Models for Optimizing the Volume and Efficiency of MC Services

MC MOVE

WHO, PEPFAR
Outline

- Background and rationale
- Outline of document
- Next steps
- Operations Research
Modelling studies indicate that if MC is scaled up so full coverage is achieved over 10 years, 2 million new HIV infections and approximately 300,000 deaths could be averted.

Even more substantial reductions in HIV incidence could be achieved if male circumcision were provided with other effective HIV prevention interventions.

An estimated 30 million HIV-negative uncircumcised adolescents and adult men in Africa.

Male circumcision scale up will require a large number of additional health providers.
Rationale

- Existing service delivery models in different countries allow for one surgeon to do a maximum of 8 - 10 male circumcisions within one day.

- Health systems in developing countries are weak, and there is a critical shortage of skilled health professionals.

- Therefore it is necessary to rationalize the use and time of available, highly qualified health personnel.

- Appropriately trained non-physician providers can safely conduct procedures, such as caesarean sections, mini-laparotomies, non-scalpel vasectomy, repair of simple obstetric fistula, and manual vacuum aspiration.
Rationale

- Appropriately trained non-physician providers can safely conduct procedures, such as caesarean sections, mini-laparotomies, non-scalpel vasectomy, repair of simple obstetric fistula, and manual vacuum aspiration.

- In Kenya clinical officers were trained in the techniques of adult male circumcision.

- WHO recommends that countries should identify non-physician providers who can be trained to perform MC.
Task Shifting and Task Sharing

- Task shifting is the complete transfer of responsibility. May be as straightforward as using clinical officers or nurses to perform all aspects of male circumcision surgery.

- Task sharing the use of lesser trained cadres to perform particular steps in the MC surgery.

- The 'surgeon' or specified trained provider retains ultimate responsibility in task sharing.

- Task sharing and shifting risks are mitigated with highly experienced provider maintaining strong supervision and mentoring.

- In both providers maintain specialization through repetitive performance.
MC MOVE  Document Outline

- Background
- Task shifting
- Clinical Techniques
  - Surgical methods
  - Haemostasis / electrocautery
MC MOVE  Document Outline

- Optimizing the efficiency of staff
  - Staff skills
  - Staff time
- Optimizing the use of facility space
  - Facility design and layout
  - Staff ratios
  - Patient flow
  - Patient scheduling
MC MOVE Document Outline

- Supply Chain Management
  - Surgical kits
  - Commodities and supplies

- Cost Efficiencies

- Quality Assurance
  - Clinical protocols and guidelines
  - Quality assurance service standards
Research Issues

- MC MOVE focuses on the Surgery
- Pilot MOVE models in various sites
  - Staff time
  - Staff ratios
  - Staff combinations
  - Use of different methods
- Safety and efficiency of non-physician providers
- Use of diathermy
- Use of MC kits
Next Steps

- Revise MOVE document
  - Quality assessment
  - More information on SOPs, outcomes monitoring
  - Incorporate Orange Farm Case Study
  - Expand to include other elements of the minimum package
- Devise M&E plan
- Outline OR
- Pilot in different sites
Next Steps

Keep MOVE MOVING

Thank you!