in the community (20 min):
  - What value and social power does the traditional circumciser bring to the community?
  - How would you explain the value of medical circumcision to the traditional circumciser?
  - List the essential components of the group circumcision event and discuss which components are MOST appropriate for the traditional circumciser and which are most appropriate for the health care provider.
- Nominate one member of your group to present a summary of your discussion to all workshop participants.

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### Integrating Clinical MC with Traditional Practices (cont.)

- Educational topics may include:
  - Physical and psychological changes that occur during adolescence
  - Sexuality and gender issues
  - Male and female reproductive health rights
  - Sexually transmitted infections
  - HIV and AIDS

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### Integrating Clinical MC with Traditional Practices (cont.)

- Educational topics may include:
  - The **ABC** of safer sex practices (**A**bstinence, **B**eing faithful, **U**se of **C**ondoms)
  - Family planning
  - Substance abuse (drugs, alcohol, tobacco)
  - Violence (including gender-based violence)
  - Community expectations of men
  - Goal setting and decision-making

Chapter 3: Educating and Counselling Clients and Obtaining Informed Consent 42

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Slide 43



### Exercise 3.3: Spontaneous Word Association

- Work individually
- Write down the first three words or phrases that come to your mind when the trainer mentions a particular word or words
- Duration: 1 minute per word:
  - Teenage boys
  - Teenage girls



Chapter 3: Educating and Counselling Clients and Obtaining Informed Consent 43

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Slide 44





**“Providers must not allow their individual prejudices and beliefs to interfere with the way they relate to young people seeking services at their place of work.”**

Chapter 3: Educating and Counselling Clients and Obtaining Informed Consent 44

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Slide 45



### Summary

- **Group education is used to support counselling services.**
- It allows clients to learn basic reproductive health information (including HIV) before a counselling session.
- Where tradition demands the holding of group circumcision for young boys, health care providers should work with the community to design a **joint education/surgical event** that will integrate traditional customs and practices with modern clinical circumcision.

Chapter 3: Educating and Counselling Clients and Obtaining Informed Consent 45

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Slide 46



### Summary (cont.)

- Basic counselling skills that all RH counsellors need in order to talk with clients in a helpful way include:
  - Empathizing,
  - Active listening,
  - Open questioning,
  - Probing,
  - Focusing,
  - Affirming,
  - Clarifying,
  - Correcting false information, and
  - Summarizing.

Chapter 9: Educating and Counselling Clients and Obtaining Informed Consent 46

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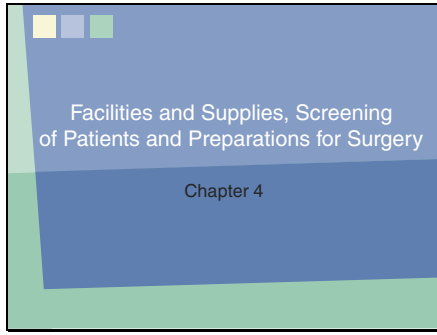
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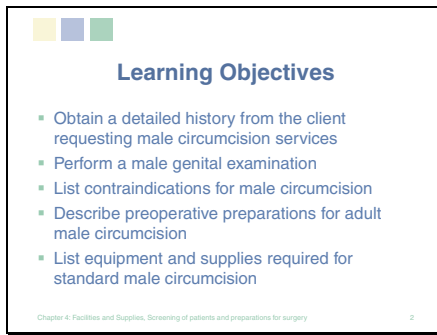
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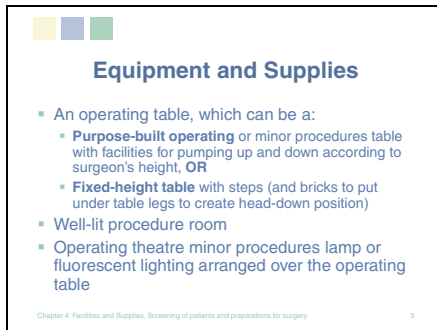
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Slide 3



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Slide 4

MC Equipment



Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 4

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Slide 5

Equipment and Supplies (cont.)

- Instrument tray wrapped with sterile drape (1)
- Dissecting forceps (finely toothed)
- Artery forceps (2 straight, 2 curved)
- Curved Metzenbaum's scissors (1)
- Stitch scissors (1)
- Mayo's needle holder (1)
- Sponge holding forceps (1)
- Scalpel knife handle and blades
- "O" drape (80 cm x 80 cm, with ~5 cm hole)
- Gallipot for antiseptic solution (e.g., povidone iodine)

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 5

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Slide 6

Equipment and Supplies (cont.)

- Povidone iodine (50 ml of 10% solution)
- Plain gauze swabs (10 x 10 cm, 15 pieces)
- Petroleum-jelly-impregnated gauze (5 x 5 cm or 5 x 10 cm) and sticking plaster
- 15 ml of 1% plain lidocaine (without epinephrine) anaesthetic solution
- Syringe, 10 ml and needles (single-use or steam sterilizable)
- Injection needles (18- and 21-gauge)
- Suture material (chromic catgut or vicryl, 3-0 or 4-0 with 3/8 circle reverse-cutting needle)
- Gentian violet (5 ml or less) or sterile marker pen
- Gloves, masks, caps and aprons
- Condoms and information materials for clients

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 6

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Slide 7

**Equipment Maintenance**

- Checklist for haemostatic artery forceps:
  - Do the points meet accurately?
  - Is the grip on the points worn?
  - Does the ratchet lock securely or is it worn?



Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 7

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Slide 8

**Equipment Maintenance (cont.)**

- Check list for surgical dissection scissors:
  - Is the cutting edge of the blade sharp?
  - Do the blades meet securely?
  - Is the screw loose?



Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 8

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Slide 9

**Equipment Maintenance (cont.)**

- Checklist for needle holders:
  - Do the points meet accurately?
  - Is the grip on the points worn?



Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 9

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Slide 10

**Equipment Maintenance (cont.)**

- **Checklist for dissection forceps (tweezers):**
  - Do the points meet accurately? (crossed points are a common problem with old worn instruments)
  - If toothed, are the teeth worn?



Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 10

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Slide 11

**Screening the Adult Client for MC under Local Anaesthesia in the Clinic**

- The circumcision team needs to ensure that clients are:
  - **Fit for surgery**
  - **Well informed** about the surgery
  - **Suitable for circumcision under local anaesthesia** in the clinic
- **If there is any doubt as to suitability, the client should be referred to the district hospital or higher level of care.**

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 11

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Slide 12

**History Taking**

**When taking medical history, enquire about:**

- Current general health
- Client taking any medicines
- Client has any known allergies to medicines
- History of haemophilia, bleeding disorders or anaemia
- Any current genital infection, ulcer or penile discharge
- Client has problems with penile erection or any other concerns about sexual function

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 12

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Slide 13

**Genital Examination**

- Physical **examination of the penis** should include:
  - Retraction of the foreskin to **inspect the glans**
  - Inspection of the **position of the urinary opening** (which should be near the tip of the glans)
  - Absence of scarring or disease
  - Easy retraction of foreskin and absence of inflammation or narrowing

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 13

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Slide 14

The diagram shows two views of the penis, labeled A and B. View A is labeled 'Appearance of the genital penis before circumcision' and shows the foreskin covering the glans. View B is labeled 'Appearance of the genital penis after circumcision' and shows the glans exposed. Labels include 'Glans', 'Foreskin covering the tip of the penis', 'Urethral meatus', and 'Corona of the penis'.

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 14

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Slide 15

**Absolute Contraindications to Clinic-Based Circumcision**

- Anatomic abnormality of the penis:** For example, the urethral meatus is on the underside of the penis (hypospadias) or on the upper side of the penis (epispadias). The foreskin may be needed for repair.
- Chronic **paraphimosis:** The foreskin is permanently retracted, thickened and swollen (refer patient).
- Genital ulcer disease:** Should be investigated and treated before MC.

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 15

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Slide 16

  
**Absolute Contraindications to Clinic-Based Circumcision (cont.)**

- **Urethral discharge:** should be investigated and treated before MC
- **Penile cancer:** refer to specialist
- Chronic disorders of the penis and foreskin e.g., **filariasis:** refer to specialist
- **Bleeding disorder** such as haemophilia (refer patient to a higher level)

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 16

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Slide 17

  
**Relative Contraindications to Clinic-Based Circumcision**

- The following conditions **require referral** to the specialist:
  - A tight foreskin as a result of scar tissue (**phimosis**)
  - **Scar tissue** at the frenulum (consequence of repeated tearing)
  - Extensive **penile warts:** Penile warts can cause a lot of bleeding. (Refer patient to site where diathermy is available.)

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 17

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Slide 18

  
**Relative Contraindications to Clinic-Based Circumcision (cont.)**

- The following conditions **require referral** to the specialist:
  - **Balanitis xerotica obliterans** (plaque of scar tissue extending onto the surface of the glans and involving the urethral meatus and foreskin) (refer patient)
  - **Sickle cell disease**
  - **Other abnormalities** of the genitalia, such as hydrocele causing swelling (refer patient)

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 18

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Slide 19



### Informed Consent for Surgery

- The circumcision team should **ensure that the client has been informed about the risks and benefits** of male circumcision, using everyday local language.
- The **oral information** should be backed up by **written information sheets** in the local language.
- The client should be allowed to ask questions. He should then be given time to reflect before being asked to sign the certificate of consent. (See Appendices 4.2 and 4.3 for sample consent forms.)

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 19

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Slide 20



### Preoperative Washing and Shaving

- The client should **wash the genital area and the penis with water and soap on the day of surgery**. He should **retract the foreskin and wash under it**.
- Immediately prior to the operation, the skin is further cleaned with povidone iodine.
- **Pubic hair shaving is not recommended (damages skin and promotes infection).**

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 20

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Slide 21



### Preoperative Washing and Shaving (cont.)

- The **advantages of NOT shaving**:
  - Saves time and razors
  - Reduces the number of sharps and the risk of sharps injuries
- The **advantages of shaving** are that:
  - It avoids contamination of the operation field
  - It is easier to fix the wound dressing to the skin
- It is **preferable to clip** long pubic hair at home or at the clinic, just before surgery.

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 21

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Slide 22

**When Scrubbing...**

- Prior to scrubbing, **remove all jewellery and ensure nails are trimmed or filed**
- Use soap, a brush (on the nails and fingertips) and **running water** to clean thoroughly around and underneath the nails
- Scrub hands and arms up to the elbows
- Hold up arms to allow water to drip off your elbows
- Turn off the tap with the elbow



Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 22

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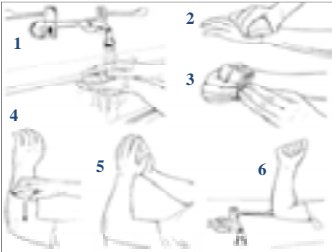
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Slide 23

**What do we learn from these graphics?**



Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 23

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Slide 24

**After Scrubbing...**

- **Dry hands with a sterile towel** and make sure the towel does not become contaminated by coming into contact with non-sterile surfaces.
- **Hold hands and forearms away from the body and higher than the elbows** until the sterile gown and sterile gloves have been put on.

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 24

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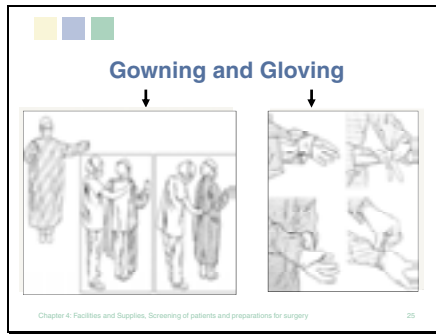
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Slide 25



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Slide 26

**Exercise 4.1: Recognition of Circumcision Equipment**

- Be prepared to be assigned to a team of 4 or 5 people.
- Your team will be given a bag containing equipment. Some of this equipment is required and some NOT required for standard male circumcision.
- When the instructor says "go", your team will have 3 minutes to select the equipment that is essential to standard male circumcision.
- Your team will gain one point for each essential piece of equipment and lose one point for each non-essential piece of equipment selected.
- The team with the MOST points that finishes first is the winner.

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 26

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Slide 27

**Exercise**

- Work individually
- Review:
  - Appendix 4.1: Sample client record form for adults and adolescents
  - Appendix 4.2: Sample disposable consumables for one adult male circumcision
  - Appendix 4.3: Detailed anatomy of the penis
- Duration: 30 minutes

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 27

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## Slide 28



### Summary

- The goal of assessing the client before circumcision is to **detect contraindications** and conditions that need treatment or referral.
- The assessment includes **history taking, physical examination** and, occasionally, laboratory testing.
- The surgeon should **adopt good aseptic technique**.
- Each clinic should **carry out a periodic review of surgical instruments for wear-out**.

Chapter 4: Facilities and Supplies, Screening of patients and preparations for surgery 28

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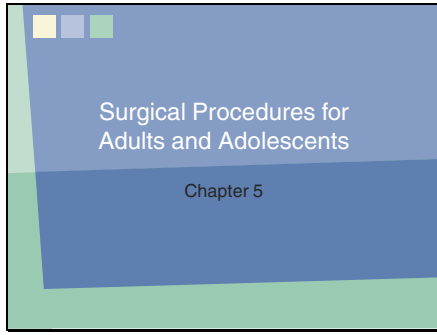
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Slide 1



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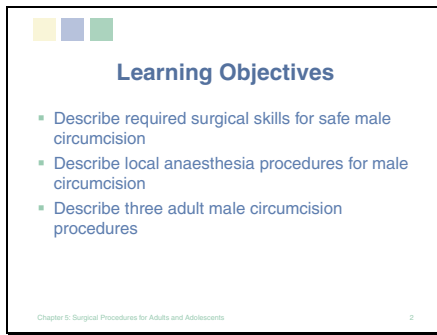
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Slide 2



- Learning Objectives**
- Describe required surgical skills for safe male circumcision
  - Describe local anaesthesia procedures for male circumcision
  - Describe three adult male circumcision procedures

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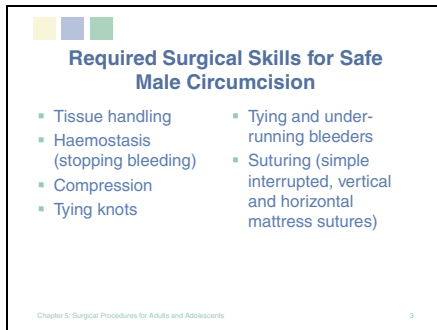
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Slide 3



- Required Surgical Skills for Safe Male Circumcision**
- Tissue handling
  - Haemostasis (stopping bleeding)
  - Compression
  - Tying knots
  - Tying and under-running bleeders
  - Suturing (simple interrupted, vertical and horizontal mattress sutures)

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Slide 4

**Tissue Handling**

- **Handle tissue gently** to minimize scarring and the risk of infection.
- **Use dissecting forceps** (tweezers) but do not use artery forceps to **hold the skin edge** while suturing.
- **Place haemostatic sutures accurately** and avoid inserting the needle too deep into the surrounding tissue.
- Avoid taking too large a bite when placing haemostatic sutures.

Chapter 5: Surgical Procedures for Adults and Adolescents 4

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Slide 5

**Haemostasis**

- **Minimizing blood loss:**
  - Is part of **good surgical technique and safe medical practice**
  - **Reduces contamination** of instruments, operating theatre drapes and gowns
  - **Lowers the risk of transmitting blood-borne diseases**, such as HIV and hepatitis B to theatre staff

Chapter 5: Surgical Procedures for Adults and Adolescents 5

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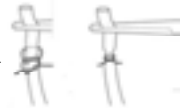
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Slide 6

**Techniques for Reducing Blood Loss**

- **Compression:**
  - By applying pressure over a gauze swab for 1–2 minutes
- **Tying bleeding vessels** → 

Chapter 5: Surgical Procedures for Adults and Adolescents 6

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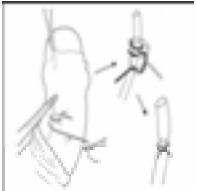
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Slide 7

**Techniques for Reducing Blood Loss (cont.)**

- **Under-running and ligation** of a bleeding vessel
- If **diathermy** is available, it **should be bipolar** (monopolar diathermy should not be used because of risk of extensive coagulation of the base of the penis)



Chapter 5: Surgical Procedures for Adults and Adolescents 7

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Slide 8

**Suture Materials for MC**

- The preferred suture material for adult male circumcision is **3.0 or 4.0 chromic catgut**.
- The suture should be **mounted on a taper cut or round body needle**. The taper cut makes it easier to pass the needle through the skin but it easily tears the skin on the inner aspect at the corona.
- An alternative is **4.0 vicryl rapide**, but this is more expensive.

Chapter 5: Surgical Procedures for Adults and Adolescents 8

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Slide 9

**Essential Suture Techniques (1)**

Three types of suture techniques are required for MC:

1. Simple interrupted sutures
2. Vertical mattress sutures
3. Horizontal mattress sutures

Chapter 5: Surgical Procedures for Adults and Adolescents 9

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Slide 10

**Match Type of Suture with Position of Suture**

Vertical Mattress Sutures		At 6 o'clock (Frenulum) Position
Horizontal Mattress Sutures		Between Mattress Sutures
Simple Sutures		At 3, 9 and 12 o'clock Positions

Chapter 5: Surgical Procedures for Adults and Adolescents 10

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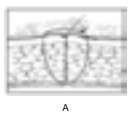
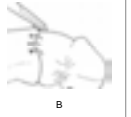
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Slide 11

**Essential Suture Techniques (2)**

- **Simple interrupted suture:**
  - A: Suture is placed holding the skin edge together
  - B: Simple sutures closing the circumcision incision

Chapter 5: Surgical Procedures for Adults and Adolescents 11

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Slide 12

**Essential Suture Techniques (3)**

- **Vertical mattress suture:**
  - A & B: Vertical mattress sutures
  - C: Suture is placed holding the skin edge and sub-cutaneous layer together
  - D: Vertical mattress suture in the 9 o'clock position

Chapter 5: Surgical Procedures for Adults and Adolescents 12

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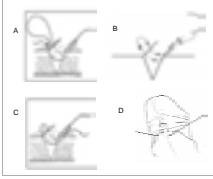
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Slide 13

**Essential Suture Techniques (4)**

- **Horizontal mattress suture:**
  - A, B & C: Horizontal mattress sutures
  - D: Horizontal mattress suture is used at the frenulum (6 o'clock positions)



Chapter 5: Surgical Procedures for Adults and Adolescents 13

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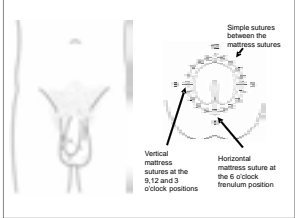
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Slide 14

**Combination of Sutures for MC**



Chapter 5: Surgical Procedures for Adults and Adolescents 14

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Slide 15

**Tying Knots**

- Knots can be tied by hand or by using instruments
- It is **more economical to tie all knots using instruments** because this saves suture material

See Figure 5-9 in Reference Manual

Chapter 5: Surgical Procedures for Adults and Adolescents 15

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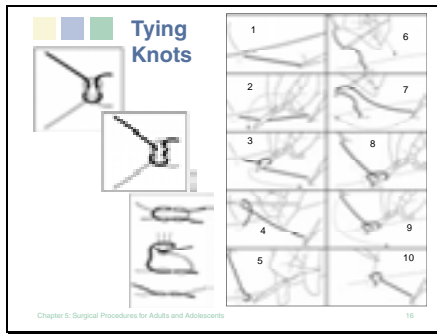
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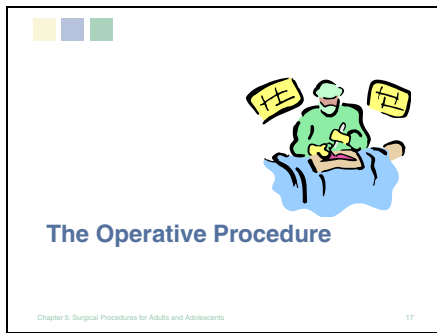
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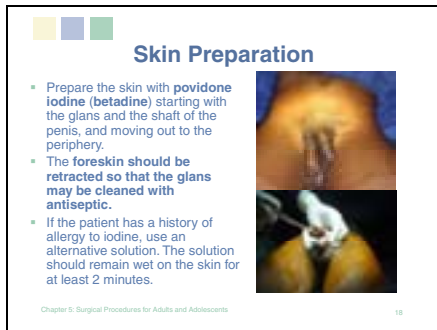
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Slide 18



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Slide 19

**Draping**



- Provides sterile operative field
- **Scrub** and put on **sterile gloves** before covering patient with sterile drapes
- In many facilities, a **single drape with a central hole** for the penis (O-drape) is used

Chapter 5: Surgical Procedures for Adults and Adolescents 19

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Slide 20

**Draping (cont.)**



Chapter 5: Surgical Procedures for Adults and Adolescents 20

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Slide 21

**Anaesthesia**



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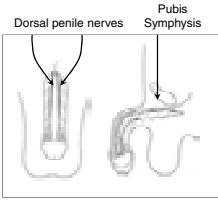
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Slide 22

**Nerve Supply of Penis**

- Twin dorsal penile nerves emerge from under the pubic bone at 11 and 1 o'clock positions and fan out towards the glans



Chapter 5: Surgical Procedures for Adults and Adolescents 22

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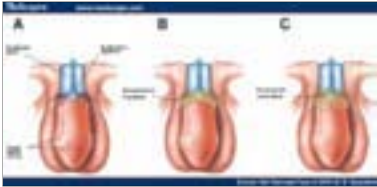
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Slide 23

**(A) Anatomic Landmarks, Innervation of the Penis, and Target Sites for (B) Subcutaneous Ring Block and (C) Dorsal Penile Nerve Block Injections**



Chapter 5: Surgical Procedures for Adults and Adolescents 23

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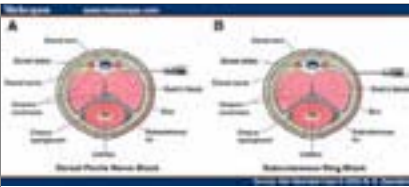
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Slide 24

**Appropriate Needle Insertion for (A) DPNB and (B) SRB**



Chapter 5: Surgical Procedures for Adults and Adolescents 24

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Slide 25



### Anaesthetic Agent

- Most commonly used local anaesthetic is **1% plain lidocaine** (lignocaine)
- Works rapidly
- Lidocaine with **adrenaline** should **NOT be used**
- Paracetamol may be given pre- and postoperatively

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Slide 26



### Maximum Dose of Local Anaesthetic

**Maximum safe dose (3 mg per kg body weight)**

Client weight	Volume of 0.5% Lidocaine (5 mg/ml)	Volume of 1% Lidocaine (10 mg/ml)	Volume of 2% Lidocaine (20 mg/ml)
8-day old (3 kg)	1.8 ml	0.9 ml	N/A
40 kg youth	24 ml	12 ml	6 ml
70 kg young man	N/A	21 ml	10.5 ml

Chapter 5: Surgical Procedures for Adults and Adolescents 26

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Slide 27



### Individual Exercise

- Calculate the maximum dosage of lidocaine for a 60 kg man scheduled for male circumcision.  
**Answer: 180 mg**
- How many mls of 1% lidocaine solution will this be?  
**Answer: 18 mls**
- How many mls of 2% lidocaine would this be?  
**Answer: 9 mls**

Chapter 5: Surgical Procedures for Adults and Adolescents 27

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Slide 28

**Dorsal Penile Nerve Block**



- Using a fine needle (23-gauge), inject 1–2 ml in base of penis at 11 and 1 o'clock positions (A & B).
- Inject 1 ml of local anaesthetic laterally towards ventral surface to complete a ring at base of penis ( C ) and wait 3–5 minutes.

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Slide 29

**Subcutaneous Penile Ring Block**



Inject lidocaine 1% subcutaneously around the base of the penis to produce a ring block and thus block the cutaneous nerves from the scrotum.

Chapter 5: Surgical Procedures for Adults and Adolescents 29

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Slide 30



**"Sensation should be tested prior to starting the procedure. This can be done by gently pinching the foreskin with an artery forceps. If there is any residual sensation, wait for a further 2–3 minutes and test again. If there is still sensation, give additional local anaesthetic."**



Chapter 5: Surgical Procedures for Adults and Adolescents 30

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Slide 31

**Retracting the Foreskin and Dealing with Adhesions**

- Retraction and separation of adhesions is common to all methods of MC
- If opening is tight, dilate it with pair of artery forceps
- Take care not to push the forceps into the urethra!



Chapter 5: Surgical Procedures for Adults and Adolescents 31

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Slide 32

**Marking Line of Circumcision...**

- This step is also common to all methods of MC
- Use:
  - A marker pen
  - Dabs of gentian violet
  - Pinch marks made with toothed dissecting forceps



Chapter 5: Surgical Procedures for Adults and Adolescents 32

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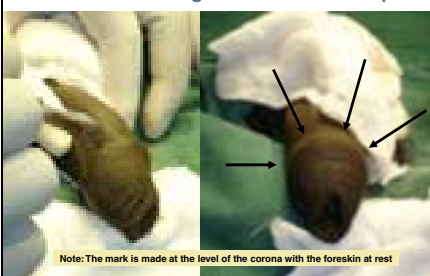
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Slide 33

**Marking with Back of a Scalpel**



Note: The mark is made at the level of the corona with the foreskin at rest

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### Summary Questions

- Name the three essential suturing techniques associated with MC?  
**Simple interrupted, Vertical mattress, Horizontal mattress**
- What is the maximum safe dose of lidocaine?  
**3 mg/kg body weight**
- T/F – Surgical gowns MUST be used for MC.  
**False**

Chapter 5: Surgical Procedures for Adults and Adolescents 34

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Slide 35



Chapter 5: Surgical Procedures for Adults and Adolescents 35

**Dorsal Slit Method**

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Slide 36



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**Dorsal Slit Method**

- Requires more surgical skill than forceps-guided method
- A surgical assistant is helpful but not required
- Small risk of asymmetric result
- Widely used by surgeons throughout the world

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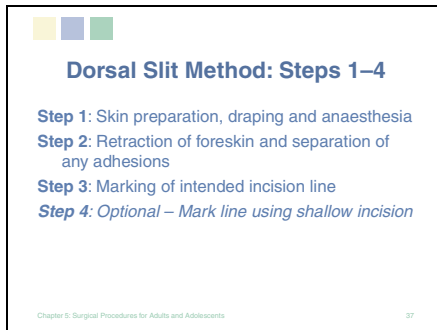
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Slide 37



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**Dorsal Slit Method: Steps 1–4**

**Step 1:** Skin preparation, draping and anaesthesia

**Step 2:** Retraction of foreskin and separation of any adhesions

**Step 3:** Marking of intended incision line

**Step 4:** *Optional – Mark line using shallow incision*

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Slide 38

**Dorsal Slit Method: Step 5**

Grasp the foreskin with two artery forceps at the 3 and 9 o'clock positions. **Take care to apply the artery forceps so that there is equal tension on the inner and outer aspects of the foreskin.**



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Slide 39

**Dorsal Slit Method: Step 6**

Prior to making a cut at 12 o'clock, **place two artery forceps on the foreskin** in the 11 o'clock and 1 o'clock positions. Check that the inside blades of the two artery forceps are lying between the glans and prepuce and have not been accidentally passed up the urethral meatus.



Chapter 5: Surgical Procedures for Adults and Adolescents 39

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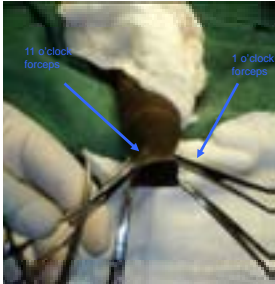
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Slide 40

After applying forceps at the 3 and 9 o'clock positions, it helps reduce blood loss if prior to making the dorsal slit, two more forceps are applied at 11 o'clock and 1 o'clock positions



Chapter 5: Surgical Procedures for Adults and Adolescents 40

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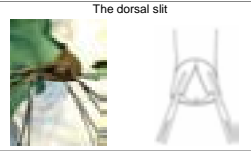


Slide 41

**Dorsal Slit Method: Step 7**

Between the two artery forceps, in the 12 o'clock position use dissecting forceps to make a cut (the dorsal slit) up to the previously marked incision line.

The dorsal slit



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Slide 42

In making the dorsal slit, aim for the cut to go as far as but no farther than the scratch mark.



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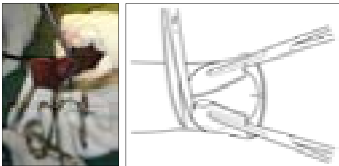
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Slide 43

**Dorsal Slit Method: Step 8**

Using dissection scissors, cut the foreskin free along the previously marked circumcision line.



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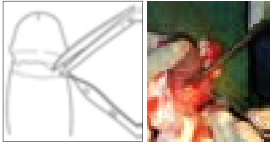
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Slide 44

**Dorsal Slit Method: Step 9**

Grasp and trim any skin tags on the inner edge of the foreskin to leave approximately 5 mm of skin proximal to the corona. Care must be taken to trim only the skin and not to cut deeper tissue.



The diagram shows a line drawing of the penis with a vertical line indicating the dorsal slit. A pair of forceps is shown grasping a skin tag on the inner edge of the foreskin. The photograph shows a surgical procedure where a pair of forceps is used to grasp a skin tag on the inner edge of the foreskin, and a pair of scissors is used to trim it.

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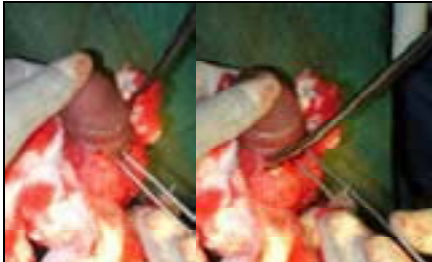
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Slide 45



Any ragged skin edge can be trimmed with dissection scissors

Chapter 5: Surgical Procedures for Adults and Adolescents 45

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Slide 46

**Dorsal Slit Method: Step 10**

**Stopping the bleeding:**

- Pull back the skin to expose the raw area.
- Identify bleeding vessels and clip with artery forceps. Care should be taken to catch the blood vessels as accurately as possible and not to grab large amounts of tissue.
- Tie each vessel or under-run with catgut and tie off. Take care not to place haemostatic stitches too deeply. When dealing with bleeding in the frenular area or on the underside of the penis, care must be taken not to injure the urethra.

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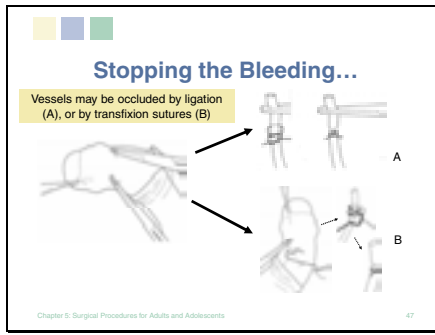
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Slide 47



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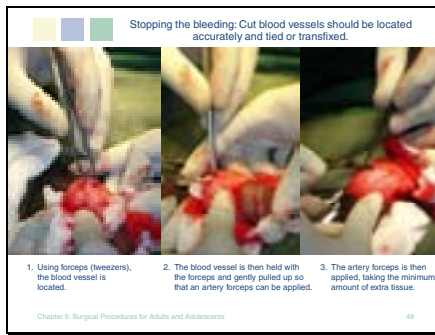
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Slide 48



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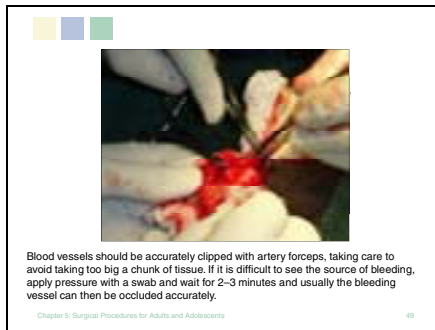
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Slide 49



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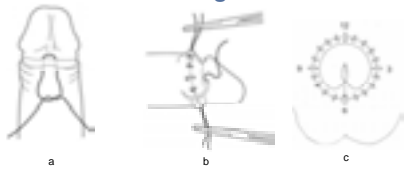
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Slide 50



**Suturing Plan**

Horizontal mattress suture at the frenulum (6 o'clock). Vertical mattress sutures at 9, 12 and 3 o'clock and simple sutures between these.

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Slide 51



**Dorsal Slit Method: Step 11**

Place a horizontal mattress suture at the frenulum. When placing the **horizontal mattress suture at 6 o'clock position**, take care to **align the midline skin raphe with the line of the frenulum** (see below). A common error is to misalign the midline and raphe, which results in misalignment of the whole circumcision closure.

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Slide 52



**Dorsal Slit Method: Step 12**

Place a **vertical mattress suture at the 12 o'clock position**. The suture should be placed so that there is an equal amount of skin on each side of the penis between the 12 and 6 o'clock positions. **Place two further vertical mattress stitches in the 3 o'clock and 9 o'clock positions** (see below).

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Slide 53

An assistant is stabilizing the penis by holding artery forceps attached to the long ends of the 6 and 12 o'clock suture. The surgeon is about to place the 9 o'clock vertical mattress suture.



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Slide 54

**Dorsal Slit Method: Step 13**

After placement of the sutures at 6, 12, 3 and 9 o'clock, place two or more simple sutures in the gaps between.



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Slide 55

Once the four mattress sutures are in place, further simple sutures are placed to accurately approximate the wound edges.



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Slide 56



**Dorsal Slit Method: Step 14**

Once the procedure is finished, **check for bleeding** and **apply a dressing** (described later).

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Slide 57



**Forceps Guided Method**

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Slide 58



**Forceps Guided Method**

- **Advantages:**
  - Can be learned by surgeons/surgical assistants who are relatively new to surgery
  - Ideal for use in a clinic with limited resources
  - Can be done without a surgical assistant
- **Disadvantages:**
  - Leaves 0.5–1.0 cm of mucosal skin proximal to corona
  - Cosmetic effect may be less satisfactory

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Slide 59



**Forceps Guided Method:  
Steps 1–2**

**Step 1:** Skin preparation, draping and anaesthesia (as previously described)

**Step 2:** Retraction of foreskin and separation of any adhesions

Chapter 5: Surgical Procedures for Adults and Adolescents 59

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Slide 60

**Marking Incision Line: Step 3a**

This step is common to all the methods of circumcision. With the foreskin in a natural "resting" position, indicate the intended line of the incision with a marker pen. The line should correspond with the corona, just under the head of the penis.



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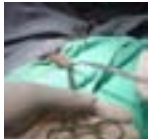
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Slide 61

**Marking Incision Line: Step 3b**

- Some uncircumcised men have a very lax foreskin, which is partially retracted in the resting position.
- In such cases, it is better to apply artery forceps at the 3 and 9 o'clock positions, to apply a little tension to the foreskin before marking the circumcision line.
- It is **important not to pull the foreskin too hard** before marking the line, as this will result in too much skin being removed.



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Slide 62

**Forceps Guided Method: Step 4**

**Grasp the foreskin at the 3 and 9 o'clock positions with two artery forceps, on the natural apex of the foreskin in such a way as to put equal tension on the inside and outside surfaces of the foreskin.**



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Slide 63

**Forceps Guided Method: Step 5**

Put sufficient tension on the foreskin to pull the previously made mark to just below the glans. Taking care not to catch the glans, apply a long straight forceps across the foreskin just proximal to the mark. Once the forceps is in position, feel the glans to check that it has not been accidentally caught in the forceps.



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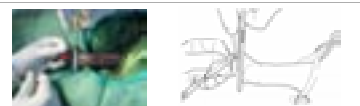
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Slide 64

**Forceps Guided Method: Step 6**

Using a scalpel, cut away the foreskin flush with the outer aspect of the forceps. The forceps protects the glans from injury, but nevertheless particular care is needed at this stage.



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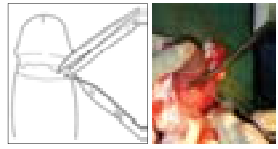
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Slide 65

**Forceps Guided Method: Step 7**

Grasp and trim any skin tags on the inner edge of the foreskin to leave approximately 5 mm of skin proximal to the corona. Care must be taken to trim only the skin and not to cut deeper tissue.



Chapter 5: Surgical Procedures for Adults and Adolescents 65

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Slide 66

**Forceps Guided Method: Step 8**

**Stopping the bleeding:**

- Pull back the skin to expose the raw area.
- Identify bleeding vessels and clip with artery forceps as accurately as possible.
- Tie each vessel or under-run with catgut and tie off. Take care not to place haemostatic stitches too deeply.
- When dealing with bleeding in the frenular area, care must be taken not to injure the urethra.

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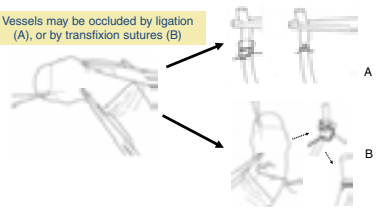
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Slide 67

**Stopping the Bleeding...**

Vessels may be occluded by ligation (A), or by transfixion sutures (B)



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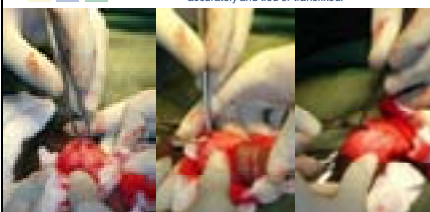
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Slide 68

**Stopping the bleeding: Cut blood vessels should be located accurately and tied or transfixed.**



1. Using forceps (wielders), the blood vessel is located.
2. The blood vessel is then held with the forceps and gently pulled up so that an artery forceps can be applied.
3. The artery forceps is then applied, taking the minimum amount of extra tissue.

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Slide 69





Blood vessels should be accurately clipped with artery forceps, taking care to avoid taking too big a chunk of tissue. If it is difficult to see the source of bleeding, apply pressure with a swab and wait for 2-3 minutes and usually the bleeding vessel can then be occluded accurately.

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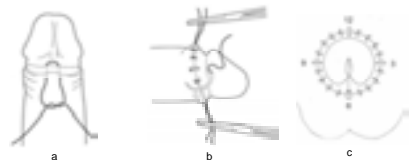
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Slide 70



### Forceps Guided Method: Step 9—Suturing Plan



Horizontal mattress suture at the frenulum (6 o'clock). Vertical mattress sutures at 9, 12 and 3 o'clock and simple sutures between these.

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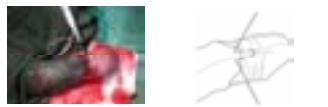
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Slide 71



### Suturing the Circumcision

Place a horizontal mattress suture at the frenulum. When placing the horizontal mattress suture at 6 o'clock position, take care to align the midline skin raphe with the line of the frenulum (see below). A common error is to misalign the midline and raphe, which results in misalignment of the whole circumcision closure.



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Slide 72

**Suturing the Circumcision (cont.)**

Place a vertical mattress suture at the 12 o'clock position. The suture should be placed so that there is an equal amount of skin on each side of the penis between the 12 and 6 o'clock positions. Place two further vertical mattress stitches in the 3 o'clock and 9 o'clock positions.



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Slide 73

**Suturing the Circumcision (cont.)**

After placement of the sutures at 6, 12, 3 and 9 o'clock, place two or more simple sutures in the gaps between.



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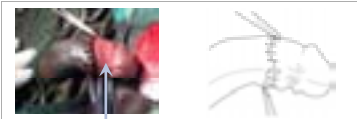
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Slide 74

**Forceps Guided Method**

- Final outcome:



*Note residual mucosal portion of the foreskin*

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Slide 75



**Suturing the Circumcision:  
Step 10**

Once the procedure is finished, **check for bleeding** and **apply a dressing** (described later).

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Slide 76



**Sleeve Resection Method**

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Slide 77



**Sleeve Resection Method**

- Provides best cosmetic results
- More room for surgical error
- The technique requires an assistant
- The sleeve resection method requires good surgical skill
- Better suited to a hospital rather than a clinic setting

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Slide 78

**Sleeve Resection Method:  
Steps 1–2**

**Step 1:** Skin preparation, draping and anaesthesia  
**Step 2:** Retraction of foreskin and separation of any adhesions

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Slide 79

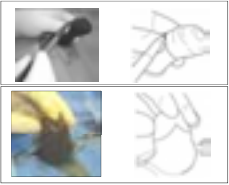
**Sleeve Resection Method:  
Step 3—Marking the Outer Line**

Mark the line of the outside cut, just below the corona

Mark the intended outer line of the incision with a V-shape, pointed towards the frenulum, on the underside of the penis

The apex of the V should correspond with the midline raphe

*Note "V" shape pointing towards frenulum*



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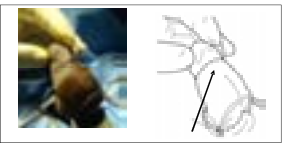
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Slide 80

**Sleeve Resection Method: Step 4—  
Marking the Inner Mucosal Line**

Retract the foreskin and mark the inner (mucosal) incision line 1–2 mm proximal to the corona. At the frenulum, the incision line crosses horizontally as shown by the arrow.



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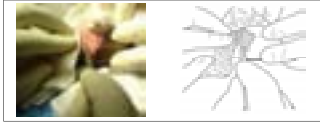
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Slide 81

**Sleeve Resection Method: Step 5**

Using a scalpel, **make incisions along the marked lines**, taking care to cut through the skin to the subcutaneous tissue but not deeper. During the incision, the assistant retracts the skin with a moist gauze swab.



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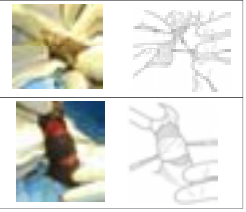
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Slide 82

**Sleeve Resection Method: Step 5b**



**Make the inner incision**

**Outer and inner incision completed**

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Slide 83

**Sleeve Resection Method: Step 6**

Cut the skin between the proximal and distal incisions with scissors.



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Slide 84

**Sleeve Resection Method: Step 7**

Hold the sleeve of foreskin under tension with two artery forceps and **dissect the skin from the shaft of the penis**, using dissection scissors. Tie off any bleeding vessels with under-running sutures.



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Slide 85

**Sleeve Resection Method: Steps 8–10**

**Step 8:** Haemostasis and suturing are the same as described for the forceps guided method.

**Step 9:** Suturing the circumcision is the same as described for the forceps guided method.

**Step 10:** Check for bleeding, and provided there is none, apply a dressing as described later.

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Slide 86

**Applying the Penile Dressing**

- Irrespective of the method of circumcision, a standard penile dressing technique is used:
  - **Check that there is no bleeding.**
  - Once all bleeding has stopped, place a piece of petroleum-jelly-impregnated gauze (*tulle gras*) around the wound.
  - **Apply a sterile, dry gauze** over this, and **secure it in position with adhesive tape.**
  - Take care not to apply the dressing too tightly.

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Slide 87



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Slide 88



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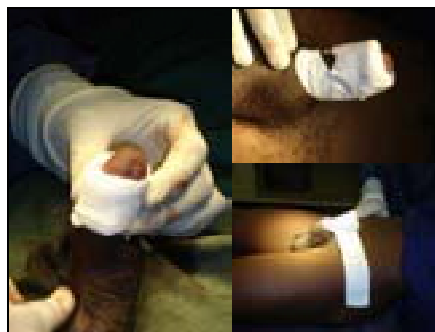
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Slide 89



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Slide 90



### Removing the Penile Dressing

- The dressing should be left in position **no longer than 48 hours**.
- If the dressing has dried out, it should be gently dabbed with antiseptic solution (aqueous cetrimide, Savlon) until it softens.
- It can then be removed gently. **It is important not to disrupt the wound by pulling at a dressing that has dried to the wound.**

Chapter 5: Surgical Procedures for Adults and Adolescents 90

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Slide 91



### Summary

- Three common methods of MC have been reviewed:
  - Description of the **dorsal slit** method of male circumcision
  - Description of the **forceps guided** method of male circumcision
  - Description of the **sleeve method** of male circumcision

Chapter 5: Surgical Procedures for Adults and Adolescents 91

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Slide 92



### Summary (cont.)

- The recommended operative techniques have been described in detail.
- Surgeons should become expert in the technique most suited to the circumstances of their practice.
- It is not recommended to learn all of the techniques. It is best to **become a master of one adult technique** and, if appropriate, one paediatric technique.

Chapter 5: Surgical Procedures for Adults and Adolescents 92

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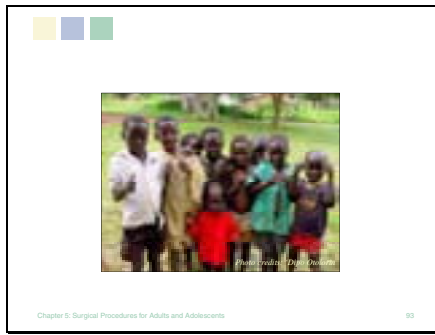
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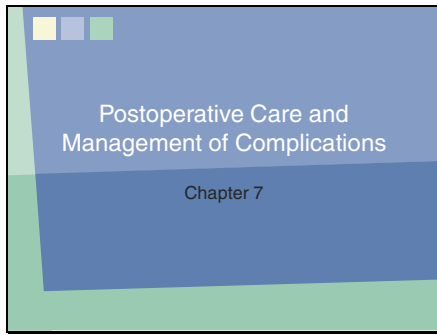
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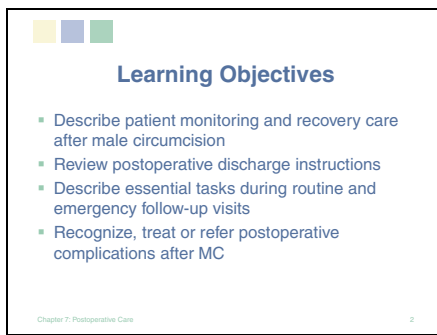
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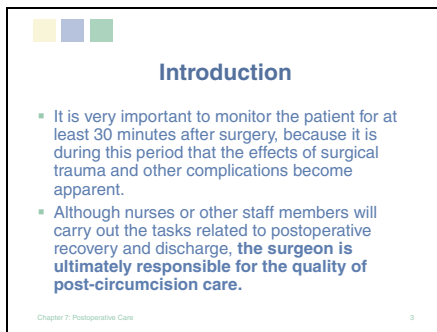
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Slide 3



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Slide 4



### Postoperative Monitoring

1. **Receive the patient** from the theatre; review the patient record.
2. **Monitor the patient's vital signs:** check blood pressure, respiration and pulse twice at 15-minute intervals.
3. **Check the surgical dressing** for oozing or bleeding.
4. **Ask the patient if he has any pain.**
5. **Observe the general condition** of the patient.



Chapter 7: Postoperative Care 4

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Slide 5



### Postoperative Monitoring (cont.)

6. **Administer drugs** or treatment prescribed.
7. **Provide bland carbohydrates (such as biscuits) and liquids** to raise blood sugar levels.
8. **Handle the patient gently** when moving him.
9. **Make the patient comfortable** according to the climate.
10. **Complete the patient record form.**

Chapter 7: Postoperative Care 5

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Slide 6



### Patient Instructions

- The **dressing should be removed 24 to 48 hours after surgery**, if there is no bleeding or oozing.
- The patient should be instructed to **wear freshly laundered, loose-fitting underwear**, which should be changed each day.
- Following dressing removal, the patient may shower twice a day, taking care to gently wash the genital area with mild soap (baby soap) and water.

Chapter 7: Postoperative Care 6

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Slide 7



### Sexual Activity following Circumcision



"It is very important to inform the patient that he should avoid **sexual intercourse and masturbation for 4 to 6 weeks after the procedure** to prevent breakdown of the wound. A **condom should then be used to protect the wound during every act of sexual intercourse for at least 6 months.**"

Chapter 7: Postoperative Care 7

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Slide 8



### Postoperative Penile Erections

- All men have periodic penile erections during sleep and younger men frequently get daytime erections.
- After the circumcision, erections will occur but these will not disrupt the process of wound healing.
- During the immediate recovery period, **prolonged or painful erection can be stopped by inhalation of one ampoule of amyl nitrate.**

Chapter 7: Postoperative Care 8

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Slide 9



### Understanding Potential Danger Signs

**Before discharge:**

- Ensure that the patient/parent understands the signs of potential problems he should watch out for, namely:
  - Increasing bleeding
  - Severe pain in the penis or genital area
  - Inability to pass urine or severe pain when passing urine
  - Pus discharging from the surgical wound, increasing swelling

Chapter 7: Postoperative Care 9

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Slide 10



### Understanding Potential Danger Signs (cont.)

**Before discharge:**

- Ensure that the patient/parent:
  - Understands that he should return to the clinic immediately or seek emergency care if a problem develops.
  - **Knows where to go** if and when complications arise.
  - Has been **given written postoperative instructions** and has been asked to repeat them.

Chapter 7: Postoperative Care 10

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Slide 11



### Patient Instructions (cont.)

**Before discharge:**

- Ensure that the patient/parent:
  - Has been **given medications** as ordered.
  - Has made a **follow-up appointment**.
  - Has a **responsible adult to accompany him home** (this is of particular importance for procedures done on underage patients).

Chapter 7: Postoperative Care 11

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Slide 12



### Final Steps for Patient Discharge

- Ensure that the patient:
  - Has been **confirmed to be discharged** by the operating surgeon or his/her designee.
  - **Record has been completed.**
- All patient records should be maintained at the service site where the procedure took place, and the site should send a copy in case the patient is transferred.

Chapter 7: Postoperative Care 12

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Slide 13



### Routine Follow-Up

- Should occur **within 7 days** of procedure
- Should include:
  - **Check of medical record** or referral form
  - **Asking about any problems or complaints:**
    - Wound discharge or bleeding
    - Urinary difficulties
    - Fever
    - Pain or other distress
    - Penile or scrotal swelling

Chapter 7: Postoperative Care 13

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Slide 14



### Routine Follow-Up (cont.)

- **Examine** the site of operation to assess healing and the absence of infection.
- Treat any complications or refer the patient to a higher level.
- Ask the patient for comments that will help improve the service.
- **Document** the follow-up visit in the patient's medical record (*complaints, diagnosis and treatment*).

Chapter 7: Postoperative Care 14

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Slide 15



### Emergency Follow-Up Visits

- **Examine** the patient immediately. Check all areas related to his complaint.
- **Read the medical record**, if available.
- Ask the patient about the sequence of events since the operation, and about any problems during the surgery or after and treatments obtained.
- **Decide on the treatment** for problems that can be handled on an outpatient basis.

Chapter 7: Postoperative Care 15

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Slide 16

  
**Emergency Follow-Up Visits (cont.)**

- Arrange for a higher level of treatment for potentially serious complications.
- Note on the patient record all problems and actions taken.
- Inform the facility where the male circumcision was performed about the emergency follow-up visit (if applicable).

Chapter 7: Postoperative Care 16

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Slide 17

  
**Recognition and Management of Complications**



**This section describes:**

- Complications that can be managed in the clinic setting
- Indications for referral to a higher level of care

Chapter 7: Postoperative Care 17

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Slide 18

  
**Organizing Referrals**

- The patient should be transferred by ambulance, lying flat.
- The patient and his family should be given a full explanation of what is happening and why.
- A clear note should be sent to the referral centre with the patient.
- The patient should be told not to eat and, depending on the length of the journey, not to drink, as a general anaesthetic may need to be given at the referral centre. Any accompanying family member should also be given this information.

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Slide 19

Timing of Complications

Complications may occur:

During Surgery	1–2 Days after Surgery	1–2 Weeks after Surgery	Late Complications
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Chapter 7: Postoperative Care 19

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Slide 20

Complications Occurring

DURING Surgery	1–2 Days after Surgery	1–2 Weeks after Surgery	Late Complications
----------------	------------------------	-------------------------	--------------------

- Excessive adhesions
- Accidental injury
- Excessive bleeding

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Slide 21

Excessive Adhesions

- If there are **excessive adhesions**, it may be very difficult to separate the foreskin from the glans (e.g., phimosis).
- Depending on the experience of the circumcision team, **it may be better to stop the procedure** and in this situation:
  - Repair the dorsal slit using stitches to stop bleeding.
  - Keep the area as clean as possible.
  - Refer the man to the referral hospital as soon as convenient.
- The man should be seen within 24–48 hours.

Chapter 7: Postoperative Care 21

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Slide 22



### Excessive Bleeding

- If there is excessive bleeding during surgery, the first rule for the surgeon is **"DON'T PANIC"**.
- Place a **swab under the penis** and then a **second swab over the bleeding point**.
- **Control the bleeding with firm pressure and WAIT!** Check effects at 5-minute intervals (timed by the clock).
- After 5 minutes, **slowly lift off the swab** and, more often than not, the bleeding will have stopped.

Chapter 7: Postoperative Care 22

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Slide 23



### Excessive Bleeding (cont.)

- If bleeding has not stopped, **apply a haemostatic artery forceps**.
- If this does not control the bleeding, then apply pressure over a gauze swab for a further 5 minutes (timed by the clock).
- At the end of this time, the swab is gently lifted again and the bleeding area is **under-run with a figure of eight suture**.
- If bleeding continues, **transfer to a referral centre** as an emergency or call a more experienced surgeon to help.

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Slide 24



### Accidental Injury

- Accidental injury can include injury to the glans, making it difficult to control bleeding.
- **The chance of these accidents is reduced if all circumcision surgeons receive proper training and certification** and if there is a system of ongoing appraisal and recertification in place.
- A dangerous situation is when the surgeon becomes overconfident or when timetable constraints result in hurried surgery.

Chapter 7: Postoperative Care 24

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Slide 25

**Accidental Injury (cont.)**

- If there is an accidental injury during surgery:
  - **Control bleeding by pressure** over a piece of gauze.
  - **Transfer** the man to a referral centre (or call a more experienced surgeon or urological specialist).
  - Pass a urinary catheter and wrap the penis in sterile gauze with the gauze taped in place, if transfer time will be long.
  - During the transfer, the **patient should be lying flat**.
  - The patient and his relatives should be told what has happened and what is going to be done.

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Slide 26

**Complications Occurring**

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Slide 27

**Bleeding**

- The most likely complication during the first 24–48 hours is **bleeding or haematoma**.
- If the patient comes back with **blood-soaked dressings**, **remove** them and **inspect the circumcision wound** for an obvious bleeding point.
- If there is **fresh blood from the skin edge**, **place further sutures** (under full sterile conditions) including local anaesthesia and sterile draping.

Chapter 7: Postoperative Care 27

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Slide 28

**Haematoma**

- **Haematoma** formation may also become manifest.
- It may be associated with considerable bruising and skin discolouration.
- **Haematomas are best left alone unless they are very large** or there is continued bleeding.
- Apply a further clean dressing and:
  - **Review the patient in 24 hours**, or
  - **Send the patient to the referral centre.**

Chapter 7: Postoperative Care 28

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Slide 29

**Wound Disruption**

- **Unusual in the first few days** and may be associated with subcutaneous bleeding and haematoma formation when the stitches cut out.
- May send the man to a referral centre where:
  - The wound can **either be sutured** or
  - **Left to heal by secondary intention.**
- If the disruption occurs within the first 48 hours of the operation, explore and re-suture the wound.

Chapter 7: Postoperative Care 29

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Slide 30

**Complications Occurring**

During Surgery	1-2 Days after Surgery	<b>1-2 WEEKS after Surgery</b>	Late Complications
----------------	------------------------	--------------------------------	--------------------

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- Wound infection
- Wound disruption and cutting out of stitches
- Fournier's gangrene

Chapter 7: Postoperative Care 30

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Slide 31

**Wound Infection**

- After 2–3 days, the most likely problem is **wound infection**.
- Treatment is by **frequent showering and antibiotics**, with **clean dressings between showers**.
- **Lying down** with the penis as the highest point of the body **promotes drainage of lymphatic fluid**.
- The wound can be nursed open, but it should be protected from flies.

Chapter 7: Postoperative Care 31

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Slide 32

**Wound Disruption and Cutting Out of Stitches**

- **When stitches cut out**, this usually indicates an **infection** and the need for antibiotics.
- If more than 48 hours, the **wound should be left to heal by secondary intention**.
- Make arrangements for **regular clinic reviews until the wound has healed**.
- The healing process after infection leaves an untidy result for the first few months. However, after a year or so the appearance becomes remarkably normal.

Chapter 7: Postoperative Care 32

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Slide 33

**Fournier's Gangrene**

- A rare risk of genital surgery is infection with multiple bacteria causing progressive skin loss, known as **Fournier's gangrene**.
- More **common in diabetic men**.
- If there are signs of spreading infection or black gangrenous skin:
  - **Urgently transfer the man to a referral centre** for the removal of all the dead skin under general anaesthesia.



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Slide 34

**Complications Occurring**

During Surgery	1-2 Days after Surgery	1-2 Weeks after Surgery	Late
----------------	------------------------	-------------------------	------

- Decreased glans sensitivity
- Oversensitivity of the glans
- Unightly circumcision wounds, ragged scars and cosmetic concerns
- Persistent adhesions at the corona and inclusion cysts
- Erectile discomfort
- Torsion (misalignment) of the skin of the penile shaft

Chapter 7: Postoperative Care 34

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Slide 35

**Summary**

- Operative complications of male circumcision can include:
  - Excessive bleeding
  - Haematoma formation
  - Sepsis
  - Unsatisfactory cosmetic effect
  - Lacerations of the penile or scrotal skin
  - Injury to the glans

Chapter 7: Postoperative Care 35

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Slide 36

**Summary (cont.)**

- Circumcision complications can be avoided by:
  - Attention to asepsis
  - Performing adequate but not excessive excision of the inner and outer preputial layers
  - Providing adequate haemostasis
  - Paying attention to cosmetic effects

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Slide 37



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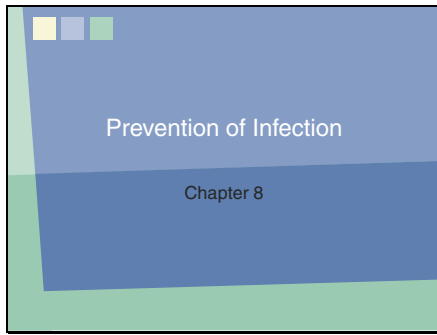
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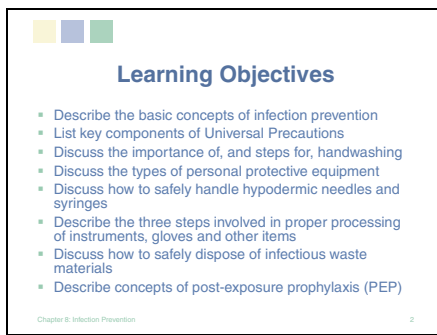
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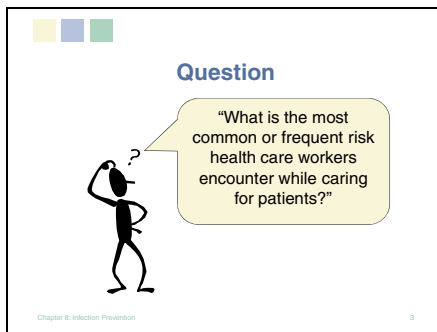
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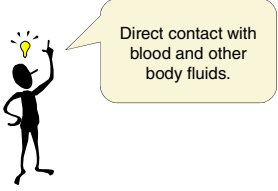
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Slide 4

Answer



Direct contact with blood and other body fluids.

Chapter 8: Infection Prevention 4

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Slide 5

Basic Concepts of Infection Prevention

- Measures to prevent infection in male circumcision programmes have two primary objectives:
  - Prevent infections in people having surgery
  - Minimize the risk of transmitting HIV and other infections to clients and clinical staff, including health care cleaning and housekeeping staff

Chapter 8: Infection Prevention 5

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Slide 6

Patient Care



Instrument Processing



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Slide 7

**Surgical Procedures**



**Cleaning after Procedures**



Chapter 8: Infection Prevention

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Slide 8

**Waste Disposal**



**Processing Patient Care Items**



Chapter 8: Infection Prevention

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Slide 9

**How Risky Is Working in Any Health Care Setting?**



Chapter 8: Infection Prevention

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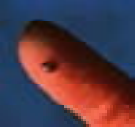
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### HIV Risk

What is the risk of acquiring HIV after being stuck with a needle from an HIV-positive patient?

**0.04%**



Source: Gerberding 1990.  
Chapter 8: Infection Prevention

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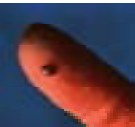
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### Hepatitis B Virus Risk

What is the risk of acquiring HBV after being stuck with a needle from an HBV-positive patient?

**27–37%**



Source: Seeff et al. 1978.  
Chapter 8: Infection Prevention

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Slide 12



### Hepatitis B Virus Risk (cont.)

- As little as 10<sup>-8</sup> ml (.00000001 ml) of HBV-positive blood can transmit HBV to a susceptible host.
- Even in the US, approximately 10,000 health care providers acquire hepatitis.

Source: Bond et al. 1982.  
Chapter 8: Infection Prevention

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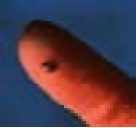
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Slide 13

**Hepatitis C Virus Risk**

What is the risk of acquiring HCV after being stuck with a needle from an HCV-positive patient?

**3–10%**



Source: Langheir 1994.

Chapter 8: Infection Prevention 13

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Slide 14

**Ways Infection Is Spread**

- The air
- Contact with blood or body fluids:
  - Open wounds
  - Needle-stick injuries, which occur:
    - While giving an injection
    - While drawing blood
    - During IV insertion/removal
    - While disposing of sharps
    - During waste disposal
    - While suturing during surgery
- Eating or handling **food contaminated** by faeces or microorganisms
- Contact with **infected animals or insects**

Chapter 8: Infection Prevention 14

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Slide 15

**Other Exposures to Skin and Mucous Membranes**

- Non-intact skin (tear in glove):
  - Abraded
  - Chapped
- Splashes to mucous membrane
- Intact skin



Chapter 8: Infection Prevention 15

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Slide 16

**Objectives of Infection Prevention in MC Programs**

- To prevent infections when providing services
- To minimize the risk of transmitting HIV to clients and health care staff, including cleaning and housekeeping staff

Chapter 8: Infection Prevention 16

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Slide 17

**Universal Precautions**

- Hand hygiene
- Personal protective equipment
- Avoiding recapping of needles
- Handling and processing of instruments and other items
- Safe disposal of sharps and other infectious waste materials
- Safe work practices

Chapter 8: Infection Prevention 17

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Slide 18

**Hand Hygiene**

“Handwashing is the single most important procedure to limit the spread of infection.”

**Vote: True.....False.....**

Chapter 8: Infection Prevention 18

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Slide 19

**Hand Hygiene (cont.)**

- Handwashing
- Hand antisepsis
- Antiseptic handrub
- Surgical scrub



Chapter 8: Infection Prevention 19

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Slide 20

**Handwashing**

- When:
  - Before and after patient care
  - Before and after using gloves
  - Between patient contact
  - When visibly soiled
- Protect hands from dryness with petroleum-free creams
- No artificial nails, wraps, etc.
- Clear nail polish okay

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Slide 21

**Handwashing Steps**

1. Thoroughly wet hands.
2. Apply plain soap or detergent.
3. Rub all areas of hands and fingers for 10–15 seconds.
4. Rinse hands thoroughly with clean running water from a tap or bucket.
5. Dry hands with clean, dry towel, if available. If not available, air dry hands (use a paper towel when turning off water to avoid re-contaminating hands).

Chapter 8: Infection Prevention 21

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Slide 22



### Handwashing (cont.)

- If bar soap is used, provide small bars and soap racks that drain.
- Avoid dipping hands into basins containing standing water.
- Do not add soap to a partially empty liquid soap dispenser.
- When no running water is available, use a bucket with a tap that can be turned off while lathering hands and turned on again for rinsing; or use a bucket and a pitcher.

Chapter 8: Infection Prevention 22

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Slide 23



### Hand Antisepsis

- Similar to plain handwashing except involves **use of an antimicrobial agent**
- Use before performance of any invasive procedures, (e.g., placement of an intravascular catheter)
- Use when caring for immunocompromised patients (premature infants or AIDS patients)
- Use when leaving the room of patients with diseases spread via direct contact

Chapter 8: Infection Prevention 23

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Slide 24



### Antiseptic Handrub

- Make alcohol/glycerin solution by combining:
  - 2 ml glycerin
  - 100 ml 60–90% alcohol solution
- Use 3–5 ml of solution for each application
- Rub the solution vigorously into hands until dry

Chapter 8: Infection Prevention 24

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Slide 25

**Surgical Scrub**

**Supplies**

- Antiseptic
- Running water
- Stick for cleaning the fingernails
- Soft brush or sponge for cleaning the skin
- Towels



Chapter 8: Infection Prevention 25

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Slide 26

**Surgical Scrub (cont.)**

**If no antiseptic soap is available:**

- Wash hands and arms with soap/detergent and water.
- Clean fingernails thoroughly.
- Scrub with a soft brush or sponge and rinse.
- Dry hands thoroughly.
- Apply handrub to hands and forearms until dry.
- Repeat handrub two more times.

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Slide 27

**Personal Protective Equipment**



- Gloves
- Masks
- Eyewear (goggles/ face shields)
- Gown/apron
- Closed shoes

Chapter 8: Infection Prevention 27

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Slide 28

**Personal Protective Equipment (cont.)**

- Gloves:
  - Utility gloves
  - Exam gloves
  - Surgical gloves
- Double gloving



Source: Gerberding 1993.

Chapter 8: Infection Prevention 28

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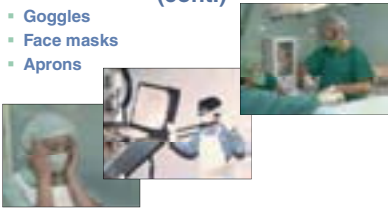
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Slide 29

**Personal Protective Equipment (cont.)**

- Goggles
- Face masks
- Aprons



Chapter 8: Infection Prevention 29

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Slide 30

**Personal Protective Equipment (cont.)**



Closed shoes → 

Chapter 8: Infection Prevention 30

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Slide 31

**Immunization for Adults**

Which of the vaccines below should every health worker receive to protect him/herself from infection from blood or body fluids?

- Hepatitis A
- Hepatitis B
- Influenza
- Pneumococcus
- Chicken pox
- Tetanus, diphtheria
- Measles, mumps, rubella (German measles)

Chapter 8: Infection Prevention 31

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Slide 32

**Immunization for Adults (cont.)**

- Hepatitis A
- Hepatitis B
- Influenza
- Pneumococcus
- Tetanus, diphtheria
- Chicken pox
- Measles, mumps, rubella (German measles)

Chapter 8: Infection Prevention 32

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Slide 33

**Safe Handling of Hypodermic Needles and Syringes**

Needles are the most common cause of injuries to all types of clinic workers



Chapter 8: Infection Prevention 33

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Slide 34

**Timing of Needle-Stick Injuries**

- Health care workers are most often stuck by hypodermic needles **during procedures**.
- Cleaning staff are most often stuck by needles **when washing soiled instruments**.
- Housekeeping staff are most often stuck by needles **when disposing of infectious waste material**.

Chapter 8: Infection Prevention 34

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Slide 35

**Tips for Safe Handling of Hypodermic Needles and Syringes**

- Use each needle and syringe only once**, if possible.
- Do not disassemble the needle and syringe after use.
- Do not recap**, bend or break needles before disposal.
- Decontaminate the needle and syringe before disposal.
- Dispose of the needle and syringe together in a puncture-resistant container.

Chapter 8: Infection Prevention 35

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Slide 36

**One-Handed Needle Recap Method**

- Place the needle cap on a firm, flat surface.
- With one hand holding the syringe, use the needle to "scoop" up the cap.
- Turn the syringe upright (vertical).
- Use the forefinger and thumb of other hand to grasp the cap and push firmly down onto the hub.



Chapter 8: Infection Prevention 36

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Slide 37

**Handling Needles and Sharps**

- Use a safe zone for passing sharps
- Say "pass" or "sharps" when passing sharps



Chapter 8: Infection Prevention 37

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Slide 38

**Handling Needles and Sharps (cont.)**

- Use a needle driver or holder, not your fingers.
- Use blunt needles when available.
- Do not blind suture.



Chapter 8: Infection Prevention 38

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Slide 39

**Handling Needles and Sharps (cont.)**

- Always remove blades with another instrument



Chapter 8: Infection Prevention 39

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Slide 40

**Handling Needles and Sharps (cont.)**



- Use a puncture-proof container for storage and/or disposal
- Do not recap a needle before disposal unless using the one-hand technique



Chapter 8: Infection Prevention 40

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Slide 41

**Instrument Processing**

Soiled instruments and other reusable items can transmit infection if they are not properly reprocessed.



Chapter 8: Infection Prevention 41

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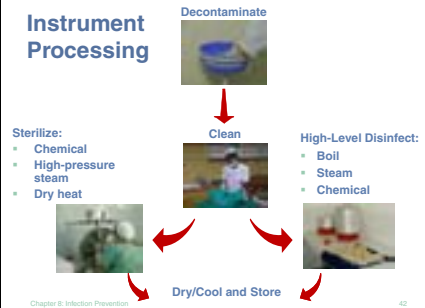
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Slide 42

**Instrument Processing**



**Decontaminate**

**Clean**

**High-Level Disinfect:**

- Boil
- Steam
- Chemical

**Sterilize:**

- Chemical
- High-pressure steam
- Dry heat

**Dry/Cool and Store**

Chapter 8: Infection Prevention 42

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Slide 43



### Decontamination of Instruments



- Immediately after use, **soak soiled instruments in a plastic container with 0.5% chlorine solution for 10 minutes.**
- **Rinse instruments immediately with cool water** to prevent corrosion and to remove visible organic material.
- **Clean with soap and water** and rinse thoroughly.

Chapter 8: Infection Prevention 43

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Slide 44



### Needles and Syringes



- Re-use of needles and syringes is no longer recommended.
- Therefore, flushing of needles and syringes is also not recommended.
- Used needles and syringes should be disposed of as a unit in a puncture-proof container.
- Dispose of container when it is three-quarters full.

Chapter 8: Infection Prevention 44

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Slide 45



### Cleaning



- Cleaning should be done **after decontamination** in order to:
  - Remove visible soil and debris, including blood or body fluids
  - Reduce the number of microorganisms on soiled instruments and equipment
  - Ensure that sterilization or high-level disinfection procedures are effective
  - Kill endospores that cause tetanus and gangrene

Chapter 8: Infection Prevention 45

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Slide 46



### Sterilization

- Destroys all microorganisms
- Used for:
  - Instruments
  - Surgical gloves
  - Other items that directly come in contact with blood or other sterile tissues

Chapter 8: Infection Prevention 46

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Slide 47



### Sterilization (cont.)

- Methods include:
  - Heat sterilization: high-pressure steam (autoclave) or dry heat (oven)
  - Chemical sterilant: e.g., glutaraldehyde or formaldehyde
  - Physical agent: e.g., radiation

Chapter 8: Infection Prevention 47

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Slide 48



### High-Level Disinfection

- High-level disinfection is a process that **destroys all microorganisms except some bacterial endospores**
- High-level disinfection is the **only acceptable alternative to sterilization**
- Can be achieved by:
  - **boiling** in water,
  - steaming, or
  - soaking in chemical disinfectants.

Chapter 8: Infection Prevention 48

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Slide 49




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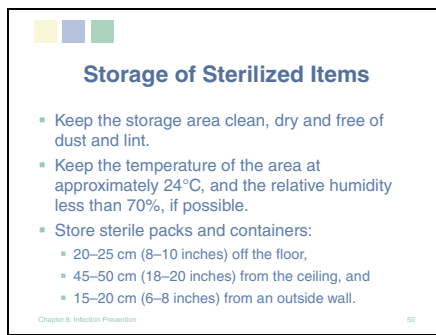
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Slide 50




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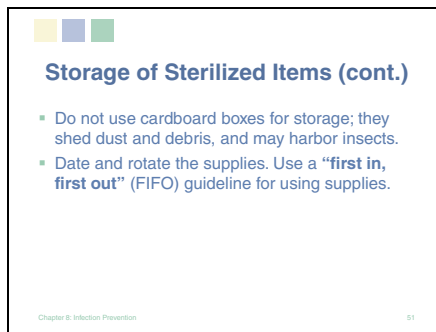
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Slide 51




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Slide 52



### Linen Processing



- Wash in hot, soapy water and dry
- Same in hospital or home

Chapter 8: Infection Prevention 52

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Slide 53



### Safe Disposal of Infectious Waste Materials

- Protect people who handle waste items from accidental injury
- Prevent the spread of infection to health care workers and to the local community



Chapter 8: Infection Prevention 53

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Slide 54



### Disposal of Clinical Waste



- Place contaminated items in leak-proof container or plastic bag
- Dispose by incineration or burial

Chapter 8: Infection Prevention 54

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Slide 55



### Steps for Disposal of Sharps



1. Do not recap the needle or disassemble the needle and syringe.
2. Decontaminate the hypodermic needle and syringe.
3. Place the needle and syringe in a puncture-resistant sharps container.
4. When the container is three-quarters full, dispose of it.

Chapter 8: Infection Prevention 55

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Slide 56



### Steps for Disposal of Sharps Container

- Wear heavy-duty utility gloves.
- When the sharps container is three-quarters full, cap, plug or tape the opening of the container tightly closed. Be sure that no sharp items are sticking out of the container.
- Dispose of the sharps container by burning, encapsulating or burying it (see below).
- Remove utility gloves.
- Wash hands and dry them with a clean cloth or towel or air dry.

Chapter 8: Infection Prevention 56

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Slide 57



### Disposal of Waste Containers #1

- **Burning:**
  - Destroys the waste
  - Kills microorganisms
  - Best method for disposal of contaminated waste
  - This method reduces the bulk volume of waste, and
  - Ensures that the items are not scavenged and reused

Chapter 8: Infection Prevention 57

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Slide 58



### Disposal of Waste Containers #2

- **Encapsulation:**
  - Easiest way to dispose of sharps containers
  - When sharps container is three-quarters full, it is made completely full by pouring:
    - Cement (mortar),
    - Plastic foam, or
    - Clay
  - After material has hardened, the container is disposed in a landfill, stored or buried

Chapter 8: Infection Prevention 58

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Slide 59



### Burying Waste

- Restrict access to the disposal site. Build a fence to keep animals and children away.
- Line the burial site with a material of low permeability (e.g., clay), if available.
- Select a site at least 50 meters (164 feet) away from any water source to prevent contamination of the water table.
- Ensure that the site:
  - Has proper drainage,
  - Is located downhill from any wells,
  - Is free of standing water, and
  - Is not in an area that floods.

Chapter 8: Infection Prevention 59

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Slide 60



### Post-Exposure Management

**If exposure occurs to the:**

- **Skin**
  - Wash with soapy water
  - Do not use caustic agent or bleach
- **Eye, nose, mouth**
  - Rinse with water for 10 minutes
- **Needle-stick or cut:**
  - Wash with soapy water
  - Allow to bleed freely
  - Apply first aid

Chapter 8: Infection Prevention 60

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Slide 61

**Post-Exposure Management (cont.)**

- Post-exposure prophylaxis (PEP) considerations:
  - Evaluate risk:
    - Source of fluid or material
    - Type of exposure
  - Evaluation of exposure source patient:
    - HIV status
    - Stage of infection
  - Test health care worker for HIV after exposure as baseline, if available

Chapter 8: Infection Prevention 61

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Slide 62

**Post-Exposure Prophylaxis**

- Treatment, if started, should be initiated immediately after exposure, within 1–2 hours.
- Decisions regarding which and how many antiretroviral agents to use are largely empiric.
- CDC recommendations:
  - Zidovudine (ZDV) and lamivudine (3TC)
  - Lamivudine (3TC) and stavudine (d4T)
  - Didanosine (ddI) and stavudine (d4T)
- Continue treatment for 4 weeks.
- Do medical follow-up.

Source: CDC MMWR 2001. Chapter 8: Infection Prevention 62

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Slide 63

**Making the Workplace Safer**

- Continue identifying risk.
- Continue to use Standard Precautions.
- Teach patients it is okay to remind health care workers to wash hands and use gloves.
- Actively role model and support IP practices.



Chapter 8: Infection Prevention 63

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Slide 64

**Supporting a Safer Workplace**

- Support from hospital administrator
- Positive feedback from supervisor



Chapter 8: Infection Prevention 64

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Slide 65

**Summary**

- Minimize and prevent exposure to infection by:
  - Using **Standard Precautions** with every patient
  - **Disposing of clinic waste properly**
  - Using **post-exposure care** when necessary
- Work together to make the workplace safer.
- Teach patients and their families how to reduce risk of exposure in the home.

Chapter 8: Infection Prevention 65

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Slide 66



*Photo credit: 'Dipo Otolorin*

Chapter 8: Infection Prevention 66

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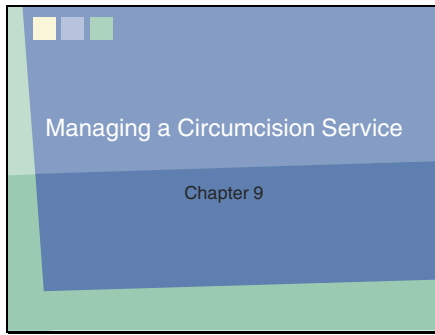
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Slide 1



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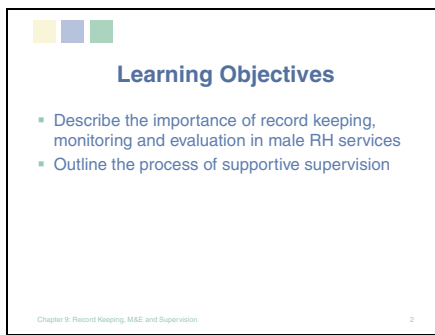
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Slide 2



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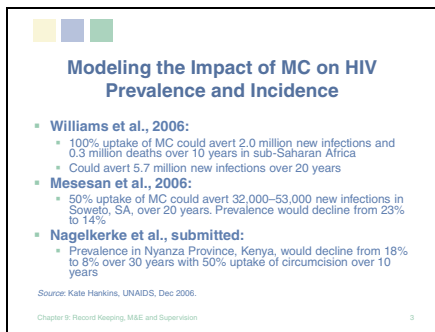
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Slide 3



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Slide 4

Record Keeping, Monitoring and Evaluation



Chapter 9: Record Keeping, M&E and Supervision 4

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Slide 5

How do we know when a sick patient is responding to treatment?

**Sick patient, e.g., with fever**  
Assessed (Hx/Exam/Labs)  
• Diagnosis made, e.g., malaria  
• Admitted (if severe)  
• Treatment given (e.g., ACT)

**Well patient**  
• Stop treatment  
• Discharge

e.g., Periodic monitoring of:  
• Patient's complaints  
• Vital signs e.g., TPR  
• Temp chart  
• Repeat blood smear/staining

Chapter 9: Record Keeping, M&E and Supervision 5

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Slide 6

Facility Indicators

- Planners also require information to make decisions about how best to spend the facility's scarce resources to meet the needs of clients. They need answers to the following questions:
  - Are we reaching our target audience?
  - Can we provide the necessary services? (For example, do we have the appropriate equipment, the staff, the drugs?)
  - Are our services of high quality? (For example, do they meet national and international standards?)
  - Do our services meet the needs of our clients?
  - Are we referring clients who need it?
  - Are our patients getting healthier?

Chapter 9: Record Keeping, M&E and Supervision 6

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Slide 7

**What Is Monitoring?**

- Monitoring is the **routine assessment** (e.g., daily/monthly/quarterly) of information or indicators-related ongoing activities to:
  - Track progress** towards the programme targets or performance standards
  - Identify those aspects that are working according to plan and those that are in need of adjustments

Chapter 9: Record Keeping, M&E and Supervision 7

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Slide 8

**Evaluation**

- Evaluation refers to the measurement of how much things have changed as a result of the intervention(s) implemented
- Multiple factors related to change
- A formal evaluation tries to demonstrate how much a specific intervention contributed to the observed change

Chapter 9: Record Keeping, M&E and Supervision 8

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Slide 9

**Purpose of Evaluations**

- Assess progress made at a particular points in time (mid-term or end-of-project evaluation)
- Assess progress towards achievement of set objectives
- Provide feedback on whether targets are being met
- Identify reasons for successes and failures
- Provide a basis of future planning

Chapter 9: Record Keeping, M&E and Supervision 9

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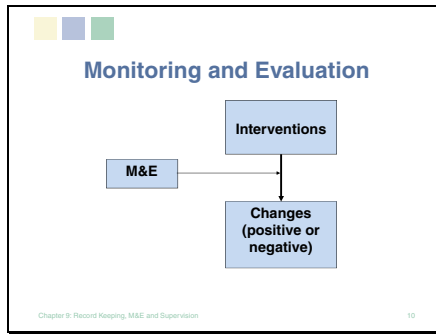
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Slide 10



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Slide 11

- 
- The slide is titled 'An Effective Monitoring System Implies...'. It contains four bullet points, each starting with a blue square. The text of the bullet points is: 1. All those involved know what information is needed and by whom. 2. The tools needed to collect the information are available. 3. All those involved know how and when to report the information. 4. One person is responsible for making sure the system is working (that indicators are up-to-date, records are being properly kept, and data are reported to appropriate partners). In the top left corner, there are three small colored squares: yellow, blue, and green. At the bottom left, it says 'Chapter 9: Record Keeping, M&E and Supervision'. At the bottom right, it says '11'.

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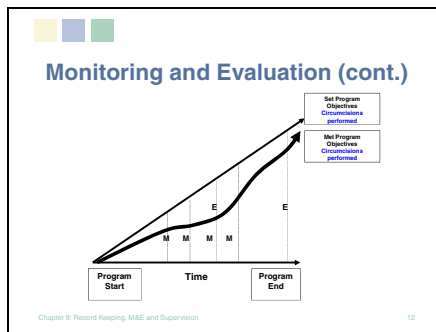
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Slide 12



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Slide 13



### Methods of Evaluation

- Review of available records and reports
- Supervisory assessment
- Staff self-assessment
- Peer assessment
- Client feedback (e.g., through exit interviews)
- Community survey
- Facility comparison

Chapter 9: Record Keeping, M&E and Supervision 13

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Slide 14



### Types of Data Collection Tools

- Patient record forms/case notes
- Outpatient clinic registers
- Admission/inpatient registers
- Operating room registers
- Special forms:
  - MC adverse events forms
  - Death reporting forms

Chapter 9: Record Keeping, M&E and Supervision 14

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Slide 15



### Tips for “Good Data” Collection

- Understand the data
- Record the data every time
- Record all of the data
- Record the data in the same way every time

Chapter 9: Record Keeping, M&E and Supervision 15

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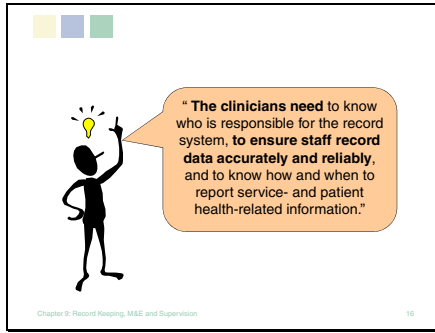
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Slide 16



“ The clinicians need to know who is responsible for the record system, to ensure staff record data accurately and reliably, and to know how and when to report service- and patient health-related information.”

Chapter 9: Record Keeping, M&E and Supervision 16

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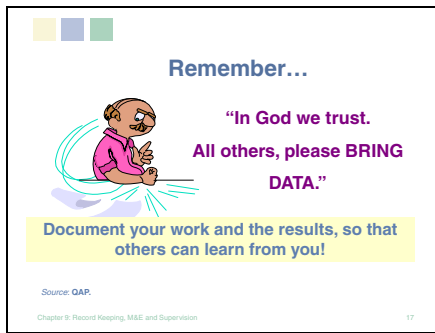
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Slide 17



Remember...

“In God we trust.  
All others, please BRING DATA.”

Document your work and the results, so that others can learn from you!

Source: QAP.

Chapter 9: Record Keeping, M&E and Supervision 17

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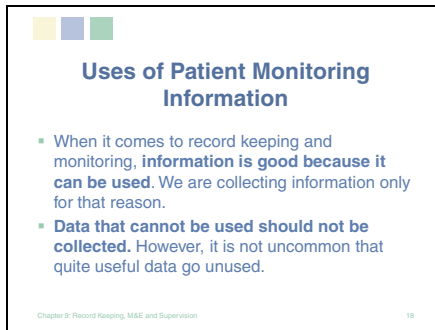
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Slide 18



**Uses of Patient Monitoring Information**

- When it comes to record keeping and monitoring, **information is good because it can be used.** We are collecting information only for that reason.
- **Data that cannot be used should not be collected.** However, it is not uncommon that quite useful data go unused.

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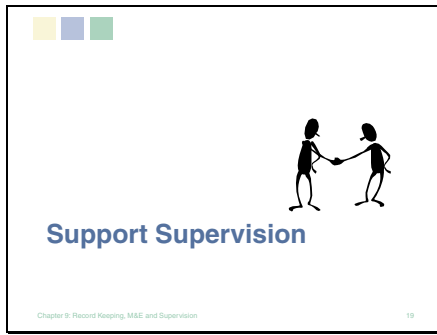
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Slide 19



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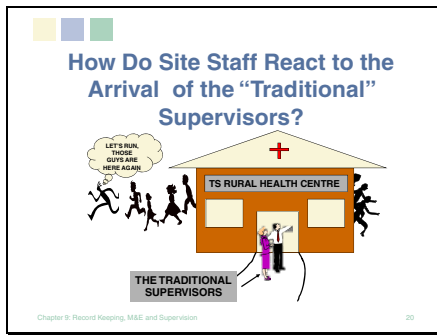
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Slide 20



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Slide 21



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Slide 22



### “Traditional” Supervision

- **Traditional approaches** to supervision emphasize “**inspecting**” facilities and **checking** individual performance.
- Traditional supervision **focuses on finding fault or errors and then sanctioning** those responsible, or thought to be responsible, for those errors.
- Traditional supervision **causes negative feelings** and it **rarely results in improved health services**.

Chapter 9: Record Keeping, M&E and Supervision 22

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Slide 23



### “Support” Supervision

- Also called “**facilitative**” supervision
- Supervision for performance and quality improvement **focuses on:**
  - The goal of providing high-quality health services
  - A process of continuous performance and quality improvement
  - A **style of encouraging, inclusive and supportive interaction**

Chapter 9: Record Keeping, M&E and Supervision 23

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Slide 24



### Goal of Supervision

- The **goal of supervision is to promote and maintain the delivery of high-quality health services**. In a traditional system of supervision, this goal is often lost or at least is not apparent to those being supervised. By clearly stating that the goal of supervision is the delivery of high-quality health care services, the **supervisor** can transform the sometimes negative impression of supervision into a positive one.

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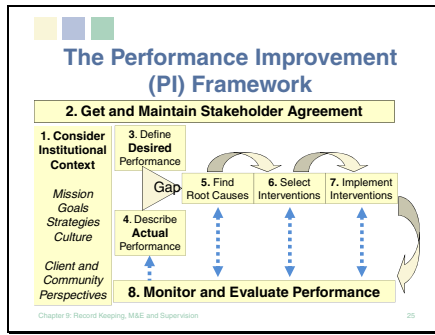
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Slide 25



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Slide 26

- 
- Performance and Quality Improvement (PQI) Process**
- The PQI process encourages the manager and his team to:
    - Set performance standards
    - Make sure that standards are met
    - Find out what is hindering or helping achieve desired performance
    - Identify and implement ways to improve performance and quality
    - Regularly monitor and evaluate how staff are performing compared to the standards
- Chapter 9: Record Keeping, M&E and Supervision 26

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Slide 27

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- Illustrative Indicators for MC Services**
- Number of clients receiving MC services in donor- or government-supported facilities
  - Percentage of men undergoing MC who experience an adverse event
  - Percentage of MC procedures performed according to standards
  - Percentage of MC clients who are counseled about HIV
  - Percentage of MC clients who received an HIV test
- Chapter 9: Record Keeping, M&E and Supervision 27

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Slide 28



### Summary

- The manager of a male reproductive health clinic has diverse roles including ensuring quality counselling services, logistical management of essential supplies, oversight for quality record keeping, and monitoring and evaluation of the program, as well as supportive supervision.

Chapter 9: Record Keeping, M&E and Supervision 28

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Slide 29



### Summary (cont.)

- To meet these responsibilities, the clinic manager must be knowledgeable about the desired levels of performance for the services being provided, how to assess current levels of performance, and how to work with other clinic staff to analyze root causes of inadequate performance and find solutions for identified problems.

Chapter 9: Record Keeping, M&E and Supervision 29

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Slide 30





*Photo credit: Dipo Otolorin*

Chapter 9: Record Keeping, M&E and Supervision 30

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