

3. Service Site Preparation

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Useful Tools	Appendix 2: VMMC Service Site Preparation Planning Template Figure 4: VMMC Client Flow Diagram
Useful International Guidance Documents	3 Supply Chain Management System (SCMS) E-catalog including all Male Circumcision Kit Options

Objective(s): To prepare the site so it is ready to provide VMMC services that meet the minimum standards, and services can be launched once the staff training is completed

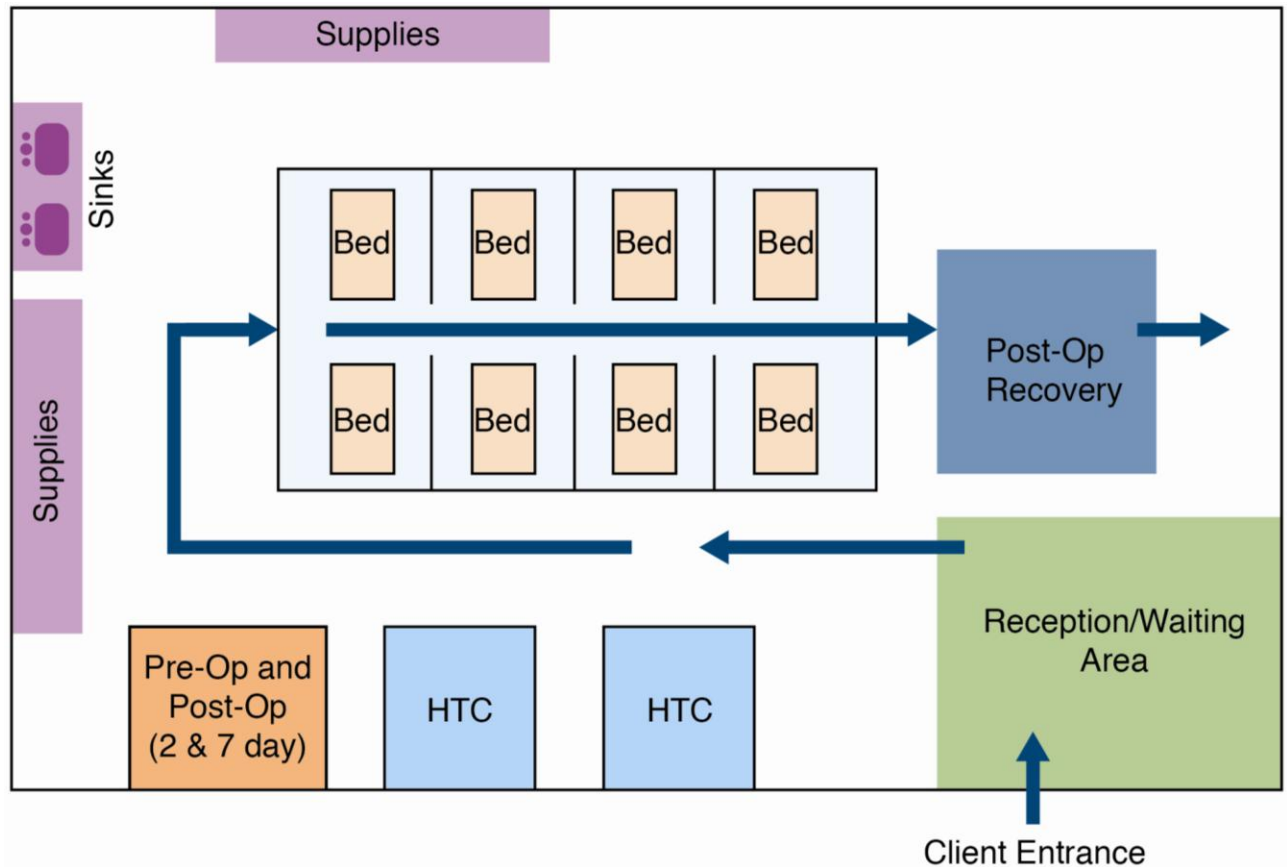
Description: It is essential that a site’s facilities, equipment, and commodities (see GUIDANCE DOCUMENT 3) are ready to provide VMMC services BEFORE staff are trained to provide VMMC services. Training is most effective when the learned skills are put to use immediately after training. Staff should finish their training, and then be transitioned into service delivery without delay. Starting services before a site is fully operational runs the risk of compromising the quality of services provided and creating potential bottlenecks, with imbalances of supply and demand for VMMC services. Based on the site strengthening plan developed collaboratively during site planning in Section 2 above, all the necessary activities should be carried out and completed prior to scheduling training and launching services. Various activities may be required, such as facility repairs or reorganization, procurement of equipment and supplies, shifting of staff rotations and duties or hiring additional dedicated staff, and specific training (e.g., training in infection prevention). All the parties involved should report on their responsibilities, and one qualified individual (often the site manager) should be charged with verifying that all the necessary actions are completed and that the site is ready to start providing VMMC services (see Appendix 2).

The overarching goal of site preparation and design is to ensure efficient client flow. Client flow should be unidirectional and allow clients to flow—from education and HTC to discharge—with ease (see Figure 4). With good planning, existing space can often be modified—with little infrastructural change—to maximize utilization of space and improve client flow.

Figure 4: VMMC Client Flow Diagram

A possible large fixed clinic site configuration that optimizes client flow

Note the client flow is unidirectional.



Tips for Organizing Facility Space for VMMC services

- Client flow should be unidirectional.
- Recovery space should accommodate more clients than surgical space. Because recovery time can be longer than procedure time, bottlenecks can occur if recovery space is inadequate.
- If space permits, client follow-up reviews should be conducted in an area that is separate from surgical areas. Separating the two areas will simplify client flow and reduce stress to staff.

Case Study—Site Preparation for Tanzania’s Lake Victoria Islands

Tanzania’s VMMC activities were expanded into the Lake Victoria Islands of Kagera region, where HIV prevalence was estimated to be 10–20% and male circumcision prevalence was estimated at less than 38% in 2010. The VMMC campaign targets about 20 inhabited islands, scattered in Muleba District, that have a highly mobile male population of approximately 25,000.

These hard-to-reach locations pose significant logistical challenges for providing VMMC outreach services, because locally made wooden boats with outboard engines are the primary means of transport. These islands have no electricity and require three to nine hours of travel time from the mainland. Health care facilities are limited on the islands because only two faith-based primary health facilities serve all 20 islands.

These islands are primarily inhabited by fishermen, though most fishermen maintain permanent homes on the mainland. The fishing business is lucrative, and many businessmen control significant economic resources on the islands, which likely contribute to the reported high availability of commercial sex on the islands. The remoteness of these islands has also been a substantial barrier to providing government services that meet the standards provided on the mainland. Local island leaders play a dominant role in providing social cohesion, basic services, and security to island residents.

Therefore, an essential first step to providing VMMC in these locations is sensitizing local leaders so that they will accept “outsiders” on the islands and facilitate the recruitment of islanders for services, logistics, and security. Preliminary visits were made to selected islands, during which the local government leaders, fish lords, and other influential people were sensitized to VMMC. These visits were followed by community sensitization meetings that aimed to engage the community in relaying VMMC promotional messages. Local leaders helped to facilitate these meetings and were active participants in promoting VMMC services to the islands’ residents.

Some islands could provide a dispensary (clinic) or other suitable physical structure that could be converted into a fully equipped VMMC site during the campaign, while other islands had no available infrastructure. Because electricity is not available on any of the islands, solar panel systems for lighting and a generator for autoclaving were brought from the mainland to support VMMC services. All other materials for the campaign—including examination beds, reusable surgical kits, all consumables and supplies for the entire campaign, information, education, and communication (IEC) materials, two autoclave machine,; and two 500-liter plastic water reserving tanks—were ferried from the mainland prior to service provision. PEPFAR provided two tents, which were fabricated to serve as a VMMC mobile clinic. Community members provided chlorine-treated water from the lake for daily non-drinking use at the clinic. In collaboration with local government authorities, an area at a safe distance from community neighborhoods was allocated where medical waste could be incinerated. For the duration of the campaign, experienced VMMC providers from hospitals on the mainland camped in the islands’ guest houses.



Setting up the VMMC mobile clinic



VMMC mobile clinic

Between October 2010 and November 2011, five VMMC campaigns were completed on these islands, during which 3,995 men received VMMC services. The AE rate was minimal (0.5%). This model served as a platform to enable the introduction of other HIV services including prevention of mother-to-child transmission (PMTCT), care, and treatment.