

Male Circumcision Situation Analysis Toolkit



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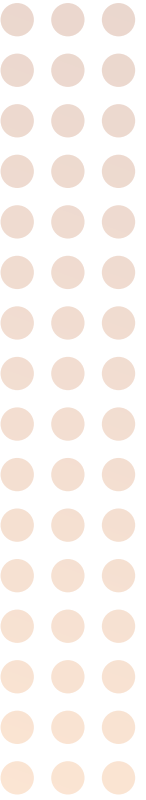
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Male Circumcision **Situation Analysis Toolkit**



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Introduction

A situation analysis is an analysis of the context and environment in which work may be undertaken.

1 The need for a situation analysis

A situation analysis is intended to inform a better choice of intervention. The situation analysis process described in this toolkit is founded on the principle that information explaining **what** is happening and **why** it is happening is essential for deciding whether and how to proceed with an intervention.

In order to decide whether and how to increase the rate of safe male circumcision it is important to understand the determinants and scale of current male circumcision practices in countries, assess the capacity to perform safe male circumcision in various clinical settings and the capacity gaps, and determine the willingness of populations to support and come forward for male circumcision.

To maximize the benefits of a situation analysis an optimal methodology would include:

- facilitating partnerships and team-building among stakeholders, thus encouraging joint ownership and responsibility for the work in the future;
- encouraging stakeholder participation in the process, thus increasing the quality of the information acquired and the acceptability of the results;
- reinforcing in-country capacities for situation analysis through both experience with the process and the provision of training materials.

Baselines

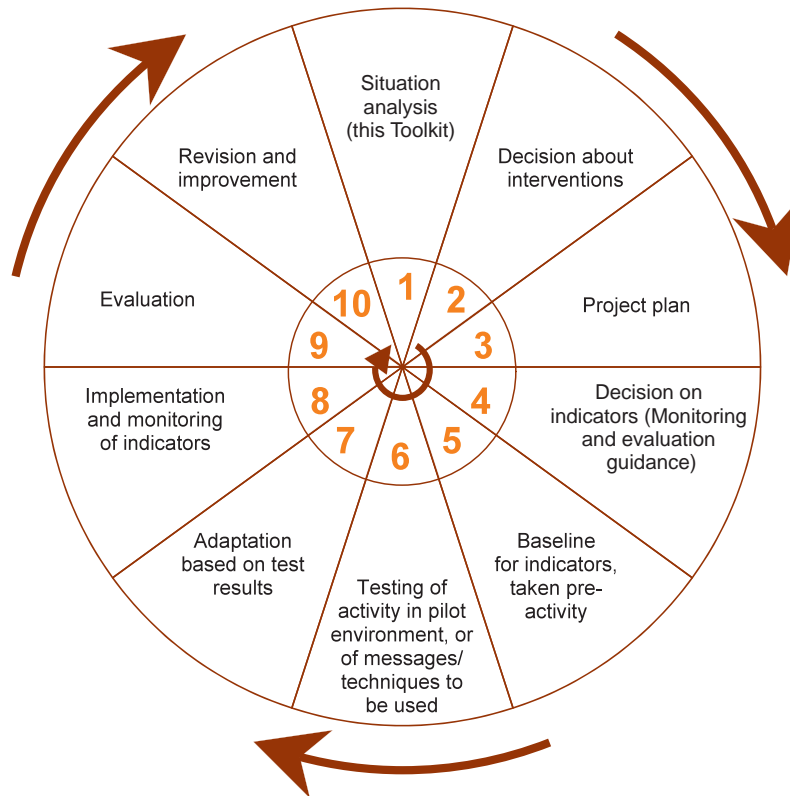
A baseline analysis is a measurement of *key indicators* of change before any intervention is started. It is constructed in such a way that it can be repeated at some future point using a comparable methodology in order to detect change. It permits the setting of realistic targets and subsequent evaluation of the extent to which the targets are being met. If no baseline analysis is undertaken the evaluation of change becomes extremely difficult.

A baseline analysis is not the same as a situation analysis, the latter being a participatory process designed to develop as full a picture as possible of current needs, attitudes and capacities. Although it may be possible to identify some baseline information through a situation analysis, this would be by coincidence and not by design. For more information on a baseline analysis and indicators, see the monitoring and evaluation guidance developed for male circumcision programmes (www.malecircumcision.org).

2 The first step

The situation analysis is the first step in a programme cycle intended to increase the rate of safe male circumcision.

Fig. 1. Programme cycle around interventions



3 Expected results

The results of the situation analysis will help the process of deciding how to proceed with a programme, through the following.

- A description of the current situation:
 - number of male circumcisions carried out, at what age, where and by whom;
 - prevalence of male circumcision among adolescent and adult males;
 - health service capabilities for safe male circumcision;
 - key behaviours and attitudes that influence male circumcision among individuals and in communities;
 - key sociopolitical and traditional influences on male circumcision.
- Informing the scale of intervention required to increase rates of male circumcision:
 - ability to meet current and future demand for services;
 - capacity and possible mechanisms to increase demand for services;
 - insight into what interventions might be effective and possible responses to them;
 - assessment of capacity gaps.

4 Key aspects of the approach

This toolkit is based on *non-extractive action research methodologies* for both quantitative and qualitative analysis. Action research is a process of planned participative involvement (often conducted by both researchers and stakeholders) that produces insights into solutions as well as problems.

4.1 Participation and consultation

Participation by stakeholders at all levels improves the value of research results and sets the tone for any work that may follow the situation analysis. Participatory approaches encourage people to identify their own experiences, reflect on them and offer solutions. This is most useful in helping to understand **why** something is happening and **how** change might take place.

The participation of key stakeholders and consultation with them throughout the situation analysis process also increases people's ownership and reduces alienation and surprise among those involved in the work. It also builds consensus on future recommendations.

4.2 Quantitative and qualitative information

To understand the situation regarding male circumcision requires both countable measures (quantitative tools), such as 'How many?' and 'By whom?', and measures of behaviour and decision-making trends (often qualitative tools).

Combining quantitative and qualitative research methods leads to a fuller picture of the number of male circumcisions being performed and the behaviours that affect male circumcision. The key definitions are as follows.

- **Quantitative methods** focus on **numerical data** and pose questions such as: '**How many?**' and '**How often?**' These methods explore '**who**', '**what**', '**when**' and '**where**'.
- **Qualitative methods** are usually designed to reveal the '**how**' and '**why**' elements of research.
- **Quantitative qualitative analysis.** If qualitative research is done systematically and representatively the results can be as reliable and objective as those produced by quantitative methods. The systematic application of qualitative methods has led to the use of numerical scales and scores to describe qualitative results, and these provide a quantitative aspect to qualitative research.

4.3 Using an analysis of supply and demand

In order to increase the rate of safe male circumcision there must be an increase in both the supply of and the demand for the service.

Supply is the ability to provide the service and is related to:

- The willingness of management to provide the service:
 - perception of the demand for the specific service;
 - perception of the ability to meet demand;
 - attitude of health workers and management to the value of the specific service, including how it relates to / impacts on other services;
 - support from local, regional and national health management systems.
- The capability of management and facilities to provide the service:
 - actual cost of circumcision, the fee for service, and ability to recoup costs;

- availability of supplies, equipment and skills required for the operation;
- ability to create 'space' in staff workloads and facility capacities without negatively impacting on other service provision.

Demand is the number of people who want the service and is related to:

- perceived necessity;
- perceived benefits at the personal, family and community levels;
- perceived 'cost' to the individual;
- perceived and actual availability and accessibility of the service.

Demand is not only the result of informed individual choice but is also determined by sociocultural norms, beliefs and traditions that should be taken into account in service design, promotion and development.

If there is an understanding of the current situation and how it has arisen, the possibility exists of identifying the important variables that must be changed in order to achieve the goal. In order to drive change (rather than simply achieve an expressed desire for change), behavioural change and service provision interventions must be clearly defined and balanced. This is why both factors are examined in this situation analysis.

A situation analysis informs an understanding of the ways of increasing demand and supply together. It is important to find a **balance** between supply and demand, as they are interlinked. If there is too little supply compared to demand, people will be frustrated and demand will drop or people may seek unsafe, unregulated service outlets elsewhere; if there is excessive supply, health planners may decide to divert resources to something else.

4.4 Behaviour change

It is important to understand three factors that will be particularly relevant to work on male circumcision.

1. **The behaviour of people and (therefore) their institutions.** Increasing the rate of safe male circumcision requires behavioural change on the part of people and communities in deciding on male circumcision or to support safe male circumcision.
2. **The behaviour of health-care workers and planners** in developing systems and prioritizing safe male circumcision services, advising patients, seeking new knowledge, etc.
3. **The behaviour of leaders at all levels** in developing policy, publicizing support, responding to advocacy and allocating resources to health systems so as to meet demand.

In order for clear decisions to be made the situation analysis needs to contribute to an understanding of these factors.

Behaviour theory can be helpful in understanding how people make decisions, such as those concerning male circumcision. Outlined here is one theory (of many) that may be useful. The 'stages of change' model considers the stages through which individuals go in changing their health-seeking behaviour. Individuals can move in both directions in the sequence. The concept can also be applied to groups of individuals.

- **Precontemplation:** An individual has a problem (whether or not he/she recognizes it) and has no intention of changing or (if the problem is not recognized) sees no reason to change. For example, in respect of male circumcision, the 'problem' is that a man is not circumcised, does not intend to become circumcised and is therefore more vulnerable to infection with HIV.

- **Processes that can help to move the individual to contemplation:** Raising of consciousness (information and knowledge), e.g. through mass media, targeted information and peer discussion.
- **Contemplation:** The individual recognizes the problem and is thinking about changing. For example, an uncircumcised man knows about the link with HIV and is thinking about being circumcised.
 - **Processes that can help to move the individual to prepare for action:** Self-re-evaluation (assessing one's feelings regarding one's behaviour) and support through debate and discussion in the family, among friends or in the community.
- **Preparation for action:** The individual recognizes the problem and intends to change her/his behaviour. In the case of male circumcision, a man intends to be circumcised and has learnt how this could be done. He has set the stage by making an appointment but has not yet kept it.
 - **Processes that can help to move the individual to action:** Self-liberation (commitment or belief in ability to change).
- **Action:** The individual is in the process of, or has just completed, the male circumcision process.
 - **Processes that can help to move the individual towards maintenance:**
 - reinforcement (overt and covert rewards), helping relationships (social support, self-help groups);
 - counter-conditioning (weakening an undesired response, e.g. lack of commitment to male circumcision or safer sex behaviours, by strengthening other responses that are incompatible with the desired response, e.g. a desire to socially conform);
 - stimulus control (avoiding high-risk cues e.g. those that would lead to a change in desire for male circumcision or a desire not to maintain safer sex behaviour).
- **Maintenance:** The individual maintains his new behaviour for six months or more. The state of being circumcised is self-maintaining but the requisite accompanying safer sex behaviours are not. The maintenance phase for male circumcision must therefore include the maintenance of safer sex behaviours.

4.5 Ethics and the situation analysis

Situation analysis acquires new information and local officials involved in research ethics may need to be consulted. Adherence to ethics for research is important for protecting the participants, the researchers and the reputation of the research results. A breach of ethics can result in the abuse or alienation of research participants and subsequent invalidation of the results or the creation of resistance to future interventions.

Training in research ethics may be obtained from several sources, e.g. the Institutional Review Board of the Office for Human Research Protections, United States Department of Health and Human Services. The situation analysis described in this toolkit may be classified, in particular, as social research. The Social Research Association has produced *Ethical guidelines* and has provided input into the RESPECT project, which is funded by the European Union.¹ Some ethical issues of relevance to this specific situation analysis are indicated below.

¹ Social Research Association. *Ethical guidelines* (available at: <http://www.the-sra.org.uk/documents/pdfs/ethics03.pdf>); *RESPECT Code of Practice for Socio-Economic Research* (available at: http://www.respectproject.org/code/respect_code.pdf).

4.5.1 Responsibilities towards respondents

1. **'Do no harm'** means protecting the physical, social and psychological well-being of people you study. This includes not raising false expectations. In the case of male circumcision, for example, it is important to emphasize that it only reduces the risk of HIV acquisition and does not give total protection.
2. **Respect people's privacy in the questions you ask and the locations where you ask them.** Male circumcision is (in some societies and for some people) a sensitive subject to discuss and this must be respected. It is not always possible to foresee the consequences of failing to keep information confidential. Beware of directly attributing information given in confidence.
3. **Giving information and obtaining consent (whether informal or formal).** These two issues are closely related because you need to give information in order to obtain informed consent. Each person involved in the work should be briefed on how to explain why they are there, what the work is about and how the results will be used. If formal consent is deemed advisable or requested by ethics authorities it may be necessary to have prepared scripts requesting verbal consent, or consent documents for signature.
4. **Compensation for participants.** This can be a difficult issue because of the common approach of non-payment for people who complete questionnaires. It is probably advisable not to pay for survey interviews, as this can lead to unrealistic expectations. With regard to group meetings, however, refreshments should be provided, travel costs reimbursed, etc. as a minimum recompense for people contributing time from their daily lives.

4.5.2 Responsibilities to colleagues

The organizers of a research team have a responsibility to their colleagues in the project to keep them safe and to design a study that will obtain accurate information. If such information is not gathered the research has no value. Safety and accuracy are *values* that the organizers must instil into a research team.

- **Worker safety should be given priority over the completion of the task.**
 - Know exactly what workers are doing and where they are at all times.
 - Plan for the safest transport, accommodation and subsistence options.
 - Ensure that workers have evidence with them at all times of what they are doing and for which organization.
- **Accurate results – problems with results may occur if:**
 - workers become tired and/or bored and start taking short cuts with their note-taking;
 - they are given impossible targets;
 - they falsify results (perhaps because of personal opinions or laziness) – checking procedures should be communicated and implemented.

Using the toolkit

The objective of the toolkit is to provide a framework and tools that can be used to carry out a situation analysis before decisions are made about embarking on work to increase rates of safe male circumcision.

The toolkit outlines a series of six tools (Table 1) that can be used to identify what is happening, why it is happening and how people think the situation might be changed.

Table 1. The tools

Tool 1	Guided desk review	Gathers all existing data from a range of sources on male circumcision rates and service provision, as well as behaviours that affect male circumcision rates.
Tool 2	Key informant interviews	Gains a confidential insight into sources of information, stakeholder perceptions and the sociopolitical and cultural environment.
Tool 3	Stakeholders' meeting	Identifies the nature of stakeholder interests, expectations and possible contributions, as well as increasing the understanding and involvement of stakeholders in the situation analysis processes.
Tool 4	Focus groups	Provides insight into current influences on male circumcision and potential responses to change among community members.
Tool 5	Service availability	Gathers information on health care facilities and staff attitudes.
Tool 6	Feedback and action	Feeds back the results of the situation analysis to stakeholders and starts the planning process for the next steps, using facilitated discussion tools.

Furthermore, this toolkit outlines two additional tools that may prove useful: a survey of individuals (Annex 1); and workshops to be held with community leaders (Annex 2). Annexes 3–5 contain brief notes that remind users of the skills required for implementing the tools, provide a guide to further reading and briefly examine different approaches to questioning.

The toolkit is applicable in the following two scenarios.

1. Countries with high or potentially high prevalence of HIV where there is little male circumcision in general.
2. Countries with high or potentially high prevalence of HIV with segments of the population in which the prevalence of male circumcision is low.

In either scenario a core multidisciplinary group is necessary to instigate and lead the situation analysis. This group should include representation from the ministry of health and may continue to exist following completion of the situation analysis in order to guide the implementation of a programme for scaling up safe male circumcision.

1 Toolkit users

The following assumptions were made about users of the toolkit when it was being created.

- **Users will be the organizers** of the situation analysis and the toolkit will be most useful to those involved in facilitating the tools.
- **Users will already have knowledge** of situation analysis work and male circumcision issues. For further information, see the following.
 - The male circumcision information package, which clearly and simply outlines facts and figures about male circumcision. The workers who will carry out the situation analysis should be briefed and should be fully familiar with this information (available at: <http://www.who.int/hiv/topics/malecircumcision/en/index.html>).
 - Additional information, which is available at www.malecircumcision.org.
 - Annex 4.
- **The toolkit will be used** in countries/areas/populations with high HIV rates and low clinical male circumcision rates.

The performance of a situation analysis does not automatically mean that further work on male circumcision will or must take place. However, if a country is considering work in this area then it is important that country-specific information be made available concerning the basic issues important to making political and resource decisions about male circumcision.

2 Budgeting

Budgeting is an important part of planning. This toolkit does not give guidance on an overall budget amount, as each country will define which tools to use, what geographical areas to cover, what sample size to use and what cost levels are associated with a specific environment. Table 2 is a generic guide.

Table 2. Budgeting example

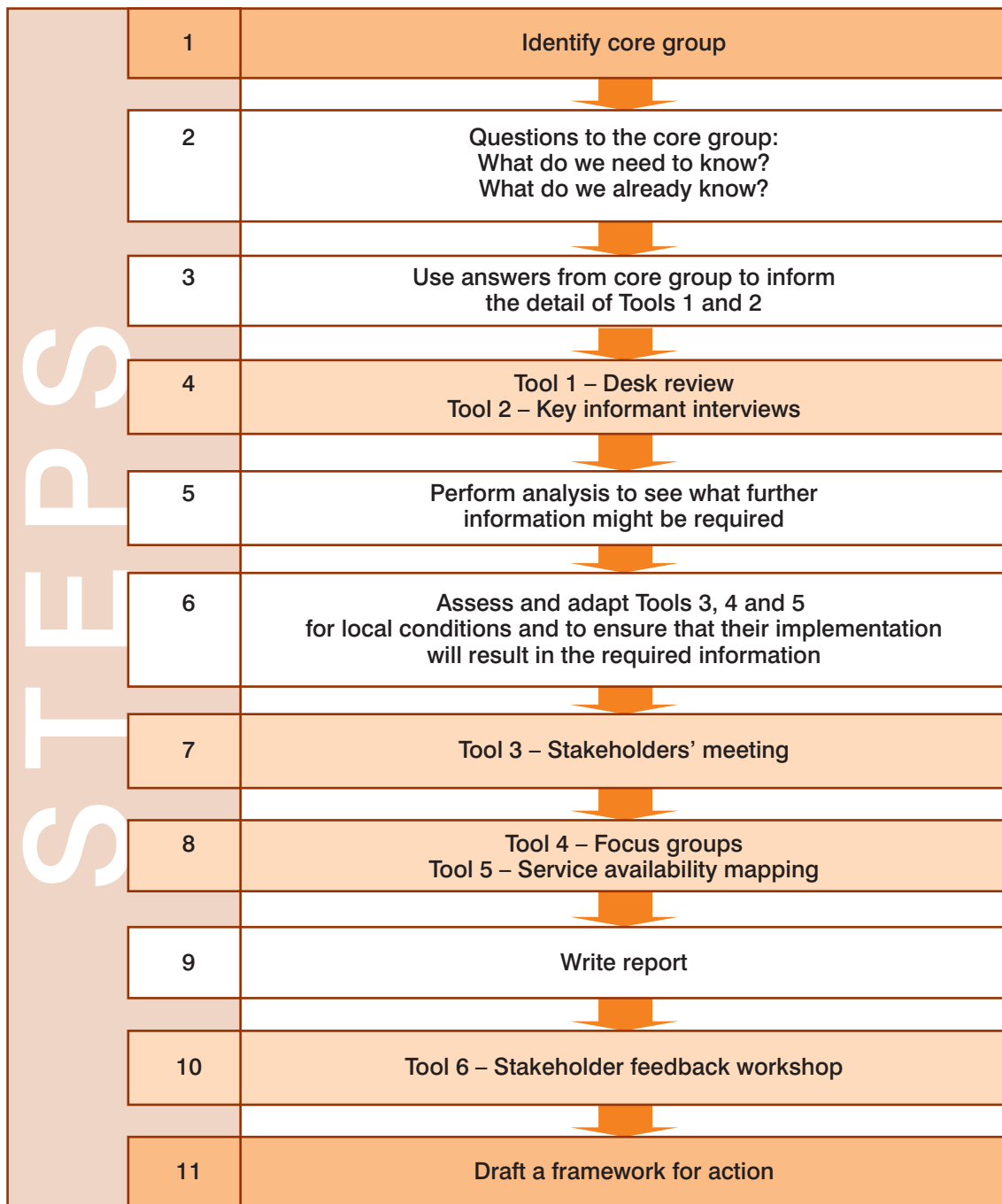
Tool	Budgeting considerations
Tool 1	1 person for 1 week Transport
Tool 2	1 person for 2 weeks – per 15 interviews for planning, interviewing, writing up and analysis Transport
Tool 3	1 person for 2 weeks – per meeting for planning, facilitation and writing up Room hire, refreshments, transport allowances and meeting equipment
Tool 4	1 person for 3 days – per 10 focus groups for planning and arranging 1 person for 1 day – per 2 focus groups for leading 1 person for 1 day – per 2 focus groups for note-taking and writing up 1 person for 2 days – per 6 focus groups for analysis Accommodation, transport and food
Tool 5	1 person for 1 day – per 2 facilities for planning, carrying out the work and writing up 1 person for 1 week – per 20 facilities for analysis Accommodation, transport and food
Tool 6	1 person for 2 weeks – for planning, meeting facilitation and writing up 1 person for 5 days – to complete the report Room hire, refreshments, transport allowances and meeting equipment Accommodation, transport and food

It is very unlikely that one person employed for the full period could complete all the work (although this depends on the sample size and locations of work). Throughout the work it will be possible to contact a WHO staff member and/or consultant for clarification.

3 Undertaking the situation analysis

Fig. 2 illustrates the process that the situation analysis follows. The process begins with the formation of the core multidisciplinary group. It is important that each step in the flow diagram is completed in order. However, it is recognized that different situations exist in different countries and that it may be necessary to adapt the process and the order in which the tools are used.

Fig. 2. Situation analysis process



4 Planning the work

It is important to note that planning must be done before starting the actual work. In order that information from, for example, Tool 1 can be fed into Tool 3, work should be completed in the sequence shown in Fig. 3. Depending on their needs, however, countries may use the tools in a different order to that suggested.

Fig. 3. Planning for implementation of the situation analysis

Month 1				Month 2		
Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7
Tool 1 Implement						
	<i>Tool 2 Start planning</i>	Tool 2 Implement				
	<i>Tool 3 Start planning</i>		Tool 3 Implement			
		<i>Tool 4 Start planning</i>		Tool 4 Implement		
			<i>Tool 5 Start planning</i>		Tool 5 Implement	
				<i>Tool 6 Start planning</i>		Tool 6 Implement

5 Adaptation of tools

Toolkit users may want to adapt tools to fit local circumstances.

5.1 Traditional male circumcision

Investigating the circumstances under which males already undergo circumcision requires a different approach to that for investigating the possibility of introducing male circumcision into societies where it is not currently practised. The latter circumstance is generally the more important in terms of reducing the risk of HIV infection, although traditional male circumcision in some countries, e.g. Lesotho, does not remove the entire foreskin, reducing the probable benefit and leading to a potential need for recircumcision. It may also be important to work to transform traditional male circumcision practice, particularly in adolescent and adult males, because of an unacceptably high rate of documented complications.

In some countries or areas, traditional male circumcision practices account for a high proportion of the total number of circumcisions. In Kenya, for example, 85% of men are circumcised and traditional male providers carry out 80% of male circumcisions. Where male circumcision is not currently practised, whether or not this occurred in the past, there are unlikely to be any traditional male circumcision providers. However, the risk arises of unskilled and unqualified practitioners attempting to set up services to meet growing demand.

The decision whether to attempt to use traditional male circumcision providers in efforts to increase male circumcision rates will depend on the individuals concerned. Traditional providers can be brought in to link with health-service providers for the actual cutting, and it is possible to explore how positive aspects of initiation rites can be incorporated while harmful aspects are transformed. For example, initiatives in Kenya involving health-related faith-based organizations are trying to bring traditional and new methods together (see report of Catholic Medical Mission Board at www.malecircumcision.org).

The toolkit focuses on the formal health-care sector, as work with traditional male circumcision providers would require a different approach. However, below is a list of possible adaptations to some of the tools to cover environments where traditional male circumcision is practised.

Key informant interviews

After Question 5 (What do you believe are the main factors affecting rates of male circumcision in this country?), add the following.

- What do you know of the meaning of male circumcision to [name the local circumcising group(s)]? Probe: Is there an extensive initiation or rite of passage linked with male circumcision? What can you tell me about this?
- What do you think being circumcised would mean to males in [name local non-circumcising group(s)]?
- Do you think there is much stigma attached to a [name circumcising group(s)] as an uncircumcised male? Probe: What do you think is the reason for this stigma?
- Do you think there would be stigma attached to males from [name non-circumcising group(s)] if they were circumcised? What do you think would be the reason for stigma?

Focus groups

- In the opening questions, add: “What can you tell me of the meaning of traditional male circumcision?” Question further, if necessary: “Is circumcision part of a wider initiation process? What can you tell me about the meaning of this wider process?”
- After Question 5 (regarding memory of circumcision – 4.3.2, page 46), add: “What does it mean to you to be circumcised? Would there be any issues for you if you were not circumcised?” PROBE.
- Ask the same questions for the non-circumcised group.
- Add a question on stigma associated with male circumcision.

These would be the minimum questions to raise in traditional circumcision settings. However, they go to the heart of the matter and probing around them should elicit further information. In order to probe, ask people if something that someone else has contributed is true for them, or what other people say, so that you can deepen the discussion by responding to what is said.

Male circumcision issues

“Male circumcision should never replace other known methods of HIV prevention and should always be considered as part of a comprehensive HIV prevention package”

Conclusions and recommendations from WHO/UNAIDS Technical Consultation, February 2007

A clear grasp of the facts and figures is fundamental to any work on male circumcision. For a full briefing, see the male circumcision information package (available at: <http://www.who.int/hiv/topics/malecircumcision/en/index.html>).

WHO and UNAIDS have now accepted male circumcision as an effective means of HIV risk reduction (see: <http://www.who.int/hiv/topics/malecircumcision/en/index.html>).

Further information is available at www.malecircumcision.org.

In addition to considering the scientific evidence that male circumcision reduces the risk of HIV infection in heterosexual men, any approach adopted by a country should take into account:

- the severity of the HIV epidemic, and regional differences in HIV prevalence;
- the current prevalence of male circumcision, including regional or tribal differences;
- the cultural acceptability of promoting safe male circumcision;
- the capability of the health-care system (public and private) to deliver safe male circumcision services;
- the need and means to work with traditional male circumcision providers to ensure that male circumcisions currently performed for cultural reasons are safe, humane and culturally acceptable;
- the risk associated with male circumcision performed by inadequately trained and poorly equipped practitioners in non-hygienic settings;
- the potential to undermine existing protective behaviours and prevention strategies that reduce the risk of HIV transmission;
- that the effectiveness of programmes implemented in the field is often less than that obtained under the ideal and well-resourced conditions of a randomized controlled trial.

1 A key message

People need to understand that male circumcision only decreases the risk of HIV infection and does not give complete protection against the virus. Circumcised men can become HIV-infected, and, if HIV-positive, can infect their sexual partners. Incorrect perceptions of protection may lead to an increase in risk behaviours, including a reduction in condom use. Men may use their circumcision status as a reason for not using condoms, while women may be less inclined to insist on condom use if their male partners are circumcised.

It is therefore essential that male circumcision does not replace other known and effective means of reducing HIV infection, such as abstinence, sex between people who both know they are HIV-negative, avoiding concurrent sexual relationships, and correct and consistent use of male or female condoms. Male circumcision is only one of several HIV risk-reduction methods that individuals and programmes can use.

It cannot be stressed enough that messages surrounding this issue must be accurate and that workers using the toolkit should be briefed appropriately.

Male circumcision will reduce the risk of HIV infection for the male during vaginal intercourse but its effect on other routes of sexual HIV transmission is unknown. For instance, it is not known whether male circumcision reduces the risk of HIV infection for men who have sex with men.

2 Potential benefits for women

It is not known whether male circumcision reduces the sexual transmission of HIV from men to women, although a reduction in HIV incidence among men will eventually result in lower prevalence in men and therefore a reduced likelihood that women will be exposed to HIV. Studies have indicated that male circumcision reduces the risk of human papillomavirus infection and of cervical cancer in women but this has yet to be confirmed in randomized trials.

Currently there are insufficient data to show whether male circumcision results in a direct reduction of transmission from HIV-positive men to women.

The discussion of male circumcision between partners provides an opportunity to start talking about other sexual and reproductive health issues, ranging from safer sex to family planning.

3 Frequently asked questions in male circumcision discussions

People from a wide range of levels in society have asked all of the following questions. It is vital that users of this toolkit are well versed in the answers so that the situation analysis process does not result in the spread of misinformation.

What are the risks of male circumcision?

As with all types of surgery, male circumcision is not without risk. Male circumcision by unqualified individuals under unsanitary conditions can lead to serious, immediate and long-term complications and even death. Where health professionals have been trained and equipped to perform safe male circumcisions, however, the rate of postoperative complications is less than 5% and the large majority of these are minor and resolve with simple, appropriate postoperative care.

Are traditional methods of male circumcision safe?

Serious complications, including penile amputation and death after male circumcision in traditional settings, have been reported. It is difficult to give overall figures for adverse events, in part because few well-documented studies of complication rates have been conducted.

Is there a need to improve male circumcision practices?

Action is required now to improve male circumcision practices in many regions and to ensure that health-care providers and the public have up-to-date information on the health risks and benefits of male circumcision. Many boys and men wishing to be circumcised do not have access either to safe male circumcision services or, in the event of complications, to post-circumcision care. Whether or not male circumcision is promoted for HIV risk reduction, it is critical that existing practices be made safer. Authorities need to ensure that all practitioners wishing to perform male circumcision are properly trained to perform the procedures and regularly supervised. Monitoring should be done to ensure that procedures are performed safely and that untrained practitioners do not perform unsafe male circumcisions.

Is male circumcision similar to female genital mutilation?

While both male and female circumcision are steeped in culture and tradition, the health consequences of each are substantially different. Female genital mutilation (FGM) is a practice that

should not be allowed to continue. WHO supports communities in their efforts to abandon the practice and to improve care for those who have undergone FGM. WHO has also made clear the need to steadfastly resist the medicalization of FGM.

Male circumcision may seem similar to FGM as far as its definition is concerned – “partial ... removal of the external genitalia” – but in practice is substantially different. Female genital cutting or mutilation comprises all surgical procedures involving partial or total removal of the external genitalia and other injuries to the female genital organs. FGM frequently involves complete or partial removal of the clitoris or clitoral hood (type I) as well additional cutting and stitching of the labia resulting in a constricted vaginal opening (types II and III). These latter procedures pose risks to the mother and infant during childbirth. A WHO-sponsored study found, for instance, increased death rates among infants during and shortly after birth and increased rates of obstetric complications if the mothers had previously undergone types II and III FGM (see: <http://www.who.int/mediacentre/news/releases/2006/pr30/en/index.html>).

There are no known health benefits associated with FGM and no research evidence to suggest that such procedures could reduce the risk of HIV transmission. For these reasons, WHO is strongly opposed to FGM. For further information, see: <http://www.who.int/reproductive-health/fgm/index.html>.

Where can one learn more about safer methods of male circumcision?

There are many approaches to performing male circumcision. WHO, UNAIDS and Jhpiego (an international health organization affiliated with Johns Hopkins University) have developed the *Manual on male circumcision under local anaesthesia* to assist health-care providers in performing male circumcision safely (see: <http://www.who.int/hiv/topics/malecircumcision/en>). This manual also gives information and guidance essential to the overall safe and ethical performance of male circumcision, including pre-surgical and post-surgical counselling and informed consent. The manual, with surgical approaches to male circumcision and accompanying counselling, is available from WHO.

What about the circumcision of male children or infants?

Studies have shown that the circumcision of male children or infants carries fewer medical risks than circumcision at older ages. Parents considering circumcision of a male child or infant should be provided with all the facts so that, taking all relevant circumstances into account, they can determine what is in his best interests. This would include considering diverse factors, e.g. positive and negative health and social benefits of male circumcision at different ages. For example, neonatal circumcision is associated with significantly reduced risks of urinary tract infection in the first year of life. Because the HIV-related benefits of male circumcision only arise in the context of future sexual activity, parents who regard this as the primary reason for circumcision may consider giving the child the option of deciding for himself when he has the capacity to do so.

Do circumcised men still have to use condoms?

Male circumcision reduces the likelihood of contracting HIV through sexual contact but it is by no means a guarantee against infection. Other forms of protection (abstinence from penetrative sex, reduction in the number of sexual partners, and correct and consistent use of male and female condoms) must also be used.

No method can completely protect against HIV infection. The combination of two or more preventive methods is therefore strongly advised.

Will men or women use circumcision as an excuse not to use condoms?

Some men and women do not want or like to use condoms. Couples may think that it is less important to use condoms if the man is circumcised, but this is unwise. Condoms protect both partners against sexually transmitted infections, including HIV, and reduce the risk of pregnancy. A woman whose partner is reluctant to use condoms can be supportive and help him to overcome his reluctance or fears.

Will circumcised men feel completely protected from HIV infection and increase any risky sexual behaviours? Will they become more promiscuous?

There is a real danger that men who have been circumcised in order to reduce their chances of becoming infected with HIV will consider themselves completely protected and forgo other ways of reducing their risk. This could negate any benefits from reduced risk of HIV acquisition. No evidence of riskier sexual behaviour was seen in three randomized controlled trials of male circumcision conducted in African countries. An additional study in a community where a male circumcision programme was offered (Agot et al.) showed no increase in risky behaviours among men who had been circumcised.

Should male circumcision be separate from other programmes and services?

Male circumcision must not be promoted or delivered as a stand-alone surgical procedure; it should be integrated with other prevention strategies. Male circumcision services provide a unique opportunity to give advice and information to men about safer sex, HIV testing and counselling, risk reduction, family planning and other sexual and reproductive health issues. Male circumcision does not have to undermine other prevention efforts; it can even enhance them by giving an opportunity to promote other reproductive health measures.

Possible biological explanations for how male circumcision protects against HIV infection?

The mechanisms by which male circumcision reduces the risk of HIV infection are not precisely known. However, several factors contribute to reduced risk.

- By removing foreskin, male circumcision reduces the ability of HIV to penetrate the skin of the penis because it results in keratinization or toughening of the inner aspect of the remaining foreskin
- The inner part of the foreskin contains many special immunological cells, such as Langerhans cells, that are prime targets for HIV. Some of these are removed with the foreskin, while the remaining cells become less accessible to the HIV virus because of the keratinization mentioned above.
- Ulcers, which are characteristic of some sexually transmitted infections and which can facilitate HIV transmission, often occur on the foreskin. Removal of the foreskin diminishes the likelihood of acquiring these infections.
- The foreskin may suffer abrasions or inflammation during sex that could facilitate the passage of HIV. Removal of the foreskin lessens the risk of abrasions.

Male circumcision makes hygiene easier; why not just promote better hygiene?

Male circumcision makes it easier to maintain good penile hygiene, but it is not known whether this is an important factor in reducing the risk of HIV infection. One cross-sectional study has shown that men with better penile hygiene have lower prevalence of HIV. No study has shown that improved penile hygiene results in a reduced risk of HIV infection.

Most men strive for good hygiene, particularly of their genitals and penis; but many men do not have proper access to water or other ways to clean themselves.

Can circumcised men become infected with HIV, and if so, how?

Male circumcision does not provide complete protection against acquiring HIV infection – it only reduces the risk. It is therefore possible for a circumcised man to become infected with HIV if he does not practise safer sex (abstinence from penetrative sex, reduction in the number of sexual partners, and correct and consistent use of male and female condoms).

Male circumcision does not give any protection from other routes of acquiring HIV infection – sharing unclean needles, injecting with unclean needles, reuse of the same injection needle, blood transfusion with infected blood, or needle-stick injuries.

If a circumcised man resumes sex before the circumcision wound has completely healed he is at higher risk of acquiring HIV infection. Clients must be advised to refrain from sexual intercourse or masturbation for the first six weeks after male circumcision and to use a condom during sexual intercourse thereafter. It is not known exactly when wound healing is complete. In any case, a circumcised man must still practise safer sex to avoid HIV infection (abstinence from penetrative sex, reduction in the number of sexual partners, and correct and consistent use of male and female condoms).

Are there any risks or benefits of male circumcision for women?

There is no proven direct beneficial effect of male circumcision on women's risk of becoming infected with HIV. However:

- If fewer men become infected with HIV because of male circumcision, fewer women will have male partners who are infected with the virus.
- There is conflicting evidence whether circumcised men who are HIV-positive are less likely to transmit HIV to female partners than HIV-positive men who are not circumcised. Performing circumcision in men who already have HIV infection is not recommended as a public health intervention, although there may be medical or personal reasons for an HIV-positive man to decide to become circumcised.

Women may be at greater risk of HIV infection if circumcised men have more sexual partners following circumcision, or if circumcised men do not want or refuse to use condoms. Careful promotion of male circumcision and counselling during the procedure is essential to minimize these risks.

Male circumcision provides an opportunity for discussion between partners on the risks and benefits of the procedure for men. This leads to a further opportunity to start discussions about other sexual and reproductive health issues, ranging from safer sex, supporting women's reproductive health, and choices for family planning.

How, where and when did male circumcision start?

It is not known when male circumcision began. It developed independently in several cultures that had no obvious links, e.g. in Africa and the Pacific Islands. It was practised among ancient Semitic peoples, including Egyptians and Jews.

Male circumcision may have developed as a means to reduce balanitis or infection and irritation of the foreskin and glans penis in dry sandy regions or where hygiene was difficult.

Does male circumcision change sensitivity and sexual pleasure?

It is not known whether male circumcision changes the sensitivity of the penis, and if it does whether this has any adverse effect on male sexual pleasure. Research in this area is very difficult to conduct and interpret. Some studies of circumcised men show that the penis is less sensitive to touch, while other studies show no effect. One study found a slightly longer ejaculation time in circumcised men.

Reports from men who have been circumcised as adults are conflicting; most men report improved or unchanged sex lives. Data recently published from the Rakai randomized controlled trial of male circumcision showed that circumcised men experienced no adverse effect on sexual functioning or satisfaction (Kigozi et al).

Sexual pleasure depends on a large range of factors, including age, alcohol consumption, fatigue, relationship dynamics and health conditions such as diabetes. Probably the most important factors are the feelings sexual partners have for each other and the time when and the place where they are having sexual relations.

What about promoting circumcision for HIV-positive men?

On the basis of current evidence this is not recommended.

- If medically indicated, male circumcision should be provided to all men irrespective of their HIV status.
- If male circumcision is requested by men with HIV infection following in-depth counselling on the known risks and benefits it should not be withheld unless medically contraindicated.
- HIV testing should be recommended for all men seeking male circumcision but should not be mandatory.

Does age at male circumcision make a difference?

In theory, the earlier male circumcision is performed, the longer the time for keratinization of the glans penis and hence greater protection is achieved. However, it is likely that six months after the procedure no more keratinization will occur, although this is not definitely known. Because randomized trials conducted among men aged 18 years or more showed that male circumcision was protective we expect it to be at least as protective if done at a younger age.

In order to maximize the impact of male circumcision it would be preferable to conduct the procedure before the start of any sexual activity.

Infant male circumcision has some additional benefits: the operation is simpler with fewer complications; it is less painful, faster, less expensive and requires no stitches; the wound heals faster and there is a lessened incidence of urinary tract infections. Moreover, the child is accustomed to his status when he reaches puberty.

A disadvantage of circumcision of male infants and babies is that in parts of Africa few traditional male circumcision providers are trained in neonatal circumcision. Furthermore, a child cannot give informed consent to the procedure and it may be preferable to wait until he is old enough to decide for himself whether he wants to be circumcised in order to reduce his risk of HIV infection.

4 Human rights, legal and ethical considerations

Male circumcision raises human rights issues, as is the case with all medical and health procedures. In line with internationally accepted ethical and human rights principles, UNAIDS/WHO is of the view that no surgical (or health) intervention should be performed on anyone if it results in adverse outcomes in terms of health or the integrity of the body, and where there is no expectation of health benefit. Nor should any surgical intervention be performed on anyone without informed consent.

As male circumcision involves surgery and the removal of a part of the body it should only be performed if: (a) participants are fully informed of the possible risks and benefits of the procedure; (b) participants give their fully informed consent; (c) the procedure can be performed under fully hygienic conditions by adequately trained and well-equipped practitioners with appropriate postoperative follow-up.

UNAIDS has developed the following guidance document on some of these issues: *Safe, voluntary, informed – male circumcision and comprehensive HIV prevention programming: guidance for decision-makers on human rights, ethical and legal considerations* (available at: http://data.unaids.org/pub/Manual/2007/070613_humanrightsethicallegalguidance_en.pdf).

Before policy-makers and programme developers promote male circumcision for specific population groups they should justify the reasons after conducting an analysis of the ethical and gender implications. This analysis should be conducted in consultation with members of the population groups concerned, stakeholders and other critical decision-makers. Countries considering the introduction or expansion of male circumcision services for HIV prevention should ensure that appropriate laws, regulations and policies are developed so that male circumcision services are accessible and provided safely and without discrimination.

Implementation efforts should ensure that policy-makers, programme managers, service providers and communities are adequately informed, and legal frameworks should be in place to protect men seeking services. All implementers need to know the provisions of the recommendations and the laws of the countries concerned.

Tools for situation analysis

1 Tool 1: Guided desk review

Tool objective: To draw together a broad picture of the situation in a particular country, using existing materials. The main output of a desk review is a report.

A desk review is a study (and report) of all existing information on a subject – in this case, male circumcision. In this context, 'desk' only means that it does not involve new field research – it does not mean that it can be completed from a desk. The guided desk review aims to look at rates of male circumcision, trends in male circumcision, influencing factors, policy environments and the provision and nature of male circumcision services. The person performing the review combines the roles of investigator, researcher and anthropologist.

A set of questions has been provided for guidance in the desk review. All statements and information must be fully referenced. Answering the guiding questions will require finding and studying written information and talking to specialists in various fields. The Internet is a source of written information but not the only one. Much published or unpublished information is only available in-country, and is often identified by local experts. Where possible, guidance about where to look for information has been included with each question. Everyone should be asked for help, from the person who sells the morning paper to family and friends.

When approaching potential sources of information, be prepared to explain the nature of the work and to respond to questions about the situation analysis or male circumcision. All statements and information must be fully referenced.

Although the guiding questions are numbered, it is unlikely that they will be completed in the numbered sequence. While discovering the answers to one question it may be possible to discover further information to help with other questions. The more information that is attached to the desk review document the better, and the more useful and easy to use it will be in the future.

It is very important to record all contact details of individuals, organizations and sources of information so that, for example, they can be contacted for follow-up questions, further clarification or additional information, or involved further in the stakeholders' meeting and key informant interviews.

1.1 Method

If materials exist, be sure to get samples of them and full references for all documents.

Documents can include memoranda, emails, reports, plans, budgets, project reports, minutes of meetings, etc. – anything in hard (printed) or electronic copy. If there is a system of writing down verbal discussions (and it is done systematically, e.g. documented contact reports, interview notes or summaries), these can be included.

Preparation

Draw up a list of types of documents needed and people you want to speak to. Remember that the person being dealt with may not have a responsibility for documents or be in agreement with their content. It may be necessary to encourage people to invest time in looking for information. In order to enable people to supply the documents needed, share with them the questions in advance of any meeting. People can be more helpful if they understand what is being looked for and why.

Review

Make a note of all documents requested, promised and actually provided, as well as of the arrangements with people and whether they were actually seen. It is very important to follow up documents and interviews because there could be challenges to the results later on. It is important to be able to show what information was obtained and that there was an attempt to contact a range of people as part of the situation analysis. When writing the final report, try to use excerpts from the documents obtained as much as possible. A desk review requires quotable evidence. Every item must be fully referenced (title of document, date, author and pages).

1.2 Questions

1. What are the key determinants of male circumcision in the country?

A *determinant* is a decisive influence, which could include religion, ethnic group, cost of procedure, age, etc. One of the tasks in the guided desk review is to identify and quantify the determinants for male circumcision, i.e. why males are, or are not, circumcised. Determinants of male circumcision are unlikely to be the same in different countries, or even in different groups within a country. Nor will they influence the same percentage of a population. Do not rely on existing knowledge. If it is thought that Islamic men are usually circumcised, ask several imams whether this is true in their country and how it is related to their faith. It is important to check every statement.

Figures and estimates from different sources may not agree. It is important to have a note of **all** the estimates in written material if they *differ* significantly. The review process cannot decide whose figures are the most accurate, so all should be noted. Table 3 is an example of the kind of information that is expected. It is a summary table, to be completed and presented at the conclusion of the desk review.

Table 3.

Determinant description (age, religion, location, culture, etc.)	% of population influenced ¹	Reference

¹ Percentage of population in which the determinant may encourage male circumcision (the total is very likely to add up to more than 100%).

2. Has there been any media coverage in the last two to three years that links male circumcision to: hygiene; HIV; AIDS; ideological issues (e.g. religion and circumcision, masculinity and circumcision, or even colonialism and circumcision); other issues?

In each case, describe what media source carried the story, when the message was carried and any resulting change it may have contributed to.

The media are very influential, regardless of whether what they say is true or false. Media coverage can be the source of rumour or common 'understandings' and is one of the most important forces for change or resistance to change.

The major newspapers in the country concerned probably keep some form of library of back issues (for radio and television, this is more difficult). Start the investigation by speaking to lead-

ing journalists (e.g. editors, health correspondents) and any organizations involved in health issues that might have useful information, e.g. the ministry of health, the local offices of international institutions, UN agencies, international and local nongovernmental organizations (NGOs) and civil society organizations (CSOs).

3. Have there been any studies of male circumcision rates in the country in the last five years?

The ministry of health, central statistics office, scientific review or ethics boards and/or major universities are often involved in some way in this type of public health or medical research (as are NGOs and international organizations). Some countries have male circumcision information obtained through demographic health surveys (DHSs), most of which are available at <http://www.measuredhs.com>. There may also be other regular surveys or ongoing studies that are relevant, such as sexual behaviour surveys or recent or ongoing longitudinal studies. The above organizations are good starting points for answering this question. You can use Table 4 to compile results. If the details of each study are too long to record sensibly in tabular form, summarize the information in this table and keep a full copy of the work for future reference.

Table 4.

Title of study	Date (dd/mm/yyyy)	Description ¹	Conclusions

¹ Authors, date, location of study, population worked with.

4. What is the estimated number of male circumcisions conducted per year in government health facilities, and are there regional variations?

- Is the service provided on demand from the patient or only by recommendation for medical purposes?
- Is the service free? If not, what is the cost?
- What levels of staff and facility are authorized to carry out male circumcisions and under what circumstances (referral or demand, patient age, etc.)?
- What, or who, determines whether a client receives male circumcision services (e.g. medical indication as determined by a doctor)?
- What determines the 'need' for male circumcision?
- Is there information on how safe the procedure is or on rates of adverse events?
- Are specific age groups circumcised?
- What regional variations are there and what are the reasons for them?
- Are there seasonal variations, and if so, why?
- Is there a male circumcision package? If so, what does it consist of (e.g. routine offer of HIV testing)? What is included before and after male circumcision has been performed?

5. What is the estimated number of male circumcisions carried out per year in nongovernmental health-care facilities (such as private or faith-based facilities), and are there regional variations?

- Is the service provided on demand from the patient or only by recommendation?
- Is the service free? If not, what is the cost?
- For each type of health facility (e.g. associated with different faiths and different private companies), what level of staff and type of facility are authorized to carry out male circumcisions and under what circumstances (referral or demand, patient age, etc.)?
- What determines the 'need' for male circumcision?
- Is there information on how safe the procedure is or on rates of adverse events?
- Are specific age groups circumcised?
- Are there seasonal variations, and if so, why?

6. What is the estimated number of male circumcisions carried out per year in circumstances other than a health facility (including traditional male circumcision), and are there regional variations?

- What types of facilities are there, and what is the training of the persons providing circumcision?
- Exactly what practices are used to conduct the procedure?
- Is there a particular time of year when the procedure is typically carried out?
- Is there some form of cost for the individual or family?
- What determines the 'need' for male circumcision?
- Is there information on how safe the procedure is or on rates of adverse events?
- Under what cultural conditions, e.g. "rite of manhood", are the procedures carried out and what cultural conditions accompany circumcisions?

7. Are there any specific programmes for male circumcision at any particular locations? That is, are programmes specifically set up for male circumcision, whether in public, private or traditional settings? If so, list them and describe their features (e.g. civil society organizations, army).

8. What other sources of information exist for male circumcision?

The army and large employers that require medical tests or who provide medical services for their staff may have information. These important sources are often ignored and should be investigated. Are there any programmes for male circumcision, the financing of male circumcision, information on numbers or proportions of men circumcised, etc.?

Table 5.

Source	Estimated numbers of male circumcisions mentioned in information	Descriptive information

9. What are the conditions under which male circumcision is carried out?

Use Table 6 as a template for capturing the individual answers to this question. Before including the results in the final report, summarize them by indicating what the majority believe to be the case and by noting particularly if individual interviewees contradicted each other.

Table 6.

Where the male circumcision is carried out (e.g. health facility, traditional event)	Percentage of all men circumcised who are circumcised in this way	Who carries out the operation (e.g. doctor, clinical officer, traditional male circumciser, traditional healer)	Other activities that are part of the process (e.g. counselling, testing, treatment)	Cost (including donated goods, such as food, labour, etc.)

10. Given all of the above information and the estimates of people spoken to, what is the estimated trend in the rate of male circumcision?

This is a summary conclusion for the work completed above.

Table 7.

Trend for clinical male circumcision	Reasons
Increasing / Decreasing / Remaining the same (Delete as appropriate)	
Source	
Trend for traditional male circumcision	Reasons
Increasing / Decreasing / Remaining the same (Delete as appropriate)	
Source	

- What factors contribute to these trends?
- Are there any variations in these trends (e.g. by faith, location or ethnic group)? If so, describe them.
- Is there any evidence that urbanization has changed male circumcision patterns?

14. **Map male circumcision prevalence in the country. That is, plot on a map the approximate rate of male circumcision broken down by district or province. If there is a district with a low rate that contains a city with a high rate you must make a note of this.**
15. **Are there normative, cultural or religious issues around male circumcision, and how firmly are they established?**

For example, are circumcised or uncircumcised men looked down upon by other groups, are there prevalent stereotypes, or are there terms that are associated with circumcision status that are derogatory?

16. **Are there any groups that might oppose male circumcision? Give details.**
17. **Are there any programmes, teaching in schools, or materials produced around or in conjunction with male sexual and reproductive health services, such as discussions or counselling around sexual relations, staying healthy, means of contraception, or even substance abuse (alcohol, drugs)? How available are these types of male reproductive health services – with or without circumcision services?**
18. **It is recommended that the supply of male circumcision services be in the context of a core package – routine offering of HIV testing; counselling about HIV, the need to adopt or maintain safer sex practices following circumcision, and provision of condoms; post-circumcision care and the need to abstain from sex for six weeks; examination for STIs and treatment if needed; and the operation itself. Repeat appropriate questions (selected from questions 1 to 17) in relation to these activities e.g. what are the key determinants of HIV testing acceptance in men, in order that a full picture of what needs to be done can be developed.**
19. **How does male circumcision translate in local languages and what are the issues that are attached to the translation, e.g. is it a negative term or a term of insult?**
20. **Is there a standard or common male circumcision package? If so, what does it consist of (e.g. routine offer of HIV testing)? What is included before and after male circumcision and how does the package differ in different conditions?**

1.3 Analysis of results

The desk review report should be based around the questions that have been asked. Any absence of information (when searched for) is almost as important as its availability and should be noted in the report.

References should be typed up for everything that is included in the report and they and the bibliography should be included in the distributed report.

2 Tool 2: Key informant interviews

Tool objective: To gather the opinions of leading influential persons, whether well-informed or otherwise, on the issue of male circumcision. This tool looks at levels of knowledge and attitudes rather than seeking correct or sympathetic answers.

Key informants are persons who are likely to have knowledge or experience relevant or important to a programme. They have either some special knowledge of the issue or some experience in this field, or represent important stakeholders (those who are able to affect the programme and those who will be affected by it).

An interview with such a person may yield much more than simply statistical data (such as might be gathered through a survey) and can include further sources of information and contacts, new ideas, past experience, deep understanding of existing constraints or opportunities, etc. A key informant interview uses open-ended questions to allow the interviewee to offer broader responses (Annex 5: Approaching questioning).

Write and ask for an appointment of 90 minutes, and follow up with a telephone call the day before the interview to check that the meeting is in the interviewee's diary. Interviews can be shortened (see below) but this is not advisable as it reduces the comparability of the results. If the person being interviewed insists on a shorter interview, reduce the number of questions (e.g. to ten) rather than try to rush through all those indicated here.

Deciding whom to interview can be difficult at first but as the situation analysis progresses this should become easier. There is no upper limit to the number of people who can be interviewed. There is also no particular statistical validity behind key informant interviews, although some broad statements should be possible. The biggest benefits of key informant interviews are in the information gathered and the opportunity to both introduce and be introduced to ideas.

Key informants should include:

- senior health service personnel of both government and nongovernmental service providers;
- traditional male circumcisers, if this group is important in male circumcision practices;
- staff with related responsibilities in the ministry of health;
- religious, ethnic and political leaders;
- senior media personnel;
- programme officers for existing male circumcision programmes;
- directors or senior staff of organizations such as health-related NGOs and HIV and AIDS organizations (including the national AIDS control council);
- youth groups;
- persons living with HIV/AIDS (PLWAs);
- women's groups;
- men's groups if not included above.

Throughout each interview, ask for impressions, estimates and ideas. This means that what people say may not necessarily be true but will be their perceived truth. Similarly, there is no guarantee of the accuracy of information given. This is a very important part of the interview, i.e. finding out what people think and feel. As these are key informants they have the power to shape the programme and their thoughts and perceptions are very important to the current situation and any plans for changing it.

It is not the interviewer's role to judge or correct statements, however wrong or right they are. Showing any judgement of those who, for example, think that male circumcision is a bad idea, will close down the discussion and reduce what can be understood about those in opposition to the idea. This in turn will reduce the chances of changing their minds later. Understanding the full range of erroneous beliefs or estimates is often the most important result of this process.

A key informant interview provides a good opportunity to test questions for use in other tools and to develop ideas about additional questions that need to be asked.

In preparation for each interview, practise explaining the links between male circumcision, health and HIV. At the beginning of the interview, explain that answers are confidential, that there are no right or wrong answers, and that the interviewee should therefore not worry when asked for opinions or estimates.

Below there are 12 questions. Keep the time frame in mind so that the interview is completed. Interviews can often be shorter, so choose in advance which questions are the most important.

For some questions, suggested follow-up questions are included. These should be asked if interviewees do not give the desired information in their initial answers.

For other questions, suggested prompts are only for use if interviewees find a question too difficult or say that they do not know the answer. The questions are all open-ended, so if the prompts do not work you can use your own questions to attempt to get a clearer idea of what the speaker means. Be very careful during this process not to imply bias about the topic or disagreement with the interviewee's opinions.

2.1 Questions

- Name of interviewee
- Organization
- Position held

1. Did you know of the association between male circumcision and a reduced risk of HIV infection before we contacted you?

Yes / No

If the answer is 'No', give a brief overview of the issue.

Follow-up: What do you think about it now that you have heard about it?

2. What do you think non-circumcised men might think about male circumcision?

3. What do you think women think about male circumcision?

4. What percentage of males in each of the following groups in your country do you estimate have been circumcised at any given time?

NOTE: If particular tribes are known to carry out male circumcision and others do not, the question should be asked for each tribe. When completed for each tribe the totals should be near to 100% of the male population.

- Baby up to 1 year old
- Child from 1 through 9 years old
- Adolescent from 10 through 17 years old
- Adult men, 18 years or older

5. What do you believe are the main factors affecting rates of male circumcision in this country?

Follow-up: Can you say which factor you think is the most important and which is the least important?

Follow-up: Is there any stigma attached to a man being circumcised or uncircumcised?

6. If we wanted to increase the provision of health-facility-based male circumcision, what do you think are the most important factors we would need to change?

Prompt: Funds/resources could be one, but how would they have to be spent?

Prompt: Do you think staff in health posts, clinics and hospitals know how to do the operation?

Prompt: What role could your organization play in increasing services?

7. If we wanted to increase the demand for male circumcision (the number of people wanting it), what sort of things should we do?

Prompt: How could we encourage men to be circumcised? How could we encourage parents to get their male children circumcised?

Prompt: Who do you think would have the most influence on people if we were to ask someone to publicly support a programme?

Prompt: What messages do you think would have the most influence on people to encourage male circumcision among adolescents or adults? What about the parents of neonates or children?

Prompt: At what age do you think parents would like to have their male children circumcised: at birth or older?

Prompt: Circumcising male neonates and babies is technically easier than circumcising older boys or men and there are fewer complications. Would this influence the decision of parents to have their male infants circumcised?

8. What ideas do you think people have about the results of male circumcision?

Follow-up: From what you have said, what do you think the main factor would be for how someone would want to be circumcised?

Follow-up: Do you think men would have riskier sex after circumcision, such as having more partners or not using a condom, in the belief that they were now protected from acquiring HIV and STIs (because of the circumcision)?

9. Who else do you think we should interview?

Follow-up: How can I contact them?

10. Are you aware of any other work being done on male circumcision or any studies that have been carried out in this country?

11. Programmes for male circumcision will probably include the offer of an HIV test, with referral to counselling and medical services if the person is HIV-positive. Taking an HIV test will not, however, be mandatory, and men who are HIV-positive may receive a circumcision. Do you think this policy of offering HIV testing will affect a programme to increase male circumcision?

Follow-up: If a country wanted to prioritize male circumcision services for men who are HIV-negative (since these men will benefit from HIV prevention), how do you think the country could go about it?

Follow-up: How might men seeking circumcision react to such a policy?

12. What do you think of the idea of giving counselling on sexual and reproductive health services to men who are being circumcised? By this, I mean advice on such things as contraceptive methods or improving sexual or domestic relationships between couples.

2.2 Analysis of results

1. Prepare the data. Have the answers to each question typed for each interview. Try to include as much detail as possible and resist the temptation to shorten the text. The typing of interviews should be done as soon after each interview as possible, preferably within 24 hours.
2. Analyse the data.
 - Look at all the answers for each question in turn and build a frequency table (mark down each unique answer in a list and, when an answer is repeated, put a tick by the answer that is already listed). An interviewee may have given several answers or made more than one point in response to a particular question. Write up the frequency table, giving a summary of the main results for each of the interview questions.
 - Look closely at which interviewees have consistently either agreed or disagreed with the majority. This might illuminate a particular grouping among the key informants, e.g. those in favour of male circumcision as opposed to those against, or those with 'correct' knowledge as opposed to those who did not know about male circumcision. Write up any groupings (without mentioning individual names for confidentiality reasons) by using generalizations about certain groups of respondents. If a particular person shows a specific trend, do not name this person in the report but refer to the trend.

3 Tool 3: Stakeholders' meeting

Tool objective: To draw the ideas and concerns of key stakeholders into the situation analysis process and to elicit information from them that will be fed into it.

Stakeholders are any individuals, communities, groups or organizations with an interest in the outcome of a programme, either through being affected by it positively or negatively or through being able to influence the activity in a positive or negative way.² The stakeholders' meeting should provide answers to the following three questions.

1. What do stakeholders expect and want to contribute to a possible programme on male circumcision in this country?
2. What are the specific strengths, weaknesses, opportunities and threats that such a programme faces in this country?
3. What factors will affect such a programme and how have those factors changed over time?

Stakeholders can be a very large group, including all those who are affected by a programme and all whose interests might be affected by it. For this situation analysis they will range from national to local institutions as well as including social groups and service providers.

For the present situation analysis the focus is on national institutional stakeholders. It is important not to leave anyone out. For instance, stakeholders who cannot attend the meeting should be included in the key informant interviews. It is important that they are not lost from the programme.

The stakeholders' meeting has a number of benefits. It will inform all stakeholders of the current situation, facilitate their understanding and thus their participation in any efforts to increase rates of male circumcision, contribute to data collection and increase ownership of the programme as a whole. The meeting will help to identify the interests of different institutions, making the most of the positives while also identifying and managing any risks. Moreover, the meeting should inform all stakeholders of any policies and programmes of the other attendees.

3.1 Booking a location for workshops and meetings

When booking a location (whether a community hall or a hotel conference room) the following matters should be considered.

- Seating arrangements: Is it possible to move the chairs and tables so that people can sit in smaller groups as well as in one group arranged in a circle? During an event, everyone will need some sort of desk space. The worst-case scenario is that of chairs in fixed positions with no tables.
- Room temperature: This is important: if it is too hot, people are likely to become drowsy; if it is too cold they are likely to become cross and bored.
- External noise: If the windows must be closed to keep noise out, what will happen to the room temperature and will there be fresh air?
- Adequate food and drinks: The whole group should take a break at least every two hours. Food and liquid are important in helping people to concentrate and keep alert. Water should be available at people's desks at least twice a day.

² DFID. *Tools for development: A handbook for those engaged in development activity*. London: Performance and Effectiveness Department; 2003. Available at: <http://www.dfid.gov.uk/pubs/files/toolsfordevelopment.pdf>

- Toilet facilities: These should be clearly marked.
- Effective lighting: If it is too dark, people may fall asleep; if it is too bright they may suffer headaches.
- Resources: These should include flipcharts (with plenty of paper that is thick enough to prevent ink bleeding through to the sheet beneath), whiteboards (with special marker pens), videos, notebooks, marker pens, name tags, and pens and paper (for participants) as needed.
- Special needs: Language interpreters, child care and facilities for the disabled should be available as necessary.
- Electricity: Make sure that suitable (international) electric plug adapters are available for any equipment needs, and that there are enough sockets for the number of machines needed to run simultaneously.
- Wall space: Adequate wall space is needed for posting results and enabling group discussion. Sometimes windows can be used instead but this is not entirely satisfactory as lighting and reading can be difficult and the temperature and air quality may be adversely affected.
- Break-out rooms: When doing group work it can be useful for the groups to be separated into different rooms to reduce distractions or interaction. If separate rooms are not available the meeting room must be large enough for the participants to split into groups.

3.2 Getting people to attend

- Some of the organizations and persons that should be invited to attend are indicated below.
 - The ministry of health
 - The office of the prime minister
 - UNAIDS country office
 - UNICEF country office
 - WHO country office
 - Leading nationwide health providers – faith-based providers and other not-for-profit providers, e.g. Save the Children
 - Major donors that support health activities
 - The national AIDS control committee
 - Health services that would deliver male circumcision (private, public, faith-based)
 - Traditional male circumcision providers
 - Religious or ethnic leaders
 - Youth groups (male and female)
 - Women's groups
 - Community representatives
 - Health-care provider associations and unions (such as those for medical doctors and nurses)
- Choose a time, date and place appropriate for the people who are going to be invited. This may need some consideration as people may be invited from various groups, e.g. women, men, leaders, office-based workers and health staff. Health personnel find Monday very busy; Friday afternoon and Monday morning are bad times for office-based staff; and community leaders may have other weekly duties and religious services to attend.

- Decide on a minimum and maximum number of attendees to be invited, and send out invitations. Ensure that people agree to attend and then follow up with reminders and any pre-meeting reading materials nearer to the time of the meeting. In the invitation (whether it is verbal or written), describe what the discussion is going to be about, why the person concerned is being invited, and why this person is important to the discussion.

3.3 Agenda

- Welcome (15 minutes)
 - Opening and welcome (5 minutes – Host)
 - Introduction (10 minutes – working Chair)
 - Explanation of why the meeting is being held and why everyone has been invited
 - Review agenda
 - Rules of the meeting
 - Non-judgemental
 - No quoting each other outside the meeting
 - Try to create an environment where everyone can speak
 - Review of main briefing documents: Why male circumcision is an intervention that contributes to reducing the risk of HIV infection and how this can be part of existing prevention activities (15 minutes – invited speaker)
- Exercise 1: Informal stakeholder analysis (40 minutes)
- Coffee (15 minutes)
- Exercise 2: SWOT analysis (1 hour)
- Exercise 3: Spider diagram trend analysis (1 hour)
- Coffee (15 minutes)
- Questions and statements from the floor (30 minutes)
- Closure
 - Explanation of what will happen next in the situation analysis process
 - Reminder that a meeting report will be circulated to all those attending (this must be followed up to ensure that it happens)

3.4 Exercises

3.4.1 Exercise 1: Informal stakeholder analysis

Tool objective: To enable the planning of partnerships and stakeholder relationships.

1. Explain to the group that they are being consulted as stakeholders, initially in the situation analysis process, and that they will be consulted subsequently if it is decided to develop the programme further.
2. Explain that there are different types of stakeholders.
 - Primary stakeholders: those affected by the programme (in this case, men and women).
 - Secondary stakeholders: those affecting the programme (in this case, health-service managers and providers).

- Key stakeholders: those who can directly influence, or are important to, the programme (in this case, the people in the room, e.g. the government, the ministry of health, the national AIDS control committee, leading health-service providers, leading NGOs, local UN agency offices, etc.).
 - External stakeholders: those interested in the outcome of the programme but who are not directly involved. (It is not possible to name them at this point – perhaps a number of organizations have indicated an interest in the programme but do not want to be involved).
3. Distribute copies of the stakeholder analysis form (see Table 9) and explain that the purpose of part of the situation analysis is to discover the needs and expectations of the stakeholders.

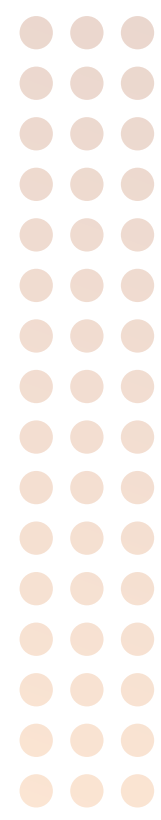
The group is therefore being asked to fill in this form under the assumption that a programme is being planned to increase rates of male circumcision among those populations with existing rates lower than 100%.

Explain that this information will be circulated to all attendees and will therefore not be kept confidential. The resulting information will be used to inform relations with stakeholders in the future and to help the programme design team to plan for outputs. Emphasize that the male circumcision programme is not yet under way and that this is part of a situation analysis. Promise to circulate the results as part of the meeting report (and ensure that this happens).

Ask the following question. “In the event of work to increase male circumcision, what would be the most likely answers to the following questions?”

Table 9. Informal stakeholder analysis form

Informal stakeholder analysis	
Name of stakeholder organization:	
1. What would your organization require from the work in order to support it? Please mention everything from what information at what time to policies and practices.	
2. What do you think your organization’s main concerns would be about the work?	
3. What would your organization expect from the results of the work? Please state in terms of the impact of the work.	
4. What would be the likely impact of the work on your organization?	
5. What is the main influence that your organization would have on the work?	



Informal stakeholder analysis	
Name of stakeholder organization:	
6. What priority (scale of 1 to 10 from low to high) would your organization give to the work and why?	
7. How could your organization be involved in the work?	
8. What information or help could your organization offer at no cost?	
9. How could the team carrying out the work obtain this information or help?	
10. What information or help could your organization offer at a cost?	

Ask people to work together with other participants from their organization or on their own if there is no one else at the meeting who works with them.

Initially, allow 40 minutes for completion.

3.4.2 Exercise 2: SWOT analysis

Tool objective: To identify the issues that the programme might face and the strengths that can be used to overcome any challenges.

A SWOT (strengths, weaknesses, opportunities and threats) analysis enables people to analyse their current situation and possible future circumstances. This can be an organizational analysis relating to internal and external factors or a more general review of an issue around which work is anticipated.

The exercise is carried out here at its simplest level but may produce some of the most helpful information of the situation analysis. The question considered by this SWOT analysis is as follows.

“In the current environment, what are the main strengths, weaknesses, opportunities and threats that a programme to increase male circumcision rates would face?”

Split the group into four subgroups and give each of these flipchart paper, marker pens, cards (15 cm x 10 cm minimum, at least four per person), sticky tack and one of the factors to work with, i.e. (i) strengths, (ii) weaknesses, (iii) opportunities, or (iv) threats.

Explain that strengths and weaknesses tend to be internal to the programme and that opportunities and threats tend to be external to it (and possibly in the future), but that this is not always the case. Therefore, each group should not only write down one idea per card but should also split the cards into two groups, viz. ‘Internal’ for those forces that originate within the programme or organizations, and ‘External’ for those forces that tend to originate from external environments, i.e. things not under our immediate control.

For example, the demand for male circumcisions is an external force but the ability to respond to the level of requests is an internal strength (or weakness), as is the ability to increase demand. The ability to recruit staff for helping to respond to requests (that is, to increase supply) is an internal strength (or weakness) and the availability of staff in the employment sector is an external threat (or opportunity). It is sometimes not clear whether a particular force should be classed as internal or external, or which SWOT category it belongs in – this is understood and expected. The important thing is to capture all ideas.

It is also acceptable for an issue to appear in several places. For example, funding is always an issue and can appear in several categories (see Table 10). Thus it is important that the details of the funding issue be clearly described in each area of the SWOT so as to capture the full information.

Table 10. An example of SWOT issue classification

Situation	SWOT	Internal/external
The programme has funds that it can allocate to male circumcision services.	Strength	Internal
The programme funds for male circumcision services are insufficient.	Weakness	Internal
Programme funds are only available for the current financial year (more will be needed in the future, particularly to sustain the services).	Threat	Internal
A large funder has indicated interest in donating money to the programme.	Opportunity	External

Ask each group to appoint a facilitator who will then lead them in a brainstorming session. The question that should be posed is as follows.

“In the current environment, what are the [insert one of the following for each subgroup: strengths/weaknesses/opportunities/threats] that a programme to increase male circumcision would face?”

Each member of the subgroup should write down one idea per card. Each subgroup should write its subgroup title at the top of a sheet of flipchart paper and stick the cards on the paper.

The subgroups should then rank their ideas (having removed any duplicates), putting them in order with the most important first.

Allow 30 minutes for completion of the task.

Bring the subgroups back into a 30-minute plenary and ask each to present its results.

After this has been done, try to create a merged and ranked SWOT result.

Finally, ask the plenary the following questions.

- Are there any missing points? If so, write them down on cards and add them to the appropriate sheets of flipchart paper.
- Are there any ideas on the flipchart that should be somewhere else or removed completely?

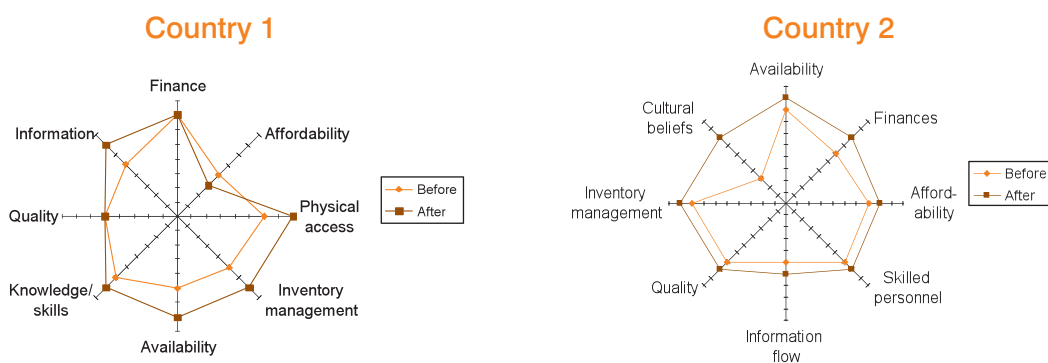
Keep all the cards and flipcharts from the SWOT analysis exercise because they may have to be referred to later.

3.4.3 Exercise 3: Spider diagram

Tool objective: The spider diagram is a trend analysis tool. It aims to identify what factors affect male circumcision and how those factors have changed over time.

The spider diagram is so called because it looks like a spider or a spider's web. It can be used for a number of different approaches. That used here has several axes or legs and produces a picture of 'then' and 'now' which can help to show what might be needed to create change in the future.

Fig. 4. Examples of spider diagrams from a programme evaluation for two countries



Introduce the concept of the spider diagram as a tool for helping to draw together a trend analysis. "Today, we are going to look at forces that affect male circumcision rates, how those forces have changed over the last five years and why they have changed. The task will take about an hour."

Ask the group to brainstorm the different factors that affect male circumcision in the country. Call a halt when the group has identified eight unique factors. Check that the group is happy with these factors and ask for suggestions to replace any of them with more important or relevant factors.

Ensure that only neutral terms (no positives or negatives) are used in the naming of factors and that an 'ideal' situation can be represented by a score of 10. For example, use 'affordability of operation' (so that '10' is the most affordable), rather than 'high cost of operation' or 'cost of operation', where the ideal score might be '0'; and use 'availability of service' rather than 'lack of service'.

Draw a spider or web, label each leg of the spider (or spoke of the web) with one of the factors, and mark the legs off with a scale of 0 (the lowest level at the centre) to 10 (the highest, 'ideal' level at the outside). The basic diagram can be drawn in advance of the meeting.

To develop the first circle (be careful not to describe it as an inner circle – **it is not**), ask the group to give a score out of 10 for each factor according to the situation **five years ago**. Mark that score on the leg with a point. Remember, a score of 10 means that the factor is 'functioning perfectly', e.g. for a factor called 'Transport' this would require a good network of well-maintained roads, available well-maintained vehicles and affordable fuel. Ask the group to suggest scores and take the average. Mark scores on the diagram for each leg, then join them up to complete the first circle.

The second circle (which may overlap or cross the first circle) requires the same process but scores are given for each factor for the situation **today**. Mark scores for each leg, then join them up with a line of a different colour or type (e.g. dotted instead of solid). It should now be possible to see how trends have developed over time – particular issues may have decreased or increased, a particular area may have dramatically improved and/or another may have deteriorated considerably.

Ask the group whether the differences between the first and second circle were the result of a specific plan or programme and ask what has caused the change (or lack of change) on each leg.

Draw on the ideal scenario (i.e. if everything were 'ideal', such as perfect provision of service and the most affordable cost of operation) by joining all the '10s' together on the diagram with a line of a different colour or type.

Ask the group to describe what the future would be like if all the factors were at 'ideal' levels. How does the group think that situation might be reached, given the current situation and past trends?

Take notes of the answers to all the questions. List them on a separate flipchart in order to confirm with the group that the answers are understood correctly.

To complete the exercise it is important to make and keep full notes of:

- all the different suggested factors during the brainstorming session (including any that are eliminated);
- the actual spider diagram with the factor scores for five years previously and currently;
- all the answers and comments made during discussions about past changes and how to work towards an ideal situation in the future.

Always copy down the final diagram and the brainstorming notes at the end of the day. This task should not be left until the next day, as by then the notes are unlikely to make sense. For the report, the diagram has to be redrawn or scanned in, so think about this before taking it down from the wall or flipchart stand.

3.5 Analysis of results

It is important to keep all brainstorming cards, flipchart sheets and minutes of the day from the stakeholders' meeting. Complete the analysis as soon after the meeting as possible, ideally the same day but not later than the next day because it is very easy to forget what people have said. For this part of the situation analysis it is not necessary to keep a note of who said what. Statements should not be linked to individuals or organizations.

Do **not** assume that members of the stakeholder group know everything about the subject. Do not restrict the questions in any other tools in the situation analysis on the basis of conclusions from this meeting. Different respondents will have different opinions and experience and all the participants must be given the chance to contribute their own information through the different tools. Remember, the people closest to the issue are most likely to have the greatest knowledge. However, some questions may be modified or added to the other tools in the light of information derived from this meeting.

3.5.1 Informal stakeholder analysis

For the informal stakeholder analysis, the completed 'Informal stakeholder analysis' forms from the meeting are required.

Type up each form so that there is a clear record of all the comments.

As there will be a limited number of forms it is possible to do an analysis of common statements "by hand and eye". In the report you will have to show who is saying what – this information does not need to be kept private. Table 11 shows in part what the results might look like.

Table 11. Analysis template

Question 1: Requirements	
▪ Financial support	Full support – Organizations X, Y and Z Partial support – Organizations A and B
▪ Renovation of facilities	Organizations X, A and C
Question 2: Concerns	
▪ Detract from current activities	Organizations X, A and C

Thus, the report will include all the responses to the original questions (Table 9). This will contribute to the future planning of the possible programme as well as giving early warning of some of the outputs and policies that might need to be put in place.

3.5.2 SWOT analysis

The group's results form the main part of the report of this exercise. If the following tasks were not completed with the group they will need to be performed at this point.

1. Look for linkages between strengths and weaknesses, opportunities and threats, and answer the following four questions for internal results.
 - Are there any stated strengths that enable weaknesses to be overcome, and if so, how?
 - Are there any stated opportunities that, if taken up, could reduce threats, and if so, how?
 - What *existing* strengths and opportunities need to be developed / taken up to cancel out or overcome the weaknesses and threats, and how could this be made to happen?
 - What *missing* strengths and opportunities need to be developed / taken up to cancel out or overcome the weaknesses and threats, and how could this be made to happen?

This should result in a set of conclusions in the form of a to-do list.

2. Consider external factors.
 - What are the positive external factors (strengths and opportunities) that the programme needs to build on and protect, and how should it do this?
 - What are the negative external factors (weaknesses and threats) that the programme will need to overcome or be prepared for, and how should it do this?
3. A detailed answer to the question posed at the beginning of the SWOT analysis in the meeting can now be written up.

3.5.3 Spider diagram

Compile a list of all the factors from the brainstorming session for the labelling of the legs of the spider diagram. Write up notes from the discussion about what has happened over the last three to five years that caused changes in the 'levels' given to each factor. Things may have become better or worse or may have stayed the same. Describe why there have been changes.

1. Write up notes about what needs to happen in order for the situation to become 'ideal' (a score of 10 for all factors).

Taking the results from the process above with the spider diagram itself, describe trends in the factors affecting male circumcision.

For each factor, write up how things were in the past, how they are now, which direction the trend is going (towards or away from the 'ideal'), and what is causing changes. Finally, add conclusions about which factors need to be targeted in order to achieve an 'ideal' situation regarding factors affecting male circumcision.

4 Tool 4: Focus groups

Tool objective: To examine closely the attitudes of people towards male circumcision and gain an insight into ideas they may have on increasing the acceptability of male circumcision.

A focus group in a developing country environment is an event where:

- a small group of people (often known to each other) is involved in a closed discussion;
- the group usually reflects the demographic profile of the population about which information is sought;
- facilitation aims for an agenda-led discussion with icebreakers, changes in tempo, and discussion stimulation – not question-and-answer consensus-forming;
- notes are taken to identify broad answer areas and illustrative quotes;
- facilitation methodologies draw on focus group methods although their organization and structure do not.

It is very important that people do not leave the focus group discussions with any ideas that men who are circumcised are safe from HIV, or that unprotected sex with them is safe. Each focus group will take about two hours to complete. Be aware that it is hard work and that many facilitators are exhausted after two groups. It is recommended that a note-taker be present and that notes be written up immediately after each group.

A combination of the range of views required and the time and resources available will determine the number of focus groups conducted. Any number from a few up to 50 or more will provide significant useful information.

Focus groups should not be conducted solely among potential recipients of male circumcision or their sex partners and should include groups who can positively or negatively influence rates of male circumcision under varying circumstances (e.g. traditional vs. formal health care).

The tool is divided into questions for the following groups.

- Men who have been circumcised:
 - at a health facility;
 - by traditional methods.
- Men who have not been circumcised.
- Women.
- Community leaders (including religious representatives, teachers, etc.). By using the opening and closing questions from the tool you have a script for this group.
- Health-care providers (to determine their views on how to structure or improve health-care services for male circumcision).

Each group should be as homogeneous as possible, e.g. women of a certain age range. It is important to avoid having young and old people or men and women in the same groups, because it is almost impossible to make focus group discussions work with mixed groups. (If you are a practised focus group facilitator you may feel that it is advantageous to occasionally have a mixed focus group in order to explore disagreements about issues, but this may be difficult concerning male circumcision.)

Note the following additional points.

- Spontaneity in the discussion can be increased with the right icebreaker exercises, changes in momentum and good facilitation.
- Traditional or exotic intimidation factors are kept to a minimum. This is not to say that women will never speak freely in front of men. However, they may not speak freely in front of men whose attitude is observed or known to be domineering.
- Unlike the purpose of many techniques that involve people from communities (e.g. participative appraisal techniques) and other 'open' discussions with aid programme recipients, the goal here is not to create consensus or reach conclusions. In fact, the methodology is specifically designed so that each group member can respond to, elaborate on, criticize and modify other people's comments. The facilitator should not lead the discussion to a conclusion under any circumstances.
- Each participant must feel that her or his specific thoughts are valued, that there are no right and wrong answers and that it is 'safe' to speak.
- While the 'majority' in one group might feel one way, the combined feelings of the minorities over a number of groups may, in fact, turn out to be the majority.

The facilitator needs to be familiar with the facts about male circumcision. Some issues that often arise in group discussions are:

- culture and heritage, identity – religion, tribe, stigma, education, coming of age;
- traditional services in comparison with medical services;
- pain management;
- complications;
- accessibility and cost of services;
- sexual and reproductive function, impotence;
- sexual pleasure;
- cleanliness, hygiene;
- disease prevention;
- increased numbers of partners after surgery;
- partner preferences.

Because some issues do not arise sufficiently often the facilitator may need to draw them out, e.g.:

- associated/linked reproductive health needs and services;
- counselling and educational aspects linked to circumcision;
- ongoing risk reduction after male circumcision;
- gender issues, women's involvement, impact on women;
- decision-making at the household level;
- pre-existing HIV status at the time of male circumcision.

4.1 Preamble

"I would like to start by thanking everyone who has come here today. We are going to ... [insert agenda for the event; when drinks will be available; whether you are providing food or a leaving gift; whether travel expenses are covered and, if so, when they will be handled, i.e. at the end of the meeting]."

"I particularly want to thank you for agreeing to discuss male circumcision. It's a very private subject and we don't really know each other – so thank you for including me in your circle today. It always helps when discussing things that are sensitive and private if we know each other a little better, so let's start by getting to know each other..."

4.2 Icebreaker: Pick and tell

'Pick and tell' is a good way for you to find out who is shy, who is funny, who is thinking, who speaks easily and who is copying what other people say. It gives everyone a chance to find out how it feels to speak in the group. This will enable you to call upon the right people at the right moment when trying to keep the discussion going.

For this exercise it is necessary to have picture cards more than equal in number to that of the people expected at the event. The picture cards should be attractive. If the group is pre-literate, photographs are more easily understood than paintings.

Avoid pictures of people and objects that are outside the group's experience, such as swimming pools. Good subjects for cards include flowers, buildings, fresh fruit and vegetables, and rural scenes, and they can come from anywhere in the world. Postcards, greetings cards and calendars are possible sources of pictures, or a selection of photographs can be used.

Lay the picture cards out, face up, on a desk or clean area of floor. Try to pick a space that people can reach from all sides.

1. Explain to the group members that they should each pick a card they like and that they will be able to keep it. Also explain that, once a card has been chosen, the person concerned will be asked to tell the group her/his name and why the card was selected.
2. When everyone has chosen a card, ask them to take a seat and ask each person to state her/his name and the reason for their choice. If too many responses are in the style of 'Because I like it', 'Because I like flowers', or 'My girlfriend will like it', start to ask follow-up questions to encourage people to reveal a little more about themselves and become more comfortable in the group situation. Try questions like: 'Why these flowers?', 'Is that a colour you like?', 'Can you describe the person you will give it to?'. Try not to insist on different answers from each person unless the follow-up questions are not working.
3. Once everyone in the group has chosen a card the facilitator should repeat her/his own name and describe a card she/he has chosen (a pre-chosen card is useful for advance preparation). Facilitators should use this opportunity to tell the group about themselves: where they are from; who is in their family; and that they are interested to hear what the group members are going to say.
4. Tell the group that they will be discussing subjects that are not normally talked about. Usually, this kind of discussion would only take place between friends and family, so the facilitator and the group are going to have to become friends very quickly! Facilitators should offer to answer personal questions if there are any and should give as much information about themselves as they can. This part of the pick and tell may last at least five minutes.
5. Finally, collect the unused cards. Remember that there must be enough cards for each focus group and that the participants keep their cards.

4.3 Focus group questions

Ensure that it is understood that male circumcision only *reduces* the risk of infection with HIV and that therefore other methods of prevention must also be used. Take note of the questions asked by the group as they are an important indication of the level of awareness of certain issues.

Start by asking about knowledge of HIV and male circumcision and then move on.

4.3.1 Opening questions to all groups

1. What is the tradition in this area around male circumcision? (The term 'male circumcision' may need to be explained.)
 - Ask for the reasons behind any tradition – why is it done or not done?
2. Who takes the decision about whether a male is to be circumcised?
 - Has this changed in recent times?
3. Do you know if male circumcision is available at the nearest health facility (government or faith-based)?
 - How much does it cost?

4.3.2 Questions to men if the majority of the group are circumcised

1. Am I right in thinking that most men in this community are circumcised?
2. What ages is it done at?
3. Who does it?
4. How much do people generally pay for male circumcision? (Remember that traditional male circumcision providers may require some payment or offering other than money.)
5. What memories do people have of being circumcised?
6. Would people have their sons circumcised? If so, at what age would people prefer them to be circumcised? (It may be necessary to prompt about it being done at birth or during childhood, and about the pros and cons of each.)
7. Who would people trust most to carry out this operation?
8. What happens during and after male circumcision in a health facility?
9. What happens during and after male circumcision when it takes place in a traditional way and is not performed in a health facility?
10. What are the benefits of male circumcision?
11. Have people heard that male circumcision can reduce the chance of catching HIV?
12. As male circumcision only reduces the chance of infection, what other ways of avoiding HIV should people use?
13. Programmes for male circumcision will probably include the offer of an HIV test, with referral to counselling and medical services if the person is HIV-positive. Taking an HIV test will not, however, be mandatory, and men who are HIV-positive may nevertheless receive a circumcision. What do you think people might think about this policy of offering HIV testing?
14. Some programmes for male circumcision for young men are considering enhancing the male circumcision service by adding sexual and reproductive health services, such as discussions or counselling about sexual relations, staying healthy, means of preventing

pregnancy and sexually transmitted infections, or even substance abuse (alcohol, drugs). Currently, men seldom have a place where they can receive these services. What do you think people might think of this idea?

4.3.2.1 Questions to men in the group who were circumcised by traditional methods

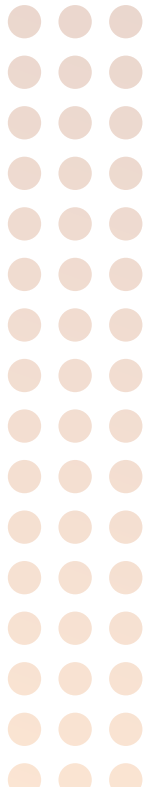
1. What do people think it is like having male circumcision done? Do people have memories of it or not?
2. Are there any risks related to the traditional male circumcision process?
3. What are the costs of traditional male circumcision (in money or other terms)?
4. What suggestions might people have for improving the way male circumcision is done in the traditional setting?
5. In some places the traditions associated with male circumcision are still observed but the actual operation happens at a health facility. What do you think people think about this?
6. Which do people think is safer: the traditional method of male circumcision, or male circumcision performed at a health facility?
7. Would people have their sons circumcised? If so, at what age would people prefer them to be circumcised? (It may be necessary to prompt about it being done at birth or during childhood, and about the pros and cons of each.)
8. What might stop parents from using a health facility for the circumcision of their sons?
9. How much would people in the community be able to pay for a male circumcision operation if it were done at a health facility?

4.3.2.2 Questions to men in the group who were circumcised at a health facility

1. What was it like undergoing male circumcision? Do people have memories of it or not?
2. What might stop someone from using the health facility?
3. What are the benefits of using a health facility?
4. What are the negatives about using a health facility?
5. How might male circumcision at a health facility be improved? What were the good things about having it done at such a facility and what were the bad things?
6. Have people ever heard of the operation going wrong?
7. How much does it cost?
8. What do people think would be a fair/affordable price for a male circumcision operation?

4.3.3 Questions to men if the majority of the group are not circumcised

1. What is the first thing that comes into people's minds when they hear the term 'male circumcision'?
2. Why might some men not be circumcised?
3. Which people are circumcised?
4. What are the benefits of male circumcision? What might be some of the negative, or bad, things associated with being circumcised?
5. What would encourage male circumcision?

- 
6. What would encourage parents to get their sons circumcised?
 7. At what age would parents prefer their sons to be circumcised? (It may be necessary to prompt about it being done at birth or during childhood, and about the pros and cons of each.)
 8. How would people react if they were told that, when a man is circumcised, he has a much-reduced risk of becoming infected with HIV?
 9. Do men ever consider getting circumcised? If so, for what reasons?
 10. Would men actually get circumcised?
 11. Who makes decisions about male circumcision in the community?
 12. How much would people be willing to pay for male circumcision in a health facility?
 13. How much is normally charged for male circumcision in health facilities in this area?

4.3.4 Questions to women in communities where men are normally circumcised

1. How are men normally circumcised in this community?
2. Have there been any changes to this pattern in recent years?
3. What does a man being circumcised mean to a woman?
4. What does a son's circumcision mean to a mother?
5. Would a woman consider marrying a non-circumcised man?
6. Would a mother consider not having her son circumcised? If 'Yes', why? If 'No', why not?
7. What do women think are the benefits of circumcision?
8. What do women think are the negative or bad aspects of a male child or a man being circumcised?
9. What would be a fair price for a male circumcision operation:
 - a. as part of a traditional rite?
 - b. in a health facility?
10. Is there any difference between sex with a circumcised man and sex with an uncircumcised man?
11. Programmes for male circumcision are likely to include the offer of an HIV test, with referral to counselling and medical services if the person concerned proves to be HIV-positive. Taking an HIV test will not, however, be mandatory, and men who are HIV-positive may still receive a circumcision. What do you consider people might think of this policy of offering HIV testing?
12. Some programmes for male circumcision for young men are considering enhancing the male circumcision service by adding sexual and reproductive health services, e.g. discussions or counselling on sexual relations, staying healthy, means of contraception, or even substance abuse (alcohol, drugs). Currently, men seldom have a place where they can receive these services. What do you consider people will think of this idea?

4.3.5 Questions to women in communities where men are normally not circumcised

1. What does male circumcision mean to women?
2. What does male circumcision mean to mothers?
3. Would a woman consider marrying a circumcised man?

4. What do women think are the benefits of male circumcision? What do women think are the negative or bad aspects of a male child or a man being circumcised?
5. Would a woman like her partner to be circumcised?
6. Would a mother consider having her son circumcised?
 - a. Why?
 - b. Who would actually take this decision?
7. How would people react if they were told that, when a man is circumcised, he has a much reduced risk of being infected with HIV?
8. Would a mother get her son circumcised, given this new information?
 - a. What might stop her?
 - b. Who would actually take this decision?
9. Would a woman consider marrying a circumcised man, given this new information?
10. What would be a fair price for a male circumcision operation?
 - a. In a traditional setting?
 - b. In a health facility?
11. What might women say about sex with a circumcised man compared with sex with an uncircumcised man?
12. Programmes for male circumcision are likely to include the offer of an HIV test, with referral to counselling and medical services if the person concerned is HIV-positive. Taking an HIV test will not, however, be mandatory, and men who are HIV-positive may nevertheless receive a circumcision. What do you consider people will think about this policy of offering HIV testing?
13. Some circumcision programmes for young men are considering enhancing the male circumcision service by adding sexual and reproductive health services, e.g. discussions or counselling on sexual relations, staying healthy, means of contraception, or even substance abuse (alcohol, drugs). Currently, men seldom have a place where they can receive these services. What do you consider people will think of this idea?
14. What would encourage male circumcision?
15. What would encourage parents to get their sons circumcised?

4.3.6 Closing questions to all groups

1. If it were possible to describe the 'perfect' situation in which adolescent and adult males could get circumcised, what would it be like?
 - a. Possible prompts: Would male circumcision be done traditionally or in a medical facility; or, if male circumcision were part of traditional initiation rites, perhaps the procedure would be in a hospital but everything else would remain the same, or a medical professional might attend a traditional event and carry out the male circumcision?
 - b. What would the cost be (or would the procedure be free)?
2. If the health programme in your country wanted to increase the availability of male circumcision services, what would be good or bad ways to do this?
3. If the health programme in your country wished to increase the numbers of people seeking male circumcision, what types of messages would people best respond to? How should the messages be given (e.g. by radio, posters, teachers, family)?
4. If the government wanted to increase the availability of male circumcision services, what would be good or bad ways to do this?

5. If the government wished to increase the numbers of people seeking male circumcision, what types of messages would people best respond to? How should the messages be given (e.g. by radio, posters, teachers, family)?
6. Are there any subjects, topics or thoughts that have not been discussed which might be important or useful for us to talk about?

At the end of the meeting, encourage the group to question the facilitator. The literal truth is not required if it might be embarrassing, although it is best if possible. Any information given, however, should be accurate.

4.4 Analysis of results

To prepare the data, type up each focus group discussion, using the main questions asked as headings and itemizing the main comments made below them, using bullet points rather than long paragraphs.

Try to indicate where there was general agreement within each group and where there was disagreement and about what. Do not only write down the statements that got agreement, as one person on her/his own can make a key statement. These notes are not intended to be transcripts of everything that took place but should be a fair representation of the discussion around each of the main questions.

4.4.1 Analyse the data

This task should be started and completed by the same person or group of people, because familiarity with all the results is important for the overall conclusions. Sort and group the reports by similar type of focus group, e.g. reports of health worker groups or non-circumcised male groups.

Draw together overall conclusions for each collection of focus groups. Try to indicate where there was general agreement across groups and where there was disagreement and about what. Do not only write down the statements about which there was agreement, as one group on its own can make a key statement. Use the main questions asked as a structure for these conclusions but remember to watch out for geographical differences. The conclusions by type of focus group form the first part of the report.

Once these initial conclusions have been completed, draw them together to identify any overall trends. At this point the questions can no longer be used as a structure. Use each identified trend or indication of a geographical trend as a heading. The conclusions on trends form the second part of the report.

5 Tool 5: Service availability

Tool objective: To identify and map specific and existing service levels and needs among institutions and staff.

The Minimum Package for Male Circumcision Services as defined by WHO includes:

- offer of HIV testing and counselling;
- active exclusion of symptomatic STIs and syndromic treatment where required;
- provision and promotion of male and female condoms;
- counselling on risk reduction and safer sex;
- male circumcision surgical procedures performed as described in the *Manual for male circumcision under local anaesthesia*.

These activities should be considered when assessing services in order to identify gaps and resources needed to achieve this package.

There are two ways of carrying out the research required to gather service availability data for male circumcision:

- Use the WHO service availability mapping mechanism and include specific male circumcision questions.

OR

- Carry out a more targeted, male-circumcision-focused survey of institutions and staff.

5.1 Service availability mapping approach

A country that wants to do a wider service availability study for a number of health issues can perform what WHO refers to as *service availability mapping* (SAM). This is a tool for collecting and presenting basic information on health services: health infrastructure, human resources and services offered. While useful for mapping an entire country, its main application is at the subnational or district level, where district health management teams can use SAM results in conjunction with the WHO HealthMapper application, developed by the Public Health Mapping and GIS programme for mapping and monitoring health services. SAM comprises a survey methodology, remote field data collection devices, and the WHO HealthMapper application.

Since there is an immediate need for information on basic infrastructure and service availability, many countries have applied an intermediate step to the collection of full national data – the SAM survey of districts. In the case of male circumcision the districts would be ones where male circumcision rates might be low, or ones that the country concerned targets for initial scale-up efforts. This district approach consists of a survey of all district health management teams. It includes questions on health infrastructure, human resources and the availability of key services. For selected services such as those of antiretroviral therapy, caesarean section or prevention of mother-to-child transmission of HIV (PMTCT), the specific name of the facility is asked. The outputs are maps and summary statistics of the situation in all districts in the country.

The cost and time vary with the size of the country or district in which SAM is conducted. For illustrative purposes, SAM conducted in a country or district of two million persons might be accomplished for US\$ 60 000 – 70 000 and would take two to three months from the time of the decision to conduct it until data collection, with data ready to be analysed (because SAM uses PDA technology and data are directly entered into computers). Data analysis requires additional time.

Further information on SAM may be found at:

<http://www.who.int/healthinfo/systems/serviceavailabilitymapping/en>

To proceed further with the SAM approach, contact the above web site or, within Africa, Mr William Soumbey-Alley (soumbeye@afro.who.int)

5.2 Male circumcision facility survey

If a SAM survey is too great an undertaking, a study that focuses solely on male circumcision could be conducted as detailed below. A male circumcision service availability survey would probably include two instruments: a survey of health facilities and a survey of health staff.

These two survey tools are designed to provide information about the current situation regarding the availability of male circumcision services or of facility and provider competences that could facilitate the introduction of male circumcision services.

Where male circumcision services are available, these tools can provide insight into what levels of service are currently offered to what age groups and by whom, as well as into which elements of a complete male circumcision package are currently being provided and the identification of gaps in need of attention.

Where male circumcision services are not currently offered the survey should provide information about the availability of the types of facilities, equipment, manpower, skills and systems that would enable the introduction of male circumcision services. Results should enable a gap analysis to be undertaken to assess what would be needed to scale up male circumcision services.

In order to be able to judge which health facilities could most easily be enabled to provide male circumcision services (among those that do not already provide such services), proxy indicators can be used to determine whether a facility is likely to have the equipment and abilities to provide the services. The goal of this survey is to identify health facilities that might provide safe male circumcision services and are accessible to the population, as well as facilities that could be upgraded with minimal intervention.

Working with in-country expertise is strongly encouraged in developing a relevant sampling framework (e.g. the central statistics office, university researchers or departments with research expertise).

The most complete and consistent information is likely to be gathered through on-site interviews and observations. Where there are constraints and limitations that restrict the ability to reach all the desired institutions and health practitioners in a timely fashion, other means of collecting the necessary information could be considered. These alternatives might include sending out surveys by post or email, or conducting interviews by telephone.

5.2.1 Health facility survey

District: _____ Name of facility: _____ Date: _____

Type (hospital, health centre, private clinic, etc.) _____

Informant: _____ (name, position)

Interviewer: _____

1. What is the approximate catchment population served by this facility? _____

2. What is the average total client load per day?

a. Inpatient _____

b. Outpatient _____

3. What proportion of the clients served by this facility are of the following ethnic or religious background?

Religion	Ethnicity
a. _____ %	a. _____ %
b. _____ %	b. _____ %
c. _____ %	c. _____ %
d. _____ %	d. _____ %
e. _____ %	e. _____ %
f. _____ %	f. _____ %
Total _____ 100%	Total _____ 100%

4. How many of the following medical personnel work at this facility?
- a. Doctors: Male _____ Female _____
- b. Clinical officers: Male _____ Female _____
- c. Nurses: Male _____ Female _____
- d. Counsellors: Male _____ Female _____
- e. Other clinical staff (specify): _____ Male _____ Female _____
5. Does this facility have basic surgical facilities?
- a. Surgical theatre(s): Yes _____ No _____
- b. Outpatient minor surgical / procedure room(s): Yes _____ No _____
- c. Functioning surgical and emergency equipment (clock, lamps, oxygen, etc.):
Yes _____ No _____
6. Does this facility have reliable electrical power? Yes _____ No _____
- Indicate the source or sources.
- a. Connected to grid _____
- b. Generator _____
- c. Other (specify) _____
7. Does this facility have an adequate water supply? Yes _____ No _____
- Indicate the source or sources.
- a. Running water from city supply _____
- b. Running water from a captive source (e.g. a well) _____
- c. Other (specify) _____
8. Does this facility offer services for individuals with sexually transmitted infections?
- Yes _____ No _____
- a. Are STI services dedicated (i.e. STI clinic)? Yes _____ No _____
- b. Are they integrated (e.g. in general outpatient services)? Yes _____ No _____
9. Does this facility offer counselling and testing for HIV? Yes _____ No _____
- a. Are services dedicated (i.e. VCT clinic)? Yes _____ No _____
10. Does this facility offer family planning counselling and services?
Yes _____ No _____

11. Does this facility have sterilizing equipment in working order?
- a. Autoclave: Yes _____ No _____ Number _____
- b. Pressure cooker: Yes _____ No _____ Number _____
- c. Other means: Yes _____ No _____
12. Does this facility have adequate supplies for basic infection prevention?
- a. Chlorine or other appropriate decontaminant: Yes _____ No _____
- b. Gloves (surgical, examination, for cleaning staff):
Yes _____ No _____ Number _____
- c. Waste disposal (sharps boxes, contaminated waste containers, etc.):
Yes _____ No _____
13. In the past 12 months, were the following routinely carried out at this facility?
If 'Yes', how many?
- a. Caesarean section: Yes _____ No _____
- b. Minor surgeries, e.g. surgical wound repair: Yes _____ No _____
- c. Vasectomy or tubal ligation: Yes _____ No _____
14. Does this facility carry out HIV testing? Yes _____ No _____
- a. How many tests during the last 12 months? _____
15. Describe the type of HIV counselling that this facility provides _____
16. Does this facility provide condoms? Yes _____ No _____
- a. How many distributed in the last 12 months? _____
17. Does this health care facility perform male circumcision? Yes _____ No _____
- If 'No' to Question 17, go to Question 25.**
18. How many male circumcisions were performed in the last 12 months? _____
19. How many male circumcisions were performed on each of the following groups over the same 12-month period?
- a. Infant (0–<1 year) _____
- b. Child (1–9 years) _____
- c. Adolescent (10–17 years) _____
- d. Adult (≥ 18 years and over) _____
20. Indicate the approximate proportion of male circumcisions done for the following reasons or indications.
- a. Medical indications _____ %
- b. Religious practice _____ %
- c. Cultural practice _____ %
- d. Personal preference _____ %
- e. Other reasons (specify) _____ : _____ %
- f. Unknown _____ %
21. What type of counselling do male circumcision patients **routinely** receive as part of the procedure?
- a. Pre-procedure counselling about the male circumcision procedure:
Yes _____ No _____
- b. Pre-procedure counselling about risks and benefits of male circumcision:
Yes _____ No _____

- c. Counselling about HIV and STI prevention: Yes _____ No _____
- d. Post-procedure counselling about postoperative care: Yes _____ No _____
- e. Post-procedure counselling about HIV risk reduction: Yes _____ No _____
- f. Post-procedure counselling about resumption of sexual activity: Yes _____ No _____
- g. Counselling about other male reproductive health topics: Yes _____ No _____
(Specify) _____
22. Who provides this counselling (more than one answer possible)?
- a. The clinician performing the male circumcision: _____
- b. A nurse or other worker assisting in the procedure: _____
- c. A counsellor: _____
- d. Other: _____ (Specify) _____
23. What is the normal charge for male circumcision paid by the patient (Specify the currency)?
- a. Infant male circumcision: _____ Currency: _____
- b. Child male circumcision: _____
- c. Adolescent male circumcision: _____
- d. Adult male circumcision: _____
24. What additional charges or costs might apply (e.g. antibiotics, return visits, extra bandaging)?
None _____ Some _____ (Specify) _____
25. If male circumcision were to be promoted in this area, in your opinion could this facility provide male circumcision services? Yes _____ No _____ Uncertain _____
- a. Explain why you gave this answer: _____
26. What might the facility need in order to be able to introduce male circumcisions (or increase the number if male circumcisions are already being performed)?
- a. Would equipment and instruments, such as surgical tables or operating instruments, be needed? Yes _____ No _____
(Specify) _____
- b. Would medications be needed? Yes _____ No _____
(Specify) _____
- c. Would disposable equipment, medicines and supplies be needed, (e.g. anaesthetics, sutures, gloves, syringes/needles, sharps boxes)? Yes _____ No _____
(Specify) _____
- d. Would staff training be needed? Yes _____ No _____
(Specify what type of staff and what type of training): _____
- e. Which type of staff is authorized to perform male circumcision?
(Specify) _____
- f. Would a surgical/procedure room to perform the surgery be needed? Yes _____ No _____
- g. If 'Yes', do you have a room that could be used if equipment were supplied? Yes _____ No _____
- h. What else would be needed? _____

5.3 Health practitioner survey

The primary purpose of this survey is to identify health practitioners who carry out, or might be able to carry out, male circumcision or components of the core package of male circumcision services. The secondary purpose is to gain information on the attitudes of health-care workers towards providing male circumcision services. When attempting to increase rates of male circumcision it is important to understand whether health-care workers are opposed to providing services or whether they would not encourage patients to undergo male circumcision.

It is proposed that the staff at the surveyed facilities be interviewed in order to minimize logistics, time and cost.

5.3.1 Health practitioner survey

Read out loud:

We are carrying out an assessment in this district of the experience and knowledge that health professionals have of male circumcision. We would like to learn of your experiences with male circumcision (if any) and your opinions about providing male circumcision at health facilities in this district. Please answer the questions as truthfully as possible. We will not use your name or refer to you personally when reporting the results. You are free to refuse to answer any questions but we would appreciate your giving us truthful answers to the questions you do answer.

District: _____ Name of facility: _____ Date: _____

Type (hospital, health centre, private clinic, etc.) _____

Gender of informant: _____ Male _____ Female _____

Interviewer: _____

1. What is your designation?
 - a. Medical officer _____
 - b. Clinical officer _____
 - c. Nurse _____
 - d. Counsellor _____
 - e. Other (Specify) _____
 2. What is your specialty, if any? _____
 3. How long have you been practising (medicine/nursing)? _____
 4. How long have you been working at this facility? _____
 5. What type of organization do you work for?
 - a. Government _____
 - b. Church-based _____
 - c. Private _____
 - d. Other _____
 6. Have you ever performed a male circumcision? Yes _____ No _____
 7. Have you ever assisted in a male circumcision? Yes _____ No _____
- If 'Yes', indicate your role or roles.

- a. Assisting the clinician during the procedure: _____
 - b. Patient screening: _____
 - c. Preoperative or postoperative preparation and care: _____
 - d. Counselling: _____
 - e. Other: _____ (Specify): _____
8. If 'Yes' to Question 6 or 7, approximately how many male circumcisions have you performed / assisted in (total)? _____
 9. In the last 12 months, have you performed / assisted in any male circumcisions?
 - Yes _____ No _____
 - a. If 'Yes', how many male circumcisions have you performed / assisted in? _____
 - b. How many of these were performed at this health facility? _____
 10. In the last 12 months, did you perform / assist in male circumcisions outside this health facility?
 - Yes _____ No _____
 11. If 'Yes', where did you perform / assist in the male circumcisions?
 - a. In another health facility _____
 - b. In a private clinic _____
 - c. In a village _____
 - d. Other: _____ (Specify): _____
 12. What were the reasons the male circumcisions were performed (the percentages should add up to 100%)?
 - a. Medical indications _____ %
 - b. Religious practice _____ %
 - c. Cultural practice _____ %
 - d. Personal preference _____ %
 - e. Other reasons (Specify) _____ %
 - f. Unknown _____ %
 13. What were the ages of the males you circumcised?
 - a. Infant (0–<1 year) _____
 - b. Child (1–9 years) _____
 - c. Adolescent (10–17 years) _____
 - d. Adult (≥18 years) _____
 14. How much is charged for a male circumcision? _____ (local currency)
 15. What additional charges or costs might apply (e.g. antibiotics, return visits, extra bandaging)?
None / Some (Specify) _____
 16. What training have you received to perform male circumcisions? _____
 17. If you were to be asked to perform / assist in male circumcisions, would you need additional training?
 - Yes _____ No _____
 18. If 'Yes', what training do you think you should receive?
 - a. Theoretical (e.g. lectures or reading): _____
 - b. Practical clinical training (i.e. performing male circumcision): _____
 - c. STI diagnosis and treatment: _____
 - d. Infection prevention: _____

- e. Counselling: _____
- f. Comprehensive (all of the above): _____
- g. Comments: _____

19. In your opinion, does circumcision give advantages to a man?
 Yes _____ No _____ Makes no difference _____

20. Do you agree with the following statements?

- | | |
|---|-----------------------|
| a. Male circumcision helps to improve hygiene: | Yes / No / Don't know |
| b. Male circumcision reduces risk of STI: | Yes / No / Don't know |
| c. Male circumcision reduces risk of HIV infection: | Yes / No / Don't know |
| d. Male circumcision prevents HIV infection entirely: | Yes / No / Don't know |
| e. Male circumcision increases risk of HIV: | Yes / No / Don't know |
| f. Male circumcision reduces risk of penile cancer: | Yes / No / Don't know |
| g. Male circumcision increases sexual pleasure: | Yes / No / Don't know |
| h. Male circumcision reduces sexual pleasure: | Yes / No / Don't know |
| i. Men who are circumcised are more promiscuous: | Yes / No / Don't know |
| j. Women prefer men who are circumcised: | Yes / No / Don't know |

21. Have you seen male circumcisions (carried out by someone else) that resulted in complications or adverse events? Yes _____ No _____

- a. How many? _____
- b. Over how many years? _____
- c. Estimate what were the main types of complication or adverse event (you may mark more than one option):
- a. Excessive bleeding _____
 - b. Infection _____
 - c. Disfigurement _____
 - d. Impotence _____
 - e. Other (Explain) _____

22. Has any male circumcision that you have performed resulted in a complication or adverse event? Yes _____ No _____

- a. How many? _____
- b. Over how many years? _____
- c. Please estimate what were the main types of complication or adverse event.
- a. Excessive bleeding _____
 - b. Infection _____
 - c. Disfigurement _____
 - d. Impotence _____
 - e. Other (Explain) _____

Read out loud:

International health organizations have concluded that male circumcision is an important and effective means of reducing the risk of HIV infection. The national government is considering recommending that males be offered circumcision to reduce the chances of men becoming infected with HIV and other STIs. We would like to get your opinions of the challenges that would have to be addressed in order to promote male circumcision and make it available to a large number of males in this district. I am now going to ask you some questions about how male circumcision might be made available to many people.

1. In your opinion, who should be permitted to perform male circumcisions?
(Mark one of the options listed)?
 - a. Medical officers:
Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree
 - b. Clinical officers:
Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree
 - c. Male nurses:
Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree
 - d. Female nurses:
Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree
 - e. Traditional and religious male circumcision providers:
Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree
 - f. Other (Specify): _____
Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree
2. In your opinion, what would be the best age for male circumcision?
 - a. Infants (0–<1 year) _____
 - b. Children (1–9 years) _____
 - c. Adolescents (10–16 years) _____
 - d. Young men (17–24 years) _____
 - e. All ages _____
 - f. What are your reasons for choosing the age group above? _____

3. In your opinion, what will be the major difficulties or challenges in providing male circumcision to a large number of males in this district?
 - a. _____
 - b. _____
 - c. _____
4. In your opinion, what could be done to increase the number of males who become circumcised in this district?
 - a. _____
 - b. _____
 - c. _____
5. If male circumcision were provided to many people in this district, what do you think the charge should be for the procedure? _____
6. If male circumcision were promoted in this district, would you be willing to offer male circumcision services? Yes _____ No _____

5.4 Analysis of results

The aim of the analysis of results from these surveys is to identify the following.

1. Institutions that currently have the capacity to provide a minimum package of male circumcision services.
 - What is the current capacity?
 - How might it be increased?
2. Institutions that currently do not have the capacity for male circumcision.
 - What do these institutions need in order to be able to provide a male circumcision service?
3. Staff that need further information on the subject.
 - What particular aspects does this information need to cover?
 - Which cadres need more information?

This is initially a mapping process and you will need to plot the results in the context of their geographical location and in relation to population and accessibility.

6 Tool 6: Feedback and action

Tool objective: To guide the feeding back of information to stakeholders and to support action planning.

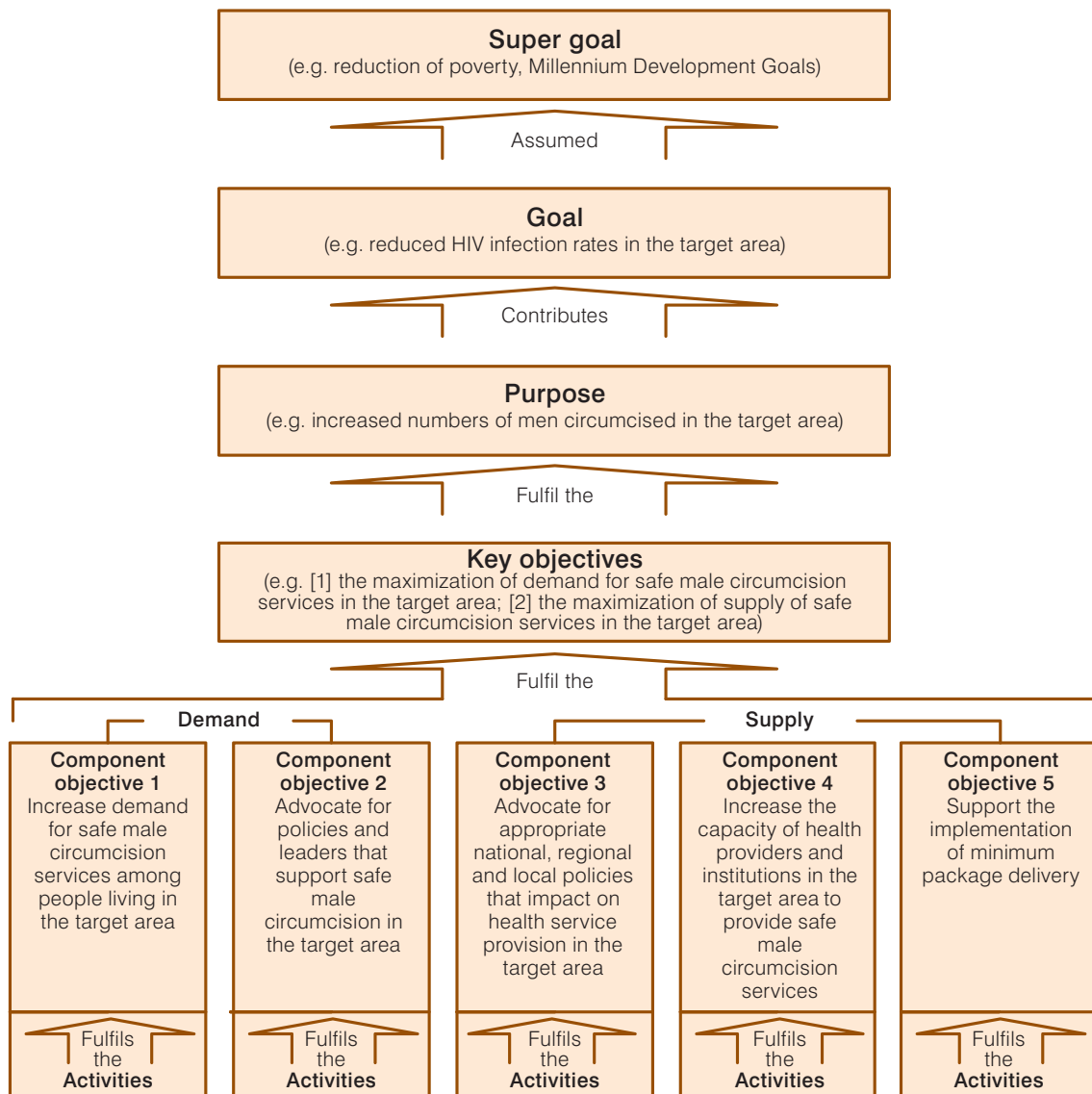
6.1 The report of results

The report of results should answer three questions.

1. What is the current prevalence of male circumcision and why?
2. What are the current trends/patterns of male circumcision supply and demand and why?
3. How might the number of male circumcisions be safely increased?

It will be important to use the action framework, stressing to people that this is only the starting point for discussions. It may even prove useful to split the results up so that they relate to the different component objectives as in Fig. 5.

Fig. 5. Example of safe male circumcision action framework



6.2 The stakeholders' feedback meeting

Invite the people that attended the first stakeholders' meeting and anyone else who has been particularly involved or interested in the programme. Disseminate the report of results and the meeting agenda at least a week in advance of the meeting. It may also be useful to circulate the action framework in order to illustrate the nature of the decisions that the group will need to take.

The meeting is meant to come to decisions, and the invited participants should think beforehand about decisions and subsequent action to be taken. If inviting everyone who attended the first stakeholders' meeting and all other interested parties might result in too large a group, key representatives of groups might be invited. However, all those people with an interest in male circumcision should feel that they are included and have 'ownership' of the meeting.

It is possible that one day would not be long enough for the meeting.

6.2.1 Agenda

Part 1

1. Welcome and introduction

- A brief summary of the link between male circumcision and HIV.
- Objectives for the day.
 1. To familiarize ourselves with the results.
 2. To decide on priorities.
 3. To look at ways forward.
- Describe briefly the situation analysis process (Fig. 2 may be helpful) and the local sampling decisions (who was interviewed, why, numbers interviewed...).

2. The results

- Describe the current situation in terms of:
 1. rates of male circumcision, cost, age carried out, place carried out;
 2. levels of male circumcision service available by area and type.
- Present an executive summary, focusing on answering the following questions.
 1. What are the prevalence and determinants of male circumcision practices in terms of:
 - levels of demand?
 - supply of services?
 2. How might the number of male circumcisions carried out be increased in terms of:
 - demand for male circumcision?
 - increased availability of male circumcision services?
- Present the starting point for the action framework and show how the information from the situation analysis has resulted in information feeding into that framework.

Part 2

1. Pose the question: Considering these results, should we continue to look at work to increase rates of male circumcision in the country?

- Encourage discussion and take careful notes of the points raised.
 - Ask for a show of hands for and against continuing.
 - Select a number of speakers from each side of the argument (e.g. five) and ask those against continuing the work to speak first.
 - Ask for another show of hands at the end of these contributions.

- If the overwhelming answer is 'No' it is very important to get the group to state its reasons. Say: "We respect your opinion. Nevertheless, there is compelling evidence that male circumcision provides important protection against HIV and many lives could be saved by increasing the number of males being circumcised. What, if anything, should we do?"
- If the answer is overwhelmingly 'Yes', continue with the meeting.
- If the room is fairly evenly split, continue the meeting and explain that the cautionary opinions of those against continuing to work on the issue have been heard and will be considered but that for the moment it would be useful to continue.

2. Looking at a framework for action³ (see Fig. 5 above)

- If there are many participants it may be useful to split them into smaller groups. Make sure that each group has either plain paper or flipcharts to work on (and pens).
- Distribute the framework for action and give the participants five minutes to read it.
- Explain that developing a framework like this takes time but that it would be particularly useful if the group could develop its own draft during the present session. Explain that, rather than going into a full logical framework⁴ at this point, the framework being used is in a simplified form. The framework that the participants are being asked to draft could be the same as the distributed version or it could be different in some places or totally different.
- Ask the participants to look at the purpose and to work on how this can be made more specific to the country (that is, who or where might the target population be, or should work be done across the whole country?).
- Ask the participants to look at the key objectives and whether they agree with them, and what kind of target they might want to see attached to such objectives.
- Ask the participants to look at the component objectives and then to discuss and note down:
 - whether they should all be included in a country framework;
 - whether any new ones should be added so as to make the framework fit local needs;
 - how they might be achieved, by writing down ideas for activities.
- Ask the participants to list activities that will fulfil the component objectives.
- Give the participants as much time as possible at each stage. Emphasize that the ideas are the most important thing and that the wording does not have to be perfect.
- Collect the results. If there is time, ask each group to present its ideas to the plenary.

3. Looking at priorities

- When each group has a list of activities, put them up on flipchart paper along a wall and ask the participants to identify their top five priorities. The participants should vote with a sticker or a mark with a marker pen (give each person five votes so that they can vote up to five times on the same activity if they wish). They will have to go up to the flipchart sheets to make their votes.
- Count the votes to establish priorities and announce the top-ranking activities. Stress that this does not mean that this is all that will happen but that these activities should be given priority.
- Write down the five top-ranking activities and display them.

³ A logical structure for classifying and organizing complex information.

⁴ An aid to logical thinking and a means whereby a project may be structured and described for analytical purposes.

4. Action

- Decisions must be taken. Exactly what they will be depends on the meeting and what the participants decide.
- Determine action steps. The meeting is not meant for detailed planning but some action steps should be determined.
- Assign responsibility for action steps.

5. Closing remarks

- Thank the participants for coming.
- Reiterate the decisions made, the action steps and the areas of responsibility.
- In all likelihood a smaller group will now take forward the ideas and decisions, and this should be explained (and possibly who will constitute this group).
- Explain that a short report of this meeting will be circulated and that everyone will be kept informed of progress.

Annexes

Annex 1: Survey of individuals

Tool objective: To learn more about the knowledge and personal preferences of men and women with regard to male circumcision for men and male children.

The surveys in this tool are purposefully kept short – if a survey is too long it is harder to get answers to all of the questions and the quality of answers will also be lower.

There is one survey for men and another for women. The survey for men includes questions for both men who are circumcised and men who are not circumcised. Instructions are included to lead the interviewer to different sections of the tool, depending on the male circumcision status of the respondent. This allows the interviewer to approach any man and ask appropriate questions.

Note: It is very important that interviewers are able to give accurate information on the subject of male circumcision, as respondents are likely to ask further questions and these should be answered fully and correctly at the end of the interview with a view to dispelling myths and avoiding misconceptions.

Three different paths can be taken through the survey tool for men, depending on the respondent:

- uncircumcised males not interested in being circumcised (Questions 1–12);
- uncircumcised males interested in being circumcised (Questions 1–15);
- circumcised males (Questions 1–5 and 16–27).

There is only one path through the tool for women, regardless of the respondent's answers.

1 Survey tool for males

Note: Text in boxes provides instructions or scripting for the interviewer.

Some questions may benefit from the use of response categories defined either from other tools or from a testing of this survey. These questions are marked in the text below.

Introduce yourself and what you are doing. For example:

“Thank you for agreeing to help us with our survey. My name is [insert your name]. I work for [insert name of organization]. We are talking to men and women in an effort to find out more about male circumcision. Your contribution will be of great importance to us.

“The interview will last about [insert a tested time for the local language].

“There are no right or wrong answers to the questions; we would just like to learn about your personal thoughts and attitudes. If you don't understand a question, please tell me, and you can add further information at any stage.

“Your answers will, of course, be kept confidential. Your personal responses will be seen by only a very few of my colleagues and your name will not be used in relation to the answers you give.”

Place of interview _____

Language of interview _____

1. Demographics

1.1 How old are you? _____

1.2 Are you a member of a specific tribe, e.g.
[insert group names as appropriate to the country]? _____

1.3 How many children do you have? Boys _____ Girls _____

1.4 Where were you born?

Name of place _____

Type of area: Rural _____ Town _____ City _____

1.5 Where are you living now?

Name of place _____

Type of area: Rural _____ Town _____ City _____

1.6 Do you practise a particular religion? Yes _____ No _____

[If 'Yes'] Which religion? _____

2. Are you circumcised?

Yes _____ No _____ Don't know _____

3. Describe what you think male circumcision is.

Listen to what the respondent says and tick and/or fill in the options below. Do not show or describe the options to the respondent.

- Removal of the entire foreskin (the skin that can be rolled forward or back over the head of the penis).
- Removal of the foreskin (the skin that can be rolled forward or back over the head of the penis), but not necessarily the entire foreskin.
- Removal of the penis.
- Don't know.
- Other (Specify) _____

Once the question has been answered, explain that male circumcision is the surgical removal of the entire foreskin, which is the skin that can be rolled forward or back over the head of the penis. If less than the entire foreskin is removed, this is not full circumcision. (Pictures of an uncircumcised, not fully circumcised, and circumcised penis might be helpful.)

4. Now that I have told you what circumcision is, let me ask you again: Are you circumcised?

Yes _____ No _____ Don't know _____

4.1 [If 'No'] Why are you not circumcised?

5. Why do you think male circumcision is carried out?

Listen to what the respondent says and tick and/or fill in the options below. Do not show or describe the options to the respondent.

- For traditional reasons, such as (State) _____
- For medical reasons, such as (State) _____
- For other reasons (State) _____

[If the respondent answered 'Yes' to Question 4, go to Question 16]

6. Would you consider being circumcised?

[Give the interviewee the choice of the following options]

- Strongly 'No'
- No
- Neither 'Yes' nor 'No'
- Yes
- Strongly 'Yes'

7. What are your reasons for this answer?

8. If you have or had a son, would you want him to be circumcised?

[Give the interviewee the choice of the following options]

- Strongly 'No'
- No
- Neither 'Yes' nor 'No'
- Yes
- Strongly 'Yes'

8.1 What are your reasons for this answer?

[Use response categories if available]

[If 'Strongly 'No' ', 'No', 'Neither 'Yes' nor 'No' ' go to Question 9]

8.2 [If 'Yes' or 'Strongly Yes'] When would be the best time for him to be circumcised?
I shall read to you several answers and you select the time you think would be best.

[Give the interviewee the choice of the following options]

- At birth or as an infant less than one year old
- When he is a child, perhaps 1-9 years old
- When he is an adolescent (10 through 17 years old)
- At some other time when he is an adult (18 years or older)
(Specify) _____

8.2.1 Why would he be circumcised at this time?

8.3 What additional times for him to be circumcised would be acceptable to you? I shall read to you several answers and you select the times you think would be acceptable.

[Give the interviewee the choice of the following options]

- At birth or as an infant less than one year old
- When he is a child, perhaps 1–9 years old
- When he is an adolescent (10 through 17 years old)
- At some other time when he is an adult (18 years or older)

(Specify) _____

8.3.1 Who would you like him to be circumcised by?

9. What do you think the benefits of a man being circumcised might be?

[Use response categories if available]

10. What do you think the problems or negative consequences of a man being circumcised might be?

[Use response categories if available]

Tell the respondent that recent studies show that male circumcision reduces the risk of being infected with HIV. Being circumcised is not enough on its own to protect against HIV and circumcised men **MUST** continue using other forms of protection.

11. Based on this information, would you consider being circumcised?

[Give the interviewee the choice of the following options]

- Strongly 'No'
- No
- Neither 'Yes' nor 'No'
- Yes
- Strongly 'Yes'

11.1 What are your reasons for this answer?

Circumcision also has other health benefits. Infants have a lessened chance of developing infections of the urine, children and adults do not have problems with the foreskin becoming too tight around the penis, there is a lessened chance of getting infections under the foreskin, and adults have a lessened chance of getting some sexually transmitted diseases.

12. Has this information changed your opinion about being circumcised?

Yes _____ No _____

[Give the interviewee the choice of the following options]

- Strongly 'No'
- No
- Neither 'Yes' nor 'No'
- Yes
- Strongly 'Yes'

If the respondent answered "No" or "Strongly No" to Question 12, this is the end of the survey. Express thanks to respondents for their time and information. Remember to ask them if they have any questions for you. You may need to refer to the briefing you have been given. However, if you do not know the answer to a question, do not be afraid to say so.

13. Would you still be worried about anything to do with male circumcision?

Yes _____ No _____

13.1 [If 'Yes'] What would you be worried about?

[Use response categories if available]

14. If you had to pay for the operation, what is the most you would be prepared to pay?

15. Would this amount have to be:

[Give the interviewee the choice of the following options]

- Saved up for?
- Borrowed?
- Neither, because my family has the money now.

This is the end of the survey for uncircumcised male respondents.

Express thanks to respondents for their time and information. Remember to ask them if they have any questions for you. You may need to refer to the briefing you have been given. However, if you do not know the answer to a question, do not be afraid to say so.

16. Why are you circumcised?

17. How old were you when you were circumcised?

18. How was it done?

[Give the interviewee the choice of the following options]

- By a traditional circumciser
- At a health facility
- Don't know
- Some other way (Describe)

[Description if needed]

19. Can you estimate the financial cost to your family of the male circumcision?

20. Did this amount have to be...

[Give the interviewee the choice of the following options]

- Saved up for?
- Borrowed?
- Neither, because my family had the money available.

21. What do you think the benefits of a man being circumcised might be?

[Use response categories if available]

22. What do you think the problems or negative consequences of a man being circumcised might be?

[Use response categories if available]

23. Are you pleased that you are circumcised?

[Give the interviewee the choice of the following options]

- Strongly 'No'
- No
- Neither 'Yes' nor 'No'
- Yes
- Strongly 'Yes'

24. Would you recommend male circumcision to others?

[Give the interviewee the choice of the following options]

- Strongly 'No'
- No
- Neither 'Yes' nor 'No'
- Yes
- Strongly 'Yes'

24.1 What reasons would you give in your recommendation?

[Use response categories if available]

25. If you have or had a son, would you want him to be circumcised?

[Give the interviewee the choice of the following options]

- Strongly 'No'
- No
- Neither 'Yes' nor 'No'
- Yes
- Strongly 'Yes'

25.1 What are your reasons for this answer?

[Use response categories if available]

[If 'Strongly 'No' ', 'No', 'Neither 'Yes' nor 'No' ' go to coloured Box below]

25.2 [If 'Yes' or strongly 'Yes'] When would be the best time for him to be circumcised? I shall read to you several answers and you select the time you think would be best.

[Give the interviewee the choice of the following options]

- At birth or as an infant less than one year old
- When he is a child, perhaps 1–9 years old
- When he is an adolescent (10 through 17 years old)
- At some other time when he is an adult (18 years or older)

(Specify) _____

25.3 What additional times for him to be circumcised would be acceptable to you? I shall read to you several answers and you select the times you think would be acceptable.

[Give the interviewee the choice of the following options]

- At birth or as an infant less than one year old
- When he is a child, perhaps 1–9 years old
- When he is an adolescent (10 through 17 years old)
- At some other time when he is an adult (18 years or older)

(Specify) _____

25.4 Why would he be circumcised at this time?

[The following Box is to be read to all respondents no matter what their answer is to Question 25]

Tell the respondent that recent studies show that male circumcision reduces the risk of being infected with HIV. Being circumcised is not enough on its own to protect against HIV and circumcised men MUST continue using other forms of protection.

26. Has this information changed your opinion about supporting your son's circumcision?

Yes _____ No _____

26.1 [If 'Yes'] Would you now support your son's circumcision?

[Give the interviewee the choice of the following options]

- Strongly 'No'
- No
- Neither 'Yes' nor 'No'
- Yes
- Strongly 'Yes'

Circumcision also has other health benefits. Infants have a lessened chance of developing infections of the urine, children and adults do not have problems with the foreskin becoming too tight around the penis, there is a lessened chance of getting infections under the foreskin, and adults have a lessened chance of getting some sexually transmitted diseases.

27. Has this information changed your opinion about supporting your son's circumcision?

Yes _____ No _____

27.1 [If 'Yes'] Would you now support your son's circumcision?

[Give the interviewee the choice of the following options]

- Strongly 'No'
- No
- Neither 'Yes' nor 'No'
- Yes
- Strongly 'Yes'

This is the end of survey for circumcised male respondents.

Express thanks to the respondents for their time and information. Remember to ask them if they have any questions for you. You may need to refer to the briefing you have been given. However, if you do not know the answer to a question, do not be afraid to say so.

2 Survey tool for females

Introduce yourself and what you are doing. For example:

“Thank you for agreeing to help us with our survey. My name is [insert your name]. I work for [insert name of organization]. We are talking to men and women in an effort to find out more about male circumcision. Your contribution will be of great importance to us.

“The interview will last about [insert a tested time for the local language].

“There are no right or wrong answers to the questions; we would just like to learn about your personal thoughts and attitudes. If you don’t understand a question, please tell me, and you can add further information at any stage.

“Your answers will, of course, be kept confidential. Your personal responses will be seen by only a very few of my colleagues and your name will not be used in relation to the answers you give.”

Place of interview _____

Language of interview _____

1. Demographics

1.1 How old are you? _____

1.2 Are you a member of a specific tribe, e.g. [insert group names as appropriate to the country]?

1.3 How many children do you have?
Boys _____ Girls _____

1.4 Where were you born?
Name of place _____
Type of area: Rural _____ Town _____ City _____

1.5 Where are you living now?
Name of place _____
Type of area: Rural _____ Town _____ City _____

1.6 Do you practise a particular religion? Yes _____ No _____
If ‘Yes’, which religion? _____

2. If a man were circumcised, what would you think of him and why?

3. What do you think the benefits of a man being circumcised might be?

[Use response categories if available]

4. What do you think the problems or negative consequences of a man being circumcised might be?

[Use response categories if available]

5. If you have or had a son, would you support his circumcision?

[Give the interviewee the choice of the following options]

- Strongly 'No'
- No
- Neither 'Yes' nor 'No'
- Yes
- Strongly 'Yes'

5.1 What are your reasons for this answer?

[Use response categories if available]

[If 'Strongly 'No' , 'No' or 'Neither 'No' nor 'Yes' ' go to following coloured Box]

5.2 [If 'Yes' or 'Strongly Yes'] When would be the best time for him to be circumcised? I shall read to you several answers and you select the time you think would be best.

[Give the interviewee the choice of the following options]

- At birth or as an infant less than one year old
- When he is a child, perhaps 1–9 years old
- When he is an adolescent (10 through 17 years old)
- At some other time when he is an adult (18 years or older)

(Specify) _____

5.3 Why would he be circumcised at this time?

5.4 What additional times for him to be circumcised would be acceptable to you? I shall read to you several answers and you select the times you think would be acceptable.

[Give the interviewee the choice of the following options]

- At birth or as an infant less than one year old?
- When he is a child, perhaps 1–9 years old?
- At puberty (10-17 years old)?
- At some other time (≥ 18 years old)

(Specify) _____

5.5 Why would he be circumcised at this time?

Tell the respondent that recent studies show that male circumcision reduces the risk of a man becoming infected with HIV. Circumcision is not enough on its own to protect against HIV and circumcised men MUST continue using other forms of protection.

6. Based on this information, would you change the way you think of uncircumcised men?

Yes _____ No _____

6.1 [If 'Yes'] How? (Possible prompt: Such as considering marrying a circumcised man?)

[Use response categories if available]

7. If you have or had a son, would you want him to be circumcised?

[Give the interviewee the choice of the following options]

- Strongly 'No'
- No
- Neither 'Yes' nor 'No'
- Yes
- Strongly 'Yes'

7.1 What are your reasons for this answer?

[Use response categories if available]

[If 'Strongly 'No' ', 'No', 'Neither 'Yes' nor 'No' ' go to coloured Box below]

7.2 [If 'Yes' or strongly 'Yes'] When would be the best time for him to be circumcised?
I shall read to you several answers and you select the time you think would be best.

[Give the interviewee the choice of the following options]

- At birth or as an infant less than one year old
- When he is a child, perhaps 1–9 years old
- When he is an adolescent (10 through 17 years old)
- At some other time when he is an adult (18 years or older)

(Specify) _____

7.3 What additional times for him to be circumcised would be acceptable to you? I shall read to you several answers and you select the times you think would be acceptable.

[Give the interviewee the choice of the following options]

- At birth or as an infant less than one year old
- When he is a child, perhaps 1–9 years old
- When he is an adolescent (10 through 17 years old)
- At some other time when he is an adult (18 years or older)

(Specify) _____

7.4 Why would he be circumcised at this time?

Circumcision also has other health benefits. Infants have a lessened chance of developing infections of the urine, children and adults do not have problems with the foreskin becoming too tight around the penis, there is a lessened chance of getting infections under the foreskin, and adults have a lessened chance of getting some sexually transmitted diseases.

8. Has this information changed your opinion about supporting your son's circumcision?

Yes _____ No _____

8.1 [If 'Yes'] Would you now support your son's circumcision?

[Give the interviewee the choice of the following options]

- Strongly 'No'
- No
- Neither 'Yes' nor 'No'
- Yes
- Strongly 'Yes'

9. Can you estimate the financial cost to your family of a male circumcision?

10. Would this amount have to be...

[Give the interviewee the choice of the following options]

- Saved up for?
- Borrowed?
- Neither, because my family has this money now?

11. If you wanted to encourage an adolescent or an adult man to be circumcised, what would you say to him?

This is the end of the survey for female respondents.

Express thanks to the respondents for their time and information. Remember to ask them if they have any questions for you. You may need to refer to the briefing you have been given. However, if you don't know the answer to a question, do not be afraid to say so.

Annex 2: One-day workshops

Tool objective: To identify the opinions and ideas of those closest to the issues of demand and supply.

Arrange workshops with either of the two groups below or with a mixture of participants.

- **Health facility managers** from both government and nongovernmental facilities in the area, including hospitals, clinics and health posts. The aim of the meeting (given the evidence that male circumcision reduces the risk of HIV infection) is to seek the advice of health workers on how the rate of male circumcision might be increased.
- **Community leaders.** The aim of the meeting (given the evidence that male circumcision reduces the risk of HIV infection) is: first, to increase our understanding of the issue of male circumcision from the point of view of the community and families; second, to seek the advice of community leaders on how best to increase the rate of male circumcision.

1 Hosting the meeting

It may be decided to offer a sitting fee, i.e. a small monetary compensation for a participant's time and effort in attending the workshop. This is more usual for community leaders than for health staff, who are usually already receiving their normal salaries. A sitting fee should only be given at the end of the workshop day, along with the reimbursement of any agreed travel expenses.

The meeting host should provide refreshments and lunch for all participants. This helps to sustain attendees' energy levels and therefore their ability to participate fully in the workshop.

The overall atmosphere of the day should be exciting: something special, interesting and important is happening. Table 12 can be adapted as the agenda for the event, with other topics of local importance being added to yield a full day meeting.

Table 12. Sample agenda

Health workers or community leaders	
15 minutes	Opening and welcome: Explain the aims of the meeting
15 minutes	Presentation on male circumcision and HIV
20 minutes	Questions from the participants
30 minutes	Kick-out and keep
Refreshment break (15 minutes)	
1 hour	SWOT analysis
Lunch (1 hour)	
1 hour	Problem tree analysis
Refreshment break (15 minutes)	
1 hour	Entry point analysis
Summary of results Thanks and closure	

Table 13. Materials required

Event and activity	Materials
Kick-out and keep	Cards (15 cm x 10 cm minimum) for writing on (10 per person, preferably in two different colours) Flipchart paper and stand Marker pens (one per person)
SWOT analysis	Flipchart paper (at least four sheets) Marker pens (one per person) Cards (15 cm x 10 cm minimum, at least four per person) Sticky tack
Problem tree analysis	Flipchart paper (at least eight sheets) Marker pens (at least four)
Entry point analysis	Marker pens

2 Kick-out and keep exercise

This is both an icebreaker and an exercise that can give some early indications of the hopes, fears, expectations and contributions of the participants. This can only be done after the formal introduction and the presentation on male circumcision.

TIP: If there are any concerns about an individual's ability to write, address this by assigning a writer to each subgroup in Option 1, or by asking people to call out their ideas verbally in Option 2. However, written answers are best as they maintain anonymity.

This is a good exercise because it:

- introduces the members of the group to each other and builds their confidence, both in each other and in the facilitator;
- gives a clear insight into the individuals involved – who is shy, who is talkative, etc.;
- can highlight where people might have inner fears or strongly held views about the process or results;
- enables all individuals to contribute, as well as recognizing the group's feelings;
- enables the group to state its needs, which can then be returned to as an indicator of success;
- gives points to which the facilitator can return if anything becomes difficult;
- indicates what might need to change in the agenda;
- creates a listening atmosphere.

Instructions for Option 1

1. Split the participants into groups of three people.
2. Each group should brainstorm answers to the question:
“What feelings do I want to kick out, or keep, about this whole event concerning male circumcision?”
3. Ask them to write down everything that each member of the group says, but make sure there are no repeats within a group – one idea per card. Each group should have two sets of cards: one for ‘keeps’ and one for ‘kick-outs’.

4. Merge pairs of groups together in order to make a number of larger groups, and ask them to develop joint lists with no repeats (and try to group similar ideas together): one for keeps and one for kick-outs. Merge groups together again so that there are now two large groups, and ask them to develop joint lists with no repeats: one for keeps and one for kick-outs.
5. Ask the groups to rank their lists in terms of:
 - the most important things to keep;
 - the most important things to kick out.
6. Use 'voting marks' for this, asking each participant to make a mark with a pen beside his or her three most preferred choices.
7. Get the two groups to present their results.
8. Compare the two lists and their rankings.
9. Draw up two joint lists (one for keeps and one for kick-outs) and rank them, either by combining the numbers already provided or by asking each member of each group to pick her/his most important points on each of the lists: one for keeps and one for kick-outs.
10. Examine any links between the statements made – sometimes two statements are opposites of each other.
11. Conclude with a set of linked ideas that the group want to keep or kick out during the event.

Option 2

- This method can be used if time is very short or the group members are already very confident in the facilitator and each other. This version takes about half an hour.
- Get the whole group to write down things they want to keep (individual ideas on individual pieces of paper).
- Get the whole group to write down things they want to kick out (individual ideas on individual pieces of paper).
- Take the separate piles of 'keeps' and 'kick-outs', read each one out and put them up on a flipchart under the two headings. During the process, remove any repeats and categorize them.
- Get the group to prioritize each list by asking each person to come forward and make a mark with a pen next to her/his three most important issues. Count the marks to establish the most popular ideas.
- Link the results in a set of statements about what the group wants to keep and kick out during the event.

3 SWOT analysis

This exercise allows a facilitator to gain a deeper analysis of issues and then incorporate this into further exercises. The objectives of this exercise are as follows.

- To enable the participants to diagnose strengths and weaknesses and to analyse their influencing factors.
- To identify and analyse obstacles that (from the perspective of the participants) limit action to overcome weaknesses or increase impact.
- To examine TWO issues: the provision of services and the ability to increase demand. This means that two SWOT analyses are required, based on the following questions.

- What are the strengths and weaknesses of the current supply of male circumcision services and what opportunities and threats could influence efforts to increase the provision of such services?
- What are the strengths and weaknesses of current efforts to increase male circumcision through health facilities and what opportunities and threats could influence such efforts?

Steps

1. Draw a 4 x 4 matrix, as below. (In order to have enough writing space, use one sheet of flipchart paper for each box.)

Strengths	Weaknesses
Opportunities	Threats

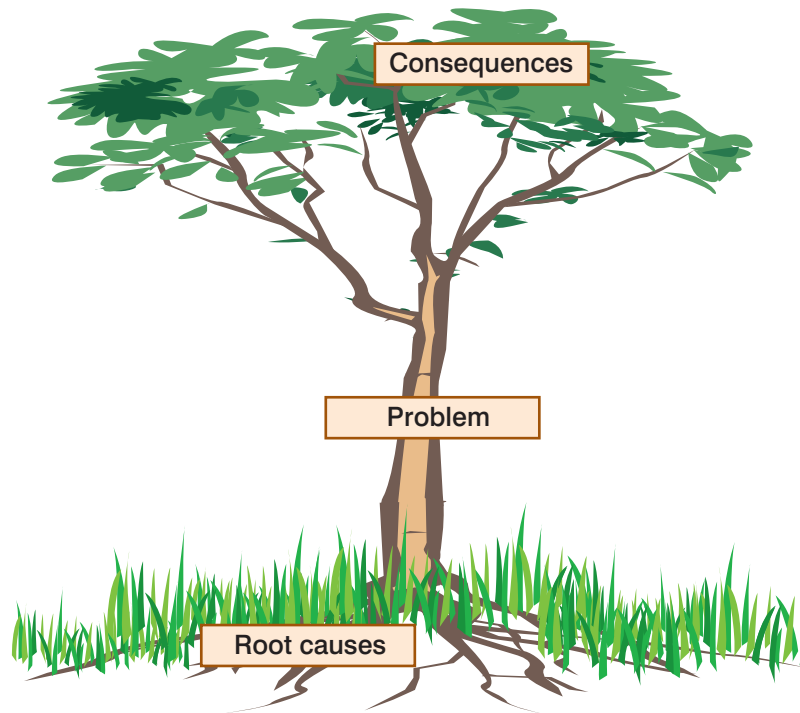
2. Explain to the participants that the SWOT analysis process will fill in these boxes with answers to a particular question. Present one of the two questions from above. Explain that strengths and weaknesses tend to be internal and that opportunities and threats tend to be external, although this does not have to be the case.
3. Ask the participants to **brainstorm** descriptions to go in each box. Stop when the group runs out of ideas.
4. Ensure that answers are **categorized** so that only unique points are listed in the boxes.
5. Issues may appear as both opportunities and threats or as both strengths and weaknesses. The group must decide where they fit best, as the same issue cannot appear twice within the SWOT analysis.
6. Ask the participants to rank the unique points in order of importance in each box. Use voting marks for this, by asking the participants to make a mark with a pen beside the **two** issues they consider the most important.
7. Identify any linkages between the issues in the boxes, such as strengths that could overcome weaknesses, or opportunities that could overcome threats.
8. By identifying linkages (or stories that use components from each box) the group will be able to suggest possible ways forward or things that need to happen as prerequisites for future work.

4 Problem tree analysis

The problem tree analysis helps to:

- analyse the root causes of a problem;
 - identify the primary consequences of a problem.
1. Present and explain the problem tree to the participants. Point out the different parts of the tree and what each represents.
 - Roots = the root causes of the problem
 - Trunk = the problem
 - Branches = the consequences of the problem

Fig. 6. Example of a problem tree



2. Split the participants into four groups.
3. Ask each group to draw a problem tree, using the top two weaknesses and threats from the SWOT analysis as problems. Allow 30 minutes for this.
 - The participants must list the root causes of the problem and write these responses among the roots of the problem tree.
 - They must name the consequences of the problem and write these responses among the branches of the problem tree.
4. After the end of the period, ask the groups to display their problem trees. Then invite the participants to take a 'walk through the forest' by grouping around each of the trees in turn while a team member presents it.
5. Draw everyone back into a plenary and explain that, while it is often said that it is best to treat the cause of a problem rather than the consequences, it does not mean that the consequences should be ignored. For example, if people are starving they need food first and the causes can be addressed later.
6. TIPS:
 - Make sure that each problem to be analysed is clearly understood.
 - If time is short, construct problem trees for only the most serious problems or prepare blank tree diagrams in advance.
 - More than the top two weaknesses and threats can be used as problems if time allows.

5 Analysis of results

The results of each individual workshop and its exercises should be obvious to the participants and should be typed up as soon as possible after each event. Notes that seem clear on the day become meaningless when a few days have elapsed.

The following instructions are for an analysis of all the results from either the community leaders' workshop or the health workers' workshop. This analysis of results could be carried out for a particular region (for example). If so, use the same instructions but on a different grouping of results, e.g. by geographical area. The chosen sampling approach will determine which factor is most relevant for the grouping of data.

Kick-out and keep. Ignore all results that relate directly to the event itself, e.g. "I don't want the meeting to be too long". Carry out a frequency tally of all the other results. This will give an idea of preconceptions, fears and hopes around the issue of male circumcision, among either health workers or community leaders.

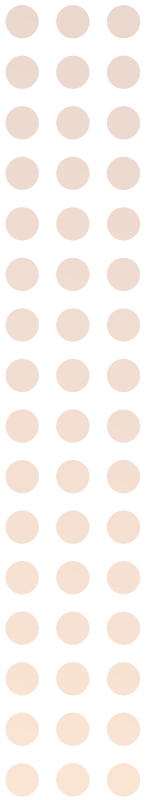
A combined SWOT analysis. Compile a list of all the strengths from each workshop and rank them by frequency of occurrence (using categorization to combine similar strengths into one). Do the same in separate lists for weaknesses, opportunities and threats so as to create the combined SWOT analysis.

In each section of the SWOT, look at the ranking totals and decide how many items to include in a summary. Some items will have higher frequencies and there should be a cut-off point below which items have significantly lower frequencies. The data will indicate where the boundary is between the significant and less significant issues.

Now review the SWOT in the same way as in the workshop and identify key linkages and issues that any intervention would need to address.

Combined problem tree analyses. Compile a list of all the problems analysed with the trees and rank them by frequency of occurrence (using categorization where appropriate). This will give an indication of the importance of certain problems to those closest to the point of intervention.

If any trees address the same problem, merge the results from them and do a frequency tally of the causes and consequences. Draw a combined problem tree showing the combined results for each problem. This should give an overview of the perceived causes and consequences of the priority problems.



Annex 3: A short guide to facilitation

TIP: Discussion of male circumcision will require the use of terms and ideas that might not usually be spoken about. It will be important to find a balance between overcoming taboos and mistakenly creating a shocked environment that closes down discussion.

The facilitator has several responsibilities regarding the group's movement through the workshop. The facilitator should:

- ensure that the group understands the process and completes each step on time;
- not allow short cuts, e.g. the discussion of solutions before problem investigation;
- document or arrange documentation of the results of each step;
- keep the group focused on steps and the overall objective.

1 Handling emotions

The subject of male circumcision is likely to lead to the emergence of emotions of some sort during the discussion. Individuals may feel a range of emotions relating to the issue: from revulsion to relief; from fear to pride; from embarrassment to support. Some (but not all) of these emotions may relate to a lack of accurate information about male circumcision. Try to put yourself in the place of the participants: for example, what might a male participant be feeling about his own circumcision status? Or what might the wife of an uncircumcised man be feeling?

TIP: Plan to make a statement that addresses the personal side of the circumcision discussion without embarrassing individuals in the room:

- “We recognize that male circumcision issues require a discussion of matters not normally discussed openly ...”
- “We recognize that male circumcision is a very personal issue but we would like to focus on how it relates to society and health provision in general ...”

2 Desirable facilitation skills

Three of the most important skills of a facilitator are the abilities to:

- ask questions;
- listen;
- objectively summarize and synthesize discussion.

Wherever possible a note-taker should work in conjunction with a facilitator, because facilitators are most effective when they can focus all their attention on facilitating the group.

The main attribute that a facilitator must have is openness to all opinions. Thus the facilitator must value the opinions of all participants, create opportunities for all participants to speak (and, conversely, not allow one person to dominate), and lead the group in shared decision-making or summarizing (while allowing dissenting views to be heard).

In many instances a group can achieve far more than an individual. If the membership of the group is appropriate and the group is facilitated well, the synergy equation comes into force, i.e. $1 + 1 + 1 = 5$, because the diverse views and capabilities that multiple individuals bring to a group exceed those of any one individual. The facilitator's task is to create synergy through the use of facilitation tools, from problem trees to energy balancing and group formation techniques.

It is important to be patient, to tolerate ambiguity and to develop a sense of timing of when to push for more ideas, more information and more participation, and, just as importantly, when not to do so.

Checklist of desirable facilitating behaviours	
<input type="checkbox"/> Planning for the activity	<input type="checkbox"/> Recording outputs of the meeting and capturing documentation
<input type="checkbox"/> Knowing how to ask questions	<input type="checkbox"/> Clarifying, sharing and disseminating information
<input type="checkbox"/> Being an active listener	<input type="checkbox"/> Maintaining the focus and the timetable
<input type="checkbox"/> Knowing how to use a flipchart	<input type="checkbox"/> Giving verbal and written feedback
<input type="checkbox"/> Remaining neutral on content issues	<input type="checkbox"/> Communicating thoughts and feelings clearly
<input type="checkbox"/> Encouraging open communication	<input type="checkbox"/> Developing a culture of the group's ability to work together
<input type="checkbox"/> Encouraging problem-solving	<input type="checkbox"/> Obtaining technical expertise for the group
<input type="checkbox"/> Knowing how to lead by using group problem-solving tools	<input type="checkbox"/> Tolerating and smoothing conflict
<input type="checkbox"/> Encouraging team decision-making	

Source: Adapted from Hackett D, Martin CL. *Facilitation skills for team leaders*. Menlo Park: Crisp Publications Inc.; 1993 (ISBN 1-56052-199-6).

TIP: For information on the role of the facilitator in group decision-making, see the following publications.

Kaner S. *Facilitator's guide to participatory decision-making*. Gabriola Island: New Society Publishers; 1996 (ISBN 0-86571-347-2).

Justice T, Jamieson DW. *The facilitator's fieldbook*. HRD Press Inc.; 1999 (ISBN 0-8144-7038-6).

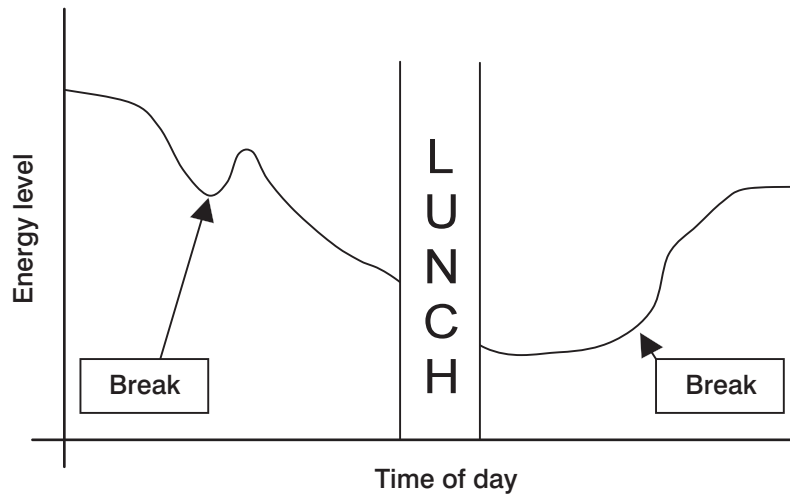
3 The energy to go forward

Low-energy participants cannot and do not participate (they are almost asleep) and high-energy participants can dominate. It is possible for a facilitator to watch for the signs of people's energy levels. The energy level is indicated by the tone and animation of the voice, body posture, eye contact, attentiveness, level of participation and level of activity directed towards a task. Are people awake or asleep? Engaged or disengaged? It is important to be able to move the energy level from low to high or vice versa, as required. This is the role of the facilitator in workshops and the role of the chairperson in meetings.

TIP: Sometimes it is necessary to have a figurehead leader of an event, but if this person is not good at getting the energy level of the meeting right, use a facilitator for the actual work.

At the beginning of a day, people often have abundant energy; after lunch they are very often low in energy. Short breaks or active exercises can help to keep energy levels up for longer sessions.

Fig. 7. Participant energy levels during a day



TIP: Prepare some energizing exercises. These can be physical exercises that wake people up by moving them around, getting more oxygen into their lungs, and creating noise and laughter.

4 The facilitation mindset

If the facilitation process is approached with the wrong mindset the situation analysis will fail: at worst it will only say what people want to hear, and at best it will fail to produce any results.

Understanding that we don't know everything

It can take a lifetime for an expert to recognize that he/she often knows very little. This very quick exercise can help to remind a facilitator that prioritizing people's knowledge and understanding is very important in a situation analysis. Remember: humility in the presence of experience.

Below are nine questions. Try to answer them – keep going to the end and then look at the answers at the end of this chapter. To get all of them correct is very unusual; situation analysis facilitators should not be surprised at how many they get wrong!

1. In a village in an irrigated area in Gujarat state, India, a line of tamarind trees between a dirt road and the fields was being cut down. Why?
2. In Sulawesi, Indonesia, five groups of livestock extension staff and villagers did a matrix scoring exercise by comparing the characteristics of different types of domestic animals: ducks, hens, buffalo, goats, horses and cattle. They then ranked the characteristics for importance to the villagers. One characteristic of great importance to the villagers was not thought of by any of the extension staff. What was it?
3. A mother in Norway did a matrix scoring exercise for the different foods she gave her children, aged 1 and 3 years. She had one criterion that some people would never have thought of but which other mothers might share. What was it?
4. Maasai herdsmen in Tanzania did matrix scoring for different sources of fodder for their cattle. They compared for one characteristic that few non-pastoralists would ever think of. What was it?
5. In a participatory poverty assessment in Bangladesh, very poor urban women listed and ranked 'do-ables' – changes they felt were feasible and would make their lives better. The first was water. What were the second and third?
6. What did villagers in Bolivia give as their priority when asked how their environment could be improved?
7. In a village in Karnataka State, India, goats had half a coconut shell tied round their necks. Why?

8. When street lighting was installed in Anantapur, a city in India, women in one area were pleased but in another area they threw stones and broke the lights. Why?
9. How was this sentence completed in a report from Ndola, Zambia: 'The poorest depend on...'?

[For answers, see Section 10.]

Source: Adapted from Chambers R. *Participatory workshops: a sourcebook of 21 sets of ideas and activities*. London: Earthscan Publications Limited; 2002 (ISBN 1-85383-863-2).

5 Managing structure, not content

Because the facilitator is centre stage in the group, he/she can bias the team, either intentionally or unintentionally. Thus, the facilitator must manage the meeting **structure** (e.g. timetable, process) while remaining neutral regarding the meeting **content** (e.g. agenda, presentations, ideas).

This position of neutrality must be understood and practised by the facilitator in order for the group to reach its full potential. It is necessary to understand which issues the facilitator can deal with (structure) and which they should not get involved with (content). It can be difficult to distinguish between structure and content and the following quiz is a useful way to practise.

Quiz: Structure or content?

Check understanding of the difference between structure and content with this quiz. Determine whether the activity is part of *structure* or *content*. Place a check mark in the appropriate column.

Activity	Content	Structure
1. Development and distribution of an agenda for a meeting and preparation of a room		
2. Statements of meeting objectives		
3. Discussion involving clarification of situation analysis objective		
4. Cost information on the situation analysis process		
5. Presentation of results of the situation analysis		
6. Splitting into groups to discuss possible ways forward		
7. A brainstorming session to develop ideas		
8. A free-flowing discussion of male circumcision resulting from facilitator questions		
9. Use of a flowchart to describe an intervention process developed by the group		
10. Presentation of existing understanding of male circumcision by a WHO Representative		
11. A designated individual recording a group's discussion points on a flipchart		
12. Report detailing the expected cost of the programme		
13. Summarizing and clarifying decisions		
14. A recommendation made by the meeting for future action		

[For answers, see Section 10.]

Source: Adapted from Hackett D, Martin CL. *Facilitation skills for team leaders*. Menlo Park: Crisp Publications Inc.; 1993 (ISBN 1-56052-199-6).

6 How to ask non-threatening questions

- **When starting a session, ask questions of all the participants together, e.g. “What are the possible reasons for an individual not being circumcised?”**

Pause and allow them time to consider the question. Do not become anxious if a question does not bring an immediate response. Relax, the group is thinking.

If a participant responds, acknowledge the response and explore it further if possible or necessary. For example:

Participant: “One reason might be because their parents did not get it done when they were a baby.”

Facilitator: “OK... and why would parents not get it done then?”

If no one responds in a reasonable amount of time, look for non-verbal signals from a participant who wants to be involved, e.g. eye contact, leaning forward, a raised eyebrow. Go to that person directly.

If no one responds to a question, consider rewording it or asking if it needs clarification: “So, what factors do you think might affect their decision?”

Repeat or rephrase questions that develop through discussion in order to dig deeper into the subject matter and obtain more answers.

6.1 Avoid biased questions

- **Example: “Is the problem caused by fear of pain and the cost of the operation?”** Answers will be biased if a question is asked in this way. The problem may be caused by many factors and the varied opinions of the group are needed, not simply their responses to a closed question that prompts them to think only about pain and cost.
- **Example: “What might be causing the problem?”** This question assumes that there is a problem but there may not be one. People may avoid male circumcision for their own reasons and may not perceive that there is any problem at all. They may be confused by the question or become defensive.
- **Example: “Why would parents not get their male child circumcised as a baby?”** An alternative would be “Did everyone understand the question? Fred commented that one reason that men are not circumcised is that their parents did not get it done when they were babies. Surely this is true for all men who are not circumcised! Why might parents not circumcise their male children?”
- **Avoid closed questions with ‘Yes/No’ answers, which limit discussion.**
- **Avoid questions that may put team members on the defensive.** Example: “Why are you not circumcised?”
- **Avoid singling people out too much with direct questions.** This can help at certain times but can quickly become counter-productive.

6.2 Types of questions to ask

6.2.1 Open-ended questions

An open-ended question cannot be answered with a single word or phrase such as ‘Yes’ or ‘No’ (the opposite is a ‘closed-ended’ or ‘closed’ question). Open-ended questions are powerful because they stimulate thinking and encourage discussion. For example:

- What does the rest of the group feel about this idea?
- How will this solution affect your organizations?
- What ways are there to evaluate this idea?
- What are some of the observations on these three potential causes?
- What can be done to eliminate this type of mistake?
- What will happen if this problem is not solved?
- Why might this solution fail?
- Why are there problems with delivering this service?

6.2.2 Greater response questions

An adaptation of the open-ended question is the 'greater response' question. In order to gain understanding and add depth to the group's involvement, a facilitator needs to know how to use three words to draw out greater information: 'describe', 'tell' and 'explain'. For example:

- Can you describe how a typical request for male circumcision is dealt with in this facility?
- Could you tell us more about staff reaction to the idea of increasing male circumcision rates?
- Would you please explain how the out-of-pocket cost to a patient for male circumcision is calculated?

6.2.3 Redirection questions

Individuals will often ask questions of a facilitator. It is important to remember that the facilitator should be neutral in terms of the content of the meeting (that is, not taking one side of an argument or another) but should be active in building and protecting the structure of the meeting.

If a question relates to structure, answer it. However, if the question relates to content, consider redirecting it to another participant. For example, a participant might ask: "Why do you think male circumcision is a good idea?" The facilitator might respond by appropriately redirecting the question in one of the following ways.

- What does the group think are positive reasons?
- That relates to what our first presenter said. Doctor, what are your thoughts?
- That question needs to be answered by someone experienced in that area. Can I refer you to the document you have in front of you?

6.2.4 Feedback and clarification questions

At certain times in meetings the facilitator needs to bring closure or clarification to a topic being discussed. At this point, it is important that all participants understand the issues that have been discussed concerning the topic. At such times, clarification and feedback questions are appropriate. For example:

- Let's see. If I heard you right, you are saying...?
- Where are we? Will someone summarize our position?
- Who can paraphrase our position regarding a way forward?

Quiz: The question match game

Test your grasp of the various types of questions that a skilled facilitator might use by matching the examples in the left-hand column below with the correct question types from the right-hand column.

Examples of questions	Question types
1. Why do you believe delivery will take three weeks?	A. Redirection
2. Three weeks?	B. Open-ended
3. I can't answer that. Phil, perhaps you could help us?	C. Clarification or feedback
4. Okay, what are the potential problem areas we have identified so far today?	D. Greater response
5. Thanks for your suggestion. Would that alternative offer additional benefits? And would those benefits be cost-efficient?	E. Chain-of-questions technique

[For answers, see Section 10.]

Source: Hackett D, Martin CL. *Facilitation skills for team leaders*. Menlo Park: Crisp Publications Inc.; 1993 (ISBN 1-56052-199-6).

7 Listening

Listening is a skill and a way of being with people. Listening can be powerful in encouraging other persons to speak and respecting what they say. The listener should listen actively for the key points in what is being said.

Listening is a primary skill of facilitation. The facilitator's quality of listening will affect the participants. Listening should be active, focused and affirming: listen for the voice of a whole group or part of a group, or for individuals. Hear where the group or an individual has been, where they are going and how they are feeling. Listen for purpose, programmes and commitments. Listen to spoken and unspoken conversation.

TIP: Participants can be energized by showing them that they are being listened to and that what is being expressed is of value.

8 Handling difficult situations

How to deal with...

Here are a few comments that less experienced and less effective facilitators might make. What might a more experienced, effective facilitator say instead?

1. "What should we talk about in our meeting today?"
2. "Here's how I think we should solve this problem."
3. "Rita, that idea makes no sense at all. You'll have to do better than that."
4. "Great idea, Fred. That's obviously the best solution offered today!"
5. "Okay, it's time to vote. Who is in favour of Rita's proposed solution? Who prefers Fred's?"
6. "We tried that approach two years ago and it didn't work."
7. "We have listed eight possible solutions. Which is the worst idea we can safely eliminate from further consideration?"
8. "No Bob, we can't discuss that. It's not relevant to the issue at hand."

[For suggested alternatives, see Section 10.]

Source: Hackett D, Martin CL. *Facilitation skills for team leaders*. Menlo Park: Crisp Publications Inc.; 1993 (ISBN 1-56052-199-6).

Whether one is facilitating a workshop, running a focus group, chairing a high-level meeting or leading a feedback discussion, difficult situations may arise. This may happen because of some of the following issues.

- **Over-ambitious schedule**

The participants may express a desire to slow down or the facilitator may feel that they must rush to complete the planned exercises. Whether a facilitator gets through a specific timetable often depends more on the nature of the group and the conditions in which they are working than on the timetable itself.

It is best to complete individual parts of the agenda in full, working forwards through the agenda, rather than rushing through everything partially. If it is not possible to complete the agenda it is better to complete the parts that are addressed and to ensure that the group understands them (rather than no one having a clear understanding of anything).

If a group appears to be moving very slowly, do not chastise them but discuss with them which sessions can be removed from the end of the agenda in order to allow time to complete the earlier sessions.

If the participants have moved through the agenda and have achieved all the work, there is no reason why the session should not finish early. This does not happen very often!

TIP: If participants express a desire to speed things up or slow them down, this may be an indicator of some other issue, such as boredom, the room being too hot, people having sat still too long, or even disagreement with a vocal member of the group.

- **Unexpected results**

It may be necessary to respond to unexpected issues that arise, or planned exercises may be deemed unnecessary in the light of workshop results. This requires facilitators to be both flexible and determined, to have both new ideas and new ways of working available to them, and to be able to argue that a planned structure should remain.

- **Team changes**

When splitting participants into smaller groups, watch carefully in case the membership of a group needs to be changed because of absences, personal conflicts or differences in participants' knowledge or experience.

- **Conflict**

Conflict in groups is normal and inevitable. It can range from mild disagreement to angry outbursts. It can be prevented by attending to group maintenance issues such as ground rules, decision-making processes and record-keeping. When it occurs it is best handled by attending to it at once. Working through and resolving conflict calls for sensitive and creative facilitation.

- **Sabotage**

Sabotage occurs when a group is unable to make a decision or is dominated by an individual or a small subgroup, or when the members of the group fail to listen to the facilitator or each other and are thus finding tasks difficult to complete. Sabotage is any behaviour in the group that slows down or speeds up progress without consensus, thereby causing dissatisfaction in the group.

Sabotage takes the synergy out of the group by undermining its ability to fulfil its purpose. Even though this may be obvious to the facilitator, such behaviour is rarely recognized by individuals who are sabotaging a group. Do not take this behaviour personally. It is often connected with one or more group members behaving as they always do to get what they want, or else they are actually exhibiting fear or distress at the process and results of group work. They may be cynical, domineering or repetitive.

Soon after this behaviour is first noticed it is useful for the facilitator to initiate a discussion on sabotage and how it shows up in a group. Each individual has his or her ways of sabotaging. Facilitators should be aware of their own sabotage patterns and how they may sabotage groups they are facilitating. When facilitators get to know their own patterns they are better able to defuse them.

- **Blame and scapegoating**

Scapegoating occurs when one person or issue is consistently blamed for things going wrong. People working hard under difficult circumstances often seek to attach blame to someone or something. Even though there may well be a particular issue that does have a big impact (for example, institutional poverty), scapegoating is a way of avoiding responsibility for making a change.

The facilitator needs to interrupt blaming and scapegoating as soon as it occurs. With scapegoating (an accumulation of blame that has not been attended to), there is always a history (a number of incidents over time) and this needs to be explored and worked through with the group. Usually, scapegoating is a cover-up for widespread feelings of inadequacy and powerlessness in the group. It may take some careful digging and encouragement to get through to the underlying issues.

In the specific case of the tools in this kit it is more likely that an issue will be scapegoated than an individual. The facilitator will need to make a judgement about the validity of the issue and encourage the group to think past the problem in order to get to deeper detail.

- **Group factions**

Factions can be produced by, for example, a fear of speaking out in front of management-level staff or by one group not accepting or understanding another group (perhaps nurses and doctors). This is the most likely problem to be faced during the situation analysis and the facilitator needs to make efforts to overcome it. This can be done by: first, giving space for the two sides to express themselves; second, encouraging the two sides to acknowledge things that they agree on; third, placing members of both sides in groups to work together on a particular issue.

9 Challenging the group

Sometimes it is useful for a facilitator to draw a group's attention to what is happening within the group or event. Possible situations are indicated below.

- Underlying conflict is coming to the surface as indirect attacks.
- The energy is low (and this is indicated through people holding back).
- Scapegoating is occurring. The group keeps getting off track and is lacking intention.
- The group is bogged down in detail and has lost sight of the vision.
- The group seems to lack commitment to reaching agreement.

The facilitator may first respond by drawing attention to what is happening, encouraging the group to be conscious of it, and restating the purpose of the event.

The facilitator may need to:

- call a short break;
- ask people to stand up and stretch;
- create buzz groups where people share in pairs;
- have a round of acknowledgements;
- introduce a trust-building exercise.

10 Quiz answers

Understanding that we don't know everything

1. Monkeys roosting in the trees ate crops. Dense branching in the tamarind trees thwarted those who tried to drive the monkeys away by throwing stones or shooting with catapults.
2. Causing trouble with neighbours. As a result, goats had been banned from the village.
3. The degree to which it would send the child to sleep. The top scorers for this were mother's milk and gruel, each with five out of five.
4. The degree to which the fodder would precipitate estrus (coming into heat) in cows.
5. The second priority was 'places where they could wash', and the third was 'that measures should be taken about dowry'.
6. They could think of no improvement!
7. The half coconut shells were tied over their muzzles when necessary to stop them eating crops they were passing through (source: Anindo Banerjee).
8. The women who threw stones had no toilets and had to defecate in the open during the hours of darkness.
9. '...funerals'. The area had a high death rate (particularly AIDS-related) and nearly every day there was a funeral. The poorest people attended every funeral and moved from one to another so that they could get some food to eat. (From the field notes of Mary Simasuku in Shah et al., 1999, p. 48.)

Structure or content?

Issues 2, 3, 4, 5, 10, 12 and 14 are content issues. The others pertain to structure.

The question match game

1) B; 2) D; 3) A; 4) C; 5) E.

How to deal with...

1. Instead of: "What should we talk about in our meeting today?", consider...
"Did everyone get a copy of today's meeting agenda that I distributed last week?"
2. Instead of: "Here's how I think we should solve this problem...", consider...
"Now that we have reached agreement as to what the problem is, what are some possible solutions?"
3. Instead of: "Rita, that idea makes no sense at all. You'll have to do better than that", consider...
"I'm sorry Rita, but I don't understand your point. Could you explain it again, please?"
4. Instead of: "Great idea, Fred. That is obviously the best solution offered today!", consider...
"Thanks for your input, Fred. Would anyone care to comment on this proposal?"
5. Instead of: "Okay, it's time to vote. Who is in favour of Rita's proposed solution? Who prefers Fred's?" consider...
"We have discussed the merits of both Rita's and Fred's proposals. Is there any way we might be able to combine the advantages of both ideas?"
6. Instead of: "We tried that approach two years ago and it didn't work", consider...
"Let me write that approach on the flipchart. Are there any other possibilities we might add to the list?"
7. Instead of: "We have listed eight possible solutions. Which is the worst idea we can safely eliminate from further consideration?", consider...
"We have listed eight possible solutions. Unless someone has a ninth option, please list on separate sheets of paper the four solutions you think would be the most viable. We will then discuss the top choices in greater detail."
8. Instead of: "No Bob, we can't discuss that. It's not relevant to the issue at hand", consider...
"I see your point Bob, but could you hold that thought until next week when we are scheduled to address that issue?"

Annex 4: References for further information

1 HIV and male circumcision

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Annex 5: Approaching questioning

There are a number of approaches to the act of questioning, and different types of questions produce different types of answers. For example, closed-ended questions (where a specific choice of responses is provided) can be used to get demographic information, and open-ended questions lead to rich and informative explanations that do not easily lend themselves to quantification.

The type of question to be used depends on what information is already known, the information required and the cultural circumstances under which the question is asked. Toolkit users may want to adapt questions in order to take these factors into consideration.

For further information on a range of question-related issues, see the Communication Initiative website (<http://www.comminit.com>).

1 Structured, open-ended interviews

Open-ended interviews are not practical if responses from large numbers of participants are needed (e.g. when generalizations are made for a population) or if a practitioner wishes to report percentages or categories. The process of interviewing everyone would take too long and open-ended responses are difficult to summarize.

1. There are five issues to consider for a successful open-ended interview. Avoid bending over a notebook all the time the interviewee is speaking. Look up, smile, nod and show a keen interest, even while attempting to write down what is being said.
2. Expressions of agreement are not required, but express interest and respect for the ideas received and for the person giving them. Make lots of eye contact; smiling is also effective. Do not judge the answers in any way but try to get as much detail as possible.
3. Keep a close watch on the time and use follow-up questions throughout the process (not only at the end of the interview if there is time to fill).
4. Write up the results of each interview straight away and not at the end of the day. At least half an hour of free time between interviews will be required to do this.
5. Be very careful not to quote other people who have already been interviewed.

For further information, see: Monroe MC. Evaluation's friendly voice: the structured open-ended interview. *Applied Environmental Education and Communication* 2001; preview issue (http://www.aeec.org/preview/research_mcm.asp, accessed 27 February 2007).

2 Strategic questioning

Strategic questioning is a method of asking questions that will make a difference. Shaping a strategic question involves the following key features.

A strategic question avoids 'Why'. Most 'Why' questions force the respondent to defend an existing decision or rationalize the present. 'Why' questions can create resistance to change.

A strategic question avoids 'Yes' or 'No' answers because these leave the respondent in an uncreative and passive state.

A strategic question empowers. When asking someone in India "What would you like to do to clean up your river?", confidence is expressed that the interviewee can contribute to designing the clean-up process.

A strategic question asks unaskable questions. For every individual, group or society, some questions are taboo. A strategic question often challenges the values that an issue rests upon. Asking taboo questions in a neutral way can be a great service to anyone with an issue on which they are 'stuck'.

For further information, see: Peavey F. Strategic questioning: an approach to creating personal and social change. *In Context* 40:36 (<http://www.context.org/ICLIB/IC40/Peavey.htm>, accessed 27 February 2007).

3 Good and bad survey questions

Toolkit users may want to change the way questions in some of the tools are worded to fit their particular country situation. There is plenty of information available on the Internet to support question development. Successful questions must be:

- useful (they must produce the required information in a usable form);
- clear;
 - Do not allow more than one idea per question. Respondents will be confused if they have to consider multiple answers in response one question and the results will be difficult to analyse.
 - Use language that the respondent will understand.
 - Ask specific questions including easily understood terms that all respondents will measure in the same way. For example, do not ask if someone is 'interested in something', as it is not clear what 'interested' means.
- tested (test both the questions and the data analysis);
- unbiased (do not ask leading questions or use emotive language).

For guidance on getting survey questions right, see: Galloway B. *Quantitative Research Guide*. The Sociology Department, Colorado College; 2003 (<http://faculty1.coloradocollege.edu/~mduncombe/Statistics/quanhome/Surveyres/goodq.htm>, accessed 27 February 2007).

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