Guidance on engaging volunteers to support the scale-up of male circumcision services

World Health Organization

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Abbreviations

AIDS	acquired immunodeficiency syndrome
AUA	American Urological Association
CSC	civil service commission
DHS	demographic and health survey
IVUmed	International Volunteers in Urology
Jhpiego	Johns Hopkins Program for International Education in Gynaecology and Obstetrics
MOH	ministry of health
MOHSW	ministry of health and social welfare
MOVE	models for optimizing volume and efficiency
NGO	nongovernmental organization
PSC	public service commission
PSI	Population Services International
QA	quality assurance
SEE	Surgical Eye Expeditions
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	voluntary counselling and testing
WHO	World Health Organization

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1. Purpose of the volunteer guide

This guide provides an overview of the Male Circumcision Volunteer Programme to assist in the provision of male circumcision services for HIV prevention. It is intended as a source of reference for policy-makers, programme managers, professional associations and volunteers wishing to participate in the programme.

2. Background

The 2008 UNAIDS global report on HIV/AIDS indicated that in 2007 there were 2.7 million new HIV infections. Of the estimated 33 million people living with HIV, 67% live in sub-Saharan Africa.[1] Reducing the number of new HIV infections is of the utmost urgency. The Millennium Development Goal target to reverse the HIV epidemic by 2015[2] calls for innovative efforts to ensure the use of all scientifically proven interventions in HIV prevention.

Conclusive evidence from three randomized controlled trials conducted in Kisumu (Kenya), Orange Farm (South Africa) and Rakai (Uganda) showed that male circumcision provided partial protection against HIV acquisition in men, reducing the risk by as much as 60%.[3,4,5] On the basis of these data and evidence from other research, including ecological and observational data showing the protective effect of male circumcision, WHO and UNAIDS in 2007 recommended adding male circumcision to the HIV prevention package in countries with high HIV prevalence and low male circumcision rates.[6] The recommendations state that male circumcision should be provided by well-trained, well-equipped competent health-care professionals and that services should meet the recommended quality standards. Furthermore, surgical services should be provided as part of a minimum package that includes:

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

The minimum package covers the need to ensure not only that personnel for performing the surgical procedures are available on site but also that there are other support staff, equipment and supplies.

Since the WHO/UNAIDS 2007 recommendations, 13 countries in sub-Saharan Africa (Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe) that were identified as priority countries for reducing new HIV infections, have expressed inter-

est in introducing male circumcision into their national HIV prevention strategies. Implementation and scale-up activities are at different stages in these countries.[7]

Joint efforts are being made by WHO/UNAIDS, ministries of health and other partners to identify conditions that will improve access to safe male circumcision services in accordance with countries' human resource capacities and infrastructures. General shortages of medical personnel in most countries have required novel approaches, including task-shifting and/or task-sharing. Task-shifting is described as the complete transfer of responsibility to another cadre of staff.[8] For male circumcision, this means shifting all aspects of the surgery from doctors to nurses or other non-physicians. Task-sharing, on the other hand, is the use of other health cadres to perform certain aspects of the task while the full responsibility rests on the surgeons. Thus, in male circumcision a surgeon performs the more complex aspects of the surgery, e.g. cutting and securing haemostasis, whereas a nurse stitches the surgical wound. In order for scale-up to be effective, other short-term solutions in conjunction with longer-term sustainable capacity-building efforts will aid the expansion of and access to male circumcision services.

In order to accommodate the demand appropriately in settings where human resources are limited, the use of volunteer surgical teams has the potential to strengthen capacity and improve access to male circumcision services. Drawing on the use of medical volunteer teams or programmes is not new in Africa. A number of health programmes have provided skilled personnel in needed areas, e.g. urological services through IVUmed, cataract surgery through SEE International and cleft palate repair through Smile Train.[9] For a detailed summary of these and other existing models of volunteer medical team programmes in developing countries, see Annex 1. These programmes have employed a combination of strategies, including short-term objectives such as enabling the provision of needed services and the long-term objectives of developing skills and capacity in the countries concerned.

3. Overview of the volunteer programme

The programme involves various partners who will interact at the global, country and volunteer levels. The aim is to coordinate all the interactions at each level and ensure the cohesion of efforts and activities.

3.1 Global-level preparations

At the global-level the coordinating body will take the lead, building a relationship with funding agencies, professional associations, technical support agencies, the ministries of health (MOHs) of the host countries and service delivery sites.

The professional associations will source, screen, recruit and provide input into the training of volunteers, continuously building a volunteer pool ready for deployment when required. The technical support agencies / NGOs will support training and assist the professional associations in developing and training volunteers. In other instances they will support the strengthening of sites.

A vital part of the global level preparation is the coordinating body and other partners' interaction with host country MOHs. MOH involvement will vary from country to country. However, the goal should always be to obtain maximum MOH participation. MOHs should provide the primary leadership role in guiding the programme in countries.

3.2 Country-level preparations

At the host country level, the MOH should conduct a needs assessment to guide the best use of volunteers. This can be done with the help of the coordinating body and other partners. Once an accurate assessment of needs and specific skills required is complete, a request can be made to the coordinating body and appropriate volunteers can be deployed to service delivery sites to assist with the provision of male circumcision services.

On identification of specific regions and sites requiring services, these sites will have to be adequately prepared to receive the volunteers. Site functionality assessments will have to be made to ensure the maximum productivity of volunteers when they are on site. This includes ensuring that sites have adequate equipment,

staff and supplies. Site preparation should also include demand generation and community mobilization before the arrival of the volunteers to guarantee good client flows through the site. Each site will have to be prepared to at least meet certain critical criteria of the WHO-recommended standards and criteria (Annex 2). These preparations can be done by the MOH with support from the coordinating body and technical agencies.

Site preparation will include safety precautions to ensure the well-being of volunteers. Logistics need to be arranged and plans made to provide appropriate accommodation, food, clean water, transportation and any other necessary support.

Once sites are identified and prepared, and formal requests are submitted from the MOH to the coordinating body for volunteers, an external assessment using a standardized checklist will be made by the coordinating body to confirm the site's readiness to host the volunteers.

As part of the in-country preparation, systems need to be implemented by the MOH to facilitate the registration of candidate volunteers in the quickest possible manner. The professional associations will need to do the preliminary screening of volunteers to confirm their qualifications and experience and determine their suitability for the programme.

3.3 Volunteer-level preparations

Volunteers will submit an expression of interest to participate in the programme to a participating professional body. The professional body will initiate the selection process by verifying the volunteers' qualifications and experience. If a volunteer qualifies, he or she will undergo programme-specific male circumcision training developed by the professional body in conjunction with specialized technical support agencies. Volunteers will need to ensure that they have adequate malpractice insurance as well as travel health insurance to cover them while abroad. The malpractice insurance can be provided in-country by the MOH or through a malpractice insurance scheme facilitated by the programme. Volunteers will be assisted by the coordinating body and the professional association to complete the paperwork required for visas, vaccinations and country-specific registration, and will then be eligible for deployment in accordance with site/country needs.

4. Objectives of the male circumcision volunteer programme

The main purpose of the volunteer programme is to support the expansion of access to safe male circumcision services of high quality in countries of sub-Saharan Africa facing human resource limitations. The overall goal is to contribute to the strengthening of service delivery systems for HIV prevention services.

The primary objectives of the programme are as follows.

1. Service delivery

To supply skilled health-care providers for male circumcision surgical services in areas with an inadequate supply of doctors and other key health-care personnel.

2. Site capacity-strengthening

To support the strengthening of existing sites to meet the WHO-recommended quality standards or to set up new sites for male circumcision service delivery. This will include the introduction of efficiency measures to improve surgical services as well as patient flow and care.

3. Training

To provide highly skilled experts to train and build the capacity of the local health care providers in the provision of male circumcision services and HIV prevention.

The focus of the volunteer programme may differ from country to country, depending on needs. Regardless of the focus, the programme will seek to strengthen local capacity for the provision of male circumcision services. Volunteer teams may also contribute by suggesting new health care approaches to improve male circumcision service delivery.

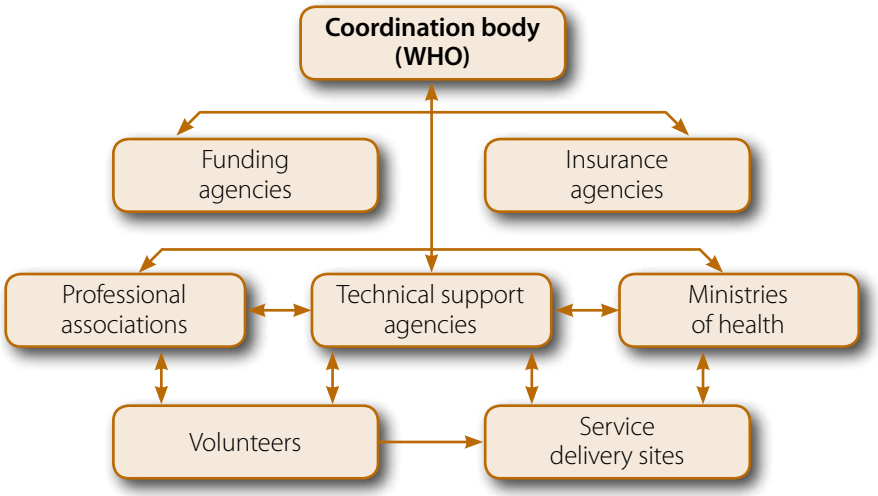
Whatever the primary objective of the volunteer teams may be, adequate and appropriate preparations need to be made on a number of levels to ensure the success of the programme. Clear goals and objectives of a particular mission will need to be established and agreed on before volunteers are deployed. These goals should be evaluated at the end of each mission.

The programme involves the following partners:

- the coordinating body;

- ministries of health;
- professional associations;
- technical support agencies;
- the volunteers;
- funding agencies;
- service delivery sites.

All the partners are interlinked and there is some overlap in roles and responsibilities. Efforts will be made to ensure that communication systems are developed and communications are free and open at all levels.



All the partners are interlinked and there is some overlap in roles and responsibilities. Efforts will be made to ensure that communication systems are developed and communications are free and open at all levels.

5. Major partners' roles and responsibilities

Key roles and responsibilities of the major partners in the volunteer programme are described below. They include the critical tasks, courses of action and preparations that need to be undertaken by each partner towards successful implementation of the programme.

5.1 The role of the coordinating body

The coordinating body will play a major role in the following activities:

- administration and general coordination of the programme;
- setting norms and standards;
- liaison with partners providing technical support;
- monitoring and evaluation.

5.1.1 Administration and general coordination of the programme

- The primary role of the coordinating body is to ensure successful coordination of partners and implementation of the programme.
- The coordinating body will establish background information on all countries and sites interested in participating in the programme and this will be made available in the Clearinghouse on Male Circumcision for HIV Prevention web site (www.malecircumcision.org).
- The coordinating body will assemble a volunteer programme working group consisting of all the key partners, which will meet periodically to report back on progress and obstacles and to share ideas about possible improvements.

5.1.2 Setting norms and standards

The fundamental role of the coordinating body is to provide overall strategic guidance by setting global norms and standards for the provision of safe male circumcision services of high quality. The coordinating body will ensure the implementation of WHO-recommended standards, guides, tools and materials.

- Policy and programme: programme planning, situation analysis, rights and gender, costing and impact assessment, monitoring and evaluation.
- Service provision: technical reference manual, training package, quality assurance, MOVE.
- Communications and advocacy: communication guide, information package.

These documents and guides are listed in Annex 3 and in the Clearinghouse on Male Circumcision for HIV Prevention website. The web site houses a resource database with key materials on research and up-to-date programming information on male circumcision for HIV prevention in participating countries.

To make the programme cost-effective, mission length should be agreed with the relevant partners. The recommendation for the minimum length of time of volunteer service is 3–4 weeks. Under specific request and review, shorter mission lengths may be considered. However, it is strongly recommended that mission lengths are extended as much as possible as this allows for better integration of volunteers into programmes and maximum benefit from the standpoints of both productivity and cost-effectiveness.

5.1.3 Liaison with partners

The coordinating body will liaise with all the key partners to ensure the smooth running of the programme.

The coordinating body and the ministry of health

- Definition of country objectives for the volunteers with clearly set goals and targets, e.g. the number of male circumcisions to be performed in a region by the volunteers in a set period of time.
- Compilation of a country-specific needs assessment and strategic plan.
- This will help to determine on a larger national or regional scale the number and placing of volunteers.
- Facilitating the finalization of memoranda of understanding and terms of reference with ministries of health implementing sites, specifically related to the use of volunteers in government facilities under the guidance of the programme.
- Clear definition and facilitation of registration processes, malpractice insurance and visa requirements for volunteers.

The coordinating body and professional associations

- Ensuring that suitable volunteers are identified for the programme. When professional associations are screening participants a number of guidelines should be followed to assess suitability for travel. The coordinating body will monitor and ensure that professional associations in volunteers' countries of origin follow correct screening criteria (see relevant criteria outlined below under the roles of professional association).
- Once the national and regional needs assessment is complete the coordinating body will undertake to communicate these needs to the professional associations responsible for the screening and recruitment of volunteers.
- The coordinating body will also work with the professional associations to collate documentation required for the registration and insurance of volunteers.

The coordinating body and funding agencies

- The coordinating body will promote the volunteer initiative and commit to ongoing engagement of funders to ensure adequate financial support and overall funding for the programme. This will include: volunteers' air fares from countries of origin/residence to host countries and per diem allowances which should cover accommodation, local living expenses (meals) in the country or area where volunteer work is being undertaken, and local transportation for the duration of the mission.
- The coordinating body will also negotiate with the MOH to gain commitment to cover a proportion of the in-country needs and expenses related to the programme.

The coordinating body and service delivery sites

The coordinating body, together with service delivery sites, will undertake site evaluation and assessment.

The coordinating body will perform a male circumcision site assessment, with the purpose of ensuring independent verification of site appropriateness and suitability to receive volunteers.

- Site suitability

  - Establishing whether the site needs extra manpower and expertise. A clear scope of needs in terms of training and improvement of local staff and clinicians would also be assessed. New and developing sites would be ideal targets for highly specialized trained volunteers to impart knowledge.
  - Personal protective safety on site, specifically in the event of a needle-stick injury or other high-risk exposures that may occur on duty. Sites would need adequate protocols and post-exposure prophylaxis supplies.
- Site functionality
  - In order to justify the deployment of a volunteer, volumes of surgery and demand would need to be high or have the potential to increase.
  - Sites must be functioning successfully, i.e. working equipment and sufficient supplies, adequate support staffing, and adequate client flow and male circumcision demand. Adherence and performance according to WHO QA standards will be an important aspect of this assessment.
- Quality assurance standards
  - The assessment will determine if the site meets the critical established WHO QA standards (see Annex 2).
- On-site support for volunteers
  - This would be assessed and take into account a key focal person as a base of referral and support for volunteers' needs, questions and concerns. Also considered would be the availability of support staff, including nurses, counsellors and housekeeping personnel.

The coordinating body will work with selected sites that do not meet all these standards and criteria in order to bridge gaps before the arrival of the volunteers.

5.1.4 Monitoring and evaluation

The coordinating body will establish indicators and undertake to monitor and evaluate progress of implementation of the programme.

5.2 The role of professional associations

Identified professional agencies will be responsible for the screening and recruitment of volunteers, host country orientation and training. The professional association will be responsible for advertising for qualified doctors. The association will establish a directory or database of interested doctors that provides an indication of the proposed dates and times the doctors are available to provide volunteer services.

The screening of volunteers must be done in accordance with established guidelines covering professional, health and personality screening.

5.2.1 Recruitment and selection

Professional screening criteria:

- Medical certification as a qualified medical doctor with a recognized university or government agency and a certificate of good standing or equivalent from the country in which the doctor is resident and currently practising.
- Adequate surgical skills competence and capabilities in the three recognized male circumcision methods.
- Certification or eligibility for certification in urology, general surgery or paediatric surgery by a well-respected national or regional professional society; or other practitioners with surgical experience and proven and verifiable surgical ability.
- Recommendation by two physician colleagues who are familiar with the applicant's standing and reputation in the applicant's current practice environment.
- Completion of a recognized training course on male circumcision for HIV prevention in sub-Saharan Africa.
- Applicants who do not fit these criteria can be eligible for special review by a recognized professional association and the coordinating body.

Health requirements:

- Volunteers must undergo a general examination to ensure that they are of sound mind and body before undertaking what may, at times, be both a strenuous physical and mental challenge in resource-limited countries and regions. Volunteers will be required to submit a letter from their personal physician stat-

ing that the volunteer is medically cleared for international travel and for a potential physical and mental challenge.

Personality screening:

- Character assessment and personality evaluation:
  - to ensure that selected volunteers are culturally and politically sensitive to host countries' conditions and able to work in a multicultural environment.

5.2.2 Training

The professional association and/or an established international NGO with experience of working in the field of male circumcision for HIV prevention will be responsible for adapting, developing and administering a training programme for volunteers. The training programme should cover:

- the evidence and WHO/UNAIDS recommendations for male circumcision for HIV prevention;
- the WHO minimum package of services for male circumcision;
- the WHO-recommended male circumcision surgical methods as described in the WHO/UNAIDS/Jhpiego *Manual for male circumcision under local anaesthesia*;
- WHO-recommended male circumcision QA standards and criteria;
- familiarization with the principles of models for optimizing volume and efficiency of male circumcision services.

5.2.3 Orientation for the specific host country

The professional association will work with the coordinating body and established international NGOs to arrange a country-specific orientation programme for all volunteers before they leave for the country concerned. Orientation materials should be provided to the candidates as indicated in Annex 5. The orientation programme will cover the following essential components:

- familiarization with the host country's health care and service delivery system;
- The epidemiology of HIV and other major disease patterns and trends;
- issues related to practising in the country, e.g. relevant policies and practices;

- country-specific information, i.e. the social, economic, cultural and political context.

5.2.4 Professional registration of volunteers

This will be done in collaboration with the coordinating body and the host country's ministry of health.

- Volunteers will need to be registered in the host country before they can provide services, as summarized below. Registration will involve various steps and stages and should therefore be initiated as soon as the volunteers have been screened and selected and have undergone the necessary training, in order to prevent delays in deployment. The MOH should facilitate this process and provide guidance and assistance to enable the speedy registration of volunteers. All the required documentation should be verified by the professional association before being presented to the MOH.
- Although there are differences between countries in the registration processes and documentation requirements, the following are more or less standard.

1. Registration with the host country's health professions / medical council. Documents for submission usually include the following (see also registration processes in Annex 4):

- certified copies of medical degree certificates;
- certificate or letter of good standing from health professions council in the home country or the country of current practice/residence;
- letters of recommendation and references;
- curriculum vitae;
- passport-size photographs.

2. Malpractice insurance coverage.

5.3 The role of technical support and implementing agencies

Various agencies provide technical support to countries in site assessment and strengthening, training, orientation, logistical support, male circumcision communication and male circumcision service implementation. These agencies will also provide support for the volunteer programme.

The technical support agencies will work with the coordinating body and the professional associations to provide support in the following areas, as previously outlined.

- Screening and recruitment of volunteers.
- Training and orientation.
- Logistical support to facilitate registration, visa applications and in-country support for volunteers during their mission.
- Site assessments and site strengthening to meet the critical WHO-recommended quality standards.
- Community mobilization to generate demand for male circumcision services in communities where volunteers are deployed. Agencies with experience in social mobilization and communication should use these skills in generating demand for male circumcision services where volunteers are deployed.

5.4 The role of the ministry of health

- At the country level the MOH should take an active leadership and coordinating role. All activities in the health sector will have to be approved by the host country's MOH.
- The MOH, together with the coordinating body, should perform a needs assessment and strategic review of the male circumcision services in the host country. The following parameters should be assessed to determine sites and areas in most need of volunteers.
  - Areas of high HIV prevalence and low male circumcision rate are key targets for sites and volunteers. These are the sites modelled to have greatest impact when using male circumcision as a preventive health care measure.

  - Waiting lists for male circumcision: long waiting lists indicate a need for extra manpower.
  - Identified sites should meet the WHO-recommended male circumcision QA standards.
  - Clinical staff qualifications, skill levels and experience (the lower these parameters are the more need there is for training focused volunteers to improve skill levels and staff infrastructure).
- To facilitate the provision of male circumcision services in an HIV prevention context and the coordination of activities, countries are encouraged to have an MOH volunteer focal person who will be responsible for overseeing the programme; this would usually be the male circumcision focal person.
- The MOH in the host country should assist and facilitate easy registration of volunteers to practise in the specified country. The appointed MOH volunteer coordinator should take the lead in assisting volunteers and other involved partners in this process.
- MOHs should also actively support community mobilization efforts, social marketing and the generation of demand for male circumcision.

It is vital that service delivery sites and MOHs monitor and evaluate the impact of using volunteers. This should involve:

- setting clear goals and objectives for the mission and reviewing them at the end of each mission;
- making efforts to review the overall effect of the programme on a quarterly basis;
- all volunteer missions working towards contributing to national targets;
- the MOH focal person maintaining contact with the coordinating body and former volunteers who have participated in previous missions in order to solicit feedback.

5.5 The role of service delivery sites

The roles and preparatory activities performed by the sites should be discussed and planned in conjunction with the host country's MOH volunteer coordinator and the coordinating body. At the clinic site the following activities and preparations are required.

5.5.1 Site assessment and preparation

A thorough review of site functionality should be done and structured efforts should be made to improve the site. This will include the following.

- Ensuring that adequate equipment and consumables are available to provide male circumcision services.
- The site assessment and suitability assessment includes assessing site capabilities to perform surgical procedures safely. For this purpose, sites need an adequate stock of supplies and equipment. The equipment and supplies list should include most of the items listed in the equipment and supplies modules of the Volunteer Programme Facility Readiness Checklist.
- Ensuring that all sites offering male circumcision surgery do so in conjunction with the WHO-recommended minimum package of HIV prevention services. To provide these services there needs to be adequate support staff at volunteer sites.
- Adequate support staff for surgeons to carry out the minimum package services and to support the surgical procedures, including VCT counsellors, laboratory technicians, nurses / clinical officers to diagnose, assess and treat STIs as well as assist or perform male circumcision procedures.
- Establishing monitoring systems for postoperative care, follow-up and counselling. The clinic facility needs to have provisions for ongoing after- care in the event of complications that present after the volunteer responsible for the surgery has left the country.
- Sites need to plan for optimum volunteer safety by ensuring the provision of on-site postexposure prophylaxis in the event of a high-risk exposure.

5.5.2 Quality assurance standards

The WHO Male Circumcision Services Quality Assessment Toolkit was developed to aid clinic sites and implementing facilities in providing male circumcision services of high quality. Sites should use the toolkit and the Facility Readiness Checklist to meet the critical criteria (see Annex 2).

5.5.3 Volunteer-hosting preparations

The in-country partners are required to provide volunteers with comprehensive orientation on arrival. This should include the following.

- An orientation to the surrounding area, including the locations of important health-care facilities, other emergency facilities, e.g. police stations, food and supply stores, local recreational areas or activities. It should include a review of safe areas to visit and be specific on dangerous or high-crime areas to be avoided.
- An orientation and overview to the project or site where the volunteer will be based. This should include the general working procedures and protocols, advice about clients who present for male circumcision, local cultural considerations and introductions to all staff on the site.

In collaboration and in accordance with coordinating body guidelines, host country preparations need to ensure adequate accommodation and living conditions for volunteers, including:

- adequate security;
- clean towels and linen on a regular basis;
- functioning sink, toilet and shower facilities;
- depending on the country, mosquito nets and/or window screens;
- guidance on internet and mobile phone access;
- access to safe drinking-water and reliable food sources.

Local transport for volunteers should be arranged and provided. Volunteers should have adequate access to safe transport. This may be a local transport service but if this is not deemed safe or easily accessible it is suggested that transport be provided by the site or the MOH.

Volunteers should be made to feel welcome and included in after-hours activities. It is recommended that partner site volunteer coordinators draw up a programme of after-hours recreational activities that volunteers could take part in. Where possible, volunteers should be hosted and entertained by local site staff.

5.5.4 Volunteer scheduling

The programme and work schedule should be arranged by the site before the volunteers arrive. This should cover client bookings, theatre schedules and indicate staff available to work with the volunteers. Sites should keep track of all activities carried out, including a record of all male circumcisions done by each volunteer team, debriefing reports, etc.

5.5.5 Community mobilization

This ensures support and demand for the services and programme.

- Community buy-in and support is essential to the success of the programme. Existing clinic/community health committees should be well briefed on the male circumcision programme and used to mobilize the community to support the programme. Community advisory boards can be established where they do not exist. These committees could serve as a platform for community suggestions and concerns, and feedback should be encouraged.
- Every deployment of volunteers should be preceded by campaigns and community mobilization to heighten awareness of services. The recruitment, screening and scheduling of adolescents and men for circumcision should be arranged before the arrival of volunteers.

Sites should have an accurate monitoring and record-keeping system to evaluate the use of volunteers. This information should be submitted to the ministry of health.

5.6 The role of volunteers

The programme requires that volunteers have gone through the necessary formalities before they can practise in any country under the scheme. Enrolment and participation in the volunteer programme has various steps, including the submission of an expression of interest, training, registration and orientation.

Step 1: Initiating entry to the volunteer register

Interested volunteers are encouraged and required to submit the following documentation to the professional association or coordinating body as the first step for enrolment into the scheme.

Volunteer expression of interest

1. Completed application form indicating dates of availability.
2. Certified copies of medical degree, diplomas and certificates.
3. Proof of current registration and/or good standing with a recognized medical council in country of residence.
4. Proof of malpractice insurance in the country of practice.
5. Curriculum vitae.
6. Letters of recommendation.

A list of countries that have indicated a need for volunteer skills can be obtained from the coordinating body or found on the Clearinghouse on Male Circumcision for HIV Prevention web site (www.malecircumcision.org).

Step 2: Document verification and selection process

The professional body will verify all submitted documentation and the volunteer will go through the selection process as described under `The role of professional associations'.

Step 3: Male circumcision training course

Volunteers who have completed Steps 1 and 2 and have approvals in place will be required to undergo a specified training course on male circumcision for HIV prevention, which will prepare them for the mission.

Step 4: Orientation

Following the completion of training, volunteers will have to undergo orientation to prepare them for working in Africa and in low-resource settings. This will include country-specific familiarization, providing them with background information on their country of deployment, including information on the health status indicators, culture, climate, economy and other issues of significance. See Annex 5 for a list of some relevant orientation material. Volunteers are required to familiarize themselves with the orientation materials provided by the coordinating body and professional associations. Further information can be accessed on the Clearinghouse on Male Circumcision for HIV Prevention web site (www.malecircumcision.org).

Step 5: Registration and insurance coverage in host country

Registration in the host country requires the following documentation to be submitted to the host country through the coordinating body.

1. Completed application forms.
2. Certified or notarized copies of medical degree, diplomas and certificates.
3. Proof of current registration and good standing with a recognized medical council in the country of residence.
4. Passport-size photographs.
5. Proof of malpractice insurance in the country of practice.

After confirmation of registration from the host country the coordinating body and the professional association will assist the volunteer to obtain malpractice insurance to cover practice in the host country.

Step 6: Visa application

Visa requirements differ from country to country but volunteers will generally need to include the following in their visa submission:

- completed visa form;
- letter of acceptance into the volunteer programme;
- invitation letter from the host country MOH or implementing site confirming dates and duration of deployment;
- visa fee (this may be reimbursed by the volunteer programme);
- passport with at least six months validity from the proposed date of the visit.

Step 7: Deployment

Before departure to the host country, volunteers need to ensure that they have:

- a valid passport;
- a current visa for the country of deployment;
- confirmation letters of appointment, accommodation and working site;
- travel health insurance;
- evacuation insurance;
- vaccination certificates;

- country of origin practising medical licence and approved registration to practise in the host country;
- medical kit with contents as outlined in the medical kit information pack;
- malpractice insurance coverage for the host country;
- summary of duties to be performed and overview of the programme;
- provided contact details of next of kin to the volunteer programme coordinator.

Step 8: Service delivery

Once the volunteers have been deployed to the assigned sites, they should carry out the services outlined in their terms of reference to the best of their ability. Good medical practice must be maintained, with volunteers adhering to the accepted ethical and medical service conduct prescribed in the Hippocratic oath.

Voluntary service contracts will be required, outlining the terms and conditions of service. Other relevant specifications will also be detailed in the contract. It is recommended that volunteers be encouraged not to routinely perform surgeries not related to the scope and objectives of the mission. However, if an emergency arises and volunteers have the required expertise they may assist at their discretion.

Volunteers will be required to compile a report for the MOH, the professional association and the coordinating body on their experiences on site and in the country, including feedback on the achievement of objectives and goals outlined before the mission began.

Annex 1:
Summary of surgical volunteer programmes

Organization	Purpose and objectives	Surgical services provided	Countries served	Type of volunteers	Length of expedition	Remuneration
IVU Med	IVUmed is committed to making quality urological care available to people worldwide. IVUmed provides medical and surgical education to physicians and nurses and treatment to thousands of suffering children and adults. To encourage the self-reliance of partner communities abroad IVUmed introduces new and appropriate surgical practices and technology which can be sustained in the local communities.	General urology, women's health, neglected tropical diseases e.g. lymphatic filiariasis.	Nearly 30 countries in Africa, Asia and the America's.	Urologists, anaesthesiologists, paediatriicians, radiologists, primary care physicians and nurses.	Variable	Transport: Volunteer/ Organization. Housing: Organization. Food: Organization.

Organization	Purpose and objectives	Surgical services provided	Countries served	Type of volunteers	Length of expedition	Remuneration
Interplast	Interplast's programmes provide corrective surgery and related care for the world's poor. As well as healing bodies, Interplast helps children to gain access to the most basic of needs, e.g. attending school and gaining a livelihood.	Plastic surgery for burns, cleft palate.	Africa: Ethiopia, Ghana, Mali, Zambia. Asia: Bangladesh, China, India, Myanmar, Nepal, Sri Lanka, Viet Nam. Latin America: Bolivia, Brazil, Ecuador, Nicaragua, Peru.	These surgical teams include volunteer plastic surgeons, anaesthesiologists, paediatricians, operating room and recovery room nurses, coordinator/ translators who provide general patient, family and team support and perform clerical work. Some teams also include nurse educators, hand therapists and physical therapists. Teams are of 10 to 15 members.	Trips generally last 2 weeks, and teams typically perform around 75 surgeries on each trip.	Transport: organization. Housing: organization. Food: volunteer. Volunteer pays US$ 325 towards travel expenses.
SEE International	The primary objective is the the restoration of sight to disadvantaged blind individuals worldwide.	Sight-restoring surgery, cataract surgery.	Ethiopia, Ghana, India, Mexico, Namibia, Nigeria, Uganda, Tanzania, Zimbabwe.	Licensed ophthalmologists, technicians, nurses.	Minimum: 3 to 4 days. Maximum: 2 weeks.	Transport: organization (local host). Doctors pay their own expenses. Local host doctors provide housing and food in 99% of the cases.

Organization	Purpose and objectives	Surgical services provided	Countries served	Type of volunteers	Length of expedition	Remuneration
The Smile Train	Provides free cleft surgery for millions of poor children in developing countries. Provides free cleft-related training for doctors and medical professionals.	Cleft palate surgery.	Cameroon, Congo, Côte d'Ivoire, Egypt, Ethiopia, Ghana, Kenya, Malawi, Mali, Mozambique, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Zambia.	Licensed medical and nursing staff.	Minimum: 7 to 10 days. Maximum: 1 year.	Stipend of US$ 2500 towards travel.
Operation Smile	Provides surgical treatment to many children who have no access to care. Provides training to in-country professionals in order to foster long-term self-sufficiency.	Cleft palate surgery.	Egypt, Ethiopia, Kenya, Morocco, South Africa.	Licensed and have to be credentialed by Operation Smile. Opportunities for fourth-year medical students who have been involved with Operation Smile.	Minimum: 1 to 3 weeks.	Transport: organization. Housing: organization. Food: volunteer. Volunteer pays a team fee of US$ 350.
Médecins sans Frontières	The objectives are to rebuild health structures to acceptable levels and provide training to local personnel.	General surgery, obstetrics, trauma.	Algeria, Angola, Burkina Faso, Burundi, Central African Republic, Chad, Côte d'Ivoire, Ethiopia, Guinea, Kenya, Lesotho, Liberia, Malawi, Mali, Mozambique, Niger, Somalia, South Africa, Tanzania, Uganda, Zambia, Zimbabwe.	Various skills and professionals with at least two years of experience in area of specialization. Surgeons, anaesthesiologists, nurses.	Minimum: 6 months Maximum: career.	Transport: organization. Housing: organization. Food: organization.

Organization	Purpose and objectives	Surgical services provided	Countries served	Type of volunteers	Length of expedition	Remuneration
International Committee of the Red Cross	Provides medical assistance and protection to the wounded and sick.	Orthopaedic, cataract and plastic surgery.	East, West, Central and sub-Saharan Africa.	Doctors, surgeons and nurses. Skills and training.	Depends on availability and needs of the site.	Varied remuneration depending on skills and tasks.
Helen Keller International	Reduces the suffering of those without access to needed vision care and needed health care.	Cataract surgery.	Burkina Faso, Côte d'Ivoire, Mali, Morocco, Niger, Tanzania, Senegal, Zimbabwe.	Licensed ophthalmologists.	Depends on availability and needs of the site.	
Physicians for Peace Foundation	Provides clinical care and medical education and training to developing countries with unmet needs and scarce resources.	Cataract surgery, cleft palate surgery.	Various countries in Africa, e.g. Algeria, Angola, Botswana, Burkina Faso, Burundi, Chad, Congo, Ghana, Kenya, Nigeria.	Licensed professionals (surgeons, nurses); tasks include teaching and education of local practitioners.	Minimum: 4 days. Maximum: 18 days.	Transport: organization. Housing: organization. Food: organization.
Operation Rainbow	Provides free plastic and orthopaedic surgery to children who do not have access to care in the United States and developing countries. Medical teams also train local health-care workers.	Reconstructive and orthopaedic surgery.	Brazil, El Salvador, Guatemala, Mexico, Philippines, Venezuela, Viet Nam.		Minimum: 10 days. Maximum: 3 weeks.	Transport: volunteer. Housing: volunteer. Food: volunteer.

Organization	Purpose and objectives	Surgical services provided	Countries served	Type of volunteers	Length of expedition	Remuneration
M.E.D.I.C.O	The main objective is the provision of medical, eye and dental services to remote areas of Central America where there is no access to basic health care. Medical professionals provide training to local health professionals. The purpose is to surgically correct deformities in developing countries where doctors and funds for these corrections are not available. Helps to train local health professionals.	Eye and dental surgery.	Honduras, Mexico, Nicaragua, Panama.	Takes licensed medical professionals.	Minimum: 1 week. Maximum: 1 week plus.	Transport: volunteer. Housing: volunteer. Food: volunteer.
Esperança	Serves the poor whose surgical needs would otherwise go untreated. Provides educational training to locals.	Gynaecological, orthopaedic, ophthalmic, urological, plastic/ reconstructive surgery.	Bolivia.	Licensed surgeons of all specialties.	Minimum: 1 week. Maximum: 2 weeks.	Transport: volunteer. Housing: organization. Food: organization.

Organization	Purpose and objectives	Surgical services provided	Countries served	Type of volunteers	Length of expedition	Remuneration
Healing the Children	Secures and makes available free medical treatment for needy children from the United States and other countries.	General surgery, nurses.	Dominica, Honduras, Kenya, Morocco, Panama, Thailand.	Volunteers who are licensed and in good standing with their licensing authorities.	Minimum: 7 days. Maximum: 10days.	Transport: volunteer. Housing: organization. Food: organization.
Catholic Medical Mission Board	Provides general surgery to people in need around the world and ensures that health care of good quality is available to all.	General surgery.	Kenya, Malawi, Nigeria, South Africa, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe.	Surgeons and nurses.	Minimum : 2 to 4 weeks. Maximum: 2 years or longer.	Transport: organization (long term), volunteer (short term). Housing: organization. Food: organization. Volunteers of more than 1 year receive a stipend.

Annex 2: Male circumcision standards and critical criteria

All standards and criteria in the WHO Male Circumcision QA Toolkit need to be reviewed and sites should strive to meet all the standards. However, not all criteria need to be met for the site to receive volunteers. Only the 'critical criteria' outlined below are essential to be met for sites to host volunteers.

The critical criteria are in bold and denoted with an asterisk (*).

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

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 quality systems for continuously improving the quality and safety of services.

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

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.

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.

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 A periodic assessment of staff competences is conducted.

4.3 Ongoing in-service education and training are provided to assist staff to fulfil their duties.

(This standard will be met by volunteers building the capacity of staff and therefore criteria are not considered 'critical' to be met before volunteers arrive.)

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

Criteria

***5.1 Information is provided to clients on male circumcision, sexually transmitted infections and HIV prevention.**

5.2 Appropriate information and educational materials are provided to reinforce information.

***5.3 Informed consent is obtained from clients.**

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

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.

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.

(This standard will be met by volunteers building the capacity of staff and therefore criteria are not considered 'critical' to be met before volunteers arrive.)

Standard 8. Infection prevention and control measures are practised.

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.

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.

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.

Annex 3: Documents and guides on male circumcision for HIV prevention

The following documents and materials can be accessed from the Clearinghouse on Male Circumcision for HIV Prevention web site (www.malecircumcision.org):

Information/advocacy documents

1. Male circumcision information package
2. Male circumcision: Africa's unprecedented opportunity
3. Male circumcision: Global trends and determinants of prevalence, safety and acceptability
4. Progress in male circumcision scale-up: Country implementation update

Guidance documents

1. New data on male circumcision and HIV prevention: Policy and programme implications
2. Strategic orientations for scaling up male circumcision for HIV prevention in sub-Saharan Africa
3. Safe, voluntary, informed male circumcision and comprehensive HIV prevention programming: Guidance for decision-makers on human rights, ethical and legal considerations
4. Male circumcision quality assurance: A guide to enhancing the safety and quality of services
5. Male circumcision and HIV prevention in eastern and southern Africa: communications guidance
6. Operational guidance for scaling up male circumcision services for HIV prevention

Tools

1. Situation analysis toolkit
2. WHO/UNAIDS/Jhpiego Surgical manual for male circumcision under local anaesthesia
3. Male circumcision training package
4. Male circumcision services quality assessment toolkit
5. Male circumcision decision-makers' programme planning tool
6. Male circumcision monitoring and evaluation toolkit

Reports

1. Strategies and approaches for male circumcision programming. Geneva: WHO meeting report, 5–6 December 2006
2. Male circumcision and HIV prevention: Operations research implications. Report of an international consultation, 21–22 June 2007.

Annex 4: General orientation materials

Searching for specific country: http://www.afro.who.int/home/countries/fact_sheets/ or http://www.cia.gov/library/publications/the-world-factbook/ for country profiles.

Other relevant material:

1. Ellis C. *Communicating with the African patient*. KwaZulu Natal: University of KwaZulu Natal Press; 2004.
2. Country-specific essential drugs list.
3. Gibbon CJ. *South Africa medicines formulary*. 8th edition. Cape Town: Health and Medical Publishing Group of the South African Medical Association; 2008.
4. *HIV 911: HIV-related services directory (Series 2).* 2009.
5. Pudfin D. *Standard treatment guidelines and essential drugs list*. Pretoria: The National Department of Health; 2006.

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1. UNAIDS. *Report on the global AIDS epidemic*. 2008
2. *End Poverty Millennium Development Goals 2015 Make it happen*. High-level event on the Millennium Development Goals; United Nations Headquarters, New York, 25 September 2008. http://www.un.org/millenniumgoals
3. Auvert B, et al. Randomized controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. *PloS Med* 2005;2(11):e298.
4. Gray R, et al. Male circumcision for HIV prevention in Rakai, Uganda. A randomized trial. *Lancet Infect Dis* 2007;396:657-666.
5. Bailey R, et al. Male circumcision for young men in Kisumu, Kenya. A randomized controlled trial. *Lancet Infect Dis* 2007;396:643-656.
6. WHO/UNAIDS. *New data on male circumcision and HIV prevention: policy and programme implications*. Montreux meeting, 2007.
7. *Progress in male circumcision scale-up: Country implementation update*. December 2009. http://www.malecircumcision.org/documents/Country
8. http://www.malecircumcision.org/publications/documents/MC_MOVE.pdf
9. http://www.imva.org/Pages/orgdb/wblstfrm.htm

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