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Organization**

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a guide
to enhancing
the safety
and quality
of services

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ACRONYMS


AIDS	acquired immunodeficiency syndrome
HIV	human immunodeficiency virus
USAID	United States Agency for International Development
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

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It was estimated in 2007 that 33 million people were living with the human immunodeficiency virus (HIV) and that 2.7 million became newly infected with the virus by the end of that year.¹ Discovering ways to prevent transmission of the virus is of primary concern to health care authorities worldwide. Auspiciously, male circumcision has been identified as a means of decreasing the transmission of HIV infection. In 2005 the South Africa Orange Farm Intervention Trial demonstrated a reduction of at least 60% in HIV infection among men who were circumcised.² Two trials in Kenya and Uganda were discontinued in December 2006 because of clear findings that circumcision reduced HIV transmission.^{3 4} As a result, WHO and UNAIDS convened an international consultation in March 2007 to review the results of these trials, discuss the policy and programme implications, and make public health recommendations. Eleven recommendations were made, among them the following.

- Countries should ensure that male circumcision is provided with full adherence to medical ethics and human rights principles. Informed consent, confidentiality and absence of coercion should be assured.
- 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.
- Male circumcision should not be delivered in isolation but as part of a recommended minimum package which includes information about the risks and benefits of the procedure, counselling about the need to adopt and maintain safer sexual practices, access to HIV counselling and testing, condom promotion and provision, and the management of sexually transmitted infections.
- Careful monitoring and evaluation of male circumcision service delivery should include consideration of possible untoward effects such as increases in unsafe sex and increases in sexual violence, and should be undertaken to ensure that programmes promoting male circumcision for HIV prevention meet their desired objectives.

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- Training and certification of providers should be rapidly implemented to increase the safety and quality of services in the public and private sectors.
 - Supervision systems for quality assurance should be established along with referral systems for the management of adverse events and complications.⁵

Male circumcision can be a relatively simple and safe procedure. However; studies have shown that serious adverse events can occur when circumcisions are poorly managed.⁶ Shortages of instruments, supplies and well-trained staff dramatically affect the outcomes of these procedures.^{7 8 9 10} Consequently, WHO is working with countries to provide technical guidance supporting the implementation of safe and effective male circumcision services.¹¹ Key strategies for providing safe procedures and minimizing the risks of complications involve developing and implementing standards, ensuring provider competence, and monitoring and improving the quality and safety of care.

This Guide has been developed to assist national and district programme and health facility managers and providers to establish and implement male circumcision services that meet an internationally agreed level of safety and quality.


It provides programme managers with information aimed at helping them to fulfil their roles and responsibilities in organizing male circumcision services that are safe and effective. It can be used to support the establishment of services in various circumstances, e.g. health centres, hospitals, mobile units, temporary sites or when a centre of excellence is being created.

The Guide is complemented by the Male Circumcision Services Quality Assessment Tool Kit, a practical set of tools for assisting facility managers and providers to assess their own performance and the quality of care provided and to define gaps that exist in the provision of male circumcision services. The tools also can be used by national and district managers to conduct external assessments of facilities.

Structure of the Guide

This Guide is divided into two sections.

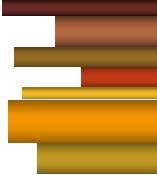
Section 1 outlines the roles and responsibilities of national and district programme managers for implementing safe male circumcision services of good quality and provides guidance for the planning of a national quality assurance programme. Ten standards are outlined that define the requirements to be met by all facilities providing male circumcision services. These standards should be reviewed and adapted or adopted at national level. Statements of intent explain the purposes of the standards and provide guidance on adapting them as required. A recommended minimum package of services is defined to emphasize that male circumcision for HIV prevention should not be focused on the surgical procedure alone. Broad guidelines for the monitoring and evaluation of national quality assurance programmes are outlined, including the use of quality assurance methodologies, e.g. accreditation. Quality assessment and improvement



programmes are provided as case studies to give programme managers practical examples for further guidance.

Section 1 also provides clear guidance on methodologies for assessing the competence of male circumcision providers. The use of non-physician providers is recommended as a way of increasing the availability of services. The Guide defines the broad competences, including attitudes, knowledge and skills, that providers need to acquire regardless of their level or category.

Section 2 provides guidance for facility managers and staff on improving the quality of male circumcision services at facility level. While the Guide focuses on activities for enhancing the quality of these services, the methods proposed can be used in all areas of health care delivery, and the skills that managers and providers gain can be used to improve the quality of other services. Information is provided to assist facility managers in establishing quality improvement teams, and five steps for performance and quality improvement are outlined. The advantages and disadvantages of different quality improvement approaches described in Sections 1 and 2 are outlined in this section.

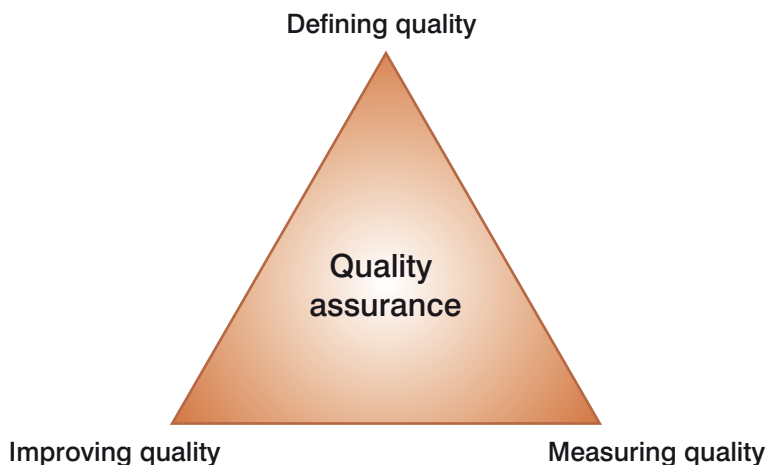


Defining quality assurance

Quality assurance is the assessment or measurement of the quality of care and services and the implementation of any necessary changes to either maintain or improve the quality of care rendered. Quality assurance has also been defined as a systematic process for closing the gap between actual performance and desirable outcomes.¹

The quality assurance triangle in Fig. 1 shows three key activities of quality assurance: defining, measuring and improving quality.¹² The quality of male circumcision services can be defined through the development and communication of standards. Quality can then be measured by determining whether the standards are being met. Various methods can be used to measure quality, e.g. self-assessment, peer assessment and external assessment. Finally, quality improvement methodology can be used to continuously improve the quality of male circumcision care and services.

Figure 1. Quality assurance triangle



1 Ruelas E, Frenk J. Presentation at the International Society for Health Care Conference, Mexico City, Mexico, 1992.

Guidance for national and district programme managers

SECTION 1

National and district government roles and responsibilities

National, district and health facility managers, service providers and the community have different roles and responsibilities in promoting safe care and services of good quality. The development of policy and strategy occurs at the national and district levels, where decision-makers are mainly concerned with keeping performance under review and developing strategies for improving quality outcomes which apply across the whole health system.¹³ This includes setting the standards and guidelines for services. It is important to recognize the connections between the different roles and responsibilities. Decision-makers at the national and district level need to properly engage health-service providers, communities and service users in order to implement new strategies for quality. Health-service providers should operate in an appropriate policy environment for quality and with an understanding of the needs and expectations of those they serve. Communities and service users need to influence both quality policy and the way in which health services are provided.

One of the key stewardship roles of national and district governments is to contribute to the sustainability of interventions for quality services. Governments that support the implementation of male circumcision services should consider how to configure them within current programmes, e.g. comprehensive HIV prevention programming, sexual and reproductive health services and minor surgical outpatient services. Responsibility within a programme at the national level needs to be clearly identified. Financial and human resource constraints mean that national and district governments have to set budgetary priorities. Costs and resources have to be anticipated and secured so as to ensure equity in access and quality of services for all potential clients. National and district governments are responsible for policy development, strategic planning, oversight and developing male circumcision service standards. Further guidance on these roles is given in *Operational guidance for scaling up male circumcision services for HIV prevention*.¹⁴

Strategic planning

The quality improvement strategy should be an integral part of a scale-up strategy for a national male circumcision programme. A situation analysis is an essential first element allowing the current status of male circumcision activities in-country to be determined and the way forward to be mapped. Assessment of the readiness of the health system is part of a situation analysis. On the basis of the findings of this assessment a quality improvement strategy can be developed. The *WHO situation analysis toolkit* provides practical guidance on conducting a situation analysis. A quality improvement strategy should contain the following main elements: aims derived from health and HIV prevention programme goals and guiding principles; selected interventions which are most likely to deliver the desired results; and a detailed plan to manage implementation. The strategy should be based on the situation related to current capacity (including available facilities, equipment, supplies and human resources), quality assessment and improvement processes, reporting mechanisms, clinical guidelines, plans for the management of complications, referral systems, measurable targets (indicators) and cost analyses. A budget has to be developed that considers the costs of training and quality improvement interventions. Various options for the implementation of quality male circumcision services need to be considered. Learning from other country experiences can assist countries to make well-founded decisions (Annex A).

Establishing a planning committee

One of the first steps in implementing interventions for enhancing safe male circumcision services of good quality is to organize a group to plan for the scale-up of service delivery. Quality improvement involves change, and it is therefore important to determine who are key stakeholders and change agents and how they will be involved. The planning group should remain involved in all stages of the implementation process, and it is recommended that a representative group (task force) be

identified to design and implement the process. This group should include national and district programme managers, service providers (surgeons, anaesthesiologists, medical doctors, nurses and counsellors), and key stakeholders representing government, nongovernmental organizations and others as identified. If there is an HIV/AIDS committee / task force or, specifically, a male circumcision committee / task force, it may assign a subgroup to focus on this strategy. The type of members is the same irrespective of whether an existing committee forms the group or a separate group is organized.

It is important to involve local communities when quality interventions are being planned for male circumcision services. Each country has different traditions and social mores, and these influence the approaches taken to implement the services. Various factors affect the acceptability of the services by the population, e.g. societal perception and gender dynamics. If male circumcision is seen as a foreign practice or as some other group's religious or cultural practice, it may be less accepted than would otherwise be the case.¹⁵ In some countries the procedure is associated with male "rites of passage" and medical intervention may be considered undesirable. If the sociocultural issues are not addressed, trust in the medical establishment may be undermined. The involvement of religious and cultural leaders is therefore crucial at the onset as well as an understanding of the preferences of people in the community.

This group should provide the main focus for accountability and preparing advice to decision-makers, as well as wider communication with interested parties. Clear terms of reference are essential. To avoid confusion, those leading the process need to know clearly from the outset who will make policy decisions and determine the range of new quality interventions. The group should know what technical and financial resources are available for implementation and should determine how to monitor progress.

Establishing aim, objectives and guiding principles

The representative group is responsible for determining the aim, objectives and guiding principles of a quality assessment and improvement process. Establishing a clear aim is fundamental to making further decisions regarding the direction of the planned activities. The aim of the quality assurance strategy should be the same as that of the national male circumcision scale-up strategy. Once the aim has been established, clear objectives should be written. Several key objectives help to define the means by which the aim will be achieved. These objectives should be outlined so that the effectiveness of the approach can be determined. Specific, measurable, clear and realistic objectives serve to keep the end in sight.

Guiding principles are typically established for a national programme. These principles provide a framework for the development of standards and the quality assessment and improvement process by laying out the beliefs and values that underlie the activities. The quality assessment and improvement process, which includes the setting of standards, should be checked against the guiding principles to determine whether they reflect these principles. Guiding principles may be adapted from the WHO/UNAIDS male circumcision recommendations: *New data on male circumcision and HIV prevention: policy and programme implications*.¹⁶ An example of an aim, objectives and guiding principles for a male circumcision quality assessment and improvement programme are provided in Box 1.

Box 1. Example of an aim, objectives and guiding principles for male circumcision quality assessment and improvement

Aim

To accelerate the prevention of HIV transmission through the provision of safe, affordable and accessible male circumcision services.

General aim of a national male circumcision scale-up strategy

Objectives

1. To adopt current evidence-based standards for providing male circumcision services.
1. To establish a minimum service package of male circumcision services.

Specific objectives for a quality assurance programme

Guiding principles

- Male circumcision is provided with full adherence to medical ethics and human rights principles. Informed consent, confidentiality and absence of coercion should be assured.
- Appropriate laws, regulations and policies are developed so that male circumcision services are accessible and provided safely and without discrimination.
- Male circumcision services are delivered as part of a comprehensive HIV prevention strategy.
- Male circumcision services are provided with due consideration for the sociocultural context and legal framework of the community.

Guiding principles of a national scale-up strategy

Policy development

The policies and guidelines adopted by a country have a direct impact on the success of quality improvement implementation and ongoing sustainability. A male circumcision service delivery policy should be developed to provide an overarching framework for developing an implementation strategy and guiding service delivery. The policy should provide guidance on issues including the target populations for service delivery prioritization, the categories of providers giving services, the level of facility for service provision, costing, communication and advocacy; and monitoring and evaluation.

Performing a surgical procedure such as circumcision carries more risk for adverse outcomes than other types of interventions, e.g. counselling and treatment for sexually transmitted infections. This element of risk needs to be taken into consideration when decisions are being made on the approaches to be used in verifying that a facility meets the standards for quality and safety. Clarity is therefore needed from policy-makers about roles, responsibilities and accountability in respect of male circumcision services, as this is important for achieving quality and gaining the confidence of the public.

Development of clinical practice guidelines

A country may have some existing protocols and guidelines that are applicable to circumcision service delivery, e.g. infection control, essential surgical care, HIV counselling and testing, and the management of sexually transmitted infections, as well as quality assurance policies. These protocols, guidelines and procedures should be incorporated into the interventions for a safe male circumcision service package of good quality. The WHO *Manual for male circumcision under local anaesthesia* contains clinical protocols, guidelines and procedures indicating how to prepare for and perform the surgical procedure as well as explaining the broader sexual and reproductive health needs and services of men. In addition, WHO has developed the *Integrated management for emergen-*

cy and essential surgical care toolkit, providing guidelines on strengthening surgical capacities, particularly at primary health care facilities.¹⁷

Agreement on standard clinical guidelines is essential for simplifying supervision and quality assurance tasks. Irrespective of where providers have been trained they should provide the service using the same standard methods and following the same protocols. Selecting a standard approach that is simple, safe and effective, requiring minimal specialized skills, helps to reduce the likelihood of complications and allows the possibility of appropriate task-shifting to lower levels of service providers.

Standard guidelines should also accommodate appropriate client selection and a process for referring complicated cases or those needing specialized care. In addition, they should clarify procedures for reporting potentially serious adverse events or accidental deaths, and the process for following-up and investigating such instances.

Adopting male circumcision standards

Countries should adopt a uniform set of male circumcision standards for service delivery. These standards delineate the quality of care and treatment expected. WHO has proposed a set of standards for providing male circumcision services (Box 2). The standards were identified by reviewing current literature on male circumcision and HIV care and treatment.

Box 2. Recommended male circumcision service standards

1. An effective management system is established to oversee the provision of male circumcision services.
2. A minimum package of male circumcision services is provided.
3. The facility has the necessary medicines, supplies, equipment and environment for providing safe male circumcision services of good quality.
4. Providers are qualified and competent.
5. Clients are provided with information and education on HIV prevention and male circumcision.
6. Assessments are performed to determine the condition of clients.
7. Male circumcision surgical care is delivered according to evidence-based guidelines.
8. Infection prevention and control measures are practised.
9. Continuity of care is provided.
10. A system for monitoring and evaluation is established.

The WHO standards should be reviewed for their applicability in the country and facilities concerned. The standards can be adopted as written above unless distinct cultural or legal variations require them to be revised. The proposed standards are not intended to exclude or suspend any health care facility that does not meet all of them, especially in resource-limited settings, but should be used to improve the quality of care provided at facilities. (See Annex B: *Recommended male circumcision standards and criteria*.)

Minimum package for male circumcision services

In December 2006, WHO convened a meeting to discuss the strategies and approaches to male circumcision programming. It was agreed that delivery of the services involved more than a surgical procedure and that a minimum package of services should be offered (Box 3).¹⁸ The male circumcision standards were designed in keeping with this package and the guiding principles. (See Annex B for standards and criteria.)

This package should be available at all facilities providing male circumcision services. These services could be offered at different locations in the same facility. However, systems and processes should be set up to facilitate easy client flow and referral from one point to another. More comprehensive packages can be offered, depending on the facility and the prevailing problems in the community. For example, male circumcision services targeted on young boys could offer counselling on improving gender norms and roles or on drug abuse. In communities where violence against women prevails, counselling or the raising of awareness on this issue could be included in the package.

Box 3. Minimum package for male circumcision services recommended by WHO

Minimum package for male circumcision services

- HIV testing and counselling
- Active exclusion of symptomatic STIs; 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*

Selecting facilities

In most cases, male circumcision services will be set up in an established health care facility. Decisions have to be made by policy-makers and programme managers on where to begin quality improvement interventions. In most instances a phased roll-out of services is necessary as not all facilities and providers can be included in quality improvement activities at the same time. Matters that have to be considered include whether there will be a pilot project and what the scaling-up plan will be. *Operational guidance for scaling up male circumcision services for HIV prevention* provides further advice on such questions.¹⁹

Facilities that would be best suited to provide safe male circumcision services should preferably meet the following minimum conditions:

- Minor surgery is currently performed.
- Appropriate equipment for resuscitation is available.
- Staff are appropriately trained and competent or are available and willing to be trained.
- Sterilization and infection control compliance exist.

These considerations do not preclude setting up services at the primary care level, in remote settings or in mobile units.

Public and private sector partnerships are encouraged. The use of private sector providers may increase the availability and accessibility of services. The private sector may also be able to help with increasing the quality of male circumcision procedures and standards. Private providers and representatives of private practitioners, through professional associations and nongovernmental organizations, could be included in discussions or meetings on quality.

Monitoring and evaluating the programme

Monitoring and evaluating the outcomes of male circumcision services should be incorporated into the existing health information system of the

country concerned. Identifying the key indicators assists district and national programme managers to oversee the quality of the services and provide targets for supervisory activities. Monitoring and evaluation provide ongoing information on the programme, usually based on a framework of specific indicators to measure performance, outcome and impacts over time.

Setting national and district indicators

Quality indicators set at the national and district levels to measure the effectiveness of male circumcision services should be focused on achieving the aim of the programme. For instance, the time taken to achieve target coverage might be used as an indicator.

In addition to the setting of indicators, methods of assisting facilities to achieve the aims and goals are important. Approaches such as supportive supervision and accreditation can be effective means of measuring and improving performance.

Supportive supervision

Supervisors can take an active role in improving the quality of male circumcision services. The provision of corrective and supportive feedback on performance has been shown to be an effective method of implementing standards. Supervisors can be helpful by making observations on performance and comparing it to the standards. They can provide technical updates and on-site training. In addition, they can assist facilities to use data and client input to identify opportunities for improvement. Joint problem-solving is encouraged with a view to identifying problems and solutions. Supervisors typically make regular visits to facilities to follow up on previously identified problems. In this approach they need skills in coaching and mentoring as well as knowledge of quality improvement methods. They need to be involved in training activities for implementing male circumcision services and may be suitable to be trained as trainers. In this case they would need additional training in conducting training needs assessments and workshops.

Supportive supervisory visits should be planned so as to maximize effectiveness and the use of time. Visits are most effective if regularly scheduled and aligned with the services being provided so that observations can be made and clients interviewed. The following preparation may be useful in connection with conducting a supportive supervisory visit.²⁰

- Develop clear objectives for the visit.
- Follow up recommendations made during previous visits.
- Collect helpful publications, materials and supplies for the health facility.
- Prepare updates and/or refresher training to present during the visit.
- Plan to spend sufficient time on accomplishing the objectives.

Supportive supervision can be provided by individuals other than facility supervisors. Facilities could select persons who have the skills and experience desired and may request their participation in the process. For instance, someone from a local nongovernmental agency might be willing to fulfil this role. Community health committees can also perform this role and can be very helpful to facilities in meeting the standards. Supervisors can become an integral part of facility teams by supporting them in assessing, planning, implementing and evaluating the implementation of quality male circumcision services.

Accreditation

Accreditation usually involves a voluntary programme in which trained external peer reviewers evaluate a health care organization's compliance with pre-established performance standards. It addresses organizational performance rather than the capability or performance of individual providers.² This approach is typically designed and implemented at the national level and would be most feasible for countries that already have an established accreditation programme or a standardization process.

² Adapted from Rooney AL, van Ostenberg PR. *Licensure, accreditation, and certification: Approaches to health*. Bethesda: Quality Assurance Project; 1999.

When designing a health care accreditation system it is wise to consider the health care structure and programmes that already exist.²¹ If a country has other accreditation programmes in place it may be most practical to include male circumcision in one of them. (See Annex A.)

A global WHO study shows that accreditation is increasingly used throughout the world as a means of improving the quality of health care.²² This approach requires additional planning and funding because an accreditation body (authority) has to be established to oversee the process.

In many countries the accreditation of health care facilities is voluntary, e.g. in Australia, Canada, and the United States of America, and is offered by nongovernmental agencies. The Council for Health Service Accreditation in Southern Africa is a voluntary programme that offers to assist facilities interested in accreditation to identify gaps and meet the standards before external assessment takes place.²³ Other voluntary programmes that have been developed for “focused”³ accreditation include the National Adolescent-friendly Clinic Initiative²⁴, seeking to improve adolescent health services in South Africa, and PROQUALI, working to improve reproductive health services in Brazil.²⁵

Various kinds of incentives exist to encourage facilities to seek accreditation. In the USA, government and insurance payments to facilities are usually contingent upon accreditation. Motivation to participate may be generated through professional pride and commitment to the aims of the services offered by facilities. Moreover, accreditation is a sign of quality and consumers can be sensitized to seek accredited services. Accreditation programmes also provide public recognition for achieving the standards. France, Italy, Scotland and other countries require facilities to achieve accreditation if they provide health care services.^{26 27 28}

Guidance on developing an accreditation programme is available: *Licensure, accreditation and certification: approaches to health services*

3 “Focused” accreditation refers to a review of one or more aspects of an organization against a set of standards.

*quality*²¹ provides information to assist countries to understand these approaches and to make decisions on their usefulness in achieving countries' aims. The International Society for Quality in Health Care has developed a toolkit that may also prove useful when accreditation options are being considered.²⁹ In addition, this body has published a checklist to guide governments and agencies on the development of new health care accreditation programmes.³⁰

Competence of providers of male circumcision

In order to perform circumcisions safely, providers must have knowledge, technical skills and experience. Competence can be defined as the ability to perform effectively. Consequently, programme managers should develop a plan to ensure that staff are competent to meet their responsibilities. Decisions have to be made on who will perform particular tasks, what competences are necessary for this, and what type of assessment will be used to determine competence.

Level of health-care provider

Additional providers are required to scale up male circumcision services. Decision-makers therefore have to consider the role of non-physician providers in order to meet this need. The successful use of non-physician providers to perform more complex clinical and surgical procedures, e.g. nurses and clinical officers, has been well-documented in various countries.^{31 32 33} Experience has also shown that appropriately trained non-physician providers can safely conduct procedures, e.g. caesarean sections, mini-laparotomies under local anaesthesia for female sterilization, non-scalpel vasectomy, repair of simple obstetric fistula, and manual vacuum aspiration.³⁴ It has been demonstrated that well-trained staff, including clinical officers, can successfully perform male circumcision.³⁵ In Kenya, clinical officers who routinely conducted consultations and selected surgical procedures were trained in the techniques of adult male circumcision.³⁶ In order to scale up the availability

of male circumcision services, therefore, it is recommended that countries should identify non-physician providers who can be trained to perform this procedure and provide comprehensive services.

Governments usually regulate the scope of practice for health-care providers. In keeping with laws and regulations a policy statement may be developed indicating the categories of staff that can perform male circumcision. If there are regulations precluding non-physician providers from performing male circumcision, policy-makers and programme managers should work through the proper channels to revise the regulations. In-country certifying bodies, such as nursing and medical councils and associations, can be helpful in negotiating these processes.

Essential competences for male circumcision providers

Male circumcision services amount to more than surgery. Some of the tasks associated with surgery are screening (which includes taking clients' health histories and performing physical examinations), obtaining informed consent, risk assessment, counselling, health education, infection prevention, and sterilizing and storing equipment. Individuals performing these tasks must be competent. When male circumcision services are being implemented, therefore, all staff members should be assessed to determine their competence in performing specific duties and their awareness of the entire package of services.

When the competences necessary for male circumcision programmes are being considered the age of the clients must be taken into consideration, as the procedure and requirements of care differ between neonates, adolescents and adults. Age-specific care competences include such elements as calculating age-specific dosages of medication, preparation for local anaesthesia, emergency responses for age groups, counselling and communication appropriate to age groups, and assessment. Providers therefore have to be assessed with respect to the performance of circumcisions specifically for neonates, adolescents and adults as appropriate in their settings.

Table 5 provides an example of a list of competences associated with male circumcision service delivery. Essential competences were identified based on the key processes involved in providing male circumcision services. For each essential competence in column one, there is a corresponding list of knowledge, skills and attitudes required to fulfil the essential competence; the final column identifies the level of provider recommended to perform each competence.

Table 1. Essential competences for male circumcision service provision

Essential competences	Knowledge, skills and attitudes required	Provider
Management	<p>Knowledge:</p> <ul style="list-style-type: none"> • Principles of facilitative supervision • Guiding principles and standards • Principles of communication, including giving and receiving feedback and constructive feedback • Development of communication plans • Designing services • Health information management • Systems management, including logistics, procurement and referral mechanisms 	Facility manager
Management	<p>Skills:</p> <ul style="list-style-type: none"> • Implementation of standards • Communication skills • Implementing a quality assessment and improvement programme • Supporting an environment for confidentiality and privacy <p>Attitude: Shared responsibility, supportive management</p>	Facility Manager

<p>Education and counselling</p>	<p>Knowledge:</p> <ul style="list-style-type: none"> • Sexual and reproductive health • HIV testing and counselling standards • Risk, benefits and potential complications of circumcision • Confidentiality • Informed consent procedures (HIV testing and surgical procedures) • Risk reduction and safer sex • Promotion of condoms • Postoperative instructions <p>Skills: Effective counselling techniques</p> <p>Attitude: Men are appropriate clients for sexual and reproductive health services; clients have rights</p>	<p>Community health worker Counsellor Non-physician provider (nurse or clinical officer) Non-specialist doctor Surgeon</p>
<p>Assessment</p>	<p>Knowledge:</p> <ul style="list-style-type: none"> • Normal and abnormal anatomy of male genitalia • Identification of medical contraindications for surgery • Referral agencies • Referral process <p>Skills: History-taking Physical examination</p> <p>Attitude: accuracy and completeness</p>	<p>Non-physician provider Non-specialist doctor Surgeon</p>



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Essential competences	Knowledge, skills and attitudes required	Provider
Treatment of sexually transmitted infections	<p>Knowledge:</p> <ul style="list-style-type: none"> • Signs and symptoms of sexually transmitted infections • Guidelines for treatment of sexually transmitted infections <p>Skills: Diagnostic, including use of flowcharts</p> <p>Attitude: Importance of use of evidence-based guidelines</p>	<p>Non-physician provider (nurse or clinical officer)</p> <p>Non-specialist doctor</p> <p>Surgeon</p>
Surgery	<p>Knowledge and skills</p> <ul style="list-style-type: none"> • Sterilization of equipment/supplies • Aseptic technique • Infection prevention • Operating room safety • Use of needle/syringe • Surgical procedure • Holding scissors and cutting sutures • Holding artery forceps and applying them to a blood vessel • Holding a scalpel and cutting tissue • Putting scalpel blade on and off handle safely • Holding tissue safely with forceps (tweezers) • Tying knots with instruments • Tying off an artery with forceps 	<p>Sterilization: Technician</p> <p>Other competences: Non-physician provider (nurse or clinical officer)</p> <p>Non-specialist doctor</p> <p>Surgeon</p>

	<ul style="list-style-type: none"> • Under-running a bleeding vessel • Suturing • Local anaesthesia • Postoperative care and follow-up <p>Attitude: Precision</p>	
Record-keeping	<p>Knowledge: Requirements for record-keeping</p> <p>Skills: Documentation</p> <p>Attitude: Importance of keeping records</p>	All levels of staff
Quality improvement and safety	<p>Knowledge:</p> <ul style="list-style-type: none"> • Male circumcision standards • Data collection • Data analysis • Use of data to make improvements • Reporting <p>Skills:</p> <ul style="list-style-type: none"> • Self-assessment • Peer assessment (giving and receiving feedback) • Working in teams • Brainstorming • Problem-solving • Developing action plans <p>Attitude: All staff take personal responsibility for the quality and safety of services</p>	Managers Supervisors All staff



As various staff members are responsible for different aspects of care and treatment it is important to ensure that all the competences exist in the team. It is recommended that all staff members receive basic training on all aspects of the minimum package.

Competence-based training

A competence-based training approach is recommended that focuses on the mastery of specific knowledge and skills rather than on a specific time frame for completion of course work or performing a specific number of circumcisions. Repetition has been found to be a useful means of assisting learners to incorporate knowledge and skills into practice. In this approach the learner is provided with the information, guidance and support needed until they can successfully carry out the tasks required for the job.

As with all adult learning activities the training of staff is more effective if it is designed to build on the learners' previous knowledge and skills. For instance, all health-care providers have been taught how to perform aseptic technique and their knowledge and skills in this area can be transferred when they are learning how to perform male circumcision. The amount of time required for training varies, depending on the learners' previous knowledge and skills. If learners have performed other surgical procedures, for example, they will probably learn how to perform circumcisions more rapidly than learners who have not had this experience.

Competence assessment

The assessment of competence ensures that all providers can perform assigned duties and responsibilities. Assessment can be carried out in facilities by approved trainers. Some countries may choose to certify staff who meet the requirements laid down.

Competence can be assessed in many ways. One of the commonest is by means of written tests. Tests can be developed and administered by

the facility manager or educator. This method can be effective in measuring knowledge but does not gauge providers' ability to perform skilled tasks. Direct observation of clinical practice is therefore used to determine whether providers can apply their knowledge and skills. Qualified physicians or non-physician providers can be trained to make these assessments.

WHO has developed a competence assessment for male circumcision services based on the *Manual for male circumcision under local anaesthesia*. Checklists based on the standards of care can be developed for use by observers to record competences demonstrated by providers in each skill. Observation begins in the classroom setting, using simulations. Once students have become competent in this setting they are observed with actual clients. In general, observations continue until the providers can perform the skills independently according to the standards.

An additional means of determining competence involves reviewing providers' documentation on clients' medical records. A combination of these three methods (written test, observation and record review) provides a comprehensive approach to competence assessment. If competence is not demonstrated, remedial strategies are employed to correct shortcomings.

The degree of supervision required has to be determined on the basis of the complexity of the task or procedure, the training and competence of the person to whom the task or procedure is assigned, and the proximity and availability of professional assistance, e.g. of a physician, on the premises. Records have to be kept of test results and observations made to verify competence.

Provider certification

Some countries may require the certification of health-care workers to perform certain tasks within the male circumcision programme, e.g. surgical procedure. In this case an authority has to be identified for over-

seeing the certification process. This authority, whether governmental or private, develops guidelines for obtaining certification. These include the following.

- Scope of certification, e.g. certified to perform adult male circumcision or provide HIV counselling
- Eligibility requirements, e.g. education, years of experience
- Curriculum
- Application process
- Testing procedures, e.g. written examination, skills test
- Level of achievement required for certification
- Recognition of achievement
- Recertification requirements

The authorities that award certification may or may not provide the education and training required to achieve it. However, they typically outline the knowledge and skills required and may provide study materials. Various medical and nursing associations offer certification for practitioners in specialty areas such as critical care, infection prevention and control, and diabetes education. In most cases the authorities conduct written examinations, and additional evidence of competence may be required from applicants, e.g. self-assessments, letters from supervisors and attendance at continuing education programmes. In some cases the demonstration of skills attainment may be required, e.g. cardiopulmonary resuscitation. The elements used for setting up private practice certification in Jordan are indicated in Box 4.

As male circumcision is an important intervention to reduce the transmission of HIV, it is important to include the procedure in pre-service training programmes for both physicians and non-physician providers.

Box 4. Private practice certification in Jordan

Country example: private practice certification in Jordan

The certification of private physicians was implemented in Jordan as part of a quality assurance programme to improve women's health. This voluntary certification programme includes family planning, breast cancer, reproductive tract infections and sexually transmitted diseases. The programme involves the following.

- Development of clinical guidelines based on WHO and International Planned Parenthood Federation standards
- Training of physicians: in class and practical training, e.g. IUD insertion, pap smear, and wet mount preparation
- Orientation to certification process
- Assessment of the trained providers
- Clinical Skills Laboratory in the Faculty of Medicine of the University of Jordan
- Assessment of counselling skills with a standardized client using a checklist

Self-assessment is part of the approach for certification. Physicians complete a self-assessment questionnaire in respect of: physical environment, technical competence, continuity of care, management, marketing to clients, and business practices.

Criteria for certification:

- Completing and reviewing monthly record of statistics
- Scoring performance using a self-assessment questionnaire tool
- Developing an action plan to resolve identified performance gaps
- Meeting minimum requirements of external assessment
- Participating in a quarterly review meeting relating to completed self-assessment and developed action plan

Certificates are awarded by the Jordan Medical Council at a recognition ceremony and the names of persons receiving certificates are published in the press; 287 physicians have received certificates in family planning, 160 in breast cancer and 56 in reproductive tract infections.

Source: Private Sector Project for Women's Health at www.psp-one.com.

Assessing ongoing competence of providers

Ongoing competence is usually assessed at the facility level. However, national and district managers have a role to play in setting the criteria for assessment. In many countries, district managers or supervisors are responsible for ensuring that assessment is carried out.

Several factors may affect the ongoing competence of providers, including how often they perform activities, and personal factors. If a skill is not practised frequently enough or if a provider becomes impaired mentally or physically, he or she may not maintain the required level of competence. This is as true for open-heart surgery as it is for male circumcision. Guidelines for maintaining competence should be written down and measures should be established to ensure that providers have the opportunity to utilize the skills concerned.

The demonstration of competence can be built into a performance appraisal system. In this case a supervisor may review selected indicators such as the circumcision statistics (numbers performed and outcomes) for each provider and the supervisor or a peer could observe clinical practice. In other programmes, recertification is a condition for maintaining certification status. For instance, in order to maintain certification in cardiopulmonary resuscitation the individual is required to attend a class annually and to demonstrate the skills successfully. Critical incidents that occur or complication rates may indicate a need to review staff performance.

Annex A: Examples of quality assessment and improvement programmes

Paediatric HIV/AIDS collaboration

An improvement collaborative was organized in Dar es Salaam, Tanzania, to improve paediatric HIV/AIDS care.³⁷ Teams were organized in seven hospitals to focus on the treatment of paediatric AIDS in the region. All of the teams adapted the WHO Paediatric Referral Care Model, including the training curricula both for pre-service and in-service providers, for the care of children infected and affected by HIV/AIDS. Standards and guidelines were updated, with implementation of critical care pathways for the management of paediatric HIV/AIDS. The teams conducted baseline assessments, identified quality gaps and developed improvement plans.

Members of each team attended regular learning sessions, which included how to use quality improvement methodology to improve the delivery of care. During these sessions, teams were also trained in emergency triage, assessment and treatment as well as the WHO algorithm for screening and testing children suspected to be living with HIV/AIDS.

The hospitals made various system improvements for patient flow, triage, and case management; and networks were established to provide HIV care beyond the referral facility. Monthly random medical audits were conducted to evaluate compliance with standards. Graphs and charts were developed whereby the results of the improvement activities were shared between the hospitals at regular intervals so that there was mutual learning as to what was working or not working. The reported results included: improved patient flow, triage, emergency assessment and treatment of critically ill children, and improved identification of HIV-infected children.

Maternal and neonatal health services

A strategy paper was developed by WHO for implementing maternal and neonatal health standards of care.³⁸ A series of steps was outlined for guideline development, including the formation of a national advisory group and the drafting, validation and endorsement of national policy guidelines. Additional steps were described on implementing the guidelines, with reference to the dissemination of policies and guidelines at the national, regional and district levels, the establishment of systems to support quality provision of care, the competence of staff and community involvement. Complementary documents described the use of performance and quality improvement to strengthen skilled attendance³⁹ and provide tools for conducting site assessment.⁴⁰ The programme has been used in Guatemala to support an accreditation programme for maternal and neonatal health facilities. The facilities are assessed in six to nine months so as to determine progress towards meeting the standards. Once the facilities achieve a satisfactory percentage of standards, accreditation status is awarded for essential maternal and neonatal care. When enough district facilities have met the quality standards, accreditation is awarded to the whole health services network of the district concerned.⁴¹

Reproductive health services

PROQUALI is a quality improvement programme developed to improve the quality of reproductive health services and increase access at the primary health care level.²⁵ The PROQUALI model is based on a competence-based training programme linked with a performance improvement model. The state reproductive health service guidelines were used to establish the competences needed by the health-care workers. In addition to staff competences the programme reviews the systems that support service delivery.

A variety of assessment approaches is used, including continuous self-assessment and peer assessment / benchmarking, internal assessment (every four to six months), supportive supervision (on demand) and year-

ly external assessment. Client involvement and community participation are important elements of the programme. Accreditation is awarded by a state-supported recognition committee with members from the secretariats of health, nongovernmental organizations, provider groups, universities and the community. Three accreditation visits are made to each clinic. The first visit is an accreditation qualifying visit, made approximately nine months after the baseline assessment. Each clinic is given a rating based on the total percentage of verification items by area, rather than on the criteria accomplished. A clinic is ready for the next accreditation visit when it attains 80% achievement in each of the five assessment areas (reproductive health services, infection prevention, interpersonal communication/counselling, physical plant and supplies, and management support systems). During the second visit the clinic can be accredited if it achieves 95% of the criteria observed; otherwise it continues to work on the unmet criteria and a third accreditation visit is made.

Baby-friendly services

The Baby-friendly Hospital Initiative,⁴² which began in 1991, is a process for implementing the ten WHO/UNICEF steps for successful breastfeeding. Elements of the programme include a clinic / birth centre self-appraisal, on-site evaluation, external review and international award. After a facility has registered its' intent to implement baby-friendly services with UNICEF, a baby-friendly assessor is assigned who assists the facility to develop an action plan and acts as an ongoing liaison and support. In January 2007, health care facilities initiated a staged approach to accreditation. In stage 1, policies and procedures will be assessed. The staff education programme will be assessed in stage 2 and there will be an assessment of care provided to pregnant women and new mothers in stage 3. A certificate of commitment will be awarded to facilities that are in the process of implementing the standards. It is projected that full accreditation will be achieved over a period of two years.

Adolescent-friendly health services

Programmes have been developed to accredit services as youth-friendly. The National Adolescent-friendly Clinic Initiative was created in response to the HIV crisis, with the goal of making public health clinics more available and accessible to young people in South Africa. The initial step in developing the accreditation process was to define youth-friendly services. Standards were developed based on various barriers to health care services identified by young people, e.g. unfriendly providers and a lack of confidentiality and privacy. The standards also took into consideration the systems for which the services were provided, e.g. with reference to the environment, the competence of staff, the availability of equipment and supplies, and management. Self-assessment by clinics was built into the process as well as external assessment. Several methods are used to measure how well the standards are achieved, including: interviews with managers, health-care providers and clients; direct observation; and reviews of medical records. Each standard is graded as met, partially met or not met; a level of accreditation is awarded on the basis of the overall score. The Initiative showed that youth-friendly clinics performed better than control clinics for most of the criteria.²⁴ Several factors were felt to be important to the success of the programme, including the involvement of youth, community and government in the development and implementation of the process.

Antiretroviral agents

As a means of scaling up access to antiretroviral agents, the Uganda Ministry of Health established the accreditation of antiretroviral therapy services, in which minimum accreditation standards must be met before therapy is delivered.⁴³ The Government is working with both public and private facilities, using a primary care model, to implement the accreditation programme. A defining feature of the Ugandan antiretroviral treatment programme is that steps were taken to ensure the quality of clinical service delivery. An advisory board developed accreditation criteria

whereby clinical centres could be authorized to prescribe such treatment. The minimum criteria for a health facility to be accredited include: the provision and achievement of targets for comprehensive basic health care services as outlined in the minimum health care package; the presence of a basic physical environment (space for HIV counselling and testing, clinical assessment, drug storage, laboratory); minimum numbers of qualified personnel with experience in HIV/AIDS management; and the ability to ensure follow-up care and support for families and communities.

Annex B: Recommended male circumcision standards and criteria

Each of the ten male circumcision standards is expressed as a statement and supported by an “intent” indicating what is required to achieve the standard. The criteria specify what should be in place in order to meet each standard.

Standard 1. An effective management system is established to oversee the provision of male circumcision services.

Intent

Management systems are developed and implemented to ensure efficient and safe provision of male circumcision. Services are designed in response to clients’ needs. Administrative and clinical policies and procedures are available that provide guidance to staff on carrying out their duties. Processes are designed for efficient staffing and scheduling of procedures, and ongoing supportive supervision is provided.

Criteria

- 1.1 Health rights policies are available and known.
- 1.2 Staff roles and responsibilities are clear.
- 1.3 Services are provided in an organized and efficient manner.
- 1.4 Barriers to accessing care are identified and minimized.
- 1.5 The facility has systems for continuously improving the quality and safety of services.

Standard 2. A minimum package of male circumcision services is provided.

Intent

The male circumcision service is more than just a surgical procedure. A minimum package of services should be available in all facilities providing male circumcision. These services could be offered in different locations within the same facility. However, systems and processes should be set up to facilitate easy client flow and referral from one point to another.

Criteria

- 2.1 HIV testing and counselling services are provided on site.
- 2.2 Syndromic management of sexually transmitted infections is provided on site.
- 2.3 Individual risk reduction and safer sex counselling is provided on site.
- 2.4 Male and female condoms are provided on site.
- 2.5 The facility ensures that the minimum package of services is integrated and that appropriate linkages are made.

Standard 3. The facility has the necessary medicines, supplies, equipment and environment for providing safe male circumcision services of good quality.

Intent

The provision of quality care requires an infrastructure capable of supporting the activities of the client and the care provider. Leaders must commit the resources necessary to provide safe male circumcision services, including adequate facilities, medications, equipment and supplies.

Criteria

- 3.1 Essential medicines required for providing circumcision services are available.
- 3.2 The necessary supplies and equipment are available for performing surgery.
- 3.3 Emergency equipment, supplies and medications are available.
- 3.4 Infection prevention supplies and equipment are readily available.
- 3.5 The environment is adequate for performing the activities required.

Standard 4. Providers are qualified and competent.

Intent

A system exists for identifying staff learning needs and for ensuring that plans are designed to meet these needs. Training activities are conducted to prepare staff to carry out their jobs effectively. The team of staff members has the necessary competences to provide the minimum package of male circumcision services.

Criteria

- 4.1 The facility has a process in place to ensure that all staff have the appropriate qualifications and competences for their assigned tasks in male circumcision.
- 4.2 There is a periodic assessment of staff competencies.
- 4.3 Ongoing in-service education and training are provided to assist staff to fulfil their duties.

Standard 5. Clients are provided with information and education on HIV prevention and male circumcision.

Intent

The facility is recognized as a resource centre for promoting healthy lifestyles. It has a role in and responsibility for developing channels for sharing sexual and reproductive health information and materials. Specific materials are available on male circumcision and are accurate, simple, age-appropriate and consistent with the minimum package.

Criteria

- 5.1 Information is provided to clients on male circumcision, sexually transmitted infections and HIV prevention.
- 5.2 Appropriate reinforcing information and educational materials are provided.
- 5.3 Informed consent is obtained from clients.

Standard 6. Assessments are performed to determine the condition of clients.

Intent

An initial assessment is performed to evaluate the suitability of clients for the circumcision procedure. The assessment takes into account the social, economic and cultural background and the health risks of each client. Ongoing assessments are performed to evaluate the status of clients in relation to the surgical procedure.

Criteria

- 6.1 An initial client history is taken.
- 6.2 Initial physical examinations are performed.

Standard 7. Male circumcision surgical care is delivered according to evidence-based guidelines.

Intent

The provision of safe clinical care of good quality is at the heart of the delivery of male circumcision services. These activities require an interdisciplinary approach. Each practitioner's role and responsibilities are determined by: her or his professional skills, competence and credentials; the care provided; and the programme's policies. Procedures and care are provided according to evidence-based guidelines.

Criteria

- 7.1 Male circumcision surgical procedures are performed according to standard guidelines.
- 7.2 Standard procedures are followed for the assessment and management of emergencies and complications.
- 7.3 Immediate postoperative care is provided according to the standard protocol.

Standard 8. Infection prevention and control measures are practised.

Intent

The facility effectively implements infection prevention and control processes by involving staff and clients in observing standard precautions. Infection control surveillance, data collection and corrective measures are conducted to reduce the incidence of surgical site infections.

Criteria

- 8.1 Infection prevention and control policies and procedures are available.
- 8.2 Infection prevention and control measures are practised according to policy and procedures.

8.3 Individuals are designated to be accountable for infection control activities at the facility.

Standard 9. Continuity of care is provided.

Intent

Systems and procedures are in place to promote effective follow-up care. Effective referrals and counter-referrals are made. Adequate and clear information is given to clients to facilitate their ongoing use of services.

Criteria

- 9.1 An effective referral system is in place.
- 9.2 The client/family is given discharge instructions.
- 9.3 There is a well-established mechanism for follow-up of clients.

Standard 10. A system for monitoring and evaluation is established.

Intent

A process is in place to monitor and evaluate the quality and safety of services. The process includes data collection and analysis, actions taken to improve care and services, and the monitoring the effect of these actions.

Criteria

- 10.1 Data are collected on the services provided.
- 10.2 Evaluation data are used for the planning and improvement of service delivery.
- 10.3 There is a system for prompt reporting and review of adverse events.
- 10.4 Data collection is thorough and accurate.

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Guidance for facility managers and staff

SECTION 2

Health-care providers at the facility level concern themselves with quality by ensuring that services are of the highest possible standard and meet the needs of individual service users and communities, who are responsible for identifying their own needs and managing their health with appropriate support from the providers. The facility manager is responsible for the quality of care and services provided at the facility. However, all staff members share in this responsibility. One of the key principles of quality improvement is that the staff are involved in the process, and the most common approach is to form quality improvement teams. Individual facility teams can be formed, although another approach is gaining popularity in which teams work towards the same aim at various facilities and a more rapid scale-up is achieved. (See “Quality improvement collaboratives” below.)

Forming quality improvement teams

It is recommended that facility managers form a facility-based team to implement the standards adopted at the national level. Team members should include all categories of service providers and community and/or user representatives. Working in multidisciplinary teams provides several benefits. Each team member contributes a different set of skills, knowledge and experience. Accordingly, there are a greater number of ideas to plan activities and resolve problems, which often creates greater acceptance of the plans and improves the chances of identifying solutions. When staff members collaborate in a team there can be a motivating effect, as teamwork fosters creative problem-solving and learning together. Giving responsibility and recognition for a job well done can also motivate staff. Working through teams and delegating responsibility are strategies that can be used to encourage participation.

The team leader’s role is not to make every decision but to lead the team through its work, ensuring that the goals are achieved and, specifically, to meet the standards for quality male circumcision services. If one person leaves a facility, other team members should be able to maintain the level of quality so that there is no service gap.

At every level of staff, e.g. registration clerks, nurses, physicians and surgeons, there should be an understanding of roles and responsibilities for implementing and meeting the male circumcision standards. A whole-site training approach is therefore recommended in order to initiate the process. Members of the national representative group or other individuals targeted to facilitate implementation of the standards, e.g. supervisors or district managers, may conduct the training. Interactive training programmes should be designed whereby staff can apply the standards in their settings. In-class training activities are most effective if followed by on-site mentoring to guide the staff on conducting the assessment and on working with their team to implement the standards.

In addition to training staff to assess and implement the standards, clinical skills may have to be enhanced or developed. The information required for developing a training plan can be obtained by conducting a staff training needs assessment. Additional training may need to be provided to improve counselling skills, performing the procedure or providing syndromic management for sexually transmitted infections. It is also common for a team to need guidance on functioning as a team, using quality improvement techniques, developing action plans and keeping on task.

Quality improvement collaboratives

More rapid achievements in scaling up improvement efforts have been reported through the use of quality improvement collaboratives. Historically, quality improvement teams were started at one site and then, when success was achieved, another team was started at another site. In contrast, the collaborative approach initiates quality improvement activities at many sites simultaneously. Sometimes this happens in a single country, although the approach has been initiated across countries. The quality improvement teams comprise doctors, nurses, other health-care providers and community members. Improvement collaboratives⁴⁴ seek to adapt and spread existing knowledge (e.g. best practices, evidence-based guidelines) to multiple settings. The teams learn about the best

clinical practices, e.g. in male circumcision or HIV counselling, and use this information to make changes in their own practices.

Management at all levels is involved: the ministry of health, district leaders and health facility managers. A local technical advisory group provides guidance to the teams. Several features of the collaborative approach have proved successful.⁴⁵ All the teams share the same aim and indicators, and “change packages” are adopted that include several evidence-based interventions intended to make clinically significant improvements. However, the teams can select different approaches to implement the changes. A communication process is established for following up each team’s progress on a regular basis (often weekly), e.g. telephone calls, emails and site visits. Additionally, the teams meet regularly to report on their progress (data) and share lessons learnt in order to build on successes. Consequently, there is more rapid progress towards achieving goals. A synergy develops when peers are working at different sites, motivating each other to succeed. This approach has been identified as an important means of rapidly scaling up quality improvement efforts. (See Annex A.)

Steps for improving quality

Teams use quality improvement methods to close the gap between what is expected (the standard) and the current situation. Various quality improvement models have been developed, although the basic approach remains the same. The steps presented here were adapted from a performance improvement framework developed through a collaborative effort among members of the Performance Improvement Consultative Group. This model is included in the *Manual for male circumcision under local anaesthesia*.

The model involves a performance and quality improvement process of five steps, summarized in Table 2. Guidance is given on how to apply the steps to improving the quality of male circumcision services.

Table 2. Steps for performance and quality improvement

Steps for performance and quality improvement	Application
1. Define desired performance	The male circumcision standards and clinical guidelines define the desired performance. Desired performance should be realistic and staff must know not only what their duties are but also how they are expected to perform them.
2. Assess performance	Self-assessment or peer assessment is used to measure performance against male circumcision standards. The assessments help to determine which standards have been met. Assessment should be done on an ongoing basis by a team.
3. Find causes of performance gaps	A performance gap exists if the team finds that what is actually occurring does not meet the standards. The team uses problem-solving techniques to identify causes (reasons) for the standards not being met.
4. Select and implement interventions to improve quality	On the basis of the causes of gaps the team selects interventions (solutions) to meet the standards and develop an action plan.
5. Monitor and evaluate performance	The team collects data to monitor the effectiveness of the planned intervention aimed at meeting the standards and makes adjustments in the interventions or plans as needed.

Step 1. Define desired performance

The male circumcision standards define the desired performance. However, the standards are not useful until communicated and implemented. Managers are responsible for developing and executing a plan to effectively communicate and implement the male circumcision standards. The dissemination of standards alone is not enough but must be combined with an appropriate implementation strategy. The male circumcision standards must be communicated to every staff member. Teaching in a lecture format and distributing unsolicited printed material are the least effective methods of communicating standards. The most effective methods include learning linked to clinical practice, interactive educational meetings, individual instruction, reminders and feedback. Instructors, peers and supervisors may provide feedback.

Performance expectations should be written into the job descriptions of staff members and the assessment of male circumcision services should be included in supervision monitoring tools. Supervisors can assist staff in meeting the performance expectations by observing the health workers' clinical work and providing feedback on the skills that need improvement. The evaluation of staff competence, based on the standards, should be part of the established performance evaluation process, e.g. annual evaluation.

Step 2. Assess performance

Assessing the quality of male circumcision services involves collecting and analysing data. The information obtained is used to make decisions that will improve the quality of care and services. Self-assessment and peer assessment are recommended approaches to assessing performance.

Self-assessment

The facility can begin work by conducting a self-assessment using the Male Circumcision Quality Assurance Toolkit to determine whether the

standards have been met. The self-assessment gives a baseline measurement providing the team with an understanding of the gap between the current situation and the expectations for achieving the standards. The following approaches can be used to collect the data

- Provider and manager interviews
- Medical record review
- Inspection of facility
- Inventory of supplies
- Direct observations
- Exit interviews

An assessment is most effective when the whole team participates. In this way all team members can see where improvements are needed and can assist in developing the plan to make the changes necessary to meet the standards. It is recommended that the team conduct self-assessments at intervals in order to measure progress towards meeting the standards. Self-assessment is also valued as an important adjunct to accreditation programmes. In some cases, self-assessment reports are required when applications for accreditation are being submitted.

Peer assessment

Peer assessment is an effective way to evaluate clinical practice. It involves health-care workers giving feedback to their colleagues so as to assist them in improving their performance. Giving and receiving feedback is an important skill and can only be fostered in an environment that is free of criticism and blame.

Any clinical procedure, protocol or guideline can be measured to determine the quality of care being provided. Direct observation is an effective way to measure performance in a real working environment and can be used to evaluate a full range of competences, including interpersonal skills. In this approach, staff members observe the actions of fellow health-care workers and evaluate their performances in relation to the steps outlined in the clinical protocol or procedure concerned.

Measurement tools can easily be developed on the basis of the clinical guidelines for carrying out these observations. Table 3 illustrates a tool that can be used to evaluate preoperative hand-scrubbing techniques. Measurement tools should be simple and easy to use. In this illustration the steps in the hand-scrubbing procedure are listed and the columns on the left allow the observer to indicate whether the steps were performed. Tools like this can be devised for most clinical procedures and protocols.

Table 3. Hand-scrubbing data collection tool

Preoperative hand-scrubbing procedure	Procedure performed*	
	Yes	No
1. Remove jewellery.		
2. Trim nails short.		
3. Wet hands with running water.		
4. Use brush and soap to clean around and underneath nails.		
5. Scrub hands and arms up to elbows.		
6. Hold arms up to allow water to drip off elbows.		
7. Turn off tap with elbow.		

* Tick the appropriate cell in the “Yes” column if the activity was observed or in the “No” column if it was not observed.

The team determines when to collect the data, for how long and who will do the collecting. Because this type of monitoring is not a research study the amount of data necessary to determine whether the standards are being met can be quite small. Five observations of different staff members washing their hands could be enough to demonstrate whether the procedure is being followed.

Medical peer review has been formalized through the use of quality circles.⁴⁶ This has proved to be a useful approach to quality improvement in countries throughout Europe. These circles are typically small groups of physicians, although they may be interdisciplinary groups, and they meet voluntarily with the aim of improving the quality of care. Common to this approach is the sharing of self-recorded data, specifically comparing data with locally developed guidelines and protocols. Some of these groups participate in continuing medical education programmes, while others use the audiotaping of consultations and receive feedback from peers using criteria of physician-patient communication. Mutual practice visits may also occur.

Both self-assessments and peer assessments are valuable tools for assessing and ultimately improving the quality of care. The advantages and disadvantages of each approach are outlined in Table 6. Recognition of the disadvantages should not discourage the use of the approaches but should give awareness of what is required to implement them so that the implementation can be planned accordingly. For instance, a team may lack the ability to conduct an accurate self-assessment but could be taught to do so.

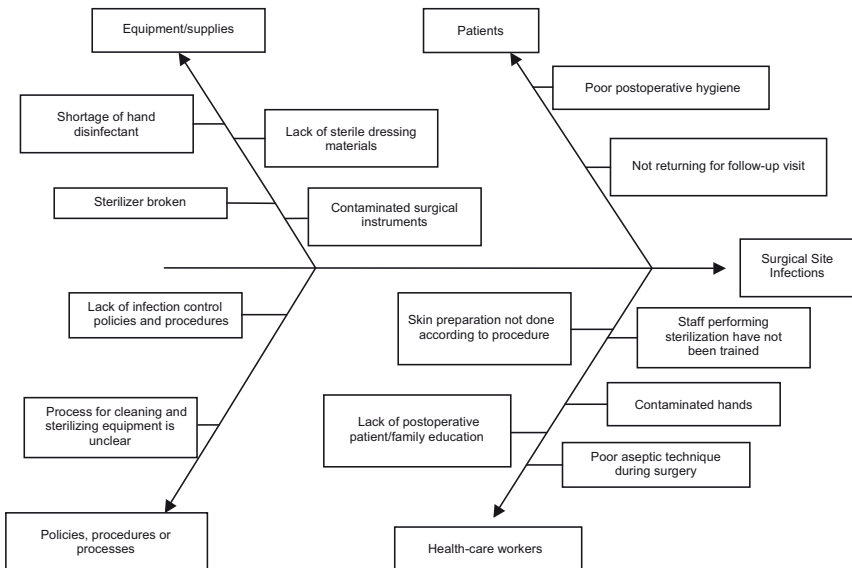
Step 3. Find causes of performance gaps

The teams should review all the assessment findings and should deal first with shortcomings that are easy to address, allowing “quick fixes”. Some of the standards may be more difficult to achieve because of underlying problems with the processes or systems. In these cases the teams can use problem-solving techniques to explore the potential causes and find solutions. A simple problem-solving approach starts by identifying individuals involved in each part of a process. For instance, if maintaining a sufficient supply of medications is proving difficult, staff involved in managing the inventory of medicines might include nurses, clerks and central supply staff. These individuals would be brought together as a team to solve the problem. Sometimes a problem can be solved at the facility level, e.g. if the team finds that the reordering process is not being followed. At other times it may be important to invite

someone from outside the facility, e.g. a supervisor, to assist in understanding the process and finding ways to make improvements.

The use of a fish-bone diagram has proved useful for many teams in organizing their ideas when problem-solving. Fig. 2 shows how such a diagram might look as a team explores the reasons for surgical site infections. The “head” of the fish identifies the problem, in this case surgical site infections, while the “bones” are arranged so that the team can categorize the potential causes of the problem as related to equipment/supplies, patients, health-care workers, and policies, procedures and processes.

Fig. 2. Fishbone diagram depicting possible causes of surgical site infections



Additional resources are available to assist teams in problem-solving, e.g. *A modern paradigm for improving healthcare quality*.⁴⁷

Step 4. Select and implement interventions to improve quality

After identification of the causes of performance gaps the next step is to select and implement interventions to improve quality. Once the team has agreed on the interventions (solutions) that they wish to conduct, an action plan can be developed. This plan should be reviewed at each team meeting in order to ensure that it is being implemented as intended. If, for example, the team feels that the reason for increased surgical site infections is related to a lack of proper surgical scrub, the action plan depicted in Table 4 might be implemented.

Table 4. Example of an action plan

Activity (What needs to be done?)	How will it be done?	Who is responsible?	When will it be done?
Review hand-scrubbing procedure with staff	Staff meeting	Mrs Zulu	1 August 2009
Obtain disposable towels for drying hands	Request disposable towels from district supply office	Alice Rush	4 August 2009
Remeasure hand-scrubbing procedure	The procedure will be remeasured in three months to evaluate the effect of the actions	Mrs Zulu	1 November 2009

Step 5. Monitor and evaluate performance

After a solution has been implemented the team has to measure whether the problem has been diminished or solved. In the case of surgical site infections the team should monitor the number of surgical site infections in order to determine whether they have decreased. If the problem has been solved, the team should work towards sustaining this gain. Consequently, the team should also continue monitoring how well staff are performing surgical scrubs. If the problem has not been solved the team should assess whether the intervention was implemented effectively, e.g. whether the actions were implemented as planned. Additional actions may be needed or different solutions may have to be tried. If one solution does not work the team should try other solutions.

Setting facility-level indicators

In addition to measuring the effectiveness of individual quality improvement efforts, it is necessary to develop indicators at the facility level to measure the overall effectiveness of improvement in the quality of male circumcision services. An indicator translates the standard into a measurable quantity. For instance, the proportion of patient records with a signed consent form for circumcision measures the extent to which the standard addressing male circumcision surgical care is delivered according to evidence-based guidelines (WHO male circumcision standard 7). A comprehensive evaluation of the quality of male circumcision services would include input, process and outcome indicators. Inputs refer to the resources needed to provide the service; processes include the activities involved in providing the services; outcome indicators relate to the main objectives of the programme. Table 5 provides examples of input, process and outcome indicators that might be used to measure the extent to which the quality of circumcision services has been improved. A list of potential indicators should be generated and then ranked in order of priority. Some consideration should be given to the feasibility of collecting the data necessary for measuring indicators (time, money, reliability of data sources, etc).

Table 5. Examples of indicators for male circumcision services

Inputs	Indicators
Trained staff	<p>Number of persons trained to provide male circumcision services by the programme in the period, disaggregated by training cadre:</p> <ul style="list-style-type: none"> a) Clinician (who performs surgery) b) Surgical assistant c) Counsellor (preoperative, postoperative, risk reduction) d) Ancillary staff (equipment sterilization and preparation)
Processes	
Surgical scrub	<p>N = Number of times the surgical scrub was performed according to procedure</p> <p>D = Total number of observations of surgical scrubs</p>
Consent	<p>N = Number of male clients undergoing circumcision in which a signed consent is on the medical record</p> <p>D = Total number of client records reviewed</p>
Outcomes	
Circumcised males	<p>Number of males circumcised using local anaesthesia by the programme in the period, disaggregated by age:</p> <ul style="list-style-type: none"> a) < 1 year b) 1–12 years c) 13–17 years d) 18+ years
Adverse events	<p>Number of male circumcision-related moderate and severe adverse events reported by the programme in the period. Disaggregated by severity:</p> <ul style="list-style-type: none"> a) Moderate b) Severe <p>Disaggregated by specific complication:</p> <ul style="list-style-type: none"> a) Bleeding b) Infection c) Scarring/disfigurement/sensory loss

Supportive supervision

Supervisors play an important role in assisting facilities to implement quality services. During supervisory visits, supervisors can assist facility teams to understand the standards and find ways to implement them. Supervisors can also be helpful in providing feedback to individuals and groups with a view to improving performance.

Advantages and disadvantages of quality approaches

Four different quality approaches, namely self-assessment, peer assessment, supportive supervision and accreditation, have been outlined as methodologies for assessing and improving quality and evaluating performance at different stages of the five steps. Facilities are encouraged to use peer assessment and self-assessment as well as supportive supervision as part of their quality approach; accreditation is recommended for facilities seeking external recognition for their services. Some of the advantages and disadvantages of the methodologies are identified in Table 6, which may assist countries in deciding the approaches that would best fit their situations and needs. Moreover, a knowledge of the disadvantages can help programme managers to anticipate these issues and plan strategies to overcome them.

Table 6. Advantages and disadvantages of quality approaches

Quality approaches	Advantages	Disadvantages
Self-assessment	<ul style="list-style-type: none"> – Encourages self-reflection – Encourages increased accountability – Self-paced – Increases understanding of standards and criteria – Allows learning from mistakes without public recognition 	<ul style="list-style-type: none"> – Requires initiative and follow-through – Participants may lack ability to assess accurately – Requires integrity and honesty
Peer assessment	<ul style="list-style-type: none"> – Encourages self-regulation of professional practice – Actively involves practitioners – Peer-to-peer support and learning – Supports critical insight and appraisal of quality care 	<ul style="list-style-type: none"> – Requires practitioner buy-in – Participants need skills for giving and receiving feedback – Requires an environment of trust and respect – May create stress or anxiety – Fairness may be affected by social factors
Supportive supervision	<ul style="list-style-type: none"> – Local availability – Can be built into overall supervisory system – Individuals with specific skills and experience can be identified for this role – Supervisor becomes part of team – Regular follow-up 	<ul style="list-style-type: none"> – Requires new thinking about the role of supervisors – Requires skills in coaching, mentoring, and teaching
Accreditation	<ul style="list-style-type: none"> – External unbiased assessment – Public recognition – Comparative database 	<ul style="list-style-type: none"> – Requires an environment to manage process, incurring more time to organize and more costs

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