Models for **O**ptimizing the **V**olume and **E**fficiency of MC Services

MC MOVE

WHO, PEPFAR

Outline

- Background and rationale
- Outline of document
- Next steps
- Operations Research

Background

- 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 maintaning 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!